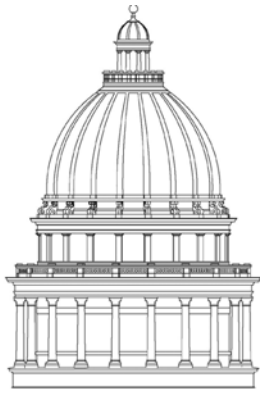
Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

REPORT NUMBER 2009-10
June 2009

A Performance Audit of the Office of Services Review



The Office of Services Review (OSR) evaluates the performance of the Division of Child and Family Services (DCFS) to determine whether required processes are followed and to assess outcomes for children and families. This report focuses on OSR's Case Process Review (CPR), which evaluates DCFS fulfillment of policy and statute. In recent years DCFS has improved their performance in these reviews. By helping demonstrate improvement in the state's child welfare system, the CPR contributed to the dismissal of the *David C. v. Huntsman* (*David C.*) lawsuit, ending federal court monitoring of Utah's child welfare system.

OSR evaluates DCFS fulfillment of case process requirements. Their findings have contributed to the *David C.* lawsuit's dismissal.

Our audit of the CPR concluded that OSR staff is accurate and unbiased in their review. We found that OSR was correct 97.5 percent of the time and there was no apparent bias in the type of errors the OSR reviewers made. Beginning in December 2010, OSR will be able to make changes to the questions included in the CPR. We recommend OSR evaluate their practices now so they are ready to make appropriate improvements when allowed.

Introduction

The 1994 Legislature passed House Bill 265 to reform the state's child welfare system and increase accountability.

In response to widespread concerns with the state's child welfare system, the 1994 Legislature passed House Bill 265 to require comprehensive changes in how cases are handled and also more accountability to the Legislature. Since then, Department of Human Services staff have been required to "randomly select" DCFS cases and report whether "state statutes, division policy, and legislative policy were followed in each sample case." Over the years, DCFS has improved their performance in the case process review, so OSR reports DCFS is performing well. As instructed by statute, the Legislative Auditor General (OLAG) periodically audits how OSR completes the reviews to determine whether OSR is accurate and unbiased.

OSR Performs Reviews of DCFS For DHS

OSR's mission has broadened from policy review to qualitative reviews and other activities.

OSR is the office in charge of quality review for DHS. Since its creation in 1995, OSR's mission and operations have broadened. Initially, the office was created to review DCFS caseworkers' adherence to statute and policy, but the Legislature has since expanded OSR's duties to include qualitative reviews, as well as other activities. Figure 1 briefly explains the various functions of OSR at DCFS.

Figure 1 OSR Performs Various Performance Reviews of DCFS.
This report focuses on the first review type, the CPR.

Case Process Review (CPR)–Evaluates caseworkers' compliance to DCFS guidelines and statutes.
Qualitative Case Review (QCR)–Evaluates the current status of children and their families as well as the performance and outcomes of the case.
Fatality Reviews–A review of the deaths of all individuals for whom there is an open case at the time of death.
Related Parties–Casework completion if a case involves a DCFS employee, or a party who may influence a DCFS investigation.

All of these reviews are meant to fulfill OSR's mission "to conduct accurate and unbiased analysis of the quality of services provided to DHS clients."

OSR is not under the auspices of DCFS. Instead, the director of OSR reports to the executive director of DHS. This organizational setup provides a separation of oversight allowing OSR to maintain independence from DCFS, the division they are reviewing. DCFS performs services protecting children in the state of Utah, through child protective service investigations, home-based care and foster care cases. DCFS, like OSR, performs their services under the direction of DHS. OSR then acts as a yardstick, measuring DCFS' performance and reporting it to DHS and the Legislature.

By reporting to the executive director of DHS, OSR maintains independence from DCFS.

