APPENDIX A: STEPHEN GROUP ASSESSMENT PROJECT TEAM

The Stephen Group (TSG) assessment project team consists of the following experienced professionals:

- John Stephen – Project lead, former Commissioner of New Hampshire's Department of Health and Human Services and Assistant Commissioner of the Department of Safety. Led similar projects in a number of states
- Will Oliver – Expertise in business process re-engineering, improved child protection and sourcing strategy for six states including Florida and Indiana
- John Cooper – CEO of a child welfare not-for-profit and former Assistant Secretary of Operations for Florida CPS. Led the Florida CPS reengineering project
- David DeStefano – Consultant for public/private partnerships, performance based contracting, program evaluation, SACWIS, and revenue maximization
- Jeff Schilz – Former policy advisor and budget director to Governor Mark Sanford, SC, focusing on HHS, Social Services, and Department of Juvenile Justice
- Richard Kellogg – Served as Commissioner, Deputy Director, and Director of Integrated Services for the states of Virginia, Tennessee, New Hampshire and Washington – Medicaid, MH/DD/SAS, LTS, Comprehensive IV-E, SE, and JJ Services
- Martha Tuthill – Senior Consultant for Florida CPS Transformation project, assisting team with vendor management, systems support and organizational improvements, former Accenture partner
- Art Schnure – Technology lead with state government health and human services technical initiative experience over the last 17 years, including modernizations of the protective services system in Rhode Island and a child care systems in Massachusetts
- Greg Moore - Served as a former state public affairs, legislative and policy director for divisions of children youth and families and juvenile justice
- Stephanie Anderson – Editorial and Project Assistant, former Executive Assistant with Texas Department of Protective and Regulatory Services

Some relevant recent projects of the TSG team include:

- Florida Department of Children and Families – CPS Transformation
- Indiana Family and Social Service Administration – Process improvement and sourcing

- Texas Department of Protective and Regulatory Services – Decrease child fatalities; reduce caseworker turnover; coordinate community-based organizations; sourcing
- Pennsylvania Department of Human Services – Improve child welfare documentation, eligibility, and federal claiming
- New Hampshire Department of Health and Human Services – Reorganization of Department of Health and Human Services
- South Carolina Department of Social Services – Budgeting and process improvement
- Mississippi – IAPD and business case for SACWIS integration with Medicaid)
- Maine – budget cost savings and best practice analysis for Governor's Office of Policy Management
- Florida – Benefit Recovery Assessment and Implementation

APPENDIX B: REVIEW OF PRACTICE MODELS AND DECISION MODELS

Practice Models

A Child Welfare Practice Model is simply defined as the basic principles and approaches that guide a child welfare agency's work.

"Child Safety, first and foremost" is the essential reason why Child Protective Services is one of the most important and most difficult of "Human Services" to conceptualize, plan, implement, and evaluate. The challenge includes deciding on the degree of risk for immediate and emergent danger to a child's safety and must take into account many factors in a compressed period of time including child/family environment, family constellation and dynamics, developmental factors key to child wellbeing, family strengths for and approaches to assuring protective capacity, permanency planning, cultural competence, and community resources. Given the importance and breadth of the child protection mission it is critical that agency leadership and staff have a clear understanding of how to get the job done right and a common focus on standardizing best practice across the enterprise.

It is critical to assure organizational effectiveness of a CPS Practice Model that there is an on-going integration strategy with operational case practice, on-going assurance of safety and risk management, continuous learning/training, linkage with Quality Assurance and Quality Improvement, use of mission important data, and IT operability.

The Children's Bureau (DHHS/Administration for Children and Families) states that "Having a clearly defined practice model can help child welfare agencies **better direct their work,** partner with families, service providers and other stakeholders, **and achieve positive outcomes."**

The National Child Welfare Resource Center for Organizational Improvement in partnership with the Muskie School of Public Service (University of Southern Maine) released "The Guide for Developing and Implementing Child Welfare Practice Models" in October, 2012. This report articulates a comprehensive pathway to conceptualizing and implementing a useful Practice Model framework targeted at positive outcomes as follows:

- Practice models guide the work of a child welfare agency and improve outcomes for children, youth and families.

- A clearly articulated practice model: helps child welfare executives, administrators and managers
- identify the outcomes they hope to achieve;
- develop a vision and consistent rationale for organizational and policy decisions
- Decide how to use agency resources;
- Define staff performance expectations;
- Develop an array of services;
- Create a qualitative case review system;
- Collaborate with families and youth
- Work across systems.
- Help supervisors fulfill their role as keepers of the agency's culture with responsibility for training, guiding and supporting frontline staff;
- Monitoring and assessing staff performance and child/family outcomes;
- Modeling the agency's values and approach to working with families; and observing and advocating for needed change.
- Gives child welfare workers

    - A consistent basis for decision making;
    - Clear expectations and values for their approach to working with families, children, and youth;
    - A focus on desired outcomes;
    - Guidance in working with service providers and other child-serving systems; and
    - A way to evaluate their own performance
    - Encourages the community, the agency's network of stakeholders, and children, youth and families to engage with the agency in fulfilling its mission.

- Ensure effective and consistent practice

Each state has taken a somewhat different approach to the development and content of a Practice Model. The Stephen Group recommends a comprehensive approach, such as the Iowa and New Hampshire models, as they address and integrate an implementation strategy that addresses safety and risk, staff and supervisor casework practice, staff qualifications, training in a learning environment, operational academic partnership, aligned Quality Assurance and Improvement actions, and effective SACWIS modifications to support the enterprise.

The entire Child Welfare Agency organization needs to be completely dedicated to the implementation of a Practice Model in order to attain a high probability of success. The National Child Welfare Resource Center for Organizational Improvement housed at the Muskie School of Public Service (University of Southern Maine) recommends a dynamic strategic planning approach for Practice Model implementation:

Leadership: commitment to the Practice Model; pace implementation and be flexible; be inclusive and transparent

Capacity: train managers, supervisors, staff, and stakeholders; designate staff and support champions; align staff selection and evaluation systems

Organization: evaluate progress and outcomes through Quality Improvement; use feedback loops at all levels of the organization and externally; revise Policy and create relevant tools.

Regardless of the approach chosen it is critical that a Texas CPS Practice Model be vibrant, transparent, meaningful to staff, children, families, Legislators, Judges, and the public; used on a day to day basis; and periodically evaluated based on outcomes for adaptation, changes in Federal and state law, and new knowledge.

The Iowa Child Welfare Practice Model

The Iowa Child Welfare (DHS) represents a comprehensive approach "to define who we serve and the intended outcomes of child welfare services, as well as the guiding principles for our work and expectations related to practice and program and organizational capacity." The Iowa model is basically strengths based and family centered model of practice at all levels."

Iowa Child Welfare states its responsibility as "providing child welfare services to those children in which child abuse has occurred and those at high risk for abuse and neglect." Iowa defines four factors to determine whether the state should open a case: 1) Age of Child; 2) Outcome of abuse investigation (which includes a safety assessment completed based on the initial face to face home visit within 24 hours); 3) Continuing risk factors; and 4) Court Action for Children in Need of Assistance (CINA Assessment) and state/DHS supervision.

Child Welfare Outcomes are clearly articulated in the Iowa Model of Practice:

- Safety for Children
    - Children are, first and foremost, protected from abuse and neglect.

