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THE BONADIO GROUP
CPAs, Consultants & More

Comprehensive Review of Child Welfare Division

Prepared by Bonadio & Co., LLP

For the Sullivan County Manager's Office

October 14, 2024

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I. Executive Summary

The Bonadio Group (Bonadio) was engaged by the County Manager of Sullivan County (the County) pursuant to the terms of the Professional Services Agreement effective February 20, 2024, for a six-month period commencing in March 2024 and ending in September 2024. In accordance with the agreement, Bonadio conducted an operational analysis of the Child Welfare Division (the Division) of Sullivan County's Department of Social Services. This review was initiated in part due to the May 2023 fatality of a child that had been under the supervision of the County's Child Protective Services (CPS). This engagement focused on determining the county's adherence to OCFS regulations through case review, determining if policies, procedures, and internal controls are in place and effective, and making recommendations stemming from these procedures.

We interviewed the vast majority of Division personnel, performed process walkthroughs, analyzed operational workflows and related documentation, and reviewed policies and procedures. We also performed a comprehensive quality control case review within the Child Welfare program, which includes the following service areas and programs:

- CPS Investigations
- Child Protective Family Assessment Response (FAR)
- Preventive Services
- Foster Care

We performed these procedures to gather first-hand accounts of the strengths and weaknesses of the Division's child welfare and eligibility functions, identify process gaps, control deficiencies, and opportunities to enhance operational efficiencies to ensure the county is best suited to accomplish its mission of assisting individuals, children, and families in need while complying with New York State Office of Children and Family Services (OCFS) rules and regulations.

Due to the size of the Division relative to the length of our engagement period, we offered all child welfare staff, including administration, management, and case aides, as well as legal personnel from the County Attorney's Office, the opportunity to speak with us individually. Interviews were performed both onsite and virtually.

Throughout the engagement, Bonadio met with the Commissioner and the Director of Services biweekly to provide updates on the status of activities performed, observations, and upcoming planned procedures. Additionally, we provided similar engagement updates to the County Manager and Assistant County Manager. This report, which was compiled at the conclusion of our review, captures our procedures performed in greater detail, as well as findings, observations, case review results, and corresponding recommended solutions for the Division's consideration.

Observations reached during our review and associated recommendations are found in each major section of this report. Our recommendations are focused on actionable improvements and utilizing the resources currently available to the county. The results of our interviews and testing were discussed with management and the themes of each recommendation were formed in conjunction with relevant stakeholders.

Overall, we noted interactions between the Division and the County Attorney have historically been and continue to be a source of frustration for both parties. During our interviews, we heard (and examined) countless examples of late or missing court documents, redundant requests, miscommunication, and unresponsiveness. We also noted an overwhelming level of mistrust between the two agencies and a stark contrast in the agencies' interpretation of 'imminent risk,' which drives the extent of long-term legal involvement and impacts child safety, well-being, and permanency. These differences, along with a lack of established communication protocol, secure share drive, and personnel resources, were identified during the course of our engagement. Sullivan County's years-long ranking of the highest per capita rate of fatal drug overdoses coupled with its lack of an in-county four-year college institution and rural economic environment relative to its proximity to Manhattan also presents unique obstacles for the Division that impact both casework and staff retention.

In light of severe staffing issues, we also noted a disproportionate level of caseworkers, primarily between CPS and preventive services units, as well as a lack of support staff in the form of case aides. Throughout this report, we highlight observations, including areas of strong casework, identify trends, and provide recommendations that address casework gaps, communication with the County Attorney's office, case volume, and distribution and utilization of community resources.

II. Summary of Roles and Responsibilities

We were not engaged to, and did not, conduct an audit, the objective of which would be the expression of an opinion on the policies and procedures in place surrounding the functions within the Division's operations. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This consulting engagement report is intended solely for the information and use of the County Manager's Office and is not intended to be and should not be used by anyone other than those specified parties.

We are independent within the meaning of, and comply with the applicable requirements of, Rule 101, "Independence", and related Interpretations and Rulings of the Code of Professional Conduct promulgated by the American Institute of Certified Public Accountants.

III. Child Protective Services

INTRODUCTION

The Division's CPS Unit receives reports of suspected abuse and maltreatment of children in the county from the New York State Central Registry (SCR). The unit is divided into teams based on case allegations at intake or allegations identified during the course of the investigation and include:

- *Family Violence Response Team (FVRT) and Child Advocacy Center (CAC)* – Caseworkers in this unit are forensically trained to manage cases involving physical and/or sexual abuse, as well as substance abuse.
- *Positive Tox* – Unit was established in November 2023 and currently has two caseworkers who investigate cases of children born with positive toxicology results. This unit was partially created in response to the grand jury investigation and due to the County having the highest per capita rate of children born with positive toxicology in the state.
- *Family Assessment Response (FAR)* – The three caseworkers in this unit are responsible for SCR reports without significant safety factors (e.g. educational neglect). The County adopted FAR in July 2023. Unlike traditional investigative cases, the FAR program aims to work collaboratively with families by identifying their unique strengths and needs; caseworkers do not make a formal determination of whether child maltreatment occurred.
- *Investigations* – Receives reports for all other cases received from the SCR. Unit includes two case supervisors, five senior caseworkers, seven caseworker positions, and two case aide positions.

CASE REVIEW SAMPLING METHODOLOGY

In accordance with our Professional Services Agreement (PSA), we performed a review of CPS cases using the Ongoing Monitoring and Assessment (OMA) Tool developed by OCFS. This instrument reviews each major area of casework through a series of questions that reflect OCFS regulation and best practices. We selected our cases from a listing of SCR Intake Reports for the 18-month period of September 1, 2022, through February 29, 2024. From the listing, we noted the following observations:

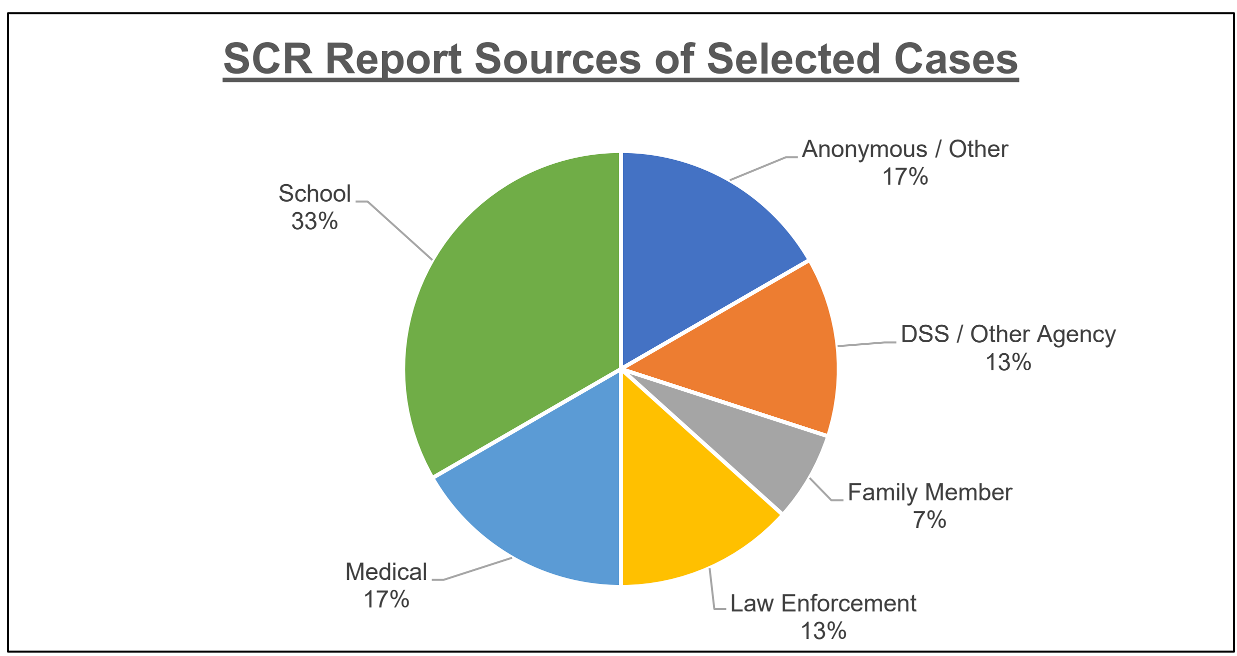
- 2,296 SCR reports were referred to the County and assigned to either the CPS or FAR unit based on allegations at intake, age of children, and family history.
- 34 of the cases were categorized as Substance Abuse / Positive Tox cases.
- 216 SCR reports were categorized as Secondary. In general, secondary responsibility is assigned to the district where the alleged subject of the report resides when it is different from the district of the alleged maltreated child's primary residence, or to the district that is current location of the child and the alleged subject (e.g., school, hospital).
- 588 of the SCR reports where the County had been assigned primary responsibility were categorized as Subsequent. Subsequent reports represent new calls that are made regarding a specific family for which there is an open CPS investigation or FAR.
- 1,592 cases were closed as of the date of our case selection on March 19, 2024.

Using a random number generator, we selected 17 cases for testing. We selected an additional three cases categorized as Substance Abuse / Positive Tox cases. Please note, in addition to our sample of 20 Investigation cases, we selected a random sample of ten FAR cases from a listing of reports with FAR tracks that came into the county from July 26, 2023 to June 13, 2024. These 30 sampled cases are all reviewed below.

All investigations related to our selection of CPS cases were closed at the time of our report. At closing, seven cases were indicated and 13 were unfounded. Inadequate Guardianship and Parent's Drug/Alcohol Misuse were the most common allegations, as shown below. Both allegations were part of the seven indicated cases reviewed and were substantiated in each case.

Allegations of Selected Cases

Other (Court Related) 2%
Ed Neglect 6%
Emotional Neglect 3%
Lack of Medical Care 10%
Lack of Supervision 3%
Child's Drug/Alcohol Use 6%
Parent's Drug/Alcohol Misuse 13%
Inadequate Food, Clothing, Shelter 2%
Lacerations, Bruises, Welts 6%
Internal Injuries 3%
Excessive Corporal Punishment 2%
Inadequate Guardianship 44%



Per the chart above, mandated reporters from local schools were the most frequent source of reports for the cases we reviewed (33%). Reports from anonymous individuals or healthcare providers were the next most frequent sources (both at 17%).

CASE REVIEW RESULTS

When OCFS performs an analysis of a county's CPS division, they use the following positive compliance thresholds to evaluate performance in individual areas:

- Strong: no program improvement plan (PIP) required: 85% and above
- Recommendation: PIP recommended: 75% - 84%
- Area Needing Improvement; PIP required: 74% and below

The metrics highlighted below report results that we consider areas of strength for the Division as well as those in need of improvement. Of the seven individual metric areas reported in this section, four exceeded OCFS's "Strong" threshold of 85% positive compliance or greater, one metric met OCFS's PIP "Recommendation" threshold, and two metrics were below the OCFS threshold of 74% as an "Area Needing Improvement".

Several performance measures we reviewed correlate directly to OCFS regulations, while others are based solely on what we consider best practice. During our case review, we noted varying levels of casework quality and find it reflective of the Division's distressed workforce level.

INVESTIGATIONS CASE REVIEW

1. CASE HISTORY

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
SCR History reviewed within 24 hours of report	19/20	95%

CPS captured sufficient information from the SCR case history in all 20 cases while one case did not perform the search within 24 hours, as prescribed by OCFS guidelines. Twelve cases included significant case detail while eight cases only noted basic information of prior cases. In the one case that did not perform the search within 24 hours, documented history review took place within five days of the intake date.

2. CONTACT WITH SCR REPORT SOURCE

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Source of the report contacted, or adequate contact attempted within 7 days of the SCR report	16/17	94%

Of the cases we reviewed, contact with the source of the referral was made or adequately attempted within seven days in nearly all instances. One exception was noted, with documented source contact attempts not occurred until five months after the SCR report. The lack of timeliness in this case is problematic as the caseworker may not have had relevant information about this case during the critical initial days of fieldwork. Please note, cases in which the source was anonymous or did not provide contact information were excluded from the positive compliance rate calculation.

3. SUPERVISION AND FOLLOW-UP

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Evidence of supervisory feedback throughout casework	19/20	95%

Our evaluation of the evidence of supervisory feedback throughout the course of the investigation was based solely on the documentation available in the case files provided to us, which generally included the Intake Report, Stage Summary, and Progress Notes.

One case had only one instance of supervisory feedback. We note that case conferences and managerial review of the case file help ensure crucial action items are reviewed and general compliance with OCFS guidelines is maintained.

4. TIMELINESS OF PROGRESS NOTES

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Progress notes completed within 30 days of event date.	12/20	60%
Progress notes completed between 30 and 90 days of event	7/20	35%
Case includes progress notes with greater than 90-day difference between event date and record of noted.	1/20	5%

We noted a positive compliance rate of only 60% in the criteria of inputting progress notes within 30 days of a case event. New York State regulations require that “progress notes must be made as contemporaneously as possible with the occurrence of the event” (18 CRR-NY 428.5). Additionally, OCFS highly recommends notes be recorded within 30 days of the event as one’s recollection of a case event greatly diminishes in accuracy and relevance after 30 days. This is especially the case given that supervisors are expected to perform periodic review of the case and will rely on recent progress notes to understand the case’s current status.

5. TIMELINESS OF 24-HOUR SAFETY ASSESSMENTS

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
24 Hour Safety Assessment Completed Timely	20/20	100%

All 20 cases exhibited positive compliance of the 24-hour safety assessments. This is crucial due to it being the first contact with the child and critical in establishing an initial understanding of child safety. This assessment also often involves first contact with the child’s family and the alleged subject, adding to its importance as an initial evaluation of the case’s circumstances.

6. TIMELINESS OF SEVEN DAY SAFETY ASSESSMENTS

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
7 Day Safety Assessment Completed Timely	15/20	75%

Most of the sampled cases exhibited positive compliance for the seven-day safety assessments. This is a primary metric measured by OCFS and is critical in establishing child safety. The positive compliance rate of this sample closely mirrors OCFS' recent monthly reporting of Safety Assessment compliance for Sullivan County. We find that this is an area where improvement is still recommended for the Division as it consistently performs below or at the NYS median compared to other NYS counties in this metric.

7. SIGNIFICANT GAPS IN CASEWORK

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
No Significant Gaps Observed in Casework Activity	11/20	55%

The positive compliance rate of 55% clearly falls in a range deemed as an Area Needing Improvement by OCFS's thresholds. We note that nine cases had a significant gap in casework activity of more than thirty days. Seven of these cases had a period of no casework performed for over 60 days, which is the OCFS' expectation for the case's entire duration (from SCR report date to Investigation Closing).

In cases with casework gaps greater than 30 days, periods of no recorded activity ranged from 39 days to 159 days, with an average of 89 days. Perhaps most troubling is that the alleged maltreated children in these cases were not observed by a caseworker for a period of 62 to 177 days, or an average of 113 days, before the investigations were closed. Although the allegations in these cases did not involve imminent risk, we find it critical that an alleged maltreated child be seen by a caseworker once a month so that any potential changes in safety factors and overall risk are identified.

FAR CASE REVIEW

A Family Assessment Response (FAR) team within Child Protective Services (CPS) offers a supportive, non-adversarial approach to handling certain child maltreatment reports. Instead of conducting formal investigations to substantiate abuse or neglect, FAR teams assess the family's situation to identify strengths and needs. This approach is less formal and typically involves voluntary participation, focusing on engaging families in a collaborative process to address underlying issues.

The primary goal of the FAR team is to connect families with community resources and services that can help them improve their situation, thereby reducing the risk of future child maltreatment. The process emphasizes building on the family's strengths, with the ultimate aim of enhancing family functioning and ensuring the safety and well-being of children without further CPS involvement.

Our FAR case review focused on key elements of the program. Initial steps taken for a FAR case mirror those for Investigation cases as 24-Hour and Seven Day Safety Assessments are still completed and family history is thoroughly reviewed once the report is received from the SCR. When the case is deemed appropriate for FAR, the Family-Led Assessment Guide governs case activity until closing.

1. INITIAL CASE RECEIPT AND REVIEW OF PRIOR HISTORY

Criteria Tested	**No. of Cases Compliant with Criteria**	**Positive Compliance Rate**
SCR Report meets FAR Eligibility	10/10	100%
Caseworker elicited sufficient supporting information from source	4/5	80%
Review of SCR records pertaining to all prior reports of family members	9/10	90%
All prior CPS/service records reviewed within 5 business days	9/10	90%

Overall, the unit performed their initial review of the selected cases well. We found that all ten cases met FAR eligibility criteria at intake and once further safety risks emerged in two of the cases, these cases were immediately transferred to the Investigations Unit. One case did not record review of family history in the Progress Notes, and one did not document any attempt to contact the source of the SCR report. Five cases were not successful in contacting the source, but sufficient attempts were made and recorded in the Progress Notes.

