

SUNSET ADVISORY COMMISSION

STAFF REPORT

*Department of Family
and Protective Services*

MAY 2014



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Cover Photo: The Texas State Capitol was completed in 1888. With the Goddess of Liberty atop the dome, the Texas State Capitol Building is 19 feet taller than the U.S. Capitol Building in Washington, D.C. The photo shows the north facade of the Capitol. The gardens in the foreground sit atop a 667,000 square foot underground structure, the Capitol Extension, which houses many legislators’ offices and committee rooms. Photo Credit: Janet Wood

**DEPARTMENT OF FAMILY
AND PROTECTIVE SERVICES**

**SUNSET STAFF REPORT
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SUMMARY

SUMMARY

Aside from law enforcement, no other government agency is more directly involved in life-and-death decisions affecting Texans than the Department of Family and Protective Services (DFPS). Its responsibility to protect society's most vulnerable — children, elderly, and persons with disabilities — is as immensely challenging as it is important.

Child Protective Services (CPS), by far the largest and most visible DFPS program, operates in an uncertain, chaotic environment in which child deaths and other tragic events unfortunately happen. Caseworkers, many of them young and recently out of CPS training, balance the often competing pressures of ensuring child safety while respecting parents' rights and keeping families together. They are also expected to exert a measure of control in these cases, even as child abuse and neglect is often a symptom of larger social problems with no easy answers or quick fixes, such as poverty and substance abuse. Despite the inherent difficulty of its protective mission, DFPS is expected to answer for every bad outcome. As a result, the agency frequently finds itself on the defensive and in a constant state of putting out fires and responding to crisis and criticism, creating a continual cycle of both legislative and self-imposed change in which outside pressures dominate its agenda.

While not catchy or exciting, DFPS simply needs to better manage its people to carry out its difficult mission.

What DFPS sorely needs is a timeout to breathe and a chance to regroup after being in near constant transition for so long. The agency needs to roll up its sleeves and get down to the mundane business of effective management, long lost in a culture of addressing every problem that pops up with a new policy or initiative. The agency is already getting this message, having identified it repeatedly through its own internal efforts, yet distractions persist. While it may not be catchy or exciting, DFPS simply needs to do a better job of planning, communicating, listening, and managing its people so that it can carry out its critical mission more effectively. Even the greatest ideas for change fall short if DFPS lacks the processes and tools to effectively implement them, and measure and communicate their impact. Better management is crucial to allowing the agency to move forward and be better equipped to withstand the harsh media spotlight and successfully contend with the fishbowl environment in which it operates.

Given the unique nature of this agency and its history of continual change and reform, the Sunset review focused on identifying management improvements and opportunities to streamline operations to help DFPS better focus on the day-to-day aspects of its difficult work. Chief among these improvements is correcting poor management practices that contribute to high CPS caseworker turnover. Past efforts to retain caseworkers have primarily focused on reducing caseloads, increasing pay, and massive hiring efforts, but they have not addressed

work environment issues that motivate many caseworkers to leave the agency. Other recommendations are aimed at improving planning, policy making and implementation, data analysis, and performance management; simplifying policies and procedures; mitigating the risks of reforming Texas' foster care system; strengthening enforcement of child care regulations to better protect children in care, including foster care; and finally, developing a more thoughtful approach to its prevention efforts and providing a more robust continuum of services for children and families.

Though Sunset staff concluded that the need for the agency's functions remains unquestioned, this report does not address continuation of DFPS as a standalone agency. The Legislature made DFPS part of the health and human services system through the 2003 consolidation, and DFPS operates within this system that has not been comprehensively reassessed in the 11 years since its formation. All of the health and human services agencies are under Sunset review this interim, providing the opportunity to evaluate the system overall. This review will be complete in fall 2014, allowing Sunset staff to base its recommendations on the most complete information.

A summary follows of Sunset staff's recommendations on the Department of Family and Protective Services.

Issues and Recommendations

Issue 1

Efforts to Reduce Turnover of CPS Caseworkers Fail to Address Key Reasons Many Staff Leave.

Child Protective Services (CPS) caseworkers contend with high workloads, low pay, and incredibly stressful, challenging working conditions. Understandably, the workers who face the demands of this job often leave the agency citing the inherently stressful nature of the job and the pay — an issue facing many child welfare agencies across the nation. The Legislature and DFPS have long been concerned with reducing chronically high caseworker turnover, which results in a number of problems that directly affect the agency's ability to meet its mission of protecting children.

Despite legislative efforts to provide more staff to DFPS to reduce workload and authorize some monetary incentives, the CPS turnover rate remains significantly higher than the state agency average. DFPS' efforts to reduce turnover have primarily focused on high-volume hiring and training of new workers, but the agency has not done enough to shape a work environment that supports and develops caseworkers to successfully address retention. By ensuring consistent and transparent management practices, DFPS can take greater strides to reduce the causes of turnover that are within its direct control.

Key Recommendations

- Direct DFPS to consolidate its existing workforce management functions under one operational unit and add additional critical functions to better support employees and systematically identify root causes of turnover.
- Direct DFPS to dedicate certain existing caseworker positions to create a mentoring program to better support new CPS caseworkers.

- CPS should revise its system for evaluating caseworker performance by better measuring casework quality and ensuring performance expectations are reasonable.
- DFPS should develop a systematic way of using turnover, when appropriate, as a tool for judging performance of CPS regional management.

Issue 2

A Crisis Culture Affects CPS' Ability to Focus on Day-to-Day Management Activities Needed to Successfully Perform Its Difficult Work.

Any assessment of Child Protective Services must be made with consideration of the challenging, unpredictable environment in which it must react to crisis situations as a regular part of its daily business. Not surprisingly, this inherent reactive approach shows up in the way DFPS approaches the very management of CPS operations, resulting in a continuing cycle of crisis and criticism that distracts the agency from developing an effective approach to CPS management and ensuring it delivers desired results. Agency management has recognized the need to take a step back and examine the most basic elements of CPS operations through a contracted operational assessment. This assessment, in conjunction with the Sunset review's recommendations to implement a more strategic, thoughtful approach to overall CPS management, can help the agency begin to focus on its own goals and efforts to improve even in the face of crisis.

Key Recommendations

- Direct CPS to implement an annual business planning process.
- Direct DFPS to report to the Sunset Commission in October 2014 on changes it plans to implement in response to the CPS operational assessment currently in progress, and any statutory barriers that may impede needed changes.
- Direct DFPS to comprehensively review and update the CPS policy and procedures handbook and develop a systematic approach to its policymaking process to ensure clear, updated policies and procedures.
- Direct CPS to develop a systematic, comprehensive approach to evaluating and monitoring regional performance, including a process to verify implementation of recommendations for improvement.

Issue 3

DFPS Faces Significant Challenges and Risks in Its Efforts to Reform the State's Foster Care System.

Texas, like many other states, struggles to provide quality care for foster children to help them heal from the trauma they have experienced and go on to lead healthy, productive lives. Foster care redesign is an attempt to change the way the State contracts and pays for foster care and address many of the system's longstanding problems, such as those related to child placement and access to services. However, this outsourcing endeavor has its own risks, and other states' and the agency's own experiences show caution is warranted.

Currently, very little data or experience exists to judge the performance of the foster care redesign model and inform decisions about broader implementation. Further, DFPS has not clearly articulated a long-range plan for implementing a redesigned foster care system statewide to mitigate inherent risks associated with the transition. Of equal concern, the uncertain timelines and the challenges of implementing foster care redesign statewide mean the traditional, or “legacy” system will continue to care for the vast majority of children in foster care. DFPS also lacks a consistent, comprehensive approach for meaningful monitoring and reporting on performance of the foster care system as a whole, including well-being and safety indicators. A more deliberate approach to evaluating and implementing foster care redesign would help DFPS mitigate the significant risks associated with the reform effort and ensure efforts to improve foster care in the legacy system continue.

Key Recommendations

- Require DFPS to develop and maintain a long-range foster care redesign implementation plan to guide the agency’s transition efforts.
- DFPS should evaluate system data and cost before broader implementation of foster care redesign.
- DFPS should develop a consistent approach to measuring and monitoring provider quality and identifying risk indicators in both the legacy and redesigned systems.

Issue 4

DFPS’ Enforcement Efforts Must Be Strengthened to Best Ensure the Safety of Children in Regulated Care.

Driven by statute, the State’s traditional approach to enforcing child care licensing regulations has been to pursue non-monetary sanctions before imposing administrative penalties. This approach dampens DFPS’ enforcement effort in favor of an extensive collaborative approach of working with regulated entities to bring them into compliance with standards and licensing requirements. Such a limiting approach to enforcement hampers the agency’s ability to meet its mission to ensure the safety of children in care. As a result, DFPS has taken very few adverse enforcement actions against providers, and rarely used its administrative penalty authority. One consequence of this relaxed regulatory environment can be seen in a high incidence of repeat violations, many of which occurred on the highest-risk standards. Also, DFPS has difficulty ensuring that it consistently and reasonably applies safety standards, affecting the level of protection children experience across the state while in regulated child care. Broadening DFPS’ range of enforcement options and requiring the agency to develop a consistent and transparent enforcement approach would allow DFPS to better protect children in regulated child care and help the agency make more consistent, fair enforcement decisions.

Key Recommendations

- Authorize the agency to assess administrative penalties for high-risk child care licensing violations without first pursuing non-monetary administrative sanctions.
- Require DFPS to develop an enforcement policy in rule to guide child care licensing enforcement efforts, and require a specific methodology to be publicly available.

Issue 5

CPS Does Not Capture Comprehensive Information to Adequately Address How Well It Is Protecting Children.

DFPS needs accurate and complete data to evaluate the effectiveness of CPS interventions in addressing child abuse and neglect. Identification of trends can guide CPS practices and policies, because they help the agency evaluate and improve its decision making to keep children safe in future cases. However, CPS does not gather and evaluate sufficient data to most accurately assess the risk to children and the quality of services it provides, and does not ensure that services provided to families address the specific risks to children. The agency also lacks clear and consistent policies for referring families for services, which may result in some families not receiving interventions needed to mitigate safety risks to children. Capturing a broader spectrum of information and analyzing it in a more meaningful way would allow the agency to evaluate its performance in a more holistic manner and better target its limited resources to services that are most successful at preventing future child abuse or neglect.

Key Recommendations

- Direct DFPS to improve its collection and evaluation of data by adding an additional measure of recidivism linked to the alleged perpetrator, clarifying and standardizing the use of unsure case findings, and broadening its child fatality investigation review process.
- DFPS should develop a clear and consistent policy for referring families to Family-Based Safety Services and develop outcome measures linked to specific services provided.

Issue 6

DFPS Should Elevate the Importance of Its Prevention and Early Intervention Efforts and Better Use Existing Data to Evaluate Program Effectiveness.

Despite pressures to cut prevention programs when funding is limited and the need for a more immediate response is obvious, preventing poor outcomes is always preferable to the incalculable costs associated with child death or injury or broken homes, and the intensive intervention of foster care. After significant cuts to DFPS' prevention programs in the budget-cutting session of 2011, the Legislature restored funding for prevention in 2013, adding \$26.8 million for the biennium — effectively endorsing DFPS as the state's primary prevention agency.

The agency has not yet demonstrated the level of commitment needed to reflect its clear responsibility for prevention and early intervention efforts, though it has made recent progress in setting up the types of leadership and coordination to move the program forward. Improved planning and better use of existing data would help the agency target the use of limited resources and demonstrate program effectiveness to the Legislature and the public. In addition, certain prevention programs at the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) are a better fit for DFPS' child abuse and neglect prevention efforts since they target risk factors for child abuse and neglect. Consolidating these efforts can help the agency strengthen the continuum of services it offers to at-risk families.

Key Recommendations

- Require DFPS to develop a comprehensive strategic plan for its prevention and early intervention programs and develop a strategy to use existing data to better focus its prevention efforts and report the outcomes of its programs.
- Transfer HHSC's home visiting programs and DSHS' Pregnant Post-Partum Intervention and Parenting Awareness and Drug Risk Education programs to DFPS.

Issue 7

A Lack of Administrative Flexibility and an Antiquated Fee Collection Process Limit DFPS' Ability to Recover Regulatory Costs.

While federal funds to pay for two-thirds of DFPS' child care regulatory effort sets Child Care Licensing apart from typical state regulatory programs, the agency does charge fees to recover costs. Unlike other regulatory programs, however, DFPS lacks the authority to set fees in rule, constraining its ability to recover costs and fund other child protection initiatives. Statutory fee amounts have not been changed since 1985, and have not recovered the cost of regulation in several years. Greater flexibility to set fees in rule would allow DFPS to adjust fees as conditions change and to recover a greater share of the cost of regulation if so determined by the Legislature.

The agency's paper-based fee collection process is cumbersome, costly, and inefficient for both DFPS and its licensees, and does not provide assurance that required fees are paid. By working with the Department of Information Resources, DFPS can move to more efficient online fee collections, producing long-term savings and significant administrative efficiency.

Key Recommendations

- Eliminate the agency's statutory licensing and administrative fee caps and authorize fees to be set in rule.
- Direct DFPS to transition to online child care licensing fee collections.

Issue 8

The Critical Nature of Its Work to Protect Children and Vulnerable Adults Imposes a Higher Burden on DFPS in How It Obtains Stakeholder Input.

DFPS has a multitude of stakeholders, including families with children; child care and other protective services providers; courts, local law enforcement, and local prosecutors; advocacy groups and other nonprofit entities with an interest in children and family issues; local, state, and federal policymakers; and the public at large. Despite the importance of stakeholder input to DFPS' mission and functions, the agency does not provide sufficient guidance to its staff on how to involve stakeholders on a regular basis, which can result in inconsistent public involvement efforts. Clear policies and rules governing DFPS' use of advisory committees and workgroups would ensure a more consistent approach to gathering and using stakeholder input.

Key Recommendation

- Require rules governing the use of advisory committees, ensuring committees meet standard structure and operating criteria, and direct DFPS to clearly define in agency policy the appropriate use of advisory committees and informal workgroups.

Issue 9

Consider Organizational Aspects Related to Family and Protective Services as Part of an Overall Assessment of Health and Human Services Agencies.

Although the name and organizational structure of the agency charged with providing protective services have shifted over time, Texas has provided these services on the state level since the 1970s, when Congress passed legislation that began federal funding of the state child welfare systems and began requiring states to protect elderly adults from abuse, neglect, and exploitation. The Sunset review found the state has a continuing need to protect its most vulnerable populations from harm, through child protection, protection of vulnerable adults, and regulation of out-of-home child care. While DFPS' functions should clearly continue, its organizational structure must be evaluated in conjunction with the health and human services system overall.

Key Recommendation

- Postpone the decision on continuation of DFPS' functions and structure until the completion of the Sunset review of the health and human services system.

Fiscal Implication Summary

Overall, these recommendations would have a cost to the State of \$181,000 in fiscal year 2016, and a positive fiscal impact to the State of \$279,000 beginning in fiscal year 2017. The fiscal implication for these recommendations is summarized below.

Issue 1 — Adding three full-time equivalent employees to resolve internal complaints and analyze and monitor factors and conditions potentially contributing to employee turnover would cost about \$181,000 per year, including salaries and benefits. However, investing these resources could help reduce the agency's approximately \$72 million annual turnover costs. Directing DFPS to create dedicated CPS mentor positions would not have a fiscal impact to the State, since the agency can use existing vacant positions for this purpose.

Issue 3 — Strengthening child care licensing enforcement could result in additional revenue from administrative penalties, but the fiscal impact could not be estimated because penalty amounts generated would depend on the number and seriousness of future violations.

Issue 6 — Transferring prevention programs from HHSC and DSHS to DFPS would not have a net fiscal impact to the State, but would require transfer of funds and staff between agencies. Transferring home visiting programs from HHSC to DFPS would require the transfer of approximately \$20 million in state and federal funds and 18 employees. Transferring substance abuse prevention programs from DSHS to DFPS would require the transfer of about \$5 million in state and federal funds and one employee.

Issue 7 — Directing DFPS to implement online fee collections for its Child Care Licensing program would save the agency approximately \$460,000 per year, beginning in fiscal year 2017. Using existing IT staff and budget, the transition to the online system could be completed by the end of fiscal year 2016.

Department of Family and Protective Services

Fiscal Year	Cost to the General Revenue Fund	Savings to Federal and State Funds¹	Change in FTEs
2016	\$181,000	\$0	+3
2017	\$181,000	\$460,000	+3
2018	\$181,000	\$460,000	+3
2019	\$181,000	\$460,000	+3
2020	\$181,000	\$460,000	+3

.....

¹ Given the mix of federal and state funds used to fund the licensing program and the involvement of other DFPS departments in administering fees, savings to state funds cannot be precisely estimated. Any savings in federal funds could be freed up for other uses.

AGENCY AT A GLANCE

AGENCY AT A GLANCE

The Legislature created the Department of Family and Protective Services (DFPS) in 2003 from the functions of the Department of Protective and Regulatory Services in the consolidation of the health and human services agencies. DFPS aims to protect children, adults aged 65 and over, and individuals with disabilities by carrying out the following key activities:

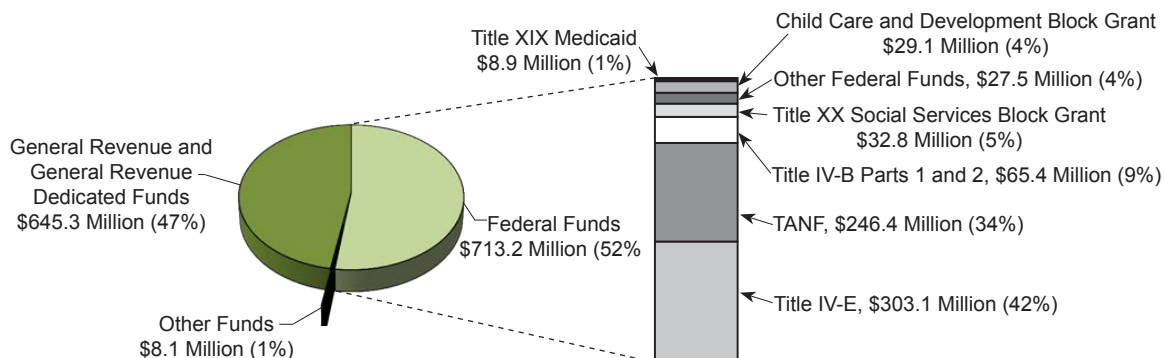
- investigating allegations of abuse and neglect of children or vulnerable adults perpetrated by a caregiver, whether in the home, in a state-run facility, in a state-contracted setting, or in a regulated child care operation;
- providing services to families and individuals to prevent future harm from abuse or neglect;
- placing abused or neglected children with other family members or in a foster home and seeking to address these children's long-term needs through adoption or transition to adult living; and
- regulating child care centers and 24-hour residential child care facilities to ensure a minimum standard of health and safety for children.

Key Facts

- **Agency Governance.** The executive commissioner of the Health and Human Services Commission (HHSC) appoints a commissioner to oversee the operations of DFPS. Together, the DFPS commissioner and the HHSC executive commissioner develop rules and policies for DFPS, with advisory input from the DFPS Council, which is appointed by the governor to provide a venue for public review and comment.
- **Funding.** The agency spent \$1.37 billion in fiscal year 2013. Of that amount, general revenue made up \$645 million, or 47 percent. Several federal funding streams made up \$713 million, or 52 percent of the total. Over 75 percent of DFPS' federal funding comes from Title IV-E of the Social Security Act for Foster Care, Adoption, and Guardianship Assistance and from Temporary Assistance to Needy Families.

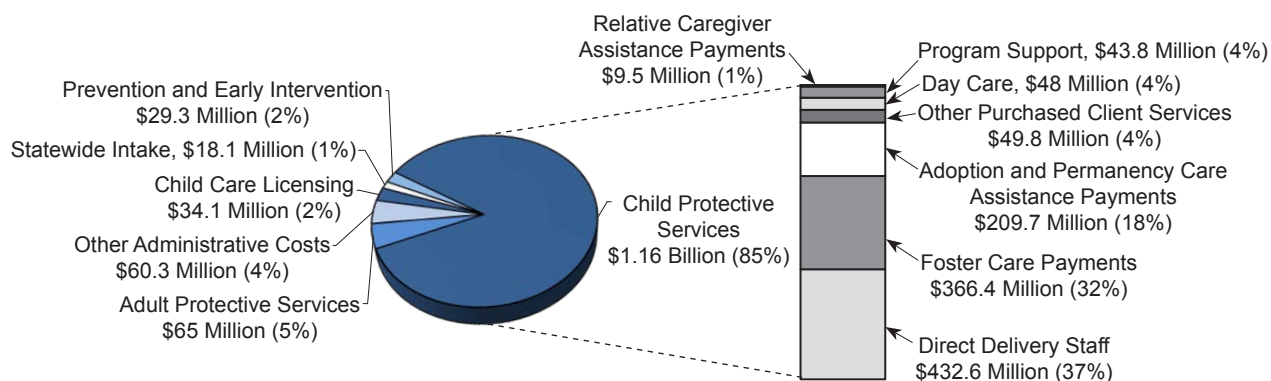
The pie charts on the following page, *DFPS Revenues* and *DFPS Expenditures*, show the types and amounts of revenues DFPS collected and how the agency spent that funding in fiscal year 2013. DFPS spent about 85 percent of its overall funding on Child Protective Services (CPS), mostly for foster care, adoption assistance, and relative caregiver assistance payments, as well as direct delivery staff. Appendix A describes DFPS' use of historically underutilized businesses in purchasing goods and services for fiscal years 2011–2013. The Legislature increased funding to DFPS for the 2014 and 2015 fiscal years by \$346.9 million, largely to pay for additional CPS caseworkers, increased prevention and early intervention services for at-risk families, and additional staff to investigate illegal day care operations.

DFPS Revenues FY 2013



Total: \$1.37 Billion

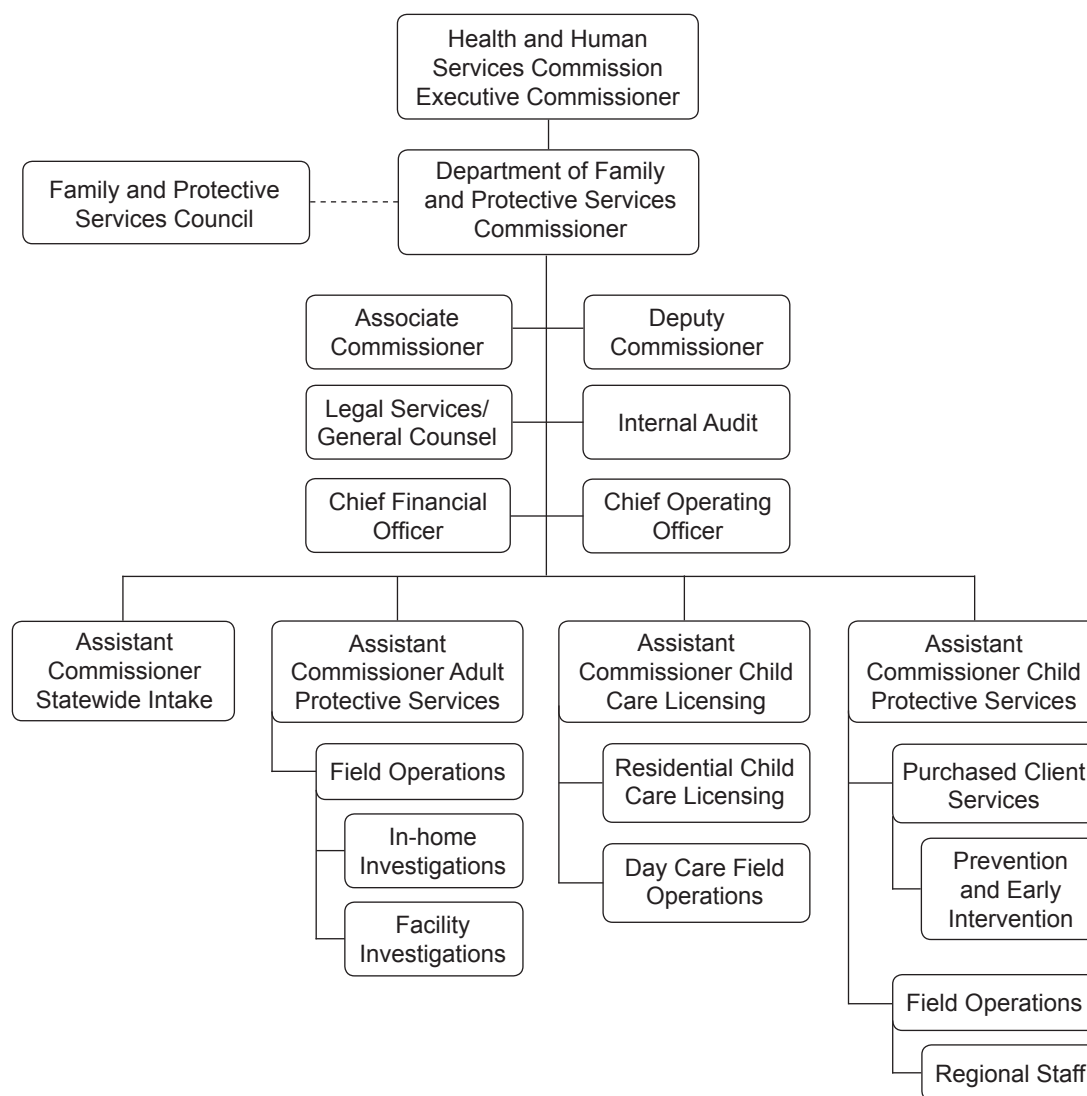
DFPS Expenditures FY 2013



Total: \$1.37 Billion

- Staffing.** At the end of fiscal year 2013, DFPS employed 10,650 staff with 11,175 authorized full-time equivalent positions. Of the filled positions, 7,759 were within CPS and 4,733 of those were CPS caseworkers. Adult Protective Services (APS) employed 958 staff, 665 of which were caseworkers. Child Care Licensing employed 509 people, 342 of which were inspectors and investigators. Most staff are located in DFPS' 11 regions. Appendix B contains a map showing the regional structure. Appendix C compares the agency's workforce composition to the percentage of minorities and females in the statewide civilian labor force for the past three fiscal years. For fiscal years 2014 and 2015, the Legislature significantly increased DFPS' authorized positions, adding 1,175. Most of the new positions are CPS caseworker positions for investigations and conservatorship, but 41 positions were dedicated to Child Care Licensing's efforts to address illegal child care. The chart on the following page, *Department of Family and Protective Services Organizational Chart*, depicts the organization's structure.

Department of Family and Protective Services Organizational Chart



- Statewide Intake.** The centralized, 24-hour Statewide Intake call center receives all allegations of abuse, neglect, or exploitation of children; adults aged 65 and older; and adults with disabilities through the Texas Abuse Hotline. Statewide Intake receives about 80 percent of reports by phone; the remaining reports come in mostly through the internet. Intake specialists input all data from reports received, assign a priority level, and route them to the appropriate program and region. Statewide Intake received 334,739 reports of alleged abuse, neglect, or exploitation in fiscal year 2013. Of those, 68 percent related to CPS, 30 percent related to APS, and 2 percent related to Child Care Licensing.

- **Child Protective Services.** CPS provides services primarily through investigations, family-based safety services, and substitute care.

Investigations. CPS caseworkers investigate allegations of child abuse and neglect perpetrated by a child's caregiver. In fiscal year 2013, DFPS received 229,334 reports of alleged child abuse or neglect.¹ The textbox, *CPS Investigation Activities*, lists several common activities CPS investigators perform to gather evidence to confirm or rule out an allegation. In fiscal year 2013, CPS completed 160,240 investigations and confirmed that child abuse or neglect occurred in 40,249 cases. CPS determined that

CPS Investigation Activities

- Interviewing children, the alleged perpetrator, and other adults, such as family members and medical professionals.
- Photographing the child and conditions in the home.
- Collecting and reviewing medical records, CPS case history, and school records.

child abuse or neglect did not occur in 100,390 completed investigations.² In the remaining 19,601 investigations, the allegation could not be confirmed, either because the family could not be located or because the evidence did not clearly support or disprove the allegation. Throughout the course of the investigation, CPS investigators assess immediate risks to the child's safety. DFPS may pursue removal through the court system if the investigation determines the child cannot remain safely at home. The agency removed 17,022 children in fiscal year 2013 with court approval.

Common Family-Based Safety Services

- Diagnostic consultations
- Psychosocial assessments
- Individual therapy
- Group therapy
- Substance abuse counseling
- Domestic violence counseling
- Mental health services

Family-Based Safety Services. CPS investigators refer cases for these services when an investigator identifies risks to the child's safety in the immediate future but determines that the child can remain safely in the home. In fiscal year 2013, the agency provided assistance and services to 29,332 families to minimize risks to children and prevent the need for children to be removed from their homes. Family-Based Safety Services caseworkers assess the family's needs as a unit and develop a voluntary service plan that outlines steps that the family agrees to take to protect the child, including engaging in services such as those listed in the accompanying textbox. The caseworker closes the family's case when family members complete their service plans and caseworkers conclude that the safety risks to children have sufficiently decreased.

Substitute Care. CPS refers families to substitute care when CPS investigators or Family-Based Safety Services caseworkers determine that the safety risks to the child are too great for the child to remain in the home. The agency petitions the court for temporary managing conservatorship of the child and, if granted, places the child with a relative or in paid foster care. Texas statute limits a child's stay in temporary conservatorship to 12 months, with one possible six-month extension. During this time, goals for the child's permanent living arrangements typically include reunification with the family, if possible, or adoption. During fiscal year 2013, CPS reunited 5,647 children with their families.

If the court elects not to reunite the child with his or her parents within the time limit, the court may grant DFPS permanent managing conservatorship, or custody, and terminate parental rights. At that time, CPS stops providing services to the family for reunification and pursues alternate permanency goals such as adoption or preparing an older child for independent living. Appendix D, *Child Protective Services State Conservatorship Timeline and Flowchart*, illustrates this process.

For children in the State's custody, the agency administers a system for paying foster care providers or certain relatives to care for the children and serve their identified needs. At the end of fiscal year 2013, DFPS had 27,924 children in either temporary or permanent custody. Of that number, 16,676 children were living in paid foster care, 10,059 in kinship care, and 722 in pending adoptive homes.³ During fiscal year 2013, DFPS had 5,364 children adopted out of its custody and 1,328 children age out of custody.

- **Adult Protective Services.** In fiscal year 2013, DFPS received 98,920 allegations of abuse, neglect, or exploitation perpetrated against individuals aged 65 or older and individuals with disabilities. Adult Protective Services (APS) investigates these allegations through two separate programs, depending on the living situation of the alleged victim.

In-home investigations. The agency primarily conducts in-home investigations when the adult in question lives in his or her own home or in a setting not investigated by another state agency. In fiscal year 2013, APS conducted 69,383 in-home investigations, validating the occurrence of abuse, neglect, or exploitation in 48,392.⁴ The majority of the investigated cases involved self-neglect. APS receives reports through Statewide Intake, investigates allegations, and provides or arranges for services on a voluntary basis to reduce or prevent further harm. APS may provide services such as home cleaning, basic personal care services, and temporary assistance to help clients pay housing or utility costs. In extreme cases, APS may seek an emergency protective services court order to remove a client from a dangerous situation.