  - Children are safely maintained in their homes whenever possible and
  - appropriate.
  - Permanency
  - Children have permanency and stability in their living situations.
  - The continuity of family relationships and connections is preserved for children.

- Academic Preparation and Skill Development Child and Family Well-Being

  - Children receive appropriate services to meet their educational needs.

- Well-Being Child and Family Well-Being

  - Families have enhanced capacity to provide for their children's needs.
  - Children receive adequate services to meet their physical and mental health needs

Iowa's Guiding Principles for their work with "children and families, each other, and the community" are Customer Focus, Excellence, Accountability, and Teamwork.

"Frontline Practice" is clearly stated for Intake and Assessment (ongoing); Case Planning and Review, Services Provision In and Out of Home, Social Worker Visits, Child Health, Family Relationships, Health and Education, Permanency and Stability, Transition for Older Youth, Standards for Cultural Competency, and Standards Related to Transitions and Case Closure."

It is important to note that the Iowa Employee's Manual (12/16/11) for Child Welfare includes a comprehensive listing and explanation of all forms with linkages as well as "How Do I" guides (Case Planning, Case Management, CPS Assessment, etc.) that are linked to concise employee guidance clearly articulated by Policy, Procedure, and Practice guidelines consistent with the Iowa Child Welfare Practice Model.

The New Hampshire Practice Model

New Hampshire assertively connected a CFSR PIP project with a comprehensive Practice Model Development Strategy that was designed to provide the fundamental case work practice foundation, increase efficiency and assure sustainability. The NH Department of Children, Youth, and Families established "Guiding Principles" (Safety, Permanency, Well Being, Family Choice, Family Voice, Prevention, and Restorative Justice) designed to inform the planning process charged with developing the Practice Model. A Design Team was chosen from across all district offices in the state and extensive external stakeholders and Youth representation. DCYF

augmented a partnership relationship with the Center for Professional Excellence in Child Welfare of the University of New Hampshire. A participative process focused on Safety Assessment, Family Engagement, and Culture and Climate within the context of the Guiding Principles.

New Hampshire's approach to Safety Assessment is noteworthy. Rather than getting stuck in the actuarial versus clinical judgment debate the Design Team chose to integrate and update the Structured Decision Making process in place with the clinical judgment aspects of the Signs of Safety model, with safety being the primary focus throughout the case. In fact, DCYF requires a safety review every 14 days for as long as danger exists in a child's home. Additionally, the New Hampshire Practice Model operationally integrates Safety Assessment, Family Assessment and Inclusive Reunification, Solution Based Casework (SBC is an evidence based case work approach that focuses on family partnership, consensus safety related problem identification, focus on everyday life patterns specific to safety risks, and consensus target solutions for prevention and safety enhancement. Christensen, University of Louisville), Solution Based Family Meetings, a "Youth Pool" for children in care direct participation, and Practice and Supervisory Standards and Training into one integrated Practice Model.

Integration, sustainability, and professional development have been augmented by updating SACWIS to accommodate new safety and risk assessment instruments. Sustainability is anchored through the DCYF Bureau of Organizational Learning and Quality Improvement based on staff training being provided by the UNH Center for Professional Excellence in Child Welfare. Professional development is supported by a continuous learning environment, targeted supervisory training and an integrated approach to quality assurance and improvement based on data analytics.

The Florida Practice Model

Florida has taken a brief and direct systemic approach to defining and communicating its practice model. The model is based on Vision, Goals, and Seven Practices as follows:

Vision: Every child in Florida thrives in a safe, stable and permanent home, sustained by nurturing relationships and strong community connections.

Goals: Safety; Permanency; Child Well-Being; Family Well-Being

Seven Professional Practices: Engage the family; Partner with all involved; Gather information; Assess and understand information; Plan for Child Safety; Plan for family change; Monitor and adapt case plans

Survey of the Literature Concerning Decision Models

There is an ample body of knowledge, research, and state experience regarding the important process of assessing safety risks and protective capacities from the initiation of a CPS investigation. Texas CPS has substantial professional knowledge regarding risk factors, assessment methods, and statistical analysis. These assets will be a key component, along with leadership and direction, supporting the success of moving forward in the development and implementation of a comprehensive Safety and Risk Assessment methodology, associated decision making logic that supports critical thinking and in the field decision-making.

Fundamentals are important. The Center for Disease Control and Prevention (CDC Website/Child Maltreatment and Protective Factors) explains the following Risk and Protective Factors:

Risk Factors for Child Maltreatment

A combination of individual, relational, community and societal factors contribute to the risk of child maltreatment. Although children are not responsible for the harm inflicted upon them, certain characteristics have been found to increase their risk of being maltreated. Risk factors are those characteristics associated with child maltreatment—they may or may not be direct causes.

Risk Factors for Victimization: Individual Risk Factors

- Children younger than 4 years of age
- Special needs that may increase caregiver burden (e.g., disabilities, mental retardation, mental health issues, and chronic physical illnesses)

Risk Factors for Perpetration: Individual Risk Factors

- Parents' lack of understanding of children's needs, child development and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues including depression in the family

- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Non-biological, transient caregivers in the home (e.g., mother's male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors

Family Risk Factors

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions

Community Risk Factors

- Community violence
- Concentrated neighborhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections.

Protective Factors for Child Maltreatment

Protective factors buffer children from being abused or neglected. These factors exist at various levels. Protective factors have not been studied as extensively or rigorously as risk factors. However, identifying and understanding protective factors are equally as important as researching risk factors. There is scientific evidence to support the following protective factor:

Family Protective Factors

- Supportive family environment and social networks

Several other potential protective factors have been identified. Research is ongoing to determine whether the following factors do indeed buffer children from maltreatment.

Family Protective Factors

- Nurturing parenting skills
- Stable family relationships
- Household rules and child monitoring
- Parental employment

- Adequate housing
- Access to health care and social services

Caring adults outside the family who can serve as role models or mentors

Community Protective Factors

- Communities that support parents and take responsibility for preventing abuse"

New York State Definitions of Safety, Immediate and Impending Danger

As a state New York has been challenged by many similar and some dissimilar challenges to assuring a safe and protected life for each child that comes in contact with the Child Welfare function.

The New York Child Welfare system is structured by counties so it was critical for the state to have operational definitions of "Safety" and "Immediate" and "Impending" Danger as a foundation for standard practice in the field.

Safety**:** "A child is SAFE when there is no immediate or impending danger of serious harm to a child's life or health as a result of acts of commission or omission (actions or inactions) by the child's parents or caregivers."

Safety Factor**:** "A behavior or condition, or circumstance that has the potential to place a child in immediate or impending danger of serious harm."

Immediate Danger: "A child is in immediate danger when presently exposed to serious harm. In deciding whether the child(ren) is in immediate or impending danger, consider the following:

- The seriousness of the behaviors/circumstances reflected in the Safety Factor;
- The number of Safety Factors present; The degree of the child(ren)'s vulnerability and need for protection; and
- The age of the child(ren).

Impending Danger**: "**A child is in Impending danger when exposure to serious harm is emerging, about to happen, or is a **reasonably foreseeable** consequence of current circumstances. In deciding whether the child(ren) is in immediate or impending danger, consider the following:

- The seriousness of the behaviors/circumstances reflected in the safety factor;

- The number of safety factors present;
- The degree of the child(ren)'s vulnerability and need for protection; and
- The age of the child(ren)."

