EXECUTIVE SUMMARY – ASSESSMENT

The Texas Health and Human Services Commissioner and the Department of Family and Protective Services (DFPS) engaged The Stephen Group (TSG) to conduct a "top to bottom" operational review of DFPS, Child Protective Services (CPS) and identify ways in which the agency can find improvement. TSG was called upon to assess the various aspects of CPS, such as organization, work flow, allocation of staff, decision making and general business processes including policy development, continuous quality improvement and budgeting, along with relevant support structures such as training, hiring, contracting, and finance. We fear that this Assessment will by the nature of the assignment provide a tone that could be construed as negative. It is important to point out that we could very easily have put together a detailed report on the many strengths of CPS that also would have been voluminous. However, the scope and objectives of this Assessment were to determine areas for improvement.

In order to provide some balance, we feel it is significant to point out that TSG's assessment found many aspects of CPS's performance and plans to be exemplary. A few examples include:

- Strong dedication at all levels to child safety, well-being and permanence. This extends far beyond compliance with rules and policy to true dedication
- Many tenured employees with deep industry experience
- Many programs of change and improvement are under way, including Foster Care Redesign, streamlining policy and many more
- Effective court relationships around the state
- The placement of many children found in volatile family situations with relatives so as to keep them as close as possible to their families
- Offer families voluntary family based services where many states do not
- High adoption rate—earning the State $10 million in federal bonus payments in SFY2014
- Collaborating through an innovative program to run a special investigative unit including CPS in El Paso and the Army at Fort Bliss

Yet, this organization which admirably serves nearly 200,000 families per year has many opportunities for improvement.

By way of background, CPS plays a critical role in ensuring the safety, well-being and permanence of tens of thousands of children each year, either by helping their families build

safer environments, or by finding homes in which vulnerable children can thrive. The dedicated staff of 5,400 direct caseworkers puts themselves in harm's way and invests themselves directly to make Texas' children safer. It is a stressful and challenging job, but one that many find intensely personally rewarding.

TSG realizes that any review of an agency with as many moving parts as CPS must be comprehensive and thorough. It was for that reason that we worked to leave no stone unturned in our efforts to unearth the reality of how CPS operates, from the ground level to top management. To do any less would be a disservice to the thousands of workers who have made this organization their passion.

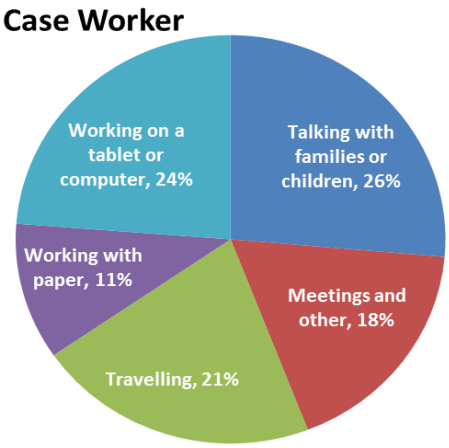
Through this assessment, TSG reviewed the operations at the State Office, visited each of the 11 regional offices, and did process mapping for them to understand the work flow. We joined in on ride-alongs with caseworkers to understand the experience workers see every day. We conducted desk reviews of cases that CPS sees daily. We interviewed hundreds of individuals throughout the process, from top leadership in the agency and regional staff to legislative employees and involved stakeholders. We reviewed hundreds of reports and data sets to understand the historical trends in key operational areas and to get a firm grasp of the numbers behind the anecdotes. We also conducted a survey that gave us feedback from close to 2,000 CPS staff to understand perceptions and views from as many individuals as possible.

While no assessment can discover every detail of an agency as large as CPS, we are confident that our forensic analysis accurately reflects the work done throughout this organization. Assessment found a number of areas in which CPS could improve to better protect Texas' children. We have outlined in this Executive Summary the following key improvement opportunities. TSG feels strongly that if CPS takes immediate steps to address these opportunities for improvement, the agency can become a national leader and model for other states in keeping children safe, enhancing well-being and establishing permanency.

Field Staff only spends 26% of time with children/families

Currently, CPS' field staff only spends a quarter of its time directly with children and families. While some time away from actively meeting with those in the system is unavoidable (travel, court, etc.), this number is clear evidence that the agency is doing more compliance than care (see Figure 1).

Figure 1 - How Caseworkers Invest their Time



There is an abundance of policy, paperwork and other requirements of the Family Code. While the Texas legislature recently made a tremendous financial commitment of taxpayer resources to give CPS the staff to keep children safe, they continue to pass ongoing expansions of the Code. This Code has piled up to create a significant administrative burden, with laws that are, in a number of cases, repetitive of clear Federal law and policy, outdated, at times contradictory and many times micro-managerial. This means a huge amount of time and resources are dedicated to compliance over time spent focused on child well-being.