2. SAFETY ASSESSMENT AND REVIEW OF CHILDREN'S HOME ENVIRONMENT

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Adequate assessment of immediate or impending danger to all children within 24 hours	10/10	100%
Seven Day Safety Assessment completed timely	10/10	100%
Seven Day Safety Assessment was appropriate	10/10	100%
Unit responded to any immediate or impending danger	2/2	100%
If any safety concerns developed after the 7 Day, were they handled appropriately?	2/2	100%

As noted earlier, the initial review of the child(ren)'s home closely follows that found with an Investigation case. This was an area of strength with the cases reviewed as all ten cases exhibited adequate assessment of immediate danger and appropriate completion of the Seven Day Safety Assessment.

3. FLAG AND CASEWORKER INTERACTION WITH FAMILY

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Caseworker completed home visits and engaged the family	10/10	100%
FAR worker applied family engagement tools effectively	10/10	100%
FAR worker partnered with family to devise solutions to noted concerns	10/10	100%
FLAG used to guide discussions with family within first 30 days?	9/10	90%

Use of the Family-Led Assessment Response Tool was an area of strength in the cases reviewed. We note FAR workers consistently collaborated with families to create goals within the FLAG model and check on their progress through regular home visits in the first sixty days of the case.

4. CASE CLOSING AND ADDITIONAL SERVICES

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Services and support put in place when determined necessary	6/6	100%
Decision to close the case was appropriate	10/10	100%
If case open longer than 60 days, there was documented reasoning for keeping case open	0/8	0%
If case open longer than 90 days, FAR worker visited family every two weeks	0/4	0%

As with the Investigations cases reviewed, the FAR cases began strongly with timely and appropriate safety assessments performed but the case closing process lagged in timeliness and documentation of key events. Two cases were closed within 60 days, but the remaining eight reviewed had no documented reason for extending the duration of the case. Additionally, four cases were open longer than 90 days and there is no evidence the FAR caseworker performed regular visits with the family past the 90 days. It is likely these four cases remained open due to high caseloads experienced by the FAR caseworker and their focus being on new reports whose safety factors were not yet fully reviewed.

5. ADDITIONAL CASEWORK CONSIDERATIONS

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Progress Notes completed within 30 days of event date	6/10	60%
No Significant Gaps Observed in Casework Activity	3/10	30%
Evidence of supervisory feedback throughout casework	7/10	70%

The four cases that did not meet Progress Note timeliness contained notes that were entered between one to six months after the event date. As stated above, OCFS recommends notes be recorded in Connections within 30 days of the event; this helps ensure no critical details are forgotten by the caseworker. Additionally, timely entering of notes allows supervisors to check on case status in Connections at any given time and review up to date case information.

Similarly, we note that seven cases had gaps in casework of more than thirty days. Four of these cases had a gap of activity for over 60 days, which is when OCFS recommends FAR reports are closed by. However, cases can be open for up to 90 days if the county is helping the family with a specified need. Three of these four cases had no casework activity for over 90 days.

In cases with over 30-day gaps in casework, periods of no recorded activity ranged from 33 days to 169 days, with an average of 83 days. We note that the alleged maltreated children in these cases were not observed by a caseworker for a period of 35 to 191 days, or an average of 118 days, before the reports were closed. Although the allegations in FAR reports do not pose significant risk and OCFS does not have strict casework contact requirements for FAR, we find that children should be seen by a caseworker within 30 days of case closing in order to identify emerging safety risks.

Additionally, of the three cases that did not have supervisory feedback throughout casework, two cases reflected only one instance of supervisory feedback during the case. One case's Progress Notes did not include reference to supervisory feedback at all during the case. It is possible that feedback was delivered informally in this instance, but documentation is important for case review purposes as it assists the caseworker and their supervisor with remembering next steps to be performed.

BONADIO COMMENTARY REGARDING CASE REVIEW

Sullivan County met or exceeded OCFC's compliance threshold of 85% in the majority of the investigative metrics we reviewed. Despite these test results, both caseworkers and management acknowledged that there is still opportunity for improvement. This reinforces that the Division has a proper understanding of their abilities, the impact of their efforts, and how future improvements should be prioritized. Many caseworkers stated they find it difficult to complete some of their duties and prioritize daily activities while handling higher caseloads and helping train new workers.

It is also common that timely entry of progress notes, as well as cases that have lower safety risk allegations, often become a lower priority than other casework tasks that directly involve child safety. We find that improvement of progress note timeliness and gaps in casework should be areas of focus for the Division since documentation of these notes directly correlate to effective supervision, case review, and comprehension of a case's current status. Additionally, progress note quality can diminish the month after an event date simply due to the limits of one's recollection. We find this true even if caseworkers handwrite notes during an event and then enter them into Connections later.

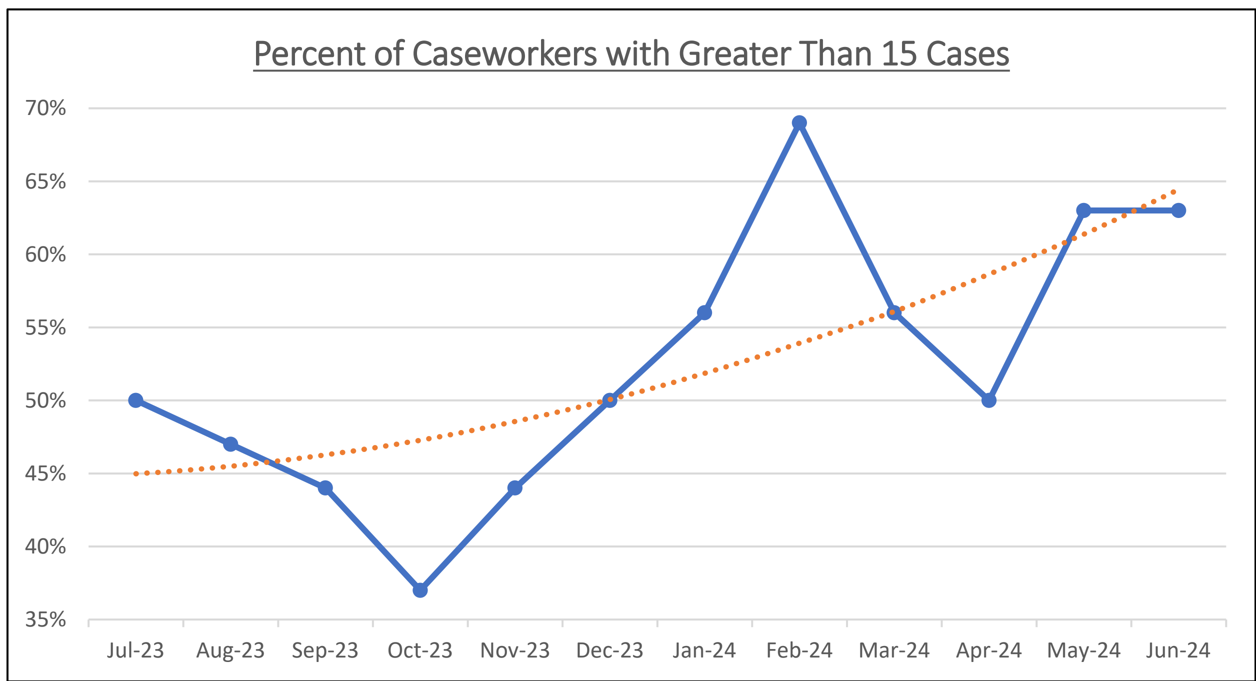
Handwritten lists will fail to capture all of the crucial elements of an event that would have likely been included if the actual progress note was written at the time of the event. Similarly, the cases we observed to have a gap in casework, and/or untimely history search performed did not have high safety factors identified in its assessments and were likely set aside as the Division focused on cases with more immediate safety needs.

ANALYSIS OF OCFS METRIC HISTORY AND CURRENT STANDINGS

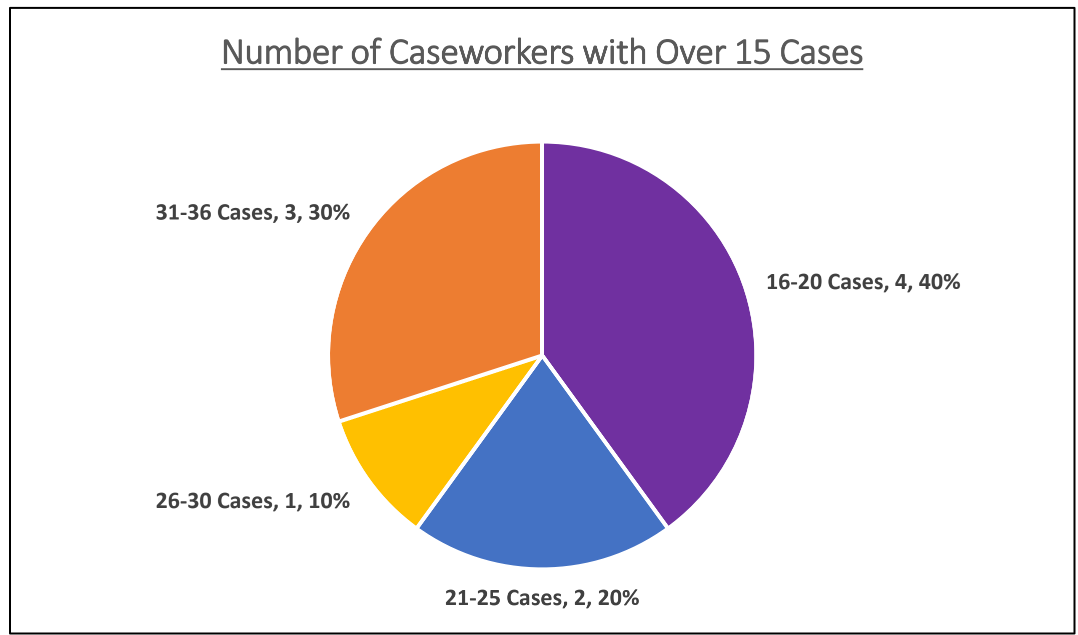
Child Protective Services Units in New York are regulated through OCFS. Three statistics are specifically tracked by OCFS related to the county's Child Protective effectiveness: the percent of workers with greater than 15 investigations, percent of overdue investigations, and percent of safety assessments approved within seven days. OCFS considers these metrics of primary importance as they are key indicators of child safety and a division's effectiveness at investigating reports received from the community. The metric results for all counties are distributed monthly to each county commissioner. The following section provides additional analysis of each metric considering the most recent data available.

Percent of Caseworkers with Greater Than 15 Cases

Each CPS case requires several facets of casework, regardless of the case's complexity. This includes home visits and interviews, collateral contacts with related parties, and review of records relevant to the investigation. Although OCFS does not set 15 cases per caseworker as an absolute maximum caseload, 15 is the threshold they measure against as a reasonable caseload to complete required elements timely and accurately.



During the 12-month period of July 2023 to June 2024, on average, the Division had over 50% of workers with caseloads greater than 15 cases. Sullivan County consistently ranked below the state median each month. The Division trended near an average of 45% for the last half of 2023 but since January 2024, its overall average percentage increased to about 60%. This results with a trendline (in orange) for the year that displays an overall trend of increasing caseloads. When compared to average caseloads of other NYS counties as of month-end June 2024, Sullivan County ranked fourth highest in average number of cases held by each caseworker.

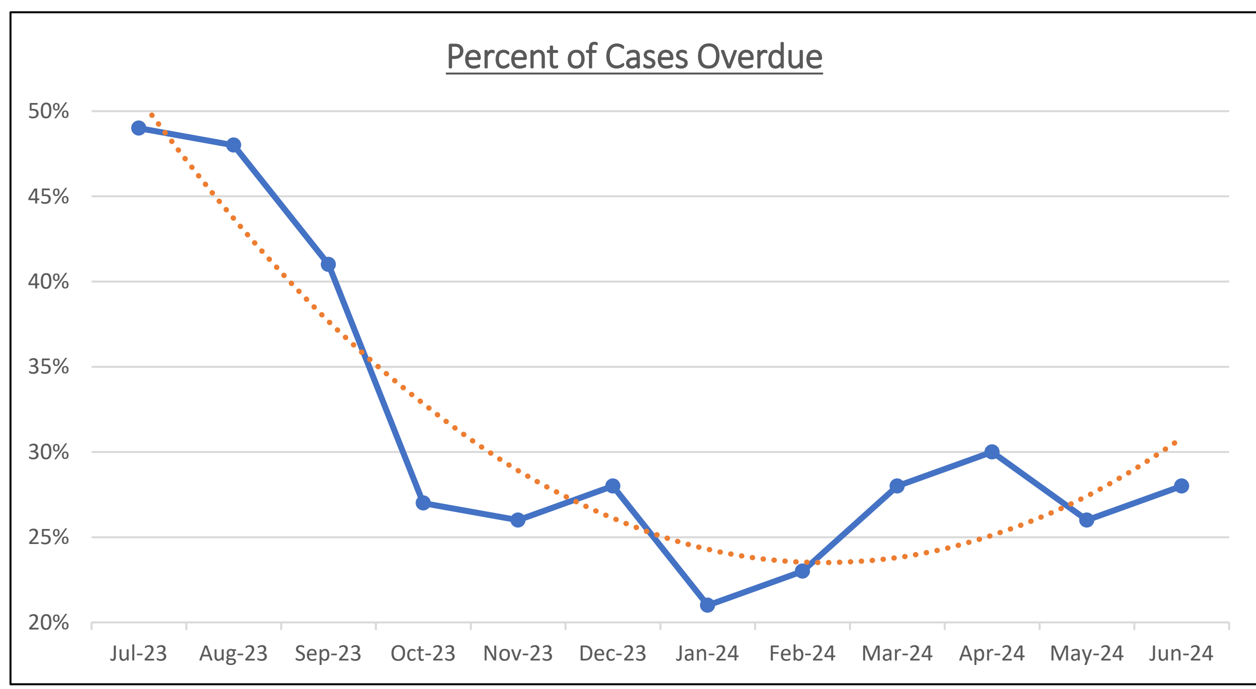


To further evaluate the current distribution of cases among workers, Bonadio obtained a listing of all caseloads as of June 17, 2024 and reviewed those with greater than 15 cases. In our analysis shown above, we note that almost half of the caseworkers with greater than 15 investigations had caseloads between 16 and 20 cases.

During our interviews with caseworkers, some with higher caseloads indicated that maintaining their cases often feels untenable. As shown in the graph above, six caseworkers have caseloads higher than 20 cases and four of them have higher than 25 cases. Caseworkers stated that a caseload of this level is unsustainable and leaves the worker only addressing cases requiring the greatest urgency. Cases with lower-level safety factors that do not present an immediate danger to the children involved end up becoming a secondary concern to the caseworker and then lead to an increase in overdue cases as the cases with lower initial safety factors remain open.

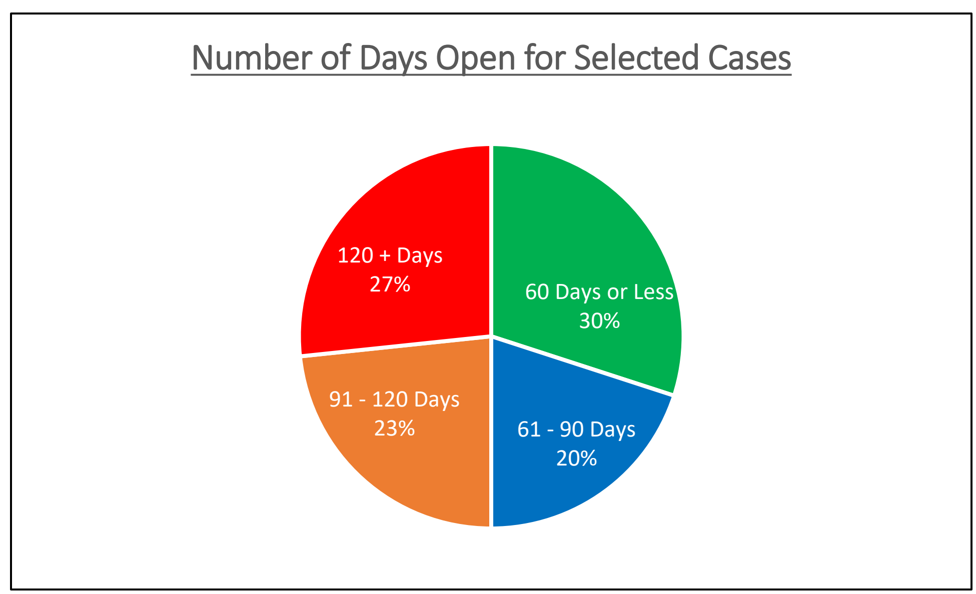
Percent of Cases Overdue

Since July 2023, on average, more than 30% of the County's CPS investigations have been overdue on average according to OCFS' monthly reporting. The percent of overdue cases ranged from 21% to 49%, with July, August, and September 2023 having the most overdue cases. Sullivan County has consistently performed below the NYS median from July to December 2023 and March to June 2024. In January and February 2024, the County ranked at or within five points of the NYS median. The County's ranking in this metric at month-end June 2024 was below the NYS median and ranked 38th of 64 counties.