(Diane DePanfilis, Ph. D., MSW, University of Maryland School of Social Work: 10/29/13)

Consensus –Clinical Judgment and Actuarial Based Safety and Risk Assessment Methods

In many respects the debate concerning the choice of Consensus/Clinical Judgment based assessment and/or Actuarial based assessment is not the point. States need to decide on what works best for their Child Welfare systems and many states have chosen a mix or hybrid of consensus/clinical judgment and actuarial assessment methods. Nevertheless, actuarial based assessments have repeatedly been proven to be more accurate in predictive validity specific to prediction of future violence ("Sixty Six Years of Research on the Clinical versus the Actuarial Prediction of Violence": N Zoe Hilton, Grant T Harris, Marnie E Rice; Counseling Psychologist, 5/2006); "The Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders"; John Monahan, et al; Psychiatric Services; 7/2005).

Breitenstein (2011) considers the matter "Settled Science" in Child Welfare and notes the following cites in this regard: 1) B. Rittner (Children and Youth Service Review, Vol. 24, No. 3, March 2002, pages 189-207); 2) Evidence for Practice: "Risk and Safety Assessment in Child Welfare: Instrument Comparisons, No. 2, July 2005 3) W. Johnson: Child Abuse and Neglect, 35, 1, pages 18-28: "The Validity and Utility of the California Family Risk Assessment Under Practice Conditions in the Field: A Prospective Study"; and 4) A. D'Andrade, MJ Austin, and A. Benton: Journal of Evidence-Based Social Work, 5 (102), pages 31-56; 2008, "Risk and Safety Assessment in Child Welfare: Instrument Comparisons".

Table 5 - The Debate over Actuarial Based Judgment[44]

Attributes of Actuarial Based Judgment	Actuarial Instruments Criticized for:
• Less Bias (Fontes, 2008) • Use statistics to weight factors to predict the future • Often statistical analysis is done in locality where the instrument is used	• Not using or curtailing the clinical judgment of the caseworker • Basis for judgment on a factor that is statistically associated with recurrence of maltreatment, and may not appear to be causally related to the outcome. This may cause caseworkers to

[44] "Safety Assessment" PowerPoint: L. Breitenstein, Ph. D. 2011. Stephen Group Adaptation

• Uses fewer factors than Consensus Based • Factors are scored and summed into an overall risk score • Families are rated low, medium and high (or numerical scale) and receive different service responses • More reliable and valid questions	discount the value because they cannot understand the theory, math, or reason behind the score. • (Evidence for Practice, UC Berkley, 2009)
Attributes of Consensus Based Judgment	Consensus Instruments Criticized for:
• Takes a comprehensive approach • Items based on maltreatment theories • Items often shared across instruments (safety/risk) • Sometimes numerical scored are given • Tend to use a single tool for all types of maltreatment reports • Can structure information for clinical assessments of risk • Helps document the decision	• Some argue that more information equates to better decisions • Poorly defined measures (nebulous, ambiguous, subjective) • Inconsistency in types of variable • Use some variables to predict all types of abuse, neglect, sexual abuse • Less weight given to recurrence of maltreatment • Reliance on variables for which there is no research • (Evidence for Practice; UC Berkley, 2009)

In a proprietary presentation to the Florida Department of Children and Families (9/14/2011) IBM-Q Linx presented a "Proof of Concept" research model on the New York State Child Protection Safety Assessment. The model utilized historical intake data, an analysis of the data set to identify children "at risk of harm", compared the assessment data produced by the analysis to the assessments of the OCFS staff for the same data set and discussed the findings with OFSC key staff. The results indicated 90% accuracy in the prediction of substantiated and unsubstantiated cases of child abuse and neglect from the data set analysis model. The vendor noted the inclusion of the following 22 data elements in the model:

- Caretaker previously committed or allowed others to abuse or maltreat child
- Caretaker's current alcohol abuse seriously affects his/her ability to care for child
- Caretaker's current drug abuse seriously affects his/her ability to care for child
- Child has or is likely to experience physical or psychological harm due to domestic violence
- Caretaker's mental illness/developmental disability impairs ability to supervise, protect or care for child

- Caretaker is violent and appears out of control
- Caretaker is unable/unwilling to meet child's basic needs for food, clothing, shelter and/or medical care
- Caretaker is unwilling/unable to provide adequate supervision of child
- Caretaker caused serious physical harm to child or has made a plausible threat of serious
- Caretaker views/describes/acts negatively toward child and/or has extremely unrealistic expectations of child
- Child's whereabouts are unknown, or the family is about to flee or refuse access to the child
- Caretaker caused serious physical harm to child or has make a plausible threat of serious harm
- Caretaker views/describes/acts negatively toward child and/or has extremely unrealistic expectations of child
- Child's whereabouts are unknown, or the family is about to flee or refuse access to the child
- Current allegation or history of sexual abuse and caretaker is unable/unwilling to adequately protect child
- Physical living conditions are hazardous
- Child is afraid of or extremely uncomfortable around people living in or frequenting the home
- Child has Positive Toxicology for drugs and/or alcohol
- Child is on sleep apnea monitor
- Weapon noted in CPS report or found in the home
- Other/criminal activity (specify):
- No safety factors identified

Safety and Risk Assessment Methods

Approximately 40 state Child Welfare agencies have implemented Safety and Risk Assessment models that represent well-designed and tested instruments that provide a platform for implementation, training, fidelity, some adaptation, and, potentially, a multi-state data base that can be adapted to a predictive analytical assessment method for further research and refinement.

SDM is used in 23 states. Eleven states use SDM alone while 12 states use SDM in combination with Signs of Safety and 5 states use SDM in combination with Action/NRCCPS. Signs of

Safety is used in 11 states. Action/NRCCPS is used in 17 states, 11 alone. Ten states use other instruments or self-developed tools, Texas being one. (Source: SACHS/Casey Family Foundation; 11/2012) The Texas Safety and Risk Assessment instruments were initiated in the mid-1990s and have been updated several times.

Structured Decision Making

SDM was created by the Children's Research Center of the National Council on Crime and Delinquency. NCCD was started in 1907 and launched the Center for research in 1993 for the purpose of implementing actuarial risk based assessment in child welfare. In 2011 CRC started an initiative to incorporate research based assessments into a unified practice approach for child welfare.

The SDM model is consistent with the TSG recommendation that CPS makes a decision on and implement a comprehensive Practice Model. The conceptualization of the SDM framework is based on a state's Practice Model and identification of the elements of critical thinking with and without assessment instruments through the life of a case. Implementation in a county, region, or state starts by the development of a partnership "Plan for Success" between the state and NCCD Center for Research/SDM with both parties bringing knowledge to the table. Identified work groups field test and may adjust the instrument to some degree to fit local conditions based on data analysis. A mutual agreement based on Practice Model, Organization Support from leadership, Policy and Procedure, Staff Development and the Implementation/Roll-Out Plan are elements of the Plan for Success. Local capacity and leadership are important factors in a successful implementation effort. Depending on scope and size three to six months are achievable time period for both developing Plan for Success, Implementation/Roll-Out strategy and timeline and staff training. The SDM implementation may include the entire framework or specific elements. Implementation planning, support, and data management/analytics training and assistance services are available. Cost depends on what the state wants NCCD/SDM to do on the ground, time, and travel. NCCD/CRC/SDM is a non-profit entity.

