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U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Human Resources

HEARING

The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm

May 18, 2016

Testimony by

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Chairman Buchannan and Subcommittee Members:

Thank you for the opportunity to address the committee on the use of data to keep children known to the child welfare system safe.

My name is Bryan Lindert, and I am Senior Quality Director at Eckerd Kids. Eckerd Kids was founded in 1968 by Jack and Ruth Eckerd, philanthropists who became household names for the national drug store chain bearing their name. Today, Eckerd Kids is a non-profit provider of services to children and youth operating in 20 states and the District of Columbia. We also manage the largest privately operated child welfare system in the country, serving more than six thousand children and youth in Tampa Bay. The number one reason children enter this system is for maltreatment from a substance abusing parent.

The aim of my testimony is threefold:

- Describe how Eckerd Kids ended a pattern of tragic child homicides that had occurred prior to Eckerd's involvement
- Explain how that success has led to partnership with five states to prevent future abuse and fatalities
- Explore the implications for our approach for other child welfare challenges including a potential improved response to repeat maltreatment due to substance abuse

Our work developing a priority tool, Eckerd Rapid Safety Feedback®, was recently featured in the final report of the bipartisan Commission to Eliminate Child Abuse and Neglect Fatalities released in March of this year. To understand why, we must explain why Eckerd Kids was selected to manage the child welfare system in Hillsborough County beginning in July of 2012. This occurred after that community experienced an unprecedented nine child deaths from maltreatment in less than three years. These cases were not co-sleeping deaths or the result of inadequate supervision. Instead they were intentional inflicted injuries including one child thrown out of a moving car on the interstate. Worse still, all occurred under the open jurisdiction of the court.

In Hillsborough, as in other jurisdictions around the country, the Department of Children and Families reviewed these cases and came to a frustrating conclusion. The fatalities kept happening to children with similar risk factors and lapses in casework. A more proactive approach was needed.

Therefore, in addition to review of the nine child death cases, Eckerd Kids conducted a 100% review of the 1,500 open child welfare cases in the county. From this review, critical case practice issues were identified that, when completed to standard, could reduce the probability of preventable serious injury or death. Among these case practices were quality safety planning, quality supervisory reviews, and the quality and frequency of home visits.

Now that Eckerd knew what to look for, the next step was to determine which cases needed to be prioritized for review. So Eckerd Kids secured a technology partner that provides predictive analytics and machine learning, Mindshare Technology (Tampa,) to identify the cases most like the prior fatalities on incoming cases in real time. Cases that were prioritized had multiple common factors such as: a child under the age of three,

a paramour in the home, intergenerational abuse, and a history of substance abuse.

Eckerd Kids then reviewed these cases against the practices identified with better safety outcomes and conducted coaching sessions with front-line staff when deficits were identified. Actions needed from these coaching sessions were tracked to completion to ensure accountability.

The results have been promising. In Hillsborough, there were no maltreatment fatalities in the three year period following implementation of the program in the population served by Eckerd. Critical case practices also improved an average of 22%. Eckerd is working with Casey Family Programs on an independent evaluation to determine if these results can be replicated in other jurisdictions implementing the program.

As a result, Eckerd Kids and Mindshare are now working to deploy Eckerd Rapid Safety Feedback® in Oklahoma, Maine, Alaska, Illinois, and Connecticut. Regardless of the jurisdiction, the process needs the same ingredients for success. These include:

- A narrowly defined challenge the jurisdiction is trying to solve such as the prevention of a fatality to a child with prior abuse reports
- Daily access to the State Automated Child Welfare Information System (SACWIS) allowing for predictions that continuously improve and update as new data is entered
- Access to quality assurance reviews assessing case practice
- Experienced staff to review the identified cases for the key safety practices and provide coaching to the field
- Willingness to embrace the paradigm shift needed to move from reactive to prospective review regarding child safety

SACWIS systems present an incredible opportunity for child welfare agencies to better target scarce resources. States have spent billions of dollars building them and countless hours collecting data on their interventions with families and a series of state and federal outcomes in them. As a result, states are sitting on valuable mountains of data about the families that come to their attention that could be used to predict the children who may experience poor outcomes beyond child fatality. These include children who are likely to experience long stays in foster care, who will age out of the system, or be re-reported for substance abuse. Right now, Eckerd Kids and Mindshare are applying the same principles used in Eckerd Rapid Safety Feedback® to identify cases at risk for return to foster care and coaching the front line staff assigned to those cases to toward best practice casework.

