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☞ Details: Audit Report 06-1 and Report 06-2, Milwaukee County Child Welfare, Department of Health and Family Services

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (July 2012)

Record of Committee Proceedings

Joint Legislative Audit Committee

Audit Report 06-1 and Report 06-2, (approximately 11:00 a.m.)
Milwaukee County Child Welfare, Department of Health and Family Services
(Public testimony will be received.)

March 14, 2006 **PUBLIC HEARING HELD**

Present:	(7)	Senators Roessler, Miller and Lassa; Representatives Jeskewitz, Kaufert, Kerkman and Cullen.
Absent:	(3)	Senators Cowles and S. Fitzgerald; Representative Travis.

Appearances For
- Pauline Crump, Milwaukee — Foster Parent

Appearances Against
- None.

Appearances for Information Only
- Janice Mueller, Madison — State Auditor, Legislative Audit Bureau
- Paul Stuiber, Madison — Legislative Audit Bureau
- Helene Nelson, Madison — Secretary, Department of Health and Family Services
- Burnie Bridge, Madison — Department of Health and Family Services
- Denise Revels Robinson, Milwaukee — Bureau of Milwaukee Child Welfare
- Andy Reitz, Washington DC — Child Welfare League of America
- Steve McMurtry, Milwaukee — University of Madison-Milwaukee
- Alberta Darling, River Hills — Senator, Wisconsin State Senate
- Jess McDonald, Springfield, IL — Child Welfare Associates
- David Larson, Milwaukee — CEO, Lutheran Social Services
- Denise Pilz, Milwaukee — Lutheran Social Services
- Linda Davis, Mequon — Milwaukee Partnership Council
- Archie Ivy, Milwaukee — Reverend; Council Chairperson, Milwaukee Partnership Council

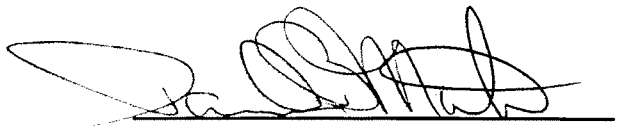
- Susan Conwell, Milwaukee — Kids Matter, Inc.
- Hugo Cardova, Milwaukee — President & CEO, La Causa
- Bill James, Milwaukee — La Causa
- Michelle Bryant, Milwaukee
- Kenneth Munson, Milwaukee — Children's Service Society of Wisconsin
- Mark Lyday, Milwaukee — Children's Hospital

Registrations For

- None.

Registrations Against

- None.



Pam Matthews
Committee Clerk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WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

For Immediate Release — February 8, 2006

For More Information Contact:

Representative Suzanne Jeskewitz (608) 266-3796
Senator Carol Roessler (608) 266-5300

Audit Finds Milwaukee Child Welfare Program In Need of Significant Improvement

(Madison) Today, the nonpartisan Legislative Audit Bureau (LAB) released an evaluation of the Milwaukee Child Welfare program, which is administered by the Department of Health and Family Services (DHFS). LAB analyzed timeliness, effectiveness, and coordination of services in its report on program issues (report 06-1) and program funding, expenditures, and staffing in its report on program finances and staffing (report 06-2). These reports identify significant areas for improvement in program management and financial administration.

From January 2001 through June 2005, program expenditures totaled $493.7 million. In June 2005, the program served 3,188 children who had been removed from their homes to ensure their safety and an additional 266 families who received services without having a child removed from the home.

"One of my many concerns is high caseworker turnover," remarked Joint Legislative Audit Committee Co-chair Suzanne Jeskewitz (R-Menomonee Falls). "Since 2003, turnover has escalated from 30.1 percent to 38.6 percent. This negatively impacts the quality of service these children receive and also resulted in additional direct costs of $1.4 million dollars. These are dollars we could have saved or spent providing additional services to youth aging out of foster care."

The audit identified concerns with the timeliness of investigations of child abuse and neglect. DHFS exceeded a 60-day statutory time limit in 30.9 percent of its investigations. LAB also reported that, early in 2005, only 27.4 percent of court-ordered services for families were provided in a timely manner.

LAB found collaboration and coordination among child welfare staff to be limited and documented problems related to establishing permanent placements in 25 of 48 cases it reviewed. To assess whether DHFS adequately ensured the safety of children, LAB reviewed 73 high-risk cases that were most likely to involve child abuse or neglect. LAB determined that DHFS and its contractors took reasonable and appropriate action in 69 of these cases, but believes that more could have been done to protect children in the remaining 4 cases.

"More careful scrutiny of child welfare cases is warranted," said Joint Legislative Audit Committee Co-chair Carol Roessler (R-Oshkosh). "We must ensure that children in need of protection and safety services receive those services. Safety service contractors must be held accountable when they fail to provide necessary services to vulnerable children. These actions are endangering life situations and must be met with serious consequences."

-more-

SENATOR ROESSLER
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-5300 • Fax (608) 266-0423

REPRESENTATIVE JESKEWITZ
P.O. Box 8952 • Madison, WI 53708-8952
(608) 266-3796 • Fax (608) 282-3624

LAB also examined the appropriateness and reasonableness of costs that nine contractors charged the program in 2004. LAB found $677,694 in unallowable and questioned costs, including a payment of a $541,604 duplicate reimbursement request submitted by Lutheran Social Services. Another contractor, La Causa, had debt totaling $6.2 million as of December 2005. This debt will have to be monitored carefully because DHFS has awarded a $10.6 million contract for the organization to provide program services in 2006.

Co-chairs Roessler and Jeskewitz plan to hold a hearing on the audit findings in mid-March and announced their intentions to closely monitor the efforts of DHFS to implement LAB's recommendations for program improvement.

Copies of the evaluation may be obtained from the Legislative Audit Bureau's Web site at www.legis.state.wi.us/lab or by calling (608) 266-2818 to request copies of report 06-1: Milwaukee Child Welfare Program Issues, and report 06-2: Milwaukee Child Welfare Finances and Staffing.

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06-1 Program Issues
06-2 Finances and Staffing

An Evaluation:

Milwaukee County Child Welfare

Department of Health and Family Services

February 2006

Report Highlights

Investigations of abuse and neglect have exceeded the 60-day statutory time limit.

Program improvements have reduced both the number of placements and the median stay in out-of-home care.

Improvements are needed to ensure the safety of children who remain with their families.

Sufficient action was taken to protect most, but not all, children from abuse and neglect.

Financial oversight should be improved.

Staff turnover remains a significant concern.

Counties have historically administered child welfare programs in Wisconsin. However, the Department of Health and Family Services (DHFS) began administering Milwaukee County's child welfare program in January 1998, following a 1993 class-action lawsuit filed in federal court. In June 2005, its Bureau of Milwaukee Child Welfare had 153 full-time equivalent employees (FTE), including 90 social workers who investigate allegations of abuse and neglect. Contractors employed approximately 500 staff to provide most other program services, such as case management for children who have been removed from their homes because of maltreatment. From January 2001 through June 2005, program expenditures totaled $493.7 million.

At the direction of the Joint Legislative Audit Committee, we conducted a comprehensive program evaluation. Report 06-1 addresses program management and performance, including:

- the timeliness of the Bureau's efforts to investigate allegations of abuse and neglect;
- the effectiveness of both out-of-home care and safety services that are provided when at-risk children remain at home, as well as the coordination of program services; and
- the Bureau's success in achieving 14 mandatory and 10 monitoring standards required by a settlement agreement arising from the lawsuit.

Report 06-2 addresses:

- program funding and expenditures, including the appropriateness of expenditures by program contractors; and
- staff turnover, qualifications, training, workloads, and salaries.

Key Facts and Findings

From January 2001 through June 2005, program expenditures totaled $493.7 million.

Early in 2005, only 27.4 percent of court-ordered services for families were provided in a timely manner.

In 25 of 48 cases we reviewed, we identified problems in achieving permanent placements for children.

One-fifth of children reunified with their parents reentered out-of-home care within 24 months.

Coordination of service delivery between child welfare, Medical Assistance, and other support programs is limited.

We found $677,694 in unallowable and questioned costs charged to the program by six contractors.

Investigations

From January 2004 through June 2005, the Bureau completed 14,224 investigations that involved 28,474 allegations of child abuse or neglect. A single investigation can include multiple allegations when, for example, more than one child is involved.

Statutes require investigations to be completed in 60 days. The Bureau exceeded the statutory time limit in 4,397 investigations, or 30.9 percent of those completed. It substantiated 15.2 percent of the allegations it investigated during the 18-month period we reviewed.

If the Bureau's investigation indicates that a child has been abused or neglected or that such treatment is imminent, the child is temporarily removed from the home. The Children's Court either determines that the child can safely be returned to the home or orders an out-of-home placement.

Out-of-Home Care

In June 2005, 3,188 Milwaukee County children were in foster care or other out-of-home placements. Nearly 40 percent of placements were in foster homes with non-relatives, although 771 children, or 24.2 percent, were placed with relatives participating in Kinship Care.

Significantly more children receive out-of-home care in Milwaukee County than elsewhere in Wisconsin, but the program's out-of-home placement rate declined 47.7 percent from January 2001 through June 2005. The Bureau's efforts to improve program operations contributed to this decline.

The median stay in out-of-home care also declined, from 39 months in June 2003 to 21 months in June 2005. However, in 25 of the 48 cases we reviewed, we identified problems such as insufficient coordination among child welfare staff. Children leave out-of-home care when their families are reunified, guardianship is transferred to a relative, they are adopted, or they reach adulthood.

Safety Services

Safety services—including parenting education, counseling, and drug and alcohol treatment—are made available to families by program contractors when children are not able to remain in the home without services. Participation is voluntary, although children may be removed from the home if family members do not agree to receive the safety services.

Safety services caseloads declined 63.4 percent from January 2001 through June 2005, from 727 to 266 families. The average period for which services were provided declined from 110 days in January 2003 to 81 days in January 2005. We found that some cases were closed prematurely.

