Maine Safety Science Model

2022 Report

Maine Department of Health and Human Services
Office of Child and Family Services

Maine Safety Science Model 2022 Report

Introduction/Overview

Maine Office of Child and Family Services (OCFS) partnered with Collaborative Safety LLC to develop and implement the Maine Safety Science Model (MSSM) into the OCFS critical incident review process. This model integrates behavior analysis science to help understand how staff make decisions in an organizational setting as well as understand how managers and supervisors shape employee performance to achieve successful outcomes. Through this work OCFS is seeking to improve the ability of staff to make decisions in a manner that eliminates hindsight bias and blaming/shaming of staff.

Safety Science Process

One component of the MSSM is the completion of a technical review by an OCFS Safety Science Analyst on all reports screened in for OCFS intervention involving a child fatality (CF), near fatality (NF), serious injury (SI), and/or ingestion (I). This review includes a summary of the current report, a list of case participants, a summary of prior history, and areas identified for further study/exploration based on review of the family's child protective history. In cases that meet certain criteria (CF/NF/High Profile), the Regional Associate Director and/or Associate Director of Child Welfare Services provide additional information regarding the current investigation which is incorporated into the technical review as a comprehensive briefing memo for the OCFS Director and Department of Health and Human Services Commissioner.

The MSSM team, which consists of the Safety Science Analysts and the Child Welfare Project Manager, present cases to a specially convened Multidisciplinary Team (MDT) that meet the following criteria - a fatality or near fatality with child welfare history within the last three years. The OCFS Medical Director determines if a case is a near fatality based on criteria defined under CAPTA.

The MSSM MDT is comprised of the OCFS Medical Director, a Forensic Child Abuse Pediatrician, the Child Welfare Ombudsman, a Regional Associate Director of Child Welfare Services, and Program Managers from Children's Behavioral Health Services, Quality Assurance, the Violence Prevention Program, and Policy and Training. The Safety Science Analysts and Project Manager also participate to present cases.

The MDT selects cases for review and mapping. Once a case is selected, the Safety Science Analyst will develop learning points and identify staff to participate in a Human Factors Debriefing. The Human Factors Debriefing is a facilitated conversation among the Safety Science Analyst and staff and/or community partners assigned to the case to explore local rationality, or "the why behind someone's decision." Exploring local rationality can assist in identifying sources of knowledge, goals, expectations, and the focus of attention when decisions were made.

After information from the technical review and human factors debriefing has been collated, the information is prepared for systemic analysis through the systems mapping process. The systems map focuses on issues that spread across five different levels including conditions/processes/actor activities, (regional) organizational factors, (central) organizational factors, external factors, and Government and Regulatory bodies. During the mapping process, the facilitator guides the participants in discussion to explore all influences at each level.

OCFS has created three regional mapping teams (Southern, Central, and Northern) that consist of Child Protective Investigation and Permanency Caseworkers and Supervisors, the Regional Associate Director for that area, a Child Protective Intake Caseworker and Supervisor, and the Program Administrator and/or Assistant Program Administrator for the district where the case originated. At times, other guests may be invited to participate in the mapping session, such as tribal representatives in cases involving the Indian Child Welfare Act (ICWA), or law enforcement.

After the mapping session, Safety Science Analysts who facilitate the mapping process complete a narrative of the map and score systemic themes based on the Collaborative Safety Systems Analysis tool. Additionally, cases that were presented to the MDT but not mapped are also scored using this tool.

Systemic themes have specific definitions developed from safety science research. The identification of these systemic influences allows for guidance when developing recommendations for system change. These themes are aggregated and presented to the MDT on a quarterly basis. The MDT is then asked to develop recommendations for OCFS leadership to consider based on those aggregate themes. Each theme is scored on a scale of 0-3 (0 indicates no evidence, 1 indicates minimal evidence, 2 indicates evidence and influence in casework, 3 indicates substantial evidence and significant influence in casework).

Summary of 2022 Data

Between February 1, 2022- December 31, 2022, the Safety Science Analysts completed 171 technical reviews.

OCFS convened the first MSSM Multidisciplinary Team (MDT) in March 2022 and has held monthly meetings since that time. Thirty-six (36: 9 CF and 27 NF) cases have been presented to the MDT and 20 cases have been selected by the MDT for full review. The MSSM team began facilitating systems mapping in May 2022. Between May and December 2022, the team completed 13 system maps. Two mapping sessions were cancelled due to scheduling conflicts, and one was rescheduled due to illness.