SDM strongly believes that assessment and assurance of Safety begins on "the first day" and is compatible with the TSG recommendation that CPS adopt and implement a revised Safety Assessment instrument and decision logic model that is completed within 24 hours of the initial face to face home visit. The SDM model includes two suites of assessment tools. The SDM Child Protection model includes the following assessment functions: Intake, Safety, Risk, Family Strengths and Needs, Risk: in-home services, and Reunification. The Foster Care/Placement model includes: Support, Placement, Provision of Care and Placement Safety.

The SDM model of child safety and risk assessment includes two suites of assessment tools. The SDM Child Protection model includes the following assessment functions: Intake, Safety, Risk, Family Strengths and Needs, Risk: in-home services, and Reunification. The Foster Care/Placement model includes: Support, Placement, Provision of Care and Placement Safety.

Signs of Safety

The Signs of Safety Model was developed in Western Australia (Turnell/Edwards) and focuses on casework practice. Based on a close working with the family, the model focuses on danger and strengths/safety factors in the family throughout the case. The model has been researched in several settings with positive findings in recent adaptation in Minnesota. The model is highly adaptive to an individual state or country's (implemented in Australia, England, Denmark, and the United States) needs. There are at least ten Signs of Safety licensed consultants/trainers available in the US.

Action/NRCCPS

The Action (for Child Protection)/NRCCPS (National Resource Center for Child Protective Services) is based on a comprehensive Practice Model that is integrated through organization/systems, leadership, decision making solutions, and work process and systems. Design, implementation, model improvement, and staff development services are available.

The Iowa Model of Safety and Risk Assessment

Iowa's approach to safety, risk assessment, and decision making is of note based on the state's integrated Practice Model noted above.

Safety Assessment:

Iowa conducts Safety Assessments on reported cases within 24 hours and utilizes a Safety Assessment Instrument (Form 470-4132; Rev. 7/09) that consists of:

- Signs of Present or Impending Danger: 3 questions (All questions are Yes/No in format)
- Current Parent/Caretaker Capabilities: 3 questions
- Current Family Safety: 6 questions
- Current Family Interactions: 1 question
- Current Home Environment: 1 question
- Narrative Sections: Threats, Child, Vulnerability, Protective Capacity
- Safety Decision:
- Safe: No Risk

- Unsafe: High Risk
- Conditionally Safe: Moderate to High risk with an implemented safety intervention
- The safety assessment instrument is completed within 24 hours and staffed with supervisor
- The safety assessment instrument is also enacted as the end assessment on Unsafe Situations; Unsupervised Visitation; Reunification; prior to case closure.

Risk Assessment:

Iowa conducts as Family Risk Assessment (Form: 470-4133, Rev.: 5/10) after the Safety Assessment process decision is resolved. The instrument is highly structured and consists of:

- Neglect: 11 Y/N questions
- Abuse: 9 Y/N questions; one weighted question on number of Prior Assessments: 0, 1-3, 4 or more
- Second Risk level Neglect and Abuse Score Matrix: Low, Moderate, High
- Policy Over-riders: 4 questions; any Y answers is a High Risk
- Discretionary Over-rider: written narrative: any Discretionary concern raises the level of risk; cannot be lowered.
- Supervisor's approval

Decision Making

Iowa utilizes a CPS/CINA (Child in Need of Assistance) Intake Decision Tree. The model is designed in three sections. The first section requires "Yes/No" decision making on the presence/absence of: Physical Abuse, Mental Injury, Sexual Abuse, Child Prostitution, Denial of Critical Care, Presence of Illegal Drugs, Manufacture of Dangerous Substances, Bestiality in the Presence of a Minor, and Cohabitation with a Reported Sex Offender. The second section requires Supervisor Decision Time on whether case requires one hour or 12 hour action. The third section requires a decision on the need for a CINA assessment, which is the step before child removal from the home.

Alternative Response Program Development

Alternative Response programs are designed to provide safety and risk assessment based assurance that a family/caregiver is lower risk compared to cases where abuse/neglect has been confirmed or at higher risk. The program essentially results in an investigation not being opened and a service support model involving extended family, community/neighborhood and targeted

services designed and implemented in a “partnership” approach between CPS and the family/caregiver. The program has met with documented success in Minnesota (Differential Response), Ohio (10 counties), and California (Alameda County) among others.

The National Center on Substance Abuse and Child Welfare (SAMHSA/ACYF – DHHS) has identified that between 40% and 80% of families involved with Child Welfare impacting up to 66% of the children in Child Welfare are seriously impacted by substance abuse. Clearly the field Investigators across Texas know this and expressed focus and the need for drug screens throughout regional office focus groups conducted by TSG. Given the high risk correlation of substance abuse and child safety TSG recommends drug screening for all cases being considered for Alternative Response, should the Alternative Response program continue, prior to the determination of not opening an investigation.

The Hays County Alternative Response pilot model includes the testing of a new “Safety/Risk” assessment instrument that is understood to combine elements from the existing Safety and Risk Assessment instruments that this report recommends be replaced by a Safety Assessment instrument administered and documented within the initial 24 hour in-home assessment and a Risk Assessment instrument based on actuarial principles thereafter and focused on throughout the life of a case.

APPENDIX C: AN EXAMPLE OF BURDENSOME FAMILY LAW LEGISLATION

The list below is a sample of the types of statutes in Texas Family Law that can be construed as burdensome and bear a disproportionately minimal relationship to child safety, permanency or well-being.

Chapter 261

Cite	Substance	Comments
TFC § 261.3021	Subject to the appropriation of money for these purposes, DFPS must: (1) identify critical investigation actions that impact child safety and require department caseworkers to document those actions in a child's case file not later than the day after the action occurs; (2) identify and develop a comprehensive set of casework quality indicators that must be reported in real time to support timely management oversight; (3) provide department supervisors with access to casework quality indicators and train department supervisors on the use of that information in the daily supervision of caseworkers; (4) develop a case tracking system that notifies department supervisors and management when a case is not progressing in a timely manner; (5) use current data reporting systems to provide department	This section represents unnecessary legislative micromanagement of the department, and could be made more general in nature (e.g. The department shall encourage the prompt documentation of critical caseworker tasks and shall use data effectively to manage the timeliness and effectiveness of its caseworkers). In particular, the required time frame for casework documentation is unduly prescriptive.

Cite	Substance	Comments
	supervisors and management with easier access to information; and(6) train department supervisors and management on the use of data to monitor cases and make decisions.	
TFC § 261. 311	Unless a notice would endanger someone's life or safety or is delayed at the request of law enforcement: • Make a reasonable effort to notify a child's parents/legal guardian within 24 hours of an interview or examination of a child as part of an investigation of the nature of the allegation and the fact that the interview or examination was conducted. • Make a reasonable effort to notify a child's parent/guardian of the disposition of an investigation within 24 hours of an investigation that is administratively closed without an interview or examination of a child.	Notifying a parent that a preliminary investigation of allegations was conducted and closed is appropriate, but there is no reason that this notice must be provided within 24 hours of case closure. This notification duty does not further the safety of any child, and could have the unintended consequence or requiring that a caseworker postpone another duty that does potentially impact child safety in order to attend to this statutory time frame for notification to the parents of a closed investigation.