The CPR analyzes the availability and existence of documentation at DCFS to determine whether DCFS follows policy and statute. This compliance review is performed annually in each region and is the sole focus of this report. OSR reviews the three basic types of cases handled by DCFS and listed above: child protective services (CPS), home-based services, and foster care. Within CPS, there are five subsections of cases: unaccepted, shelter, unable to locate, medical neglect, and priority one. A description each type of case is provided in Appendix A. The CPR process is described in Figure 2.

Child protective services, home-based services and foster care functions are all reviewed by OSR.

Figure 2 The CPR Process Randomly Chooses DCFS Cases to Evaluate. In the course of the evaluation, reviewers decide whether specific criteria/policies have been documented as completed.

- A random sample of cases is chosen for each case type in each of five regions.
- An OSR reviewer searches the DCFS SAFE computer system to determine whether specified requirements were documented.
- After each region has been reviewed, the OSR reviewers go to the region to have an exit interview with the case workers about their findings. Reviewers gather information they may have missed and then discuss problems, as well as strengths, in the documentation with the caseworkers.
- The reviewer makes the final determination about whether each measure was appropriately documented.
- OSR does a quality assurance review and then compiles and reports the results.

OSR performs this review on 100 percent of the shelter, unable to locate, medical neglect, and priority one cases, and approximately 4.3 percent of the remaining case types that are handled by DCFS.

OSR Reports DCFS Is Performing Well

In addition to providing accountability to the Legislature, the CPR has been a part of the federal court's monitoring of DCFS performance.

The CPR has demonstrated improved performance by DCFS. As noted above, the CPR was initially required by the state's 1994 Child Welfare Reform law as the Legislature demanded that DCFS be more accountable for their performance. After the state entered into a settlement agreement in response to the *David C.* lawsuit, the CPR became an important part of the federal court's monitoring process. The fact that OSR reported improvements in DCFS performance on the CPR helped lead to the dismissal of the *David C.* lawsuit in January 2009.

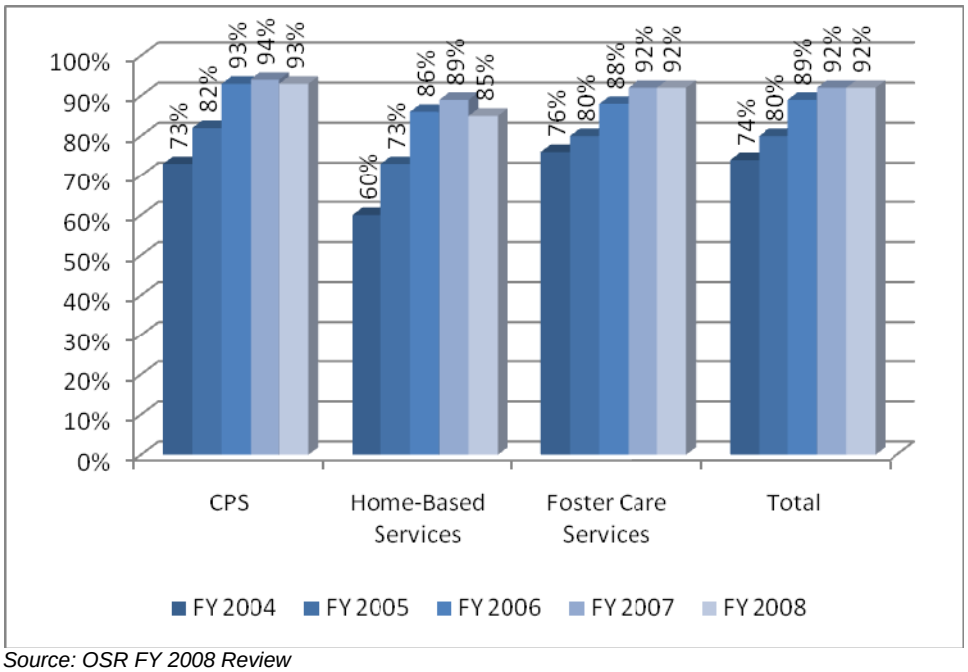
DCFS Performance in the CPR Has Improved Steadily in the Past Five Years. The OSR Annual Report details that in fiscal year 2008,

DCFS fiscal year 2008 performance did not decline, following a three year trend of acceptable performance.