Beyond the Family Code, workers must deal with CPS policy, IT burdens, organizational delays and clerical responsibilities such as data entry. All of these actions interfere with the ability of direct care workers to do what they are truly passionate about – helping children and families. As one worker from Region 10 said succinctly, "I love going to see the children, but the paperwork is too much.[1]"

The consequences of these administrative burdens go beyond reducing the time that workers get to build relationships with families. They also mean longer waits to close cases, which leave families in limbo, and worker burnout that leads to high turnover and lower morale which impacts performance. We found that this administrative burden falls across the entire range of CPS direct services, from investigations to ensuring family well-being and permanence.

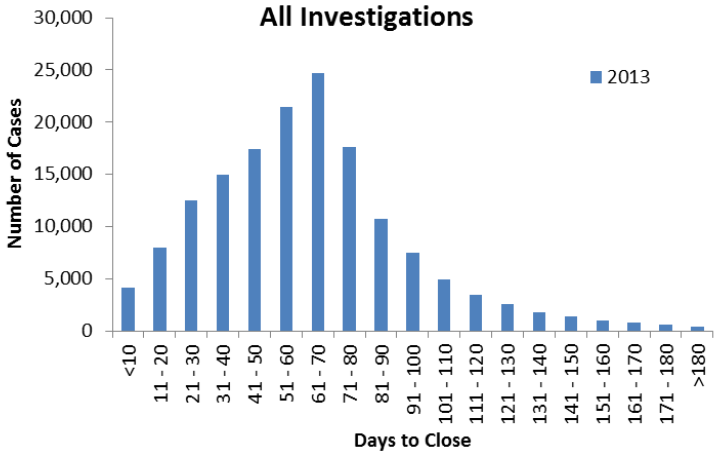
[1] TSG, CPS employee survey response

Investigations are remaining open for unnecessarily long periods of time.

Currently, CPS bases its performance on whether or not a case is closed in 60 days. The data show that once an investigator misses the initial target date, there is little incentive to resolve the issues quickly. Thus, CPS may remain involved with the family for longer than necessary.

Moreover, CPS policy and practice does not encourage caseworkers to close a case as quickly-as-possible to ensure that children are safe. An open case can be an emotionally excruciating period for any family, especially for those with cases which are closed without finding. Instead, the current structure uses only a 60 day measure, providing a strong incentive to close a case just before the 60 day mark, and no incentive to close expeditiously after that point[2]. Figure 2 shows the trend to keep investigations open until the 60-day deadline. Then for those cases that miss the deadline, the management metrics provide no encouragement to close cases soon after. Instead, caseworkers get credit for these tardy cases in their caseload.

Figure 2 - Histogram of days to complete investigations – 2013



TSG found, however, that investigations are being closed faster in 2013 compared to 2009. Table 1 below shows that the average close time has dropped two days, and that the median (50th percentile) has dropped by three days.

[2] CPS leadership has acknowledged this observation. During the course of the Assessment, CPS was experimenting with changes to the metrics that respond to this situation.

Table 1 - Average and median time to close investigations – 2009 and 2013

	2009	2013
Median	63	60
Average	65.5	63.7
Mode	63	63

This improvement is encouraging, but misaligned goals mean that investigations are still open longer than they need to be.

Employees are working under stress and in fear in order to avoid penalties or termination

Many supervisors focus on tracking numbers and metrics rather than creating a supportive environment. Accordingly, workers are fearful of making mistakes – mistakes that could end up getting them fired. This causes a paralysis for field workers, shifts more decisions up to supervisors as caseworkers protect themselves, and adds stress to an already stressful job which further drives turnover.

Policy is inconsistent, burdensome and not well understood

Internal CPS policy piles up and is not well-distributed to staff. When new policy is added, it frequently does not repeal old policy, it merely adds an additional layer. This means most caseworkers do not internalize existing policy or new changes.

There is little fiscal control to recognize the impact on caseload with proposed increases to the complexity of the process and the caseworker's job. This adds a number of unnecessary and low-priority steps to the field worker, already heavily burdened with high case load.

The ad hoc timing of policy updates contributes to a sense of constant uncertainty about how to handle current situations. As the policy unit might be working simultaneously on multiple policies that contradict one another, there are poor controls on tracking the various policies under development.