Chapter 264

Cite	Substance	Comments
TFC § 264.016	Mandates that for each child ages 16 and older in DFPS conservatorship, DFPS must: (1) Obtain a free credit report; and (2) Provide information on how to interpret the credit report the process for correcting inaccuracies.	This is one area of responsibility that could easily be shifted from caseworkers to the child's external advocates, and only fall to the department if at age 16 or older the child has no AAL/GAL/CASA to perform this service. While again the legislation had the aim of protecting vulnerable foster children from identity theft the implementation is exceedingly difficult. Each credit bureau has different requirements for obtaining the credit report of a minor. In addition, resolving inaccuracies is a complex workload for which the child-protective agency is not necessarily equipped, as recognized in the comparable federal provision quoted below. This duplicates, with some minor and confusing differences, a federal Title IV-E mandate at 42 U.S.C. 675(5)(I), which requires that each state have a "case review system" for ensuring, among many other things, that: (I) each child in foster care under the responsibility of the State who has attained 16 years of age receives without cost a copy of any consumer report (as defined in section 603(d) of the Fair Credit Reporting Act) pertaining to the child each year until the child is discharged from care, and receives assistance **(including, when feasible, from any court-appointed advocate for the child**) in interpreting and resolving any inaccuracies in the report.

Cite	Substance	Comments
TFC § 264.107(e)	Requires the department, when making a placement decision to: (1) consult with the child's caseworker, AAL, GAL, and CASA, unless making an emergency placement; and (2) use "clinical protocols" to match children with the best placement resource	Subsection (e) was initially added to 264.107 by SB 6 in 2005 to support outsourcing of case management services; however, as originally enacted the duty to consult with the listed persons in Subdivision (e)(1) was "when possible". In 2013 external advocates successfully lobbied to change this requirement to make it more rigid by replacing the "when possible" language with the less flexible "except in an emergency" language (SB 425, 83rd Leg.). This is the type of overly-prescriptive provision that reflects the external view that CPS workers fail to adhere to best practices because they don't care, rather than as a result of multiple competing priorities, and represents an additional incursion into the decision making authority of the legally responsible conservator because of mistrust of the agency's decision making. In addition to the statutory language, external stakeholders are actively pressing the agency to implement a protocol that calls for the following protocol in contracted placements (along with a similar protocol for kinship placement moves): • caseworker sends discharge notice to CASA/AAL/GAL within 2 business days of receipt • caseworker asks for responses from CASA/AAL/GAL within 3 business days • DFPS MUST take the input received into account and include any requested criteria in its placement search • IF criteria determined infeasible, caseworker must provide an

Cite	Substance	Comments
		explanation of why such criteria are not feasible • Once a placement is identified, the caseworker must notify CASA/AAL/GAL of the choices, explain the caseworker's intended choice, and discuss any concerns the CASA/AAL/GAL may have • Once the placement is made, the caseworker must give notice of the placement to the CASA/AAL/GAL within 3 business days DFPS understood the enacted language as a compromise that would allow for input by some of the persons/entities with the best knowledge of the child's needs and characteristics, but still permit the caseworker and the agency to carry out its business. What reads in the statute as one consultation will, in the view of DFPS' external stakeholders, be a minimum of THREE separate consultations with the three listed entities, and potentially more. This is a deeply burdensome workload for a choice that, ultimately, rests with the child's legal representative.

Chapter 266

Cite	Substance	Comments
TFC § 266.004(c)	If DFPS or its agent is authorized to consent, file with the court and each party the name of the individual who will exercise the duty and responsibility of providing consent	Unnecessary to provide notice of the medical consenter designation to the court and all the parties within 5 days of initial designation and within 5 days of any changes. The court does not need that information for any

	on behalf of the department within 5 days of the court authorizing DFPS or its agent. File notice of any changes within 5 days of the change.	purpose at that time. Notice could be provided to the court at the next hearing when the summary of medical care is provided, or within ten days of any designation or change. Unclear why other parties need the information within 5 days either, with exception of attorney ad litem or guardian ad litem. Extreme paperwork burden with regular changes in medical consenters for some children.
TFC § 266.004(h)	Develop or approve mandatory training for medical consenters (other than biological parents whose rights are not terminated, unless the court orders the biological parent to participate in such training).	Mandatory training for all medical consenters is burdensome. Training as currently implemented by policy can be several hours long. The estimate posted on DFPS' public website is that consenters should allot 2.5 hours for the training that includes 105 slides (with an additional 57 in a supplemental module for DFPS staff). Training does add some value, but may not be realistic, particularly for kinship caregivers who do not voluntarily seek out the foster care system, but are effectively conscripted by events in their family, may not be able to read at the grade level required for the training (though efforts were made to make the training as readable as possible), and may not have access to the Internet, in which case they have to review a paper copy.
TFC § 266.004(h-2)	Each person required to complete a training program under Subsection (h) must acknowledge in writing that the person:(1) has received the training described by Subsection (h-1);(2) understands the principles of informed consent for the administration of psychotropic medication; and (3) understands that non-pharmacological interventions should be considered and discussed with the prescribing physician, physician assistant, or	Burdensome implementation. Additional documentation requirements with possibly little value added to caregiver's decision-making capability.

	advanced practice nurse before consenting to the use of a psychotropic medication.	
TFC § 266.007	Provide at each hearing under Chapter 263 a summary of medical care that includes information regarding: (1) the nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child; (2) all medical and mental health treatment that the child is receiving and the child's progress with the treatment; (3) any medication prescribed for the child and the condition, diagnosis, and symptoms for which the medication was prescribed and the child's progress with the medication; 4) for a child receiving a psychotropic medication: (A) any psychosocial therapies, behavior strategies, or other non-pharmacological interventions that have been provided to the child; and (B) the dates since the previous hearing of any office visits the child had with the prescribing physician, physician assistant, or advanced practice nurse as required by Section 266.011; (5) the degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child; (6) any adverse reaction to or side	**Summary of comment:** Overly prescriptive requirement in terms of amount and detail of medical information to be provided to the court; judges wanted additional information provided so the summary in the court report is even lengthier than that required by statute. Partially duplicative of federal law. **Detailed comment:** State law is also (partially) duplicative of federal law. "Case plan" is defined in federal law to include certain information regarding the child, including the child's educational and health records. The educational and health records must at least contain the most recent information available regarding: names and addresses of the child's health and educational providers; the child's grade level performance the child's school record; a record of the child's immunizations; the child's known medical problems; the child's medications; and any other relevant health information concerning the child determined to be appropriate by DFPS. 42 U.S.C. 675(1)(C) 42 U.S.C. 675 and 42 U.S.C. 671 The law further requires a "case review system" whereby a child's health and education record is reviewed and updated, with a copy supplied to the caregiver with whom the child is placed. The record is also provided to the child when the child ages out of foster care. 42 U.S.C. 675(5) 42 U.S. Code 675 and 42 U.S.C. 671 Texas also has an assurance in the state plan on point: …The State assures that it is operating, to

	effects of any medical treatment provided to the child; (7) any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis; (8) any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet; and (9) other information required by department rule or by the court. The summary must be provided to the court, the medical consenter, the GAL or AAL, the child's parent, and any other person determined necessary or appropriate for review by the court or DFPS.	the satisfaction of the Secretary…a case review system (as defined in section 475(5) of the Act) for each child receiving foster care under the supervision of the State/Tribe Attachment C, Title IV-B, subpart 1 Assurances. 1.b. Attachment C - Assurances