- All case types met the goal of over 85 percent compliance for the last three years.
- Evidence of completion for required activities occurred in 92 percent of cases reviewed.
- No marked declines occurred on individual measures in any of the case types. A marked decline is defined in the *David C.* agreement to terminate the lawsuit as falling 10 percent below the standard.

DCFS' improvements are further shown in Figure 3.

Figure 3 DCFS Has Improved Their Performance In the CPR Review. Any results over 85% are considered acceptable.



Source: OSR FY 2008 Review

Performance in the above case types has improved almost 20 percent since 2004.

DCFS' Improved Performance Has Led to the End of the *David C.* Lawsuit. In the agreement to terminate the *David C.* lawsuit, the parties agreed that "significant reforms to Utah's child welfare system have been achieved." According to the director of the National Center for Youth Law, the plaintiffs in the *David C.* case, Utah has effectively reformed their child welfare system and made it one of the best. System improvements can be attributed to many changes throughout the DCFS child welfare system. Progress has been made in the following areas:

The parties to the *David C.* lawsuit agree that significant reforms have been achieved.

- Budget –$45 million in 1993 to $162.8 million in 2008
- Caseworkers –282 in 1993 to 612 in 2007
- Training – Program and tracking system established

Improvements have been made in DCFS' budget, caseworker numbers and training program.

While the system improvements can be attributed in part to the above advances, they are demonstrated, in part, by increases in DCFS' CPR performance. OSR continues to provide a check on DCFS and its employees.

Scope and Objectives

OLAG evaluated eight percent of OSR's CPR cases to fulfill *Utah Code* 62A-4a-118(4)(a).

The purpose of this audit is to evaluate the accuracy of OSR's case process review to provide evidence about its reliability. ***Utah Code*** 62A-4a-118(4)(a) charges that "the legislative auditor general shall audit a sample of child welfare referrals to and cases handled by the division and report his findings." In order to fulfill this statute and evaluate OSR's case process review, we randomly selected from three DCFS regions a sample of the cases OSR reviewed. Figure 4 shows the selection process.

Figure 4 OLAG Evaluated About 8 Percent of OSR's Review Cases. We audited cases in the Western, Eastern, and Salt Lake Valley regions of DCFS.

Review Category	OSR Sample Size	OLAG Sample Size	Percentage
CPS General	134	11	8%
Unaccepted CPS	132	9	7
Shelter Removals	161	13	8
Unable to Locate	86	8	9
Medical Neglect	16	2	13
Home-based Services	124	11	9
Foster Care	132	8	6
Total	**785**	**62**	**8%**

After selecting these cases, we evaluated them using the same questions the OSR reviewers used, or performed a double read. OLAG accompanied OSR on the exit interviews in order to have the same information as OSR for the review. OLAG and OSR then compared answers, and determined whether the answers were the same, or, if there was a disagreement, if OLAG was correct. We then compiled the answers to determine whether OSR was accurate and unbiased in their review.

OSR Is Accurate and Unbiased in The CPR Review of DCFS

Our audit work showed that OSR provides a reliable evaluation of DCFS adherence to child welfare policy requirements. The double

read that we performed found that OSR reviewers were correct in 97.5 percent of the CPR questions. OSR reviewers also demonstrated a high level of performance in OSR's own internal double reads, as well as in reviews by the *David C.* court monitors. The errors made were evenly distributed among the OSR reviewers and did not demonstrate any unequal reviewer performance. Furthermore, our analysis of the errors that were made did not indicate any type of bias by OSR. The errors did not show any pattern in consistently incorrect questions or similarly incorrect answers.

Our Review Showed OSR Is Accurate

Of the cases audited, OLAG found OSR reviewers' answers were correct 97.5 percent of the time. This means that either OLAG's initial review produced the same answer as OSR or, when compared, OSR could show why their answers were correct. Figure 5 shows the breakdown by case type of agreement levels between the OSR reviewers and the OLAG reviewers.