The policy updates are not reinforced with technology support and training to make them effective in changing behavior in the field. Policy is often difficult to understand. Ultimately,

staff does not necessarily consult policy in the CPS Handbook, instead turning to supervisors for direction. This adds to the burden on managers and sometimes results in conflicting interpretations.

The construction of policy also does not sufficiently consult field staff to get real-world experience in how a new policy might impact operations. At the same time, there is no opportunity for validation in the field before a policy is implemented.

In addition, the important link between policy and child outcomes was often not specifically described. TSG observed that this leaves the field caseworker to treat policy in the vein of compliance rather than as a tool for better child outcomes.

Caseload and workload are not synonymous and administrative and other burdens are making managing cases more challenging

Not all child protection cases are equal and CPS hands cases out based on caseload and not workload – they do not assess case difficulty in a structured or standard way. We found that workload can increase even as caseload stays the same. This reduces the ability of caseworkers to interact directly with families and instead turn their attention to non-value added activities. Moreover, there are numerous handoffs that take place throughout the process of bringing a case to resolution. These transactions, often in paper, add more and more work, as well as delays, for the caseworker, with little beneficial outcome for the children and families involved.

Decision making and critical thinking gives way to checking with supervisors: staff are not empowered to make critical decisions

In part because of laws and policy that are hard to understand and implement, caseworkers have replaced decision making and critical thinking with asking their supervisors (holding a "staffing") for direction. Caseworkers are not truly empowered to make critical decisions. This slows the decision making process. More importantly, it moves the decision away from the person most closely involved with the situation – the caseworker. The decision is ultimately with a supervisor who is not generally meeting with the family. Thus, the caseworker is not exercising his/her judgment directly. These approval meetings are called "staffings" and in many cases occur at regularly scheduled times rather than at the point of need for the case or for the front-line worker.

This lack of empowerment has a number of effects, such as slowing down critical decisions, potentially delaying case closures, putting additional demands on supervisors' time and not allowing caseworkers to build their decision making skills. Beyond all this, it sometimes builds a level of frustration among field workers that adds greater stress and causes some to leave CPS.

Safety and risk assessment tools are used as mere formalities

Tools to assess safety and risk are more formalities than actual mechanisms to help caseworkers assess potentially risky situations. They are not well structured and standardized, and decisions are being made about safety and risk that are overly subjective. Staff has begun to view these assessment tools as "check the box" exercises and not a predictive tool to identify child safety or the potential for risk in a family.

TSG found no formal, immediate safety assessment done within 24 hours of seeing a child. TSG also found no tool that caseworkers use to structure objective criteria as a model of the danger a child might experience. Such decisions are often complex requiring difficult judgment calls on the part of the caseworker. Instead, the "safety assessment" tool is a 7 day tool, in which the child could potentially be exposed to significant harm in that timeframe. This tool is completed after the decision has already been made—thus it is documentation rather than decision support. The companion "risk assessment" is done over the course of 30 days, also without the benefit of structured, objective analysis to create an understanding of potential threats to well-being.

Information Technology is not maximizing field worker time

The current IT tools and resources demand considerable time resources away from children and families. Staff spends considerable time doing administrative work to load information in the systems, often in burdensome manners. Both the software and the hardware have not been optimized with the goal of ensuring that caseworkers are spending as much time as possible meeting with children and families.

The IMPACT system is not in sync with current versions of forms that are used and forces arbitrary work-arounds and repetitive entry of data. This causes delays and considerable frustration among caseworkers and can mean that those accessing the system might not have immediate availability to the most recent updates in a particular case – a huge issue if a case has been handed off from one worker to the next.

While CPS has made tremendous strides in terms of expanding mobility, the field worker is still subject to many limitations once they leave the office. This is largely due to the inability to get away from a paper-based system, as opposed to a seamless electronic transfer system. This causes many delays and limits the ability of caseworkers to stay away from the office and be in the field. Furthermore, implementation seems to have emphasized the technical aspects of mobility, though not the user implications. As a result, caseworkers complain that they have lost the benefit of nurturing relationships "around the water cooler." This need not be the case, but seems to be the result of incomplete implementation.