For each family served, safety services contractors are paid $4,77 regardless of which services are

provided or how long the case remains open. Through 2005, both case management and safety services contractors were contractually required to provide quarterly reports identifying the services provided to 10.0 percent of their cases. However, the Bureau has neither requested nor received any of these reports since early 2003.

Improving Performance

We analyzed 73 high-risk cases that were most likely to involve child abuse or neglect. In 69 of these cases, the Bureau and its contractors took reasonable and appropriate action. However, we found four cases in which efforts were insufficient to ensure children's safety. These included one case in which children were allowed to live in a condemned house for more than four months and another in which an infant died as a result of abuse.

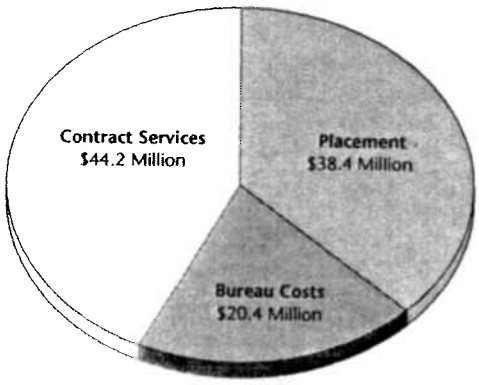
We also found that 20.1 percent of children who were reunified with their parents from January through June 2003 reentered out-of-home care within 24 months. Further, 11.4 percent of families who ceased receiving safety services during the first 6 months of 2004 had children removed from the home within the next 12 months. This rate exceeded the 4.0 percent contractual limit. However, because the Bureau does not monitor compliance, no funds have ever been withheld from safety services contractors.

Through June 2005, the Bureau met 8 of 14 performance standards required under the court-approved settlement agreement between the State and plaintiffs in the 1993 class-action lawsuit. Each standard will remain in effect until there is agreement by the parties to the lawsuit or an arbitrator determines that it has been met. We found errors in the way the Bureau calculates its performance related to one permanency standard, which have overstated program success.

Program Finances

Program expenditures fund the Bureau's costs, placement costs, and services provided by contractors. In 2004, they totaled $103.0 million.

Milwaukee County Child Welfare Expenditures



We reviewed the appropriateness and reasonableness of costs that nine contractors charged the program in 2004. We found $677,694 in unallowable and questioned costs charged by six contractors, including payment of a $541,604 duplicate reimbursement request submitted by one contractor, Lutheran Social Services.

Another contractor, La Causa, has had difficulty controlling costs in the past. As of December 2005, La Causa's debt was $6.2 million. This debt will have to be monitored carefully because DHFS has awarded La Causa a $10.6 million contract to provide program services in 2006.

We also have concerns that 2006 case management contracts pay a fixed case rate regardless of the amount of service provided to families.

Staff Turnover

Turnover of child welfare staff is a significant concern in Milwaukee County and nationwide. Among the case managers employed by program contractors, turnover was 30.1 percent in 2003 and increased to 38.6 percent in 2004. In contrast, annual turnover among the Bureau's social workers has been approximately 10.0 percent.

Recommendations

Our report includes recommendations for DHFS to report to the Joint Legislative Audit Committee on its actions to:

- ☑ improve the timeliness of its investigations and the delivery of court-ordered services; reduce the time children spend in out-of-home care; ensure the adequacy of safety services; and improve service coordination with Medical Assistance, W-2, and other social services providers *(p. 82, report 06-1);*

- ☑ monitor families who return for additional safety services within 12 months, as well as those who have children placed in out-of-home care in the 12 months following receipt of safety services, and enforce contractual provisions if returning cases exceed prescribed rates *(p. 52, report 06-1);*

- ☑ ensure that all children in out-of-home care receive annual medical and dental examinations *(p. 66, report 06-1);*

- ☑ continue to work to improve the retention of child welfare staff *(p. 36, report 06-2);*

- ☑ appropriately calculate the Bureau of Milwaukee Child Welfare's compliance with performance standards specified in the settlement agreement *(pp. 57, 59, and 66, report 06-1);*

- ☑ collect and analyze information on services that contractors provide to families *(p. 18, report 06-2);* and

- ☑ monitor and assess La Causa's financial condition *(p. 23, report 06-2).*

In addition, we recommend that DHFS:

- ☑ require contractors to repay $582,981 in unallowable costs and to either repay $94,713 in questioned costs or provide additional documentation *(p. 27, report 06-2);* and

- ☑ ensure that new staff complete pre-service training before managing cases *(p. 33, report 06-2).*

Finally, we include a recommendation for the departments of Justice, Public Instruction, and Workforce Development to require Lutheran Social Services to reimburse them for public funds spent on unallowable costs *(p. 25, report 06-2).*

Additional Information

For copies of reports 06-1 and 06-2, which include responses from the Department of Health and Family Services, call **(608) 266-2818** or visit our Web site:

www.legis.state.wi.us/lab

Address questions regarding this report to:

Paul Stuiber
(608) 266-2818

The Legislative Audit Bureau is a nonpartisan legislative service agency that assists the Wisconsin Legislature in maintaining effective oversight of state operations. We audit the accounts and records of state agencies to ensure that financial transactions and management decisions are made effectively, efficiently, and in compliance with state law, and we review and evaluate the performance of state and local agencies and programs. The results of our audits, evaluations, and reviews are submitted to the Joint Legislative Audit Committee.

Legislative Audit Bureau

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Janice Mueller
State Auditor


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State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

March 1, 2006

Honorable Carol Roessler, Co-Chair
Joint Legislative Audit Committee
8 South, State Capitol
Madison, WI 53702

Honorable Suzanne Jeskewitz, Co-Chair
Joint Legislative Audit Committee
314 North, State Capitol
Madison, WI 53702

Dear Senator Roessler and Representative Jeskewitz:

The Legislative Audit Bureau's (LAB) reports (06-1 and 06-2) on the Bureau of Milwaukee Child Welfare recommended that the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1st on certain items:

- *La Causa finances*: steps to monitor and assess La Causa's financial condition on an ongoing basis, and whether we will require La Causa to repay the $488,256 in unallowable costs identified by DHFS auditors and, if so, the time line for doing so.

- Collecting and analyzing *information on services* that contractors provide to families.

- *Calculation methods for specific outcome and program data* concerning children in care of the Bureau of Milwaukee Child Welfare.

These LAB recommendations and our responses are detailed below, along with our response to certain other recommendations on unallowed and questioned costs and other data calculation methods. We believe that it is useful to fully resolve as many financial and data integrity questions as promptly as possible.

As recognized by LAB, program improvement recommendations require longer term strategies. We will report on these in February of 2007 as recommended by LAB.

La Causa Finances

LAB Recommendations: (1) Report on steps the Department is taking to monitor and assess La Causa's financial condition on an ongoing basis, and (2) whether it intends to require La Causa to repay the $488,256 in unallowable costs identified by DHFS auditors and, if so, the time line for doing so.

(1) La Causa has long been active in the Milwaukee community delivering a wide range of social services, and has been a valued partner of ours in delivering essential child welfare services. At the same time, the Department has been well aware of La Causa's financial challenges for some time.

Since 2003, the Department has collected and analyzed revenue, expenditure, cash flow, and liability information from La Causa on a monthly basis. We continue to closely track La Causa's financial condition. Fortunately, La Causa's financial condition has improved since 2003, when La Causa's audit showed the agency's liabilities exceeded assets by $2.6 million. Hugo Cardona, La Causa's President and CEO since June, 2004, has taken decisive measures designed to turn the organization's financial condition around. La Causa's deficit position improved by $437,000 in 2004 and is expected to improve by another estimated $400,000 in 2005 once the books are closed. While these improvements are encouraging, we will continue to work closely with La Causa on a monthly basis. We are confident that La Causa will continue to reduce its debt and be able to provide quality services and good outcomes for children and families.

(2) With respect to unallowable and questioned costs identified by the audit as they relate to La Causa, we have combined these with separate findings made by the Department's auditors as well as findings reported by La Causa's own independent auditors as part of their contractually required annual financial and compliance audits. Our goal is to coordinate audit findings and negotiate one comprehensive net recoupment amount that La Causa can plan for financially and begin to pay back. We have met with La Causa and have reached an agreement in principle regarding repayment. One further meeting is scheduled within the next week to review a limited number of questioned costs that remain to be resolved. We are confident that these remaining costs will be resolved by mutual agreement.

Information on Services

LAB recommendation: Report on efforts to collect and analyze information on services that contractors provide to families.

More timely, accurate, and complete information on services is a laudable goal. We will work with our providers and others to take the following steps to address this issue:

- Document the information that is, and is not, now collected in a consistent, analyzable format and would be valuable to have in determining the scope and effectiveness of services;

- Document the feasibility and cost of adapting current data collection systems, including provider service authorization and tracking systems and e-WiSACWIS, to collect and report the needed service information; and

- Present options to the Milwaukee Child Welfare Partnership Council and solicit input on the best solution within reasonable financial and administrative constraints for both providers and the Department.

We plan to time these steps in conjunction with our larger effort to establish a more coordinated service network with enhanced consistency and quality for families. As expressed in the DHFS Request for Proposals in 2005 for Ongoing Case Management and Safety Services, and in other communications to the community, the Department is committed to pursuing a strategy for ensuring that a wide array of cost effective network services are available as needed by children and families and are effectively managed. We already have initiated efforts to work with our private partners to develop a shared service network and management strategy. Improving services data will be part of the broader service network development plan.

Calculation Methods for Specific Outcome and Program Data

LAB recommendation: Report on steps the Department has taken to ensure the Bureau of Milwaukee Child Welfare appropriately calculates the percentage of children who receive a termination of parental rights petition or an exception when the children have been in out-of-home care for 15 of the last 22 months, such as counting children only once and including only those children who are actually in out-of-home care at the 15-month point.

Since the release of the audit report, Department staff have dissected the methodology used for the past three years for calculating this standard. The Bureau's Program Evaluation Managers have adjusted the methodology and have reviewed the data to ensure that it is accurate. The new methodology has been reviewed with plaintiffs' counsel and by mutual agreement the Department will apply it for our Period 3 final report which will be released publicly later this month.