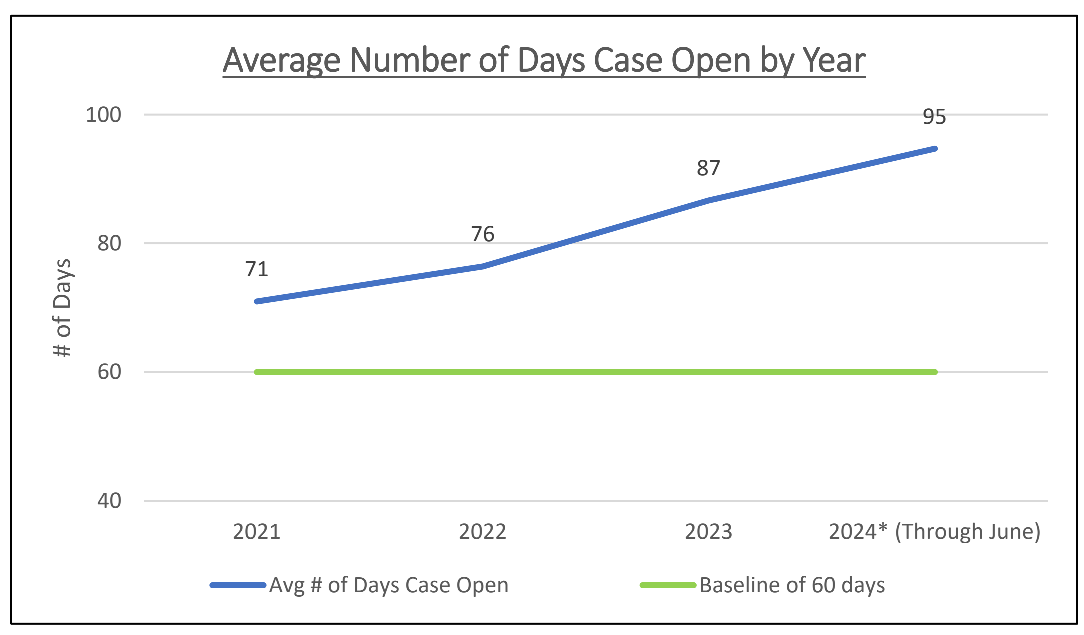


Per chapter six of the *New York State Child Protective Services Manual*, "CPS has the sole responsibility for making a determination within 60 days after receiving a report whether there is some credible evidence of child abuse or maltreatment so as to either indicate or unfound the report." This requirement seeks to encourage caseworkers to balance required case activity with the need for timely determination and potential subsequent action regarding case allegations.

We found that 70% of our cases selected were overdue (21 cases). The pie chart on the following page details these results. Of these cases, six were closed between 61 and 90 days, seven were closed between 91 and 120 days, and eight were closed more than 120 days after the intake date. Only nine cases in our selection were closed timely in 60 days or less. The overall average number of days our selected cases were open was 99 days, with the longest investigation in our selection open for a total of 208 days – more than three times higher than the OCFS recommended duration of 60 days.



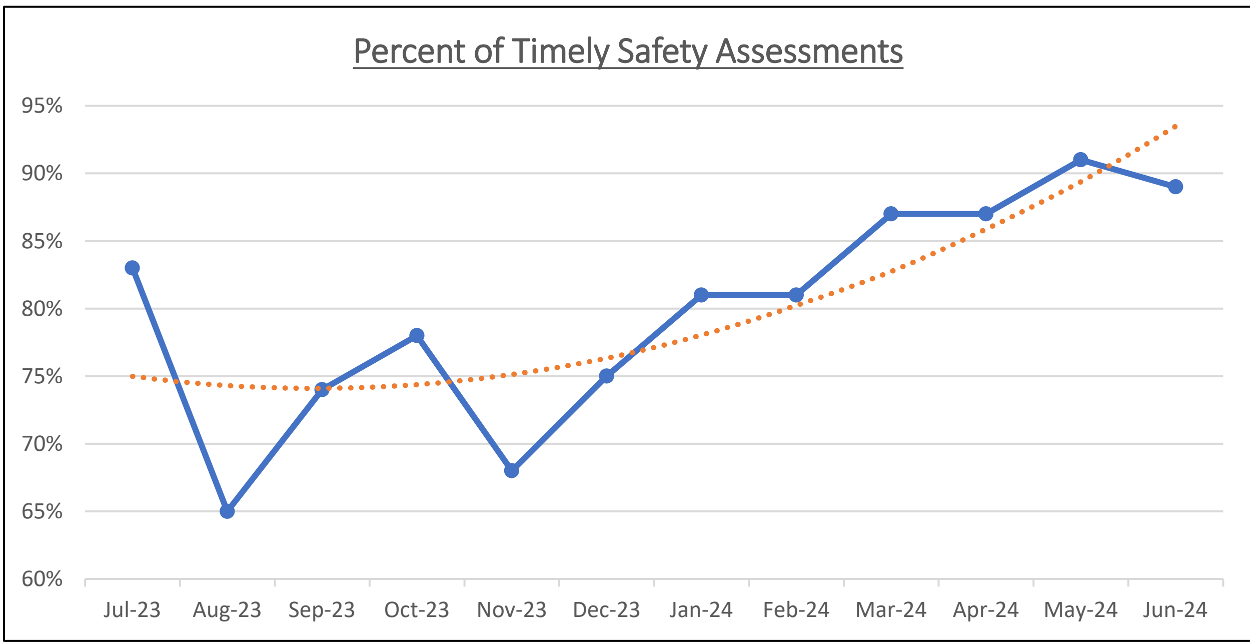
Additionally, as shown below, during our analysis, we reviewed cases with opening dates since January 2021 and found that fully processing an investigation on average has taken about 82 days: 71 days in 2021, 76 days in 2022, 87 days in 2023, and 95 days through the first half of 2024. This is a full 37% longer than the time recommended by OCFS. Further, of cases that are overdue during this period, they are on average overdue by 42 days: 28 days in 2021, 35 in 2022, 48 in 2023, and 56 days through June 2024. This shows that the causes of cases being overdue are persistent, especially with the number of cases received decreasing by over 1% from 2021 (1,061 cases) to 2022 (1,050 cases) to 2023 (1,030 cases).



As of mid-June 2024, caseworkers that had more than 15 open investigations also carried 82% of the overdue cases despite being 63% of the total number of caseworkers. 43% of all cases were past the 60-day OCFS metric per the June 17, 2024 OCI report, with days these investigations were open ranging from 61 (one day late) to 192 (132 days overdue).

Percent of Timely Safety Assessments

Timeliness of safety assessments is the third metric distributed to counties monthly by OCFS and is performed at the initial stages of an investigation. The assessments determine if there is an immediate safety concern with the children reported in the case and help set the direction of the case through interviews with the children, the subject, and any readily identifiable collateral contacts. Supervisory review is required before completion and should include guidance as to next steps that should be taken by the caseworker. This assessment must be approved within seven days of receiving the SCR report.



Sullivan County has experienced an improvement in safety assessment timeliness thus far in 2024 compared to most of 2023 (please note that this metric denotes improvement when the percentage increases and worsening of conditions as the percentage lowers). The timeliness of assessments has been about 80% on average since July 2023. The County has consistently ranked at or within ten points of the state median since January 2024. The most current reading is one of the highest for the Division thus far in 2024 at 89%.

Of the 287 cases shown on the caseload listing pulled on June 17, 2024, only 26 cases had overdue safety assessments. Half of these were only one day overdue, and the other half had safety assessments performed two to five days late. We note that this statistic is fairly positive compared to other counties in the state and the County's other two metrics.

BUDGETED POSITIONS & CASELOADS ANALYSIS

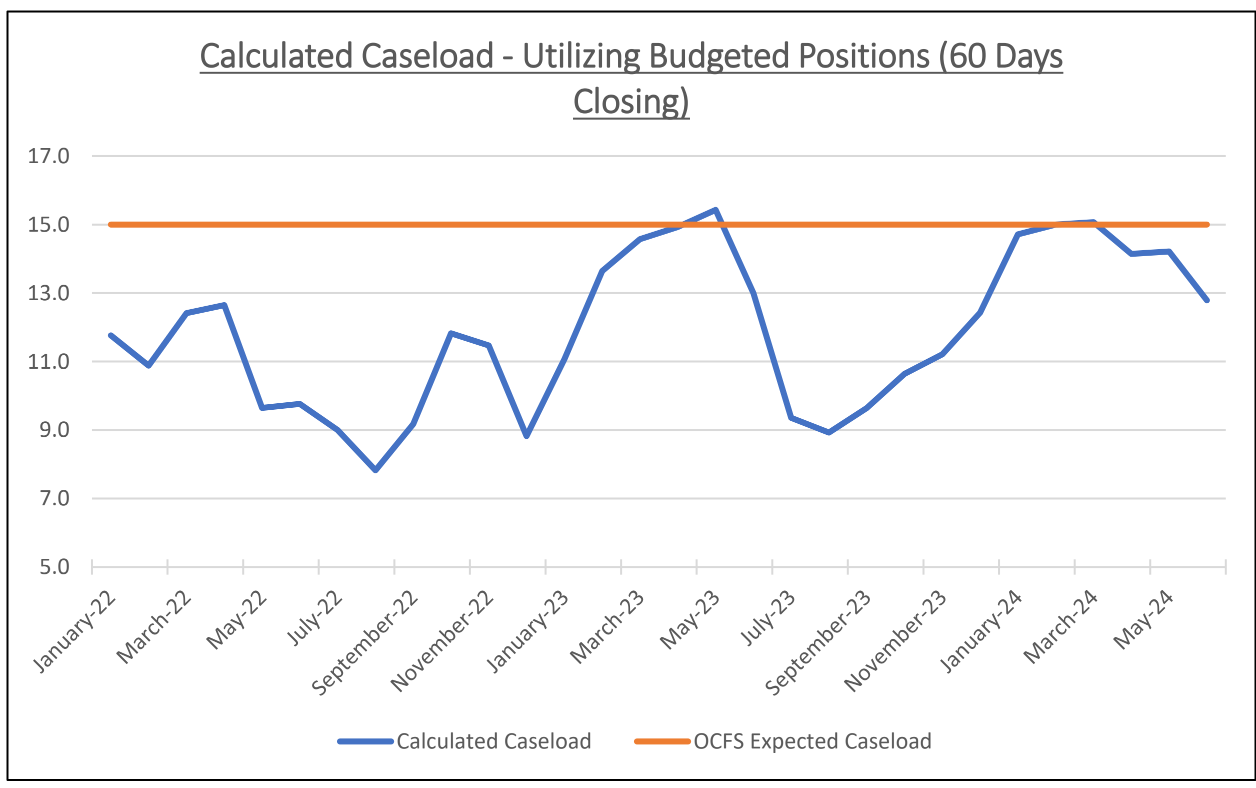
The three metrics analyzed on the previous pages demonstrate that while the Division is efficient at processing incoming investigations during their initial stages, the Division has difficulty effectively completing these investigations. We find this primarily due to turnover and fewer experienced caseworkers. Over the past two years, the Division has struggled with a gradual decline in available caseworkers, with a staff of 17 CPS caseworkers in September 2022, a decrease to 15 in September 2023, and a decrease to about 13 caseworkers able to have a full caseload as of mid-June 2024. Caseworkers absent due to sickness, vacation, FMLA, or training further reduce the number of caseworkers available to receive new SCR reports. We note that in total, about 17 caseworker and senior caseworker positions are currently budgeted for CPS.

The analysis in this section considers whether the Division has budgeted sufficient positions for CPS investigations. We find that this initial question is often difficult to determine but is crucial when evaluating a division's effectiveness. If too few positions are available, no amount of shuffling or new procedures will sufficiently increase productivity to meet casework demand. Alternatively, if an adequate number of positions are budgeted, the Division may further focus on greater efficiency and compliance. In an effort to find a common basis for discussion of budgeted positions, our analysis starts with the basic assumption that the OCFS recommended caseload of 15 cases is reasonable. This is also reflective of statements made during our interviews with caseworkers and in line with statements made by staff in other counties we have worked with in previous engagements. Considering this, we find the OCFS recommended caseload both a reasonable basis for our calculations and a starting point for objectively discussing workforce levels in the Division.

Budgeted Positions and Casework Effectiveness

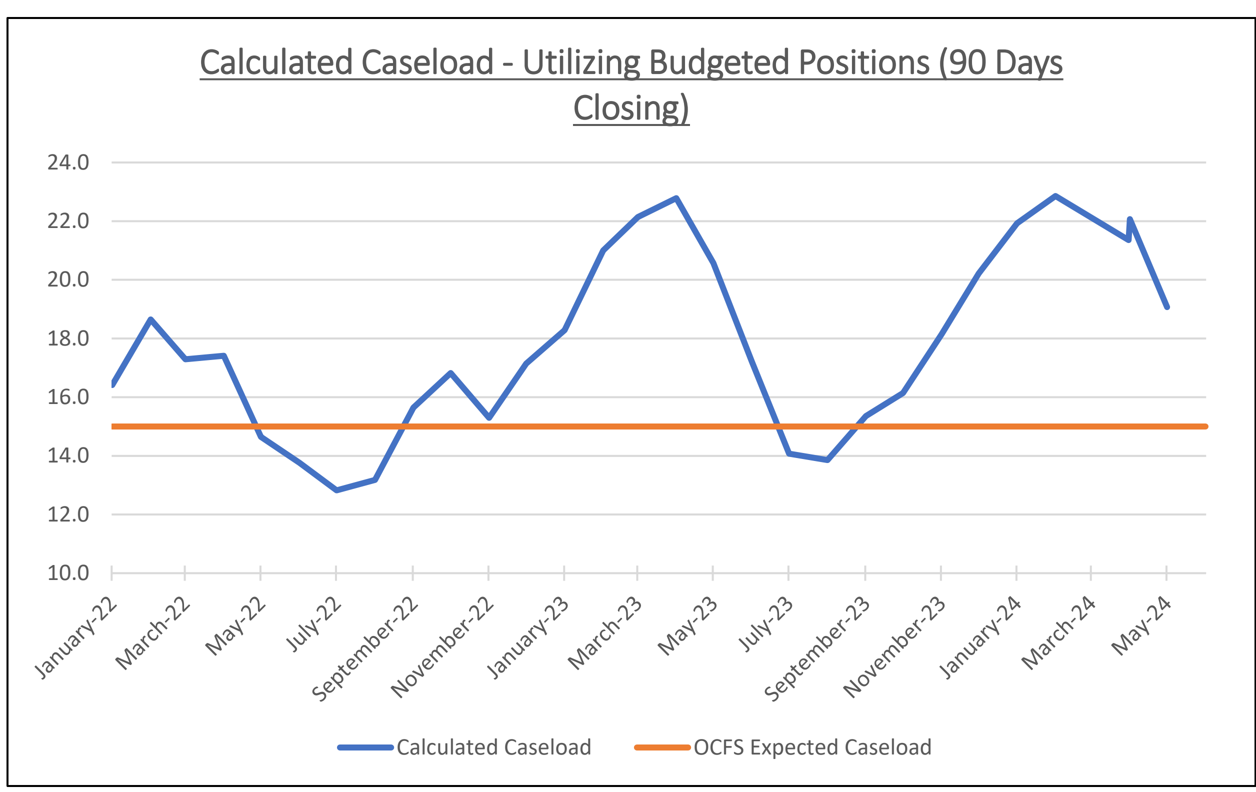
As noted above, the Division has not recently been fully staffed and as of June 2024, has approximately 7 open CPS caseworker and senior caseworker positions. The two graphs on the following pages consider how effective the Division would have been if fully staffed from January 2022 through June 2024. The first graph depicts the average caseload size if on average cases close within the 60 days expected by OCFS. The second graph displays caseloads if the average case is closed in 90 days.

In an effort to accurately reflect the number of staff that would actively accept reports at any given time, we have removed three positions from the total available in all months. This accounts for those caseworkers not taking reports due to vacation, sickness, or training. We find that our estimate of three caseworkers, or over 10% of available caseworkers, is an attempt to provide conservative calculations, as in reality, fewer individuals are out on average in a division.



Each calculation utilizes SCR report data obtained from Connections. The number of reports utilized for each month accurately reflect the Division's intake for the period. This analysis of caseloads utilizing 60-day closings shows that caseloads would remain below the OCFS recommended level of 15 cases for nearly the entire period under review. The overall average for the period would be just above two-thirds the recommended level at about 12 cases.

The results shown on the 90 days closing graph on the next page significantly differ. Estimated caseloads are above 15 cases for almost the entire period. Caseloads average at 17.8 cases per caseworker for the period.