We found OSR's review was correct 97.5 percent of the time.

Figure 5 OSR Was Correct in Their Review 97.5 Percent of the Time. Individual categories' rate of incorrectness ranged from 0 to 7.5 percent.

Review Category*	Number of Cases Reviewed	Number of Questions Reviewed	OSR Correct	OSR Incorrect
CPS General	11	88	98.9%	1.1%
Unaccepted CPS	9	27	100.0	0
Shelter Removals	13	65	98.5	1.5
Unable to Locate	8	40	92.5	7.5
Medical Neglect	2	2	100.0	0
Home-Based Services	11	88	97.7	2.3
Foster Care	8	200	97.0	3
Total	**62**	**510**	**97.5%**	**2.5%**

** No priority one cases were reported in the 2008 review period.*

In our duplication of OSR's review, we found that only 2.5 percent of OSR's answers were incorrect. This is consistent with OSR's high-level performance in OLAG's past audits. The relatively high level of erroneous answers in the unable to locate category did not cause a great deal of concern for the OLAG double reader, as they

all occurred in the same case. The errors all related to a similar confusion over the child's placement. Because of this, we see no cause for concern over the relatively higher percentage of incorrect answers.

OSR's management performs their own internal quality control measures, including an internal double read.

The OSR reviewers also perform well in their own internal double read, achieving between 94.7 and 98.4 percent correct in the last three years. OSR management also performs other quality control methods.

OLAG Audit Used the Same Methods of Comparison as the Court Appointed Reviews. As part of the court oversight of the *David C.* case, an outside group performs yearly double reads to ensure that OSR is as accurate as possible. The Child Welfare Policy and Practice Group (CWPPG) was the group selected to perform this function on the CPR cases. In CWPPG's double reads for fiscal years 2006-2008, OSR was correct between 97.0 and 98.3 percent of the time.

The court monitor's double read reported between 97 and 98.3 percent correct readings by OSR reviewers.

In this audit, after reading the cases to determine whether the DCFS caseworkers met certain criteria, we compared our answers to those of the OSR reviewers. If OLAG could not determine why OSR arrived at a particular answer, each side demonstrated the information used to determine their answer. This is considered the unadjusted level of disagreement. Frequently, the OSR reviewer was able to show that their conclusion was correct. Figure 5 on page 6 reports those instances where OSR was incorrect in differences, or the adjusted level of disagreement. Of the questions reviewed, OSR was able to demonstrate that they were correct in disagreements 11.2 percent of the total, while OLAG was correct 2.5 percent. Our unadjusted level of agreement was 86.3 percent, in comparison to CWPPG's 2008 unadjusted level of 93 percent. Our adjusted level was 97.5 percent, in comparison with CWPPG's 2008 adjusted level of 98 percent. The 2008 CWPPG report said, "Both the unadjusted and adjusted levels of agreement represent an admirable level of agreement."

There was no evidence of more errors by one reviewer than the other, or that either reviewer missed the same question consistently.

Error Levels Were Evenly Distributed Among the OSR Reviewers. In addition to maintaining a reasonably low level of error, the OSR reviewers' error levels were evenly dispersed. There are three OSR reviewers, two of whom do the majority of the reviews. The error rate for the three was quite even, and there is no evidence

that any one reviewer has more errors than another. There is also no evidence that reviewers consistently missed the same questions.

The Double Read Cases Showed No OSR Bias

In our audit of OSR's CPR process, we found no evidence of reviewers having a bias in relation to any of the questions asked. There was no duplication of incorrect questions. In addition, there was no clear trend of types of mistakes by OSR reviewers. Figure 6 lists each question that was wrong and the reason it was incorrect.

We found no evidence that reviewers were biased in either specific questions, or type of mistake.

Figure 6 There Was No Review Question That Was Consistently Wrong. The reasons for incorrectness also present no consistent type of mistake.