APPENDIX D: DETAILED COST ESTIMATE OF TECHNOLOGY RECOMMENDATIONS

#	Mos.	D/M	Technology / Tasks	Low Hours Estimate	Low Cost Estimate	High Hours Estimate	High Cost Estimate	Comments
DEVELOPMENT ITEMS								
1	18	D	Improve the ease of use of IMPACT in support of the caseworker's daily activities in Items 2-9 below.	See below items for the components to accomplish the overall IMPACT ease-of-use goals				
2	12	D	- Incorporate the logic from the practice model for assessing safety & risk into IMPACT	**9,200**	**$1,288,000**	**10,950**	**$1,533,000**	Support the actual decision making process for safety and risk assessment at the time the decision is made rather than an after the fact documentation.
-			Integrate the logic from the safety and risk practice model into the IMPACT process flows	1,500	$210,000	2,000	$280,000	Assessing safety and risk is a difficult process, so additional time is needed to research other states efforts and adapt the design to meet TX needs. Integration with IMPACT may be tricky, if new database fields are needed. Regional differences may need consideration in the design.
-			Safety & risk tool analysis and design including investigation of potential external tools and the integration into IMPACT.	1,500	$210,000	1,700	$238,000	
-			Safety & risk tool development including unit testing of tool and its IMPACT integration	2,000	$280,000	2,500	$350,000	
-			Safety & risk tool testing	1,500	$210,000	1,600	$224,000	
-			Safety & risk tool documentation and training	2,000	$280,000	2,000	$280,000	
-			Safety & risk tool rollout	300	$42,000	500	$70,000	
-			Safety & risk tool stabilization	300	$42,000	500	$70,000	
-			Before and after measurement of the effects.	100	$14,000	150	$21,000	
3	6	D	- Fast way for users to come up to speed on the background of the case via an improved Family History Summary.	**3,320**	**$464,800**	**6,768**	**$947,520**	Must determine the appropriate level of family history summary required.
-			Family history summary outreach to determine user interface elements	120	$16,800	192	$26,880	Users need the ability to "get" a family's situation fast when they've been assigned the work. Caseworker input is essential so the right data is presented in a clear fashion. This is a "pure" IMPACT change and requires the developers to thoroughly understand the app.
-			Family history summary analysis & design	400	$56,000	720	$100,800	
-			Family history summary development	1,700	$238,000	4,080	$571,200	
-			Family history summary testing	600	$84,000	960	$134,400	
-			Family history summary documentation & training	120	$16,800	180	$25,200	
-			Family history summary rollout	120	$16,800	180	$25,200	
-			Family history summary stabilization	200	$28,000	360	$50,400	
-			Before and after measurement of the effects.	60	$8,400	96	$13,440	
4	15	D	- Add needed forms to IMPACT to mesh with practice and validation logic in use at the regions.	**2,280**	**$319,200**	**4,296**	**$601,440**	Also see associated Maintenance Item M1 below.
-			Determine a definitive list of forms to be put into IMPACT.	120	$16,800	240	$33,600	Documentation shows 313 paper forms used now state-wide and in Harris & Bexar Counties, with 199 forms now listed in IMPACT - a difference of 114. Further analysis will determine those forms that should be placed into IMPACT. 40 forms are assumed for this estimate, at 30/50 hours (low/high) per form for development.
-			New forms development and integration into IMPACT	1,200	$168,000	2,400	$336,000	
-			New forms testing	400	$56,000	720	$100,800	
-			New forms training & needed documentation	120	$16,800	216	$30,240	
-			New forms rollout	300	$42,000	480	$67,200	
-			New forms stabilization	80	$11,200	144	$20,160	
-			Before and after measurement of the effects.	60	$8,400	96	$13,440	
5	18	D	- Faster way to document information (data intake) in IMPACT.	**7,590**	**$1,062,600**	**13,176**	**$1,844,640**	
-			Additional outreach to determine appropriate data intake fields and format	200	$28,000	360	$50,400	Make the app easier to use, remove duplicate data entry, make data entry easier via better screen layouts, require fewer keystrokes, and populate data from other areas of the app to eliminate/reduce double entries. The key is to minimize data entry time in IMPACT. This could be a substantive change in the way IMPACT works, so it will require careful up-front design. A revised user interface will require additional training to enable users to adapt.
-			Revised intake/reduced data entry analysis and design	700	$98,000	1,200	$168,000	
-			Revised intake/reduced data entry development	4,000	$560,000	6,960	$974,400	
-			Revised intake/reduced data entry testing	1,300	$182,000	2,160	$302,400	
-			Revised intake/reduced data entry training & documentation	750	$105,000	1,320	$184,800	
-			Revised intake/reduced data entry rollout	400	$56,000	720	$100,800	
-			Revised intake/reduced data entry stabilization	120	$16,800	240	$33,600	
-			Before and after measurement of the effects.	120	$16,800	216	$30,240	