LAB recommendation: Report on steps the Department has taken to ensure the Bureau of Milwaukee Child Welfare considers other ways to calculate the percentage of children who have been in out-of-home care for more than 15 of the last 22 months and subsequently receive a termination of parental rights petition or an exception.

As noted in the audit, the current method used to calculate the percentage of children who receive TPR petitions or exceptions after being in out-of-home care for more than 15 of the last 22 months complies with the *Jeanine B.* settlement agreement. After careful consideration, we have decided to continue using this methodology. While we agree with the LAB that there are other ways to calculate this standard, the current methodology used is consistent with the settlement agreement and expectations from plaintiffs' counsel.

LAB recommendation: Report on steps the Department has taken to ensure the Bureau of Milwaukee Child Welfare uses the actual number of children in out-of-home care to calculate the percentage of children who remain in out-of-home care for more than 24 months, and reports these results along with the results from the methodology specified in the settlement agreement.

As the audit states, "the settlement agreement requires the Bureau to calculate the percentage of children who remain in out-of-home care for more than 24 months as a percentage of 5,533 children, which was the number of children in out-of-home care when the agreement was approved in 2002." The LAB suggests that the percentage should instead be based on the current number of children in out-of-home care. We agree with the audit on both points: that the settlement agreement requires one calculation, and that a differing calculation would be more helpful. Because the settlement agreement requires reporting based on the 2002 figures, we have honored its requirements and will continue to do so. For over a year, we have also reported by the alternate method LAB prefers, as a voluntary supplement to what the settlement agreement provides.

Unallowed and Questioned Costs

LAB recommendation: Require the child welfare contractors to repay the $582,981 in unallowable costs and either repay the $94,713 in questioned costs or provide additional documentation that adequately justifies the expenditure of program funds.

Today, March 1, the duplicate payment to Lutheran Social Services of $541,604 has been recouped. On the remaining unallowed costs, the Department has communicated with all six vendors found to have unallowable costs and will deduct these amounts from their April 1st payments to fully recoup all unallowable costs. With respect to the category of questioned costs, we have asked each vendor to provide us with an explanation and justification for each questioned item. We will review their responses to determine if the expenses are allowable under federal and Departmental allowable cost policies. Any expenditures that are not allowable will be recouped.

Further, we will take administrative action to modify our procedures concerning one issue of unallowed cost and one issue of questioned costs. The majority of the unallowed costs concerned a duplicated claim paid to Lutheran Social Services (LSS). We have carefully reviewed what occurred in this instance and considered what procedural controls are necessary to minimize the risk of similar occurrences.

The LSS duplicate payment appears to have been the result of human error by staff at both LSS and the Department. LSS submitted two cost reports for December, 2004. This is unusual but not prohibited by the Department's policy so long as the costs in the second report are allowable and not duplicated with prior claims. The opportunity to submit a second cost report is intended to only allow contractors to claim additional costs inadvertently left out of a first report. However, LSS mistakenly included all of the month's costs in the second report. Department staff did not review the two reports in sufficient detail to determine that the second report included duplicate costs and should not have been paid.

This duplicate payment is an anomaly, but a serious error. Upon review, we believe that the Department's procedures for paying providers are fundamentally sound. LAB has reviewed these procedures every year in its annual Single Audit and for many years has routinely found payment processes to include adequate internal controls. However, issuing a duplicate payment is not acceptable and requires us to further tighten controls. One improvement has already been made: second monthly cost reports claiming material amounts of funding will be more closely scrutinized by supervisory staff, with payments delayed or denied as necessary until Department fiscal staff have adequate assurances that no duplicate costs are being claimed. Additional controls are being reviewed.

The second issue involves expenditures questioned, but not disallowed, by LAB on items provided to line staff with the intent to increase employee morale or to recognize staff achievements. LAB recognizes, and the Department is concerned, that improving morale and reducing staff turnover is a key strategy to improve the quality of our services and outcomes for children and families. We do not believe that incentives to staff should be entirely precluded. At the same time, we are very mindful of public expectations that all expenditures need to be reasonable, limited, and appropriately focused on the staff turnover we want to reduce.

Federal allowable cost policies that the Department has followed with its contractors recognize that this general category of costs can, under certain circumstances, be considered allowable as a legitimate business practice. The question is whether Department policies should be made stricter and clearer than the federal allowable cost guidelines in order to limit such expenditures, and whether these specific questioned costs should be disallowed or not.

I have concluded that for the future, the Department should reduce the uncertainty about the type and extent of such purchases that are allowable by our contractors. We will incorporate specific guidelines for contractors based on the rules that apply to state government itself, which limit the amount of such expenditures to a nominal level.

With respect to the past contract costs questioned by LAB, as with the other questioned costs, we have asked for an explanation and justification for these items by the vendors. We will review the responses to determine reasonableness in light of the standards established by the current federal and Departmental allowable cost policies.

Data Methodology for Health Screen Reporting

LAB Recommendation: Report on steps the Department has taken to ensure the Bureau of Milwaukee Child Welfare uses an appropriate methodology for calculating the percentage of children who receive initial health screenings within five business days of entering out-of-home care.

We have reviewed our procedures and have made changes based on the LAB's recommendation. In addition, last July, the Bureau began working with the Children's Protection Center (CPC), the organization responsible for administering the screens, to develop a new tracking system to ensure children receive a health screen within five business days of entering out-of-home care.

The CPC was able to allocate staff time to assist in the coordination, tracking, and verification of children receiving the health screens. Further, it was agreed that children would be seen on the same day they are removed from their homes when it is in the best interest of the child and CPC is able to accommodate the appointment. We are confident these new procedures will improve our performance and we will continue to show improvement into the future.

Closing

Since the audit was issued on February 8, the Department has taken several steps to address the concerns raised by the two very thorough audits of the Bureau of Milwaukee Child Welfare. The Department takes seriously its obligation to be an effective steward of resources with which the Legislature has entrusted us. We will continue to work to improve performance of the Bureau of Milwaukee Child Welfare and make improvements in the administration of this vitally important function.

Thank you for the opportunity to report on steps the Department has taken to address the financial and data collection matters raised in the audit as well as items relating to the *Jeanine B.* settlement agreement. I will report again to you at your scheduled March 14th hearing. If you have any questions before that time or later, please feel free to contact me.

Sincerely,

Helene Nelson
Secretary

cc: Members of Joint Audit Committee
Jan Mueller, State Auditor


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Asbjornson, Karen

From: Matthews, Pam
Sent: Monday, March 06, 2006 9:48 AM
To: Asbjornson, Karen; Chrisman, James; Shannon, Pam
Subject: FW: Milwaukee Child Welfare
Attachments: Linda's CV.doc

FYI...

From: Davis127@aol.com [mailto:Davis127@aol.com]
Sent: Sunday, March 05, 2006 1:45 PM
To: Sen.Roessler; Rep.Jeskewitz
Subject: Milwaukee Child Welfare

March 5, 2006

Dear Sen. Roessler and Rep. Jeskewitz:

First and foremost, thank you for your concern for the children in the Milwaukee child welfare system. I know that you are not only concerned about the fiscal oversight of BMCW but also good government and good outcomes for kids. I join you in those concerns. I am full time, independent volunteer and advocate who is dedicated to improving the lives of abused and neglected children. I would like to share a few of my thoughts regarding the upcoming meetings and reports. In addition, I have included my volunteer "resume" so that you may understand the depth of my commitment and knowledge of the issue of child welfare both nationally and in Milwaukee.

It is the "season" for reports on the Bureau of Milwaukee Child Welfare which those of us who care about the kids welcome. This March, we have the year-end report on the federal lawsuit settlement as negotiated with Children's Rights, Inc. of New York, the comprehensive case study report and the Legislative Audit Bureau report.

First it is important to recognize and acknowledge that this kind of public scrutiny is not only important, it is also unique to our system. Most child welfare systems around the country do not have the kind of reporting that we have in Milwaukee. That is a shame for the kids who are in those child welfare systems. Our kids deserve our constant diligence on their behalf especially when we, the community, are suddenly their parents either directly or indirectly by virtue of the state taking them into custody because of the extreme abuse or neglect they have suffered in their young lives. Along with so many others involved inside and outside of the system, I always welcome fact-based research on behalf of our kids.

This "season", however, I am concerned that we may have other agendas at work in addition to good outcomes for our kids and good government. I fear that balance in reporting the strengths and weaknesses of Milwaukee child welfare will become secondary to political and financial concerns.

Child welfare is NOT a partisan issue. It is a public health and well being issue. I have personally

been appointed to projects involving child welfare by both Governor Thompson and Governor Doyle proving that both sides of the aisle care about kids and are, frankly, responsible for kids who are in out of home care.

It is true that the Bureau of Milwaukee Child Welfare and all its partners have many improvements to make. It is also true the system is much improved in the last 8 years since the state took command. We have gone from 7000 to 2800 children in out of home care with thousands of children now living in "forever homes" as the kids like to call them. This is an extraordinary achievement by all parts of the system. We have increased successful adoptions exponentially. We now have every child who comes into care seeing a health care provider at the Child Protection Center in a very short period of time usually within 5 days. The Bureau has returned money to the state due to the lowering of caseloads from hundreds of children per case worker to now lower than 11 families (22 kids on average) per worker. This, by the way, is an incredible achievement not accomplished in many jurisdictions. We have two significant federal waivers. One to create the first in the nation managed health care organization for our kids and one to create a subsidized guardianship program so families can keep kids with close relatives, usually grandparents.