Sharing information from the top of the organization and back is a struggle

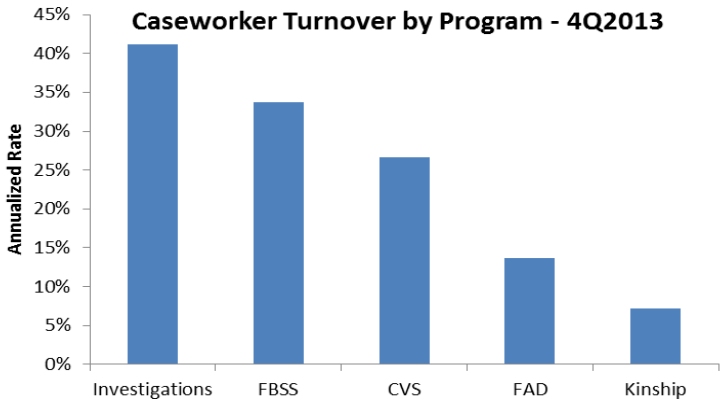
The challenge of disseminating policy to the caseworker is just one example of the difficulties that exists in communication from top-to-bottom within the organization. Workers are not confident that they know new policies, strategies and expectations from State Office and consistently check with a supervisor, which slows them down and undermines their decision making.

At the same time, State Office struggles to get quality feedback from workers in the field that would support their decisions or send a signal that practices should change. This isolation encourages choices that might not make the most sense and makes it more difficult to determine best practices that would improve performance across the organization.

Turnover is a major organizational burden

As an agency, CPS sees an extraordinary amount of turnover – over one quarter (25.5%) of the workers leave annually. However, among direct care staff, the turnover rate is even greater (see Figure 3). This represents an extraordinary organizational challenge to replace these workers and maintain a consistent level of performance.

Figure 3 - Caseworker Turnover

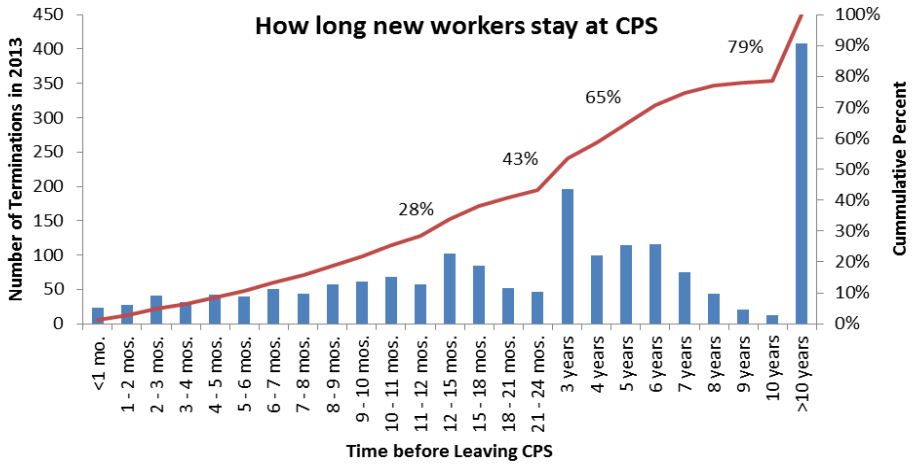


In large part because of administrative, compliance and technology burdens, many CPS workers get frustrated and burned out, causing them to leave the agency, which creates a major strain across the organization. This puts additional stress on remaining workers, and creates a culture that challenges any group's ability to internalize its mission.

Most organizations deal with stressful workplace environments either by seeking ways to remove obstacles, to lift the burden off the workers, or to create simplified workplace processes (for example, fast food restaurants). Although CPS' work environment and mission are more complicated than other industries, CPS needs to do more to remove obstacles or lift the burden off its workers.

Figure 4 shows that over one quarter of new workers leaves within 12 months—43% within the first 2 years. This allows situations to grow where workplace turnover is endemic and institutional knowledge is stripped from across the agency. Moreover, the process of constantly providing a significant investment in training new employees who leave shortly after they start is a poor use of taxpayer dollars, and puts a greater demand on other, more experienced employees, who are continually working to bring along new workers, while getting pulled away from their cases. We found that the highest turnover is among newer staff, with 5 or fewer years of services. Every time a less experienced worker leaves, it places a loss of a significant resource across the agency, both in terms of sunk costs in that worker, as well as the replacement cost for a new hire.

Figure 4 - How Long New CPS Workers are Retained



Data collection and metrics do not represent useful management tools

CPS is awash in data. There are numerous data collection and analysis sources for nearly every function across the organization. However, state and regional leaders lack a management dashboard to use these data to consider predictive trends and identify potential "hot spots" that require intervention before a bad outcome occurs. Instead, management has available 2,700[3] disparate data reports to try to make sense of what is often a fuzzy picture. This means that despite large quantities of data, it is useful primarily for historical analysis, not proactive decision making.

At the same time, the metrics used by the agency are not well aligned towards maximizing child safety, well-being and permanence. There is a tendency to try to use the same metrics for all purposes – updating the legislature, conforming to federal requirements, and managing the performance of employees. While this does simplify the reporting process, it does not create value that leads to quality improvement.