Review Category	Question Topic	Reason OSR Was Incorrect
CPS General	Interview with child	OSR reviewer answered yes when the guidelines indicate NA
Shelter	Visit with child	OSR reviewer missed evidence regarding a child visit
Unable to Locate	Check with schools	OSR reviewer did not realize child was not school aged
Unable to Locate	Check with law enforcement	OSR reviewer missed evidence of contact with law enforcement
Unable to Locate	Check with referent	OSR reviewer did not realize shelter was the referent
Home Based	Stepparent involvement	OSR reviewer did not find a stepmother
Home Based	Home visit	OSR reviewer answered NA when the guidelines indicate yes
Foster Care	Private child visit	OSR reviewer missed evidence regarding a child visit
Foster Care	Timely health assessment	OSR reviewer typing error
Foster Care	Dental follow-up	OSR reviewer answered yes when the guidelines indicated NA
Foster Care	Timely planning	OSR reviewer miscalculated the timing of plan timing requirements
Foster Care	Parental involvement	OSR reviewer missed evidence of parental involvement
Foster Care	Stepparent involvement	OSR reviewer missed evidence of a stepparent due to SAFE discrepancies

There is no evidence that any specific questions are causing problems in the review, or that the reviewers are inclined to make similar errors in their answers.

OLAG discovered 13 questions OSR answered incorrectly. Reviewed questions can be answered in four basic ways: yes, indicating the documentation showed the caseworker followed statute

and policy; no, indicating the documentation could not prove policy had been followed; partial credit (PC), indicating some but not all of the documentation for a particular question was shown; and not applicable (NA), indicating the question does not apply to the case. Of the questions incorrectly reviewed, they were answered incorrectly in the following way:

- Yes that should be no – 2
- Yes that should be NA/PC – 4
- No that should be yes – 5
- No that should be NA – 2

Although we found all four types of corrections in the double-read process, one concern is that questions incorrectly identified as no answers are more likely to be caught in the final interview than questions incorrectly identified as yes. This occurs because when the reviewer tells the caseworker that they received a yes on a review question, the case worker is unlikely to argue that the question should have received a no. On the other hand, if the question receives a no, the caseworker will search through the available information to identify where they could conceivably get a yes. This is one reason the double-read process is essential – to mark where yes answers are given inappropriately.

There is no evidence that OSR is inclined to give inappropriate yes or no answers.

OSR Should Review the Content of the CPR Questions to Determine Possible Improvements

Now that the *David C.* lawsuit has ended in 2009, OSR will soon have the opportunity to go through its own processes and CPR questions to determine which should change. They should consider possible system changes, as well as the effect that developments in technology and policy should have on the review.

When the *David C.* lawsuit was coming to a close, the plaintiffs and the State of Utah signed an agreement to terminate the lawsuit. This agreement established that the reforms and improvements made to the system need to be sustained. As part of this agreement, the state contracted "to continue operating in accordance with the Milestone Conditions [including the OSR reviews] until at least December 31, 2010." This period will soon come to a close, allowing

The period of compliance with termination conditions will soon end, allowing OSR to adjust aspects of the CPR.

OSR the opportunity to examine their own processes to determine how best to proceed. This analysis should include both process and question/wording scrutiny.

There are multiple possibilities for system change, potentially allowing the CPR system to be more useful and effective. Potential changes include the following:

- Combining some cases reviewed in CPR and QCR could maximize efficiency. A separate random sample is taken for the CPR and the QCR, with no overlap. Some overlap of cases may reduce duplication of effort and increase the ability for OSR to provide continuum of services.

- Including some of the federal review questions in the CPR could better prepare DCFS for the federal review. For example, in home-based care, the CPR questions whether a monthly visit has been made in the home, but there is no requirement that the children or parents are seen. The federal review asks for effective, face-to-face visits. OSR could check for performance of this requirement in anticipation of the federal review.

System improvements could be made to avoid duplication of OSR's effort.

Other possible system improvements could be identified by OSR in the course of in-depth analysis. This would increase OSR's usefulness to DCFS and the state as a whole.

Changes in both technology and policy should be considered when revising CPR questions.