Facility investigations. APS conducts facility investigations of alleged abuse, neglect, and exploitation of individuals receiving mental health, intellectual disability, or developmental disability services in state-operated or state-contracted settings. In fiscal year 2013, APS conducted 10,818 facility investigations and confirmed 1,373 allegations. Of the total investigations, 55 percent took place in state-supported living centers and state hospitals. Facilities within APS investigatory purview include those listed in the textbox, *Facility Settings Investigated by APS*. The agency does not provide services through facility investigations, but conducts investigations and provides objective findings to the service provider so that the provider can take actions to protect the individual in care.

Facility Settings Investigated by APS

State-operated facilities

- State-supported living centers
- State hospitals

State-contracted settings

- Private intermediate care facilities
- Local mental health authorities
- Intellectual and developmental disability waiver service providers, such as Home and Community-based Services and Texas Home Living

- **Child Care Licensing.** This program includes Day Care Licensing and Residential Child Care Licensing divisions. Both divisions develop minimum standards to ensure the safety and well-being of children in out-of-home care; inspect operations to ensure compliance; investigate allegations of minimum standards violations and abuse or neglect of children in care; and take enforcement action.

Day Care Licensing. The agency regulates day care operations, such as licensed child care centers, by establishing and enforcing minimum standards. The chart on the following page, *Day Care Permit Types*, describes each type of regulated day care facility. In fiscal year 2013, the agency conducted 37,128 day care inspections and completed 18,429 investigations. The agency cited operations for 90,157 deficiencies, resulting in 157 corrective actions, such as probation, and 26 adverse actions, including license suspension, revocation, or denial.

Day Care Permit Types

Operation Type	Description	Type of Permit	Number of Facilities (FY 2013)
Licensed Child Care Centers	Provide care for 13 or more children for less than 24 hours a day.	License	9,533
Licensed Child Care Homes	Provide care for seven to 12 children for less than 24 hours a day.	License	1,756
Registered Child Care Homes	Provide care in caregiver's own home for four to six unrelated children. Care can be provided for six additional school-aged children before and/or after the customary school day.	Registration	5,266
Listed Family Homes	Provide care in caregiver's own home for compensation for three or fewer children.	Listing	5,411
Other	Includes small employer-based child care and temporary shelters.	Compliance certificate	14
TOTAL			21,980

Residential Child Care Licensing. The agency regulates 24-hour child care operations, primarily DFPS' foster care providers, by establishing and enforcing minimum standards. The regulated operations are responsible for the care, custody, supervision, assessment, training, education, and specialized treatment of youth in their care. The chart, *Residential Child Care Permit Types*, describes the types of regulated residential facilities. In fiscal year 2013, the agency conducted 4,691 inspections and completed 5,108 investigations of these facilities, citing operations for 6,053 deficiencies. Those deficiencies resulted in 12 corrective actions and one adverse action.

Residential Child Care Permit Types

Operation Type	Description	Type of Permit	Number of Entities (FY 2013)
Child Placing Agencies	Place children in child care facilities, foster homes, or adoptive homes.	License from DFPS	370
Foster Family Homes	Provide care for six or fewer children in the primary residence of the foster parents and verified by a child placing agency as meeting state standards set by DFPS.	Verification by Child Placing Agency ⁵	8,583
Adoptive-only Homes	Homes screened and approved to legally adopt children in DFPS conservatorship who are eligible for adoption.	Verification by DFPS	724
Foster Group Homes	Provide care for seven to 12 children in a home verified by a child placing agency as meeting state standards set by DFPS.	Verification by Child Placing Agency ⁶	370
General Residential Operations	Provide care for 13 or more children and may provide various treatment, emergency care, or therapeutic services.	License from DFPS	235
Independent Foster Group Homes	Provide care for seven to 12 children in a home licensed by DFPS.	License from DFPS	4
TOTAL			10,286

- **Prevention and Early Intervention.** Prevention and Early Intervention, housed within CPS, focuses on preventing child abuse, neglect, and juvenile delinquency. The agency identifies potential areas for community intervention, such as assisting families in crisis, and contracts with local providers to deliver services. DFPS delivers no services directly and contractors perform all of the outreach and identification of eligible participants. The two largest programs, both mandated by statute, are the Services to At-Risk Youth program and the Community Youth Development program. In fiscal year 2013, these programs together served 40,444 people and accounted for about \$21 million of the \$29.3 million in total prevention expenditures. For fiscal years 2014 and 2015, the Legislature increased funding by \$26.8 million to pay for increased contracted services for at-risk families, such as home visits and crisis counseling. Appendix E provides more detail on DFPS' prevention and early intervention programs.

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¹ CPS received 229,334 reports of alleged abuse or neglect and completed 160,240 investigations. The remaining 69,094 reports were merged with previous reports or open cases, administratively closed, formally screened out, or alleged at the end of one fiscal year and completed at the beginning of another.

² In CPS investigations, the agency considers allegations of abuse or neglect to be confirmed when greater than 50 percent of the evidence gathered supports the conclusion that the alleged act of abuse or neglect occurred. "Ruled-out" allegations indicate that less than 50 percent of the evidence supports the allegation.

³ The remaining 467 children were placed in other substitute care arrangements, including independent living programs and court-ordered placements, or had unauthorized absences.

⁴ The term "validated" refers to APS in-home cases in which greater than 50 percent of the evidence indicates that the alleged act of abuse, neglect, or exploitation occurred.

⁵ DFPS acts as the child placing agency for 1,366 of these foster family homes.

⁶ DFPS acts as the child placing agency for six of these foster group homes.

ISSUES

ISSUE 1

Efforts to Reduce Turnover of CPS Caseworkers Fail to Address Key Reasons Many Staff Leave.

Background

The State places tremendous responsibility and high demands on Child Protective Services (CPS) caseworkers, who contend with difficult working conditions, high workloads, and low pay. They are the backbone of the State's effort to protect children, and make life-and-death decisions every day. Caseworkers constantly struggle to balance the often competing pressures and interests of keeping children safe while respecting parents' rights and keeping families together. They intervene in families' lives without invitation, placing themselves in adversarial, sometimes dangerous situations and witness the grim realities of child abuse and neglect, including child deaths and serious injuries, simply to fulfill their basic job duties. Caseworkers are expected to exert a measure of control in such an environment, even though child abuse and neglect is most often a symptom of difficult, chronic intergenerational social problems, such as poverty, domestic violence, and substance abuse. The textbox, *Types of CPS Caseworkers*, describes the three main CPS caseworker specializations and the focus of their involvement in families' lives.

Types of CPS Caseworkers

Investigations: Conduct investigations of child abuse or neglect that occur in a family.

Family-Based Safety Services: Provide or coordinate services to families referred through investigations to mitigate ongoing risk of abuse or neglect and prevent the need for removal.

Conservatorship: Provide or coordinate services to families in which children have been removed from their homes and placed in the State's custody because of significant risks to their safety.

Due to the inherent difficulties of caseworkers' jobs, turnover in CPS will always be higher than in other fields. Across the country, turnover at child welfare agencies averages around 30–40 percent.¹ However, given the high stakes of CPS' work, the Legislature and the Department of Family and Protective Services (DFPS) have long been concerned with reducing chronically high caseworker turnover, which results in a number of problems that directly impact the agency's ability to meet its mission of protecting children from abuse and neglect, as described in the textbox, *Negative Impacts of Caseworker Turnover*. DFPS continually invests significant time and resources into hiring and training new caseworkers. The agency estimates that each caseworker that leaves has a total cost impact of \$54,000 to the agency. In fiscal year 2013, CPS lost 1,346 caseworkers, resulting in an overall \$72.7 million impact to the agency. At the end of fiscal year 2013, DFPS employed 4,733 CPS caseworkers located in 11 regions. See Appendix B for a map depicting the regional structure.

Negative Impacts of Caseworker Turnover

- Delayed investigations.
- Lack of continuity in providing services to families and children.
- Lack of consistent, timely visits to children in state custody.
- Added workload for remaining workers, causing further turnover.
- Significant costs to the State in recruitment and training costs as well as lost productivity.

DFPS Human Resources-Related Functions

- Recruitment
- Hiring
- Program-related training for new and existing staff
- Performance evaluations
- Disciplinary actions

The Health and Human Services Commission (HHSC), which oversees DFPS' operations within the consolidated health and human services system, sets a common human resources policy for all health and human services agencies to follow, and carries out many human resource functions, such as managing compensation and benefits and resolving employee complaints and grievances through its Office of Civil Rights. DFPS still conducts some human resources-related functions, such as those listed in the accompanying textbox.

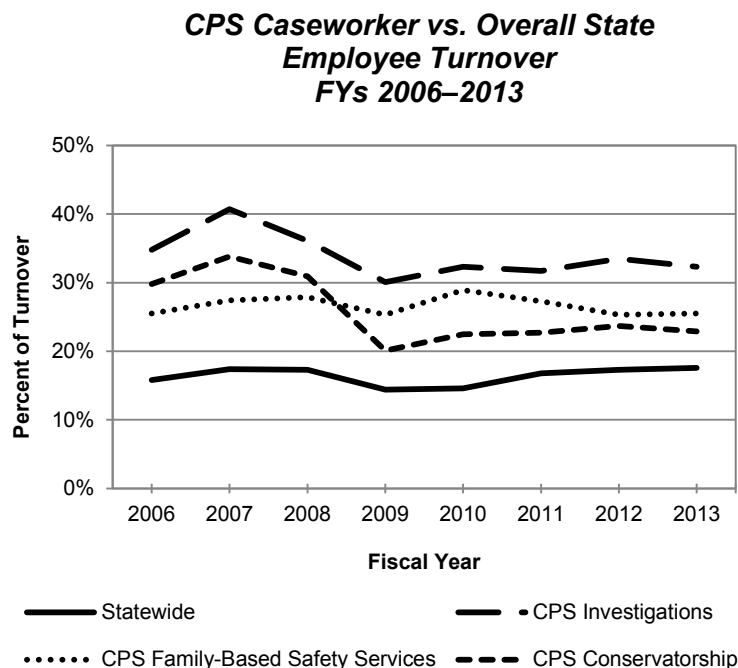
As part of an effort to identify root causes of turnover by directly asking caseworkers and other staff about the issue, Sunset staff conducted an anonymous online survey of all DFPS staff in January 2014. Approximately 62 percent of all DFPS employees (6,954 employees) working in all divisions and regions of the agency responded to the survey; 5,188 of those respondents worked in CPS. The survey asked a variety of questions related to employee training, supervision, management support, workload, and work environment. Although turnover is a concern in other DFPS programs with direct delivery staff, such as Adult Protective Services and Child Care Licensing, CPS turnover is significantly higher. As a result, the Sunset review focused primarily on how DFPS could better address turnover among CPS caseworkers, although some of the resulting recommendations of this analysis would apply agencywide to benefit all employees.

Findings

CPS has perpetually high rates of turnover among caseworkers, despite continued hiring efforts and investments in workload reduction.

Recognizing high caseloads as a contributing factor to caseworker turnover, the Legislature has made significant and continued investments to increase

the number of caseworkers to decrease caseloads. Since 2005, the Legislature has added 2,931 CPS direct delivery positions. For fiscal years 2014–2015 alone, the Legislature added 694 new CPS caseworker positions. Although turnover has decreased overall since 2006, it still remains consistently higher than the state agency average, as illustrated by the graph, *CPS Caseworker vs. Overall State Employee Turnover*. Also, in an effort to specifically target investigations turnover, which has been chronically higher than other CPS stages of service, the Legislature has authorized DFPS to pay \$5,000 annual stipends to investigative caseworkers and supervisors.



Statewide, investigator turnover is consistently higher than that of Family-Based Safety Services or conservatorship workers. However, turnover among all types of caseworkers varies widely by region, by county, and even down to the individual unit level headed by a single supervisor. For example, Family-Based Safety Services caseworker turnover varied greatly from region to region ranging from nearly 40 percent in Region 7 (Austin) and Region 5 (Beaumont) in fiscal year 2013 to less than 10 percent in Regions 2 (Abilene) and 10 (El Paso). In the same fiscal year, turnover was as high as 58 percent for these caseworkers in Travis County; turnover was over 100 percent in some CPS units across the state.

With high overall turnover rates, CPS also faces high vacancy rates and has difficulty hiring and training new workers fast enough to fill all available positions. During fiscal year 2013, one out of every eleven CPS caseworker positions was vacant. As illustrated by the table, *CPS Investigations Turnover, Caseload, and Vacancy Data by Region*, higher vacancy rates are related to higher caseloads and higher turnover, creating a vicious cycle. Further, because new caseworkers must go through three months of training before taking on a caseload, turnover can have long-term effects on vacancy rates, and, in turn, caseloads.

CPS Investigations Turnover, Caseload, and Vacancy Data by Region – FY 2013

Region	Turnover Rate	Average Daily Caseload	Average Vacancy Rate	Average Vacancy Rate in February 2014
1 (Lubbock)	32.7%	18.7	7.5%	13.3%
2 (Abilene)	19.9%	23.8	9.3%	10.4%
3 (Arlington)	23.8%	18.5	7.7%	9.8%
4 (Tyler)	29.7%	18.1	9.4%	6.9%
5 (Beaumont)	21.9%	19.4	6.0%	8.8%
6 (Houston)	35.9%	21.5	13.0%	11.2%
7 (Austin)	40.4%	21.2	11.9%	27.7%
8 (San Antonio)	34.4%	17.9	8.4%	11.6%
9 (Midland)	47.6%	24.4	20.0%	24.6%
10 (El Paso)	21.9%	19.9	9.3%	1.5%
11 (Harlingen)	41.4%	21.1	9.9%	7.0%
State Average	32.3%	19.9	10.0%	12.1%

DFPS continues to focus on high-volume hiring and training of new workers, while not adequately addressing management issues that drive many caseworkers to leave their positions.

- **Turnover presents an ongoing problem for the agency in stabilizing workload.** The agency's effort to address turnover is overwhelmingly focused on hiring and training new CPS caseworkers to both fill vacancies

One out of every six new caseworkers leaves CPS within six months.

resulting from constant turnover, as well as fill new positions allocated by the Legislature for the 2014–2015 biennium. The agency has had difficulty reducing vacancy rates while filling newly allocated positions because each month DFPS hires over 200 new CPS caseworkers while losing over 100. This constant hiring and turnover cycle makes keeping up with turnover alone difficult, but hiring the additional 694 caseworkers at a pace sufficient to attain a fully staffed workforce is even more challenging. Even once DFPS hires caseworkers, one out of every six leaves within the first six months of employment — not long enough to help the agency reduce caseloads and provide relief for other caseworkers, since training alone lasts three months.

- **Ample evidence shows the role of the agency’s work environment in contributing to turnover.** DFPS has made some efforts aimed at reducing turnover among caseworkers, as shown in the textbox, *DFPS Efforts to*

DFPS Efforts to Reduce CPS Caseworker Turnover

- **Rookie Year:** Supervisors voluntarily welcome employees before their first day on the job and provide targeted support throughout a caseworker’s first year.
- **Certification:** Direct delivery staff earns pay increases by achieving specific amounts of tenure, completing approved training programs, and maintaining satisfactory performance.
- **DFPS LEADS:** Provides an integrated training curriculum to develop management skills.
- **First Years Recognition Program:** Recognizes new employees’ tenure by providing tenure certificates.

*Reduce CPS Caseworker Turnover.*²

However, these, in addition to the agency’s hiring efforts, have not been sufficient to significantly reduce turnover and do not directly address overall work environment and supervisory relationships, the two largest reasons caseworkers cite for leaving their positions. Responses to the State Auditor’s Office (SAO) state employee exit survey from fiscal year 2012 through the first quarter of fiscal year 2014 had 33 percent of CPS caseworkers citing

poor work environment as the main factor driving their decision to leave the agency and 15 percent citing supervisory relationships. Twelve percent indicated that pay was their primary motive. While some factors related to the difficult work environment are inherent in the CPS system, other aspects are within the agency’s direct ability to influence, as are supervisory relationships. The agency continues to focus on getting high volumes of caseworkers in the door, but does not address internal management issues that cause many caseworkers to leave quickly thereafter. The inability to retain existing caseworkers hampers DFPS’ ability to use all the positions allocated by the Legislature to reduce caseloads, and ultimately its ability to effectively carry out its mission of protecting children.

DFPS’ own internal management reviews highlight the degree to which the agency struggles to support its caseworkers. These reports reveal consistent themes of CPS’ management practices that workers commonly describe as unfair, unsupportive, bullying, unreasonable, and fear-driven.³ Many caseworkers and managers even reported concern about retaliation for cooperating with these reviews.⁴ The State Auditor’s recent 2013 audit on CPS retention and staffing highlighted many of these same concerns. The

textbox, *Work Environment Factors Contributing to CPS Turnover*, provides a summary of common findings.⁵ The recurring findings of SAO audits and internal reviews demonstrate that DFPS has not done enough to create a work environment that supports and develops caseworkers to successfully address retention.

The results of Sunset staff's survey as well as interviews with caseworkers echoed many of these same themes. Responses to the survey frequently showed that many caseworkers do not feel valued by their direct supervisors, higher level regional management, or even CPS leadership. When asked what DFPS could do to improve retention, caseworkers commonly emphasized greater support from management and agency leadership, better training for supervisors and caseworkers, a less punitive work environment, lower caseloads, and higher pay. While caseworkers indicated pay and caseloads were definitely concerns, the work culture created by CPS management greatly impacts retention and could be directly addressed by the agency.

- **Agency management practices can affect the work environment and the ability and satisfaction of caseworkers in performing their work.** Key points of concern for caseworkers relate to being held accountable by supervisors for performance measures that do not relate to the quality of work and are out of the caseworkers' control, being inconsistently penalized for not meeting these performance measures, and not having an outlet for resolving these issues. The following material provides more detail on specific management concerns identified through the Sunset review that contribute to high CPS caseworker turnover and can be addressed by the agency.

Caseworker performance measures arbitrary, inadequate, and unnecessarily punitive. More than 55 percent of CPS caseworkers responding to Sunset's survey indicated they do not have adequate time during the workday to successfully do their job. More than half responded that they did not think the agency's expectations for their job performance are reasonable. DFPS bases its target caseload and the corresponding caseworker performance requirements on a workload time study conducted in 2004. This study no longer reflects current workload, however, since the Legislature has significantly increased requirements by passing major reform legislation in 2005 and 2007, in addition to other bills.⁶ DFPS itself has added new policies and practices over time, likely contributing to higher workloads for caseworkers. The State Auditor's Office identified this same issue through an audit published in 2009, which found CPS workload measures were outdated and recommended an updated time study.⁷ However, DFPS did not implement this recommendation and continues to use the 2004 information.

Work Environment Factors Contributing to CPS Turnover

- Unsupportive and punitive culture.
- Caseworkers do not feel valued by the agency.
- Staff does not feel safe to raise concerns or make complaints, fearing retaliation or punishment.
- Perception of favoritism.
- Use of disciplinary levels or threats of levels in place of employee development.
- Unhelpful to unfair performance evaluations, with more agency focus on timeliness outputs than child safety outcomes.
- Management does not value staff development.

Fifty-four percent of CPS caseworkers believe the agency's job performance expectations are unreasonable.

Further, the measures themselves focus largely on casework output measures of timeliness that often bear only an indirect relationship to child safety and quality casework. The textbox, *Example CPS Caseworker Performance Measures Related to Timeliness*, describes common performance measures to which management holds caseworkers accountable. With such a heavy focus on quantity, CPS cannot accurately gauge the quality of services provided to children and families. In fact, internal reviews have illustrated that the focus on timeliness measures may negatively impact the quality of casework.

Example CPS Caseworker Performance Measures Related to Timeliness

- **Case initiation timely:** Interviewing the alleged victim within 24 or 72 hours of the initial allegation, depending on the priority level.
- **Case documentation timely:** Documenting interviews by the end of the next calendar day.
- **Delinquency rate:** Number of cases closed and approved by the supervisor within 60 days of initiating the investigation.
- **Initial substitute care plan timely:** Percent of plans of service completed within 45 days of the child entering substitute care.
- **Face-to-face visit timely:** Percent of children with which the caseworker made face-to-face contact during the month.
- **Documented face-to-face visit timely:** Percent of contacts for the month documented within seven days of the contact.
- **Court document completion:** Percent of court documentation completed 10 days before a court hearing.

The agency's focus on timeliness of casework may come at the expense of quality.

DFPS also unfairly holds workers accountable for some measures out of caseworkers' direct control.⁸ For example, when an investigator leaves the agency, management assigns their cases to other workers. If any of the cases are already delinquent, meaning they have been open beyond the agency's 60-day investigation timeframe, the agency still holds newly assigned caseworkers responsible for these cases. Caseworkers also may be assigned cases with only a few hours left to initiate the case within established timeframes, but are still responsible for initiating timely. Compounding the unfairness of this practice, managers may punish caseworkers based on these measures, such as requiring overtime on nights and weekends, denying earned leave, and placing the caseworker on formal corrective action levels, as described below.

Punitive, inconsistent use of corrective action levels by management. The agency uses the Positive Performance Management system established by HHSC's human resources policy. The corrective action system involves a series of levels. Each level lasts a set amount of time and carries a predetermined set of consequences, as summarized in the textbox on the following page. While HHSC policy prescribes that level one actions should be a positive tool to encourage performance improvement, DFPS gives managers broad discretion and conducts little oversight of their use of level one, allowing them to attach negative consequences if they wish. While regional management and DFPS attorneys support and guide supervisors on using levels two

and three, the more serious levels, DFPS does not enforce human resource policies requiring supervisors report the use of level one actions to HHSC or that level one actions not carry negative consequences. As a result, the agency allows managers to use level one actions as a punitive measure and does not systematically monitor their use.

DFPS' Use of Positive Performance Management

- **Level one:** Used to correct a minor performance problem and lasts three months. Consequences vary depending on the manager.
- **Level two:** Used to address most first-time serious offenses or continued minor offenses that cumulatively constitute a serious problem and lasts six months. Consequences include ineligibility for extended sick leave, educational leave, merit payments, merit salary increases, and promotions.
- **Level three:** Used to address continued minor offenses, some first-time serious offenses, continued serious offenses, or some first-time major offenses. Consequences are the same as for level two actions, but include time off for the employee to decide whether or not to resign. If the employee does not resign, consequences last for 12 months.

Through Sunset's survey and internal agency management reviews, caseworkers report that supervisors commonly threaten them with level one corrective actions instead of coaching or other performance development techniques, often to penalize them for not meeting timeliness measures. The levels system does not allow for appeals.

Inequitable workload distribution. The agency does not distribute cases in a consistent manner within regions across the state, leading to inefficiencies that increase travel time and workload, and possibly impact outcomes for children.⁹ Without an effective, consistent way of distributing cases to workers, DFPS creates situations like the one in Harris County, where caseworkers routinely drive across the large metropolitan area to investigate allegations or serve families. Both the 2013 SAO audit of caseworker retention and DFPS' internal management review of Region 6 (Houston) highlighted the negative impacts of the current system, which the agency has yet to address.¹⁰

Supervisors also have the discretion to distribute cases to their caseworkers however they prefer, which an internal report indicates contributes to perceptions of favoritism and unfair management practices.¹¹ Inequitable workload distribution can cause caseworkers to fall behind their cases, unfairly penalizing them and putting children at risk. Without a system to assign cases with both efficiency and fairness in mind, CPS will continue to struggle with caseworker retention.

Underutilized and unfair complaints process. Nearly half of all CPS caseworkers responding to Sunset's survey indicated they believe the process for resolving internal complaints is unfair. Agency employees make formal administrative complaints to the HHSC Office of Civil Rights, but made

Caseworkers report that supervisors threaten corrective action instead of coaching to improve performance.

Fear of retaliation among caseworkers may deter them from making complaints.

only 71 administrative complaints last year — despite DFPS having 10,650 employees. Instead, DFPS encourages employees to take internal complaints to their manager or the manager of the person against whom they have a complaint. While solving management problems at the lowest level possible is ideal, the current system does not allow for employees to make complaints within the agency but outside their chain of command and also discourages complaints about overall workplace or program culture.

The agency also lacks a formal system for making anonymous complaints, which is important within the current management structure of CPS because of the persistent fear of retaliation among caseworkers and supervisors.¹² Over 75 percent CPS caseworkers in Region 10 (El Paso) responding to Sunset's survey indicated that the agency's process for resolving complaints was not fair, compared to 26 percent in Region 9 (Midland). This variation suggests some regions or regional management may be more effective and fair at resolving complaints than others. However, without a system for receiving and resolving anonymous complaints, CPS cannot reliably identify especially punitive work environments before the issue rises to the level of a formal administrative complaint or results in a critical retention problem.

Lack of systematic management accountability for caseworker turnover. Despite the crucial role supervisors and other regional managers play in caseworker retention, CPS does not formally measure supervisors and regional management on turnover rates within their regions and units. While turnover may be caused by factors outside management's ability to influence, such as the oil boom in Region 9 (Midland), the high degree of variability in turnover among regions and down to the unit level may also be an indicator of management's treatment of employees affecting retention. DFPS internal management reviews point to problems with specific managers and supervisors that create punitive work environments, and some of these reports directly recommended removing supervisors or other managers from their positions or requiring additional management training to resolve critically high turnover rates.

Merit pay not effectively designed to increase retention, contributing to perceptions of negative work environment. The HHSC executive commissioner authorized merit pay awards to DFPS for one-quarter of the agency's workforce in fiscal year 2014. DFPS allocated these awards to each manager in the organization based on the number of workers under their supervision, but gave them very little guidance on how to make these awards. To ensure merit awards effectively reinforce quality work and support retention, the agency should have established criteria and guidelines for their use.

- **CPS does not adequately develop and support existing staff, especially new caseworkers.**

CPS' basic skills development training for new workers does not provide sufficient on-the-job training, and CPS has not made sufficient efforts

Variable turnover across the state indicates how management's treatment of employees could contribute to turnover.

to provide critical support to new workers transitioning from training to working in the field.

Caseworkers need additional hands-on training in the field. When asked for suggestions to improve staff retention by Sunset staff's survey, over 300 CPS staff comments emphasized the need to better train new caseworkers. Sixty-nine percent of CPS caseworkers and supervisors indicated that basic skills development does not adequately prepare new staff for their jobs. While basic skills development training typically lasts 12 weeks for all DFPS programs, CPS training provides three to five fewer weeks of on-the-job training than both Adult Protective Services and Child Care Licensing. Caseworkers only work two cases, often easy cases, while in basic skills development.

However, basic skills development is only one aspect of preparing and developing caseworkers for their responsibilities in the field. To supplement the initial 12-week training, CPS relies on supervisors to mentor new caseworkers and ensure continued training, and has set a policy that new caseworkers have a capped caseload for the first five weeks in the field. However, turnover rates are so high within CPS that some supervisors may be training one-quarter to one-third of their caseworkers each year, and many do not follow the capped caseload policy.

When asked for suggestions to improve training for new caseworkers and to improve caseworker retention overall, hundreds of caseworkers underscored the need for dedicated mentors. Previously, CPS had a peer trainer system in which seasoned caseworkers did not carry caseloads and were dedicated specifically to helping new staff transition and learn on the job, but the agency cut these positions from the program in 2011 due to budget constraints. When Sunset interviewed caseworkers who were trained in this fashion, they reported that it was an effective way to better support new workers as they transition to carrying a full caseload. Reinstating these positions would also take some of the workload off of supervisors and other tenured caseworkers, who juggle their existing workload with the demands of training new staff. Additionally, since the Legislature added 694 new caseworker positions to CPS, this influx of new workers will require better on-the-job training support if the agency hopes to retain these workers.

Agency does not conduct annual performance evaluations. CPS management does not systematically identify opportunities for staff development and growth through formal measures, such as performance evaluations. As of March 2014, over 35 percent of the CPS workforce did not have a current performance evaluation. Without annual performance evaluations, the agency cannot identify caseworkers who need additional guidance and retain the most skilled caseworkers. The agency requires current performance evaluations for candidates to qualify for merit bonuses and promotions. As a result, caseworkers may be unfairly denied opportunities for advancement if their supervisor fails to conduct timely performance evaluations.

Some supervisors train one-quarter to one-third of their caseworkers each year due to turnover.

Caseworkers may be unfairly denied opportunities for advancement if supervisors fail to conduct performance evaluations timely.

A recent SAO audit noted problems with the employee performance system.

Caseworkers and supervisors describe the current numbers-based performance evaluation criteria as “meaningless,” which may contribute to the high rate of incompleteness.¹³ These output measures make up half of the caseworkers’ performance evaluations; the second half allows supervisors to provide additional feedback. The 2013 SAO audit on caseworker staffing observed that these sections often contradict, as objective performance standards may be low while the supervisor rates overall performance as high.¹⁴ Such disconnects between the overall performance of a caseworker and the performance measures on the evaluation indicate that the agency does not use accurate or comprehensive performance standards. To make the performance evaluation process more meaningful, however, CPS must update outdated performance standards and balance current performance measures with quality casework measures, as well as monitor to ensure managers complete evaluations timely. The Adult Protective Services program at DFPS recently added some casework quality measures to its performance standards for caseworkers; CPS should be able to do the same.

DFPS lacks a coordinated, focused effort to support its workforce and identify root causes of turnover.

DFPS dedicates several units to various types of workforce support, such as hiring, basic and ongoing employee training and certification, and internal communication. However, these units operate independently and do not cohesively form the level of continual support needed to sustain the large, dynamic, and complex DFPS workforce. The agency locates these tasks within operations or in the programs themselves. DFPS is currently planning to consolidate these functions, but this change is not yet complete.

In addition to the current workforce support functions, the agency continuously develops initiatives geared toward improving caseworker retention. However, DFPS does not systematically identify areas with high turnover due to the work environment, nor proactively address work environment issues that may lead to high turnover. The textbox, *Workforce Support Gaps at DFPS*, outlines areas which could benefit from dedicated staff to provide additional employee support and systematically monitor statewide trends to identify management problems the agency could more proactively address.

Workforce Support Gaps at DFPS

- Tracking use of corrective actions to evaluate consistent use and identify punitive management practices.
- Systematic tracking and identification of regions, counties, and units with unusually high turnover.
- Analyzing employee exit surveys and interviews.
- Addressing complaints and anonymous complaints outside an employee’s chain of command.
- Monitoring the implementation and effectiveness of retention efforts, such as merit pay.
- Monitoring management’s compliance with policies surrounding new caseworker development.
- Monitoring completion of annual performance evaluations.

Recommendations

Management Action

1.1 Direct DFPS to consolidate its existing workforce management functions under one operational unit and add additional critical functions to better support employees and systematically identify root causes of turnover.

This recommendation would direct DFPS to consolidate its existing workforce support functions, such as caseworker and management training and hiring, into a single unit under the chief operating officer. This unit would have some additional responsibilities that DFPS does not currently perform, including handling employee complaints outside the direct chain of command and monitoring management trends, such as areas with critical turnover problems. In addition to existing functions that would be part of this unit, DFPS should also perform, at a minimum, the following additional workforce support functions.