[3] Estimate of MRS, the group that creates the reports

Metrics are used to discipline workforce, not as a tool to inform decisions

Supervisors are driven to use metrics as a mechanism to make sure caseworkers "meet their numbers," not as a tool to balance workload, identify workers in need of training or recognize structural issues that should be resolved. This creates a culture of fear where caseworkers are focused more on meeting numbers and checking off boxes than on the quality of service for the children in families under their care.

Not surprisingly, many field workers do not feel supported by their supervisors, instead feeling that there is an effort to use metrics to discipline or fire them. This adds to the stress in the workplace and ultimately reduces productivity and increases turnover.

Supervisors are very experienced, but lack of succession planning should be a concern

We heard from caseworkers that supervisors are being promoted without experience, and that there are too many who are inexperienced, but the data does not demonstrate this. Instead, supervisors have, on average 11 years of experience. In fact, the data show that there are a small number of supervisors with fewer than 6 years of experience. This finding could mean that CPS faces an intermediate problem of replacing these supervisory positions in several years, as natural attrition leads to gaps in the management structure. Complementing this problem, the agency has no effective process in place to identify caseworkers who appear to possess quality supervisory skills to put them in a position to grow.

Poorly aligned quality assurance and quality management

CPS' quality assurance/management structure is not designed to be self-optimizing and creating a constant feedback system throughout the organization. This leads to distorted incentives in the field, confusion among those charged with legislative and executive oversight and less than optimal management practices among supervisors.

The monitoring systems for quality management are inconsistent and not effectively used for improvement. Unsurprisingly, there is no integrated quality plan to lift performance across the agency. Within each region, there is no mechanism in place to validate whether a quality improvement plan or structure has been fully implemented or even instituted. This means there

are uneven quality standards from region to region, which hinders the effectiveness of overall quality standards and application of best practices models. This also means that there cannot be an effective feedback loop to inform training about shortcomings, so that personnel can correct performance and improve outcomes.

CPS does not have a dedicated function focusing on continuous improvement and program integrity at the regional level. While various operations across the department consider specific aspects of program performance, there is no single point of examination of quality and effectiveness.

There is no process within CPS to find the "bright spots" of performance that could demonstrate exceptional practices that could be replicated across the agency. This represents a missed opportunity to build a constantly learning and growing organization.

True quality management requires a tremendous amount of coordination across various workgroups, functions and roles within an agency. We did not identify the level of integration among the existing various aspects of CPS to support an effective quality building process – instead the agency has a siloed approach to quality in which the various quality assurance programs are not interacting to inform decision making about the direction of improvement opportunities.

External outreach is reactive

CPS responses to the media to the legislature and stakeholders, are often times reactive (not proactive), sometimes allowing for a very negative picture to take root and persist. Frequently, the public and legislature only hear about CPS after a tragedy such as a child death or after a major cost overrun. Counterbalancing positive stories are far less common and not well communicated by the agency. Moreover, this can result in the legislature passing laws or the agency crafting policies to solve publicity problems, instead of actual direct issues identified in the field.

Such a negative view of an essential government function serves no one well. The legislature complains of a "data dump" without useful information. Key stakeholders are very concerned about the lack of communication about major IT transformation efforts. The media believe the agency is hiding information and then feel incentivize to produce critical coverage. This all

seems to derive from the lack of a unified communications strategy to manage the relationship with external stakeholder across the board.

CPS' budget process is ad hoc and not transparent

Past problems with the CPS' budget have led to conflict, tremendous consternation and misunderstanding between CPS and the legislature. While part of this stems from the State budget process, there have been issues with the CPS budgeting process.

There appears to be a gap in CPS' ability to accurately forecast its own budgetary needs. The agency does not meet frequently to discuss financial models and how actual experience may be varying from approved or predicted budgets.

There is a lack of transparency that is fostered by a lack of communication among CPS, DFPS and the legislature. There is no regular report from Budget to CPS leadership highlighting issues, and no regular vehicle for operating leadership to explain budget variances. The result is that issues are not surfaced in a timely fashion. Furthermore, data is not being delivered in real time to the policymakers who could adjust the agency's priorities or budget. This allows a perception to take place that CPS is either not being forthcoming or is incompetent.

Training is insufficiently preparing caseworkers

Initial training is insufficiently preparing new workforce to be ready to take on real-world CPS challenges. There is not enough high-quality, on-the-job training. There are insufficient mentorship opportunities available during the initial training and once new workers begin their work. CPS' initial training is heavily focused on compliance and policy and does not adequately emphasize real world experience. It does not seek to create a culture of ongoing learning.