Both graphs taken together present useful insight into the adequacy of currently budgeted positions to sustain the historical volume of reports received by the Division. The first graph represents caseload levels at optimal efficiency while the 90-day closing graph more closely reflects the Division's current efficiency level. Using data provided through Connections, we collectively averaged case duration for each year during this period. We found that the average CPS case duration was approximately 82 days and thus resembling that of the 90-day closing graph. This suggests that if fully staffed, the Division would maintain average caseloads above the 15-case recommended level.

Additionally, we calculated the number of caseworker positions needed to maintain caseloads of 15 cases if the average case closes in 90 days. We found that approximately 20 budgeted positions would be needed, based on the number of SCR reports received by the County over the last year (July 1, 2023 – June 30, 2024). As in prior calculations, this includes omitting three caseworkers from those available to take reports due to training, sickness, or other factors. Thus, a total of 17 caseworkers on average must be available to receive new cases to maintain caseloads of 15 cases with 90-day closings.

The previous calculations establish a baseline understanding of positions needed to fulfill state metric requirements in optimal circumstances. Further discussion of this topic should consider Division budgeted positions in light of current circumstances. We acknowledge that the calculations do not specifically account for factors that cause above normal work burden at a particular point in time, such as periods of high turnover and cases of greater complexity (e.g. cases involving legal proceedings or child removals).

We note that as of mid-June 2024, the Division had approximately 13 caseworkers available to receive SCR reports, two caseworkers less than the number required to maintain optimal caseloads at 60-day efficiency, based on the number of SCR cases in the previous 12 months. Additionally, the Division is approximately seven caseworkers short of maintaining their real average closing time of nearly 90 days. Considering the calculations presented in this section, we recommend the County consider the analysis above when determining whether additional caseworker resources should be allocated.

IV. Preventive Services

INTRODUCTION

Preventive services are provided to families in the community to prevent the removal of children from their homes and qualify as "reasonable efforts" required by law. The Preventive Services Unit (Preventive) consists of seven workers including one case supervisor, five caseworkers and one clerk. During our engagement, there we no official vacancies in this unit. Preventive is supervised by a designated Services Coordinator, whose role and responsibilities mirror those of a traditional Grade B Supervisor in other LDSS.

In general, the Preventive Services Unit handles cases that originate from the CPS Investigative Unit; cases that originate from the FVRT/CAC or Positive Tox units are not transferred to this unit and instead, remain with the designated FVRT/CAC Senior Preventive Caseworker who is forensically trained. If a case is indicated (and often before the investigation is even closed), investigative personnel will email an internal referral form to a designated Preventive email address. This email account is monitored by the preventive unit clerk and initiates the case transfer process.

The Case Supervisor is responsible for deciding which cases will be accepted and identifying services best suited for the family. The case then progresses from the Connections Family Services Intake (FSI) stage to a Family Services Stage (FSS). Cases that are not opened in Preventive are considered for Medicaid services or are referred to Unite Us, a social care technology platform to connect clients to network partners (e.g., providers) to identify and deliver services.

Within the past 18 months, the Unit transitioned to a contract model and is authorized to spend $1,123,500 annually on these services including, but not limited to, crisis intervention, homemaker services and youth empowerment. Please note, these contracted services do not include an additional $55,000 in supervised visitation services with a separate provider, Dispute Resolution. Unit caseworkers are assigned to monitor casework performed by a handful of contracted agencies, including Children's Home of Wyoming Conference (CHOW), Youth Advocacy Program (YAP), Rehabilitative Support Services (RSS) and Access: Supports For Living. In general, once the Unit case supervisor reviews the referral and determines that the family is eligible for services, she will assign unit and agency workers functional roles and responsibilities that correlate to the Connections system roles that are highlighted below.

- Case Manager: There is one Case Manager for each family receiving services. The Case Manager role is assigned to the unit preventive caseworkers and is responsible for the following:
    - Coordinating and attending an initial face-to-face with the family and the service
    - Approving a service plan
    - Monitoring casework contact
    - Completing the Initial FASP and approving subsequent FASPs
    - Completing courtesy home visits at their discretion
    - Reviewing case notes and attending case conferences

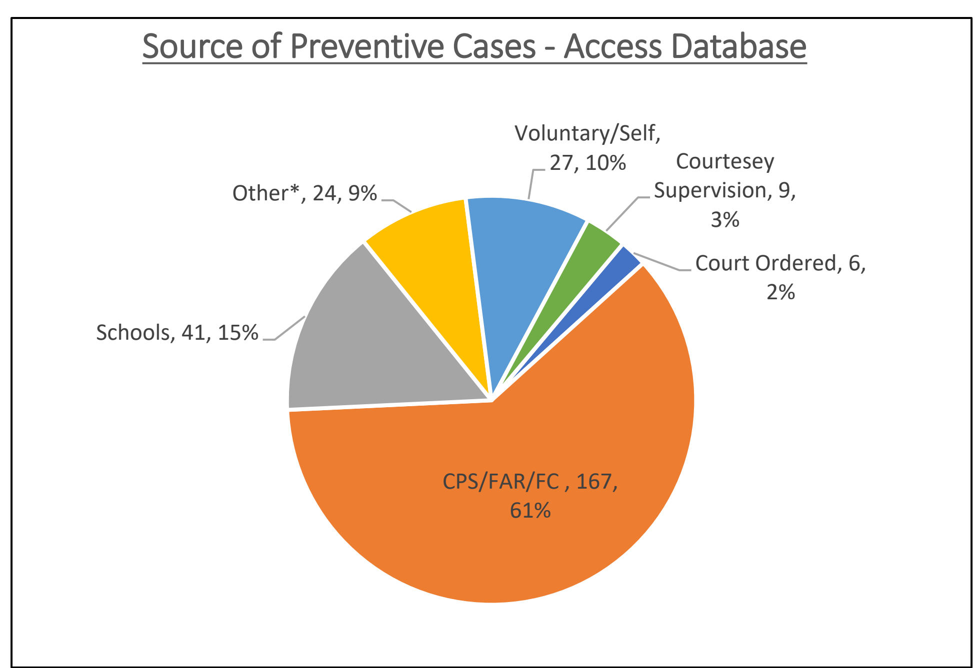
- Case Planner (CP). The CP role is assigned to the service providers and is responsible for:
    - Developing a service plan with the family
    - Meeting with the family/child face-to-face in accordance with OCFS guidelines
    - Following up with collateral contacts and additional service providers
    - Completing the FASP
- Any additional employees involved in the case are assigned a Caseworker role.

Per our interviews, the Unit's caseloads and responsibilities vary based on the referral source, case circumstances, and third-party agency caseworker. While referrals originating from CPS and FAR are documented via an internal form, schools utilize a paper referral form or call the case supervisor directly. Unit workers stated that at times they do not perform fieldwork and feel they have capacity to take on additional work. Workers also expressed frustration with the rate of recidivism, and the length of time they spend on cases that have been opened for "far too long." This is not uncommon as many DSS struggle with defining an appropriate time to close cases as no two cases and criteria to do so is often subjective in nature. Per the May 10, 2024 Family Services Open Caseload Inquiry (OCI) report, 79 cases were open; however, 11 of these cases were in the FSI stage and therefore, may not be progressed per the family's request or lack of cooperation.

Unlike CPS investigations, OCFS does not provide extensive regulatory requirements workers must adhere to at each stage of a Preventive case that are used to measure the quality of preventive services casework. In preventive service cases, especially ones that are not court-ordered, the decision of when to end services and close the case is reliant on the unit's evaluation of the services effectiveness and the family's cooperation. During our case review, we relied on our experiences with other LDSSs, our understanding of the unit's internal processes, and our professional judgement to assess the consistency and quality of documented casework.

CASE REVIEW SAMPLING METHODOLOGY

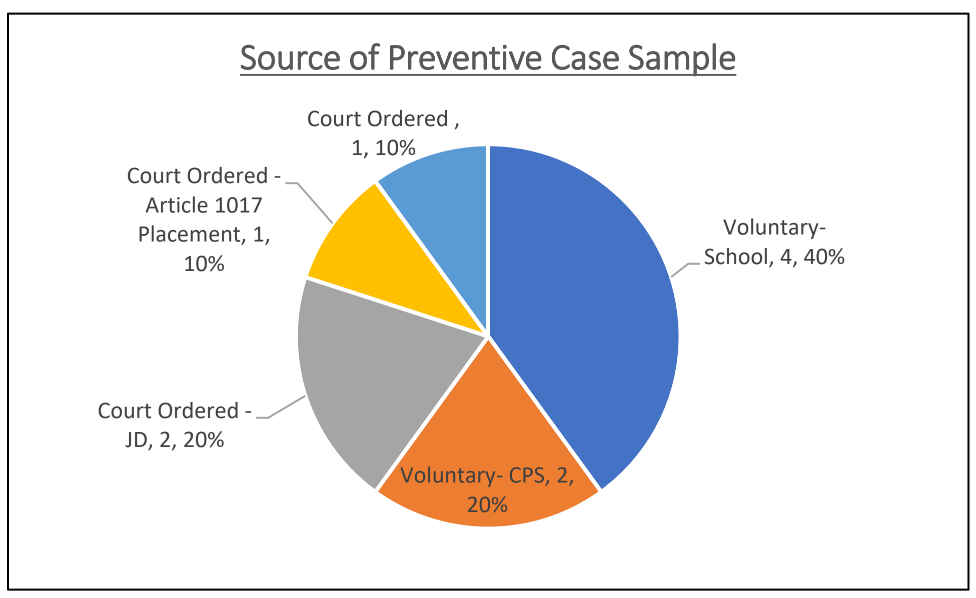
In accordance with our PSA, we performed a review of ten preventive services cases. We obtained the manually maintained Microsoft Access database used to track referrals and filtered the detail to include cases active within the 18-month period of November 1, 2022 through April 30, 2024. Per the database, 280 cases (approximately 15 per month) were referred to the Unit and 157 cases (approximately 8 per month) were closed during the period. These statistics include cases that were not progressed to an FSS stage and cases that were closed shortly thereafter.



We intended to select our sample from the Database; however, it appeared that it was not entirely accurate (refer to Observation and Recommendation No. 3). Utilizing auditor judgement, we selected our sample of cases from the May 10, 2024 Open Caseload Inquiry (OCI) Report. We intentionally selected a variety of referral sources that were progressed to an FSS stage and open for a minimum of three to six months to ensure we had sufficient detail to assess quality of casework and trends in processes.

CASE REVIEW RESULTS

Our case selection varied in terms of source, children's ages, behaviors and extent of safety concerns. Specifically, seven of the ten cases we tested included children between the ages of 8 and 17. Issues included children's mental health and threats of self-harming, parent's housing and/or school attendance. Two of the remaining three cases included young children and/or allegations of domestic violence and drug abuse. Each of the ten cases were deemed to be at "imminent or serious risk of placement into foster care" at the time that the initial candidacy was performed. Case sources are captured in the pie chart on the following page.



1. FREQUENCY OF CASEWORK CONTACT WITH FAMILY RECEIVING SERVICES

Per the OCFS Preventive Services Manual, there must be a minimum of 12 casework contacts with a child and/or at least one family member within each six-month period of service beginning at the Case Initiation Date (CID). Only contacts made by certain providers "count" towards required casework contacts in a preventive services case. Both a person providing specialized or supportive services (e.g., a worker from the contract agency) and the case planner (the Division's preventive caseworker) count towards this requirement. Two of these contacts must take place in the family's home.

Please note, we excluded one court-ordered, JD case from this test criteria as the child had recently entered an out-of-state inpatient substance abuse at the time the case was progressed. During this time, the assigned worker made contact via phone with probation officers, medical providers, and the child's legal guardian.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
12 Casework Contacts Within 6-Month Period	7/9	78%

In the cases that met the testing criteria, we identified multiple instances of caseworkers having face-to-face contact with the families receiving services multiple times a month and thus exceeding the required minimum. A vast majority of these face-to-face visits performed by workers from contracted agencies, including YAP, CHOW and RSS MST, exceeded the frequency requirement and even overlapped with DSS workers' visits. We found that DSS caseworkers and supervisors had contact with the families, albeit less frequent than agency workers and most contact was limited to initial face-to-face contact following case candidacy.

The following two cases were identified as exceptions:

- Case A-
  A case was referred to the Unit by CPS in November 2023 but the family was not seen until January 2024. A court-ordered educational-neglect case was submitted by CPS to the Preventive Unit five weeks after the CID. The assigned initial Preventive worker was not successful at meeting with the family but documented their attempts. The case was subsequently transferred to a new worker who also documented their efforts at meeting with the family. Outside of court, workers did not see the family for over three months.

- Case B-
  The family appeared to be working with various service providers and in February 2024, had expressed that they no longer wanted to work with the Division. As of May 10, 2024, the children had not been seen since and the case remained open per the Family Services OCI. While this may not necessarily indicate a true gap in casework, it does reinforce the importance that cases are closed timely.

2. FREQUENCY OF CASE CONFERENCES WITH AGENCIES

According to our interviews, Preventive workers meet with workers from contracted agencies on a consistent basis to discuss family progress, next steps, goals, and whether they believe the case should remain open. Due to the number of agencies and Division workers involved in these cases, consistent communication and transparency is critical to avoid casework redundancies and gaps.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Quarterly Review Performed	9/10	90%

Overall, documented case conferences are an area of strength in the Unit. In many cases, we noted virtual and in-person case conferences were held and documented more than quarterly, and often, monthly. Please note, we did not assess compliance with supervisory review as case conferences typically overlapped and served as evidence that DSS Case Managers or Supervisors were actively managing the case, guiding service providers and aware of the families' progress. We also noted that for cases where a separate investigation was active at some point throughout the services case, workers from the CPS and FAR units were appropriately included in case conferences.

One case failed to meet our testing criteria and also failed to meet the testing criteria in Test 1- Frequency of Casework Contact (case B above). Throughout the 12+ month service period, case conferences with workers from the unit as well as CHOW were held at several weeks after the referral date and not again until six months later. We note that the case was transitioned to a new worker on two separate occasions during a 12-month timeframe due to staff turnover. The family expressed they found this disruptive to their case. These exceptions demonstrate how turnover disrupts the consistency of casework and often has a negative effect on level of care received by a family.

3. TIMELINESS OF REFERRALS TO CONTRACTED SERVICE PROVIDERS

Once an internal referral form is completed and submitted to the Preventive Intake inbox, cases are assigned to preventive workers. Among other information, the referral source indicates the agencies with which a family is currently engaged, if any. For voluntary and court-ordered cases, workers most often meet with the family at their residence to obtain signed releases. While most referrals are submitted within the first few weeks of the CID and in conjunction with the initial home visit, workers may submit additional referrals as they became increasingly familiar with the family's situation. Submitting referrals timely is crucial as the longer they are outstanding, the longer the family is not receiving services and thus, unable to work toward their agreed upon goals.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Referrals Submitted Timely to Providers	8/10	80%

Generally, this was an area of strength within the unit. We did identify two cases that did not meet the case criteria. For the first court-ordered case, a six-week delay in case assignment and an eight-week delay in an initial home-visit created the gap in this aspect of casework. The second exception involved a non-court ordered case. The case was referred to the Unit by CPS; however, the assigned Preventive caseworker did not initiate casework contact until eight weeks after the referral was received and the case opened. It should be noted that CHOW was working with the family at the time and the case was closed, at the request of the family, shortly after initial contact was made.

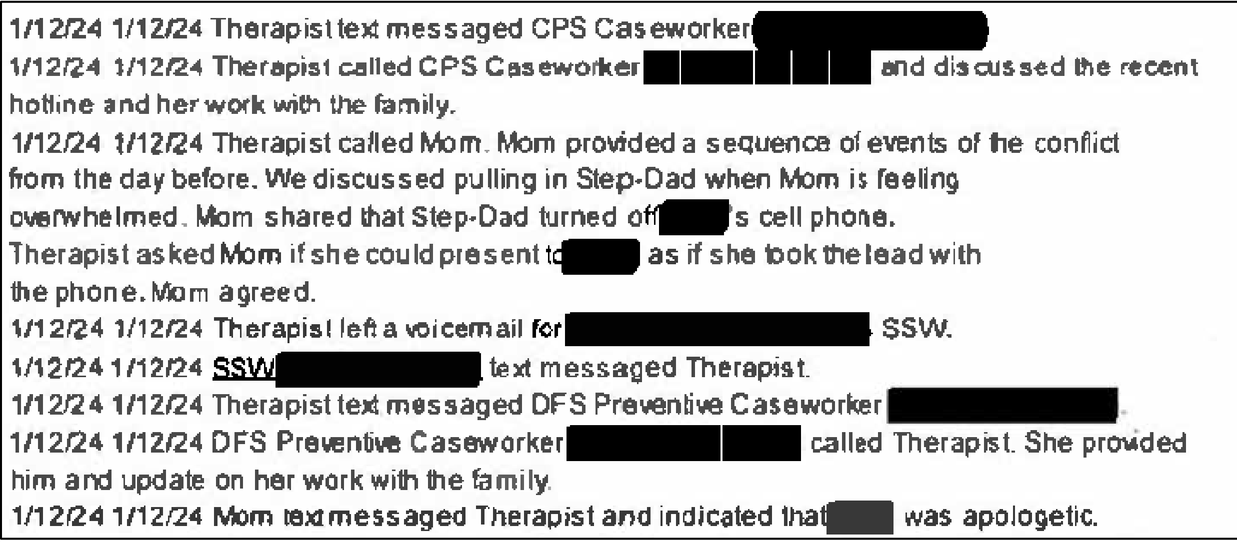
4. PROGRESS NOTES INPUT WITHIN 30 DAYS OF CASE EVENT

OCFS guidelines state that progress notes should be input within 30 days of the case event. This ensures both relevance of the content and accuracy of the progress notes.