- Monitor and provide regular reports to DFPS management on areas such as compliance with annual performance evaluation requirements, capped caseload policies, use of positive performance levels, and areas with critical turnover problems.
- Analyze employee exit surveys and interviews.
- Evaluate the effectiveness of DFPS' retention efforts, such as merit pay.
- Create an employee complaints process, including anonymous complaints, and make regular reports to DFPS management on complaint data and trends.

This unit would assist DFPS in ensuring better coordination and a more clearly centralized unit for workforce support, allowing the agency to more holistically identify and address management problems that lead to turnover and make better informed and systematic efforts to address turnover. Workforce management, when better addressed, could improve the quality of direct delivery services and allow DFPS to better support all its employees.

1.2 Direct DFPS to dedicate certain existing caseworker positions to create a mentoring program to better support new CPS caseworkers.

This recommendation would direct DFPS to use a limited number of existing, vacant CPS caseworker positions to create dedicated mentor positions to support newly trained caseworkers. These mentors would not carry caseloads and be solely dedicated to assisting new workers upon exiting basic skills development training. Mentors could instead act as secondary caseworkers for new workers' cases. This would help lessen much of the strain on supervisors of constantly training new caseworkers and ensure new caseworkers receive the support they need to successfully transition to carrying a full caseload. If resources are available, the agency should also consider making mentorship for new caseworkers a widespread practice across all direct delivery programs, not only CPS.

1.3 DFPS should more clearly define its policy on the use of corrective performance actions, provide additional guidance to managers on appropriate use, and require centralized reporting of all level one actions.

This recommendation would direct DFPS to create agency-specific policy clarifying the proper use of the HHSC positive performance level system, which details the specific instances in which the levels should be used, relevant to CPS caseworkers and supervisors. The policy should also clarify that positive performance level one actions must not have negative consequences and should stipulate that level one

actions cannot disqualify or exclude staff members from benefits or opportunities. The agency should also include specific guidance on appropriate use of levels through its supervisor training, caseworker training, and training for higher level regional management. The agency would create this policy in consultation with HHSC's Human Resources Division and the policy would be subject to approval by the executive commissioner.

As part of this recommendation, DFPS should also require all managers to report all corrective action levels taken, including level one actions, to the centralized workforce support unit described in Recommendation 1.1 for oversight and monitoring. The agency should encourage employees who have been threatened with level one actions or have been given consequences for a level one action to notify the centralized workforce unit. The agency also should monitor the usage of positive performance actions across all regions to identify potential variation and report this information to DFPS leadership on a regular basis. With a more clear and enforced policy, corrective action levels would be more fairly assigned and not be used as threats. Consistent and fair application would create a less punitive work environment and encourage supervisors to truly coach caseworkers to improve performance.

1.4 DFPS should develop a systematic way of using turnover, when appropriate, as a tool for judging performance of CPS regional management.

This recommendation would direct CPS to incorporate turnover as a performance measure in supervisors' and regional managers' performance plans and evaluations. The agency should use supervisor, program director, program administrator, and regional director performance evaluations to identify areas with low retention and possible work environments that contribute to low retention that these managers could directly address. This would help DFPS recognize managers who adopt effective strategies to increase retention to help replicate those practices agencywide, as well as identify managers who need additional training and resources devoted to improving turnover. This would also incentivize regional managers to solve work environment issues within their own regions, possibly with the help of the workforce management unit described in Recommendation 1.1.

1.5 CPS should revise its system for evaluating caseworker performance by better evaluating quality.

This recommendation would direct the agency to develop measures that better reflect quality of casework for incorporation in performance plans and evaluations. While some quantitative output measures are important to measure and gauge caseworker performance, CPS should incorporate measures that more directly tie to casework quality and services provided, rather than focus primarily on the timeliness of casework activities and documentation. CPS could also revise the way it captures some of its current measures for caseworkers, such as distinguishing between measures within the caseworkers' control and cases that fall outside their realm of control, such as inherited delinquent cases. The agency should develop and implement more qualitative measures of caseworkers' performance by October of 2016 prior to the Sunset Commission's compliance process. As part of this recommendation, the agency should also consider ways to revise and improve performance criteria for the Adult Protective Services and Child Care Licensing programs to ensure criteria have a more direct tie to quality.

1.6 DFPS should provide guidance to managers on awarding merit pay to ensure transparency and consistent criteria for merit pay awards to foster increased morale and retention.

This recommendation would direct DFPS to develop a clear, consistent, and publicized set of standards that all managers of direct delivery staff must use when considering which staff members receive merit

pay. The agency should not set a threshold for performance based on quantitative metrics, but instead should use the quality performance standards established in Recommendation 1.5 on which to base merit pay decision criteria. This approach would improve transparency and ensure merit pay awards are more directly tied to overall caseworker performance, making them a more effective tool to promote retention.

1.7 DFPS should establish a system for collecting confidential internal complaints.

This recommendation would direct DFPS to establish a system for collecting confidential complaints from all staff. The agency could operate this system through the DFPS intranet and the workforce management unit discussed in Recommendation 1.1 could handle the complaints. When establishing the system of collection, the agency should make every possible effort to allow complaints to remain anonymous, but at a minimum all complaints should be kept confidential. To facilitate anonymous complaints, DFPS could set up an external webpage on the existing agency website to allow employees to submit complaints without requiring or obtaining identifying information. Such a system could allow for the optional input of identifying information, such as region, program area, or local office, but it would not require this information. The established system should, to the extent possible, not allow anyone outside of the workforce management unit to directly access complaint information, to maintain confidentiality and ensure employees feel secure in submitting a complaint.

Additionally, the agency should ensure a clear understanding among employees regarding the differences in purpose between anonymous complaints and formal complaints. The purpose of implementing an anonymous complaints process is to allow the agency to identify systemic issues with workplace culture and not to directly resolve an individual's issue with a supervisor or other staff. Implementing this recommendation would allow DFPS to provide an outlet for management issues staff may be afraid to submit as formal complaints, and also allow the agency to more systematically identify management problems that may contribute to high turnover.

1.8 DFPS should regularly do casework time studies to more accurately develop caseload goals and policies that are fair and attainable for caseworkers.

This recommendation would direct DFPS to conduct regular casework time studies to ensure that the targeted caseload and caseworker performance goals set by the agency are achievable and reasonable. This would also help the agency identify problems within the current system and measure the impact of new agency policies on the time it takes to complete casework. The agency should complete the first casework time study by October 2016. These studies should be conducted once every three years thereafter, with the methodology that has been used in the past and can be standardized and validated internally.

1.9 DFPS should develop a standardized and objective method for fairly and efficiently distributing cases.

This recommendation would direct DFPS to create an efficient, systematic method of distributing cases to units within each region for statewide application. This recommendation would also require the agency to develop a transparent and efficient method of distributing cases to caseworkers within units. An objective, systematic method for distributing cases would reduce work on the part of the supervisor, travel expenses for the agency, and travel time for the caseworker. The agency could maintain flexibility in the system for supervisors to distribute cases on their own, if subjective factors need to be considered for specific workers. By building many variables into the current routing system to assign cases based on existing workload, tenure, and geographic location of current open cases the need for such flexibility should be rare.

Fiscal Implication

Overall, these recommendations would have a negative fiscal impact to the State of about \$181,000 annually, but ultimately should contribute to improved retention, saving some \$54,000 for each caseworker retained.

Recommendation 1.1 would require consolidating current functions already performed by the agency within one clear chain of command and adding three additional full-time equivalent employees to carry out new functions directed by Recommendation 1.1. DFPS indicates that two full-time equivalent employees with starting salaries of about \$40,000 would be needed for complaint resolution. Sunset estimates one additional position would be needed to conduct the analysis and monitoring required by Recommendation 1.1, with an annual salary of \$60,000. Adding these three additional employees would cost about \$181,000 per year, including salaries and benefits. However, investing these resources could help reduce the agency's significant overall turnover costs, and with reduced turnover ultimately help DFPS better serve children and families. Losing just 100 fewer caseworkers per year — less than 10 percent of the 1,342 lost in fiscal year 2013 — would save the agency about \$5.4 million.

Recommendation 1.2 could be achieved by repurposing a portion of existing vacant CPS caseworker positions to new mentorship positions. Based on the number of employees CPS previously dedicated before 2011 budget cuts, 55 positions could be needed. However, CPS could reallocate vacant caseworker or special investigator positions to create these positions within each region. In the short term, dedicating these positions would reduce the number of caseworkers available to carry cases. However, CPS already has a high vacancy rate and has difficulty filling existing positions. Dedicated mentors increase the likelihood that CPS can retain new workers by providing better on-the-job training and support. Ultimately, improved support of new caseworkers can also help reduce the agency's \$72 million annual turnover costs.

Recommendations 1.3 through 1.8 would not have a significant fiscal impact to the State. Recommendation 1.7 requiring DFPS to conduct regular time studies would be cost neutral, as the agency indicates it already has internal capacity to implement this recommendation.

Department of Family and Protective Services

Fiscal Year	Cost to the General Revenue Fund	Change in FTEs
2016	\$181,000	+3
2017	\$181,000	+3
2018	\$181,000	+3
2019	\$181,000	+3
2020	\$181,000	+3

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¹ Government Accountability Office, *HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff* (Washington, D.C.: March 2003), p. 5.

² Texas Department of Family and Protective Services (DFPS), *Rider 11 Human Resources Management Plan Mid-Year Update* (Austin: April 2013), pp. 9–10.

³ State Auditor's Office (SAO), *An Audit Report on Staffing and Caseloads at the Department of Family and Protective Services* (Austin: March 2009), pp. 17–20; Texas Department of Family and Protective Services, *Management Review Region 6 Child Protective Services* (Austin: September 2013) p. 2; Texas Department of Family and Protective Services, *Management Review – Region 10 – 2011 (CPS)* (Austin: November 2011), pp. 1–8; Texas Department of Family and Protective Services, *Region 10, CPS Conservatorship Review* (Austin: May 2013), pp. 1–6; Texas Department of Family and Protective Services, *Region 4 CPS Operational Review* (Austin: Summer 2002), pp. 6–16; Texas Department of Family and Protective Services, *Results of the Case Review and Interview Process, Houston, Texas, September 17–21, 2012* (Austin: September 2012), pp. 3–7; Texas Department of Family and Protective Services, *Review of Turnover in Alice, Texas 2013* (Austin: Summer 2013), pp. 6–11; LBJ School of Public Affairs–University of Texas at Austin, *Report of Findings and Recommendations Leadership Development Assessment Department of Family and Protective Services* (Austin: December 2013), pp. 2–4; Texas Department of Family and Protective Services, *Region 7 Review – Belton, Killeen, Copperas Cove* (Austin: January 2014), pp. 1–2.

⁴ DFPS, *Management Review – Region 10* (November 2011), pp. 2–6; DFPS, *Region 4 CPS Operational Review* (Summer 2002), p. 16.

⁵ State Auditor's Office, *An Audit Report on Caseload and Staffing Analysis for Child Protective Services at the Department of Family and Protective Services*, report no. 13-036 (Austin: May 2013), pp. 1–17; SAO, *An Audit Report on Staffing and Caseloads* (March 2009), pp. 1–20; DFPS, *Management Review Region 6 Child Protective Services* (September 2013), pp. 2–4; DFPS, *Management Review – Region 10* (November 2011), pp. 1–8; LBJ School, *Report of Findings and Recommendations*, pp. 2–4; DFPS, *Region 10, CPS Conservatorship Review* (May 2013), pp. 1–6; DFPS, *Region 4 CPS Operational Review* (Summer 2002), pp. 6–16; DFPS, *Results of the Case Review and Interview Process* (September 2012), pp. 3–7; DFPS, *Review of Turnover in Alice*, pp. 6–11; DFPS, *Region 7 Review* (January 2014), pp. 1–2.

⁶ S.B. 6, 79th Texas Legislature, Regular Session, 2005; S.B. 758, 80th Legislature, Regular Session, 2007.

⁷ SAO, *An Audit Report on Staffing and Caseloads* (March 2009), pp. 1–37.

⁸ SAO, *An Audit Report on Staffing and Caseloads* (May 2013), pp. 3–4.

⁹ DFPS, *Management Review Region 6 Child Protective Services* (September 2013), pp. 2–4; DFPS, *Management Review – Region 10* (November 2011), pp. 4–6; SAO, *An Audit Report on Staffing and Caseloads* (May 2013), pp. 7–9; DFPS, *Region 10, CPS Conservatorship Review* (May 2013), pp. 5–6.

¹⁰ DFPS, *Management Review Region 6 Child Protective Services* (September 2013), pp. 2–4; SAO, *An Audit Report on Staffing and Caseloads* (May 2013), pp. 7–9.

¹¹ DFPS, *Region 10, CPS Conservatorship Review* (May 2013), pp. 5–6.

¹² DFPS, *Region 10, CPS Conservatorship Review* (May 2013), pp. 2–6; DFPS, *Region 4 CPS Operational Review* (Summer 2002), p. 16.

¹³ SAO, *An Audit Report on Staffing and Caseloads* (May 2013), pp. 1–37.

¹⁴ Ibid.

ISSUE 2

A Crisis Culture Affects CPS' Ability to Focus on Day-to-Day Management Activities Needed to Successfully Perform Its Difficult Work.

Background

Any assessment of Child Protective Services (CPS) must be made with consideration of the challenging context in which it operates. This environment is uncertain and often dangerous, where bad things unfortunately happen, with tragic and heartrending results. In such an environment, the agency must react to situations fraught with uncertainty, where the unpredictable nature of human behavior competes with the agency's own ability to control such outcomes. The agency, however, must answer for every one. Not surprisingly, this inherent reactive approach shows up in the way the agency approaches the very management of its CPS operations.

A few statistics help illustrate the size and complexity of Child Protective Services' critical work. With 7,759 employees, CPS carries out its work through 11 regions, with CPS State Office in Austin providing central oversight and administration. CPS completed 160,240 investigations in fiscal year 2013, confirming abuse or neglect in 40,249 cases; provided services to 29,332 families to mitigate risks to child safety; and, with court approval, removed 17,022 children from their parents' care.¹ The Department of Family and Protective Services (DFPS) had 27,924 children in either temporary or permanent custody at the end of the same fiscal year.²

Findings

A continuing cycle of crisis and criticism distracts the agency from developing an effective strategic approach to managing Child Protective Services and ensuring that its efforts deliver desired results.

By the nature of its work, CPS is constantly reacting to external pressures and criticism that put it in a perpetual state of both legislative and self-imposed change. Tragedies happen in CPS cases, and when they do, CPS often finds itself on the defensive, scrambling in search of solutions to respond to specific cases. This constant state of managing crises, however, distracts the agency from developing an effective, strategic approach to managing its operations, including planning, policy making and implementation, communication, performance management, and leadership development — all critical areas that need improvement and attention for CPS to move forward and to better achieve desired results.

CPS is in a constant state of both legislative and self-imposed change.

The agency has a history of repeatedly identifying the same management and communication problems and not adequately addressing them. The textbox on the following page, *External and Internal CPS Review Findings*, provides several examples of past evaluations that identified many of the same issues that Sunset staff found during this review that have not been adequately remedied.³

External and Internal CPS Review Findings 2011–2013

- **State Auditor’s Office: Audit of CPS Caseload and Staffing Analysis (2013):** Lack of consistent, timely evaluation of caseworkers and supervisors; and lack of fairness in evaluating caseworker performance.
- **Region 6 Management Review (2013):** Inconsistent application and interpretation of policy by regional management. Lack of follow through by State Office in ensuring effective implementation of initiatives. Punitive work environment and excessive focus on output measures instead of quality casework measures.
- **Conservatorship Assessment Report (2012):** Ineffective communication of important information to caseworkers, inconsistent policies and processes, and no process for evaluating how new initiatives affect caseworker activities and workflows.
- **Region 10 Management Review (2011):** Staff fear of retaliation by management, poor communication, inconsistency in decision making, and uneven workload distribution.

While the reviews described are more recent, agency documents highlighting similar problems date back as far as 2002. Some of these issues described in the chart relate specifically to caseworker retention, which is addressed more directly through Issue 1.

Current CPS Initiatives

- Alternative response
- Addressing child fatalities initiative
- Enhanced family-centered safety decision making
- Foster care redesign
- Permanency roundtables
- Trauma-informed care
- Family group decision making
- Parent collaboration group
- Fatherhood initiative
- Continuous quality improvement and data placemat
- CPS practice model
- Organizational effectiveness

Aside from its inadequate response to management reviews, CPS more actively pursues a multitude of initiatives intended to improve the quality of services it provides. The textbox, *Current CPS Initiatives*, provides examples of these efforts, some of which are legislatively mandated, but many others internally driven. While on its face each individual initiative appears worthy, none are clearly tied to an overall set of specific CPS goals and priorities, and prevent the program from focusing its efforts only on the most important, impactful changes and ensuring each is implemented effectively. CPS often creates strategic plans for individual initiatives, but has no overarching plan to tie all of its work together.

CPS’ initiatives are also missing clearly identified outcomes and methods to measure and communicate their impact, preventing the agency, stakeholders, and the Legislature from determining the results of these significant investments of time, effort, and money. Tying these initiatives to clearly identified goals can also help State Office achieve buy-in from CPS field staff, who often does not understand the reasons driving changes made on the state level. Efforts by CPS State Office to engage regional staff in a planning process resulting in a clear direction could also help gain staff’s cooperation in implementing new initiatives, since successful implementation ultimately depends on them. The agency participates in the health and human services agencies’ strategic planning process and also completes an annual operational plan as required

by the Health and Human Services Commission, but these plans are very broad and high level and do not generally provide performance measures or implementation details. CPS as a program needs a more detailed, internally driven process to establish not just overarching goals and priorities, but also to guide implementation, measure performance, and provide for meaningful field staff input. Without a clear vision for itself and its own plan to achieve established goals and demonstrate positive impacts, CPS will remain susceptible to managing by crisis and allowing outside pressures to dominate its agenda.

What the agency needs is a timeout to regroup; to get off the treadmill of perpetual change; to stop the whac-a-mole of trying to hammer every new problem or tragedy that arises with a new initiative while the next problem pops up. The agency needs to get about the mundane business of planning, listening, communicating, and managing its people to help them best do their incredibly difficult job. Current agency leadership has recognized the need to take a step back and re-examine the most basic elements of CPS structure and performance. DFPS has contracted for a comprehensive operational assessment of CPS, which is currently underway and is scheduled to be complete in June 2014. This management review is delving into specific CPS business processes and design issues, and the results of this assessment can complement the Sunset review. Together, the operational assessment and the Sunset review provide the opportunity for comprehensively evaluating how CPS manages its difficult work and better focusing the agency on activities that further its protective mission.

The agency needs a timeout to regroup; to get about the mundane business of managing its people.

CPS' lack of follow-through and poor policy implementation result in staff frustration and lack of assurance that clients are treated consistently across the state.

The Sunset review identified a pattern of ineffective management practices from CPS State Office in managing the 11 regions, which carry out the day-to-day direct service work of protecting children. With remarkable consistency, stakeholders and agency staff themselves identified many of these same issues as longstanding and ongoing problems. In a survey of DFPS staff conducted by Sunset staff, hundreds of comments from CPS field staff indicated frustration with the way CPS State Office creates and implements policy changes and new initiatives; ineffective communication; lack of consistency in policy application from region to region and even from supervisor to supervisor; as well as disenchantment with what staff sees as an unwillingness of management to implement changes in response to employee input. The following material lays out these issues in more depth.

Application of CPS policy varies from region to region and even supervisor to supervisor.

- **Unusable, outdated policy handbook and incoherent approach to making and disseminating new policy.** Clear policies and procedures are absolutely essential to guide CPS field staff, since their workloads are high and they do not have time to sift through multiple documents for guidance. Clear policy guidance is also critical because of high turnover and the short tenure of many staff. However CPS' actual policies and procedures are

lengthy, convoluted, and not kept up-to-date. As a result, field staff report policy is open to interpretation and inconsistently applied by different staff. Caseworkers have to resort to word of mouth from peers or advice from their supervisors to decide what steps are needed to carry out their important work. The textbox, *Problems With CPS Policymaking and Implementation Process*, describes the various issues with CPS policies and procedures as they are, in addition to the process for making and implementing policy changes.

Problems With CPS Policymaking and Implementation Process

- CPS handbook is unwieldy and unusable, with over 2,100 pages, and many staff indicate they do not use it for guidance.
- New policy can originate in a variety of places in State Office, without a clear point of responsibility for overseeing this work.
- Policy change occurs primarily via memo, which can remain in effect indefinitely without being incorporated into the CPS handbook. Active policy memos date back as far as 2004 and are not publicly accessible on the DFPS website.
- No front-end process to evaluate the need for and urgency of implementing a policy change or how it will impact caseworkers' workload, resulting in frequent changes that overwhelm CPS field staff.
- Insufficient support and communication from CPS State Office in providing training materials or guidance to support regional management in ensuring they communicate needed changes to caseworkers, how to implement them, and reasons for the change.
- No consistent process to evaluate implementation and effectiveness of policies and initiatives.
- No regular, comprehensive review of policies and procedures to evaluate and identify opportunities to eliminate or streamline any requirements which fail to add value.

Overall, these issues result in a lack of consistent understanding about existing policy and create significant obstacles to implementing new efforts in an effective, consistent manner. While CPS is currently working on developing a better process for making policy, these efforts are not yet complete.

Compounding staff confusion about policy is that each region has its own protocols and practices, but these are not well documented. CPS State Office may have anecdotal knowledge of these but lacks complete, systematic knowledge of these protocols. Regional variation from state policy and procedures is a common theme in several evaluation reports and DFPS internal audits, and consistently identified by staff and stakeholders during the Sunset review. A related issue is that individual regions also implement new approaches to address identified problems, such as specialized units to handle specific types of cases, like child fatality investigations; however CPS State Office has no systematic process to identify and evaluate effectiveness of these efforts. This lack of connection affects the State Office's ability to identify regional practices that achieve positive results for possible statewide application, and also to keep an eye on areas in which regions are not following state policy.

Each CPS region has its own protocols and practices, which often vary from state policy.

- **No systematic approach to evaluating and providing feedback on regional performance or monitoring to ensure regions correct identified problems.** CPS State Office staff gathers a wealth of information on

regional performance through separate quality assurance processes and occasional on-site regional management reviews, as described in the textbox, *CPS State Office Regional Performance Review and Quality Assurance Processes*. Staff compiles this information in reports, providing recommendations to the regions to correct identified issues. While these processes individually add value, the results and recommendations are not compiled and provided to the regions in a comprehensive manner such that systemic issues are identified in a holistic way. Further, State Office has no formal process to monitor regional management's implementation of identified solutions. For example, the recent internal audit on child death investigations found that while a lead child safety specialist provides a quarterly report to each region that identifies trends in investigations and makes recommendations for improvement, no follow-up actually occurs to track implementation by the regions.⁴ CPS State Office is currently working on implementing a continuous quality improvement process and a dashboard of performance measures to address the issues identified above, but has not yet fully implemented it.

CPS State Office Regional Performance Review and Quality Assurance Processes

- **Regional Management Reviews:** Primarily qualitative reviews performed by State Office staff in response to a problem identified by regional management or agency leadership.
- **Child and Family Services Review:** Quarterly reviews of cases receiving ongoing services, using federally established criteria and resulting in regional and statewide performance reports and improvement plans.
- **Investigations Quality Assurance:** Quarterly case reviews of investigations closed and not opened for ongoing services, resulting in quarterly reports on regional performance trends.
- **Child Safety Specialist Review:** Reviews certain higher risk investigations and identifies regional performance trends.

CPS State Office also conducts on-site reviews of regional performance, usually by management request in response to an identified issue, such as unusually high turnover. Only one of these management reviews, completed in 2013, was a more holistic analysis of regional performance and management that used a combination of data analysis and qualitative research to identify broad, systemic issues.⁵ Overall, CPS does not have a consistent, proactive process for conducting these reviews; instead, they are ad hoc and responsive to an already identified problem. Also, these reviews do not have a corresponding process to follow up and monitor implementation of recommendations. As a result, serious problems can continue without being fully addressed.

- **Lack of follow through in reporting findings and resulting changes from various efforts to gather employee input.** CPS uses a variety of surveys, workgroups, focus groups, and other avenues to obtain the input of its employees. While this practice can be very useful in identifying problems and developing solutions, CPS frustrates its employees by not clearly communicating the results of those efforts or resulting changes. Sunset staff's survey of DFPS employees garnered hundreds of comments

Many CPS employees feel management does not consider their opinions or value their expertise.

from CPS staff frustrated by what they view as agency management's lack of follow-through in implementing changes as a result of the input they provide. When asked how they would rate DFPS' process for using employee input to improve operations, 51 percent rated it "poor" or "very poor." While CPS management may in fact make changes using employee input, it does not routinely report back to employees on input provided or changes made. This lack of follow-through is discouraging to employees and makes many feel management does not seriously consider their opinions and value their expertise.

CPS does not prioritize developing new staff to move into management positions.

Perhaps due to its constant and consuming focus on hiring and training new workers, CPS has not developed a comprehensive strategy to identify and develop staff to move into key management positions. Almost half of all CPS managers above the supervisor level are either already retired, immediately eligible to retire, or will be eligible to retire within the next five years. CPS needs a strategy to further develop current management as well as identify opportunities to develop lower-level staff in preparation to move into key management roles. Only about 23 percent of CPS respondents to the Sunset survey agreed that the agency promotes the highest quality staff, while 41 percent disagreed. A more thoughtful and strategic approach to identifying and developing new managers could help improve these numbers.

Thirty-five percent of CPS employees do not have a current performance evaluation.

The Sunset review identified two specific issues the agency should evaluate and address as part of a succession plan and overall leadership development strategy. First, no management or leadership training is required of regional managers above the supervisor level, such as program directors, program administrators, regional directors, or State Office staff. Second, beyond CPS, the agency as a whole does not promote the performance evaluation process as a useful tool to help develop staff by providing formal feedback on performance, as well as identifying training and other development needs. Overall, about 35 percent of CPS employees do not have a current performance evaluation on file, and many employees have not had an evaluation in several years.

CPS must maximize the opportunity to better use data to manage operations and measure performance, and align technology changes with impending operational changes.

CPS' case management IT system, IMPACT, contains a wealth of information, but the agency's ability to use that data for management is limited because the system is outdated and has a number of limitations, as discussed in the textbox on the following page, *Limitations of IMPACT*. Recognizing these limitations, the 83rd Legislature appropriated approximately \$28 million to DFPS for fiscal years 2014 and 2015 for the first two years of a four-year project, known as IMPACT modernization. The first two years of funding allow DFPS to set the foundation for implementing the system changes program staff

need for management. The second two years, provided the agency receives needed funding, include DFPS' implementation of real-time performance management tools for supervisors and caseworkers, business intelligence tools for much easier data analysis, and other much needed improvements.

Given the potential for significant change to CPS' processes as a result of the current operational assessment and the Sunset review, CPS will need to carefully identify and plan for all the changes the program will require from IMPACT modernization. For example, business intelligence has great potential to assist CPS in systematically collecting more and better quality data for use in management as well as data analysis and research. However, in order for business intelligence to add value, CPS will have to identify what specific information is necessary to collect to ensure this capability is built into the system. For example, CPS recently formed a data and policy analysis group that provides new expertise to evaluate policy and program performance more strategically, but CPS needs to ensure that the right data is collected through IMPACT in order to provide analysis useful to effectively guide policy.

Limitations of IMPACT

- Data is difficult to extract and unavailable for real-time use to manage and monitor workflow.
- System does not assist caseworkers with prompts and decision-making tools.
- Redundant data entry requirements.
- Many forms and case documents cannot be uploaded and must be kept in paper form.
- Potentially useful data not systematically captured.
- Even small changes to accommodate program needs require DFPS to incur significant expense. For example, changes to IMPACT to accommodate implementation of Alternative Response, a new stage of service in CPS, cost about \$2 million.

While problems highlighted in these findings are most evident in CPS, agency leadership should evaluate the application of similar management practices agencywide.

The Sunset review identified several basic differences in the ways DFPS' different program areas manage themselves, with no uniform expectations coming from agency leadership. While the problems identified in this issue are most prominent in CPS, other program areas could benefit from management improvements, such as succession planning and business planning. Conversely, some management practices and projects are already in place in the Adult Protective Services (APS) program, as shown in the textbox, *APS Management Practices*. These practices have broader agency application and can serve as a template for how DFPS can improve overall. DFPS' divisions manage themselves differently, and more consistency in implementing improved management practices agencywide could benefit all divisions, not just CPS.

APS Management Practices

- Annually updated business plan.
- Regular on-site regional management reviews.
- Consistent handbook updates.
- Planned rollout of process and policy changes to regions, including training for staff on major changes.
- Business plan includes a project to design a management development program for regional management and State Office staff.

Recommendations

Management Action

2.1 Direct CPS to implement an annual business planning process.

Under this recommendation, CPS would develop a detailed annual business plan to help the program focus its efforts and prioritize activities and resources that best support its overall goals for improvement. CPS State Office would lead this process, but seek and use input from regional staff to gain buy-in and achieve a common understanding of CPS' direction and goals, and how new and ongoing initiatives further them. CPS could use its existing CPS regional staff advisory committees to provide a venue for gaining this input. At a minimum, CPS' business plan should include:

- long-term and short-term goals;
- identification of priority projects and ongoing initiatives that clearly link to established goals;
- clear expectations of staff, including identification of the person or team responsible for each initiative, specific tasks and deliverables expected, resources needed, and timeframes for completion of each deliverable as well as each initiative as a whole; and
- connection of each project to an expected result or outcome, with performance measures identified as well as procedures for measuring these results to ensure effective evaluation of the outcome of each initiative.

Having a detailed, regular planning process would allow CPS to systematically set goals and priorities and to focus its efforts and limited resources first on the most critical projects and more easily show impacts of each initiative. Involving regional staff in developing this plan could also help CPS State Office gain the buy-in of staff because the intended benefit and purpose of each initiative would be clearer. A business plan would provide a means of clearly communicating expectations and results to agency staff. It would also allow CPS to maintain its focus on priorities even in the face of crisis, and be equipped to demonstrate to stakeholders, the Legislature, and the public what improvements the program is achieving as well as its overall performance.

2.2 Direct DFPS to report to the Sunset Commission in October 2014 on changes it plans to implement in response to the CPS operational assessment currently in progress and any statutory barriers that may impede needed changes.

Under this recommendation, DFPS would submit a report to the Sunset Commission in October 2014, preceding the November 2014 Commission hearing, on changes planned or in progress as a result of the ongoing CPS operational assessment scheduled to be completed in June 2014. As part of this report, DFPS should specifically identify any statutory barriers that complicate or prevent implementation of needed changes in response to recommendations made through the ongoing CPS operational assessment. DFPS should recommend statutory modifications or repeal as needed. This assessment process and resulting report to the Sunset Commission would provide a mechanism for the Legislature to monitor DFPS' implementation of changes to CPS, as well as provide an opportunity for the agency to bring forward any needed statutory changes for consideration by the Legislature through the Sunset process.

2.3 Direct DFPS to submit a progress report to the Sunset Commission in 2016 on changes made as a result of the CPS operational assessment.

This recommendation would direct DFPS to submit this report by October 1, 2016, as part of the Sunset compliance process. A progress report would provide an update to the Sunset Commission and provide accountability for the agency to act on recommendations made through the assessment in addition to any statutory barriers identified in Recommendation 2.2.