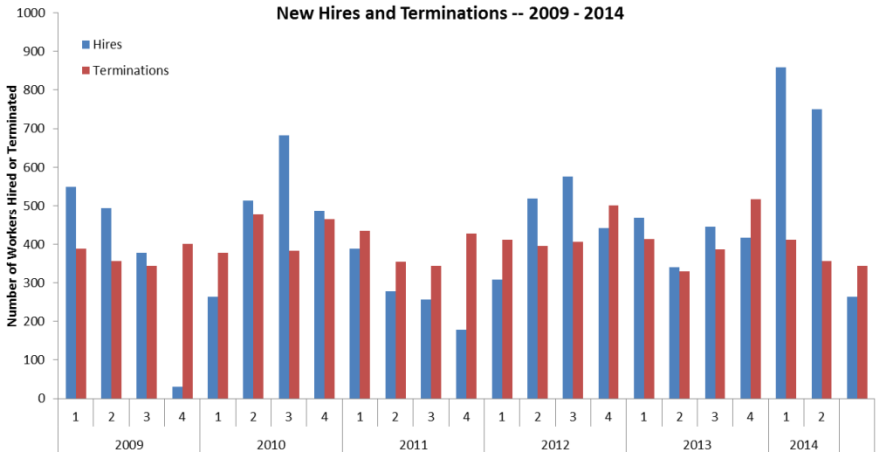
Thus, new employees are often ill-prepared to step into a challenging work environment. At the same time, these new workers are matched with more experienced staffers, who often have to push their own caseload aside to provide learning opportunities, adding to their workload.

Training is not used effectively as an opportunity to weed out individuals who might realize that case work is not for them. They do eventually self-select out, but only after placing additional burden on the system to replace them after they begin in the field.

Moreover, CPS has not built an effective program for developing experienced caseworkers into capable leaders when they step into the supervisory role. Even long tenured supervisors manage as if they were new to the job.

CPS is also adversely affected wide swings in the number of new hires. As Figure 5 demonstrates, there is significant variability not just from year to year, but quarter to quarter, on the number of new employees the agency brings on board. This places a tremendous burden on trainers, staff and new hires. Identifying, training and integrating such a variable number of new workers undercut CPS' ability to control the quality of new staff and assist them in the moving into productive roles.

Figure 5 - New CPS Hires and Terminations 2009-2014



Lack of flexibility in personnel

The current CPS model uses a two year rolling regional average of caseloads to determine staffing levels. This method does not leave the regions, or CPS as a whole, well prepared to deal with the inevitable spikes and troughs of caseload fluctuations. This takes away an important management tool for agency leadership to balance the load across the state.

Summary

CPS has many talented and dedicated staff. What they need is support from across all levels of the State to reach their desire and ability to help improve the safety, well-being and permanence of children across Texas. This means that policymakers must come together to remove the obstacles to greatness and allow CPS to become a national leader in child protective services.

For this to happen, there must be a culture throughout all interested parties – inside and outside of CPS – to change. Working on the key findings identified here and the numerous areas described in detail in the following thorough report represents tremendous opportunity for all involved for a roadmap for a world-class organization.

This Assessment is merely the first step in a long process for improvement. TSG will, in the near future, offer our recommendations on changing CPS for the better. We will continue to solicit the input of many, many individuals from across the state, and national leaders in this area, to find how we can make the best of this chance to transform.

We would like to thank the many people to whom we spoke for their willingness to share their honest perspectives on the agency. Without their input, the quality of this report would have been seriously diminished. We would also like to thank DFPS Commissioner John Specia for his steadfast commitment throughout this process to openness and transparency, and his unwavering desire to enhance CPS operations. We are humbled by the cooperation and commitment they displayed.

PURPOSE AND SCOPE OF THE ASSESSMENT

Purpose of the Assessment

The Stephen Group (TSG) was retained by the Texas Health and Human Services Commission (HHSC), the State agency that oversees the Department of Family and Protective Services (DFPS), and DFPS, to conduct a broadly-scoped operational assessment of the Child Protective Services (CPS) Agency, within DFPS. The objective of the assessment is for a "top to bottom" operational review of CPS. The assessment assesses the various aspects of CPS, such as organization, work flow, allocation of staff, decision making and general business processes including policy development, continuous quality improvement and budgeting, along with relevant support structures such as training, hiring, contracting, and finance. The goal of the assessment is to identify what operational changes can better enable CPS to help families build environments for children to promote safety, well-being and permanence.