Criteria Tested	Positive Compliance Rate
Notes Input within 30 Days of Event	95%

The unit and agency workers' compliance with this metric is an area of strength. We noted a general trend of robust case activity as well as case conferences and updates with non-agency service providers (e.g., medical providers) logged on the actual event date or within the week. One case contained multiple incidents of late notes (e.g., four months post event date). It should be noted that all these incidents involved a case supervisor entering notes, including text messages and face-to-face contact, with the family on behalf of an RSS MST therapist as these specific service providers do not have Connections access. On several occasions, notes were over a page and a half.
Our corresponding recommendation related to this observation is captured in IV- General Child Welfare Observations & Recommendations.

The excerpt below illustrates the tedious nature of the activity:


1/12/24 1/12/24 Therapist text messaged CPS Caseworker [redacted]
1/12/24 1/12/24 Therapist called CPS Caseworker [redacted] and discussed the recent hotline and her work with the family.
1/12/24 1/12/24 Therapist called Mom. Mom provided a sequence of events of the conflict from the day before. We discussed pulling in Step-Dad when Mom is feeling overwhelmed. Mom shared that Step-Dad turned off [redacted]'s cell phone. Therapist asked Mom if she could present to [redacted] as if she took the lead with the phone. Mom agreed.
1/12/24 1/12/24 Therapist left a voicemail for [redacted], SSW.
1/12/24 1/12/24 SSW [redacted] text messaged Therapist.
1/12/24 1/12/24 Therapist text messaged DFS Preventive Caseworker [redacted].
1/12/24 1/12/24 DFS Preventive Caseworker [redacted] called Therapist. She provided him and update on her work with the family.
1/12/24 1/12/24 Mom text messaged Therapist and indicated that [redacted] was apologetic.

5. CORRESPONDENCE WITH COLLATERAL CONTACTS AND SERVICE PROVIDERS

As mentioned in the Background section, Case Planners are responsible for, among other duties, following up with collateral contacts, such as school personnel, medical providers, law enforcement, and additional service providers. Case Planners must obtain updates from these external agencies at various points in the case to measure the family's progress and to explore ways to re-engage families that are non-responsive. While OCFS does not define a specific frequency, we used our professional judgement on a case-by-case basis to determine assess compliance in these specific areas. For most services, we considered less than monthly but more than quarterly an ideal frequency. We also considered the extent of communication with schools for school-aged children if the case circumstances (e.g., behavior and attendance) warranted additional communication.

Criteria Tested	Positive Compliance Rate
Correspondence with Collateral Contacts and Service Providers	90%

Overall, we found that Case Planners consistently obtained updates and maintained communication with service providers. In six of the ten cases, the only service providers involved with the families were RSS MST and YAP. Evidence of correspondence was documented via formal meetings between the two agencies as well as the Case Manager noting that they reviewed the notes and were up to date on case circumstances. In the remaining four cases, Case Planners initiated and maintained contact with service providers on a consistent basis throughout the case.

Our case review found that contact with school personnel was the only collateral contact that was largely infrequent and an area in need of improvement. Please see our Recommendation #4 in Section VII of this report for further discussion of the Division's interaction with school districts.

V. Foster Care

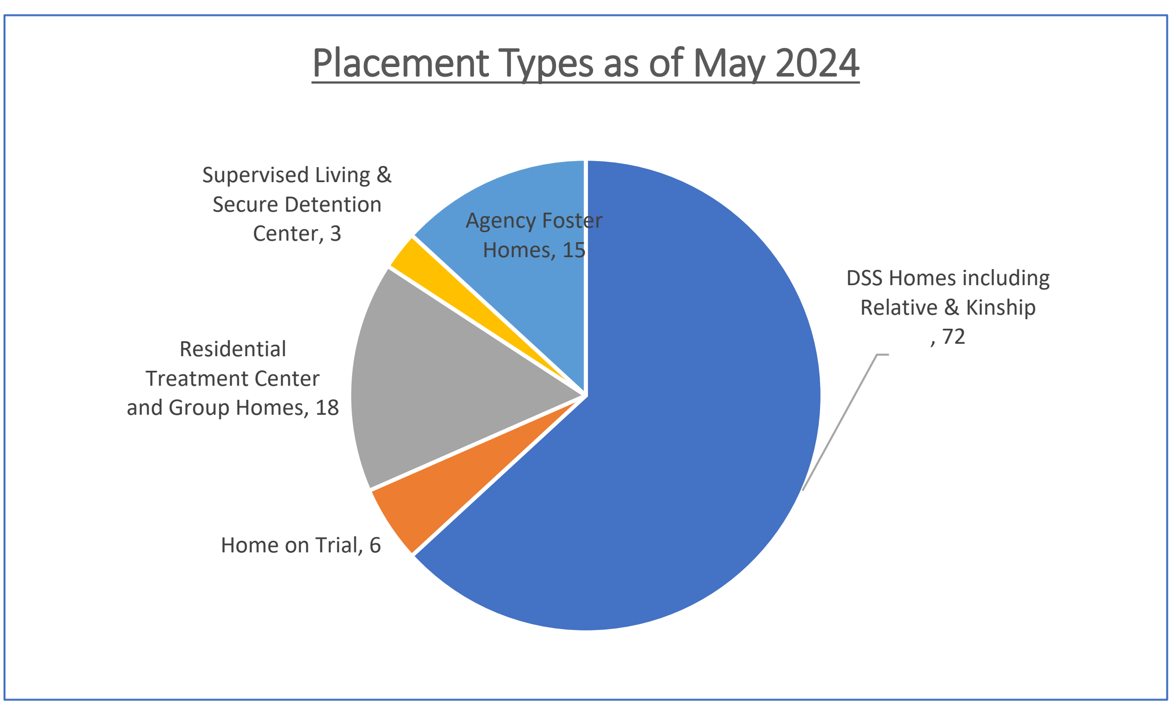
INTRODUCTION

The Foster Care Unit at the County consists of seven workers – one case supervisor, four caseworkers, one clerk, and one Senior Social Welfare Examiner. Throughout the course of our engagement, there we no official vacancies in this unit. However, as of month-end August 2024, one foster care worker had resigned. This unit is supervised by a designated Services Coordinator, whose roles and responsibilities mirror those of a traditional Grade B Supervisor in other LDSS. Following a recently implemented robust case transfer process, cases get transferred from the Investigations Unit to the Foster Care Unit. In rare instances, investigative cases that originate from the FVRT/CAC or Positive Tox teams are not transferred to the Foster Care Unit and instead, remain with the designated FVRT/CAC Sr. Preventive Caseworker who has been forensically trained.

Cases are subsequently transferred to a foster care worker based on contract agency. At the onset of our engagement, CPS and Foster Care were not holding formal case transfer meetings. Although this is not an OCFS requirement, based on our experiences with other NYS DSS, case transfer meetings are a best practice that eliminates confusion as to which worker is responsible for which required tasks and dates for which tasks should be completed relative to court CID. A well-defined case transfer process also minimizes the likelihood that time-consuming tasks are duplicated during this notably transitional period for both the Division and the family. Towards the end of our engagement, the Division implemented a robust case transfer process for all foster care and Article 10 direct placements. Specifically:

- Transfer meetings are mandated for every placement
- Case conferences between supervisor and caseworker are formally documented, demonstrating the collaboration and timely follow-up on critical tasks
- A template to guide caseworkers on each face-to-face foster home visit
- A monthly Birth Parents Update Case Summary form

As of the date of our foster care case selection, 114 children were in the County's care. Like most counties, the County relies on a combination of local DSS foster homes, approved relatives and kinship as well as a handful of third-party voluntary agencies for all placements. These placement types, as well as the child's assessed level of care (LOD) correspond to per diem rate, which we assess in Observation No. 3. The pie chart on the following page illustrates the breakout in placement type of the County's foster care population as of May 2024. Please note, we combined kinship, relative home and local foster homes certified by the County (as opposed to a third-party agency where administrative fees apply) to highlight the volume of these types of placements as they are the most cost-effective option for the County. It should be noted that the volume and percentage (63%) of these types of placements is well above the average rate of 53% of two other NYS counties we have worked with in the past year. The rate of placement types also demonstrates the Departments commitment to keeping children with kin and in family-based settings under the Family First Prevention Service Services Act.



CASE REVIEW SAMPLING METHODOLOGY

In accordance with our PSA, we selected ten cases in which children were removed from their homes and placed into the care and custody of Sullivan County Foster Care. We selected eight cases from the Unit's manually maintained *Foster Care Placement* Excel spreadsheet. This listing reflects all children in the County's care as of the first week of June 2024 and includes placement date and general placement type (e.g., Residential Foster Home and Therapeutic Foster Boarding Home). To ensure our sample was representative of the Unit's population during our scope period and included children that were recently discharged, we selected two cases from a December 2022 through June 2024 Cognos Discharge Report.

We split our foster care case review results and related observations into three sections: Child Safety, Well-Being, and Permanency, Internal Operating Procedures, and Fiscal Operations. Due to the subjective nature of certain aspects of a case review and the fiscal impact to the County, we used our professional judgement to categorize each of the various items into one of the three sections. Please note, our cases and sample size subject to Section 3- Fiscal Operations, our sample of cases varied based on per diem rates, placement type and Title IV-E Foster Care determination.

CASE REVIEW RESULTS

SECTION 1: CHILD SAFETY, WELL-BEING, AND PERMANENCY

1. FREQUENCY AND LOCATION OF FACE-TO-FACE CONTACT WITH CHILD

Per OCFS, during the first 30 days of placement, caseworkers must have contact with the children as often as necessary to implement the services and at a minimum, twice. Furthermore, at least one of the initial contacts must take place at the child's placement location. Please note, for four of the ten cases we reviewed, the children were placed into care or freed for adoption well in advance of our scope period and therefore, these criteria did not apply.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Children seen twice within the first 30 days of placement.	5/6	83%
The first contact was at the placement location	5/6	83%
After the 1st 30 days of placement, caseworkers had face-to-face contact with the child and those caring for them at least monthly.	8/10	80%
At least two of the monthly contacts every 90 days were at the child's placement location	8/10	80%

Compliance with this criteria appears positive; however, we noted cases with concerning gaps and a general lack of compliance with required face-to-face visits. Case specifics regarding the three cases that did not meet the criteria are below:

- Case A
  - The initial home visit in April 2024 was performed by a preventive caseworker. The assigned foster care caseworker, who was brand new to the Division, had transported the child from his temporary placement to his kinship placement on day prior.
  - Weekly supervised parent/child visitations appeared to replace monthly face-to-face visits at the child's placement location.
  - We were not able to confirm who was present (and documenting notes) at each of the visits; the caseworker, the case aide and/or the parent time coach from the dispute resolution center. Per OFCS regulations, contacts by case aide do not count towards minimum required contacts.
  - From the time the child was placed into care (April 2024) through the end of our scope period (July 2024) we did not identify a single instance of supervisory oversight.
  - Per case notes, the child was last seen by a case aide, who provided transportation for a cancelled visitation on June 28, 2024.

The child was later pronounced deceased four weeks after the end of our scope period. The autopsy listed the child's cause of death as a heart condition. OCFS's investigation is ongoing as of the date of our report.

- Case B
  One child was not seen in person for a period of four months, but caseworkers still maintained communication with this teenager while she was visiting a different state.
- Case C
  The case did not include any documented contact with the child for a two-month period.

While these gaps, according to documented notes, were concerning, the Division has since created a caseworker trainer position to help new workers assimilate to their new roles and oversee casework requirements.

2. STABILITY OF CHILD PLACEMENT

Foster care is intended to be a temporary and safe arrangement for children until they can safely return home or to another planned permanent arrangement. In addition to frequent and consistent face to face contact with children, the division has an obligation to continually assess the safety and appropriateness of the child placement and initiate a change in placement if/when it is deemed to be in the best interest of the child and consistent with achieving the child's permanency goal.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Children in Stable Placement	10/10	100%

In each case we reviewed, children were placed in stable environments and if any changes in placement were needed, temporary or long-term, these movements appeared to have been made in the best interest of the child(ren) involved.

3. VISITING WITH PARENTS AND SIBLINGS IN FOSTER CARE

The frequency and location of court-ordered visitations varied by case. In general, we noted the following:

- Visitations typically occurred in the DSS building, a public location, or the placement location.
- Families were granted two hours visits two to three days a week.
- Visitations were supervised by a Sullivan County case aide, caseworker, or workers from another agency.
- Progress notes were often detailed, demonstrating that the case aide was attentive.
- Sullivan County case aides often provided transportation to and from the agency for the children and/or parents.

To assess whether the division made concerted efforts to ensure visitation between a child in foster care and their mother, father and/or siblings was of sufficient frequency to promote the continuity in the child's relationship, we reviewed cases to determine if the visitations were following court order and if there were any trends in cancellations due to a lack of agency resources.
We also used visitation notes, the number of no-shows and lack of follow-ups by the parents as a basis for whether the division appropriately continued or modified the child's permanency goals. Please note, two of the ten cases did not apply as visits were not required by the court.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Concerted Efforts Made to Ensure Visitation Was Sufficient to Promote Continuity Between Child and Family	7/8	88%

Overall compliance with this permanency item is additional area of strength within the Division. While we noted multiple instances in nearly every case of parents failing to show or cancelling last minute, we only identified one instance few minor instances of cancelled visits due to the Division's lack of available transportation.

In general, we noted extensive coordination between the caseworkers, case aide unit, bio parents, and foster parents to establish, cancel, and reschedule ever-changing transportation needs and to accommodate parents' adherence to scheduled visits. In many cases, we identified multiple instances of parents failing to appear for transportation or failing to confirm their attendance on time. Additionally, we noted many visit related notes were transcribed by the case aides and subsequently entered into Connections by the caseworkers as case aides do not have access to Connections. Please see our recommendations regarding the Division's case aides and transportation further on in the report.

4. RELATIVE PLACEMENT

Prior to placement, OCFS and OSRI require that caseworkers make diligent efforts to identify relatives and suitable others (e.g., family friends) that are willing and able to be temporary or permanent resources. While neither agency explicitly states how to measure a division's adherence to this, we reviewed progress notes to determine if caseworkers documented their discussions with parents on this topic and the extent that they followed up with relatives. Please note, four of the ten cases were opened, or the children were freed for adoption, prior to of our scope and therefore, these criteria did not apply.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Concerted Efforts Made to Place Child with Relatives	6/6	100%

In each case, we noted documented evidence of both initial and ongoing (or attempts at) discussions with families to identify names of potential resources.

5. ACHIEVING PERMANANCY GOALS

Per OCFS, each child with a permanency planning goal (PPG) of return to parents and who have been in care for 15 of the most recent 22 month must either be discharged from care or the LDSS must file a petition to terminate parental rights. If the child cannot be returned home, other permanency goals include discharge to adoption, discharge to relatives or, for children who have reached the age of 18, are released to their own responsibility.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Appropriate Permanency Goals Were Established Timely	10/10	100%
Concerted Efforts Made to Achieve Reunification, Guardianship, Adoption or Other Planned Permanent Living Arrangement	10/10	100%

Overall, this is another area of strength within the division. Given the subjective nature of this criteria and the difficulty to assess permanency efforts in an objective manner, we reviewed progress notes to determine if caseworkers had consistent discussions with foster parents and biological parents regarding the child's permanency plan relative to the parent's overall progress with services. In cases in which the PPG remained 'returned to parent' we confirmed that there was evidence that parents successfully completed court-ordered services, remained compliant with visitation, and appeared eager to reunite with their children. Likewise, when parents continued to struggle with services and/or consistently missed visitations, we confirmed that caseworkers remained in contact with the biological parents and encouraged them, where appropriate, to surrender their parental rights and remained transparent with the foster parent regarding whether they are a willing to be a pre-adoptive home.