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6	6	D	- Faster way to upload photos, audios, emails by field personnel	**1,840**	**$257,600**	**3,276**	**$458,640**	
-			Additional outreach to ascertain user uploading needs	80	$11,200	144	$20,160	Bandwidth is not the only issue, it's making it easier (faster) for users to "attach" disparate information to a case. Once an artifact is connected to a case, need ways to quickly transmit all items up to IMPACT.
-			Improved upload analysis & design	300	$42,000	480	$67,200	
-			Improved upload development	800	$112,000	1,440	$201,600	
-			Improved upload testing	400	$56,000	720	$100,800	
-			Speedier upload training & documentation	60	$8,400	120	$16,800	
-			Speedier upload rollout	100	$14,000	168	$23,520	
-			Speedier upload stabilization	60	$8,400	108	$15,120	
-			Before and after measurement of the effects.	40	$5,600	96	$13,440	
7	6	D	- Easier error correction in IMPACT for field personnel	**3,520**	**$492,800**	**6,504**	**$910,560**	
-			Outreach to determine a prioritized list of serious errors where correction is needed in the field	80	$11,200	144	$20,160	The data collected in IMPACT is inherently complex, making some corrections of mistakes difficult. Thus, the most common/problematic mistakes should be categorized, with effort focused on those items providing the biggest improvements for casework ers.
-			Mistake correction analysis & design	400	$56,000	720	$100,800	
-			Mistake correction development	2,000	$280,000	3,600	$504,000	
-			Mistake correction testing	700	$98,000	1,440	$201,600	
-			Mistake correction training & documentation	120	$16,800	216	$30,240	
-			Mistake correction rollout	80	$11,200	144	$20,160	
-			Mistake correction stabilization	80	$11,200	144	$20,160	
-			Before and after measurement of the effects.	60	$8,400	96	$13,440	
8	6	D	- Easier closing of cases	**4,880**	**$683,200**	**8,688**	**$1,216,320**	
-			Outreach to fully understand the work required to close a simple and difficult case.	60	$8,400	144	$20,160	The job of closing a case can be complicated. There may be a need to streamline policy and process that would be reflected in this design, but early analysis will determine the path to take. The app needs to help a user get through the closing process.
-			Easier case closing analysis & design	400	$56,000	720	$100,800	
-			Case closing development	2,800	$392,000	4,440	$621,600	
-			Case closing testing	1,200	$168,000	2,640	$369,600	
-			Case closing training & documentation	200	$28,000	360	$50,400	
-			Case closing rollout	80	$11,200	144	$20,160	
-			Case closing stabilization	80	$11,200	144	$20,160	
-			Before and after measurement of the effects.	60	$8,400	96	$13,440	
9	6	D	- Support preparation of documents for court by exporting information from IMPACT to Word.	**1,485**	**$207,900**	**2,280**	**$319,200**	Inventory the number of forms that would save significant time for field workers.
-			Via outreach, determine the definitive list of court documents to be exported to Word.	60	$8,400	96	$13,440	Documentation of the presently used paper forms reveals a total of 24 Legal and Court forms. Assume 15 forms will need to be exported from IMPACT at 40/50 hours per form needed in development. Expect the design to be straight-forward, but forms will need to be well-tested to filter out errors that can result from unusual cases.
-			Court doc Word extract - do needed outreach to determine special form circumstances, to allow good integration w / IMPACT.	120	$16,800	180	$25,200	
-			Court doc Word extract. Analysis & design of form export process.	75	$10,500	180	$25,200	
-			Court doc Word extract. Develop the export of forms from IMPACT, formatting the paper document, and placing data on the pages.	600	$84,000	900	$126,000	
-			Court doc Word extract testing	350	$49,000	480	$67,200	
-			Court doc Word extract rollout	120	$16,800	192	$26,880	
-			Court doc Word extract stabilization	120	$16,800	180	$25,200	
-			Before and after measurement of the effects.	40	$5,600	72	$10,080	
10	18	D	Automate the request for purchased client services	**1,620**	**$226,800**	**3,024**	**$423,360**	
-			Investigate client service automation tools & techniques	100	$14,000	240	$33,600	Need ways to electronically access information on available client service organizations & personnel, searchable from IMPACT. Will most likely require real-time usage of new external data sources.
-			Client service automation analysis & design	280	$39,200	480	$67,200	
-			Client service automation development & unit testing	480	$67,200	792	$110,880	
-			Client service automation testing	200	$28,000	384	$53,760	
-			Client service automation documentation & training	240	$33,600	480	$67,200	
-			Client service automation rollout	120	$16,800	216	$30,240	
-			Client service automation stabilization	120	$16,800	240	$33,600	
-			Before and after measurement of the effects.	80	$11,200	192	$26,880	

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11	18	D	Reduce time caseworker spends locating children and adults. Implement the best solution(s) in TX.	**1,900**	**$266,000**	**5,040**	**$705,600**	
-			Check out existing data interfaces, tap internal CPS know ledge, and outreach to other state systems to find the best data for person search solutions	160	$22,400	528	$73,920	The low estimate is based on utilization of existing data interfaces. The high estimate assumes the addition of tw o significant new data interfaces.
-			Improved person search analysis & design	320	$44,800	600	$84,000	
-			Improved person search development & unit test, w ith potential new data interfaces needed	720	$100,800	2,160	$302,400	
-			Improved person search testing	240	$33,600	600	$84,000	
-			Improved person search documentation & training	120	$16,800	288	$40,320	
-			Improved person search rollout	160	$22,400	456	$63,840	
-			Improved person search stabilization	80	$11,200	240	$33,600	
-			Before and after measurement of the effects.	100	$14,000	168	$23,520	
12	18	D	Reduce need to print, scan, and fax documents and increase system generated communication. Include creation of electronic 2054's that now must be separately faxed to the provider.	**2,800**	**$392,000**	**5,184**	**$725,760**	Assumes the State does needed policy changes to allow electronic communications
-			Outreach to determine those docs that can be made paperless.	120	$16,800	192	$26,880	Assume 50 communications at 30/50 hours per item to develop.
-			Paperless form communication analysis & design	160	$22,400	240	$33,600	
-			Paperless form communication develop & unit test	1,500	$210,000	3,000	$420,000	
-			Paperless form communication testing	480	$67,200	768	$107,520	
-			Paperless form communication documentation & training	140	$19,600	240	$33,600	
-			Paperless form communication rollout	160	$22,400	264	$36,960	
-			Paperless form communication stabilization	160	$22,400	360	$50,400	
-			Before and after measurement of the effects.	80	$11,200	120	$16,800	
13	15	D	Expand the Spanish language version of forms, court documents, and other information that is given to the family to be more complete.	**800**	**$112,000**	**1,848**	**$258,720**	See associated Operations & Maintenance Item M2 below.
-			Determine the list of artifacts that should be translated to Spanish for distribution to clients.	60	$8,400	96	$13,440	Assume 20 initial items at 25/50 hours per artifact to develop.
-			Analyze and design the needed Spanish language	200	$28,000	480	$67,200	
-			Development of artifacts.	500	$70,000	1,200	$168,000	
-			Make needed changes to IMPACT.	40	$5,600	72	$10,080	
14	15	D	Automate the linking of email correspondence concerning a case with the IMPACT case records.	**2,020**	**$282,800**	**3,384**	**$473,760**	
-			Email-IMPACT linkage analysis & design	320	$44,800	576	$80,640	The linkage of emails to a case must be as easy as possible. It requires linking Outlook and IMPACT, w hich may w ell be tricky.
-			Email-IMPACT linkage development & unit test	480	$67,200	768	$107,520	
-			Email-IMPACT linkage testing	320	$44,800	528	$73,920	
-			Email-IMPACT linkage documentation & training	300	$42,000	480	$67,200	
-			Email-IMPACT linkage rollout	200	$28,000	360	$50,400	
-			Email-IMPACT linkage stabilization	320	$44,800	528	$73,920	
-			Before and after measurement of the effects.	80	$11,200	144	$20,160	
15	6	D	Improve documentation & training on Outlook and other mobility tools to allow easier email setup on iPhone, regional email lists and other user friendly features.	**400**	**$56,000**	**660**	**$92,400**	Computer-based training is a potential approach to allow ongoing information dissemination after the initial rollout
-			Determine best w ays to inform users of w ays to improve their use of current CPS technology	40	$5,600	60	$8,400	Technology training can yield big benefits, so the State can more fully use the tools already in place.
-			Outlook training course/artifacts design	60	$8,400	96	$13,440	
-			Create needed Outlook training materials	120	$16,800	192	$26,880	
-			Do Outlook training	120	$16,800	192	$26,880	
-			Outlook training follow up	40	$5,600	72	$10,080	
-			Before and after measurement of the effects.	20	$2,800	48	$6,720	
16	24	D	Implement workflow management in IMPACT - to track the progress of work associated with a case and allow leadership to spot bottlenecks and help the organization continuously learn how to expedite.	**10,520**	**$1,472,800**	**25,320**	**$3,544,800**	Integrating workflow with IMPACT could prove to be complicated, resulting in a wider range between the low and high.
-			Outreach to determine the w orkflow mgmt tasks to be tracked, including coordination of CPS organizational needs.	200	$28,000	480	$67,200	A resulting w orkflow system should allow the tracking of time betw een milestones and provide details on w homever is responsible for the task. The high figures result from placing foundational w orkflow s w ithin the existing IMPACT app.
-			Workflow mgmt analysis & design including needed management reporting artifacts and Investigation of external w orkflow management tools amenable to integration w ith IMPACT	400	$56,000	960	$134,400	
-			Workflow mgmt development & unit test	5,800	$812,000	13,920	$1,948,800	
-			Workflow mgmt testing	2,900	$406,000	6,960	$974,400	
-			Workflow mgmt documentation & training	300	$42,000	720	$100,800	
-			Workflow mgmt rollout	400	$56,000	960	$134,400	
-			Workflow mgmt stabilization	400	$56,000	960	$134,400	
-			Before and after measurement of the effects.	120	$16,800	360	$50,400	