The operational assessment is divided into the following three tasks as part of Phase 1 of the project:

> Task 1 - Develop and agree on a Project Plan for Tasks 1 and 2
> Task 2 - Business Process Mapping and assesses the strengths and weaknesses of internal operations of CPS
> Task 3 - Offer recommendations as to how CPS can be managed and operated more effectively and efficiently.

Phase 2 of the project is optional and consists of implementing the recommendations contained in Phase 1, Task 3. The current document is the report of Phase 1, Task 2.

Assessment Scope

Through this assessment, TSG has conducted a comprehensive review of the internal operations of the CPS Division. The assessment serves as the basis for recommendations as to how CPS can be managed and operated more effectively and efficiently, in accordance with State and federal law. During Phase 1, Task 1, DFPS and TSG agreed on a number of operational areas to focus on, which are contained in this report. TSG and DFPS also agreed on documenting,

reviewing, mapping and assessing the CPS business process at the State and Regional level, as part of Phase 1, Task 2.

Following this Assessment, TSG will collaborate with DFPS to provide recommendations through Phase 1, Task 3. TSG will:

- Recommend an improvement strategy ("to-be") with specific recommendations to correct the problems/issues and to streamline procedures, case progression, and workflow along with rationale about how and why this improvement is needed;
- Develop an implementation plan that identifies immediate and longer term changes.

Overall Assessment Team and Method

About The Stephen Group

The Stephen Group (TSG) is a business and government consulting agency. TSG combines strategic government and private sector intelligence with a deep government and regulatory experience that offers State agencies tactical and practical information that addresses their most critical challenges, transforms their agencies and helps achieve extraordinary results. State agencies measure those results as significant improvements in efficiencies, quality of service, increased cost savings, and (ultimately) benefit to the taxpayer. For more information on the TSG assessment project team and background see Appendix A.

CPS Collaboration and Support

CPS provided strong support for the Assessment project. Some examples of the solid support include:

- A dedicated CPS Lead Project Coordinator to work directly with TSG on information, data, and scheduled meetings across the state
- 1,800 responses to a survey addressing management and change readiness
- Over 250 State and regional interviews
- Regional Investigator ride-a-longs and interviews
- Dedicated focus groups at each of the state regions and in the state-office areas of Policy, Budget and Quality. These included an average of 10 top workers and lasted between one and three days each
- Caseworker surveys describing user issues with CPS systems support

- Meetings with members of CPS upper and middle management, including the regional management
- Access to and meetings with key legislative staff
- Access to and meetings with key stakeholders
- Over 2GB (nearly 500 files) of data extracts and reports

CPS provided unequivocal support to every aspect of the Assessment.

OVERVIEW OF CPS

Texas' Department of Family and Protective Services (DFPS)—Child Protective Services (CPS)

DFPS is charged with protecting children, adults who are elderly or have disabilities living at home or in-state facilities, and licensing group day-care homes, day-care centers, and registered family homes. The CPS Division is charged with investigating reports of abuse and neglect of children; providing services to children and families in their own homes; placing children in foster care; providing services to help youth in foster care make the transition to adulthood; and placing children in adoptive homes.

CPS is also part of the Texas Health and Human Services Commission's (HHSC). CPS is responsible for[4]:

- Investigating reports of abuse and neglect of children
- Providing services to children and families in their own homes
- Placing children in foster care
- Providing services to help youth in foster care make the transition to adulthood
- Placing children in adoptive homes

CPS manages the expenditure of $1.2 billion annually, as shown in Table 2.

[4] http://www.dfps.state.tx.us/child_protection/

Table 2 - CPS 2013 Budget Summary[5]

	2013
CPS Staff	469,000,000
Purchased Client Services	97,900,000
Foster Care Payments	366,400,000
Adoption Subsidy Payments	205,000,000
Permanency Care Assistance	4,700,000
Relative/Other Designated Caregiver Reimbursement Program	9,500,000
Other Client Services	4,700,000
Total CPS Expenditures	1,157,200,000

According to the 2013 DFPS Fact Book, CPS is staffed by 8,235 workers spread across 11 regions as well as state-wide operations. In 2013, the CPS workers included 4,733 direct caseworkers and 3,501 other support staff and management, as shown in Table 3.