2.4 Direct DFPS to comprehensively review and update the CPS policy and procedures handbook.

Under this recommendation, DFPS would review and revise the CPS policy and procedures handbook by updating or creating new content, evaluating the continuing need for each policy, identifying opportunities to eliminate redundancy of caseworker efforts and steps that do not add value, and reduce overall complexity when possible. CPS should complete this review and update in tandem with the operational assessment, using the business process maps created through that process as a guide for handbook revisions. This revision effort would provide many benefits to CPS staff and stakeholders by ensuring content is up-to-date and that the processes required of staff are as clear as possible and all add value to the quality of CPS casework. DFPS should complete this revision by October 1, 2016, preceding the Sunset compliance process.

2.5 Direct CPS to develop a systematic approach to its policymaking process to ensure clear, updated policies and procedures that mitigate risk of noncompliance and staff confusion.

Overall, this recommendation would direct DFPS to make a major change in CPS' process for identifying, developing, and disseminating policy change to ensure a more thoughtful approach that promotes a clear understanding of CPS policy and procedures. Under this recommendation, CPS would do the following:

- Designate staff responsible for overseeing overall development of policy to ensure proposed changes are evaluated using the criteria discussed below, and that they logically fit together as a whole.
- Establish criteria for evaluating the need for and urgency of a change and ensuring the policy serves to further a specific goal and includes analysis of the impact on caseworker workload.
- Establish a regular, reasonable schedule for communicating policy changes and for updating policy and procedures, including firm deadlines by which a policy memo must be included in the handbook or archived on the DFPS intranet.
- Establish a communication plan for implementing policy changes in the regions to ensure staff understands the intended result and reasoning behind each change to policy, including but not limited to training materials to help supervisors and other managers communicate reasons for change and how to implement it.
- Make policy memos and communications publicly accessible to ensure critical stakeholders, such as the courts and service providers, are aware of changes to CPS policy.
- Develop a mechanism to follow up and evaluate the implementation of major changes to ensure each has had the desired outcome.
- Establish a regular timeframe and process for conducting a comprehensive review of CPS policies and procedures to evaluate the continuing need for each.

Implementing a more effective process for creating and disseminating policy would help ensure policy changes are vetted for their impact on operations before implementation and on an ongoing, regular basis; reduce confusion about policy and improve implementation by using a more structured, planned process for introducing changes; and promote more consistent use of policy throughout the state.

2.6 Direct DFPS to require CPS regions to fully document their protocols and practices, report these, and update them on a regular basis.

As a result of this recommendation, CPS State Office would have a full understanding of where regions are doing things differently and why, and identify trends and ways in which state policy does not work appropriately in one or more regions. In addition, CPS could use this process to identify any potential best practices for broader implementation across the state.

2.7 Direct CPS to develop a systematic, comprehensive approach to evaluating and monitoring regional performance, including a monitoring process to verify implementation.

Under this recommendation, CPS State Office, with input from regional staff as needed, would develop a systematic approach to gathering and reporting on regional performance, and a follow-up process to evaluate implementation and impacts of State Office policies and recommendations for improvement. This approach should include, at a minimum, the following elements.

- A regular on-site regional review process that evaluates overall regional performance using a common set of criteria for each review. Common criteria should help CPS evaluate overall regional performance, practices, and the effectiveness of regional management, and would allow for regions to be compared to one another more easily through this review process. On-site reviews already occur, but this process would be more regular and use common criteria to establish a benchmark for evaluation.
- Regular reporting and recommendations from State Office to each region using performance and trend information observed through indicator data and through various existing quality assurance processes. CPS would combine information from its data reports on regional performance with each individual quality assurance processes to provide one comprehensive report giving a complete view of regional trends.

The two processes described above should include a monitoring strategy to allow CPS State Office to check on implementation of recommendations made to regions, and evaluate their effectiveness. Implementing these approaches to evaluating regional performance would allow CPS State Office to accomplish several objectives, including evaluating the effects of state policy in practice; providing valuable, comprehensive feedback to regional management to help them improve; and monitoring to ensure regions take action in response to identified problems.

2.8 CPS should develop a process to report results of staff surveys and other feedback mechanisms back to employees, including suggestions made and management actions taken.

This recommendation would direct CPS to be more systematic in the way it solicits and uses employee input. While gathering input is a positive step, CPS needs to both report results of these surveys and other feedback gathering efforts to employees, and also report to employees on what changes, if any, resulted from the feedback provided. Implementing this practice could help ensure that agency management

more fully considers employee input and could help employees feel more invested in the organization as a result, which could improve morale, important at an agency with high turnover.

2.9 Direct DFPS to ensure its planning efforts for IMPACT modernization support improvement and align with possible CPS operational changes.

This recommendation would direct DFPS to ensure it thoroughly plans for meeting CPS' needs through IMPACT modernization, and use information gained and recommendations made through the CPS operational assessment in identifying ways IMPACT could better support caseworkers and provide the data needed for performance management and business intelligence. CPS should consider the need for tools to provide prompts and decision-making support for caseworkers, and ensure it seeks input from regional staff in identifying needed changes to IMPACT. CPS should also identify critical data that should be captured through IMPACT for both workload management purposes, as well as broader data analysis used to inform CPS policy.

2.10 Direct DFPS to develop a succession planning strategy, to prepare for impending retirements and provide opportunities for advancement to lower-level staff.

The agency should develop a succession plan to prepare for both anticipated and unanticipated departures of key management staff, including identifying positions critical to DFPS' operations and establishing a comprehensive strategy for preparing new staff to assume these responsibilities. Also, DFPS should identify critical vacant positions and positions at risk of becoming vacant in the near future, and provide training and development opportunities to employees eligible to move into these positions. A succession plan would help DFPS to address future needs with current resources and ensure continuity of leadership since such a large proportion of its managers is eligible or close to retirement eligibility. It would also provide a clearer path for advancement to lower-level staff to develop and move into management roles, thus enhancing employee retention.

Fiscal Implication

These recommendations would not have a fiscal impact.

Recommendation 2.1 would not have a fiscal impact since planning and prioritizing use of resources and staff time is an essential management function, and ultimately could help CPS focus its resources on the most impactful projects. In addition, the agency already has numerous mechanisms in place to engage field staff, such as the CPS advisory committees and staff surveys. The Adult Protective Services program within DFPS has implemented a similar process within existing resources.

Recommendation 2.4 is an essential agency function that CPS has not handled effectively. No additional resources are needed to improve this process.

Recommendation 2.7 would not have a fiscal impact since these processes already occur. Instead the recommendation would simply require unifying these existing processes to make them more effective. For example, CPS already conducts on-site reviews, but this recommendation would require CPS to establish standard criteria and a regular schedule to ensure consistency in evaluation.

Recommendation 2.9 assumes the Legislature will appropriate the needed funding for the second phase of IMPACT modernization, and directs the agency to ensure that needed planning occurs for the agency to take full advantage of the opportunity to improve its IT system, in conjunction with policy, evaluation, and process changes.

Recommendation 2.10 would not have a fiscal impact since succession planning and preparing for future staffing needs are essential agency functions and should be handled with existing resources.

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¹ Texas Department of Family and Protective Services (DFPS), *Annual Report & Data Book 2013* (Austin: 2014), pp. 39, 45, and 48.

² Ibid., p. 49.

³ Texas Department of Family and Protective Services, *Management Review Region 6 Child Protective Services* (Austin: September 2013); Texas Department of Family and Protective Services, *Management Review – Region 10 – 2011 (CPS)* (Austin: November 2011); State Auditor's Office, *An Audit Report on Caseload and Staffing Analysis for Child Protective Services at the Department of Family and Protective Services*, report no. 13-036 (Austin: May 2013); Texas Department of Family and Protective Services, *Conservatorship Assessment Report* (Austin: September 2012).

⁴ Texas Department of Family and Protective Services, *Internal Audit Child Death Investigations* (Austin: July 2013), p. 17.

⁵ DFPS, *Management Review Region 6 Child Protective Services* (September 2013).

ISSUE 3

DFPS Faces Significant Challenges and Risks in Its Efforts to Reform the State's Foster Care System.

Background

The State of Texas is the legal parent of almost 17,000 foster children. The courts removed these children from their parents' care due to abuse or neglect severe enough to warrant such action, with the expectation these children will be better off, at least temporarily, in state custody. Texas statute provides for a 12-month legal process in which the courts must decide the fate of the child, which could be family reunification, placement with a relative, adoption, or permanent state custody while the Department of Family and Protective Services (DFPS) continues work to identify a permanent home for the child. During these 12 months, a DFPS conservatorship caseworker works with the parents and the child with the intention that treatment or other services can help these parents again provide a safe home for their child, and help the child recover from the trauma experienced.

The agency contracts with private providers for about 90 percent of foster placements, with the other 10 percent provided directly by DFPS. In fiscal year 2013, the agency contracted with approximately 300 child placing agencies and residential operations, which DFPS also regulates through its Child Care Licensing program. The agency spent about \$366 million in both state and federal funds on foster care in fiscal year 2013. Of the 27,924 children in state custody at the end of fiscal year 2013, 16,676 were in paid foster care. The other 11,248 were in other types of placements, 10,248 of which were kinship placements.¹

Government systems can never replace a child's parents, and Texas, like many other states, struggles to provide quality care for these children to help them heal from the trauma they have experienced and go on to lead healthy, productive lives. The textbox, *Shortcomings of the Texas Foster Care System*, lists several longstanding, well-known concerns that DFPS has been attempting to address for many years.

Shortcomings of the Texas Foster Care System

- Services and placements not located where children need them, forcing the agency to place some children hundreds of miles away from their home communities, siblings, schools, and other supports.
- Information for matching a child to a placement is often inadequate.
- Frequent placement changes causing further instability in already chaotic lives.
- Lack of sufficient foster care capacity to accommodate all children's needs, especially those with more intensive behavioral or physical health needs.
- Inability to accurately assess and distinguish among contractors based on the quality of care they provide, resulting in some children receiving better care and services than others.
- Providers are not allowed to work with birth parents, resulting in services delivered to the child and family separately.
- Ongoing concerns about safety of children in foster care, including the recent increase in child deaths.
- Frequently poor educational and life outcomes for foster youth.

Through a variety of attempts at reform, some legislatively directed, DFPS has delivered incremental changes, such as the creation of a child placement database to better match children with foster placements and the use of performance outcome measures in residential child care contracts to better understand provider quality. More large-scale attempts to reform foster care, including efforts to further privatize the system, have failed to come to fruition. In addition to trying to fundamentally reform foster care, the agency uses an informal workgroup of about 20 staff and 10 residential providers called the Committee for Advancing Residential Practices to provide feedback to the DFPS commissioner and staff on current initiatives and future licensing or contract requirements and to share tools, suggestions, and information to improve foster care system.

In January 2010, DFPS began working with stakeholders to develop recommendations for a redesigned foster care system that addresses identified issues with the current system and supports improved outcomes for children, youth, and families. As a result, DFPS, with the assistance of an informal workgroup, the Public Private Partnership, issued recommendations in a December, 2010 report to the Legislature, *Improving Child and Youth Placement Outcomes: System Redesign*.² In 2011, the Legislature authorized DFPS to redesign the foster care system in Texas according to the recommendations laid out in this report.³ The partnership comprises 26 members, appointed by the commissioner, representing stakeholders, including providers, the judiciary, advocates, and agency staff. Today, the partnership continues to serve as the guiding body during implementation of the model, communicating with member and public constituencies, and informing and advising the commissioner about foster care redesign issues. The Public Private Partnership is advisory in nature, while the DFPS Commissioner is responsible for decision making.

The model developed by DFPS to implement foster care redesign is an attempt to change the way the State contracts and pays for foster care services, with a variety of goals aimed at addressing many of the longstanding problems noted previously. In many ways, foster care redesign is the “managed care” version of foster care, while the traditional or “legacy” system is a “fee-for-service” model. In this new system, the agency authorizes one provider, known as a single-source continuum contractor, to assume responsibility for placing children in foster care and ensuring that they receive needed services within a specific geographic region, or catchment area. The system also changes the way the State funds foster care to address incentives for keeping children at an appropriate level of care. By legislative direction, DFPS retains case management for children in foster care under the system. Though the agency currently has two foster care redesign contracts in place, DFPS still serves the vast majority of foster children through the traditional, or “legacy” foster care system.

The chart on the following page, *Comparison of Foster Care Redesign and Legacy Systems*, illustrates how the redesigned system differs from the traditional system of delivering foster care in Texas.

Comparison of Foster Care Redesign and Legacy Systems

Category	Foster Care Redesign	Legacy System
Contract Type	Competitively procured performance-based contracts with single-source continuum contractors.	Individual open-enrollment, efforts-based contracts with general residential operations and child placing agencies who verify their affiliated foster homes.
Contract Structure	A single entity contracts directly with the State to manage foster care and other purchased services in a defined geographic location, called a catchment area. The contractors may subcontract with other providers to deliver paid foster care to children and services to families, such as counseling or drug treatment.	The individual residential providers contract directly with the State to house and care for children in paid foster care.
Payment and Performance Structure	Involves gradual implementation of model elements that govern which clients the contractor will serve, how they will serve clients and at what intervals, and the methodology DFPS will use to pay contractors, as follows. • Stage 1: Single-source continuum contractors receive a single, blended rate for each child and must pass through a minimum amount to the foster parent. • Stage 2: DFPS provides an allocation of funds to contractors to coordinate and provide services to families of the children in care. • Stage 3: DFPS combines a blended rate with a case rate (i.e. the total number of days a child remains in paid care) to create a single blended case rate it will pay to the single-source continuum contractors in each catchment area for each child in paid foster care. DFPS also allocates monetary incentives to or recoups remedies from the contractor based on performance outcomes related to the child's length of stay in paid foster care.	• Residential care contracts specify the rates that child placing agencies must reimburse foster families for children in their care, based on four separate unit rates for 24-hour residential child care depending on the child's level of service, i.e. basic, moderate, specialized, or intense. • By contracting for specific placement types, verified to serve specific service levels, providers are limited in their ability to provide continuity of care for the child. Thus, if a child's well-being improves or declines while in a contracted placement, then the child's service level is adjusted, triggering the need for a placement change. • DFPS purchases and arranges for support services for families separately from the child, preventing providers from working with the family as a whole. • The contracts include performance measures, but they are not tied to monetary incentives based on performance outcomes.
Child Referral Requirement	Single-source continuum contractors cannot refuse a referral from DFPS for child placement.	Providers can refuse a referral from DFPS for child placement.
DFPS as a Child Placing Agency	DFPS will no longer recruit and verify its own foster homes in redesign catchment areas.	DFPS acts as a child placing agency, directly recruiting and verifying about ten percent of all foster homes.

Findings

Despite longstanding pressure on the legacy foster care system, foster care redesign presents inherent challenges and risks to DFPS and to the State.

Very little data exists to judge the impact of DFPS' foster care redesign model.

The foster care redesign model to outsource the administration of the foster care system is a risky endeavor, just like any effort to outsource a state government function. DFPS currently has two redesign contracts in place, but they are so new that very little data or experience currently exists to judge the performance of the model and inform decisions about further implementation. Under the first contract in Regions 2 (Abilene) and 9 (Midland), the single-source continuum contractor, Providence Service Corporation, began placing children less than a year ago, and the second contract for part of Region 3 (Arlington), awarded to All Church Home Child and Family Services, is still in the start-up phase. Examples of significant challenges DFPS faces with foster care redesign include:

- a fundamental shift in the way DFPS provides and pays for foster care, involving a significant culture change, with new roles and responsibilities for the agency and the provider community;
- no additional investment of state funding with the expectation that the quality of care provided to foster children will improve;
- operating the legacy system and redesigned systems simultaneously for an indefinite statewide rollout period;
- higher risk contracts with more responsibility concentrated in a smaller number of contractors, making the success of each single-source continuum contract especially critical;
- more complex contract management and monitoring responsibilities for DFPS, since contract oversight requires a fundamentally different approach to contract management and financial expertise that is new for the agency; and
- the dismantling of the legacy system by dissolving DFPS' direct contractual relationships with child placing agencies and other residential care providers. If a contractor fails or pulls out of the contract, DFPS is then faced with the difficult task of assuming the contractors' responsibilities temporarily while the agency procures a new contract.

A major concern of other states' foster care reform efforts is the financial viability of contractors.

Other states, with some of the same systemic issues as Texas, have tried various methods of foster care privatization with some difficulty. A major concern associated with similar models of care is the financial viability of contractors with larger contractual risks, such as the ability to manage a subcontracted network of service providers. The textbox on the following page, *Privatization Challenges in Other States*, describes challenges faced by other states, such as Kansas, Missouri, Nebraska, and Tennessee, which have attempted to reform their foster care systems. In Florida, where privatization efforts have since

matured, the state started off slowly by implementing a community-based care model in a limited number of catchment areas, which eventually served to inform the statewide rollout of their privatized system.⁴

Privatization Challenges in Other States

- Failure of contractors to remain financially viable.
- Problems building internal monitoring capacity for tracking service costs, contractor performance, and client outcomes.
- Lack of stakeholder communication and buy-in, such as from judges, families, and agency caseworkers.
- Challenges overseeing two systems simultaneously during transition phase.

DFPS has not clearly articulated a long-range plan for implementing a redesigned foster care system statewide to mitigate inherent risks associated with the transition.

Agencies responsible for implementing large outsourcing efforts should have articulated expectations, goals, and timelines to guide long-term implementation. In the absence of statutory direction on timelines or criteria to consider for long-range implementation decisions, to date the foster care redesign rollout has occurred in a manner consistent with the recommendations contained in the agency's December 2010 foster care redesign report.⁵ The report called for the rollout to occur in one or two catchment areas before expanding to other areas of the state, but provided no details about statewide implementation beyond the first two procurements.⁶ In fact, the report implied the need for an evaluation period to inform decisions on future procurements. In the letter of recommendations to the agency accompanying this report, the Public Private Partnership suggested an evaluation of the catchment areas and modification of the model, if needed, prior to expanding implementation to more geographic areas.⁷ Subsequent attempts by the group to clarify its position on the timing and pace of redesign implementation have not been successful.

DFPS has not clearly communicated a long-range strategy for the statewide rollout of foster care redesign. Instead, staff has been learning as they go, tweaking subsequent contract documents with lessons learned from the previous procurement. Agency staff indicates they believe implementation of redesign warrants such a flexible approach so as not to stifle the innovative work of providers envisioned in the model. However, a number of areas posing risk to the success of foster care redesign have been identified through initial procurements, indicating the need for DFPS to take a more detailed, comprehensive long-term strategic approach going forward. A comprehensive plan need not stifle innovation since it can and should be altered as conditions change, but without it, the agency has no roadmap for the overall effort. Examples of these critical areas include the need for the agency to do the following.

The agency has no roadmap for statewide implementation of foster care redesign.

- Communicate rollout timelines and limitations.
- More clearly delineate and define the case management roles and responsibilities of DFPS and the single-source continuum contractors.
- Identify training needs and address long-range and continuous plans for the training and cross training of staff.
- Articulate plans for evaluating the costs and tasks involved with each single-source continuum contract procurement to better inform future resource needs.
- More formally communicate plans for evaluating the performance of contractors and the foster care redesign system as a whole.
- Report on transition issues resulting from redesign implementation.

Without clear strategic guidance from the Legislature, stakeholders, or agency leadership, Texas remains unprepared to manage current and future foster care redesign efforts.

Because foster care redesign implementation could last many years, DFPS should continue identifying and implementing improvements to the legacy system.

The uncertain timeline and inherent challenges of implementing foster care redesign statewide means the legacy system will continue to care for the vast majority of children in the State's conservatorship for years to come. As previously noted, concerns with the legacy system persist, and because of the immediacy of some of the issues, such as safety, the agency should continue to focus on identifying ways to address them.

Despite foster care redesign, concerns with the legacy system persist.

The agency has made extensive efforts to address recent concerns about the safety of children in foster care. In fiscal year 2013, seven child fatalities occurred in foster care as a result of abuse or neglect by the child's caregiver, the highest number since 2007.⁸ In response, DFPS has focused significant efforts on improving child safety through foster parent training and support, information sharing among providers on best practices, and better monitoring of provider quality. As part of its overall effort to improve safety, DFPS collaborated with stakeholders through its legacy provider workgroup, the Committee on Advancing Residential Practices, to recommend rule changes to improve the safety and quality of care for foster children. The new rules, if adopted, require more robust foster home screening and monitoring methods. These and other efforts to identify areas for improving the legacy system should continue, regardless of foster care redesign implementation.

DFPS lacks a consistent, comprehensive approach to meaningfully monitor and report on performance and identify risk in the foster care system as a whole.

- **Disjointed quality assurance efforts.** The legacy system and foster care redesign are separately undertaking new approaches to performance evaluation. CPS has a quality assurance team that conducts case reads of children in care, using a tool provided by the federal government in the last round of Child and Family Services Reviews, to gauge safety, permanency and well-being outcomes. This team takes a continuous quality improvement approach to quality assurance by using the results to provide feedback to the caseworker and supervisor on individual cases as well as aggregate trends and patterns to management.

At the same time, DFPS has contracted with a research and policy center at the University of Chicago for assistance with evaluating outcomes of foster care redesign. As part of that evaluation, the center will work with the single-source continuum contractors to interpret the outcomes data, identifying trends and areas for improvement.

Both of these efforts to evaluate system quality will require long-term involvement of and coordination within and between systems to ensure more meaningful outcomes are achieved for the system as a whole, and that providers are held accountable for meeting state and federal expectations.

- **No holistic approach to measuring overall provider quality.** DFPS' approach to measuring performance of the legacy system and the redesigned system through contracts does not provide enough comparable information to judge the quality of the system as a whole. Some differences occur in the measurement of certain indicators related to youth preparation for adulthood, education outcomes, youth participation in service planning, and youth participation in "normal" activities, such as extracurricular activities. Appendix F, *Performance Measures in Foster Care Contracts*, provides a comparison of the measures DFPS currently uses in legacy system contracts and foster care redesign contracts. While using the same measures in both types of contracts may not be feasible, DFPS should still have a common framework for measuring overall provider quality in the foster care system.
- **Inadequate quality indicators for measuring well-being.** DFPS should also develop a broader array of indicators to evaluate the overall quality of foster care services and their impact on children and families. Current contract measures do not go far enough to adequately measure the social and emotional well-being of children in the State's care. True indicators of child well-being would measure factors such as educational success, health, and behavior outcomes, answering questions such as those listed in the textbox, *Example Indicators of Child Well-being*.⁹ The federal

Current foster care contract measures do not go far enough to evaluate the overall quality of care.

Example Indicators of Child Well-being

- Is the child in good health?
- Is the child doing well emotionally and behaviorally?
- Is the child developing, learning, progressing, and gaining skills at an appropriate rate?
- Is the child regularly attending school, on grade level, and getting passing grades?

DFPS' approach to foster care contract monitoring is reactive.

government is expected to provide a revised case reading tool that better emphasizes child well-being measures in the next round of Child and Family Services Reviews. States will be required to use the new federal tool, but also can, and should, add additional criteria to better gauge provider quality in improving child well-being.

The agency could also use these indicators as a means of better targeting its contract monitoring efforts in both systems. For example, Florida's child welfare agency tracks and reports a variety of measures by contractor that are not specifically included in their foster care contracts and reports them publicly using a website scorecard. The scorecard is intended to drive performance by making it transparent and promoting competition among contractors. The agency produces the scorecard monthly for review, discussion, and action by executive management to understand differences in performance, barriers to improving performance, and strategies for improvement.¹⁰

- **Data collection efforts not sufficient for developing true risk indicators.** Many aspects of the current foster care oversight process reflect the same contract oversight processes for other programs and contracts at DFPS. While this approach focuses on identifying high-risk contractors, DFPS has recognized certain shortcomings that prevent the agency from better predicting problems before they occur. The current approach is reactive, focusing on the occurrence rather than the avoidance of abuse, neglect, and safety deficiencies. Further, by using the same risk indicators for all contracts across the agency, this approach has trouble distinguishing actual risks that vary significantly by contract type, especially the high risks associated with foster care. The accompanying textbox provides examples of possible new safety risk indicators for foster care identified by the agency. Also, the current risk assessment process occurs once a year, which does not allow for a more continuous, real-time assessment of risk.

Examples of Possible Safety Risk Indicators

- Number of emergency behavior interventions per quarter.
- Number of non-verbal children in a single home (e.g., under three years of age or medically fragile).
- Reason for movement of foster parents between child placing agencies.
- Failed background checks of frequent visitors.
- Conservatorship caseworker rating of home.

In addition to these concerns, the agency has difficulty extracting usable data in standardized formats from its existing IT systems to capture objective risk indicators. The agency has expressed an interest in developing risk indicators that will enable it to better predict potential problems in foster care contracts. However, it will need to change the way it collects and uses data and outcomes to achieve this goal.

The agency's foster care advisory groups lack the clear structure, purpose, and formality needed to best serve their crucial roles.

The agency relies on two informal advisory groups to provide feedback on agency initiatives and foster care practices, and assist with the ongoing challenges of operating dual foster care systems. Both groups, the Public Private Partnership and the Committee for Advancing Residential Practices, are appointed by the

commissioner to provide input and expertise on foster care redesign and legacy system issues. While well positioned for these purposes, they have loosely defined purposes, memberships, and methods of operating. Because foster care is such a critical DFPS responsibility, these groups warrant a more formal and permanent mechanism for continuing to cultivate, sustain, and strengthen the necessary partnership between the agency and its stakeholders, including the provider community.

- Public Private Partnership.** As foster care redesign has transitioned from the conceptual to implementation phases, this group lacks needed formality in terms of structure, purpose, membership, and responsibilities, especially given its critical role in guiding major reform of the State's foster care system. While the partnership originated as a group to guide change in the foster care system as a whole, it now focuses only on foster care redesign. Recently, group members have raised concerns about gaps in membership, attendance, subcommittee structure, and voting procedures, which have motivated an informal effort to develop bylaws. Also of concern is the role of providers on the committee and potential conflicts of interest, particularly among those now contracting or subcontracting in the foster care redesign system. Further, as different service delivery models roll out to other areas of the state through foster care redesign, the group should provide an avenue for input from community groups affected by redesign efforts in each catchment area.
- Committee for Advancing Residential Practices.** DFPS developed this committee in 2012 as an informal advisory group to assist the agency with operational issues in the legacy system. The committee provides input to the agency on a number of issues, as outlined in the accompanying textbox. This group also provides an avenue for providers to introduce other topics of concern for discussion and to share best practices. The membership has recently grown to include providers who contract in both the legacy and redesigned systems, triggering recent discussion about the committee's role in foster care redesign, as well as its evolving role in assisting the agency with the legacy system. This discussion indicates the need to more formally clarify the structure, purpose, and responsibilities of this valuable committee.

Groups providing advice to DFPS on managing foster care need more clearly defined responsibilities.

Committee for Advancing Residential Practices Focus Areas

- Performance measures in residential contracts.
- Minimum standards reviews and changes, such as recent safety rule changes.
- Ways to overcome barriers to permanency.
- Implementation of new legislation related to background check requirements, medical consent, and psychotropic medications.
- Foster care rate increases.
- Promoting normalcy in the lives of foster youth.

Recommendations

Change in Statute

3.1 Require DFPS to develop and maintain a long-range foster care redesign implementation plan to guide the agency's transition efforts.

The purpose of this implementation plan is to present a focused, transparent, meaningful vision to guide all of DFPS' short- and long-range planning efforts. Specifically, the plan should describe the agency's expectations, goals, and approach to foster care redesign implementation. As such, the plan should, at a minimum, accomplish the following objectives.

- Communicate rollout timelines and limitations.
- Clearly delineate and define the case management roles and responsibilities of DFPS and the single-source continuum contractors.
- Identify training needs and address long-range and continuous plans for training and cross-training of staff.
- Articulate plans for evaluating the costs and tasks involved with each single-source continuum contract procurement to better inform resource needs.
- Articulate plans for evaluating the performance of contractors and the foster care redesign system as a whole, including the contract monitoring approach.
- Report on transition issues resulting from foster care redesign implementation.

The foster care redesign report referred to in statute can be used for the basis of plan development as it already contains many of the elements of the redesign planning process needing elaboration. The plan is meant to be a working document that DFPS would update annually, reporting progress towards implementation goals. While DFPS should remain flexible and allow enough room for providers to innovate, it needs a clear vision to dispel uncertainty among stakeholders and to guide its efforts.

Management Action

3.2 DFPS should thoroughly evaluate system data and cost before pursuing broad implementation of foster care redesign.

This recommendation would direct DFPS to decide on broad-based implementation of foster care redesign after thorough evaluation of performance and cost data from experience under the new system. Under this recommendation, the agency would have some flexibility in deciding when sufficient data will be available for performing this thorough evaluation, but would need to use this flexibility cautiously to avoid the risk of rolling out too many single-source continuum contracts before their performance can be adequately judged. The purpose of the evaluation would be to assess early indications of the successes and challenges of the initial catchment areas, and compare contractor performance to baselines already established in the redesigned model. This recommendation is not intended to take the place of or interfere with the agency's continuous quality improvement plans, but would direct DFPS to set a point in time by which the agency will have sufficient data to inform decision making regarding widespread redesign rollouts.

The agency should also perform a simultaneous internal analysis of the costs involved with initial procurements to better understand the cost of foster care redesign to the State, single-source continuum

contractors, and community partners as a whole. This information would help determine what DFPS can reasonably accomplish in supporting the redesigned system. The analysis should also reveal areas of financial risk, such as the impact of resource transfers and the level of investment required from contractors to adequately manage foster care in their respective catchment areas. The agency should work with the initial single-source continuum contractors to determine their actual start-up and administration costs, and HHSC, using its expertise in rate setting and reviewing and analyzing cost reports. DFPS should also consult with its financial contract manager to identify the type of financial data that should be used in this assessment to best illustrate the overall cost of foster care redesign.

Under this recommendation, the agency would present the results of any data and cost analyses to the Public Private Partnership for discussion and feedback on how this information would better support the systems in the current catchment areas, and how best to move forward with foster care redesign in other areas of the state.

3.3 DFPS should develop a consistent approach to measuring and monitoring provider quality and identifying risk indicators in both the legacy and redesigned systems.

Under this recommendation, DFPS should identify and develop common quality and risk indicators and performance measures to gauge and communicate the performance of the entire foster care system. Additionally, DFPS should add more indicators to better evaluate the safety and well-being of children and youth in the State's care. This recommendation would not require the agency to change current measures in single-source continuum and legacy foster care contracts, but DFPS may have to amend contracts to accommodate any additional data collection that may be needed from contractors as a result of the new measures. The agency would also need to ensure that business processes and IT systems are capable of capturing quality and risk indicators. These changes would improve DFPS' ability to monitor performance of the foster care system and better predict problems before they occur.

As part of this recommendation, the agency should publicize legacy foster care system performance in a scorecard fashion, comparing the performance on selected measures across all legacy providers. The agency should follow through on its plans to do the same for the single-source continuum providers. DFPS should also include information in its residential contracts and on its website that clearly articulates how the agency will use performance measure results to improve individual provider quality and the legacy system as a whole.