In closing, it is important to note that we are not advocating decisions made by machines. What is needed is a second set of eyes to ensure we are doing our best work to ensure positive outcomes for the children and families in our care.

Therefore, we are advocating that data and coaching together provide a support for those men and women working with families to help them focus attention where it is needed most. I know from past experience as an investigator and supervisor in the field, I would have appreciated the help.

Mr. Chairman and members of the Subcommittee, thank you again for this opportunity. I will present my entire testimony in full for the record and look forward to answering any questions.

Hillsborough County, Florida

Using Data to Improve Practice and Keep Children Safe

"If the only thing you do is come up with a list of cases that are high risk, all you've done is identify the train that's coming at you on the tracks. You've got to have a way to switch the track," said Bryan Lindert, Senior Quality Director at Eckerd Kids in Hillsborough County, Florida.

Switching tracks is exactly what leaders in Hillsborough have in mind when it comes to preventing fatalities of young children. They are doing it through an innovative process they developed called Eckerd Rapid Safety Feedback© (ERSF). ERSF uses real-time data to identify a list of high-risk cases, but that is only the beginning. Once the cases are identified, they are flagged and reviewed, often leading to an immediate, intensive meeting between quality management (QM) specialists and the case management team for the family. It is the combination of the two — data and intensive intervention — that makes ERSF both different and promising.

The History in Hillsborough County

The changes in Hillsborough were born from tragedy: A 1-year-old allegedly killed by his mother's boyfriend; a 4-month-old tossed from a car on an interstate; a 16-month-old taken from his mother and allegedly beaten to death by his father. From 2009 to 2011, nine children in Hillsborough County died from maltreatment. Each of these children was under 3 years of age. All but one had an open, in-home child protective services (CPS) case.

Sadly, the state of Florida is no stranger to child homicide, but no other county had as many deaths in so short a time as Hillsborough in those two years. The state response was definitive. Eckerd Kids was named to replace the lead child protection agency in the county. Eckerd officials reviewed all nine fatalities in depth, as well as other deaths in the region, looking for common characteristics. They then reviewed every open case in the county, some 1,500 families with more than 3,000 children, looking for additional system gaps and practice concerns that could lead to serious injury or death.

They found that families in which a fatality or serious injury occurred shared multiple risk factors, including in-home, open cases with a child under 3 years of age; young parents; a paramour or unmarried partner in the home; intergenerational abuse; and domestic violence, substance abuse, or mental health problems. Staff identified current cases with immediate practice concerns, which they used to pinpoint nine critical practice issues.

The goal was to take what they learned from the past and use it to prevent fatalities in the future. But to do this, they needed more data.

Putting Data to Work for Child Safety

Enter Mindshare Technology.[30] Using state historical data about maltreatment, the data software company developed predictive models to quantify the likelihood that a particular child would experience a life-threatening episode. Once the model was finely tuned, staff began to feed it daily with data from Hillsborough about new investigations and new cases.

This technology scans the system, looking beyond cases that match predetermined risk factors. It then identifies cases that match the risk factors and produces reports. These include new cases as well as updates on cases already in the system. "Mining the data daily is critical to the success of this process," said Greg Povolny,[31] founder and CEO of Mindshare. "Predictive analytics is not a one-time job. The intention is to zero in on children for the long haul."

Data Analytics Lead to Action

ERSF is a combination of data and practice change focused on prevention of child fatalities. This is the process in Hillsborough County:

- After getting case notices, QM staff review each case, guided by a list of critical practice questions. If answers to any of those questions raise concerns, QM specialists call a meeting with the supervisor and worker for the family the same day.
- Meetings focus on practice and compliance issues that can jeopardize safety. Together the QM and case management teams address these issues through immediate and more focused visits to the home, improvements to safety plans, access to specific services, and more.
- Additional meetings, follow-up, and coaching continue until risk factors no longer exist, the case is closed, or the child turns 3 years old.
- If necessary, the child is removed. The end goal is always the child's safety.

This Is Not Traditional Quality Assurance

Launched in January 2013, ERSF is different from traditional quality assurance (QA) programs. QA is typically limited to a random selection of cases and uses up to 200 questions to assess practice. Traditional QA is not based on data that identifies specific children at greatest risk of severe maltreatment.