When I started volunteering in child welfare in 1990, I learned about the struggles of the system. First, the system had no public scrutiny, no public knowledge as to what was happening to the kids. The most frequent caseworker was "Vacant", meaning kids had no case worker. Information on foster homes and where kids were placed were kept on 3" x 5" cards. No one was quite sure how many kids were even in the system. No computer system like we have now existed. This kind of unsophisticated system was in place as recently as 1997. No formal child-parent visitation program was in effect. Several of us who cared about the kids both working for the county or not, welcomed the lawsuit by Children's Rights....the best thing that ever happened for our kids. This is all to say the system is extraordinarily improved and is working in so many ways thanks to everyone in the political arena and the community who have stepped up to make the improvements happen whether or not they were getting paid to help and no matter which side of the political aisle they were affiliated with.

Where we are now is at a crossroads. We have improved in so many of the compliance areas, i.e. caseload size, caseworkers visiting children at least once a month, children getting a visit at the Child Protection Center to document their health status, all those areas of the lawsuit settlement with which we are compliant, etc.

What has changed on a "corporate culture" level is leading to these changes and the improvements to come. The system was originally set up to be competitive with a negative pallor over it. Private agencies were to compete against each other for services to and for children. This proved to be nonproductive and demoralizing. Rather we need to band together to find or create all the services our children need...a Herculean task considering our community does not have enough providers of many of the services needed such as pediatric mental health providers, etc. The new leadership of Burnie Bridge, the Division Administrator of Children and Family Services, shows much promise in the short period of time Ms. Bridge has been at the helm. The Bureau, private agency partners, Partnership Council, many advocates and judges are all coming together for the first time to jointly recognize and solve the remaining most difficult challenges of the system. This may sound trivial but is the foundation for making improvements to the system. I have been one of the harsh critics of the system while trying to bring resources of all kinds to improve the lives of children. For the first time, I am hopeful about substantial quality improvements for the kids. The foundation has been laid and now we need to build in ways to ensure positive outcomes for the kids. In no way do I demean the hard work it has taken to build this foundation. I just want us to focus on where to go from here.

Ms. Bridge has instituted several initiatives, as well, that show much promise. The Allied Health Services project creating a managed health care program for children in out of home care was dormant until Ms. Bridge brought it back to life. Whether or not the managed care project is implemented (which is very much a decision of the federal government and the current budget cuts), the work done for this project will lay the foundation for an improved health care system for kids. The Partnership Council in cooperation with internal work groups has taken on turnover of caseworkers. Several recommendations have been agreed upon including salary parity which has already taken place and has already shown some promise. Much more needs to be done and institutionalized as recommended by the independent report of McDonald, Flower and Sumski and another report by the Child Welfare League of America but the first steps have been taken. With help from the legislature, foster parents in Wisconsin are getting closer to the financial support they need, deserve and would receive if they lived in the region outside of Wisconsin. The Quality Service Review process known nationally has begun to be implemented in Milwaukee as it has been across the state. The integration of child welfare and W-2 services has two pilot projects (out of 6 statewide) in Milwaukee. Much success has already taken place in understanding both the services and the barriers people face when they are involved in both systems. The new Ombudsman's Office has already issued its first six months report which provides independent recommendations and insights into the system from yet another vantage point. Finding and developing new community interest and capacity is a huge challenge. Working with the Milwaukee faith community to help the system is in its infancy but shows great promise. Likewise, the managed health care project is an attempt to help encourage physicians, dentists, and mental health providers take children in the foster care system into their practices...no small challenge. Improved training of case workers is also being implemented. All of these initiatives have either started or taken hold in the past eight months.

This is all to say that while we look at the shortcomings of the system, some of which are substantial, complex and difficult, I caution that we look at where we have come from and where we are now.

As for the future, my biggest disappointment in the LAB report was that it focused on compliance issues and not quality outcomes for our kids which is our biggest hurdle yet. The watershed moment that we are currently facing for the Bureau is to move to including QUALITY outcomes for our children in addition to being compliant with good process. The LAB report was extremely helpful in looking at those compliance issues. Our challenge now is how we make sure we are providing a better life for the children who have been so badly beaten, burned, starved or sexually abused that we had to take them away from their families. How are our children doing in school? How are our children improving vis-à-vis their health? How are our children prepared for life after child welfare? How are we preparing our kids for adulthood when they are 18 and "turned out" from the system without adequate knowledge, services or plain old income? How can we take a large system like child welfare and work with even larger systems like Milwaukee Public Schools or the health system? These are challenges that will take time but we are dedicated to the task and to the kids. Until we find ways to work with these larger systems and get support from these other systems, some of the items such as placement stability may not improve.

I hope that as those of us who are devoted to the children in child welfare and improving the system, we do not lose sight of the kids. The issue is not who is Governor, how we balance a budget by cutting money for services for kids who neither can vote or pay taxes and thus have no special interest group constantly lobbying for them, or any other political issue but rather how can we as their surrogate parents provide them with a system that constantly improves just as we as parents of our own children strive to constantly improve the lives of our own children.

My worst fear in this "season of scrutiny" is that we will so demoralize those who work in the system

or make the liability of providing services to our children so high that individuals, agencies or systems will either quit working with us or not join us. Scrutiny is an important and necessary way to improve the system. Let's make sure that the tone of scrutiny we use is to improve the system on behalf of the kids and those who are willing to serve them. It is a difficult balance but I am sure you and your committee will help show us the way.

Thank you again for your keen interest on behalf of the kids. I hope some day you are personally able to join in riding along with caseworkers in Milwaukee, meeting foster parents, sitting in on Children's Court actions, joining us at a Partnership Council meeting, visiting the Child Protection Center or the Adolescent Health Program and talking to our kids. These are meaningful, educational and uplifting moments. You would be heartened by meeting those folks who are so dedicated to such a difficult challenge and even more difficult subject of child abuse. The kids will just simply fill your minds and your hearts with memories. Thanks for your consideration.

Sincerely,

Linda Davis

Chair, Child Welfare Philanthropy Group
Member, Partnership Council
Executive Committee Member
Chair, Health Committee
Allied Health Services
Co-Chair Advisory Committee
State Integration Project for W-2 and Child Welfare
Member, Core Team
Quality Service Review (QSR) Project
Member, Steering Committee

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The difficult I can do right now. The impossible will take a little while...Ira Gershwin

Asbjornson, Karen

From: Shorter, Ginnie
Sent: Wednesday, March 15, 2006 9:07 AM
To: Asbjornson, Karen
Subject: FW: [Possible Spam] Follow up to the LAB Meeting yesterday

CR email

From: Davis127@aol.com [mailto:Davis127@aol.com]
Sent: Wednesday, March 15, 2006 8:54 AM
To: Rep.Jeskewitz; Sen.Roessler
Cc: Sen.Darling; Schulze, Connie
Subject: [Possible Spam] Follow up to the LAB Meeting yesterday

Dear Madam Co-Chairs: I failed yesterday to thank you both for making the extra effort to hold the Legislative Audit Committee hearings in Milwaukee. I know this is unusual but your efforts sent a very strong message that both our W-2 clients and our kids are important. THANK YOU. I hope it will happen again.

I didn't want to take the time yesterday to comment on a couple of things mentioned in the meeting and offer any help I can give in these or other areas. In addition, I would love to talk more about the efforts of the Partnership Council at some time. The Partnership Council has gone from a group that had no influence to a group that has really bonded and working on issues. As you know, the Partnership Council was created by legislation and I believe along with other members that we owe the legislature some accountability as to our work as well as a stronger relationship with a variety of legislators.

You mentioned yesterdat the correspondence that you have received from Richard Wexler and wanting to look into his allegations. As Chair of the Child Welfare Philanthropy Group, I paid for and invited Mr. Wexler to meet with us almost five years ago. He was invited to meet with us to give us his opinions on child welfare and Milwaukee specifically. I'd be happy to meet with you to discuss our impressions if that will help. Additionally, I have seen his most recent correspondence and it worries me on many levels. My biggest concern is Mr. Wexler's general process of misrepresenting issues by limiting the facts he uses to make his pre-conceived, pre-determined positions. For example, his recent letter talks about kids "churning" in and out of the Milwaukee system and infers that case workers are grabbing kids out of their families. It is worrisome that Mr. Wexler would put this kind of concern forward with the intent of his hypotheses making it into the newspaper rather than fact-based research. He fails to take into account that the allegations of child abuse resulting in children being removed from their families must go in front of a judge to justify that removal. Even if we had a rogue caseworker, that person would have to justify their decisions in front of our Children's Court judges. He has been concerned from the very beginning that Milwaukee (and all child welfare agencies across the nation) remove children too frequently and without cause. I also think this does not reflect the removal numbers we have seen in Milwaukee. In fact, in 2005, the Partnership Council questioned the LOW number of children coming into our system. We did not want BMCW to keep children out of the system in order to meet caseload sizes, etc. which is directly in conflict with Mr. Wexler's assertions.

Mr. Wexler, to my knowledge, has not been in Milwaukee since I brought him here over five years ago. He is not a child welfare "expert" but rather a journalist who is highly interested in the subject. This is just to say that while I am interested in some of his assertions, I think it is important to put his assertions and motivations in context while looking into his allegations.

Secondly, there was mention yesterday by both Rep. Jeskewitz and Senator Darling regarding the possiblility of creating a Children's Village (long term residences) here in Milwaukee similar to the SOS Children's Villages in other parts of the US and the world. Sen. Darling was absolutely accurate that there was a strong, multi-year attempt to get a Village built in Milwaukee a few years ago that resulted in the Milwaukee Children's Village being spun off to Lutheran Social Services. I thought I would add that the Child Welfare Philanthropy Group (CWPG) which I chair (made up of 11 private funders) looked at the possibility of funding this effort. We decided to decline the opportunity to participate by contributing our funds once we read the outcomes report of the SOS Children's Villages particularly the one located in Florida. I don't have the report still as it has been years but I remember lots allegations of abuse, teen pregnancies, etc. In addition to

these negative outcomes, I do not believe the state would have been allowed to refer children to the Village due to federal regulations of some kind but I may be wrong on that. Susan Dreyfus was the Administrator at the time and could give better understanding of any federal limitations. In addition, these types of long term esidential treatment are no longer considered best practice for our kids. The cost of the project was prohibitive particularly when we looked at the annual budgets that would require millions of dollars each year in private donations to sustain the effort. There was no business plan that met our requirements for sustainability or outcomes; hence we did not join in the effort. The Child Welfare Philanthropy Group is always interested in creative best practice initiatives but this one did not meet our minimal standards.