SECTION 2: INTERNAL OPERATING PROCEDURES

1. FREQUENCY AND EXTENT OF SUPERVISORY REVIEW / CASE CONFERENCES

Typically, caseworkers are expected to meet with their supervisor regarding their cases throughout the life of the case. Conferences should be documented as a progress note; however, the person ultimately responsible for entering the notes into Connections (the supervisor or the caseworker) can vary by unit and supervisor.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Evidence of supervisory feedback throughout casework	7/10	70%

Overall, documented formal case conferences and supervisory reviews are an area of needed improvement throughout the Division as we noted a general lack of consistency in terms of meeting frequency and general supervisor involvement.

2. PROGRESS NOTES INPUT WITHIN 30 DAYS OF CASE EVENT

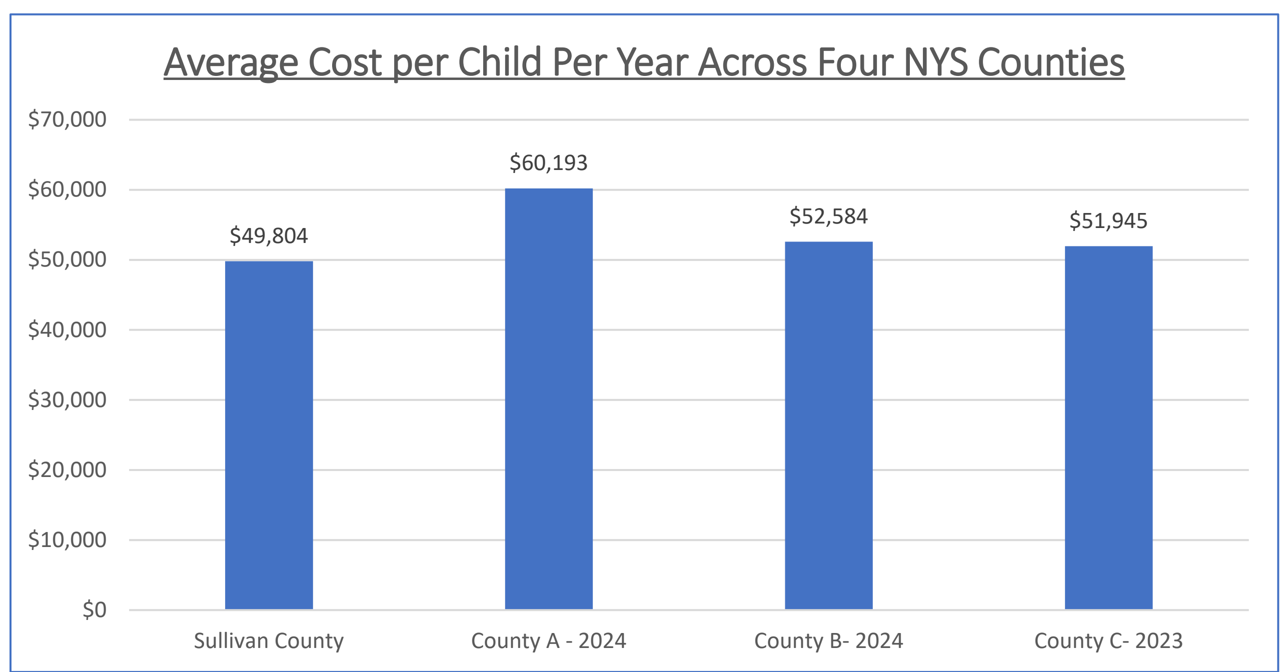
OCFS guidelines state that progress notes should be input within 30 days of the case event. This ensures both relevance of the content and accuracy of the progress notes.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Progress notes completed within 30 days of event date.	0/10	0%
Progress notes completed between 30 and 90 days of event	3/10	30%
Case includes progress notes with greater than 90-day difference between event date and record of noted.	7/10	70%

This is an area that needs improvement. We noted case activity logged between over one month to over six months post event date, well past the 30-day mark.

SECTION 3: FISCAL OPERATIONS

Room and board for children in care typically represent a child welfare department's largest annual expense. Like many costs in recent years, room and board increases have surpassed the average inflation rate. We reviewed fiscal reports for May 2024 and found the County incurred total room and board of approximately $473,750 for room and board for 112 children during the month. This is equivalent to $15,282 per day. Pending any significant changes in placement and discharge numbers and program types, this is equivalent to approximately $5,578,018 annually. These costs are composed of both foster home per diem rates as well as administrative fees payable to third party voluntary agencies based on maximum state aid rates (MSAR) set by OCFS. Please note, these costs do not include the fees associated with two children in secure detention centers, which are for adolescent offenders who are younger than 16 years old. Depending on the sentence, these youth may remain in OCFS custody up to age 21.



The chart above captures the average yearly cost per child across four NYS counties we have recently worked with, including Sullivan County. Sullivan's average annual cost per child is equivalent to approximately $49,804 - below average of the four counties shown. Since rates are generally set by CFS, we can attribute this to the County's dedication to keeping children in the least-restrictive and cost-effective foster home setting as possible as well as management's thorough understanding of the agency's cost structure and program specifics.

In the following pages, we assess the internal factors that affect the County's overall foster care costs and rate of federal reimbursement via the Title IV-E Foster Care program. For clarity and consistency purposes, we included our recommendations within each testing sub-section.

1. TITLE IV-E FOSTER CARE CASE CODING

OBSERVATION

Title IV-E of the federal Social Security Act applies to both foster care and adoption assistance. The County is reimbursed by the federal government for up to 56% of foster care room and board costs and monthly adoption subsidies for children who meet specific requirements. Accurately determining and coding eligibility in the NYS Welfare Management System (WMS) is crucial. Without the determination, or if the supporting file is incorrect or missing, the County will not be reimbursed for eligible costs. However, coding each case in WMS is a manual process across all LDSS and typically performed by someone who does not perform Title IV-E determinations.

This process is prone to human error and creates instances in which counties are not appropriately reimbursed by the federal government for cases that meet all the specified criteria. In order to test the accuracy of this process in Sullivan County, we agreed a sample of children listed as IV-E eligible per the social welfare examiner's manually maintained foster care caseload spreadsheet to the WMS claiming category per BICS Services Indirect Payment report for Service Type R-SER-MT (regular service and maintenance) for the June 2024 service period. Details for the discrepancies between the spreadsheet and WMS are captured below.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Child's Determination per the Foster Care Caseload Spreadsheet Agreed to WMS Coding	8/10	80%

Our testing resulted with the following two exceptions:

1) One child was incorrectly listed as IV-E eligible but correctly coded as non-IV-E in WMS as the respondent in the case was receiving unemployment benefits during the month of the petition.

2) One child was originally determined IV-E eligible at placement in April 2017; however, the child was subsequently placed in a Qualified Residential Treatment Program (QRTP) in June 2023. Per our case review, the QRTP court determination was not approved within 60 days of the child's placement, an OCFS requirement, which automatically renders the child's room and board costs ineligible for federal reimbursement (equivalent to $480.86 per day). Since the child was originally determined to be IV-E eligible, the child could, pending placement location and timing of critical tasks, be IV-E eligible again had the court approval been completed timely.

RECOMMENDATION

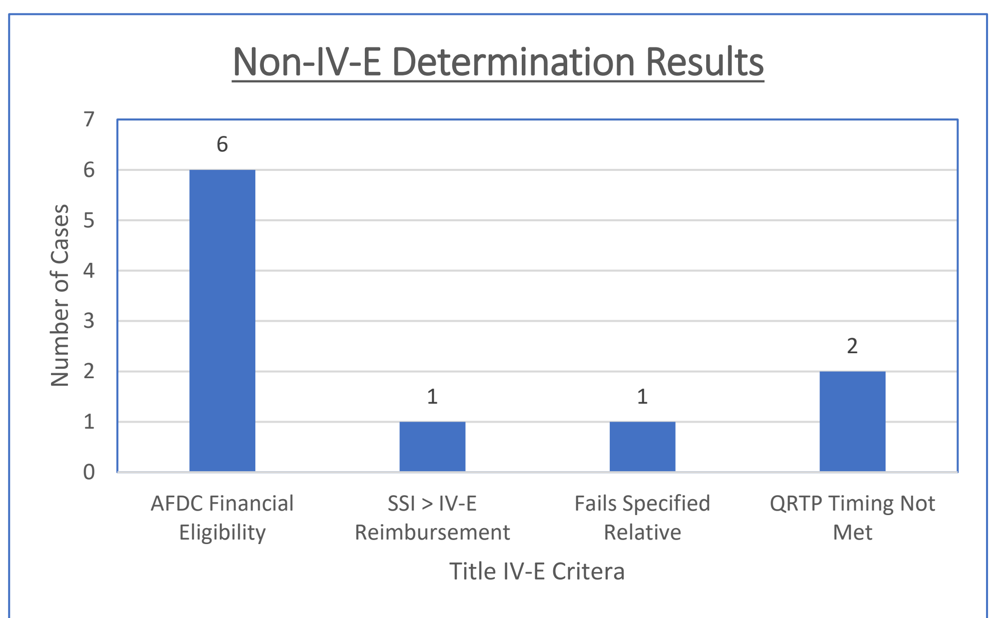
Although we only identified instances of cases that were not updated in the spreadsheet to reflect their current WMS claiming status as opposed to instances of lost funding, we recommend an employee independent of the Title IV-E process compare the eligibility supervisor's spreadsheet of active children in care with their respective eligibility determination to the BICS indirect services report on a periodic (e.g., monthly) basis and facilitate changes directly in WMS and/or the spreadsheet prior to month-end. This will increase the likelihood that WMS claiming is consistent with initial determinations (pending freed date) and that the County claims and receives all eligible federal funding reimbursement while remaining OCFS compliant.

Due to the volume of children in care and the number of people (both internally and externally) involved in performing necessary steps, it is not uncommon for LDSS to miss critical dates mandated by OCFS, rendering these placement types non-reimbursable. Many tasks require multiple inputs from several different sources, such as identifying a suitable foster home, determining their Title IV-E Foster care eligibility, writing payment lines in WMS, requesting assessments, performing assessments, and setting court dates. This is further compounded by the sheer volume of children's movements while in care, the manual and tedious process of initiating, communicating and tracking these movements and other case details, and Connections system limitations.

2. TITLE IV-E FOSTER CARE DETERMINATIONS

OBSERVATION

We reviewed a sample of ten case files that were coded non-IV-E (codes 04, 08, and 14) in WMS to identify potential trends in internal process limitations that prevented a case being determined IV-E eligible independent of case circumstances. The line graph below depicts our results.



Overall, we noted case files were robust, well organized, and contained appropriate documentation of countable income in the correct month to support the determination. The eligibility supervisor was experienced in this area and demonstrated an extensive knowledge of Title IV-E requirements. We also noted that she appears to consistently exhaust all available resources, such as coordinating face to face meetings with families when they are onsite for visitation purposes to obtain source documentation and obtaining family's authorization to request income information from their employer.

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Internal Factors (Outside of Case Circumstances) Did Not Affect Eligibility	8/10	80%

While we did not identify any cases that were incorrectly determined non-IV-E due to lack of information or misinterpretation of rules, we identified two cases (including one mentioned in Observation No. 1) in which the children were originally determined to be IV-E eligible but claiming ceased due to the Division missing OCFS mandated QRTP due-dates. Specifically, the second case was changed as the child's Qualified Individual (QI) Assessment was not completed within 30 days of the child's placement. It should be noted that a child's movement to a different vendor ID, even at the same facility, triggers a new assessment. Communication breakdowns between third-party agencies, the caseworker, case manager, or case planner and Division personnel responsible for coding movements in Connections are often the cause of these issues. Based on both children's length of stay and per diem rates, we estimate the total Title IV-E reimbursement dollars forfeited for both cases were approximately $204,606 as of July 2024.

RECOMMENDATION

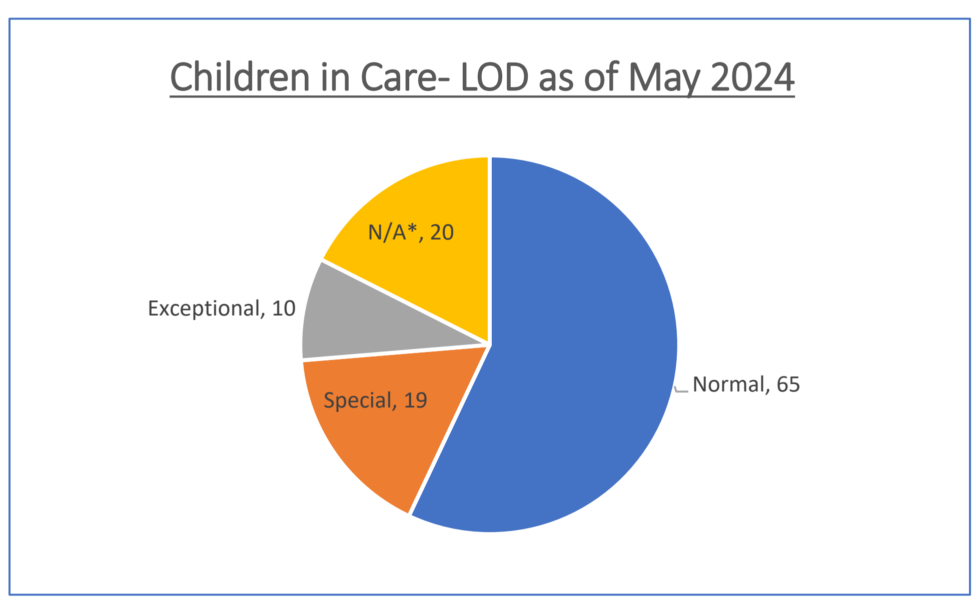
We recommend the Division hold a QRTP refresher training for all applicable staff and establish a clear and concise documented policy listing necessary steps for completion. The policy should state who is responsible for both performing and monitoring critical tasks relating to QRTP settings including requesting and following up with external QI assessors, setting court dates, and Long Stayer Reviews and entering legal codes in Connections. This policy should also address anticipated due dates for time-sensitive tasks such as Long Stayer Reviews and court dates.

3. ANNUAL REASSESSMENT FOR ROOM AND BOARD RATE ABOVE THE TRADITIONAL RATE

OBSERVATION

Similar to most counties, Sullivan relies on a combination of local DSS foster homes, approved relatives and kinship, as well as a handful of third-party voluntary agencies for all placements. The foster care unit initially sets the Level of Care (LOC) and is almost always normal (LOD 1) at the time of removal, unless the Division knows the child's needs are higher.

A foster home may request a change in the rate and provide documentation to justify the increased rate, which is reviewed and approved by the Director of Service. The pie chart below depicts the breakdown of the County's foster care population by LOD as of May 2024.



We judgmentally selected a sample of nine children (three with LOD 2 special rates and six with LOD 3 exceptional rates) from the eligibility supervisor's listing of children in care. Please note, four of these nine children (11% of the entire population of children in care) were also in therapeutic (as opposed to regular) programs. Therapeutic program types include weekly visits to the child in their foster home and includes counseling and clinical services. Children who have suffered trauma or children who have mental health or behavioral issues, or who struggle to adjust to foster care, are often provided with this service. The per diem administrative rates the agencies charge range between $74.00 and $127.38. For each child, we requested the most recent medical documentation to support the higher LOD and, if applicable, therapeutic program and OCFS-LDSS-7018 form to determine if it was approved by designated personnel (e.g., supervisor).

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Children Reassessed Annually for higher LOD and therapeutic program	0/6	0%

All children were initially reviewed and approved by the Director of Services; however, we were not able to obtain documentation that the six children who had been in care for over one year had been subject to an annual reassessment. It should be noted that the placement dates for our sample ranged between August of 2018 to January 2024. Per our interviews, the Division does not currently track children's LOD and program and thus does not consistently re-evaluate children's conditions.

RECOMMENDATION

We recommend the Division perform the following updates:

- Expand the functionality of the social welfare examiner's spreadsheet of children in care to include columns for LOD, program type, and date of reassessment.

- The Division should specify the frequency of evaluations based on the LOC and program type (e.g., every other year for Exceptional children and every year for Special children and/or children in therapeutic programs) and the personnel responsible for documenting and approving rates above "normal" via Form LDSS-7018. The Division should monitor the date of assessments and reassessments per the spreadsheet to ensure they are performed in accordance with internal protocol.

There is a $35 per diem difference between each LOD level, which is equivalent to approximately $1,050 a month and $12,600 a year, and the $62 per diem difference between a traditional versus a therapeutic program ($22,630 a year). It is critical the Division consistently monitor children's programs and the assessed level of difficultly to ensure both children's conditions correspond to the LOC the County reimburses the foster parents and County funds are not inappropriately disbursed to providers.

4. TANF CODING FOR FREED CHILDREN

OBSERVATION

Per OCFS regulations, to be eligible for EAF, the need for services must be due to an emergency. Authorization remains in effect for as long as the needs arising from the emergency continue. According to OCFS, a child being freed for adoption by the court qualifies as a situation in which the emergency has ended. Thus, for a sample of freed non-IV-E, EAF children, as indicated on the social welfare examiner's spreadsheet, we verified that they were no longer coded "04 Emergency Assistance To Families (EAF)" in WMS and their eligibility code was changed "08 MA."