ERSF prioritizes the cases that need the best and most intense casework. "We read the case files independently," said Suzanne Barlow, Quality Manager at Eckerd, which allows them to confront the understandable, but sometimes fixed, frame of reference brought to the case by workers and supervisors.

The QM and case management teams then work together to develop a better safety plan and articulate steps required to keep the child safe. Addition of targeted services and community support — and ensuring parents and caretakers actually receive them — are part of the discussion.

Follow-up is part of the package, as is coaching, which promotes the transfer of new skills learned by case managers and supervisors in one case to others.

The Bottom Lines

ERSF pulls together data sharing, better casework by a CPS agency, and collaboration with a wider range of community services. It requires an upfront investment to identify the risk factors, train the QM team, and produce the operational predictive model. Once it is set up and a trained QM team is in place, it can move forward without a lot of additional expenses. The startup cost for a jurisdiction is approximately $200,000, with approximately $90,000 in yearly fees to support the portal maintenance and for ongoing fidelity activities.

Interest in ERSF has spread throughout Florida and to other states and jurisdictions across the country, including Alaska, Illinois, Connecticut, Oklahoma, and Maine. Although the process and use of data are similar in different jurisdictions, said Lindert, "the identification of high-risk cases and the practice questions will be tailored to each." Oklahoma, for example, is looking to introduce ERSF with investigations. That state's practice questions and risk model will look different from those in Hillsborough.

As of December 2015, more than 2,000 ERSF reviews had been completed in Hillsborough County, including multiple coaching sessions for some cases. Child fatalities still occur. But in Hillsborough, there have been no more abuse-related deaths[32] in the population targeted by ERSF.

A formal evaluation of ERSF is underway, but research shows a 36 percent improvement in sharing critical case information with providers (including mental health, substance abuse, and domestic violence services); a 35 percent improvement in supervisory reviews and follow-up by case managers; a 25 percent improvement in the effectiveness of safety plans; and a 22 percent improvement in the quality of case management contacts and discussion with families.[33] Eckerd and Mindshare have shown in Hillsborough that the intricate dance between data and practice can keep an important sector of children safe.

To Povolny, ERSF was a welcome opportunity for those in Hillsborough to be thought leaders. "There are so many program areas in desperate need of change," he said. "Florida is doing it."

NOTES FOR HILLSBOROUGH COUNTY, FLORIDA: USING DATA TO IMPROVE PRACTICEAND KEEP CHILDREN SAFE

[30] CECANF supports public-private partnerships like the one described here but does not endorse any specific product or corporation.

[31] Testimony presented at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Transcript-Tampa-FINAL.pdf).

[32] There were four infant fatalities in Hillsborough County in 2015. All were tragic, but none was part of the ERSF process. Two of the deaths took place during the investigation period, which, in Hillsborough, is the responsibility of the Sheriff's Office. The other two were unsafe sleep deaths; these were investigated independently by the Sheriff's Office and not substantiated as abuse or neglect.

[33] Eckerd Rapid Safety Feedback. (n.d.). Retrieved from http://www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback.

Within Our Reach

A National Strategy to Eliminate Child Abuse and Neglect Fatalities

COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES | FINAL REPORT, 2016

Recommendations

RECOMMENDATION 2.1:
The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

The steps in this process are as follows:

2.1a HHS should provide national standards, proposed methodology, and technical assistance to help states analyze their data from the previous five years, review past child abuse and neglect fatalities, and identify the child, family, and systemic characteristics associated with child maltreatment deaths. HHS also should encourage states to explore innovative ways to address the unique factors that states identify as being associated with higher rates of child abuse and neglect fatalities.

2.1b States will submit a methodology to HHS for approval, describing the steps they would like to take in using data to identify under what circumstances children died from abuse or neglect during the previous five years.

2.1c After HHS approval, states will identify and analyze all of their child abuse and neglect fatalities from the previous five years to identify under what circumstances children died from abuse or neglect, protective factors that may prevent fatalities from occurring, and agency policies and practices across multiple systems that need improvement to prevent fatalities.

2.1d Based on these data, states will develop a fatality prevention plan for submission to the HHS Secretary or designee for approval. State plans will be submitted within 60 days of completing the review of five years of data and will include the following:

1. A summary of the methodology used for the review of five years of data, including specifics on how the reviewers on the multidisciplinary panels were selected and trained.

2. Lessons learned from the analysis of fatalities occurring in the past five years.

3. Based on the analysis, a proposed strategy for (1) identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data)

and (2) putting immediate and greater attention on these children.