The CWPG is always happy to help. We consider the state a "donor" to child welfare too and see ourselves as kindred spirits in improving child welfare. Our strongest asset is our knowledge rather than our money. We work closely with DHFS on child welfare projects and would be happy to do so with the legislature if that would be helpful.

I hope you found the time spent on yesterday's meetings informational and helpful. I am close to Jess McDonald from Illinois and I hope you take him up on his offer to help. He would be helpful in responding to the Richard Wexler assertions vis-a-vis Cook County and Milwaukee as well as general child welfare practice. He is considered the "guru" of child welfare nationally since he took Illinois from one of the worst systems in the nation to the "gold standard". It should be noted that his study of the turnover problem in Milwaukee ....which he did at NO charge to the state ....is now seen as a national influence. We have great national expertise helping us now including Paul Vincent, Jess, Connie Flower (Jess' colleague), etc.

Thanks again for your interest. I was asked once what one thing I would want to fix Milwaukee child welfare. My answer was if I only got one thing it would be to have the political will in our state to make the changes necessary and devote the resources needed. I am so appreciative on behalf of the kids that you and your committee join us in having the political will to help the kids. The kids don't vote, pay taxes or have money to pay lobbyists, but they do have us!!

I am happy to come to Madison any time I can help. Thanks again. Linda

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The difficult I can do right now. The impossible will take a little while...Ira Gershwin


FORWARD
E PLURIBUS UNUM

Testimony of Susan Conwell
Executive Director, Kids Matter, Inc.
March 14, 2006

Items Requiring Additional Attention and Discussion by the Legislative Audit Committee:

1) Audit Provides An Opportunity to Look Toward Future Outcomes for Kids. The Audit provides an opportunity to reflect on our aspirations for what a well-funded child protection system can and should do for children and families in Milwaukee County. We cannot and should not waste this opportunity comparing this system to the county operated system that existed in 1995.

- Comparisons between the Milwaukee County child protection system and the Bureau of Milwaukee Child Welfare are not productive. The Bureau of Milwaukee Child Welfare has more than twice the funding and more than twice the staff available to Milwaukee County. With the additional funds, BMCW was able to create a Safety Services program and hire an entire array of contracted service providers that were previously unavailable. New federal laws such as the Adoption and Safe Families Act have changed the fundamental assumptions of child welfare systems around the nation and created a focus on permanency and adoption that did not exist before 1998. A new federal audit process has created national performance indicators, requiring each state to create performance improvement plans whose outcomes are monitored and tied to financial penalties. Wisconsin's child welfare system was audited by the federal government for the first time in 2003. It isn't 1995 anymore. Comparing BMCW performance to an underfunded, understaffed county system that operated under a different legal framework cheats our kids. Of course improvements have been made. With an additional $55 million in funding and more than 500 additional BMCW and service provider staff, it would be a crime if nothing improved.
- The question we should be asking is whether the system is achieving results on behalf of kids and families that we should expect from the number and array of resources available.

2)Additional Funds Have Created Additional Resources; Coordination and Timeliness of Resources Remain Challenges. The injection of additional funds into the child welfare system has made a difference – particularly in enhancing the 220-SAFE child abuse hotline, creating a network of service providers, reducing length of stay in foster care and reducing caseload size. However, the complex system of contracts and subcontracts has created new issues, such as difficulty in coordinating services, lack of timely provision of services, and challenges to accountability. The Audit shows that BMCW is rarely able to provide services in a timely manner (only 27.4% of court ordered services are in place within the expected period of time after children are removed from home) (Audit Page 35), coordination of services among multiple providers was lacking (Audit Page 34), and frequent turnover among staff limit effectiveness of services.

3)Reentry rates and status of children in foster care. 20% of all children who are reunified with their parents reenter foster care within 24 months. (Audit, Page 5) 11.4% of families who ceased receiving Safety Services during the first six months of 2004 had children removed from the home within the next 12 months. (Audit, Page 5) Twelve months after entry into foster care, the top two outcomes for children in foster care were continuing on in foster care and reunifying with a parent. However, the third most common outcome or status of the children was "other," a category that includes entry into a correctional facility, runaway, unknown outcome, and death. (At twelve months, "other" is a more common outcome than adoption, guardianship or placement with a relative.) (Audit Page 41)

4)Safety Services: Major Concerns Highlighted by Audit. The Audit raised numerous concerns about outcomes of Safety Services and fiscal monitoring of Safety Services programs. As noted above, 11.4% of families who ceased receiving Safety Services during the first six months of 2004 had children removed from the home within the next 12 months (Audit, Page 5) 3.5% of families receiving Safety Services had also received them within the prior six months; 7.5% had received them within the prior 12 months. (Audit, Page 51) The numbers of families receiving Safety Services declined 39.6 percent from January 2003 through June 2005, from 462 families receiving Safety Services to 279 families (Audit, Pages 43 and 44). The Audit also describes premature closing of cases, decreasing length of time that services are provided, and that 100% of cases were not in compliance with BMCW standards for team meetings. (Audit pages 44-50)

5)BMCW has made progress toward meeting many settlement requirements, particularly regarding process improvements. However, performance in areas such as stable placements for foster children and appropriate medical care is not meeting goals. The percentage of children with three or fewer placements in out-of-home care has decreased since 2003 (Audit, Page 63); fewer children received timely health screens than reported by BMCW (Audit, Page 64).

6)Lack of stability continues to plague BMCW. Case manager turnover rates remain high and have increased. Case managers take cases prior to completion of training. Loss of foster parent families continues at a high rate.

- The Audit notes a turnover rate of 30.1 percent in 2003, that increased to a turnover rate of 38.6 percent in 2004. (Audit, Page 7) 42.9% of case managers hired by contractors in 2004 had left their jobs by June 2005. (Audit, Part Two, Page 30)
- In 2004, 26.5% of case managers did not complete required pre-service training before managing cases. Of the case managers hired in the first half of 2005, 33.9% did not complete training before managing cases. (Audit, Part Two, Page 32)
- In 2002, BMCW reported having more than 1800 foster homes. BMCW's foster care recruiting information now shows 987 licensed foster homes (including relative and nonrelative homes), with one-quarter of these homes on hold and not an option for placement.

7)Audit Reports Serious Financial Accountability Concerns. Auditors reviewed approximately $2.8 million of 2004 receipts (a sample of $493.7 million in program expenditure from January 2001 through June 2005). Auditors identified $677,694 in unallowable costs of the $2.8 million, including a duplicate reimbursement request of $541,604 submitted by Lutheran Social Services. (Audit, Part Two, Appendix 1) Even excluding the duplicate payment, the Auditors disallowed 5% of the expenditures in the sample. If this rate of unallowable expenses extends through the child welfare system that costs $110 million in 2003, there may be $5.5 million in unallowable costs annually.

8)Contractors returned $16.7 million dollars between 2001-2004. (Audit, Part Two, Page 19). Based on the daily requests we receive from families for food, clothes and beds, this is unconscionable.

9)DHFS response to Audit relies too heavily on promises rather than proven strategies. DHFS' response to Audit highlights new initiatives being undertaken, but fails to mention that several of these initiatives are seven or more years old, or have yet to be implemented.

- Master's Degree Program. While the Master's Degree program is a worthy program, the program has been in existence for many years, and should not be considered an effort to slow turnover rates.
- Managed Care Health Initiative. The managed care health initiative was approved by the Legislature in 1999. While appreciating that the effort is moving forward, we are also conscious that this initiative has been in the works for seven years, and we are still waiting for the rollout of the program. Meanwhile, too few foster kids are getting to the doctor, and foster children lack access to scarce services such as board certified psychiatrists or specialists in child psychiatry.
- Ombudsman. The ombudsman program was presented to the community in a very different format than was recently implemented. The ombudsman program as proposed included a staff attorney, and the function requires an attorney. Many of the contracting agencies serve regulatory functions. Services are provided by contract. However, when the program was actually created, the attorney was left out. Only one agency bid on the contract. None of us are in a position to say if the program is successful as the ombudsman's office hasn't released its first report.
- Collaboration with faith based groups to recruit foster parents. We collaborate regularly with faith groups and value and support such partnerships. We support all efforts to expand the pool of foster parents. The current effort is still in the planning stage.
- Proposed new quality assurance process. This is a promising initiative that has our complete support. However, there have been two meetings so far regarding this new initiative, and no dollars have been allocated to it.

10)Irregularities and inconsistencies in data reporting.

> "Although DHFS maintains a statewide information and case management system that represents an official, legal record for each case, its information is sometimes inaccurate and incomplete, largely because of data-entry errors made by state or contract staff. We restricted most analyses to January 2003 or later, the period for which the most reliable data was available."
>
> An Evaluation: Milwaukee County Child Welfare: Program Issues, page 11

> "We have been paying a lot of money for data we can't really use."
>
> Susan Conwell, March 14, 2006

Numbers of children in foster care

- DHFS' response to the Audit describes past progress as follows: "BMCW has made significant progress since the State took over administration of the program in 1988. ... There were approximately 7,000 children involved in the system, and children remained in out-of-home care for long periods of time." (Response of DHFS Secretary Helene Nelson, Page Two)
- Inconsistent use of terms makes it very difficult to compare data relating to numbers of children placed in foster placements versus the number of children on child protection orders (some of whom are being supervised in their own homes).
- For example, in 1995, Milwaukee County had 3,968 children under protective orders. (Source: Milwaukee County Children's Services Strategic Plan, Hornby Zeller Associates, Fall, 1995) This number likely includes children in foster placements and under supervision at home.
- According to DHFS data at the time, there were 6,076 children "on caseload" in December of 1998, at the conclusion of one year of BMCW operation. (Source: Progress 2000, Bureau of Milwaukee Child Welfare, published February 15, 2000)
- By December, 1999, there were 7,902 children "on caseload." At one point, in October of 1999, BMCW hit a record caseload of 8,047 children. (Progress 2000)
- Rates of detention of children into the foster care system are given as follows:
    - 1999 -- 2425 children taken into protective custody (Progress 2000)
    - 2000 -- 1944 children taken into protective custody (Progress 2000)
    - 2001 -- 1571 children taken into protective custody (BMCW report to Partnership Council)
    - 2003 -- 948 children placed in foster care (Audit p. 30)
    - 2004 -- 1171 children placed in foster care (Audit, p. 30)

Given available data, it may be more accurate to assume that between 5000 and 6000 children were under child protection orders at the beginning of 1998 (though we may never have completely accurate data). An additional 2425 children were taken into protective custody in 1999, creating a caseload of more than 8000 children in October, 1999, during that DHFS operated the child welfare system in Milwaukee County.