Systemic Themes

Through the Safety Science process, systemic themes are identified with specific definitions based on research. The themes/influences provide guidance when organizations develop recommendations for system change. All cases presented to the MDT, regardless of whether they are mapped, are scored utilizing the system analysis tool. The tool results in a rating of the various systemic factors in each review which are defined below:

- **Prescribed Practice**: When practice prescribed by policy or practice standards is absent, conflicting, vague or does not adequately support work.
- **Cognition:** A faulty understanding of a situation due to a cognitive fixation or cognitive biases (e.g., confirmation bias, focusing effect, tunneling).
- **Production/Efficiency Pressure**: Demands to increase production and/or efficiency (e.g., workload, economic) which impacts safe work practices.
- **Teamwork/Coordinating Activities**: Ineffective joint coordination of activities between two or more entities including internal staff and external partners (e.g., CPS and licensing, CPS and law enforcement, foster care, and other external entities)
- **Demand-Resource Mismatch:** When resources within the agency are not compatible with the needs of staff (e.g., training for onboarding staff, staff shortages).

- **Knowledge Gap:** An absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice (e.g., absence of knowledge regarding policy or practice).
- **Documentation**: Absent, incomplete, or inconsistent documentation within electronic or hard copy case file.
- **Procedural Drift:** An accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance and experienced success.
- **Supervisory Support**: Difficulties in carrying out supervisor functions (e.g., decision support, clinical supervision, knowledge transfer, availability)
- **Equipment/Tools/Technology**: An absence or deficiency in the equipment, tools, and/or technology used to carry out safe work practices.
- **Service Availability:** The absence of or difficulty accessing a particular external service or support.
- **Medical**: Difficulties in obtaining or understanding medical records and/or integrating medical information into plans of care.

Definitions of Systemic Themes: (as defined in the Systems Analysis Tool developed by Collaborative Safety LLC)

Key Findings

Staff Knowledge/Skill Building

Themes of staff knowledge, training, and experience were identified as factors contributing to barriers in work practices. In terms of knowledge, staff perceive that the onboarding process for new staff is challenging, and that the Foundations training does not prepare caseworkers for the complexities of the work, which influences staff turnover. Additionally, staff perceive that they receive limited training regarding legal matters in the Foundations training, including training on evidence and ICWA, which impacts staff confidence in filing petitions.

Staff also described other situations in which they perceive having limited knowledge, including how to assess a family's needs and challenges, consider cultural differences, engage with resistant families, and work with older youth and non-verbal children. Staff also report limited knowledge of how to proceed when a child is diagnosed with certain medical conditions, for example, a lack of an established agency protocol for situations where a child is diagnosed with Failure to Thrive. Staff also shared that this knowledge gap is influenced by the limited information sharing between medical providers and the Department, as well as having limited access to expert medical consultation after regular business hours.

In the Human Factors Debriefing meetings with caseworkers and supervisors, staff cited shared decision making about cases in supervision between caseworkers and supervisors as a strength. Additionally, supervisors consult with their Program Administrator, Assistant Program Administrator, and Assistant Attorney General in a Team Decision Making meeting when there are complex case decisions and the need to determine whether to file court action.

In response to these concerns, OCFS is developing a supervision framework that outlines core competencies, practice expectations and leadership skills for the supervisory team, as well as outlining training and tools for providing quality, effective support to caseworkers. Current expectations require supervisors to complete field observations with all staff to provide coaching and mentoring.

In partnership with the University of Southern Maine, OCFS has updated and released several policies to clarify and outline practice expectations for staff. Each policy released includes a training component to familiarize staff with the revisions. Updated policies include Family Team Meetings, Permanency, Child Protection Investigations, Entry into Care, and Youth Transition. Additional training opportunities for staff include Working with Substance Affected Families, Quality Contacts, and Discovery.

Safety Planning

Staff work hard to ensure that children can remain safely in their homes whenever possible, and this influences the use of in-home safety plans. At times, these decisions drift from policy expectations, and are impacted by the perception that the courts will deny a Preliminary Protection Order (PPO) if reasonable efforts to prevent removal, including safety plans, are not attempted prior to requesting a petition. Staff also cited concerns related to limited placement options for children entering care as a factor.