Under this recommendation, DFPS should continue to identify practices that could improve the legacy system. For instance, DFPS drives provider quality through its contract monitoring practices. In addition, through the Committee for Advancing Residential Practices, the agency has a mechanism in place to help identify the specific monitoring that helps drive quality outcomes from providers in the legacy system. As such, this recommendation would require DFPS to continue to use this committee to assist with identifying ways that contract monitoring practices and other means can be used to achieve improved outcomes.

3.4 Rules should be adopted for the use of foster care advisory committees, ensuring the groups meet the structural and operational needs for advancing the agency's goals.

This recommendation would direct DFPS to establish the Public Private Partnership and the Committee for Advancing Residential Practices in rule as formal DFPS advisory committees. Under this recommendation, rules should be adopted establishing each committee, including:

- definition of the purpose, role, responsibility, and goals of the committees;
- size and quorum requirements;
- qualifications of the members, such as experience or geographic location;
- appointment procedures for the committees;
- terms of service;
- adoption of bylaws to govern committee practices, such as voting procedures, attendance requirements, and conflicts of interest;
- regular evaluation of the need for and purpose of each committee;
- duration of the committees; and
- compliance with the Open Meetings Act.

The agency would structure and use these committees to provide advice to the commissioner or staff, but not be responsible for developing rules or policymaking. Committee meetings would also be publicized on the agency's website and open to the public. Formalizing these committees would allay concerns about the appropriate, membership, terms, purpose, and goals of the committees and elevate the importance of these valuable groups as necessary partnerships with the State in achieving the critical safety, permanency, and well-being goals for children in the State's care.

Fiscal Implication

DFPS has already been planning and implementing foster care redesign efforts within its existing budget. Expanding redesign planning efforts could require some additional staff time and administrative costs, but the agency should be able to implement these recommendations through its existing budget. Formalizing the advisory committees would not result in a fiscal impact to the State, since the recommendation would not authorize reimbursement of committee member travel expenses.

¹ Texas Department of Family and Protective Services (DFPS), *Annual Report & Data Book 2013* (Austin: 2014), p. 49.

² DFPS, *Improving Child and Youth Placement Outcomes: A System Redesign* (foster care redesign report), (Austin: December 2010).

³ S.B. 218, 82nd Legislature, Regular Session, 2011.

⁴ Section 409.1671, Title XXX, 2011 Florida Statutes.

⁵ DFPS, *Improving Child and Youth Placement Outcomes: A System Redesign* (foster care redesign report) (December 2010).

⁶ Ibid, p. 3.

⁷ Letter from Public Private Partnership to former DFPS Commissioner Anne Heiligenstein, December 13, 2010, p. 4.

⁸ DFPS, *2013 Safety Forums Summary* (Austin: 2014), p. 3.

⁹ Quality Service Review Institute, a Division of the Child Welfare Policy and Practice Group, *Quality Service Review – A Reusable Protocol for Examination of Youth-Focused, Family-Centered Services for a Child/Youth and Family* (Santa Fe, NM: Adapted for Use by the New Mexico Children, Youth, and Families Department, 2013).

¹⁰ Florida Department of Children and Families, *Community-Based Care Lead Agency Scorecard* (Tallahassee, FL: 2014).

ISSUE 4

DFPS' Enforcement Efforts Must Be Strengthened to Best Ensure the Safety of Children in Regulated Care.

Background

The Department of Family and Protective Services (DFPS) is responsible for protecting the health, safety, and well-being of children in regulated day care and residential care facilities. To achieve this mission, the agency's Child Care Licensing (CCL) division establishes minimum standards of care, licenses or otherwise regulates different child care facilities, and conducts monitoring inspections and complaint investigations in the regulated operations to ensure compliance with statute, standards, and rules.¹ The agency also provides technical assistance on meeting licensing standards, rules, and law, and informs the public about the different types of residential and day care operations DFPS regulates. The *Agency at a Glance* section on page 14 describes the different types of residential and day care operations DFPS regulates.

The minimum standards have been adopted in rule to mitigate risk for children in regulated care by outlining the basic requirements to protect their health, safety, and well-being.² The standards are weighted on a five-point scale from high to low, based on the risk that a violation of that standard presents to children.

A residential child care facility must be licensed by CCL to contract with the agency to provide foster care to children in state legal custody. Several other types of residential child care operations must hold a license to operate in Texas, such as treatment centers that provide behavioral health and substance abuse services on a 24-hour basis to children and facilities housing children in the custody of the U.S. Office of Refugee Resettlement. The agency inspects residential facilities annually, at a minimum. For day care operations, the type of permit required generally relates to the size of the operation, which also guides the inspection schedule. For all regulated child care operations, CCL investigates allegations of abuse and neglect, as well as reports of standards violations within certain timeframes based on assigned priority levels.

The agency generally approaches enforcement by first working with facilities to voluntarily correct deficiencies through the use of technical assistance and voluntary plans of action. Depending on the seriousness of the situation and operation's compliance history, the agency can impose more formal means of corrective action, such as evaluation or probation, to try to gain compliance. Both types of corrective action can impose conditions beyond minimum standards and basic permit requirements, as well as more frequent inspections, with evaluation being less restrictive and generally lasting six months compared to one year for probation. If more stringent action is needed, the agency may impose administrative penalties, or adverse enforcement action, such as denial, suspension, or revocation of the operator's permit.³ The table, *CCL Enforcement Data*, gives a breakout of enforcement activity by residential and day care operations.

CCL Enforcement Data – FY 2013⁴

Type	Day Care	Residential Child Care	Total
Regulated Facilities	21,980	10,286	32,266
Inspections	36,687	4,684	41,371
Investigations	17,491	5,160	22,651
Standard Violations Cited	89,659	6,050	95,709
Corrective Actions	157	12	169
Adverse Actions	26	1	27

The agency can also seek an emergency suspension to address an immediate risk to the health and safety of children in care. Through the courts, DFPS can pursue other remedies, if warranted, such as injunctions, and civil and criminal penalties.⁵

By agency rule, an operation has a right to administrative review of a cited deficiency, remedial action, or investigative finding of abuse or neglect substantiated by CCL.⁶ CCL staff conduct administrative reviews to determine if the investigative finding was appropriate. In more serious cases resulting in adverse enforcement action, the operation's designee can request a due process hearing held by the State Office of Administrative Hearings.

Findings

Emphasis on achieving corrective action in child care licensing without enforcement action has not helped gain compliance with requirements intended to protect children.

- **Cautious approach to enforcement.** The State's traditional approach to enforcing child care licensing regulations, as directed by statute, has been to pursue non-monetary sanctions before imposing administrative penalties.⁷ The effect of such legislative direction has been to dampen the agency's enforcement effort in favor of an extensive collaborative approach of working with regulated entities to bring them into compliance with standards and licensing requirements. Collaborative approaches like corrective plans, probation, and evaluation periods can take up to one year or longer for operations to come into compliance, or not, before the agency can begin to pursue more stringent enforcement action that may be needed to spur action. All the while, children are in those facilities.

Collaborative approaches to enforcement can take up to one year or longer for operations to come into compliance.

The desire for a lighter enforcement hand may stem from concerns that a strong enforcement approach could harm child care providers and ultimately affect the affordability of day care and the availability of foster care for abused and neglected children. However, to go slow on enforcing regulations designed to protect children from safety risks out of concern that some providers may have trouble meeting such protective standards is essentially to accept a level of risk to children simply because the state needs providers, regardless of their quality. Conversely, if the concern is that stronger enforcement will result in bureaucratic standards being imposed to little effect in protecting children, the standards process itself would need to be called into question. The current balance of enforcement effort between friendly collaboration and strict discipline does not show this concern to be the case.

The effect of this cautious approach to enforcement has been that the agency has taken very few enforcement actions against providers, especially in the area of residential child care. In fiscal year 2013, the agency had only 26 adverse enforcement actions out of almost 22,000 regulated day care facilities, with almost 90,000 standards violated. The agency has only taken four adverse actions against residential child care facilities in the last five years. Further, CCL has never used its administrative penalty authority against residential operations, and has used this authority only four times against day care operations.

- **Repeat violations.** One consequence of a more relaxed regulatory environment can be seen in a high incidence of repeat violations that can result when regulated entities perceive that they will not be held accountable for ignoring the State's requirements. This behavior may certainly be seen in the child care licensing community. The chart, *Top Five Repeated Violations for Day Care and Residential Operations*, describes the most commonly violated standards. Most of these repeat violations occurred on the highest-risk standards, mostly associated with criminal history check requirements. Overall, 31 percent of residential operations and 23 percent of licensed child care centers had repeat violations of the minimum standards or law in fiscal year 2013.

Top Five Repeated Violations for Day Care and Residential Operations – FY 2013

Standard Cited	Risk Level	Total Number of Violations	Unique Number of Operations With Repeat Violations
Day Care Operations			
The day care operation failed to request a name-based criminal history check every 24 months for persons required to get background checks.	High	1,969	192
The day care operation failed to request a name-based criminal history check for each person employed at the operation.	High	1,697	233
A caregiver at a day care operation failed to adequately supervise children.	High	1,528	240
A day care operation was not free from safety hazards, such as accessible electrical outlets, poisonous plants, or pools and bodies of water.	High to Medium-High	1,375	225
A day care operation failed to request a fingerprint-based criminal history check when required by law.	High	1,304	200
Residential Operations			
The residential care operation failed to request a name-based criminal history check every 24 months for persons required to get background checks.	High	142	18
One or more employees at a residential operation used or threatened to use corporal punishment with a child in care.	High	114	26
A residential operation failed to request a name-based criminal history check for persons 14 or older who frequent the operation while children are in care.	High	106	22
Child placing agency staff and caregivers — one or more caregivers at a residential operation failed to demonstrate competency, prudent judgment, and self-control in the presence of children and when performing assigned tasks.	High	100	21
General residential operations — one or more employees at a residential operation failed to demonstrate competency, prudent judgment, and self-control in the presence of children and when performing assigned tasks.	Medium-High	72	14

*Current law
hamstrings
the agency's
ability to keep
children safe in
regulated care.*

- **Ongoing regulatory limitations.** In 2013, the Legislature allowed the agency to begin to impose administrative penalties more expeditiously for several violations relating to background and criminal history check requirements.⁸ Specifically, statute now allows the agency to impose administrative penalties on operations violating background and criminal history check requirements without first having to pursue corrective action, and the agency has recently developed new procedures to implement this change.⁹ However, DFPS is still directed by law to pursue corrective action before it can more rigorously enforce other high-risk standards, such as those related to adequate supervision of children and safety hazards that can also significantly affect child safety. Such a limiting approach to enforcement hamstrings the agency's ability to meet its mission to ensure the safety of children in care and ultimately holds the agency responsible for ensuring safety while withholding the authority to achieve this result.

The agency has difficulty ensuring that it consistently and reasonably applies safety standards.

*Inconsistent
enforcement
means some
children may
not experience
the same level
of protection
across the state.*

- **Variations in citing standards.** An agency's enforcement efforts should help ensure standard treatment of regulated entities in correcting problems. Also, certain standards that directly relate to a child's safety should leave little room for subjectivity or error in how they are enforced. Yet variations in citing critical safety standards appear to exist. For instance, in fiscal year 2013, urban regions like Dallas-Fort Worth and El Paso were much less active in citing day care operators for violating key safety standards like background checks and fire safety than other urban regions like Houston and San Antonio. Such variation can also be seen among more rural regions, where Lubbock and Abilene were much less active in citing day care operators for these same key safety standards than Beaumont, which was consistently among the most active of all regions in issuing citations. Similar variation can be seen in citations against residential operations. The result is that children may not experience the same level of protection across the state while in regulated child care.
- **Non-use of risk assessment.** The agency does not effectively use available resources to support consistent enforcement decisions. CCL has risk analysts dedicated to assisting with sanction decisions by determining the most appropriate enforcement action for reducing the risk of harm to children in a licensed facility.¹⁰ The risk analyst considers factors, such as the nature and severity of the violation, compliance history of the operation, and any aggravating or mitigating factors. CCL staff are not required to follow risk analysts' recommendations and often do not. Of 42 recommendations to impose administrative penalties over the past five fiscal years, the agency has only done so once, in fiscal year 2009, for a day care violation.
- **Lack of feedback loop for improving regulatory processes.** The agency does not make full use of mechanisms to improve regulatory processes. For example, a performance management unit within CCL performs

quality assurance duties for the purpose of reducing risk to children in care. This unit analyzed the quality of technical assistance and its effect on mitigating risk to children in child care operations. The unit also analyzed administrative reviews, finding reasons for overturning investigative findings that included insufficient evidence, insufficient documentation to support decisions, incorrect standard citation, and additional standards cited unnecessarily. These are reasons many standards violations are overturned during administrative reviews, approximately 36 percent of residential standards violations and 25 percent of day care standards violations in fiscal year 2013, which has consistently been the case over the past five years. In neither instance, however, did the agency use this information on technical assistance or administrative reviews to improve the quality of inspections or investigations.

The agency lacks an administrative tool that may help deter illegal day care activity.

A regulatory agency should have enforcement authority not only over its permit holders, but also over those who engage in unlicensed activity. Illegal operations present higher risk to children because they do not get inspected or meet training, background check, or other basic health and safety requirements. In fiscal year 2013, the agency validated 36 percent of abuse and neglect investigations in illegal day care operations compared to 14 percent of abuse and neglect investigations in regulated day care operations. The agency was recently given additional resources to target unlicensed day care, and is using these resources to identify illegal operations and try to bring them into regulation. However, not all violators will want to comply or cooperate with the agency's efforts. Cease-and-desist orders would provide an additional tool for faster action and to demonstrate DFPS' efforts to stop illegal operations, which could help the agency obtain future injunctive relief.

DFPS does not use available resources to target improved child care inspections and investigations.

Recommendations

Change in Statute

4.1 Authorize the agency to assess administrative penalties for high-risk child care licensing violations without first pursuing non-monetary administrative sanctions.

This recommendation would allow the agency more discretion in applying administrative penalties to violations of CCL standards deemed high risk by the agency, rather than singling out background check standards as the exception for applying administrative penalties more expeditiously. Specifically, this recommendation would clarify that the agency does not have to exhaust other non-monetary administrative sanctions before imposing administrative penalties for high-weighted safety standards. The recommendation is not intended to direct the agency to stop providing technical assistance or pursuing corrective action plans to bring regulated entities into compliance with standards and regulatory requirements. However, broadening statutory administrative penalty authority would provide needed flexibility to the agency to help accomplish the ultimate goal of mitigating the higher risk of harm to children in care.

4.2 Require DFPS to develop an enforcement policy in rule to guide child care licensing enforcement efforts, and require a specific methodology to be publicly available.

This recommendation would require the adoption of a CCL enforcement policy in rule to lay out the agency's general approach to enforcement and to guide and communicate its overall philosophy. The policy would summarize general expectations for holding licensed operations accountable, and would communicate the agency's framework for using its regulatory tools, from technical assistance, to corrective action plans and adverse enforcement action. This policy would articulate the agency's vision for its strengthened enforcement effort and set the tone for making more objective regulatory decisions.

The recommendation would also require the agency to establish and make publicly available a specific methodology to use when determining disciplinary actions for day care and residential child care operations that have violated state laws or agency rules. The methodology would provide guidance on when to use each of the available tools, including technical assistance, voluntary plans of action, and more stringent approaches, such as evaluation, probation, suspension, revocation, denial, administrative penalties, and emergency suspension, serving as an overall guide for enforcement decision making. The guidance would relate the agency's actions to the circumstances of the case, based on considerations such as the nature and seriousness of the event, the operations' compliance history, and aggravating and mitigating factors.

While adopting an enforcement methodology would help the agency make more consistent, fair disciplinary decisions, the matrix should not be used as a one-size-fits-all approach, as CCL would maintain flexibility in determining the most appropriate sanction for each violation. Adopting an enforcement policy in rule would give the public and stakeholders the opportunity to comment, and would provide the day care and residential child care operations with ready access to the agency's enforcement guidelines, allowing them to better understand the potential consequences of their actions.

4.3 Grant cease-and-desist authority to DFPS limited to the unlicensed provision of child care in accordance with child care laws.

This recommendation would allow the agency to issue cease-and-desist orders when it discovers an individual or entity operating a child care operation without a permit. This recommendation would also authorize the agency to assess administrative penalties on unlicensed individuals or entities who fail to comply with the agency's order. These changes would help DFPS better protect consumers from unlicensed child care practices, but would not affect the agency's authority to also seek an injunction through the attorney general.

Management Action

4.4 Direct DFPS to develop a more robust quality assurance process for standards cited that directly relate to child safety.

This recommendation would direct DFPS to use the performance management unit within Child Care Licensing to better support the program by evaluating trends, concerns, and successes; detailing and recommending specific changes; and providing guidance on how to implement those changes. Further, the performance unit should use its evaluation of existing enforcement support processes, including technical assistance and administrative reviews, to improve regulatory processes. CCL executive management should work in collaboration with the unit to create and prioritize an evaluation schedule, similar to the way internal auditors develop audit plans.

In conducting performance analyses, the unit should pull a cross-regional sampling of cases to assess and compare variances in the quality of work. Analysis regarding technical assistance should focus on the quality of assistance given to providers and whether that assistance mitigated risk of harm to children in care. Analysis of administrative review decisions should focus on the reasons that cited violations are overturned to point to inspection quality issues and any inconsistencies found in the administrative review process itself.

The agency should use this process to devise a systematic method for implementing improvements to CCL's regulatory efforts statewide. This effort should take the form of an action plan, for implementing procedural changes, including specific details about how the evaluation results will be used to target gaps in training, and an implementation timeline. The performance management unit should track the outcomes of their recommendations as a way of ensuring implementation is completed. If through this process best practices are identified, the agency should incorporate those practices into implementation efforts, and devise a system for regions to regularly share best practices with one another.

Fiscal Implication

The recommendation to strengthen child care licensing enforcement could result in additional revenue from administrative penalties, which is deposited in the General Revenue Fund. However, the fiscal impact of these changes could not be estimated because penalty amounts generated would depend on the number and seriousness of future violations, which could vary significantly based on many factors that cannot be predicted.

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¹ Chapter 42, Texas Human Resources Code.

² 40 T.A.C. Chapters 743, 744, and 746–750.

³ Subchapter D, Texas Human Resources Code, Remedies.

⁴ Illegal and exempted operations are not included in this data.

⁵ Ibid.

⁶ 40 T.A.C. Chapter 745, Subchapter M.

⁷ Section 4, Chapter 746 (S.B. 427), Acts of the 83rd Legislature, Regular Session, 2013. This Act amended statute that previously read, “Non-monetary, administrative penalties or remedies, including corrective action plans, probation, and evaluation, shall be imposed when appropriate before monetary penalties.”

⁸ Ibid.

⁹ Department of Family and Protective Services, *Procedures for Imposing Administrative Penalties for Background Check Deficiencies*. FC200e (Austin: 2014).

¹⁰ Section 42.021(b), Texas Human Resources Code.

ISSUE 5

CPS Does Not Capture Comprehensive Information to Adequately Assess How Well It Is Protecting Children.

Background

Child Protective Services (CPS) within the Department of Family and Protective Services (DFPS) investigates child abuse and neglect allegations and provides services to families to prevent future abuse or neglect and keep families together. Investigators assess a child's safety in the home and balance that level of risk with the potential harm of removal from his or her parents' care. The agency's call center, Statewide Intake, receives and routes allegations of abuse or neglect to CPS. Investigators gather evidence and assess child safety through interviews with the alleged victim and perpetrator, other family members, neighbors and family friends, school personnel or day care providers; review medical documentation and prior history with CPS; and other means as necessary. Caseworkers seek to identify all safety threats to the child and pursue the least restrictive intervention that can keep the child safe. The textbox, *Investigations and Family-Based Safety Services*, shows the number of families served and the findings of each case in fiscal year 2013.

Investigations and Family-Based Safety Services – FY 2013

- Completed investigations: 160,240
- Completed fatality investigations: 804
- Confirmed dispositions: 40,249
- Ruled-out dispositions: 100,390
- Unable-to-determine dispositions: 16,233
- Unable-to-complete dispositions: 3,368
- Children removed: 17,022
- Families receiving Family-Based Safety Services: 19,999

The investigator's finding for each allegation is called a disposition. The different possible dispositions are described in the textbox, *Investigation Disposition Definitions*. Investigators make a determination about each allegation for each child involved upon closing an investigation. For example, an investigator may find enough evidence to confirm that a parent physically abused one child, but not enough evidence to confirm that the same parent physically abused a second child. In this scenario, the investigator would assign a 'reason-to-believe' disposition to the first allegation of physical abuse for the first child and would assign a 'ruled-out' disposition to the second allegation of physical abuse for the second child. In addition to assigning a disposition to each individual allegation of abuse or neglect, the investigator also gathers and assesses information about the continued risk to children in the home and makes an overall risk finding, regardless of whether or not the actual abuse or neglect allegation is confirmed. While the investigator did not confirm that the parent abused the second child in this example scenario, the investigator may find enough evidence

Investigation Disposition Definitions

- **Reason to believe:** Preponderance of evidence (over 50 percent) indicates that the allegation occurred.
- **Ruled out:** Preponderance of evidence indicating the allegation did not occur.
- **Unable to determine:** No preponderance of evidence to support or rule out the allegation.
- **Unable to complete:** Investigator cannot gather enough information to complete the investigation because CPS cannot locate the family or compel the family to cooperate with the investigation.

to suggest that the child is at risk of future abuse or neglect and assign an overall risk finding to the case and the home. Risk findings indicate ongoing risk that could pose a threat to the child's future safety. In these cases, the investigator refers the family to Family-Based Safety Services, another type of protective service. Confirmed abuse or neglect is not a precondition for referring a family for these services. Instead, investigators base referral decisions on the risk finding.

Family-Based Safety Services Caseworker Activities

- Assess family's needs and risks.
- Create a plan of service for each family member.
- Provide or coordinate services, such as psychological assessments, therapy, substance abuse treatment, or domestic violence intervention.
- Meet regularly with the family to assess risk level.
- Obtain updates from service providers on family progress.

Family-Based Safety Services caseworkers provide or coordinate services to give families the skills or treatment needed to reduce the risk of future abuse and neglect while still allowing the child to remain at home and avoid the need for removal. The accompanying textbox describes Family-Based Safety Services caseworker responsibilities.

CPS also investigates child fatality cases when Statewide Intake receives a report that a death may be related to abuse or neglect, or if the fatality occurs in an open CPS case. These investigations are similar to typical investigations of abuse or neglect, but the investigator determines if the child's death was due to abuse or neglect.

The agency uses contracted or internal resources to improve the quality of investigations. DFPS contracts with child advocacy centers, which primarily conduct taped, forensic interviews of children who have been sexually abused and coordinate with law enforcement, medical personnel, and CPS to investigate complex abuse cases. The child advocacy centers employ staff trained in forensic interviewing and often provide therapeutic services to children and families. As a component of "CPS Reform," in 2005, DFPS began integrating more forensic tools into CPS investigations.¹ For example, DFPS contracts with the Forensic Assessment Center Network to provide a statewide resource for caseworkers to get medical opinions on complex abuse and neglect cases. The agency also hired special investigators to provide additional forensic experience and expertise to investigations. Special investigators have at least two years of law enforcement experience and can work as secondary caseworkers on complex or high-profile investigations.

Findings

CPS does not gather and evaluate sufficient data to most accurately assess the risk to children and the quality of services it provides.

DFPS needs accurate and complete data to evaluate the effectiveness of CPS interventions in addressing child abuse and neglect. Identification of trends can guide CPS practices and policies, because they help the agency evaluate and improve its decision making to keep children safe in future cases. However, DFPS' ability to use trends and patterns detected through outcome measures is most effective if the data provides the most relevant, holistic picture of CPS performance. The following material describes gaps in the agency's data collection that prevent the most accurate, complete assessment of its services.

- **Lack of comprehensive recidivism data.** The rate at which children return to CPS is the primary indicator DFPS uses to assess the accuracy of its risk assessments and effectiveness of services in preventing further abuse and neglect. The agency bases its recidivism measure on whether or not an abused or neglected child re-enters the CPS system through a new investigation with a confirmed allegation or risk finding within 12 months.

While CPS' current recidivism measure is valuable, it does not account for other indicators that could alert CPS to a pattern of abuse or neglect in a family, and does not clearly demonstrate the effectiveness of CPS services in preventing parents or other caregivers from repeating abusive behavior, as described below.

Fails to fully detect a single perpetrator's pattern of abuse committed against multiple children or in multiple households. Because DFPS tracks incidents of repeat abuse or neglect by the individual child or the household in which the abuse occurred, the current recidivism measure does not track and report some incidents of repeat abuse or neglect perpetrated by the same caregiver, but against a child who was not in the household at the time of the prior incident. For example, if CPS confirms a parent abused a child, and several months later the same parent abuses another child not yet born when the previous abuse occurred, the recidivism measure would not detect this repeated abusive behavior by the perpetrator. As a result, the current measure, linked to the individual child and specific household, could understate patterns of repeat abuse that may assist CPS in better identifying the true risk level and provide more effective intervention.

DFPS links reoccurrence of abuse to the child, not the perpetrator.

Fails to track CPS' effectiveness at intervening in patterns of abuse. The agency targets most of its services to parents, but the current recidivism measure generally does not track and report the number of caregivers receiving services that subsequently abuse another child. As a result, the current measure does not fully capture the success of services provided to each caregiver and may misstate the number of perpetrators who reabuse children. For example, the current measure shows recidivism within a household that received services through CPS. If an investigator confirms that a mother neglected her child and the family receives Family-Based Safety Services, and several months later the father in the home abuses the child, this would be counted as recidivism, despite the fact that two different caregivers perpetrated abuse in the same home. Family-Based Safety Services may have positively affected the mother's behavior, but not the father's. Currently, the measure of recidivism would not capture the success of Family-Based Safety Services on the mother's actions because it is not linked to each individual perpetrator.

The agency cannot report how effectively its services reduce perpetrator recidivism.

Without a recidivism measure linked directly to the perpetrator of the abuse, the agency cannot fully measure the success of the intervention and cannot assess the broader effectiveness of services provided to specific parents with specific needs. By using both the measure of recidivism linked to the child and the recidivism of the caregiver, DFPS could report how accurately they

discerned the safety of the child and how effectively services worked to prevent caregivers from repeating abusive behavior.

- **Unsure findings may not accurately reflect the risk to children.** When the agency cannot conclusively rule out or confirm abuse, it assigns an unable-to-determine or unable-to-complete disposition. High numbers of unsure findings could indicate deficiencies with the quality of the investigation, such as the caseworker not gathering enough evidence through interviews, not seeking a medical opinion, not talking to the right people surrounding the family, or not being able to find a family that relocated. While DFPS expects some level of these inconclusive dispositions, Sunset staff case reviews, interviews with agency staff, and an internal agency report indicate that caseworkers have misused the dispositions, resulting in a distorted number of unsure findings.

High numbers of unsure findings may indicate problems with the quality of the investigation.

Unable to Determine. CPS policy states that caseworkers should assign unable-to-determine findings to allegations which lack sufficient evidence to confirm abuse or neglect, but for which not enough evidence exists to rule it out. According to Sunset staff's interviews with agency staff and review of case files, caseworkers in practice sometimes assign findings of unable to determine when the evidence is sufficient to indicate that the abuse or neglect occurred, but the identity of the perpetrator is unclear. The level of risk to children is clearly higher in cases with confirmed abuse or neglect compared to cases with unconfirmed abuse or neglect. CPS' existing policy does not provide enough direction to caseworkers on how to assign the unable-to-determine disposition in this previously discussed scenario or clearly define appropriate action. Assigning an unsure finding when abuse can be confirmed understates the risk to the child in the home and distorts the case history, which is critical for helping caseworkers fully assess risk in future investigations.

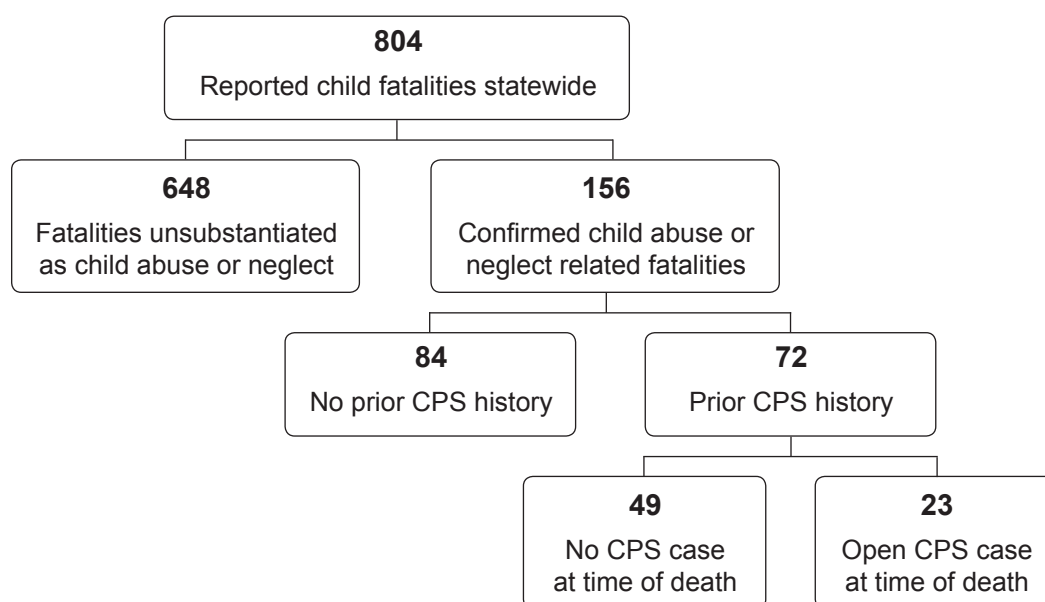
Assigning an unsure finding when abuse can be confirmed understates risks to the child.

Unable to Complete. CPS policy states that caseworkers should assign unable-to-complete findings only when the family cannot be located or the family cannot be mandated to cooperate with the investigation through a court order. Discussions with stakeholders and a CPS internal report highlight the need for further clarification of and training on this policy, as caseworkers may be assigning unable-to-complete findings inappropriately. A significant difference in risk to the child exists between cases in which the family moved or could not be accessed, compared to cases in which the caseworker collected enough evidence to decide not to rule out an allegation. Without clearer policy and training on the appropriate use of the dispositions, caseworkers may not accurately document and track the risks to children.

- **CPS' current fatality investigation review process does not comprehensively assess quality of these investigations.** The number of child fatalities due to abuse or neglect each year is a valuable measure to CPS, especially in cases with prior CPS involvement. Currently, CPS' intensive child fatality review process includes several levels of qualitative review, and is intended to help CPS determine if changes to policy or

practice are needed to improve future decision making. For child fatality investigations in which the investigator and regional managers conclude that a child's cause of death was abuse or neglect, CPS State Office staff conducts an additional review. If State Office staff disagrees with field staff's finding that a death was due to abuse or neglect, it overturns the disposition. In fiscal year 2013, staff overturned the disposition in 10 cases, representing about six percent of the total number of child fatalities due to abuse or neglect. The chart, *Child Fatalities in the General Population*, outlines total number of fatality investigations and the findings of those investigations in fiscal year 2013.