Doubtless the number of children in foster care has decreased dramatically since the peak in 1999. However, it is inaccurate for DHFS to portray the high numbers of children in out-of-home care as a problem created by some other entity. It is certainly acceptable to

fix a problem of one's own making, but it is not acceptable to project that problem backward in time and blame it on someone else.

The Legislature and DHFS are charged with the duty of remembering that all those bits of data represent individual children and families. It is traumatizing for children to be removed from their homes unnecessarily. I urge the Legislature to take a good look at the data relating to detention of children, and question DHFS' assertion regarding past progress.

Audit notes errors in BMCW's methodology for calculating its performance related to children who receive TPR petitions or exceptions after they have been in out-of-home care for 15 of the last 22 month; inaccuracies in calculation of percentage of children in out-of-home care for 24 months; and errors in calculating rates of children receiving initial health screenings. (Audit, Pages 56-66) These performance reports ar required pursuant to the *Jeanine B.* class-action settlement agreement.

Recommendations
Kids Matter, Inc.
(formerly, In Their Best Interests, Inc.)
March 14, 2006

1) Consolidate multiple monitoring and advisory functions in an independent accountability agency, similar in scope to the Office of the Inspector General for Child Welfare in Illinois (a public agency with investigative powers that reports to the legislature).
   - Currently, multiple layers of advisory and monitoring boards, performance evaluators and consultants result in multiple reports on similar topics.
   - With no independent authority, overlapping monitoring and advisory functions have not been able to increase the number of placement resources for children, stabilize staffing patterns, increase agency accountability, or improve outcomes for children. Even when multiple reports identify common areas of need, the issuing bodies have no authority to advance a response to identified problems.

2) Start with the needs of the children and families, and build budget initiatives that respond to those needs. Specifically, create incentives and supports to strengthen the pool of caregivers, particularly for foster children over the age of ten, and include kinship families in these efforts.
   - The Audit notes a 5% increase in the foster care rate, which amounts to an extra $15/month for children six and under, and an increase of $19/ month for children between the ages of 12 and 14. (Audit, Part Two, Page 14.)
   - Compare expenditures for foster and kinship care, versus higher level care. Approximately 386 kids receive $21.9 million of care, while approximately 3,000 kids receive 11.6 million of care. (Audit, Part Two, Page 13). (Data is approximate as count of children is point in time as of December, 2004, while expense data is cumulative for 2004.)
   - We appear to be approaching a crisis in the availability of nonrelative, licensed foster homes. BMCW foster parent outreach materials indicate 987 licensed foster homes in December, 2005 (including relative and nonrelative foster homes). Of this number, approximately one-quarter are on hold for any number of reasons (from an investigation into the home to a pending adoption). 40% of foster children go into nonrelative, licensed foster care.

3) The Division of Child and Family Services must strengthen its capacity to contract with private providers and its ability to oversee these contracts.
   - DCFS must have back-up plans in the event that a provider is no longer able to provide a service and the ability and willingness to terminate a contract in the event a contractor is not providing adequate services.
   - DCFS must develop procedures for ensuring that primary contractors provide adequate supervision over subcontractors.
   - More frequent audits are necessary to strengthen financial accountability.

- The Legislative Audit Committee should pay particular attention to the Auditor's concerns regarding new contracts, including that contract provisions provide for payment at a monthly rate "even if they do not initiate services for families after their children have been placed in out-of-home care." (Audit, Page 82)

4) Find ways to simplify service delivery. The problems that kids and families face are already complex enough without having to worry about missed service purchase orders, multiple referrals, and five month waiting lists.

5) Recognize that as numbers of children in foster care stabilize, and as average placements in foster care become shorter, the families that remain and the children who have lengthy placements or repeated returns to foster care are likely to have chronic family problems. Coming up with options for families with multiple challenges including chronic mental health issues that resist treatment, developmental delays, addiction and alcoholism, will present new challenges to BMCW. BMCW must collaborate with rehabilitation specialists, mental health providers, and caregivers to create options for families with chronic needs.

Note: No additional dollars are needed to implement these recommendations.

2005 Annual Progress Summary Report
January – December 2005

Presentation to the

Milwaukee Child Welfare Partnership Council

January 13, 2006

- Safety
- Permanence
- Well-Being

Executive Summary

Key milestones reached in 2005

- There has been a 53.5% reduction in the number of children in out-of-home care since 1998.
- For three consecutive years, one-third of the children in out-of-home care have achieved permanency through reunification, guardianship or adoption.
- For three consecutive years, the efficacy in the timeliness of adoption within 24 months has improved from 14.4% to 21.7%.
- Since 1999, more than 8,300 families have been transferred to Safety Services, which diverted a significant number of children from out-of-home placement.
- There has been a 45.4% decrease in the number of families entering out-of-home care since 1999.

Challenges and Opportunities for 2006

- Expand and strengthen faith-based and community partnerships for foster care recruitment.
- Increase the numbers and quality of foster homes for children who need out-of-home care.
- Continue to improve recruitment and retention of a diverse, competent, qualified and supported professional child welfare workforce across all program areas within BMCW.
- Further reduce the length of time to achieve adoption for children.
- Increase stability of children in out-of-home care by reducing the number of foster home placements.
- Improve timely physical, developmental, dental and behavioral health care for children in out-of-home care.

Permanency Achieved for Children During 2005: A comparison 2001-2005

	2001	2002	2003	2004	**2005**
Reunification	854	1110	907 (15.9%)	704 (14.7%)	**677 (15.6%)**
Guardianship	246	371	324 (5.7%)	198 (4.1%)	**232 (5.4%)**
Adoption	265	504	584 (10.3%)	560 (11.7%)	**373 (8.6%)**
Subsidized Guardianship					**101 (2.3%)**
Permanency Counselor:		Voluntary TPR			**125***

*The number of children who achieved permanency through the Permanency Counselor program are counted in the number of adoptions.

- In 2005, 31.9% of the children who had an out-of-home placement achieved permanency compared to 30.5% in 2004.
- The rate of reunification and guardianship has remained consistent since 2003.
- Although the number of adoptions has decreased there is increased efficacy in the timeliness of adoptions within 24 months

(Percentages are based on total number of children in out-of-home care)

Referrals to Ongoing Case Management and Safety Services 1999 to 2005

Safety Services safely maintains children in their homes

- **Families transferred to Ongoing Services and Safety Services**

	Ongoing	Safety Services	Ratio: Ongoing to Safety
1999	1036	1392	1 to 1.3
2000	689	1326	1 to 1.9
2001	632	1296	1 to 2.1
2002	567	1245	1 to 2.2
2003	508	1202	1 to 2.4
2004	584	1036	1 to 1.8
2005	**566**	**841**	**1 to 1.5**

The Safety Service program has diverted a significant number of children from entering out-of-home care every year since it began. Prior to the advent of Safety Services in 1998, families and children were transferred to Ongoing Case Management.

- Since 1999 the data indicates that, overall, for every family referred to Ongoing nearly 2 were referred to Safety Services.

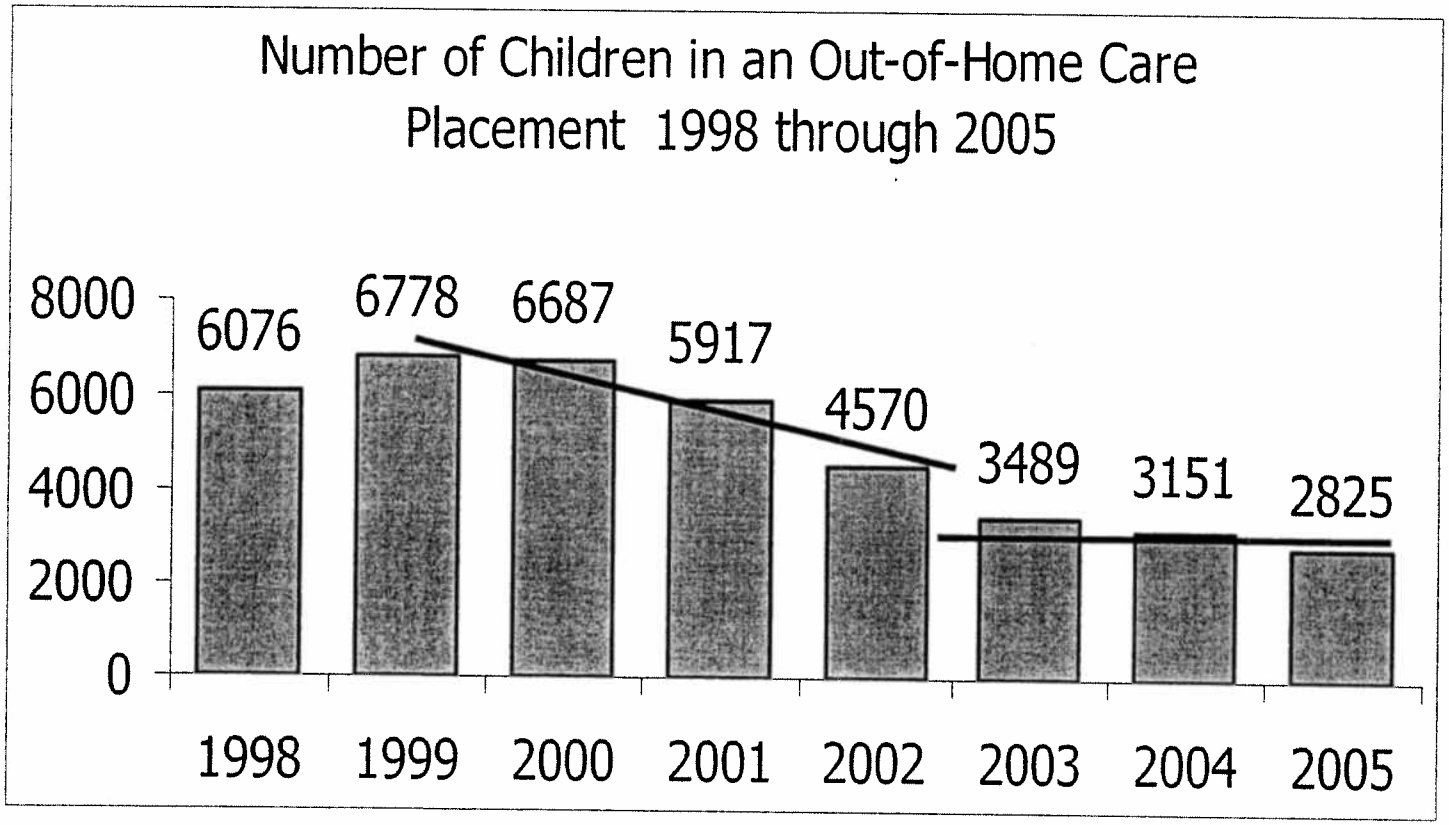
Comparison of Families Entering/Exiting Ongoing Services 1999 to 2005