In response, OCFS has researched national best practices regarding safety planning through consultation with the federal Administration for Children and Families, Capacity Building Center for States and Casey Family Programs. OCFS is also forming a workgroup to develop a stand-alone safety planning policy. Current practice permits staff to initiate a short-term alternative care plan, which allows for a child to be temporarily placed with an alternative caregiver for 5 days for further investigation activities or planning to be completed.

Time Frames

Themes related to timeframes regarding intake reports, investigations, and response times were raised in the mappings. For the Child Protective Intake Program, a practice memo was previously issued establishing expectations that calls be completed within 10 minutes with an additional 15 minutes to document the report and send it to a supervisor for approval. During case reviews, staff reported that this expectation impacted their ability to gather relevant information, review history, and validate case members in the system.

Investigation staff reported feeling pressure to complete investigations on time, to close overdue investigations, and to prevent new investigations from becoming overdue. The statewide expectation is that 90% of investigations will be closed within the 35-day time frame, leaving a 10% margin for investigations that require more assessment time. Staff reported the pressure to meet these expectations influences their decisions to close investigations without all tasks completed - specifically in investigations where the family is not willing to engage - and to focus on other higher priority tasks.

Additionally, staff report confusion regarding response timeframes. Using the Structured Decision Making Tool (SDM), staff are guided to select a response timeframe of 24 hours or 72 hours, however some reports require an “immediate response.” Staff describe a lack of clarity around what types of situations necessitate an immediate response versus a response within 24 hours. Staff perceive that this lack of clarity may lead to differing expectations between supervisors and/or other districts.

OCFS convened a workgroup of staff to review investigation timeframes, identify redundancies and recommend changes to improve policy and practice. OCFS researched national best practices related to investigation timeframes and requirements for activities that must be completed during an initial investigation of safety in collaboration with the Administration for Children and Families Information Gateway. The investigations policy workgroup submitted a series of recommendations to OFCS leadership that included suggestions for

timeframes, practice, and technology enhancements. OCFS Leadership supported 10 of the 11 recommendations and developed a plan for implementation. The one recommendation not accepted was addressed through a practice change in another policy. The updated investigations policy and technology enhancements will be effective in July 2023 and include an extension of the investigation timeframe from 35 days to 45 days, adjusts the initial 72-hour response timeframe to three days, allows the initial 24-hour timeframe to be changed when child safety is not impacted, and extends the investigation timeframe when a new report is received on an open investigation.

Vacancies/Workload

Staff perceive that a cycle of vacancies is initiated when caseworker shortages influence workers feeling overwhelmed which contributes to more staff leaving the Department resulting in additional vacancies. Staff perceived that vacancies are also influenced by a limited pool of qualified applicants, the COVID-19 pandemic, caseworkers being assigned to multiple supervisors, and lines being transferred to other districts as a result of the workload analytic tool.

Supervisors describe the perception that there is not enough time to mentor new staff and that this is influenced by their perceived pressure to get new workers out in the field quickly to provide relief to veteran staff.

Staff describe high workload and caseload assignments. There is a perception that assignment of new cases/investigations differs between districts and is influenced by factors such as time off requests, COVID-19 quarantining protocols, crises and immediate response situations, and competing job tasks. Some examples of other case tasks include caseworkers being responsible for covering their own visits and transportation for families, as well as Children's Emergency Services (CES) afterhours coverage and ED/hotel coverage.

OCFS has established an afterhours CES (Children's Emergency Services) unit to respond to emergency reports outside of traditional working hours. This unit has 16 caseworker lines and three supervisor lines. OCFS is in the process of recruiting to ensure that the program is fully staffed.

OCFS tracks turnover on a 12-month rolling average. In 2022, the turnover average was 31%. This is slightly lower than the turnover rate for 2021, which was 32%. The OCFS Recruitment and Retention Specialist recruits both virtually and in person through job fairs, college presentations, and other speaking opportunities throughout Maine and neighboring New England States. OCFS also utilizes recruitment strategies such as outreach to national organizations, expanded media outreach, and paid media ads both online and in print.

Structured Decision Making (SDM)

SDM, an evidence and research-based system of tools, was implemented with the purpose of creating statewide consistency in decision-making at intake, in investigations, and within permanency cases. Staff described that instruction regarding the use of the SDM tools has contributed to a difference in practice since its implementation. Specifically, staff report a reliance on using the outcome of the tool versus their professional knowledge and experience when making decisions.