Child Fatalities in the General Population
FY 2013



While this process serves as additional quality control to ensure that CPS accurately and consistently determines abuse or neglect dispositions, State Office does not perform this review for all CPS child fatality investigations. When CPS field staff concludes that a child's death was not caused by abuse or neglect, CPS State Office does not review these cases to ensure the correct disposition is assigned. By reviewing exclusively the fatalities assigned an abuse or neglect disposition, CPS State Office only checks the quality of a small subset of all fatality investigations, since 648 out of 804 investigations resulted in a finding of unsubstantiated abuse or neglect in fiscal year 2013. Instead, CPS could review a sample of all fatality investigations to properly control for quality more comprehensively.

*CPS only checks
the quality of
a small subset
of all fatality
investigations.*

DFPS does not ensure that services provided through Family-Based Safety Services address the specific risks to children in each family.

While DFPS tracks basic effectiveness of the Family-Based Safety Services program through reoccurrences of abuse or neglect within one year, the agency does not track the effectiveness of specific services offered to evaluate each service's effectiveness at mitigating specific safety risks. A more comprehensive assessment of services provided could allow DFPS to focus on those that most effectively address safety risks and prevent reentry into the CPS system. If DFPS identifies ineffective services, the agency could in turn redirect those resources. This would better position the agency to help prevent repeated incidents of child abuse or neglect in the same families.

Service plans are often generic and not linked to specific safety risks.

- **Services not tailored to family members' needs.** Once CPS accepts a family into Family-Based Safety Services, caseworkers assign services to family members to reduce the safety risks to the child in the home. However, caseworkers and stakeholders described these service assignments as generic and not specifically tailored to each family member's needs. Without linking each service to the identified safety risk, DFPS cannot ensure that services effectively reduce the risk of abuse or neglect. The agency is also unable to ensure that caseworkers tailor service plans to each family member. Linking safety risks to services would also allow the agency to better capture and evaluate the effectiveness of each service.
- **Lack of evaluation of service effectiveness.** The agency does not currently know which services provided through Family-Based Safety Services work most effectively at preventing future abuse and neglect. While DFPS captures recidivism rates for Family-Based Safety Services as a whole, it does not track outcomes for individual services. For example, the agency does not measure how effective domestic violence intervention programs or group therapy sessions are at reducing child abuse in the home. The agency should conduct more thorough assessment of performance outcomes for each service provided, in addition to the overall performance measures for Family-Based Safety Services, to better understand how to most effectively direct its limited resources. One resource DFPS already uses to measure outcomes of its prevention services is the Protective Factors Survey, which is also used by other states to demonstrate the effectiveness of services similar to Family-Based Safety Services. If each service had performance outcomes, the agency could identify services that did not have a clear impact on improving child safety. The agency could use that information, in tandem with the surveys caseworkers complete related to the quality of service providers, to only allocate funding to effective services.

The agency does not know which family-based services are most effective in preventing abuse.

DFPS lacks clear and consistent policies for referrals to Family-Based Safety Services.

The agency does not have a standardized system for determining which families CPS accepts for services. The types of families in need and degrees of risk

accepted for services vary across regions, counties, and even individual managers. For example, while in some areas of the state the agency limits eligibility for services to families with substance abuse and domestic violence problems, in other areas it accepts a broader array of families. When interviewed by Sunset staff, CPS investigators expressed confusion about which types of cases are appropriate for Family-Based Safety Services. A DFPS internal management report also highlighted the gap between which families qualify for services from the investigator's perspective and which families supervisors accept in practice. Investigators also described the case transfer process as cumbersome and highly contingent upon the Family-Based Safety Services supervisor to determine if the family receives services. The agency is currently working to streamline this policy to standardize criteria, but has not yet completed or implemented this process.

The type of families accepted for Family-Based Safety Services varies by region and even by supervisor.

CPS does not know how effective certain investigations resources are because it does not meaningfully track usage and outcomes.

Caseworkers use special investigators, child advocacy centers, and the Forensic Assessment Center Network to conduct more forensic investigations or collect more forensic information before confirming or ruling out allegations. While the intent of these resources is clear, caseworkers may use them inconsistently or are simply unaware they exist. Because the agency does not gather easily aggregated data on the usage of these resources or when the resources would have been most appropriately used, DFPS cannot evaluate whether caseworkers appropriately and consistently take advantage of such resources.

- **Unclear role and added value of special investigators.** Special investigators' role in CPS has shifted over time, from carrying cases to consulting on complex or high profile cases. Stakeholders and agency staff expressed mixed sentiments on the added value of special investigators. Review of internal documents revealed significant variations in the use of special investigators and confusion on what tasks are most appropriate for special investigators to perform.² DFPS published a list of tasks appropriate for special investigators, but also allows regional directors to assign special investigators other tasks as necessary, such as carrying caseloads in areas where caseloads are highest. The agency also hired special investigators to provide more forensic expertise in CPS through training and consultation. However, a DFPS internal report shows that less than half of the special investigators reported being asked to provide consultation to investigative staff and less than a third reported being asked to train or model advanced interview techniques to investigative staff.³

Stakeholders and agency staff expressed mixed sentiments on the added value of special investigators.

One of the agency's goals for special investigators was to reduce the number of unsure findings by incorporating additional forensic expertise. From fiscal year 2006 to 2009, unsure findings decreased by six percentage points. However, from fiscal year 2009 to 2013, unsure findings remained stagnant, making up between 12 and 13 percent of all completed investigation dispositions.

The agency does not track usage of available resources to gauge benefits to CPS investigations.

Since first hiring special investigators in 2006, the agency has reduced the number of full-time equivalent positions from 430 to 202. While the agency is still trying to find the best and most consistent fit for special investigators, DFPS has not clearly demonstrated to staff and stakeholders the added value of special investigators.⁴ Interviews with agency staff and stakeholders indicated that many of the special investigators' tasks could be handled by caseworkers or other CPS staff, such as child safety specialists, diligent search units, and agency law enforcement liaisons.

- **Not ensuring maximum use of the child advocacy centers.** While child advocacy centers provide value to for both CPS and law enforcement on sexual abuse and other serious abuse cases, DFPS does not track their usage systematically. By not identifying and tracking the number of cases that would have benefited from the use of a child advocacy center, the agency cannot ensure that caseworkers maximize use of the resource.
- **Not ensuring maximum use of the Forensic Assessment Center Network.** The network provides medical input on complex abuse and neglect cases, but DFPS does not track its usage systematically. The network allows caseworkers to send electronic medical documents to doctors who specialize in child abuse and neglect; the doctors examine the records and determine whether they are consistent or inconsistent with the alleged abuse or neglect. Stakeholders reported that many caseworkers do not receive adequate training on the benefits of the network and do not maximize its use.

Recommendations

Management Action

5.1 DFPS should add an additional measure of recidivism linked to the alleged perpetrator.

This recommendation would direct DFPS to develop and evaluate an additional measure of recidivism linked to individual perpetrators to assess the effectiveness of CPS services in preventing repeated abuse or neglect by parents or other caregivers. This measure could use the designated perpetrator role already used in the agency's IT system to track the rate of recidivism for designated perpetrators and caregivers with unknown roles. Similar to the current recidivism measure linked to children, the new perpetrator measure could track how many caregivers in all investigations subsequently perpetrated abuse or neglect in another investigation within 12 months, as well as how many caregivers who received services, regardless of their role, perpetrated abuse or received services again within 12 months. Adding this measure would allow DFPS to better identify patterns of abuse perpetrated by one caregiver against multiple children and in multiple households. Monitoring and evaluating this data would also allow the agency to identify high recidivism rates among parents who received services or did not receive services, to better understand the effectiveness of the agency's intervention. DFPS should also continue to track the current recidivism measure linked to the child.

5.2 The agency should clarify and standardize the use of unsure case findings.

This recommendation would direct DFPS to clarify through policy and additional caseworker training the appropriate use of each disposition finding, especially unable-to-complete and unable-to-determine findings. For example, this policy should clearly distinguish between findings of unable to determine,

where the evidence does not clearly suggest that abuse or neglect occurred, and findings of reason to believe, where the evidence indicates that abuse or neglect occurred, but the identity of the perpetrator is unclear. This recommendation would help ensure that caseworkers assign the most accurate dispositions to each allegation, improving the quality of the agency's data and allowing for better tracking of risk and outcomes for children and families.

5.3 DFPS should broaden its child fatality investigation review to include a sample of all fatality investigations.

This recommendation would direct DFPS to broaden its current review process to include a sample of fatality investigations with all disposition findings, including fatalities ruled out for being related to abuse or neglect. The sample should include a representative number of each type of disposition, depending on the cases submitted to be closed by the regions.

Under this recommendation, *all* fatality investigations confirmed to be closed by the lead child safety specialist responsible for the investigation would be submitted to State Office staff in much the same way as abuse and neglect-related cases are currently submitted for review. The case review would be modeled after the review currently conducted on abuse or neglect-related fatalities, but would allow the review team to ask the regional staff to gather more information and come back for second review before the case is closed and the disposition finalized.

The size of the sample and model for reviewing the fatality investigations should be determined outside of CPS, to ensure objectivity in the model. DFPS could use other existing units, such as Management and Reporting Statistics or the Center for Policy Innovation and Program Coordination, to determine an appropriate sample size and help develop the review methodology.

By broadening the scope of fatality investigation reviews, the agency would better ensure it accurately reports the number of fatalities due to abuse or neglect each year and have a more comprehensive quality control process for all child fatality investigations.

5.4 The agency should develop a clear and consistent policy for referring families to services.

Under this recommendation, DFPS would develop policy establishing clear standards for what risk findings or combinations of risk indicators make a family eligible for Family-Based Safety Services. The policy should also include a streamlined chain of command for ultimately determining if a family receives services that is outside of the Family-Based Safety Services program area, such as using the regional risk managers, to ensure objectivity. A clear and consistent process would increase the value of Family-Based Safety Services outcome measures, if the same types of families are accepted across the state. The process would also increase the perception of fairness and lessen confusion among investigations staff, since the variables allowing a family to be accepted would be consistent and universally applied. As a result, case transfer would be less cumbersome and more predictable.

5.5 DFPS should develop more specific outcome measures for Family-Based Safety Services.

To accurately gauge the success of each family-based safety service provided, the agency should require caseworkers to link each service to an identified safety risk or risks that the service is intended to reduce. The agency could then examine how well specific services work. For example, the agency could evaluate all the cases involving domestic violence in the home and the rate of recidivism for families that completed domestic violence programs. DFPS could also look at the rate of recidivism among families overall that

receive group therapy, compared to the rate among families with domestic violence present that received group therapy. Another performance measure the agency could consider is how quickly caseworkers are able to close cases involving families, depending on the service provided. Overall, DFPS should develop a process to more closely link individual services to specific identified safety risks.

Developing better measures would also allow the agency to identify services that do not significantly improve child safety, which would allow CPS to focus on providing only those services that effectively keep children safely in their homes. Improved measures would also better equip the agency to ensure that caseworkers tailor services to family members' specific needs, minimizing the use of generic service plans and expenditure of limited resources on ineffective services.

To successfully achieve this recommendation, CPS should conduct an initial study of Family-Based Safety Services outcome measures to identify those best suited to judging the success of specific services provided in relation to specific risks. The agency should explore the applicability of the Protective Factors Survey currently used to measure outcomes of its prevention services to measure outcomes for Family-Based Safety Services. Another opportunity the agency has to develop these measures and capture the necessary data for evaluating effectiveness is through the IMPACT modernization process, in which CPS is redesigning its IT system to make it better fit the agency's needs. As part of this process, DFPS should identify the measures needed to evaluate Family-Based Safety Services outcomes and ensure capability in the redesigned system to capture needed data. Once the agency determines the services' effectiveness, CPS can in turn better train and guide caseworkers on which services to most appropriately use to reduce the risk of repeat abuse or neglect based on each family's needs.

5.6 DFPS should monitor the use and evaluate the effectiveness of investigation resources.

This recommendation would direct DFPS to monitor the use of investigation resources and in turn evaluate the use of these resources to confirm or rule out allegations of abuse or neglect. The agency should develop a process for identifying cases that would benefit from child advocacy centers, the Forensic Assessment Center Network, or special investigator input. The agency should also identify the number of cases that actually used these resources. Both measures would allow the agency to identify areas in which caseworkers are missing opportunities for effectively using these resources.

Monitoring the use and opportunity for use of these resources would also allow the agency to gauge how effective the resources are at confirming or ruling out allegations of child abuse or neglect. The agency does not currently measure use of these resources against performance outcomes, such as lower unsure disposition rates or fewer incidents of recidivism. If this data cannot currently be collected, ensuring IMPACT can capture this data through the agency's IMPACT modernization process would be one way the agency could achieve systematic data collection and easier evaluation.

Fiscal Implication

These recommendations would not have a significant fiscal impact on the State. While many of the recommendations require the development of performance measures or clarification of policy, the agency already contributes significant resources to units within the agency and within CPS to these functions. Additionally, the Legislature has invested significant funding to allow DFPS to update its case documentation system, IMPACT. Through its planning efforts, DFPS can ensure the system is capable of capturing needed measures for better evaluation of CPS interventions, services, and use of investigation resources.

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¹ S.B. 6, 79th Texas Legislature, Regular Session, 2005.

² Texas Department of Family and Protective Services, *Special Investigator Report* (Austin: 2012), pp. 3-6.

³ Ibid.

⁴ Ibid.

ISSUE 6

DFPS Should Elevate the Importance of Its Prevention and Early Intervention Efforts and Better Use Existing Data to Evaluate Program Effectiveness.

Background

Prevention is always a hard sell for governments when the need for a more immediate response is obvious. So it is for programs intended to prevent child abuse and neglect when the actual incidence of abuse and neglect strains the ability of Child Protective Services (CPS) to adequately respond. In the budget-cutting session of 2011, the Legislature reduced funding for prevention programs, in favor of frontline caseworkers. Despite such pressures, preventing poor outcomes is always preferable to the incalculable costs associated with child death or injury or broken homes, the intensive intervention of foster care, and the ongoing effects of trauma on people's lives. In 2013, the Legislature restored funding for prevention at the Department of Family and Protective Services (DFPS), adding \$26.8 million for the biennium, including funding for two new programs.

The agency's Prevention and Early Intervention division, housed within CPS' contracting arm, provides a variety of services to children and families primarily directed at preventing child abuse and neglect and juvenile delinquency, such as those listed in the accompanying textbox.¹ DFPS provides these services entirely through contracts with providers. Certain prevention programs are mandated by statute or budget rider and have specific line items in DFPS' appropriations, while other funds are more discretionary in nature.

Appendix E, *Department of Family and Protective Services Prevention and Early Intervention Programs*, provides more detailed descriptions of each program, with basic information on clients served and 2013 expenditures for each. The appendix also shows the 2014 budgeted amounts to reflect the Legislature's funding increases.

Measuring the impact of prevention programs is not a simple matter, but DFPS uses an approach designed to measure the effect its programs have on a family's protective factors, or factors known through research to be associated with reduced incidence of child abuse and neglect. DFPS uses the Protective Factors Survey, a nationally validated survey tool used by 25 other states. The survey is designed to measure changes in family characteristics shown to be protective against child abuse and neglect for participants of prevention programs as a way of judging the impact of those programs. Protective factors measured by the survey are listed in the textbox, *Protective Factors Survey Measurements*.

DFPS Prevention Services

- Home visits
- Parent and family education
- Respite care
- Youth mentoring
- Career preparation and youth employment programs
- Family and individual counseling, including crisis counseling

Protective Factors Survey Measurements

- Family functioning and resiliency
- Social and emotional support
- Concrete support
- Child development and parental knowledge
- Nurturing and attachment

Additionally, statute requires DFPS to contract primarily for evidence-based programs, which are programs evaluated through research and shown to be effective.²

As the state's child protection agency, DFPS provides at-risk families a continuum of services that share some of the same basic objectives of preventing abuse and neglect, as shown in the textbox, *CPS Service Delivery Continuum*. The Legislature created Alternative Response in 2013 as a flexible response system

CPS Service Delivery Continuum

Lower risk: Prevention and Early Intervention

- Provides services aimed at preventing families from entering the CPS system, such as home visiting and family counseling.

Medium risk: Alternative Response

- New CPS stage of service designed to address less severe allegations of abuse and neglect without using a traditional CPS investigation, to start in November 2014.
- Provides voluntary services and continually assesses parents' protective capacities.

Higher risk: Family-Based Safety Services

- CPS stage of service designed to help families in which abuse or neglect has already been confirmed or risk factors for child abuse and neglect are present to help prevent the need for removal.
- Family-Based Safety Services caseworkers create a service plan to address existing safety risks to children, such as domestic violence intervention or substance abuse treatment. These services may be court ordered.

to address certain less serious cases by working with the family and providing services, instead of conducting a traditional investigation. DFPS has not yet implemented Alternative Response, but the agency expects CPS caseworkers will make referrals to certain prevention programs, particularly those that offer home visitation and other forms of parent education, to reduce further risk to children. Family-Based Safety Services provides intervention services to families with higher risk levels or already confirmed abuse or neglect, similar to services provided through the agency's prevention programs and Alternative Response, such as family counseling, parenting education, and home visiting.

As part of its prevention component, the Health and Human Services Commission (HHSC) administers the federally funded Texas Home Visiting Program, started in 2011, as well as the state and federally funded Nurse Family Partnership, started by the Legislature in 2008.³ These programs are home-based interventions conducted by trained professionals to assist parents of young children and expectant parents, focusing on reducing incidence of child abuse and neglect, reducing domestic violence, increasing school readiness, and improving maternal and child health. HHSC spent about \$11.1 million

in fiscal year 2013 in federal funds for the Texas Home Visiting Program, serving 1,762 families as of July 2013. HHSC used a combination of state and federal funds totaling \$8.8 million for the Nurse Family Partnership program, serving about 1,700 families in fiscal year 2013.

The Texas Department of State Health Services (DSHS) operates two programs that focus on serving parents that have risk factors for substance abuse, many of whom are already involved in the CPS system. The Pregnant Post-Partum Intervention program and the Parenting Awareness and Drug Risk Education (PADRE) program both aim to reduce the risk of parental drug use, improve parenting skills, and prevent domestic violence and child abuse and neglect. These programs are also funded through a combination of state and federal funds, totaling \$4.4 million for Pregnant Post-Partum Intervention and \$700,000 for PADRE with a combined capacity to serve about 5,000 individuals.

Findings

DFPS has not demonstrated the level of commitment needed to reflect its clear responsibility for prevention and early intervention efforts.

The Legislature effectively endorsed DFPS as the state's primary prevention agency last session by increasing its prevention funding by about \$26.8 million for the biennium to total funding of \$88.8 million.⁴ To help ensure that the new prevention investment would result in improved outcomes, the Legislature required DFPS, through appropriations rider, to develop a comprehensive plan spelling out how the agency would spend the money, and seek public input to develop the plan.⁵ The associated funding is relatively flexible with the intent that DFPS use it in ways the agency has not attempted before and emphasize community-based programs. As a result of DFPS' planning effort the agency has created two new programs, described in the textbox, *New DFPS Prevention Programs*. The Healthy Outcomes through Prevention and Early Support (HOPES) program will focus on targeting services to certain high-risk geographic areas and serving families with children age five and younger, who are statistically most at risk of abuse and neglect. The Helping through Intervention and Prevention program will provide home visiting services to parents with prior CPS history to prevent the need for future agency involvement in their lives. This program will likely use HHSC's home visiting contractor network to make needed referrals. Despite the new funding and programs, DFPS' overall approach to prevention needs improvement, as detailed below.

New DFPS Prevention Programs

Helping through Intervention and Prevention

- Statewide home visiting service aimed to provide parental assistance and education to families with prior CPS history who have newborn children.

Healthy Outcomes through Prevention and Early Support

- Community-based child abuse and neglect prevention program targeted to families with children five or younger. It provides classes on child development and parenting skills.

- One of the DFPS commissioner's priorities is to develop ways the agency can better collaborate with communities, including as part of its prevention efforts, but this priority currently lacks a clear path for implementation without a regular strategic planning process for prevention. DFPS currently has no unified, consistent strategy for prevention services and cannot be sure it is targeting the state's most pressing needs or using funds most effectively.
- A program with an \$88 million biennial budget and of high priority to the Legislature should not be buried in an agency contracts function. Prevention has long suffered from a lack of prioritization within the agency, relegated to a purely contracting function within the Purchased Client Services division of CPS. Furthermore, the agency has not established clear ways of communicating and coordinating its prevention efforts with Alternative Response and Family-Based Safety Services, other areas of CPS that have a prevention or intervention focus and offer some of the same types of services to children and families. More consistent, systematic

Despite new funding and programs, DFPS' approach to prevention needs improvement.

coordination among these three areas can help ensure DFPS identifies opportunities for collaboration and develops a unified, consistent strategy across its prevention and intervention continuum.

- Despite challenges, DFPS has made some recent progress in setting up the types of coordination and leadership needed to move the program forward. Recognizing the need for prevention to not only be a contracting function, but also a true program within the agency, DFPS has begun to split contracts and program staffs into separate, distinct groups using additional funds for staff appropriated for the 2014–2015 biennium. This approach will allow the agency to better focus staff on both of these critical areas. Contracting staff are clearly needed to manage and monitor contracts, but prevention also needs program staff to focus on identifying the most critical needs and services it should contract for, and targeting its limited funding in the most effective manner.

DFPS does not adequately use data it already collects to inform decisions or demonstrate outcomes to the Legislature and the public.

Proper collection and analysis of outcomes data is vital to show the effectiveness of prevention programs. For example, it could help the agency make more informed decisions on the programs and services in which it invests limited funds. If data indicate that certain prevention programs are showing better outcomes than others, then DFPS can redirect funds to those programs that are more effective and maximize the benefit gained from limited funding. More robust data analysis can also help to improve the prevention program's long-term strategic planning, since staff can be more informed on which programs are working to further goals established in the plan and be able to better measure and show progress.

The lack of performance measures to show impact of prevention efforts could put funding at risk in austere budget times.

DFPS collects a significant amount of potentially useful outcomes data from its contractors, primarily using the previously mentioned Protective Factors Survey.^{6,7} While DFPS has made some efforts to develop performance measures and determine how to use the data collected, it has not yet adequately developed clear, meaningful performance measures or a framework for analyzing this data to demonstrate the impact of its prevention programs. As a result, DFPS misses an opportunity to better tell the story of how its prevention programs impact the lives of Texans to the both the Legislature and the public, putting its prevention dollars at greater risk of future cuts, particularly in times of limited budgets when prevention programs are often the first programs cut or eliminated. The program has suffered from significant funding reductions in times of budget austerity, particularly in 2003 and 2011.

Certain prevention programs at HHSC and DSHS are a better fit for DFPS' child abuse and neglect prevention efforts.

While home visiting programs lead to a number of positive outcomes, research has shown these types of programs, such as HHSC's Nurse Family Partnership

and Home Instruction for Parents of Preschool Youngsters, to be the single best intervention for preventing child abuse and neglect.^{8,9} The goal of these programs to improve health and well-being, reduce abuse and neglect and domestic violence, and improve self-sufficiency are clearly in line with DFPS' mission of protecting children and enabling families to stay together without the need for CPS intervention.

The Department of State Health Services has two prevention programs, Pregnant Post-Partum Intervention and PADRE, that are directed at parents who have risk factors for substance abuse, many of whom are already involved in the CPS system. By targeting substance abuse, these programs address a primary reason for families' involvement in CPS. These programs also seek to improve parenting skills, promote healthier parent-child relationships, and prevent family violence. While aspects of these programs also relate to health outcomes, their emphasis on risk factors for child abuse and neglect makes them a good fit with DFPS' goal of preventing harm.

DFPS currently provides home visiting services as part of several prevention programs, including its new HOPES and Helping through Intervention and Prevention programs, funded by the Legislature just last session. DFPS prevention programs offering home visiting are listed in the accompanying textbox. Separating the State's home visiting programs between two agencies unnecessarily fractures the provision of comparable and complementary services in the effort to protect families and children. Housing all home visiting programs at DFPS would provide an opportunity for the agency to strengthen its existing continuum of services to at-risk families.

DFPS Programs Offering Home Visitation Services

- Community-Based Family Services
- Texas Families Together and Safe
- Community-Based Child Abuse Prevention
- Healthy Outcomes through Prevention and Early Support
- Helping through Intervention and Prevention

Recommendations

Change in Statute

6.1 Require DFPS to develop a comprehensive strategic plan for its prevention and early intervention programs.

This recommendation would require DFPS to develop a five-year strategic plan for its prevention and early intervention programs with annual updates detailing progress in implementing the plan. In building the plan, DFPS should include the following approaches and elements.

- Proactively involve stakeholders and communities in the planning process.
- Identify ways to leverage other sources of funding or provide support for existing community-based prevention efforts.
- Include a needs assessment to target highest risk populations and geographic areas, identifying programs that best target these needs.

- Establish goals and priorities for the agency's overall prevention efforts.
- Report results from previous prevention efforts using available data in the plan.
- Identify additional ways of measuring program effectiveness and results or outcomes.
- Identify ways to collaborate with other state agencies on prevention efforts.
- Identify specific strategies to implement the plan as well as develop measures to allow for reporting on overall progress toward the plan's goals.
- Post the plan on the agency's website.

DFPS would be required to develop the first plan no later than September 1, 2016, and adopt subsequent plans every five years thereafter. DFPS should update the plan on an annual basis and provide this update to the Legislature. A regular planning process would help DFPS best guide its prevention efforts and help ensure the agency uses limited funding in the most effective manner.

6.2 Transfer the Nurse Family Partnership Program to DFPS.

This recommendation would transfer authority to administer the State's Nurse Family Partnership program from HHSC to DFPS, including associated funding and staff. The statute would authorize DFPS to administer the program and assume all existing contracts. This transfer would help solidify DFPS' continuum of services to at-risk families by placing a program with proven effectiveness against child abuse and neglect within the appropriate agency.

Management Action

6.3 Direct HHSC to work with DFPS to transfer the federally funded Texas Home Visiting Program to DFPS.

This recommendation would direct HHSC to transfer funding, staff, and functions of this program from HHSC to DFPS. HHSC has authority to transfer the program and associated funding and staff to DFPS given the consolidated enterprise structure of the health and human services agencies. No statutory change is needed to accomplish this transfer, allowing it to occur by September 1, 2015 to align with statutory transfer of the Nurse Family Partnership under Recommendation 6.2, and the transfers contemplated in Recommendation 6.4. This transfer of HHSC's federally funded home visiting program would help DFPS solidify its prevention and early intervention efforts by charging the agency with a program with clear linkage to child abuse and neglect prevention.

6.4 Direct HHSC to work with DFPS and DSHS to transfer the Pregnant Post-Partum Intervention program and the Parenting Awareness and Drug Risk Education program to DFPS.

This recommendation would direct HHSC to transfer funding, staff, and functions of the Pregnant Post-Partum Intervention program and the Parenting Awareness and Drug Risk Education program from DSHS to DFPS. HHSC has the authority to transfer the programs and associated funding and staff to DFPS due to the consolidated structure of the health and human services agencies. No statutory change is needed to achieve this transfer, allowing it to occur by September 1, 2015 and align with statutory transfer of the Nurse Family Partnership under Recommendation 6.2, and the Texas Home Visiting Program under Recommendation 6.3. DSHS staff indicates the optimal time for such a transfer is at

the time of contract renewal, which occurs at the end of the fiscal year and aligns with the transfer date in this recommendation. This transfer would expand and strengthen DFPS' prevention continuum to provide a wider array of services directly targeted at preventing child abuse and neglect.

6.5 Direct DFPS to develop a strategy to use existing data to better focus its prevention efforts and report the outcomes of its programs.

Under this recommendation, DFPS should develop a strategy to better use existing data, primarily the Protective Factors Survey. The agency should develop meaningful performance measures and determine the most effective way of analyzing the significant amounts of data already being collected by DFPS contractors and reported to the agency. Stronger analysis and use of this data would assist DFPS to better evaluate the efficacy of each program and contractor and make more informed decisions on services to provide. DFPS should report to the Sunset Commission by October 2016, in time for the evaluation of implementation of Sunset recommendations. Once DFPS develops a more cohesive strategy for using the survey data and develops performance measures, the agency should report this data in its annual data book to publicly show the impacts of its prevention efforts.

Fiscal Implication

Given the Legislature's significant investment in child abuse and prevention efforts, prudent, focused, and effective use of these funds is essential. These recommendations are intended to provide DFPS with a framework to better plan and focus expenditure of prevention funds. Condensing all similar programs within one agency's planning and operational efforts will also allow for more efficient and better-targeted use of these funds. The following information details the fiscal impact of implementing these recommendations.

Recommendation 6.1 requiring a strategic planning process would not have a cost, since DFPS has conducted similar planning efforts previously using existing staff, and planning is an expected component of agency operations. Similarly, Recommendation 6.4 would not have a cost.

Recommendations 6.2 and 6.3 directing the transfer of the Nurse Family Partnership and the Texas Home Visiting Program from HHSC to DFPS would not have a fiscal impact to the State, but would require transferring appropriated general revenue, federal grant funding, and 18 employees from HHSC to DFPS, which would occur by September 1, 2015. HHSC reports these transfers could occur without any funding or other barriers.

Recommendation 6.4 would require the transfer of about \$5 million in state and federal funds and one employee from DSHS to DFPS for the Pregnant Post-Partum Intervention program and the Parenting Awareness and Drug Risk Education program. DSHS staff indicates this transfer may require a contract between DSHS and DFPS, since the funding for the Pregnant Post-Partum Intervention program comes from a federal substance abuse block grant tied to DSHS.

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¹ Chapter 265, Texas Family Code.

² Section 265.004, Texas Family Code.

³ Social Security Act, Title V, Section 511 (42 USC § 711), as amended by Section 2951 of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

⁴ Goal C: Prevention Programs, page II-34, Chapter 1355 (H.B. 1), Acts of the 82nd Legislature, Regular Session, 2013 (The General Appropriations Act); Goal C: Prevention Programs, page II-34, Chapter 1411 (S.B. 1), Acts of the 83rd Legislature, Regular Session, 2013 (The General Appropriations Act).

⁵ Rider 30, page II-45-46, Article II (S.B. 1), Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

⁶ FRIENDS National Resource Center for Community-Based Child Abuse, University of Kansas Institute for Educational Research and Public Service, *The Development and Validation of the Protective Factors Survey: A Self-Report Measure of Protective Factors Against Child Maltreatment*, accessed March 28, 2014, http://friendsnrc.org/direct-download-menuitem/doc_download/158-protective-factors-survey-phase-4-summary-slides.

⁷ The states using the Protective Factors Survey are: Alabama, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Montana, Nebraska, New Mexico, New York, Nevada, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin.

⁸ "Preventing Child Abuse and Neglect," Nurse Family Partnership National Service, accessed April 4, 2014, <http://www.nursefamilypartnership.org/proven-results/Preventing-child-abuse-and-neglect>.

⁹ Texas Statewide Blue Ribbon Task Force, *The Texas Statewide Blue Ribbon Task Force Final Report*, accessed March 28, 2014, <http://www.blueribbontaskforce.com/btrfdrupal/sites/default/files/Statewide%20BRTF%20Final%20Report.pdf>.