Families entering and exiting Ongoing Services

Year	Families entering	Families exiting	Ratio: entering to exiting
1999	1036	788	1 to .8
2000	689	914	1 to 1.3
2001	632	830	1 to 1.3
2002	567	1120	1 to 2.0
2003	508	938	1 to 1.8
2004	584	721	1 to 1.2
2005	**566**	**647**	**1 to 1.1**

- Both the number of families entering and exiting Ongoing services has declined since 2002 .
- Since 2002, the ratio of families entering and exiting Ongoing services has gradually achieved equilibrium; in 2005, for every 1 family that entered Ongoing services, 1 family exited.

Children in Out-of-Home Care 2001 to 2005



The data suggest that the rapid downward trend in children placed in out-of-home care first reported in 2002 may have reached a 3-year plateau as indicated by the slower rate that children left out-of-home care between 2003 through 2005.

Summary

The areas highlighted in this report cover critical milestones in child welfare; achieving permanency, and ensuring the safety of children in their homes whenever possible. The information provided indicates a common trend across the various data sets presented; the current status of these milestones may be the net effect of the permanency and safety strategies implemented by BMCW since 1998. These strategies include, but are not limited to:

- Partnership with the private agencies who provide ongoing, safety, licensing and adoption services
- Partnership with University of Wisconsin-Milwaukee Child Welfare training
- Partnership with the Children's Court Center; implementation of the Permanency Plan Review Court
- Partnership with the Assistant District Attorney's office to increase the number of TPR attorneys
- A Permanency Counselor at Children's Court Center who facilitates voluntary TPRs
- Implementation of Safety Services and the diversion of families from Ongoing Case Management
- Implementation of Family Intervention Support and Services (FISS) and the diversion of families with adolescents from Ongoing Case Management
- Coordinated Services Team meetings, enhancing parent participation in case planning and including foster parents and adoption staff in meetings
- Enhanced service provider networks, increasing the number of services available to parents
- Child Abuse Review Team: Multi-Disciplinary Team Staffing and the Child Fatality Review Panels
- Use of the Child Protection Center during the Initial Assessment process.
- Implementation of the Subsidized Guardianship waiver to achieve permanency for children.
- Mobile Urgent Treatment Team for Foster Families (MUTT-FF) providing support to foster families
- Assessment Homes, Centers and Placement Stabilization Centers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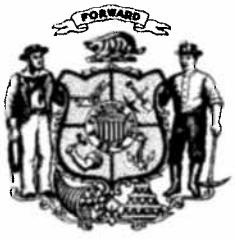
FORWARD

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TO: Sen. Carol Roessler
Co-Chair, Joint Legislative Audit Committee

FROM: Bob Andersen [signature]

RE: Audit Report 06-1 and Report 06-2, (approximately 11:00 a.m.)
Milwaukee County Child Welfare, Department of Health and Family Services.

DATE: March 29, 2006

Attached is a letter, dated February 8, 2006, written to DWD Secretary Roberta Gassman by attorney Pat DeLessio of our office, which Pat asked me to deliver to you for you to include in your file on this audit report.

The letter includes Pat's recommendations for coordination between the W-2 and child welfare systems and for the services that should be provided.

If there is any further information you would like on this matter, please feel free to contact me or Pat.

February 8, 2006

Roberta Gassman, Secretary
Department of Workforce Development
201 East Washington Avenue
P. O. Box 7946
Madison, Wisconsin 53707-7946

Dear Secretary Gassman:

This is written in regards to the integration of W-2 and child welfare services in Milwaukee. In recent months, members of the CAP public policy committee, myself included, have met with Denise Revels-Robinson, BMCW, to discuss these issues. I would like to take this opportunity to bring the following concerns to your attention.

The first is the need for information. In order to better serve families it would be helpful to have a clearer understanding of the families that have received, or are receiving, services from both systems. Ms. Revels-Robinson has agreed to collect certain data regarding families entering the child welfare system during the months of October through December 2005 and January 2006. This information will, among other things, attempt to identify those families that have had some level of contact with a W-2 agency. Once this information is produced by the Bureau, DWD would then review each case to determine the level of services received from the W-2 agency. In addition, it would be helpful if DWD collected information, for a set period if time, regarding those W-2 families who have been, or are now, involved with BMCW.

Although not a scientific study, we hope that this data will provide an estimate of the number of families using both systems, a sense of the services the W-2 agencies need to develop to help prevent child welfare issues from developing and how the systems can work together more effectively. Mary Musk, DWD regional office, attended our last meeting and indicated that the information requested could be obtained. We are currently working on a list of the data to be collected and will share that with you

when it is completed.

The second issue relates to the actual working relationship between BMCW and W-2 agency staff. The new W-2 contracts require each agency to have a liaison to work with child welfare staff. I am also aware of the La Causa/UMOS and Making Connection programs. However, we feel that additional steps are needed to coordinate services to families and that DWD, along with BMCW, must take the lead on developing and implementing certain requirements. It is not enough to leave it to each W-2 agency.

W-2 and child welfare services intercept at several points - when families are receiving W-2 and safety services, when children are removed from the home but the absence is expected to be temporary, when children who have been removed are expected to soon return, and when families are reunited after parents have met all conditions for the return of their children. It is important that the agencies, BMCW and W-2, develop and implement procedures for each stage.

For example, in those cases receiving W-2 and safety services and in cases in which children have returned home, W-2 staff should attend Coordinated Service Team and other meetings, if requested by BMCW staff, to ensure that the parent's activities are both coordinated and realistic and that the family is receiving all the services they need. In those cases in which children are removed from the home and the family is receiving W-2 services, procedures should be developed to determine if the absence is a "temporary absence" as defined in W-2 policy so that benefits continue and the parent can maintain a home for the children's return.[1] Finally, when children are expected to be reunited with a parent and the time is drawing near, that parent should, if needed, be able to receive W-2 services to assist with the reunification. These services should include education, training, job development and/or payments of some type. When services should begin and the actual services to be provided would be decided through joint meetings of BMCW and W-2 staff.

[1] I am aware that there is a temporary absence work group that is reviewing the feasibility of extending the temporary absence time limit from three to six months. I strongly support this change. However, it is also necessary to take action to insure that the policy is actually followed.

The final issue is in response to your letter of January 27, 2006 in which you indicate that you will be establishing a task force to address the needs of teen parents. The CAP public policy committee has a young parents work group that includes many direct services providers in Milwaukee, as well as staff from MPS and the city health department. This group is the group that has been meeting with Ms. Revels-Robinson. On occasion Burnie Bridge, Brenda Bell-White and Mary Musk have also attended these meetings. Instead of another group I would urge the department to work with the CAP public policy committee in a more formal fashion, in a manner that will lead to actual changes in practice and policy.

I, and many others, have long advocated for better integration of child welfare and W-2 services. The W-2 program is a program designed specifically to help parents with children. Yet for far too long it has failed to recognize the needs, demands, and obligations of W-2 participants as parents.

It is my hope that the two systems can now begin to work together in a meaningful way. DWD should designate Milwaukee staff to meet with the Bureau and representatives from the CAP public policy committee to develop procedures for the collection and reporting of the data identified above, to develop written procedures and requirements for the interaction of W-2 and Bureau staff as well as the provision of services to families involved in both systems (including families in which reunification is expected), and to address the needs of teen and young parents through the coordination of service providers and the identification and development of needed services.

I look forward to your response.

Very truly yours,

Patricia DeLessio
Attorney at Law

PDL/eca

cc: Brenda Bell-White, Section Manager, DWD regional office
Bill Clingan, Administrator, Division of Workforce Solutions, DWD
Denise Revels-Robinson, Director, BMCW

Burnie Bridge, Division of Children and Families, DHFS
Mary Thomas, Co-Chair, CAP. Public Policy Committee


FORWARD
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Executive Summary

2005 Comprehensive Case Review Report
Prepared by BMCW Program Evaluation Managers

March 2006

Bureau of Milwaukee Child Welfare
Wisconsin Department of Health and Family Services
Division of Children and Family Services

Bureau of Milwaukee Child Welfare
2005 Comprehensive Case Review Report
Executive Summary

Prepared by BMCW Program Evaluation Monitors
March 2006

Introduction

Each year the Bureau of Milwaukee Child Welfare (BMCW) conducts a comprehensive review of each program area. The 2005 Comprehensive Review was conducted between August 2005 and January 2006. The purpose of the review is to assess the work being performed in each BMCW program area by identifying strengths, areas of progress, concerns and trends. Ultimately, the review provides information that helps improve practice. After an analysis of the findings, we are able to make recommendations regarding training and skill development of staff or programmatic changes that may be required to ensure we meet our responsibility for the safety, well-being and achievement of permanence for children in our care.