Staff described receiving messaging from leadership to rely on the SDM tool as it is evidence based. This messaging influences staff perceptions that the tools will determine which intake reports will meet the threshold

for CPS intervention and what the level of risk is within a family. This messaging also contributes to staff being reluctant to use overrides and their fear of making a wrong decision.

OCFS has implemented new worker support groups for each district in partnership with the OCFS Training Team and the use of SDM tools is a training topic discussed at these meetings. Additionally, SDM refresher trainings are offered at the district level and the use of SDM tools has been incorporated into the Quality Contacts, FTM, and Investigation policy trainings which were conducted for all staff.

Katahdin

In January 2022, the Office of Child and Family Services (OCFS) transitioned from the Maine Automated Child Welfare System (MACWIS) to Katahdin, its new comprehensive child welfare information system. MACWIS was a narrative log-based information system, while Katahdin is a data driven system. Staff discussed how the initial Katahdin training was more general and did not teach practical uses. Additionally, workers describe being uncertain of what information to enter into Katahdin, as well as having received unclear messaging about where to document specific types of information.

Staff also describe challenges reviewing historical information in the new system, citing that the conversion data from MACWIS does not appear in chronological order. Additionally, staff describe that there are now multiple steps involved in reviewing prior history within a family which leads to confusion. Lastly, staff perceive that entering documentation into the new system is more time-consuming than it was in MACWIS.

OCFS and the Information Services Team have released a series of enhancements to the Katahdin system to address feedback from staff. Additional enhancements scheduled include adding client names and document titles to allow for easier research and including a detailed list of a client's history.

OCFS and Deloitte are currently partnering on an enhancement to strengthen the case print and discovery print feature which will address feedback from both internal and external partners, for example from parent attorneys, Guardians ad litem and the Child Welfare Ombudsman.

OCFS provides ongoing training and support to staff related to the Katahdin system, including monthly Katahdin trainings, biweekly meetings for district Super Users, training videos and other tools on the OCFS website and a document outlining where and how to document required information into the system.

Conclusions and Next Steps

In 2022, the Maine Safety Science team completed technical reviews on all 171 screened in reports involving serious injuries, ingestions, and child fatalities. Thirty-six of those reports met criteria for presentation to the Maine Safety Science Multidisciplinary Team and 13 systems mapping sessions were completed. This process identified the systemic themes influencing practice outlined above.

In addition to continuing reviews using the process previously described, the Safety Science team has consulted with Collaborative Safety LLC and will begin exploring areas of success in mapping meetings and in Human Factors Debriefings to identify and promulgate effective policy and practices. Time during the Human Factors Debriefings will be dedicated to exploring how staff are successful in completing their work and managing their workload. During the mapping meetings, time will be dedicated to exploring what they learned from the

discussion that they were previously not aware of in addition to how their teams are effectively managing their workload.

OCFS has identified Strategic Priorities for 2023 through 2026 which focus on safety, permanency, well-being, and building consistency in practice which will help address the identified systemic themes and key findings.

OCFS Child Welfare Strategic Priorities 2023-2026

Safety

- Improve the consistency and quality of CPS intake screening decisions
  - QA/QI reviews of SDM screening decisions
  - Case consultation and supervisor coaching
- Improve the consistency and quality of CPS investigations
  - Ongoing implementation of the Family First Prevention Services Act
  - Review and revision of the Safety Planning policy and practice
  - QA/QI reviews of investigations

Permanency and Well-Being

- Improve the consistency, quality, and timeliness of permanency for children in care
  - Permanency Review Process
  - Family connection activities
  - QA/QI reviews
- Improve the quality of the health and well-being of children in care
  - Ensure all youth in care have recommended and required health visits and immunizations
  - Ongoing implementation of the Plan of Safe Care
  - Psychotropic medication management
  - Ensure all youth in care age 14 and older have their strengths and needs assessment completed and results incorporated into their child plan

Consistency

- Achieve goals outlined in the CFSR/PIP measurement plan by January 2024
  - Develop and implement district PIPS to align practice with policy and meet agreed upon PIP goals
- Strengthen the child welfare workforce through efforts to improve recruitment, retention, and support
  - Katahdin implementation and system refinement
  - Update child welfare policies in collaboration with USM
  - Provide quality training opportunities
  - Implement the Maine Safety Science Model
  - Engage staff at all levels of the organization in system change processes