4. Other proposed improvements as identified through child fatality review teams.

5. A description of changes necessary to agencies' policies and procedures and state law.

6. A timeframe for completing corrective actions.

7. Identification of needed and potential funding streams to support proposed improvements as indicated by the data, including requests for flexibility in funding and/or descriptions of how cost savings will be reinvested.

8. Specifics on how the state will use the information gained from the review as part of its CQI process.

2.1e If states find during the review of five years of data that investigation policy is insufficient in protecting children, their plans should ensure that the most vulnerable children are seen and supported. States should review current screen-out policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children under age 1 are responded to within 24 hours. Alternatives to a CPS agency investigation should be considered. Congress and states should fund the necessary resources. Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.

2.1f Once their fatality prevention plan is approved, states will implement this plan by identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data), putting immediate and greater attention on these children, and conducting multidisciplinary visits and reviews of cases to determine whether the children are safe and whether families need different or additional supports, services, or interventions. If children living at home with their families are found to be unsafe, services should be provided in order to ensure they can be safe in their home. If removal is determined to be necessary, all existing state and federal due process laws remain in effect. Home visits should only be conducted under state-authorized policies and practices for CPS investigations.

2.1g Once a state begins the review of current open cases, as outlined in its fatality prevention plan, each state should provide a report to HHS every month until conclusion of the review.

2.1h HHS will increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities. HHS will establish a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities to collect data from the states and share it with all those who submit data so that state and local agencies can use this data to inform policy and practice decisions (see Recommendation 6.1c)

2.1i: We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country's child welfare system.

1. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded and recommends that Congress immediately authorize and then appropriate at least a $1 billion increase to the base allotment for Child Abuse Prevention and Treatment Act (CAPTA) as a down payment on the funding necessary to ensure that state CPS agencies are consistently effective and have sufficient funding to keep children protected and that families receive the services and supports they need to ensure their children's safety. These Commissioners further believe that the first year of funding should support state efforts to implement the case reviews of children known to CPS. This will help to ensure children's

continued safety and determine the broader reforms necessary both to better protect children from abuse and neglect generally and to dramatically reduce child abuse and neglect fatalities. Thereafter, the ability of a state to draw down its share of these new funds will be contingent upon the state having a fatality prevention plan in place and approved by HHS to fundamentally reform the way the child welfare system is designed and delivered with the goal of better protecting children and significantly reducing child abuse and neglect fatalities and life-threatening injuries.

2. One group of Commissioners recommends an increase in funding but leaves the responsibility to Congress to identify the exact amount of funding needed by all responsible agencies to carry out activities in this goal, sources of that funding, and any offsets in funding that are available to support this recommendation.

3. One group of Commissioners recommends that initial costs be covered by existing funding streams, cost-neutral waivers for children ages 0-5, and a prioritization of services for children ages 0-5 who have been demonstrated to be at the highest risk for a later fatality. An overhaul to the structure of federal funding is required to better align resources pertaining to the prevention of and response to safety issues for abused or neglected children. Furthermore, we still have few approaches, programs, or services that demonstrate evidence in reducing child abuse and neglect fatalities. Rather than continuing to fund programs with no evidence of effectiveness, we should support state and local funding flexibility, innovation, and research to better determine what works. The child welfare system is woefully underfunded for what it is asked to do, but a significant investment needs to wait until additional evidence is developed to tell us what works.

4. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded but does not favor making a request for specific dollar amounts in this report. However, if funding is recommended, it should be recommended for all recommendations made by this Commission. Many of the recommendations proposed will require dollars, and all of the recommendations will work toward reducing child abuse and neglect fatalities.

These steps not only will save lives today, but will create a state and national learning community that improves practice, interventions, and shared responsibility and accountability across systems that regularly interface with children and their families.

Even as this Commission's report is being distributed to generate action to prevent future fatalities, we estimate that at least 3,000 children will die from abuse or neglect in the year ahead if there is no further and immediate intervention on their behalf. The Commission recognizes that each state is unique and may identify different characteristics of children at highest risk of fatalities in their jurisdiction. However, it is also true that the collective knowledge gained through this process will benefit all states through a national learning community. If this data-driven prospective review of cases works to prevent deaths, and fatality rates decline, states might consider extending the practice beyond this two-year commitment. This may continue until they have integrated the improvements into their practices, developed confidence in the accessibility of needed services and supports, and established shared accountability across systems for day-to-day functioning.