The review was conducted by teams consisting of Program Evaluation Managers, BMCW Site Managers, Fiscal Evaluation Managers, other BMCW staff, and professionals from diverse agencies, institutions and advocacy groups familiar with child welfare issues. The community consultants were representatives from Children's Hospital of Wisconsin, Milwaukee Public Schools, Milwaukee Health Department, the District Attorney's Office at Children's Court, Milwaukee Mental Health Association, State Department of Health and Family Services, Division of Health Care Finance, Saint Aemilian-Lakeside, Task Force on Family Violence, Social Development Commission, COA Youth and Family Centers, In Their Best Interests, Neighborhood House and Court Appointed Special Advocates (CASA).

The review included cases from Intake, Initial Assessment, Independent Investigations, Safety Services, Ongoing Case Management, Adoption and Out-of-Home Care. Cases were selected for each program, either at random or according to pre-selected criteria, to ensure a diverse caseload for review. All programs and sites, with the exception of Intake, were asked to have caseworkers, family members, foster parents and/or service providers available for interviews with reviewers. All cases selected for review, except for the Out-of-Home Care program, were open at some time during the period from July 1, 2005 to September 30, 2005. The Out-of-Home Care sample was taken from children placed during November 2005.

The findings are based on a review of case files and data on the WiSACWIS data system, as well as insights and information obtained by interviews with case

managers, licensing and placement specialists, foster parents, service providers, parents and children receiving services through the BMCW, and Adolescent Assessment and Placement Stabilization Center staff.

Intake

Sample size: 60 cases (50 screened in, 10 screened out). All screened-in cases were also reviewed for work done by Initial Assessment.

Strengths:

- Screening decisions are appropriate.
- Responses to referrals made during non-business hours were appropriate.
- Rational for screening decisions was provided for both screened-in and screened-out referrals.

Concerns:

- Intake documented prior referrals listed on WiSACWIS, but did not consistently describe the findings of these referrals.
- Reasons for screening decisions were unclear in three cases.

Initial Assessment (IA)

Sample size: 50 cases (10 from each site) were reviewed.

Strengths:

- Sound placements were made to ensure child safety.
- Cases referred to the Safety Services program had specific services identified at the time of the referral to the program.
- Families reported favorable interactions with the initial assessment social worker.
- Sound decisions for case disposition, whether to transfer, close or continue a case following the completion of the initial assessment, were made.

Concerns:

- There were limited efforts to involve fathers during the initial assessment process.
- One-third of the cases had an inadequate assessment of underlying causes for the referral.
- Documentation of information gathered, that would normally be expected, was missing, including documentation of collateral contacts.

Independent Investigations

Sample size: 25 investigations of alleged maltreatment in licensed foster homes. (Per Statute, BMCW contracts with an outside agency to conduct these investigations).

Strengths:

- Investigations were thorough, addressed all concerns and demonstrated good quality overall.
- Foster parents interviewed during the review considered the investigators fair and impartial and reported the investigator was interested in gathering the information necessary to make a sound determination.
- The determination of maltreatment followed directly from the documentation and explanation provided by the investigators.

Concerns:

- The method of documenting interviews made it difficult to determine if *CPS Standards of Investigation* were followed with respect to interview protocol.
- Poor communication between programs was noted when independent investigations were being conducted.

Out-of-Home Care

Sample size: 27 cases were selected for review; including nine children who had been in Placement Stabilization Centers, nine in assessment foster homes and nine in Adolescent Assessment Centers.

Strengths:

- For cases where there had been a foster home placement, 80% had updated support plans that were specific to the foster parents and child.
- Assessment home providers acknowledged sufficient support provided by the OHC coordinators.
- Teen residents reported feeling safe and that the center's staff cared about them.

Concerns:

- There is a lack of placement resources for adolescents
- Many of the support plans created for foster homes in which children had been moved to the stabilization centers were generic.
- The assessments of children's needs provided by the centers lacked depth.

- Assessment home providers have no formal or standardized method for sharing their assessment of a child's needs with BMCW staff.
- Adolescent Assessment Centers and Placement Stabilization Centers are intended to serve different populations. The review showed that children have been inappropriately placed in both types of centers.
- The length-of-stay requirements are being exceeded.

Ongoing Case Management

Sample size: 50 ongoing cases (ten from each site) were reviewed, including.

Strengths:

- Placement decisions were well made and considered the child's needs.
- Improved service planning and selection was seen since the 2004 review.
- Improved effort to engage families was evident.
- Good contact was maintained with service providers.
- Coordinated Service Team (CST) meetings are occurring regularly.

Concerns:

- Documentation lacked justification for changes of placement.
- Actions taken to ensure visitation decreased in 2005.
- Concurrent planning is not well understood or used appropriately.
- CST meetings do not consistently involve all case participants.

Safety Services

Sample Size: 25 cases (five from each site) were reviewed.

Strengths:

- Based on interviews with families, they are generally appreciative of intervention efforts and describe good relationships with safety service workers.
- Most cases included documentation of regular contact with the family.
- In 60% of the cases, the reasons for closing were clear and complete, and the families were referred to community services when appropriate.
- Safety service managers were attentive to safety concerns in the families.

Concerns:

- Not all family members are consistently assessed, especially for chemical dependence or mental health issues; parents were not fully assessed in 12 cases (48%).
- Coordinated Service Team staffings were not clearly delineated in both the documentation and in the families' perceptions of their meetings with safety managers.
- The measure of *efforts to engage family in service* received the lowest scores mainly because fathers were not part of planning or services.
- Continued service needs were not addressed at the time of closing for three cases (12%).

Adoption

Sample size: 25 cases that were open for services with a primary staff person assignment in Ongoing Case Management and a secondary staff assignment to an adoption worker with Children's Service Society of Wisconsin were reviewed.

Strengths:

- Adoption workers demonstrated more involvement with on-going case managers, out-of-home care staff, family members and services providers, which facilitated better case planning.
- Individualized and targeted recruitment efforts to find appropriate permanent placements for children with unique needs were evident.
- Thorough and timely assessment of families and children was noted.
- Communication between adoption staff and caregivers improved compared to past reviews.
- Increased attendance at CST meetings was noted.

Concerns:

- Poor documentation across all areas of the program was noted.
- Advocacy by adoption workers on behalf of families and children when barriers to permanency are identified is lacking.
- Adoption workers report spending little time interacting and preparing children for adoption.
- Life Books are not being completed for children.

Conclusions and Final Recommendations

The BMCW and its partner agencies have developed the framework for best practice in child welfare. This partnership recognizes that the strengths or practical concerns in one program can impact all others. Improvements have been made across all program areas. It is recommended, however, that all programs continue to focus on the following identified areas where practice needs to be strengthened across all child welfare program areas:

- Strengthen meaningful engagement with biological parents, children, out-of home caregivers, and between child welfare professionals involved with the child. Specific collaborative strategies are needed to engage biological fathers, incarcerated parents, and relative caregivers in realistic decision making on placement and permanency planning for their children.
- Provide greater clarification to biological families, foster parents and service providers and their role as team members in implementing the CST process.
- Conduct and use assessments that contain comprehensive and descriptive information. The information should include: child safety, development, physical and mental health status, and the underlying causes of maltreatment, as well as the capacity, functioning and needs of parents, and the ability of out-of home caregivers to care for the child.
- Improve timely information sharing and communication across program areas that is critical to the success of a coordinated child welfare system.
- Maintain frequent, consistent and quality interactions with children by child welfare professionals as a necessary component to a quality assessment and reinforce as a standard of child welfare practice.
- Plan and implement visitation between children, their parents and siblings, and evaluate the impact on the stability of out-of-home placement and achieving timely permanence.
- Develop and implement individualized support and service plans that match the identified needs of the child, parent and caregiver. Improve coordination and communication within and between programs and service providers (private and public) regarding consistency and timeliness of support and services.
- Strengthen and improve timely and descriptive documentation regarding problem solving, contacts with parents, caretakers and service providers about needed services, placement decisions, permanency plans and outcomes.

- Give attention to improving documentation by supervisors about their oversight and direction of case activities.
- Improve quality of case management provided to Kinship families caring for children in out-of-home care, and to foster parents; to ensure child safety and placement stability.
- Identify realistic permanency options and appropriately use concurrent permanency planning, especially in cases where the child has been in out-of-home care for more than 24 months.
- Collaborate on strategies to address the overall lack of foster homes, specifically for adolescents, and the impact on all programs when a child is placed in an out-home-care home or center and their needs are not met.
- Develop and conduct cross program training as a collaboration between BMCW and its contract agency partners, including the University of Wisconsin (UW-M) Training Partnership, for all child welfare supervisors regarding a coordinated response to children and families through:
  - comprehensive and integrated assessments,
  - placement decisions that ensure the safety and permanency of children,
  - realistic and timely permanency planning,
  - development of strategies associated with concurrent permanency planning,
  - training of child welfare supervisors from all programs together not as an individual unit,
  - inclusion of out-of home caregivers, kinship providers and assessment and placement stabilization center staff in cross training,
  - incorporating case studies indicating best practice into training.
- Strengthen the relationship between programs, network service providers, and community resources, in order to ensure timely and coordinated service delivery.

Overall, program areas demonstrated consistency in their efforts to address concerns noted in prior comprehensive reviews. As indicated in the current report, each program area demonstrated improvements and sustained performance since 2003. In areas where programs fell short of their 2004 performance, it is recommended that all programs will be as diligent as they have been in developing and implementing targeted strategies to address performance concerns identified in the 2005 review.