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17	24	D	Support the assignment of cases to workers with greater insight into the actual workload the worker is carrying, skills needed, and mentor responsibilities. Purpose: create a non-GPS technical system to assign workers to cases.	**2,400**	**$336,000**	**4,668**	**$653,520**	Note: also see Item 20 covering a GPS system that could work in conjunction with this system and Item 18 to show workload in a geographic view.
-			Outreach to various regions to get the input and variables needed to make a case assignment system work correctly	200	$28,000	336	$47,040	Suggest low-hanging fruit be tackled first, since there may be factors that could be hard to computerize. Assigning workers to tasks involves a variety of decisions, some which are quantifiable (eg. drive time) and some that are less so (eg. worker skill sets). Regions will have their way of doing things that must be taken into account by the system.
-			Search for external case assignment tools that may be suitable for use with IMPACT	160	$22,400	288	$40,320	
-			Case assignment analysis & design	400	$56,000	720	$100,800	
-			Case assignment development & unit test	600	$84,000	1,440	$201,600	
-			Case assignment testing	320	$44,800	624	$87,360	
-			Case assignment documentation & training	300	$42,000	540	$75,600	
-			Case assignment rollout	160	$22,400	288	$40,320	
-			Case assignment stabilization	160	$22,400	240	$33,600	
-			Before and after measurement of the effects.	100	$14,000	192	$26,880	
18	9	D	Support a geographic view of workload through a visual display of field workload.	**1,160**	**$162,400**	**2,172**	**$304,080**	Note: also see Item 17 covering a case assignment syste and Item 21 for a GPS-based drive-time reduction system.
-			Outreach to determine the best geographic view approach	40	$5,600	96	$13,440	Assumes IMPACT will need to integrate a tools to display a geographic graphics view for TX. Also assumes that IMPACT presently has sufficient workload information to produce the view. If not, hours will go up to collect and store the additional data.
-			Select, acquire, and understand how to integrate a graphics tool into IMPACT	200	$28,000	408	$57,120	
-			Workload geographic view analysis & design	120	$16,800	192	$26,880	
-			Workload geographic view development & unit test	400	$56,000	696	$97,440	
-			Workload geographic view testing	180	$25,200	360	$50,400	
-			Workload geographic view documentation & training	20	$2,800	36	$5,040	
-			Workload geographic view rollout	80	$11,200	144	$20,160	
-			Workload geographic view stabilization	80	$11,200	144	$20,160	
-			Before and after measurement of the effects.	40	$5,600	96	$13,440	
19	6	D	Create an on-going enhancement request process	**180**	**$25,200**	**348**	**$48,720**	The process would actively solicit usability improvements from the front line caseworkers and considers time away from the family as a cost of not doing these types of enhancements.
-			Outreach to recruit interested & qualified people to prioritize proposed IMPACT & technical improvements	60	$8,400	108	$15,120	Expect this would largely require state personnel to set up the system. Nonetheless, potential vendor hours are shown in the estimate.
-			Establish CPS enhancement request process	40	$5,600	96	$13,440	
-			Convene sessions on a regular basis each year	80	$11,200	144	$20,160	
20	24	D	Complete the vision for mobility of reducing drive time to/from the office. Create a GPS-based technical solution.	**4,140**	**$579,600**	**7,308**	**$1,023,120**	Note: also see Item 17 covering a case assignment system that could work in conjunction with this system.
-			Perform the needed process, policy, & organizational changes for a GPS Drive-Time system to work.	180	$25,200	288	$40,320	Coordinate with process, policy, and organizational changes to achieve the vision for mobility of reducing drive time to/from the office while still supporting the need for team and supervisory support to the caseworker. This modification will require the usage of caseworker addresses, traffic information, and destination GPS data to produce an effective result.
-			Investigate available external GPS Drive-Time tools that	100	$14,000	192	$26,880	
-			GPS Drive-Time analysis & design	280	$39,200	600	$84,000	
-			GPS Drive-Time development & unit test	1,200	$168,000	1,920	$268,800	
-			GPS Drive-Time testing	1,000	$140,000	1,680	$235,200	
-			GPS Drive-Time documentation & training	500	$70,000	960	$134,400	
-			GPS Drive-Time system configuration with required TX	160	$22,400	288	$40,320	
-			GPS Drive-Time rollout	300	$42,000	540	$75,600	
-			GPS Drive-Time stabilization	220	$30,800	480	$67,200	
-			Before and after measurement of the effects.	200	$28,000	360	$50,400	
21	6	D	Time with families tool	**1,500**	**$210,000**	**2,000**	**$280,000**	Support submission and aggregation of time caseworkers spend with families

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SELECTED ONGOING OPERATIONS & MAINTENANCE ITEMS									
M1	M	M	Move to a model where the technology continuously reinforces the process and procedure by keeping forms in sync with practice and the validation logic in sync with the regional workflows.	**865**	**$121,100**	**1,752**	**$245,280**	Ideally, the State should establish a process to ensure form changes are routinely synched up with IMPACT and to add/remove forms as needed from usage. Also see associated Development Item above.
-			Continued analysis of forms throughout the year.	60	$8,400	120	$16,800	Based on figures from above, assume 20 forms annually at 30/50 hours/form
-			Ongoing forms development and integration into IMPACT	600	$84,000	1,200	$168,000	
-			Ongoing forms development testing	125	$17,500	240	$33,600	
-			Ongoing forms development rollout	40	$5,600	96	$13,440	
-			Ongoing forms development stabilization	40	$5,600	96	$13,440	
M2	M	M	Ongoing Spanish language document updates and additions	**310**	**$43,400**	**744**	**$104,160**	See associated Development Item above.
-			Analyze and design the needed Spanish language artifacts, whether they're new or translations from existing artifacts.	10	$1,400	24	$3,360	Assume 10 new or revised documents annually at 30/60 hours per form
-			Development of artifacts.	300	$42,000	720	$100,800	
M3	M	M	Potential upgrade of bandwidth infrastructure to resolve peak usage loads	**270**	**$37,800**	**558**	**$78,120**	The work will likely be done by the State. Nonetheless, the potential hours are estimated at a vendor rate.
-			Investigate usage statistics to determine if periodic slowness (latency) negatively impacts CPS field workers in a significant way.	30	$4,200	72	$10,080	
-			Design a solution to mitigate broadband slowness	20	$2,800	60	$8,400	
-			Develop/implement a bandwidth solution	80	$11,200	168	$23,520	
-			Bandwidth solution testing	40	$5,600	66	$9,240	
-			Bandwidth solution rollout	40	$5,600	72	$10,080	
-			Bandwidth solution stabilization	40	$5,600	72	$10,080	
-			Before and after measurement of the effects.	20	$2,800	48	$6,720	
M4	6	D	Training and support for Super-Users in each office	2,000	$280,000	4,000	$560,000	

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