Criteria Tested	No. of Cases Compliant with Criteria	Positive Compliance Rate
Freed EAF Children No Longer Coded '04' in WMS	4/5	80%

One freed child, in care since September 2018, was erroneously coded '04-EAF' in WMS. We also noted that children freed for adoption date was not consistently included in the social welfare examiner's spreadsheet.

RECOMMENDATION

We recommend the Division perform the following:

- Expand the functionality of the social welfare examiner's spreadsheet to include "Date Freed for Adoption." Additionally, in conjunction with the Recommendation No. 1 Title IV-E Foster Care Case Coding, the social welfare examiner reconciling the spreadsheet to the BICS indirect service report on a monthly basis will help to ensure both the spreadsheet is accurate and WMS claiming is compliant with OCFS regulations.
- Review the remaining TANF-EAF children in the County's care that were not included in our case review to identify those that have been legally freed for adoption.
- Process a retroactive entry in WMS and/or change the eligibility coding from an 04 to an 08 effective on the date the child was freed.

BONADIO COMMENTARY REGARDING CASE REVIEW

While the tools to objectively assess services / foster care case work at the DSS level are not nearly as explicit nor robust as they are in other child welfare areas such as investigations, quality and timely casework is just as crucial in maintaining child safety, well-being and permanency. These cases offer unique challenges as cases are typically active and ongoing for years. Therefore, it is crucial that documented supervisory oversight exists, and caseworkers receive timely and constructive feedback. To facilitate this, entering case notes timely should be an area of focus for the Division as notes are evidence of supervision, feedback, case review, and understanding comprehension of a child's current status. Additionally, the quality of progress notes typically diminishes the month after an event date simply due to the limits of one's recollection. We find this true even if caseworkers transcribe notes during an event and submit them to a caseworker who subsequently enters them into Connections.

Another item worthy of note was the volume of workers involved in many of these cases, which made it difficult to keep track of who was associated with what agency and what specific role they had with the child and the case, as well as the overall varying amount of detail in the notes. In fact, one case we reviewed had a total of 20 people entering notes over a 16-month period. These individuals included caseworkers, supervisors, case aides, agency workers, and service providers. This is likely due to turnover, promotions, supervisors assisting with casework, internal transfers and potential duplication of tasks. Furthermore, foster care and preventive caseworkers often perform tasks that are beyond the scope of a caseworker's job responsibilities. These are tasks performed in addition to assessing child safety and overall physical well-being at each face-to-face contact. For example, in one court-ordered Preventive case we reviewed, the caseworker provided the client with transportation to Walmart, a doctor's appointment, and a pharmacy to pick-up a prescription. In a separate case, we noted the caseworker assisted in completing and submitting registration paperwork for long-term housing, opening bank accounts, and dropping off kitchen supplies from the United Way.

According to our interviews, caseworkers have also assisted in enrolling children in schools and services, completed children's passport applications, and spend hours a week coordinating ongoing and ever-changing visitations and transportation needs between case aides, foster parents, and biological parents. Caseworkers also copy case aides' notes (usually in the form of an email) into Connections as case aides do not have Connections access. This tedious task is exacerbated when parents frequently cancel or miss appointments, do not live together, and/or children do not reside within proximity to the Division or their biological parents.

In addition to our case review results, we also want to highlight one significant opportunity for improvement we noted through both our foster care case review and our general engagement procedures that did not fit into any of our testing criteria.

We noted instances, via emails and review of hard copy case files of the following:

- The social welfare examiner making several requests for legal documentation (e.g., removal orders, petitions, and permanency hearings) from the County's Attorney's Office without success.
  According to our interviews, both the Director of Services and the CPS Service Coordinator have requested the County Attorney's Office include the social welfare examiner on all email correspondences to avoid repeated requests for documentation required for OCFS purposes.
- A missing petition that could not be produced from legal as they "did not have time" to prepare the order.
- Several contentious emails between the Division and the County Attorney's office regarding specific wording in court orders and conflicting interpretation of Title IV-E's legal authority requirement which among other things, can affect the Division's ability to claim Title IV-E.
- Incorrect orders, including orders stating that the children were in the care and custody of the commissioner and placed with a relative or suitable other under an Article 10 Direct Placement. While these temporary placements are subject to supervision by the Division, children in direct placement are, by definition, not in foster care.

Please note, we address many of the underlying and longstanding issues between the two agencies and provide corresponding recommendations in the following sections, including access to a share drive for efficient document sharing purposes and established communication protocol. To mitigate the risk that court orders lack required language, rendering an otherwise IV-E eligible case non-IV-E, we recommend the following:

- Periodically, all legal personnel (new and existing, attorneys and support staff) attend a Title IV-E Training session. This can be a state-level training via a webinar or one facilitated by county IV-E personnel with appropriate assistance and oversight.
- In addition to covering the specific legal language that must be included in relevant orders, legal personnel should utilize templates with the required IV-E language and be educated on the fiscal consequences of a non-IV-E foster care case. All orders (or modifications) stipulating a child 's placement into foster care should explicitly state that the order transfers care and custody to the commissioner. If the Division feels it is appropriate, we can provide robust legal documents that other DSSs utilize.

VI. Family Court – Child Welfare & County Attorney's Office Procedures

INTRODUCTION

The primary focus of this engagement was to the review of the Child Welfare Division of Sullivan County. This principally involves review of CPS, Foster Care, and Preventive Services but also included evaluation of supporting services as they interact with the Division. During this engagement, we observed the Division's Family Court activities supported by the Assistant County Attorneys, both directly and indirectly, through the following means:

- *CPS and foster care Case Review*:
  - Case notes
  - Petitions (for fiscal purposes only)
  - Court Orders (for fiscal purposes only
  - Other supporting documents
- *Interviews*:
  - County Attorney, Assistant County Attorneys, and staff
  - DSS management, supervisors, and caseworkers
- *Correspondence between departments, as available and relevant to our procedures*
- *Review of Fair Hearing data*

Personnel at both the Child Welfare Division and County Attorney's office acknowledged areas of progress in the relationship between the two departments over the past year. Most notably, Division personnel and management commonly stated that emergency child removals performed by the Division have been fully supported by the County Attorney's Office. These removals are initiated by Division staff due to circumstances that place a child in imminent risk. Once the child has been removed (and not returned) the County Attorney's Office must file a petition no later than the next court day; however, the court may order an extension for a petition for emergency removal (upon good show cause) up to three business days from the date of the child's removal. A hearing must be held immediately after. As of the date of this report, all emergency petitions have been filed timely by the County Attorney's Office since January 2024.

Based on our review of materials described above, we found that the most significant opportunity for improvement is establishing a framework for improved communication and collaboration between the County Attorney's Office and the Division, as well as increased efficiency of jointly held procedures. Currently, the county has not established written procedures that govern the processing of a petition for court-ordered services or child removal. This includes the initial stage of the Division requesting a petition from the County Attorney to its presentation before Family Court.

CURRENT STRUCTURE

Interviews performed with personnel from both the County Attorney's Office and the Division indicated that little formal structure exists for Family Court responsibilities shared between the two groups and focus of activity is often based on upcoming Family Court deadlines. This is understandable considering both Legal and the Division are consistently not fully staffed but we find that this does not negate the need for a framework of communication between both groups. Implementing standard procedures and corresponding timeframes or "due dates" will improve overall efficiency, clarity, and collaboration when processing petitions for Family Court.

The procedures below were identified as key points in case processing during our interviews with Division and Legal personnel, as well as our review of supporting documentation. We have outlined essential elements of each procedure and provided recommended process steps and guidelines.

RECOMMENDED PROCEDURES AND GUIDELINES

Legal Team Case Assignment:

The Assistant County Attorneys assigned to the Division represent Child Welfare cases in Family Court. The County Attorney assigns new cases to the Legal team based on attorney caseloads, the court schedule, and estimated time required to represent the case. Fair hearing cases are assigned to one attorney while all other attorneys are responsible for arguing petitions and other cases. Two assistant attorney positions are currently vacant.

We find this structure reasonable given the varying schedule of Family Court and the necessity of escalating cases or performing emergency removals. Strictly assigning cases on a "round robin" basis or dedicating an attorney to a group of caseworkers and their caseload would likely result with persistent imbalance of workload among the attorneys.

During our interviews, several Division employees stated that delays or ineffective conversation often occurs between the County Attorney's Office and the Division prior to a case being assigned to an attorney. Common causes of this are referrals coming from multiple sources and multiple venues (e.g., phone calls and emails) in Child Welfare and discussions of cases occurring between Child Welfare personnel and Legal before it is assigned to an attorney.

We recommend that a single individual in Division management refer Child Welfare cases to Legal. The individual will refer cases by emailing the Petition Request Form (see Appendix I) to the County Attorney. This tool describes key elements of the case and Division approval of the referral. Once the request form is received by the County Attorney, we recommend the County Attorney's Office assign the case within 48 hours and immediately notify a specified contact in the Child Welfare Division. Cases of emergency removal performed by the Division should be assigned to an attorney within 24 hours. These steps will reduce redundant emails and overall confusion of who should receive supporting documents for petitions.

Availability of Supporting Documents:

During our interviews, multiple individuals from both the Division and Legal stated that obtaining supporting documentation from the other group was often delayed, required speaking to several individuals, or reaching out multiple times once reasonable time elapsed since original request. In discussions with Legal, this most often involved supporting evidence needed for drafting petitions or supporting evidence reviewed in preparation for a court appearance. It was stated that case progress notes are periodically completed untimely and other supporting documents such as medical and school records are forwarded without adequate time for review before a court date.

The Division relayed similar issues with the availability of court documents: draft petitions are often not available for review before being due in Family Court and receipt of the final, signed court orders often occurs several months after the associated hearing. Additionally, supporting documents from both the Division and Legal are needed for Title IV-E determinations. A delay or lack of specific wording within court documents can render an otherwise Title IV-E eligible case ineligible for federal reimbursements.

It is understood that there are often legitimate reasons for delays in obtaining documents, especially in an environment that is understaffed and must shift focus during emergencies. However, we find that having no methodology for document sharing creates unnecessary delay and confusion. Both the County Attorney's Office and the Division would benefit from the following guidelines:

- *Supporting Document Shared Drive*: Currently, documents are shared between departments almost exclusively through email and frequently require discussion of whether a document was already provided or is still outstanding. We recommend the County establish a shared drive as the primary means of distributing documents between Child Welfare, the County Attorney's Office, and Family Court.

  The following examples illustrate types of shared drives available:

  1. *Internal Server Folder*: Basic option that solely houses documents on county server, with access given to specified users. No additional cost.

  2. *Microsoft SharePoint*: Cloud-based application that notifies users when files are uploaded. It is our understanding that the county has access to SharePoint, but it is not currently in use by the departments.

  3. *MyPortal*: Guided, cloud-based application. Users create listing of items needed, once files are uploaded by assigned personnel, the user indicates whether the item provided satisfies the initial request. Requires used-based subscription.

  Files should be organized according to case name and include relevant subfolders by (e.g. year of petition, type of document) for each child. All users should adhere to the same methodology to ensure efficient retrieval of data.

Additionally, a supporting document checklist that indicates which case documents have been provided and those still outstanding should be included with the casefile. This ensures all parties are aware of document availability without making separate inquiry with Child Welfare. This form should remain in digital format only to ensure the most updated data is available for all parties on the shared drive.

This repository will be especially useful when documents are needed at multiple points over a period of time. Searching for documents in email is cumbersome and often omits the needed document due to variations in subject headings or file names from person to person.

- *Point Person for Each Document Type*: Identify a single person or title for inquiries related to each document type. This will increase efficiency of obtaining documents and reduce inquiries made to unnecessary broad groups of employees. A general guideline is below.

    - Case Investigation / Foster Care Materials – Relevant Caseworker
    - Draft Petition / Signed Court Orders – County Attorney's Office Legal Secretary
    - IV-E Related Documentation – Foster Care Caseworker

  If inquiry to the designated employee remains unanswered in 48 hours, we recommend following up with relevant supervisory groups. During interviews, it was stated that the inquiries are often made directly or copied to supervisory groups in order to ensure quick response. This is unnecessary and wasteful of supervisors' time.

- *Supporting Evidence Due Date Guidelines*: Supporting documentation for non-emergency petitions should be uploaded to a shared drive (see below) with sufficient time for review and creation of the petition by the County Attorney's Office. The following items should be included:

    - Progress Notes
    - Connections CPS Investigation Summary
    - Intake Report
    - Investigation Evidence (photos, statements, audio/video recordings)
    - Other Supporting Items, as applicable, including:
        - Family Action Service Plan
        - Prior Court Documents
        - Relevant Police, Medical, and Educational Records

  For non-emergency petitions, uploads should be completed within 48 hours of the CPS report being indicated. Due to the immediate need of emergency petitions, support must be uploaded as soon as the case is indicated or support is obtained.

Additionally, once court orders are issued (and in lieu of emailing department personnel and still receiving requests from other vested people, such as the social welfare examiner for the same documents) Family Court personnel should upload orders directly to a designated shared folder. This prevents delays due to orders being emailed to select personnel and makes the document readily available when needed by county personnel in the future.

Case Conferences:

During our engagement, it was consistently stated that case conferences between Child Welfare personnel and the Assistant County Attorneys occurs infrequently or in an abbreviated manner immediately before the Family Court proceeding. It was stated that this can result with Child Welfare personnel and their assigned Assistant County Attorney having inconsistent understanding of the case's factual information or conflicting objectives for the Family Court appearance.

Case conferences between a child welfare department and their legal team are essential for ensuring that cases are handled effectively and in the best interest of the child. These meetings allow for a comprehensive understanding of the case, combining the welfare team's insights into the child's needs with the legal team's expertise in navigating legal requirements. This collaborative approach enables the team to develop a strategic plan, make timely decisions, and address potential risks, ensuring that all actions are compliant with legal and ethical standards.

Moreover, case conferences provide crucial support for social workers, offering a space for discussion and guidance, which helps prevent errors and burnout. The documentation from these meetings also serves as a record of accountability, demonstrating that the child welfare division acted responsibly in the management of child welfare cases.

We also recommend both a Child Welfare Supervisor and the relevant caseworker obtain copies of petitions for their review before final signing occurs and the petition is filed with Family Court. Points of consideration should then be discussed with the Assistant County Attorney. Providing the petition for child welfare's review helps ensure the accuracy of information contained therein and strengthens both the Division and County Attorney's standing during Family Court.

Establishment of DSS Managing Attorney Position

To bridge the communications gap between the Division and County Attorney's Office without disrupting the existing organizational structure, we recommend the County Attorney's Office establish a Managing Attorney for Social Services. The Managing Attorney will be a direct-line report to the County Attorney but will be fully assigned to the Department of Social Services.

This mirrors similar structures in other counties where the County Attorney has overall responsibility for the legal operations of the county, but the myriad responsibilities of a County Attorney's Office require a division of labor and expertise that are distributed among senior attorneys. Communication between the Division and the Attorney's Office will be less redundant and work completed more efficiently as most decision-making responsibility will shift from the main office of the County Attorney to the Managing Attorney. A portion of the Managing Attorney's caseload will be reduced in order to account for their increased responsibility – we recommend the reduced percentage be determined through the experience of the Managing Attorney during the first six months of undertaking the new position.

Periodic Review by County Management:

Successful implementation of the above recommendations will require periodic review and modification by management. We recommend the County Attorney, the Managing Attorney, and the Health and Human Services Commissioner meet monthly and discuss relevant cases, changes in metric data, concerns from employees, and any potential improvements to the guidelines and procedures. If all agree to a modification, the framework can be modified without further approval. Before meeting, each team should obtain feedback from mid-level management regarding Family Court case proceedings in the prior month.

Additionally, we recommend the County Attorney, Managing Attorney, and Health and Human Services Commissioner meet with county management semi-annually. This meeting should include the County Manager and representatives from the County Legislature and discuss overall progress in Family Court case management from the perspective of each department.

We recommend each meeting review tracked metrics, provide update on areas for improvement identified during the prior meeting, and identify action items with specific performance timelines. This meeting should also be a forum to discuss any procedural differences not resolved during the monthly meeting between the Commissioner and County Attorney's Office.

We find that organizations with similar feedback loops address areas needing improvement before they become systemic and negatively affect overall operations. The metrics described in the following section will inform these reviews in a way that is both extensive and impartial.