[5] TSG analysis of the 2013 CPS Data Book. Note: this is data from 3Q2013. It is slightly different from the 4Q2013 headcounts used throughout this Assessment

Table 3 - CPS Workforce – 2013[6]

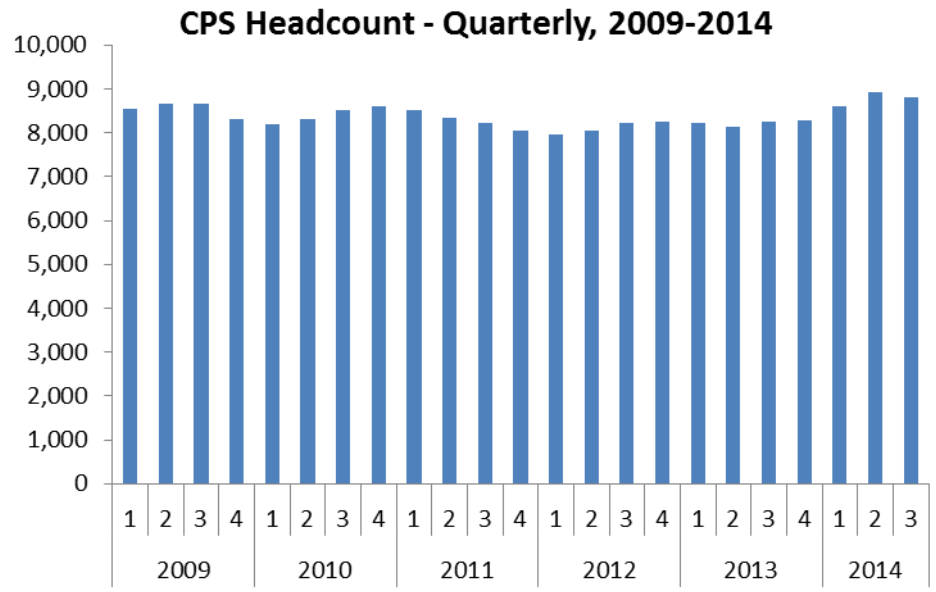
	2013
Caseworkers:	
Investigation	1,804
Conservator-ship	1,614
Family-Based Safety Services	845
FAD	192
Other Workers	171
Kinship	107
Supervisors	734
Program Directors/Administrators	172
Admin/Clerical	973
Case Aides	476
Other Staff	811
CPS Program Support	336
Total CPS Staff	8,235

Figure 6 shows the size of the CPS work force from 2009 through the first three quarters of FY 2014. The Figure shows that the CPS workforce has experienced only modest fluctuation over the past 5 years in terms of filled positions.

CPS has done an effective job of replenishing headcount lost to turnover. Figure 6 shows that the total headcount has fluctuated on slightly over the past 5 years. The legislature allowed CPS to hire 1,000 new caseworkers…but these served only to replace those lost through attrition.

[6] TSG analysis of CPS Data Book, 2013

Figure 6 - CPS Workforce – 2009-2014[7]



These workers investigate and manage services to improve the safety, well-being and permanence of children at risk for abuse. Table 4 shows that the number of investigations CPS conducted has fluctuated over recent years

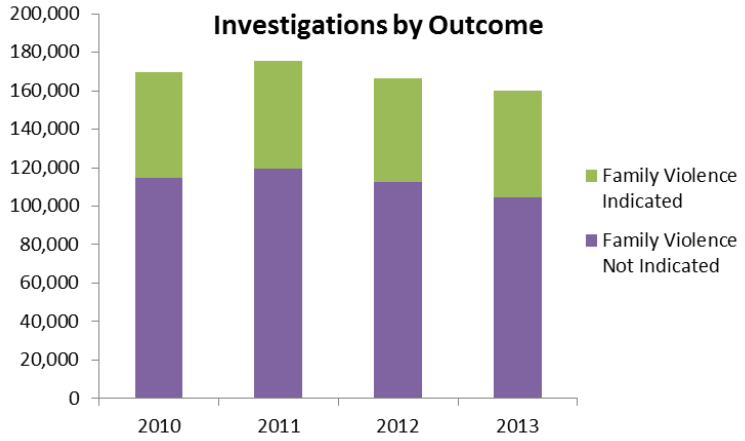
Table 4 - Investigations[8]

Fiscal Year	2010	2011	2012	2013
Family Violence Indicated	54,842	56,068	53,705	55,754
Family Violence Not Indicated	114,741	119,353	112,505	104,486
Completed Investigations	169,583	175,421	166,211	160,240

In total, CPS manages a total of between 160,000 and 180,000 investigations annually. About one third of these results in a finding of abuse, as shown in Figure 7.

[7] TSG Analysis of MRS data from the Data Warehouse
[8] TSG analysis of CPS Data Book, 2013

Figure 7 - Investigations by Outcome[9]



[9] TSG analysis of CPS Data Book, 2013.