ISSUE 7

A Lack of Administrative Flexibility and an Antiquated Fee Collection Process Limit DFPS' Ability to Recover Regulatory Costs.

Background

The Child Care Licensing program (CCL) at the Department of Family and Protective Services (DFPS) regulates child care operations that range from day care facilities to residential child care facilities, such as child placing agencies used by the State's foster care system. The agency seeks to ensure the safety of children by establishing standards for facilities; licensing or registering these facilities and inspecting them for compliance with standards; investigating allegations of abuse and neglect or other complaints; providing technical assistance to facilities or taking enforcement action, as needed, to address problems; and providing information to the general public to help them make informed decisions regarding child care.

Funding for the program totaled \$34.1 million in fiscal year 2013, with state general revenue accounting for \$11.6 million, or about one-third. Federal funds made up almost all of the remaining funding, with the Child Care Development Fund Block Grant, administered by the Texas Workforce Commission, providing \$19.1 million, Foster Care Title IV-E funding coming in at \$2.2 million, and Title XX Social Services Block Grants providing just under \$1 million. Federal funds pay mostly for day care regulation. On the other hand, DFPS pays for the regulation of residential child care facilities from state funds.

While the use of federal funds to pay for two-thirds of its child care regulatory effort sets CCL apart from typical state regulatory programs, CCL is like other regulatory programs in charging fees to cover regulatory costs. Statute specifies the type and amount of each fee, as described in the chart, *Child Care Licensing Fees*. Statute also details when the fee is due and the consequences of failure to pay on time. Child care licensing fees are deposited in general revenue.^{1,2} In addition, annual fee payments are not connected to a license renewal process. All licenses are non-expiring once an operation demonstrates compliance with regulations under a one-year initial permit.³ The agency sends fee notices to licensees, and receives payment by mail. Web-based payments are not available.

Child Care Licensing Fees

Type	Amount
Licensed child care facility	
License application fee	\$35
Child care facility initial license fee	\$35
Child care facility annual license fee	\$35+\$1 for each child the facility is permitted to serve
Registered or listed family homes	
Registered family home annual registration fee	\$35
Listed family home annual listing fee	\$20
Child placing agency	
Child placing agency initial license fee	\$50
Child placing agency annual license fee	\$100

Findings

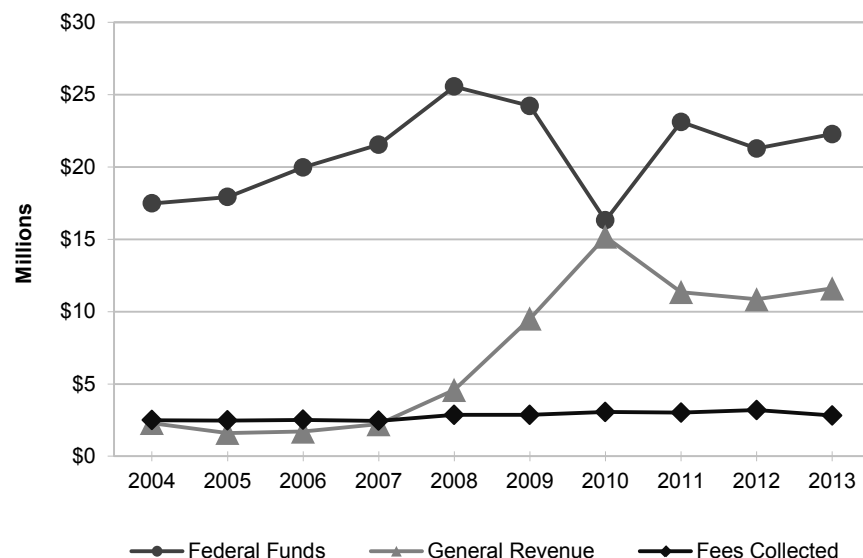
DFPS lacks authority to set regulatory fees in rule, constraining its ability to recover costs and fund other child protection initiatives.

The Legislature has established a practice in many regulatory programs of eliminating statutory fee amounts and allowing agencies to set fees in rule. The Legislature essentially sets the caps for fees by appropriating specific amounts of expected fee collections back to an agency. This practice allows for greater administrative flexibility and is consistent with the general practice for most agencies to set fee amounts necessary to recover the cost of regulation. Greater flexibility to set fees in rule allows agencies to adjust fees as conditions change and to recover a greater share of the cost of regulation if so determined by the Legislature. In addition, by having to set fee levels in rule, the agency provides greater opportunity for stakeholder and public participation.

Statutory child care licensing fees have not increased in almost 30 years.

Statutory child care licensing fees have not been increased since 1985. In fiscal year 2013, licensing fee collections totaled \$2.8 million, compared to general revenue funding of \$11.6 million and a total cost of \$34.1 million for child care regulation. As recently as 2007, fee collections recovered the state's share of funding for CCL regulation. However, as the graph, *CCL Funding Sources*, shows, state general revenue funding has significantly outpaced fee collections since fiscal year 2008. In fiscal year 2013, fee collections accounted for about one-quarter of the State's CCL funding and only 8.6 percent of overall program funding. This gap in fee collections and state funding will be larger still for fiscal year 2014 because of an additional \$4.2 million in general revenue funding aimed at strengthening enforcement against unlicensed operations. Again, this money came without an accompanying fee increase.

***CCL Funding Sources
FYs 2004–2013***



Because fee levels have stayed the same for 30 years, they do not adequately reflect the current regulatory environment and the considerable changes made to ensure greater protection of children. For example, the recent emphasis on criminal background checks for child care workers and enhanced enforcement efforts require additional staff, but with no corresponding revenue increases from the regulated community.

Child care licenses are not subject to renewal, limiting DFPS' ability to ensure timely payment of outstanding annual fees and ensure overall regulatory compliance.

Most state licensing programs require licensees to renew their license periodically, and many attach certain conditions upon the ability to renew, such as paying any outstanding fees or demonstrating compliance with enforcement actions. License renewal also allows agencies to know which operations are still active, particularly those that only require a registration or listing and are not subject to routine inspections that allow licensing staff to keep track of their status.

While statute outlines a license renewal process for DFPS, the agency has elected to make its licenses non-expiring and not subject to renewal.⁴ This approach limits the agency's ability to ensure payment of annual fees and compliance with regulations, since the license continues in effect without re-evaluating the operation's regulatory standing. However, because of problems discussed below, the agency was not able to provide information about overdue fee payments. Also, the lack of a renewal process increases DFPS' difficulty in ensuring current knowledge of which registered and listed operations are still active, important information for consumers.

Non-expiring licenses limit the agency's ability to ensure fee payment and compliance with regulations.

DFPS' paper-based fee collection process is cumbersome, costly, and inefficient for both the agency and its licensees, and does not provide assurance that required fees are paid.

DFPS' current fee collection process inhibits the agency's ability to ensure operations pay required fees, and requires an inordinate amount of agency staff time to administer. DFPS' process consists of mailing a form to the licensee, who then completes the form and returns it by mail along with a check or money order.⁵ Fee collections are then manually entered into a system that does not adequately interface with CCL's licensing information system, resulting in significant difficulty in ensuring complete and accurate fee collections. This deficiency also prevented the agency from providing fee amounts in arrears.

DFPS' fee collection process requires mailing a form with a check or money order.

Aside from being burdensome to licensees and agency staff, a June 2012 DFPS internal audit found several problems with CCL's fee collection and recording practices, such as high error rates and inability to track which operations have not paid required fees.⁶ The textbox on the following page, *DFPS Internal Audit Findings: CCL Fee Collections (2012)*, outlines the audit's key findings. While CCL made some incremental improvements to its fee collection process as a result of this audit, the most impactful change needed is switching to an online fee payment method, which has not yet occurred due to limited resources.

DFPS Internal Audit Findings: CCL Fee Collections (2012)

- Very high error rates in the fee collection process, without DFPS taking remedial actions. Control deficiencies in fee collection and recording practices, with DFPS issuing licenses without first receiving required fees.
- No standard practice to reconcile fees collected and the fee data entered into DFPS' licensing information system, leading to a \$62,068 discrepancy between different accounting systems in fiscal year 2010.
- No consistency in sending notification letters to operations delinquent in paying fees because systems were not in place to alert DFPS to delinquent fee payments.

The Department of Information Resources can help DFPS move to online fee collections through Texas.gov and produce long-term savings and administrative efficiency.

The Department of Information Resources (DIR) operates the State's website, Texas.gov, which facilitates the filing and renewal of more than 700 Texas licenses, including vehicle registration, concealed handgun licenses, birth certificates, and regulatory fees, among others. State agencies are generally required to use Texas.gov for processing payments, unless specifically exempted.⁷ Fifty-three state agencies that require fees payments have moved to digital collections through Texas.gov.

CCL staff has studied the feasibility of a digital fee collection system and found that an online fee payment system would reduce the number of errors and simplify the payment process. Due to cost considerations, DFPS has not yet pursued implementation of an online system. DIR staff has indicated that Texas.gov could provide a solution to collect DFPS license fees online using a Texas.gov application called FeePay. According to DIR, FeePay will undergo upgrades during summer 2014 that will provide the functionality DFPS needs to implement online fee collections. While such a transition would require significant effort on the part of DFPS IT staff and modifications to the licensing information system, the agency could accomplish this transition if given sufficient time to complete implementation in light of limited resources available.

Recommendations

Change in Statute

7.1 Eliminate the agency's statutory licensing and administrative fee caps and authorize fees to be set in rule.

This recommendation would give the agency needed flexibility to adjust fees as appropriate, without passing legislation for each change. All fees would be set by rule, subject to the public comment process in the Administrative Procedures Act. Fees would continue to be deposited to general revenue, and the Legislature would set the fee recovery expectations through the appropriations process.

7.2 Require DFPS to implement a renewal process for child care licenses and registrations.

This recommendation would require the adoption of rules establishing a renewal process for child care licenses and registrations that includes renewal periods, staggering of renewals, dealing with late renewals, and ultimately expirations. Rules should also include conditions for renewal, such as payment of licensing fees and compliance with enforcement actions. Such a renewal process would strengthen the agency's ability to keep track of child care operations and help ensure overall regulatory compliance with child safety standards. This recommendation would not require instituting any new fees. This requirement would not take effect until September 1, 2016, to allow enough time for DFPS to implement online fee collections as recommended in 7.3, since online fee payment capability would make implementing this renewal process much simpler.

Management Action

7.3 Direct DFPS to transition to online child care licensing fee collections.

This recommendation would direct DFPS to work with DIR to ensure that DFPS systems interface properly with Texas.gov for the online collection of all fees associated with the Child Care Licensing program. Under this new fee collection system, all providers would be required to make payments digitally, without the option to use the current paper-based process. DFPS should complete this transition by August 31, 2016, providing sufficient time for the agency to complete the project within current resources and ensure child care providers are aware of the new system. This recommendation would result in significant cost savings and administrative efficiency for DFPS, as well as a much more streamlined and simple system for licensing fee payments, maximizing the timely receipt of such renewals and payments and minimizing error rates. This recommendation does not preclude DFPS from implementing this recommendation sooner or in a different manner if additional funding becomes available.

Fiscal Implication

Recommendation 7.1 could result in a gain to general revenue, but the amount cannot be estimated at this time because the fiscal impact depends on the fee amounts ultimately set in rule.

The implementation of a licensing and registration renewal process under Recommendation 7.2 would not add requirements to the regulated community that would significantly increase the agency's workload. Developing a renewal process for documenting fee payments the agency already requires and dealing with late renewals and expirations would not result in a significant fiscal impact, especially if this provision were implemented in conjunction with transitioning to online fee collections as contained in Recommendation 7.3. By strengthening the agency's ability to obtain timely renewals, this change could increase revenue to the State by reducing delinquencies in renewal fee payments, but the amount cannot be determined. Further, any additional fee-generated state revenue for child care licensing can free up federal funds for other child protection purposes beyond the CCL program.⁸

According to a cost analysis provided by DFPS, Recommendation 7.3 would result in annual savings of approximately \$460,000 due to the elimination of mailing, accounting, and other administrative costs associated with the current paper-based fee collection system once the transition is complete. Switching to a digital system to collect fees would ultimately require much less administrative effort on the agency's part, and would likely increase the overall amount of fees collected since the agency could readily track compliance with fee payments. This additional revenue cannot be estimated, however.

DFPS' transition to Texas.gov would require significant effort on the part of its information technology staff and would require upgrades to the licensing program's data system. DFPS indicates existing staff could make the changes necessary to transition to Texas.gov without the need for outside contracted staff, if given sufficient time to complete the project, due to limited IT resources and other priority projects already scheduled. Once the transition is complete, DFPS would begin to realize costs savings. However, given the mix of federal and state funds used to fund the licensing program and the involvement of other DFPS departments in administering fees, savings to state funds cannot be precisely estimated. Any savings in federal funds could be freed up for other uses.

Department of Family and Protective Services

Fiscal Year	Savings to Federal and State Funds
2016	\$0
2017	\$460,000
2018	\$460,000
2019	\$460,000
2020	\$460,000

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¹ Section 42.054, Texas Human Resources Code.

² Section 42.0521, Texas Human Resources Code.

³ 40 T.A.C. Section 745.347.

⁴ Sections 42.050 and 42.072, Texas Human Resources Code

⁵ 40 T.A.C. Section 745.517.

⁶ Texas Department of Family and Protective Services, *Child Care Licensing Fees Audit* (Austin: June 2012).

⁷ Section 2054.113, Texas Government Code.

⁸ Title XX Social Services Block Grant funds can be used elsewhere in the agency. Foster Care Title IV-E funds could be used if eligible administrative expenses exist in the agency. The availability of Child Care Development Fund Block Grant funds for other uses in the agency would depend on the State's showing that it meets a federal requirement for using these funds for child care quality and availability.

ISSUE 8

The Critical Nature of Its Work to Protect Children and Vulnerable Adults Imposes a Higher Burden on DFPS in How It Obtains Stakeholder Input.

Background

Federal and state laws recognize the importance of open, responsive government by requiring agencies to meet basic standards for public information and public input. Texas statutes, such as the Texas Public Information Act and Texas Open Meetings Act, require all state agencies to follow basic guidelines ensuring minimum standards for public involvement and public information.¹

The Texas Sunset Act directs the Sunset Commission and staff to consider the efficiency and effectiveness with which advisory committees operate.² State agencies use advisory committees to provide independent, external expertise on how the agency's policies and procedures affect certain entities or stakeholders or to help develop recommendations for new agency or state policy directives. The textbox, *Advisory Committees*, provides additional information on the use and structure of these bodies. DFPS has two advisory committees created in statute, the Parental Advisory Committee and the Advisory Committee on Promoting Adoption of Minority Children.^{3,4} In addition, the executive commissioner of the Health and Human Services Commission (HHSC) or the commissioner's designee has the authority to appoint advisory committees under standard provisions governing advisory committees.⁵

Advisory Committees

An advisory committee is defined as a committee, council, commission, task force, or other entity with multiple members that has as its primary function advising a state agency in the executive branch of state government. Typically, advisory committees are standing committees with broad-based jurisdiction that can be created in statute or by a state agency. The Legislature has adopted specific requirements for advisory committees contained in Chapter 2110 of the Texas Government Code.

DFPS has a multitude of stakeholders, including families with children; child care and other protective services providers; courts, local law enforcement, and local prosecutors; nonprofit entities and advocacy groups with an interest in children and family issues; local, state, and federal policymakers; and the public at large. These stakeholders are diverse and spread out across the state, and many have limited time or resources to travel to Austin or provide in-depth, detailed input on complex subject matter. Given the importance of protective services for the state's most vulnerable populations and the level of public interest in DFPS and its functions, public involvement is vital to the agency's operations.

Findings

DFPS lacks a consistent approach to ensure it obtains needed stakeholder involvement.

Despite the importance of stakeholder input to DFPS' mission and functions, the agency does not provide sufficient guidance to its staff on how to involve stakeholders on a regular basis, which can result in inconsistent public involvement efforts. As an agency headed by a single commissioner, appointed

by the executive commissioner of HHSC, the agency does not have a governing body to hold regular public meetings to set policy and make decisions. The Family and Protective Services Council does provide a forum for stakeholders on rules and other matters of interest, but its work occurs late in the process after proposals have been formed and decisions largely made.

Chapter 2110 of the Government Code lays out the basic structure and duties of state agency advisory committees. The chapter creates guidelines for committee membership and reimbursement, and requires state agencies to define the purpose of each committee, and to regularly evaluate committees to determine their continued usefulness. To ensure that committees remain useful, the chapter creates automatic expiration dates for committees four years from their creation, and requires agencies to act, through rulemaking, to continue needed committees.

Involving the public, to be meaningful, should be more than simply following minimum requirements set out in laws and regulations. These efforts should include early and frequent contact with stakeholders, beginning with planning and continuing through implementation of a new rule, policy, or program.

Activities should include outreach tied to decision making and use a variety of techniques targeting different groups and individuals, and must include clear buy-in from senior management and the commissioner to be effective.

While DFPS makes many efforts to gather and use stakeholder input, it relies mainly on informal workgroups, as well as some advisory committees that do not meet standard operating criteria. A sample of these is listed in the textbox, *DFPS Advisory Committees and Workgroups*. As a standard practice, DFPS does not establish its advisory committees in rule, lacks standard operating procedures for them, and does not regularly evaluate their continuing need. Agency staff also routinely uses more informal workgroups to obtain stakeholder input on very specific policy topics, but DFPS has not established any guidance or policy on when staff should create these workgroups and for what purpose.

DFPS Advisory Committees and Workgroups

- Public Private Partnership
- Committee for Advancing Residential Practices
- Parent Collaboration Group
- Youth Advisory Committees
- Interagency Foster Care Committee
- Disproportionality and Disparities Advisory Committees
- CPS Staff Advisory Committees
- Day Care Regional Advisory Committees
- Differential Monitoring Workgroup

DFPS has two statutorily created advisory committees that are difficult for the agency to modify over time to serve its needs.

Statutorily created advisory committees generally fill needs that the Legislature has identified to provide information or expertise to agencies on certain matters. While such advisory bodies impose feedback loops that agencies have not established for themselves, they may also lock agencies into narrowly defined avenues of obtaining information that do not allow flexibility for agencies to change or abolish as needs and priorities evolve. Statutory provisions may also affect the ability of advisory committees to operate effectively to meet the needs of agencies.

One of the agency's two statutorily created advisory committees, the Parental Advisory Committee, does not have a chair, has not met since 2008, and is currently inactive. The Parent Collaboration Group, which DFPS established in 2002 as an informal workgroup, provides input on similar issues of interest to parents and could be expanded to serve broader concerns intended of the Parental Advisory Committee. The Advisory Committee on Promoting Adoption of Minority Children is active and functioning. In the future, however, DFPS may find the need to modify the committee's purpose or composition, which it can more easily accomplish if the committee is established in rule instead of statute.

Recommendations

Change in Statute

8.1 Require rules governing the use of advisory committees, ensuring committees meet standard structure and operating criteria.

This recommendation would require rules be adopted to ensure that any advisory committees DFPS creates are in compliance with Chapter 2110 of the Texas Government Code. DFPS would have to comply with requirements including defining the advisory committee's purpose and responsibilities and regularly evaluating the need for each committee.

Given the importance of stakeholder feedback to DFPS' mission, the agency should also consider including other important structural criteria, not required by law, in either its policy or rules, such as:

- size and quorum requirements of the committees;
- qualifications of the members, such as experience or geographic location;
- appointment procedures for the committees;
- terms of service; and
- compliance with the Open Meetings Act.

8.2 Remove DFPS' two advisory committees from statute.

This recommendation would remove the Parental Advisory Committee and the Advisory Committee on Promoting Adoption of Minority Children from statute. Removing the committees from statute would eliminate one unnecessary committee and also allow DFPS the flexibility to make changes to the other, as described in Recommendation 8.4.

Management Action

8.3 Direct DFPS to clearly define in agency policy the appropriate use of advisory committees and informal workgroups.

Under this recommendation, DFPS should adopt a policy that clearly distinguishes between the purpose and appropriate use of advisory committees and informal workgroups. Informal workgroups would not be subject to the requirements of Chapter 2110, but DFPS policy should ensure workgroups have well-

defined purposes and timelines for completing their tasks. Establishing this policy would help ensure DFPS maintains the appropriate balance between the transparency provided by advisory committees and the ability to obtain more immediate and early input using workgroups.

8.4 Direct DFPS to establish in rule the Advisory Committee on Promoting Adoption of Minority Children.

This recommendation would require rules be adopted recreating the Advisory Committee on Promoting Adoption of Minority Children. While Recommendation 8.2 would remove the committee from statute, this recommendation would direct DFPS to establish it in rule and ensure it follows standard operating criteria described in Recommendation 8.1. Establishing this committee in rule would allow DFPS to continue a useful advisory committee, but allow the agency to make changes as needs and priorities evolve, such as changes to membership or duties.

Fiscal Implication

Requiring rules governing the use of advisory committees would not have a fiscal impact to the State because it would not authorize travel reimbursement for any advisory committees created.

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- ¹ Chapters 551 and 552, Texas Government Code.
- ² Section 325.011, Texas Government Code.
- ³ Section 40.073, Texas Human Resources Code.
- ⁴ Section 162.309, Texas Family Code.
- ⁵ Section 40.030, Texas Human Resources Code.

ISSUE 9

Consider Organizational Aspects Related to Family and Protective Services as Part of an Overall Assessment of Health and Human Services Agencies.

Background

Although the name and organizational structure of the agency charged with providing protective services have shifted over time, Texas has provided these services on the state level since the 1970s, when Congress passed legislation that began federal funding of state child welfare systems and began requiring states to protect elderly adults from abuse, neglect and exploitation.¹ The mission of the Department of Family and Protective Services (DFPS) has three basic elements.

- Protect children by investigating reports of abuse and neglect; providing services to families when risk is indicated; removing children from their homes if not safe; and placing children with relatives or a paid foster placement upon removal.
- Protect adults aged 65 or older and persons with disabilities from abuse, neglect, and exploitation by conducting investigations in clients' homes and in state-run and contracted facilities and providing protective services as appropriate.
- Ensure the safe operation of out-of-home child care providers, including day care centers and foster care providers, through a regulatory program of minimum standards and licensure.

In fiscal year 2013, DFPS employed 10,650 staff, with 8,788 working in 11 regions. Agency expenditures for the same year were \$1.37 billion, about 85 percent of which the agency spent on Child Protective Services, primarily for directly delivery staff and foster care payments. Over half of DFPS' funding, about \$713 million, came from various federal sources, with the balance from general revenue.

Findings

The State has a continuing need to protect its most vulnerable populations from harm.

The State has a fundamental interest and core responsibility in protecting children, the elderly, and individuals with disabilities from abuse, neglect, and exploitation by their caregivers, in both in-home and out-of-home settings. Maintaining the State's primary responsibility for protecting these populations ensures a more consistent statewide effort that would be difficult for local governments and nonprofits to provide in a state as large and diverse as Texas. The State can provide resources and deliver services that local governments typically cannot, at least without a significant investment, which further taxes local capabilities.

If these functions were discontinued, the State would lose federal funding associated with child welfare and other related federal funds, for a total loss of about \$1.5 billion annually to DFPS and to other agencies. For example, the

The state needs a consistent, statewide effort to protect its most vulnerable citizens.

State would lose its entire Temporary Assistance to Needy Families (TANF) federal block grant, since federal statute requires states to carry out child welfare functions to receive TANF funds.² The following material further explains the State's continuing interest in activities for protecting children and vulnerable adults and regulating child care providers.

DFPS' child protection role is fundamentally different from law enforcement's.

- **Child protection.** Protecting children from abuse and neglect at the hands of their caregivers is an unquestioned role of government. Texas has a large and growing child population, totaling almost 7.2 million at the end of fiscal year 2013.³ The number of confirmed reports of abuse and neglect totaled 40,249 for the same year, and involved 66,398 confirmed child victims.⁴ While the most serious incidents become matters for criminal prosecution with law enforcement focusing on gathering evidence and building a case against a perpetrator, the State's role is to protect children and to preserve and reunify families. Law enforcement is not trained or equipped to provide services and case management to families needing assistance to keep children safe and help ensure their well-being.

The State is able to provide the focus and infrastructure to deliver resources and services to protect children and assist families throughout Texas, ensuring a minimum level of protection and services that likely would not otherwise exist. The State also maintains a foster care system to provide care for children who cannot live safely with their parents and are placed in the State's conservatorship by the courts. Although important aspects of the child protective services system could be improved, as discussed elsewhere in this report, this state-level approach is well suited to providing the focused, consistent approach for protecting children in a state as large and diverse as Texas.

Many incidents of harm against vulnerable adults do not fit definitions of criminal conduct.

- **Protection of vulnerable adults.** The government has an interest in protecting older adults and individuals with disabilities from abuse, neglect, and exploitation to ensure that these vulnerable populations are not harmed, either through self-neglect or at the hands of a family member or caregiver. The 3 million people in Texas aged 65 or older comprise one of the fastest-growing segments of the state's population. They and individuals with disabilities are at risk because of their inability to tend to their own safety needs. Many allegations do not fit legal definitions of criminal conduct, but still involve significant harm to these individuals. The State is able to perform a role that law enforcement and local governments are not generally equipped to perform — to investigate such cases and follow up and refer for services to prevent further harm. The agency investigates incidents that occur in the home, where it validated 48,392 allegations in fiscal year 2013 and in facility settings, where it confirmed 1,373 allegations. The majority of facility investigations occur in state-operated facilities, such as state hospitals and state-supported living centers. The agency also investigates in state-contracted settings that provide services for people with mental illness and intellectual and developmental disabilities.

- **Child care regulation.** State regulation of the child care industry is needed to ensure the safety of children in out-of-home care, including day care centers and residential facilities such as foster homes. DFPS regulation of day care and residential operations includes setting minimum standards to ensure these operations meet basic health and safety needs, such as conducting criminal background checks for child care workers and complying with fire protection standards.⁵ DFPS also licenses child care operations, ensures compliance with regulatory requirements, investigates reports of abuse and neglect in its regulated operations, and takes enforcement action as necessary. During fiscal year 2013, DFPS conducted 41,819 inspections at child care facilities, and completed 3,620 investigations of abuse and neglect and 19,917 investigations of minimum standards violations. These inspections and investigations resulted in 96,210 citations and 196 enforcement actions.

The state ensures safety of children in out-of-home care settings through regulation of providers.

While DFPS' functions should continue, its organizational structure must be evaluated in conjunction with the health and human services system overall.

The Legislature made DFPS part of the health and human services (HHS) system through the 2003 consolidation, but its functions remained largely unchanged from its predecessor agency. Although its functions and activities remain relatively distinct from the other HHS agencies, DFPS operates within this system that has not been comprehensively re-assessed in the 11 years since its formation. DFPS and all of the HHS agencies are under Sunset review during this interim, providing the opportunity to assess how well the overall system is working and how to organize all system agencies to best serve their important missions.

The Sunset reviews of the Health and Human Services Commission and the HHS system are scheduled for completion in fall 2014. Sunset staff will study the overall organizational structure of this area of government and evaluate issues that cut across agency lines. Delaying decisions on continuation of all HHS agencies, including DFPS, until that time allows Sunset staff to finish its work on the system overall and base its recommendations on the most complete information.

All DFPS reporting requirements continue to be useful.

The Sunset Act establishes a process for the Sunset Commission to consider if reporting requirements of agencies under review need to be continued or abolished.⁶ The Sunset Commission has interpreted these provisions as applying to reports that are specific to the agency and not general reporting requirements that extend well beyond the scope of the agency under review. Reporting requirements with deadlines or expiration dates are not included, nor are routine notifications or notices, posting requirements, or federally mandated reports. Reports required by rider in the General Appropriations Act are

DFPS operates in a system that has not been reassessed in the 11 years since its formation.

also omitted under the presumption that the appropriations committees have vetted these requirements each biennium. Appendix G lists DFPS' reporting requirements, all of which Sunset staff found useful and should be continued.

Recommendation

9.1 Postpone the decision on continuation of DFPS' functions and structure until the completion of the Sunset review of the health and human service system.

While DFPS' functions are clearly needed, the Sunset Commission should not decide on continuation of DFPS and its functions until Sunset staff completes evaluation of the HHS system in fall 2014. Deciding the best structure for DFPS' functions in the context of a comprehensive evaluation of the HHS system would permit a broader analysis of organizational options than the review of DFPS alone can provide.

Fiscal Implication

This recommendation would not have a fiscal impact to the State.

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¹ The passage of the federal Child Abuse Prevention and Treatment Act in 1974 began federal block grants to states to protect children from abuse and neglect; and amendments to Title XX of the Social Security Act in 1975 required states to provide protection for elderly people. Over time, Child Protective Services and Adult Protective Services functions have evolved as a result of further federal and state statutory direction, but the beginning of these functions on the state level began with these two legislative events.

² 42 U.S.C. Section 602(B)(3).

³ Texas Department of Family and Protective Services, *Annual Report & Data Book 2013*, (Austin, TX: 2014), p. 33.

⁴ Ibid, pp. 39 and 41.

⁵ 40 T.A.C., Title 40, Part 19, Chapters 746-750.

⁶ Sections 325.0075, 325.011(13), and 325.012(a)(4), Texas Government Code.

APPENDICES

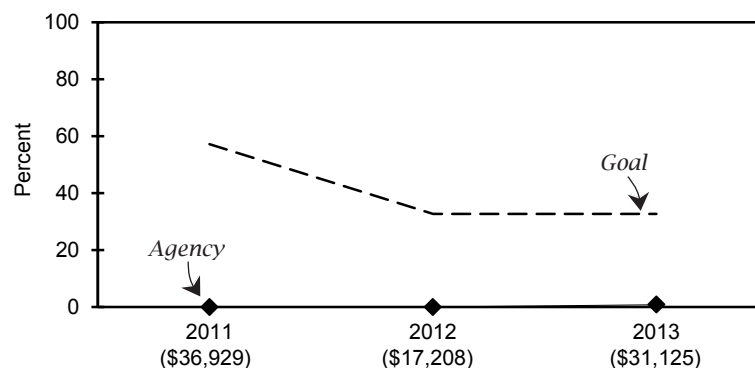
APPENDIX A

Historically Underutilized Businesses Statistics 2011 to 2013

The Legislature has encouraged state agencies to increase their use of historically underutilized businesses (HUBs) to promote full and equal opportunities for all businesses in state procurement. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews.¹

The following material shows trend information for the Department of Family and Protective Services' (DFPS) use of HUBs in purchasing goods and services. The agency maintains and reports this information under guidelines in statute.² In the charts, the dashed lines represent the goal for HUB purchasing in each category, as established by the comptroller's office. The diamond lines represent the percentage of agency spending with HUBs in each purchasing category from 2011 to 2013. Finally, the number in parentheses under each year shows the total amount the agency spent in each purchasing category. The agency exceeded the statewide HUB purchasing goals for the commodities category all three years. While DFPS exceeded the HUB goal for other services in 2013, it did not meet the goal in 2011 or 2012. The agency also had difficulty meeting the goals for special trade and professional services in the last three years. The agency complies with other HUB-related requirements such as adopting HUB rules, creating HUB subcontracting plans for large contracts, appointing a HUB coordinator, establishing a HUB policy, creating a HUB forum program, and developing a mentor-protégé program.