Key Metrics:

Currently, no metrics track the path of a Family Court case at any of its stages and objectively identifying overall process bottlenecks is not possible. We recommend the Division track the following dates related to each key process in Family Court cases:

1. *CPS Case Indicated* – The initial trigger for further action taken through Family Court
2. *Date Petition Request Form (Appendix I) sent to Legal* – Date the Division submitted the request to Legal
3. *Date Assigned to Attorney* – Date the County Attorney assigns it to an Assistant County Attorney
4. *Petition Filed with Court* – This triggers assignment of Court Date
5. *Case Conference (if any)* – Conference between assigned attorney and Child Welfare before case is presented in court. This is not required by opportunity to review case details and position.
6. *Court Date* – Date petition is heard; should also include date orders given by judge (if different)
7. *Court Order Signed* – Order signed by judge and delivered to relevant parties
8. *Court Order Modified (if applicable)* – Occurs if order is changed after issued

Similar to the monthly CPS performance reports distributed by OCFS, we find that the data listed above is essential to identifying consistent process delays or areas requiring additional resources. Once populated, the number of days between each of the above actions should be calculated and reviewed against short- and long-term trends.

Individual case examples of process delays were shared with us during our engagement, but we find these provide limited usefulness as the dynamics of one particular case are likely not representative of the population.

Effective implementation of the procedures recommended above will likely require frequent procedural adjustments to determine the most effective structure and must be based on the impartial feedback provided by comprehensive metrics. We do not consider this list of metrics exhaustive and additional relevant metrics should be added as identified.

VII. General Child Welfare Observations & Recommendations

1. USE OF CASEWORKER AIDES

OBSERVATION

The Case Aides/Transport Team operates in the Foster Care and Preventive Units. It consists of four case aides and one senior case aide, is exclusively dedicated to providing routine transportation services (e.g., court-ordered visits) and supervising visits. Per our preventive case review, in four of ten cases we selected, case aides provided transportation to doctor appointments, workforce development, and school, in addition to providing visitation and/or transportation for eight of the ten foster care cases. When this engagement began in February 2024, there were approximately 100 children in care. As of August 2024, the number of children in care has increased approximately 20%, while the number of case aide positions has remained consistent.

As part of our procedures, we reviewed a regular and overtime (OT) tracking spreadsheet for a pay-week ending in our scope period; four case aides worked a total of 134.75 OT hours over a two-week period (or 16.75 hours per week per case aide in OT). OT is subject to approval from the foster care and preventive service coordinator. Per our interviews and our review of the tracking spreadsheet, this is not abnormal. Given that the case aide salary ranges between $39,474 and $41,552, the work week is 35 hours, and case aides receive two weeks of PTO, case aides are compensated approximately $23.28 per hour or $34.92 per hour in OT. This is equivalent to $3,137 in OT costs per pay period and $81,562 per year and approximately two FTE positions.

The current process for requesting, coordinating, and scheduling visits is tedious, outdated, and inefficient. After coordinating with biological and foster families, caseworkers complete a hardcopy *Transportation Request Form* and submit it to the case aide supervisor. The case aide supervisor maintains a spiral-bound calendar, where she handwrites each case aide's schedule for the coming week. Per interviews, management does not have consistent visibility into case aide's schedules, which is critical for overall department planning. Visibility into scheduling is also necessary for caseworkers and eligibility welfare examiners as they work to coordinate in-person meetings with families to gather necessary information.

RECOMMENDATION

To increase collaboration (and visibility) between the units and management, utilize resources effectively and efficiently, and minimize the amount of client transportation on the weekends and in the evenings, we recommend the following:

- The Division reassign and integrate the case aide positions directly into the CPS, foster care and preventive units. Given that transportation and visitation services are required for the vast majority of foster care cases, it is reasonable to place more case aides in the foster care unit than the preventive unit where they can communicate more directly.

- To further streamline processes, case aides should be granted access to Connections. Case aides will input their own notes into Connections instead of the current process of handing them off to others in the Division with Connections access, such as the caseworker.

- We recommend shifting responsibilities of coordinating visitation and transportation to the case aide themselves based on the court-ordered frequency. Caseworkers should also utilize the modified *Transportation Request Form* (Appendix II) to document and communicate their request to the case aide. This editable PDF form includes space for the type of request (recurring, one-time or miscellaneous) case background/additional information (e.g., parents should have separate visits), name of children to be transported and their age, if a car seat or booster is needed, and the pick-up and drive-to addresses.

- Implement an Excel Weekly Schedule template with 30-minute intervals that is maintained on a shared drive. Services Coordinators and/or Case Supervisors should schedule case aides as far out in the future as possible. Other Division personnel, who may not have direct involvement with scheduling or physically transporting and supervising visits, should be provided read-only access. See screenshot below for an example.

WEEKLY SCHEDULE

SCHEDULE START TIME	TIME INTERVAL	WEEK START DATE
7:00 AM	30 MIN	5/1/16

TIME	SUN May 1, 2016	MON May 2, 2016	TUES May 3, 2016	WED May 4, 2016	THURS May 5, 2016	FRI May 6, 2016	SAT May 7, 2016
7:00 AM							
7:30 AM							
8:00 AM							
8:30 AM							
9:00 AM							

- Create a formal Case Aide policy that includes both allowable and disallowable types of client travel. Transportation and visitation in the evening and weekend should only be granted when the case aide has demonstrated that the family is unable to adhere to court-ordered visitation hours during normal business hours.

- Lastly, we recommend the Division periodically review historical transportation forms to quantify the number of requests not directly related to visitation or court-ordered services. During our case review, it was apparent that case aides periodically perform ancillary services for families such as transportation to grocery stores or summer camps. These services, though helpful to the family, are not within the duties of the case aide and siphon case aide efforts away from the primary objectives of the Division. As part of this review, we recommend management monitor the case aide calendar to determine if current staffing levels compliment the number of children and families who need transportation and visitation services.

2. CASEWORKER VACANCIES AND NYS HELP PROGRAM

OBSERVATION

In accordance with OCFS requirements, caseworkers must have a bachelor's degree from an accredited college or university and score competitively in the civil service exam. We note there are approximately 300 private and public educational institutions that offer a bachelor's degree in the state of New York, but none are in Sullivan County. Currently, the State University of New York (SUNY) Binghamton University located 84.5 miles from Liberty, NY represents the closest four-year school. According to the most recent census, only 27.5% of the County's population possess a bachelor's degree or higher, compared to the NYS average of 38.8%.

We find that these factors and the rural nature of the county contribute to consistent caseworker vacancies experienced by the Division. While the Division does not maintain detailed historical data regarding budgeted vs. filled caseworker positions, management stated that turnover and vacancies are consistent headwinds, especially for CPS. We note that as of the date of this report, there are six vacancies in CPS. it is apparent that the Division struggles with hiring and retaining caseworkers, especially in the CPS unit.

RECOMMENDATION

We recommend the Division consider leveraging the NYS Hiring for Emergency Limited Placement (HELP) Program. This program assists New York State agencies in filling vacant job positions across the state by providing funding for workforce expansion, training, recruitment, and staffing solutions. CPS units in other counties have specifically benefited from increased applicant pools as the program often waives the civil service exam requirement for caseworker positions until current vacancies are filled.

We note that Sullivan County's public assistance division recently utilized the HELP program successfully and we recommend management who led that effort assist CPS with the application process. Counties of similar size to Sullivan that we have recently worked with have had success with significantly reducing CPS caseworker vacancies through the program. It is likely that Sullivan County would experience similar results. waiving the examination requirements for civil service positions with high levels of vacancies.

3. INTAKE, TRACKING, AND HANDLING OF PREVENTIVE SERVICES CASES

OBSERVATION

Preventive Services referrals are submitted to a dedicated email maintained by the unit. For most non-court ordered related referrals, the Service Coordinator determines which cases will be accepted for monitoring and assigns the case to a preventive caseworker who performs and documents initial case candidacy in Connections. As highlighted in our Preventive Services Case Review Results, cases that were monitored by the unit varied in terms of source, children's ages, behaviors, and extent of safety concerns.

At the onset of our engagement, the Division used a dedicated Microsoft Access database to track the incoming date and source of referrals that are accepted into the unit, closing date, and reason (if applicable) as well as the date and name of the caseworker assigned. Towards the end of our engagement, the unit started tracking incoming referrals in an additional Excel sheet. However, criteria to distinguish which types of cases the unit should accept, such as allegation type, extent of safety factors, history with the division and age of children, versus what cases should be referred to Unite Us or community-based providers are not well-defined.

In conjunction with our case selection process, we also noted the database did not accurately reflect relevant case details and therefore, would not be an effective tool for managing caseloads. Specifically, we noted the following discrepancies.

- The database indicates 110 active cases had been opened for a minimum of two years. However, per the OCI, only eight cases had been opened for over two years.
- For one case we reviewed, it was listed in the Database as a CPS (voluntary) referral when in fact, it was court-ordered.
- One case was listed in the Database as received 9/23/23 without a close date.
- Per the supporting documentation, (e.g., Preventive Services Referral) the caseworker contacted the family one week after receiving the request and closed the intake after the family denied needing any additional services.
- There was an active CPS investigation during our scope period for at least four of the ten cases. In one case, the DSS unit caseworker assigned to the case turned over twice and thus, three separate workers were working the case in a 12-month period. As a result, multiple people from multiple agencies were simultaneously involved with the same family. In three of these cases, there was no documented evidence that communication between the units occurred.

RECOMMENDATION

Due to the increasing number of providers accessible through Unite Us, the recent shift to a preventive services contract model, and lack of consistency in terms of which cases are accepted for monitoring, We recommend the Unit implement the following:

- Define criteria on which cases should be accepted for monitoring versus which should be referred to Unite Us and community-based service providers. These guidelines should be incorporated directly into the Preventive Services Excel spreadsheet.
- Replace vague source columns (e.g., voluntary) with specifics such as law enforcement, self-referral, and schools.
- Continue to specify the name of the school and/or school district and distinguish which cases are Juvenile Delinquents (JD) and Person in Need of Supervision (PINS).
- Select which of the following decisions- No Services Needed, Community Based, Unite Us and Unit Monitoring, applies to the case.
- Lastly, the Service Coordinator or an employee independent of the process should periodically reconcile the spreadsheet detail to OCI and update remaining elements, specifically caseworker, date closed, and closure reason.

With detailed referral information centrally located and updated, we anticipate the Unit can better analyze and identify trends in intake volume, source, case length and closure rate.

4. COMMUNICATION WITH LOCAL SCHOOL DISTRICTS

OBSERVATION

In lieu of calling in an SCR report for non-safety related issues, community members, including schools, may contact the Division directly to make a referral for voluntary services. Per our preventive case sample, four of our six non-court ordered cases originated directly from social workers or other school personnel at various school districts within the County. Three of these cases involved children between the ages of nine and 15 with non-safety related factors, including mental health and school attendance issues. Similar to non-voluntary cases, once the voluntary referral was accepted and needs assessed, the majority of the casework was handled by an external agency.

Also, in two of the four cases, an SCR report was made at some point during the services case. Thus, resources from multiple units and agencies, including, the assigned preventive worker and their supervisor, therapists, social workers, MST workers and CPS caseworkers were involved in a single case in which safety was not an issue. This trend was evident throughout our testing of both CPS Investigation and FAR as schools accounted for the largest single source of SCR calls.

RECOMMENDATION

We recommend a designated individual or team of individuals from CPS, Foster Care, and Preventive engage with school districts and schedule on-site presentations with mandated reporters on a yearly basis. The presentation should incorporate the following:

- The mission, and the limitations, of the County's Child Welfare Division
- Trends in allegation types and challenges facing the County in addressing the allegations
- The typical life cycle of an investigation and voluntary preventive services case; highlighting the reliance on community-based service providers and the internal and external resources dedicated to these families and cases.
- Encourage schools to engage directly with service providers when safety is not a concern.

We recommend the CPS, foster care, and preventive units service coordinators hold periodic 1:1 calls with a representative from each school district to streamline communications, keep school personnel (and the Division's workers) abreast of any new, relevant case information, and brainstorm alternative ways to engage with families both at the external services and school level. We anticipate that scheduled, consistent communication will reduce the overall number of SCR reports as the schools become more confident of both the County's handling of cases and mandated reporters become better informed of the Division's responsibilities.

5. CASEWORKER SAFETY IN THE FIELD

OBSERVATION

During our interviews, staff identified caseworker safety as a top concern. Visits to a child's home are often tense meetings, especially if a family member is accused of abuse or neglect. At times, the caseworker encounters hostile individuals who openly threaten their safety. This is a consistent concern for caseworkers in any county given the nature of their work, but with Sullivan County being primarily a rural county these concerns are often enhanced.

The County has attempted to address this concern with the resources available to it. Caseworkers are strongly encouraged to notify their seniors when they perform home visits and removals are most often performed with other members of the Division. We note that two New York State Troopers are partially assigned to the Family Violence Response Team. When onsite at the Division, these Troopers primarily assist by processing any relevant criminal cases in conjunction with investigations being performed by the FVRT. This ensures both groups are up to date on a particular case's dynamics and not duplicating work.

RECOMMENDATION

We recommend the County consider assigning one or more deputies to the Division. The deputy's primary responsibility would be ensuring caseworker safety by accompanying them during potentially hostile home visits or child removals. We note that several NYS counties have integrated Sheriff deputies into their Departments of Social Services for this purpose (e.g. Oneida County).

When requested to accompany a caseworker on a home visit, deputies arrive to the home alongside the caseworkers in plainclothes but are armed, identifiable as law enforcement, and wear body cameras. They are primarily responsible for ensuring safety of the caseworker and de-escalation with the subject family when required. If an arrest becomes necessary, it is not carried out by the deputy but is rather referred to local law enforcement.

In past conversations, the Oneida County Commissioner stated that this program was developed in response to similar concerns for safety. Sullivan and Oneida County are similar in size, geography, and demographics. Both are primarily rural and require home visits to areas that are off main roads and without cellular phone service. The addition of the deputies significantly reduced caseworker fear in performing home visits and is viewed as a model response as caseworker confrontations with families has significantly decreased since the program was implemented.

When not assisting with home visits, the deputies perform supporting duties at Oneida County, such as security support for the building and background checks of subjects identified in SCR reports. If an SCR report subject has a violent criminal record the deputy will accompany the caseworker to the safety assessment home visit. The deputies also assist the Sheriff Department during periods of high service demand, such as major community events, emergency situations, and overtime patrols. The positions are partially funded by the Department of Social Services.

We recommend the Division communicate with other counties, such as Oneida, who have implemented this program and determine if a similar model is feasible in Sullivan County. If implemented, it is likely that caseworkers would feel much more secure, general department efficiency would improve as less time is spent waiting for the arrival of local law enforcement, and caseworkers would have fewer confrontations with hostile SCR subjects.

To test its merits, a single deputy could be tasked to these duties as a yearlong pilot program. Afterward, the County may consider its effectiveness. Safety when in the field is almost always a top concern during interviews with county caseworkers and we find that this program is the most robust method of addressing caseworker safety that we've observed in New York State.

6. EMPLOYEE COMPENSATION

OBSERVATION

Given our experiences with other LDSS, compensation is often, but not always, a topic brought up in our interviews. Throughout our engagement with the County, compensation appeared to have a significant impact on both employee satisfaction and retention. We often heard from multiple people in various units and positions that they did not believe they were adequately compensated and were aware of positions external to the agency that offered greater pay and less stress. Some staff even mentioned that they rely on picking up on-call shifts to feel comfortable with their wages; however, this option is only available to those working in CPS.

Lile many other LDSS throughout the state, the Division was not immune to significant turnover in the last few years. Not only is turnover costly to the County, but it is disruptive and stressful to caseworkers.

While we do not perform extensive salary compensation analyses, in previous engagements, we typically research and compare surrounding county's caseworker salaries to assess the competitiveness of our subject county's compensation and determine an adequate baseline market value for each position. However, there was a lack of publicly available data on surrounding counties' caseworker salaries and therefore, were unable to perform this assessment.

When workers resign, remaining caseworkers have no choice but to absorb their caseloads, typically at various stages of an investigation (or ongoing monitoring) with no prior experience with the family and minimal time to prepare. Per our review of Progress Notes of CPS, preventive, and foster care cases, the effects of turnover at both the caseworker and senior caseworker level on casework were evident. Critical casework activity stalled for weeks at a time and families subject to ongoing protective monitoring expressed frustration with the disruption in casework and the lack of consistent personnel.

RECOMMENDATION

In order to retain staff, the County could consider compensation strategies, such as offering a quarterly retention bonus between $300 and $500 for full-time employees and recruitment bonuses for those who are able to enlist their peers to work at the Division. The Division should determine, and communicate, the maximum amount an employee is entitled to throughout a specified period. We find this would be helpful due to the County's turnover rates, the widespread feeling among staff that they are underpaid, and our analysis of the Division's metrics and caseloads discussed previously.

Additional caseworkers are needed to lower overall caseloads, improve case timeliness, and improve case quality. Increasing the competitiveness of the salary is likely the most effective means available to the County to increase interest in the caseworker position and move toward a more balanced workforce.

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We appreciate this opportunity to work with the County. Throughout the entirety of the engagement, we found Sullivan County employees to be transparent and cooperative. If you have any questions concerning this report or if we can be of service to you in any other way, please feel free to contact us at any time.

Very truly yours,

BONADIO & CO., LLP

Tim Ball, CFE
Executive Vice President