OSR's review of the CPR process should also include reviewing the questions to be included and the wording of the current questions. In discussions between OLAG and OSR management and staff, as well as in our own observation, it has become apparent that some questions have simply become obsolete. Whether this is because of developments in technology or changes in DCFS policy, these questions should be reviewed to determine if they are still useful. Some questions may be ready for revision for the following reasons:

- **Technology changes**–Time sensitive questions, such as whether priority in CPS cases was met. These cases are now tracked clearly in SAFE, and therefore may not need to be specifically reviewed by OSR.
- **Policy changes**–Questions that may no longer follow policy, such as health visits for children under 18 months.

DCFS policy requires multiple health visits, while OSR searches only for one visit, no matter the age of the child.

Examining these improvements has the potential to make OSR more effective in their efforts to improve practice at DCFS. OSR management has already begun to examine some options to improve after the 2010 review, and minor changes were made after the fiscal year 2007 review.

Recommendation

1. We recommend OSR begin evaluating their review processes and questions in order to make changes where appropriate.

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APPENDIX A

Case Types Reviewed by OSR

	Case Definition	Reviewed to Find:
CPS General	Investigation by caseworker into accusations of possible abuse or neglect of children	Priority timeframe to see the children, offering of services, timely case completion, appropriate party interviews, and support of case findings
Unaccepted CPS	Referrals of possible child abuse or neglect rejected for full investigation by DCFS intake	Documentation of the nature of the referral, support for the reason for dismissal, and staffing of the referral
Shelter Removals	Removal of children and placement in a temporary shelter before either being returned to the home or placed in more permanent care	Appropriate child visits, gathering of safety information on the child, and investigation of appropriate kinship placement
Unable to Locate	Referrals of abuse or neglect in which the family in question cannot be found	All reasonable efforts to locate the family and children in question have been made
Medical Neglect	Accusations of medical neglect	Consultation by a health care professional
Priority One Cases	CPS cases rated priority one, which involve severe maltreatment and require a response within 60 minutes	Performance of a medical exam within 24 hours of the case beginning
Home Based Services	Family preservation services, voluntary protective services, and court-ordered protective supervision services, all of which occur while the child is still in the home	Aspects of a Child and Family Plan, and monthly home visits for the review period
Foster Care	Families with children in out-of-home care due to abuse, neglect, or dependency	Appropriate placements, visits with the child and their caregiver, appropriate health and mental health provision, educational services, and required aspects of a Child and Family Plan

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Agency Response

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State of Utah

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June 2, 2009

John M. Schaff, Auditor General
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PO Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Schaff:

The Department of Human Services, Office of Services Review (OSR) is in receipt of the Legislative Auditor General's (ULAG) Performance Audit of the Office of Services Review Report (report No. 2009-10). The OSR very much appreciates the thoroughness of the review and is in agreement with the recommendations of the report. In doing this type of review the OSR recognizes that reader errors will occur given the volume of written material that must be reviewed. We are pleased that ULAG once again found OSR's error rates remaining low and that there is no bias in the way questions were answered.

The Auditor's review made one recommendation: 1) we recommend OSR begin evaluating their review processes and questions in order to make changes where appropriate. In connection with this the Auditor points out two potential areas of change: 1) combining some cases reviewed in Case Process Review (CPR) and the Qualitative Case Review (QCR) to maximize efficiency and 2) including some of the federal review questions in the CPR in order to better prepare for the upcoming federal review. We are in agreement with both of these suggestions. We are already in the process of setting up meeting times with the Division of Child and Family Services to discuss how we can incorporate certain federal review questions and/or replace similar questions in the current CPR for the next round of reviews. We will also look over the feasibility of doing some type of CPR/QCR combination as we meet this summer as well.

Once again thank you for your staff's time and energy in performing this service for our office and the Department of Human Services and how it helps improve the services that are offered to Utah's children and families.

Sincerely,

Brad M. McGarry, Director
Office of Services Review

Cc: Lisa-Michele Church