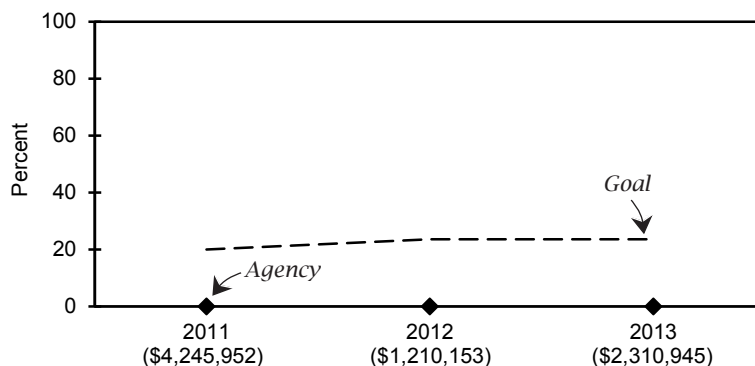
Special Trade



The agency did not meet the statewide purchasing goal for special trade. However, overall expenditure amounts are small compared to total agency purchases.

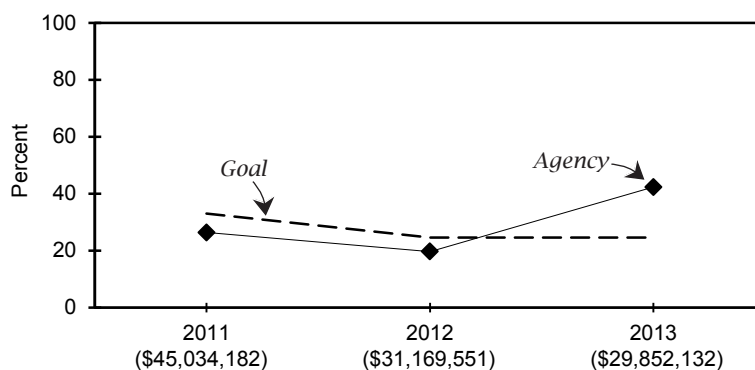
Appendix A

Professional Services



The agency did not meet the statewide purchasing goal in this category in any fiscal year. The expenditures in this category are made up of medical services and financial and accounting services. HUB availability is limited for the types of medical services DFPS procures. Also, almost all of DFPS' financial and accounting contractors are nonprofit organizations, which are not eligible for HUB certification.

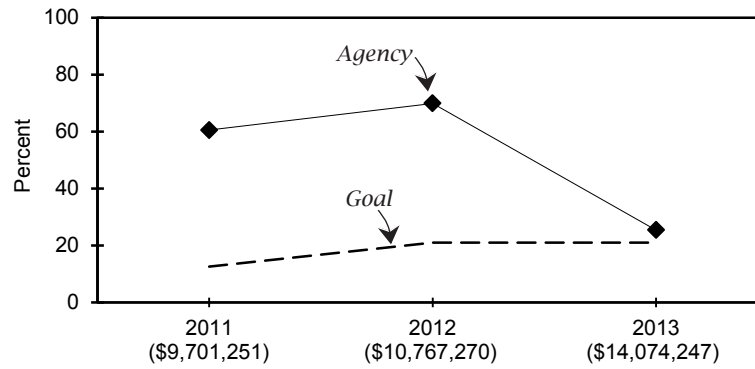
Other Services



The agency's purchases for this category fell slightly below the statewide purchasing goal in 2011 and 2012, but exceeded the goal for this category in 2013.

Appendix A

Commodities

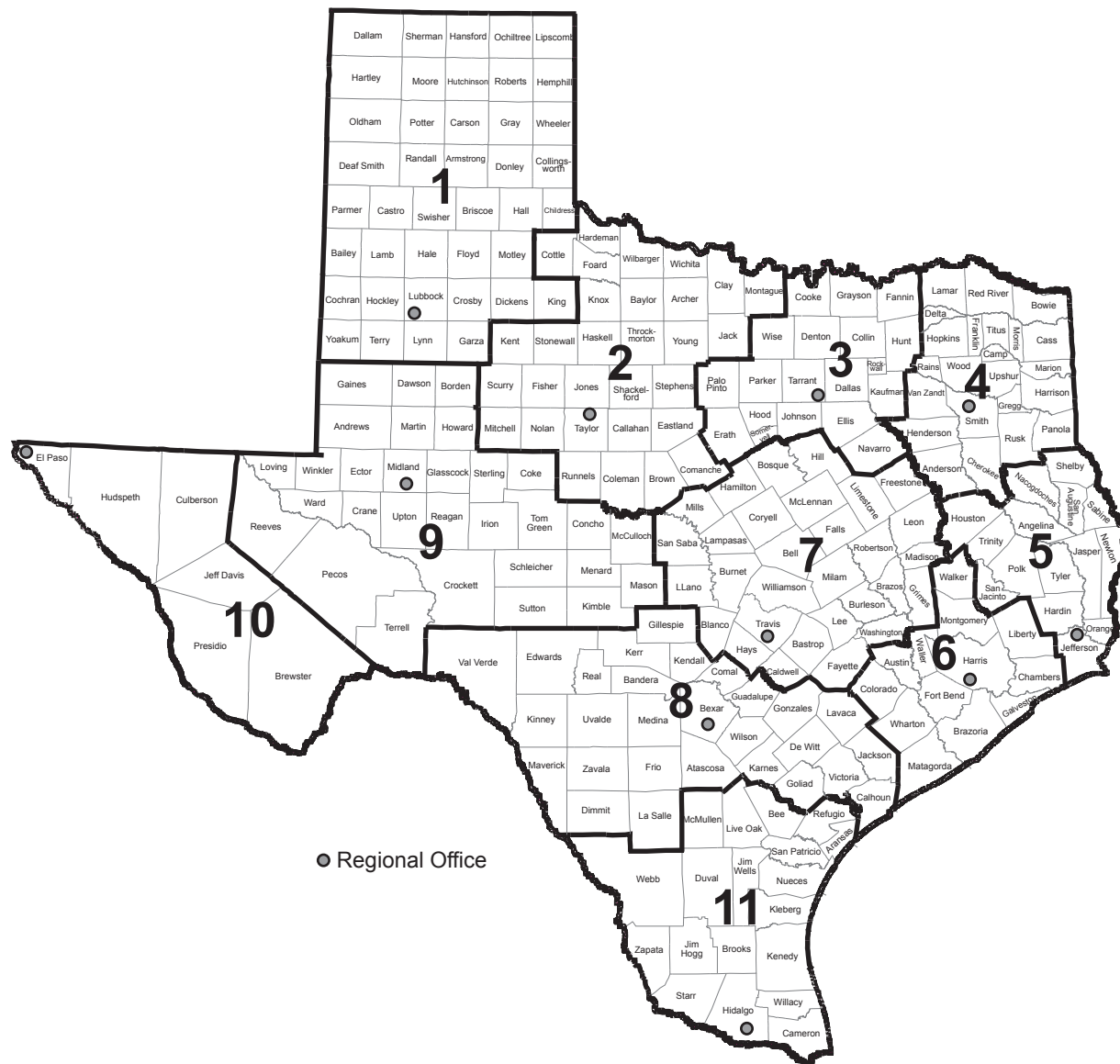


Purchases in this category far exceeded the statewide purchasing goal for 2011 and 2012. While dropping in 2013, it still exceeded the goal.

¹ Section 325.011(9)(B), Texas Government Code.

² Chapter 2161, Texas Government Code.

DFPS Regional Map

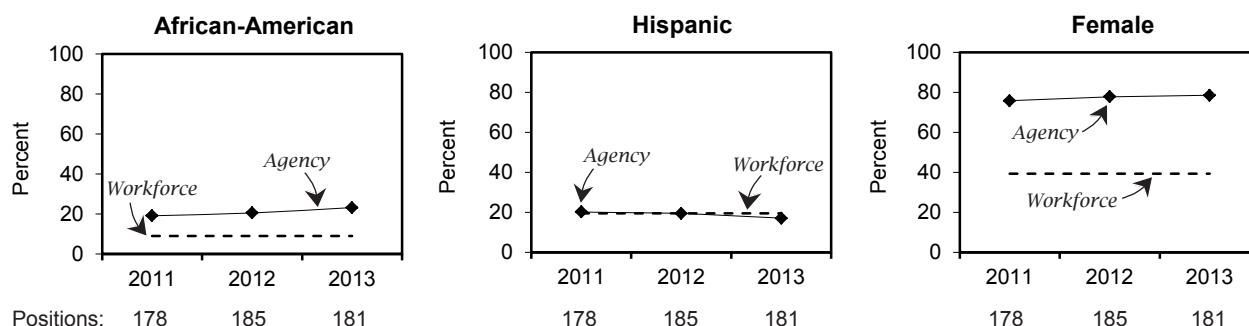


APPENDIX C

Equal Employment Opportunity Statistics 2011 to 2013

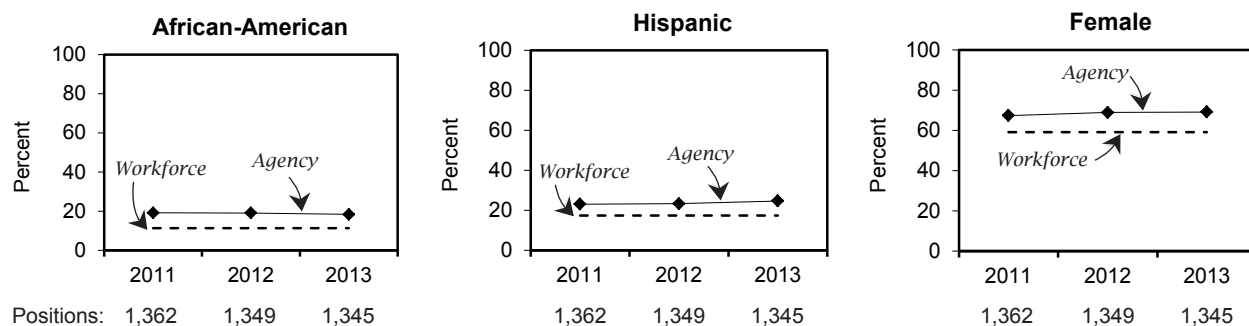
In accordance with the requirements of the Sunset Act, the following material shows trend information for the employment of minorities and females in all applicable categories by the Department of Family and Protective Services.¹ The agency maintains and reports this information under guidelines established by the Texas Workforce Commission.² In the charts, the dashed lines represent the percentages of the statewide civilian workforce for African-Americans, Hispanics, and females in each job category.³ These percentages provide a yardstick for measuring agencies' performance in employing persons in each of these groups. The diamond lines represent the agency's actual employment percentages in each job category from 2011 to 2013. The makeup of the agency's workforce is at or above the comparative civilian workforce percentages in almost all categories.

Administration



The agency met or exceeded the civilian workforce percentages in all categories for the last three years.

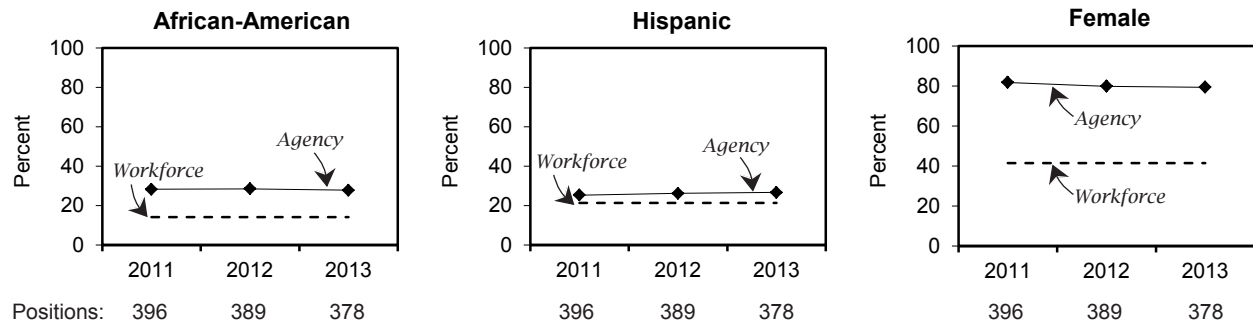
Professional



The agency exceeded the civilian workforce percentages for all three groups in all three years.

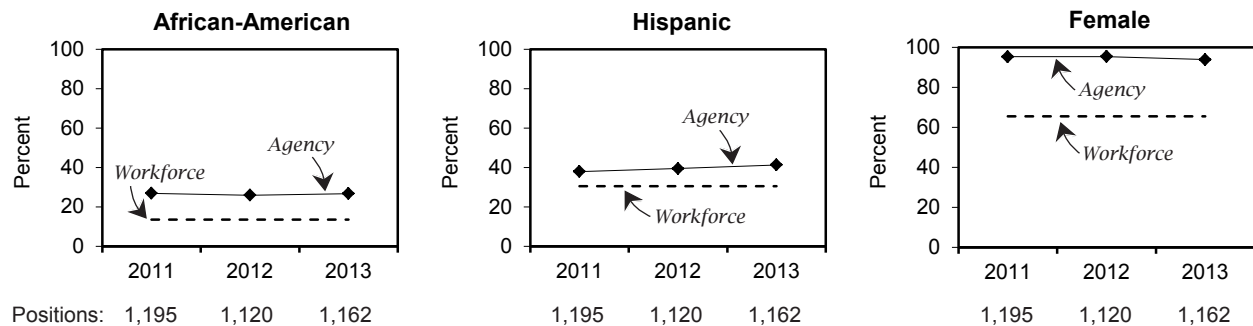
Appendix C

Technical



The agency exceeded the civilian workforce percentages for all three groups in the last three years.

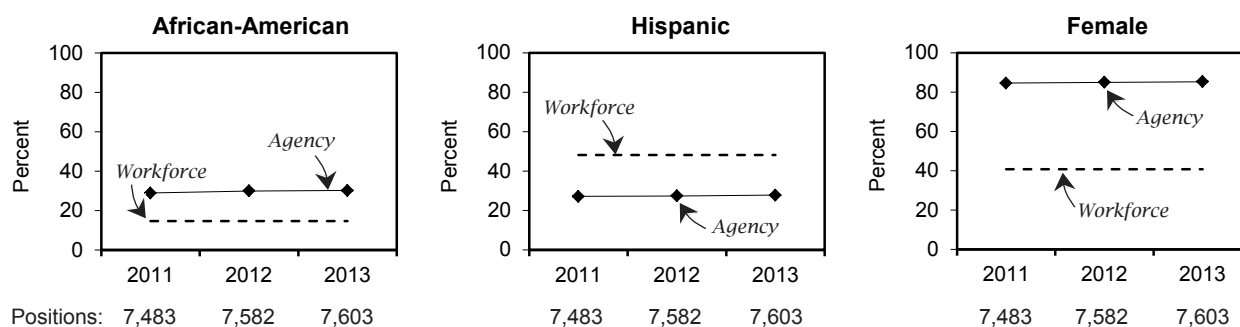
Administrative Support



The agency exceeded the civilian workforce percentages for all three groups in the last three years.

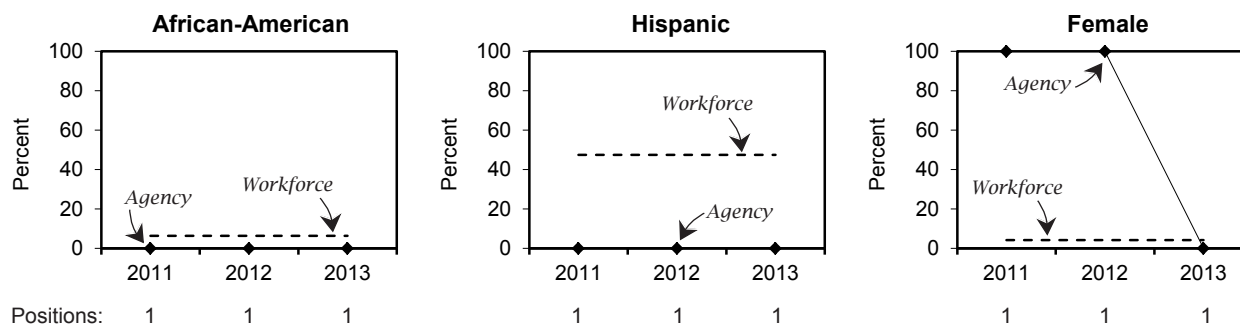
Appendix C

Service/Maintenance⁴



The agency exceeded the civilian workforce percentages for African Americans and females in the last three years. The agency did not meet the percentages for Hispanics during the last three years.

Skilled Craft



The agency only has one position in this category, and therefore only met the percentage for females.

¹ Section 325.011(9)(A), Texas Government Code.

² Section 21.501, Texas Labor Code.

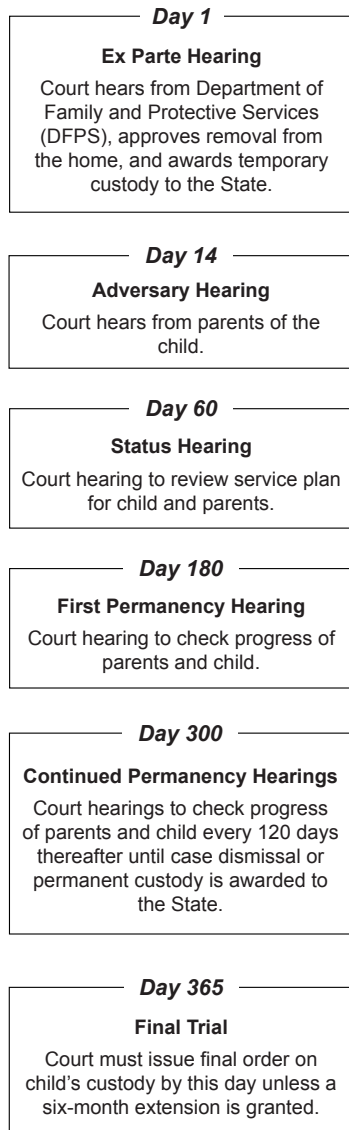
³ Because the Texas Workforce Commission has not released statewide civilian workforce percentages for fiscal years 2012 and 2013, this analysis uses fiscal year 2011 percentages for those two years.

⁴ The service/maintenance category includes three distinct occupational categories: service/maintenance, para-professionals, and protective services. Protective service workers and para-professionals used to be reported as separate groups.

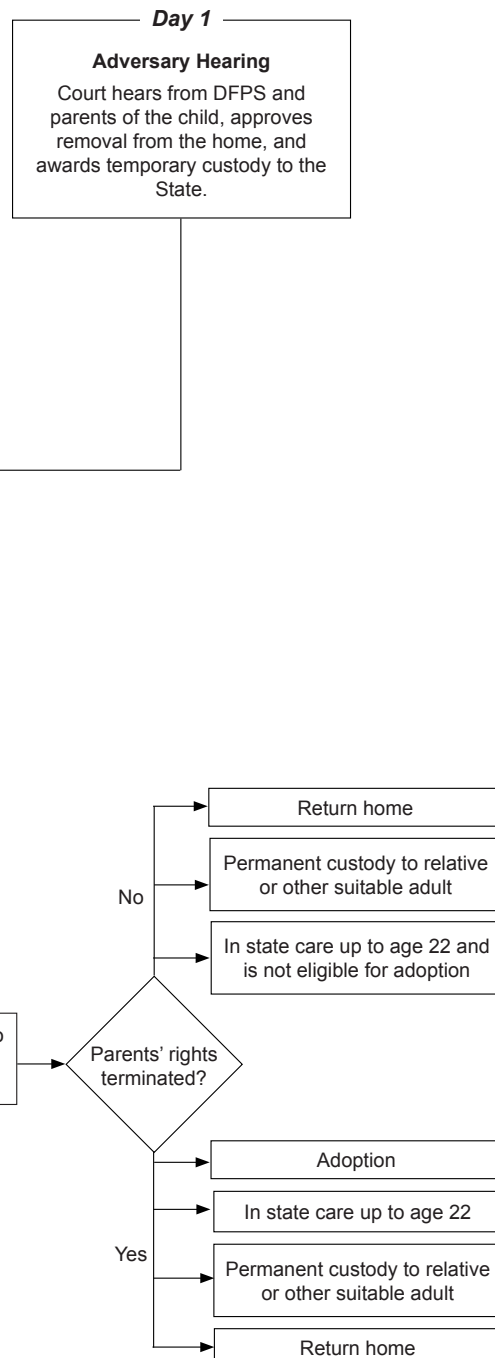
APPENDIX D

Child Protective Services State Conservatorship Timeline and Flowchart¹

Emergency Removal



Non-Emergency Removal



¹ Chapters 262 and 263, Texas Family Code.

APPENDIX E

DFPS Prevention and Early Intervention Programs FYs 2013–2014

Program Name	Program Description	Funding Source	Number Served	Expenditures (2013)	Budget (2014)
Services to At-Risk Youth ¹	Provides services to families with minor children not under CPS investigation and to youth at risk of juvenile delinquency, truancy, or runaway. Example services include family and individual counseling, parenting skills training, and short-term emergency respite care.	State and Federal	23,677	\$16,383,499	\$19,147,078
Community Youth Development ²	Serves children and youth ages 6–17, with a focus on ages 10–17, only in 15 specifically targeted zip codes, determined by the agency. The program provides recreation, life skills classes, mentoring, leadership development, and academic support services.	State and Federal	16,767	\$4,553,351	\$6,039,300
Texas Families Together and Safe ³	Provides services designed to promote parental competency and to help parents become more self-sufficient through training, home visits, counseling, child care, resource referral, and basic needs support.	Federal	1,736 families	\$2,306,039	\$2,610,039
Statewide Youth Services Network ⁴	Provides services to youth ages 6–17, with a focus on ages 10–17. The program primarily provides community and school-based mentoring and leadership development programs.	State	4,384	\$1,525,069	\$1,525,000
Community-Based Child Abuse Prevention ⁵	Supports families with minor children after referral from CPS. Primarily, the program delivers respite care for children, basic parent education, and supports general prevention awareness efforts.	Federal	990 families	\$3,084,299	\$3,133,988
Community-Based Family Services ⁶	Provides services to families with minor children, and includes CPS referrals. The program provides home visitation, parental education, support groups, family counseling, and resource referrals.	State	287 families	\$595,576	\$635,465
Texas Runaway and Youth Hotlines ⁷	Provides prevention services to youth, parents, and other family members to provide crisis intervention, advocacy, and information/referrals to services.	State	7,462	\$252,343	\$307,859

Appendix E

Program Name	Program Description	Funding Source	Number Served	Expenditures (2013)	Budget (2014)
Helping through Intervention and Prevention ⁸	New initiative that will provide a statewide network of home visiting services targeting families with newborns who have had prior CPS involvement. The program will also be available to foster youth in CPS conservatorship who have recently had children or are pregnant. Open enrollment began in November 2013, and service delivery started in April 2014.	State	n/a	n/a	\$1,007,000
Healthy Outcomes through Prevention and Early Support (HOPES) ⁹	New initiative that will establish flexible, community-based abuse and neglect prevention in 10 specific counties, only for families with children age five or younger who are at risk for abuse and neglect. The program will provide classes on nurturing and attachment, child development, parental resilience, and promoting child social and emotional competence. HOPES is currently in the procurement phase, with contracts to be awarded in July 2014.	State	n/a	n/a	\$7,889,146
Total				\$28,700,176	\$42,294,875

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¹ Section 264.301, Texas Family Code.

² Rider 16, page II-83, Article II (H.B.1), Acts of the 75th Legislature, Regular Session, 1997 (the General Appropriations Act); Section 40.0561, Texas Human Resources Code.

³ 42 U.S.C. Section 629 et seq; 42 U.S.C. 629g.

⁴ Rider 32, page II-39, Article II (H.B. 1), Acts of the 80th Legislature, Regular Session, 2007 (the General Appropriations Act); reauthorized by Rider 25, page II-43, Article II (S.B. 1), Regular Session, 2009 (the General Appropriations Act); reauthorized by Rider 32, page II-46, Article II (H.B. 1), Regular Session, 2011 (the General Appropriations Act).

⁵ Child Abuse Prevention and Treatment and Adoption Reform (42 U.S.C. Section 5116 et seq.).

⁶ Section 264.204, Texas Family Code.

⁷ These hotlines were transferred from DFPS' Prevention and Early Intervention division to DFPS' Statewide Intake division in April 2012.

⁸ Rider 30, page II-45-46, Article II (S.B. 1), Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

⁹ Ibid.

APPENDIX F

Performance Measures in Foster Care Contracts

Legacy Residential Contracts	Foster Care Redesign Single Source Continuum Contracts
The child's placement remains stable.	Children/youth have stability in their placement.
Children placed with a child-placing agency remain in their placements.	
Children placed with a contractor remain in their placements.	
No equivalent performance measure. Instead, a contract provision requires the contractor to provide services in the least restrictive placement setting.	Children/youth in foster care are placed in the least restrictive placement setting. Percent of children/youth in foster care placed in a foster family home.
Children are safe in care.	Children/youth safe in care.
Children are able to maintain healthy connections with caring family members who can provide a positive influence in their lives.	Children/youth are able to maintain connections to family and community. - Percent of children/youth placed within 50 miles of their home. - Percent of children/youth in foster care who have at least one monthly personal contact with a family member who is not a parent or sibling.
Children are able to maintain connections to siblings.	Children/youth are able to maintain connections to family and community. - Percent of cases where all siblings are placed together. - Percent of children/youth in foster care who have at least monthly personal contact with each sibling in foster care.
No equivalent performance measure. Instead, a contract provision requires contractors to connect foster youth to Preparation for Adult Living training.	Youth are fully prepared for adulthood. - Percent of youth in foster care who have a regular job at some time during the year. - Percent of 17-year-old youth who have completed Preparation for Adult Living life skills training. - Percent of youth age 16 or older who have a driver's license or state identification card.
No equivalent performance measure. Instead, a contract provision requires contractors to enable child/youth to assume responsibility in service plan implementation, as well as access to court hearings.	Children/youth participate in decisions that impact their lives. - Percent of children/youth age 10 or older who participated in development of any DFPS-approved service plan. - Percent of children/youth who participated in at least one discussion about the child's/youth's opinion regarding placement options. - Percent of court hearings attended by children/youth age 10 or older.
The contractor makes regular updates to the CPS Child Placement Vacancy Database.	No equivalent performance measure. Instead, single-source continuum contractors have their own tools for placing children and youth.
Each child's education portfolio is up to date.	No equivalent performance measure. Instead, contract provisions require each child's education portfolio to be up to date.
Children benefit from routine recreational activities, including extracurricular activities.	No equivalent performance measure. Instead, contract provisions require single source continuum contractors to ensure access to recreational activities.
No equivalent performance measure. DFPS tracks this data element, but not as a part of the contract.	Length of stay in care. This data element is directly tied to provider incentives/remedies, but not a contract performance measure.
No equivalent performance measure. DFPS tracks this data element, but not as a part of the contract.	Reentry within 12 months of a closed case. This data element is indirectly tied to provider incentives/remedies, but not a contract performance measure.

APPENDIX G

Department of Family and Protective Services Reporting Requirements

Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
1. Quality Assurance Program for Adult Protective Services	Section 40.0515(g), Texas Human Resources Code	Requires the Department of Family and Protective Services (DFPS) to submit a quarterly report on Adult Protective Services performance, including a separate analysis for certain outcome measures.	Governor, Lieutenant Governor, Speaker	Continue
2. Licensure and Child Care Facilities	Section 42.023, Texas Human Resources Code	Requires DFPS to report annually on its licensure and regulation of child care facilities.	General public on request	Continue
3. Recommendations on Promoting Adoption of Minority Children	Section 162.309(j), Texas Family Code	Requires DFPS to produce a biennial report containing the Advisory Committee on Promoting the Adoption of Minority Children's recommendations to improve the adoption rates of minority children and action taken by DFPS to implement these recommendations.	House and Senate	Continue
4. Foster Children in Drug Research Programs	Section 266.0041(l), Texas Family Code	Requires DFPS to report annually information related to foster children who participated in drug research programs during the previous fiscal year.	Governor, Lieutenant Governor, Speaker, relevant committees in House and Senate	Continue
5. Statistical Report on Child Abuse and Neglect	Section 261.004(c), Texas Family Code	Requires the agency to examine and compile data on all reported cases of child abuse and neglect.	Legislature and general public	Continue
6. Equal Employment Opportunity	Sections 40.032(e), (f), Texas Human Resources Code	Requires DFPS to report annually regarding the implementation of an equal employment opportunity program.	Texas Workforce Commission, Governor	Continue
7. Database of Foster Homes	Section 42.0451, Texas Human Resources Code	Requires DFPS to maintain a database of licensed and verified agency foster homes.	Department of Public Safety	Continue

APPENDIX H

Staff Review Activities

During the review of the Department of Family and Protective Services (DFPS), Sunset staff engaged in the following activities that are standard to all Sunset reviews. Sunset staff worked extensively with agency personnel; attended advisory council meetings; met with staff from key legislative offices; conducted interviews and solicited written comments from interest groups and the public; reviewed agency documents and reports, state statutes, legislative reports, previous legislation, and literature; researched the organization and functions of similar state agencies in other states; and performed background and comparative research.

In addition, Sunset staff also performed the following activities unique to this agency.

- Surveyed all 11,000 DFPS employees on employee training, supervision, management support, workload, and work environment.
- Participated in ride alongs for CPS investigations and Family-Based Safety Services; Adult Protective Services facility and in-home investigations; and Residential Child Care Licensing investigations and inspections.
- Toured the Statewide Intake call center and listened to incoming calls.
- Toured a residential treatment center, a child advocacy center, a forensic assessment center, and an emergency shelter.
- Visited regional DFPS offices and interviewed staff in Region 6 (Houston), Region 7 (Austin), and Region 8 (San Antonio).
- Met with a variety of agency stakeholders, such as foster care, prevention, and other service providers; advocacy organizations; members of the judiciary; and former foster youth.
- Observed CPS court proceedings, including adversarial, status, and permanency hearings, as well as family drug court in Travis County and Bexar County.
- Met or spoke with members of the DFPS Council, the Region 6 (Houston) Child Care Advisory Council, and the State Child Fatality Review Team Committee.
- Observed foster care stakeholder meetings, including the Public Private Partnership and the Committee for Advancing Residential Practices.
- Attended internal DFPS meetings, such as critical case meetings, facilities intervention team staffings, and a training governance meeting.
- Met with staff at other state agencies, such as Texas Workforce Commission, Department of Aging and Disability Services, and Health and Human Services Commission.
- Attended the 2013 DFPS Adult Protective Services Conference.
- Attended the 2013 DFPS Contracting Conference.

Sunset Staff Review of the *Department of Family and Protective Services*

————— *Report Prepared By* —————

Amy Tripp, *Project Manager*

Carissa Nash

Faye Rencher

Joel Simmons

Janet Wood

Joe Walraven, *Project Supervisor*

Ken Levine
Director

Sunset Advisory Commission

Location

Robert E. Johnson Bldg., 6th Floor
1501 North Congress Avenue
Austin, TX 78701

Mail

PO Box 13066
Austin, TX 78711

Website

www.sunset.texas.gov

Email

sunset@sunset.state.tx.us

Phone

(512) 463-1300