To ask a question during the presentation use the Q&A Panel in WebEx

Select “All Panelists”, type your question, and click Send.
Announcements

DHS Updates

Collaborative Safety Model
Announcements - webinars

Upcoming SPP LC Webinars:

• December: No SPP LC webinar

• Registration is now open for all of 2020. Please register to receive updates and PowerPoint handouts.

• Next year’s topics to be shared as they are scheduled.
What’s happening at Regional Meetings?

Waiver Reimagine Service array streamlining and alignment feedback
What is the Account Validation Service (AVS) authorization form?

As of September 1\textsuperscript{st}, 2019 DHS requires MA enrollees to complete an Account Validation Service (AVS) authorization form. The AVS authorization form is a document that permits the state to request information from financial institutions as a condition of MA eligibility. This will ensure all financial accounts are identified when applying for, or renewing, MA.
Who is required to sign this authorization form?

People enrolled in or applying for Medical Assistance for People Who Are Age 65 or Older (MA) and People Who Are Blind or Have a Disability (MA-ABD), including people who:

- Live in the community
- Live in a long-term care facility and request Medical Assistance for payment of long-term care
- Request services through a home and community-based services (HCBS) program BI, CAC, CADI, DD, and EW.
- Request coverage under Medical Assistance for Employed Persons with Disabilities (MA-EPD)
- Request coverage under Medicare Savings Programs (MSP)
When will people receive the request to sign the authorization form?

DHS will send a request for information and the *Authorization to Obtain Information from the Account Validation Service (AVS), DHS-7823 (PDF)* by mail monthly, beginning in September 2019, with the final mailing in April 2020.

Details about the mailing schedule in the [AASD and DSD eList Announcement Oct. 24, 2019: MA-ABD applicants and enrollees must sign authorization form to ensure continued MA eligibility](#)
How long will people have to return the authorization form once they receive it?

They will have 10 days to return the authorization form to their financial worker. The cover letter will provide exact dates for the individual based on when the request to sign was made.
Will a person’s MA close if they do not return the authorization form?

• Yes, it is possible that the person’s MA will close. The signed authorization (DHS-7823) is a condition of MA eligibility.

• MA eligibility for these enrollees cannot be closed earlier than the month following the month in which the authorization (DHS-7823) is due.

**Example:** If the signed authorization is due in January, MA cannot be closed earlier than February.
How will a Case Manager know if a person receives an Account Validation Service authorization form?

• For people who receive waiver services, financial workers will notify the case manager that the person’s MA is being terminated and the reason for termination.
What do I do if the person does not return the authorization form within the 10 day requirement and I am notified that MA is closing?

- Do not close the waiver span in MMIS.

- End service authorization lines effective the last day of MA eligibility as soon as that date is known. This notifies providers, who can also support the person in returning the authorization form.

- Send a Notice of Action (DHS-2828B) with the date their waiver services will be terminated including the reason as provided by financial worker.

- Work with and support the person to complete the required paperwork and submit it to the person’s financial worker.

- Conduct annual reassessments as scheduled, even if a person is temporarily not enrolled in MA.
What do I document as the explanation for services ending on the Notice of Action?

Example language that can be used when drafting a Notice of Action:

You (or your legal guardian) have not completed and returned The Authorization to Obtain Financial Information from the Account Validation Service (AVS) form (DHS-7823). The AVS form must be signed by each applicant or enrollee and his or her spouse, if applicable. The AVS form is a condition of Medical Assistance (MA) eligibility. MA is a condition of XXX waiver eligibility. In order to continue accessing your waiver services including XXX please return The AVS Form to XXX before XXX.
MA has ended and the person is no longer receiving waiver services, what happens next?

• We recommend waiting 90 days to close the waiver span in MMIS before exiting the person from the waiver.

• No additional Notice of Action is needed before completing the exit screen.
What if the person returns the authorization form and MA is reinstated with no lapse in coverage?

• By waiting 90 days to end the waiver span, there is an opportunity for the person to return the Account Validation Service authorization form and for MA to be reinstated without a lapse in coverage.

• The individual would still be open to the waiver.

• A new assessment and support plan would not be necessary.

• When the person is re-enrolled in MA, enter new service agreement lines effective the day of MA re-enrollment.

• Update the CSSP with any necessary changes and re-send to the person and providers confirming that services are authorized and in place.
References for specific details, responsibilities and timelines:

• Bulletin #19-21-02: DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA) (PDF)

• AASD and DSD eList Announcement Oct. 24, 2019: MA-ABD applicants and enrollees must sign authorization form to ensure continued MA eligibility

Additional Questions: dsd.responsecenter@state.mn.us
New Rate Sheet DHS-6790M

Consolidated all Rate Management System (RMS) worksheets for day and employment services into a single form.

- Adult day services
- Structured day services
- Day training and habilitation
- Prevocational services (hourly)
- Employment services
- Transportation (DTH 15-minute and waiver)

Link: [eList Announcement Oct. 14, 2019](#)

Questions, concerns, or feedback email [dsd.employmentfirst@state.mn.us](mailto:dsd.employmentfirst@state.mn.us)
Clarification of MMIS exit codes for BI, CAC, CADI, AC, EW & ECS MMIS Changes for activity dates 10/1/19 and later:

• A new exit code 17 is available to indicate loss of financial eligibility

• Most exit codes require at least 10 days, but not more than 60 days, between the **Activity Type Date** and the **Effective (Assessment Result) Date** of the exit to support advance notice requirements

• Exit code 20 has been redefined as change in level of care.

Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF).

Link: eList Announcement 10/8/19
Advance notice:

• Part of the due process requirements.

• When a person’s program is terminated, lead agencies are required to provide advance notice to the person at least 10 days from the date the Notice of Action (Assessments and Reassessments), DHS-2828A (PDF) is mailed to the person.

• For more information, see CBSM – Notice of action.
DHS/DSD & Vocational Rehabilitation Services (VRS) Memorandum of Understanding (MOU):

• Specific to people accessing HCBS waiver who want to pursue competitive integrated employment.

• **DHS interim guidance** will remain in place while DSD & VRS work on the implementation and rollout of the MOU.

• MOU goes into effect January 2021.

• Updates and requests for stakeholder input will happen leading up to January 2021.

**Link:** [eList Announcement 10/8/19](#)

**Questions Contact:** DSD.EmploymentFirst@state.mn.us
Beginning Jan. 1, 2020, authorizations for skilled nursing visits (SNVs) must indicate if a registered nurse (RN) or a licensed practical nurse (LPN) will perform the visit.

- T1030 = RN
- T1031 = LPN

For people served by LPNs, all existing service agreements that span beyond Dec. 31, 2019, must be updated before Jan. 1, 2020.

Resources:
- eList announcement 10/29/19
- CBSM – Changes in authorization of SNVs

Questions: hcsd.dhs@state.mn.us
CFSS Updated Resources: Public Web Page

CFSS Public Web Page

Features:

• Overview of the New Service

• Frequently Asked Questions (FAQs)

• Future updates will be posted on this page
CFSS Videos:

• [CFSS Introduction video](https://example.com/video) (YouTube video - 4 minutes)
• [CFSS Interactive Training Video](https://example.com/video)

Additional Questions: [DHS.CFSS@State.MN.US](mailto:DHS.CFSS@State.MN.US)
DSD training news and Information Page

Missed a training session?

See the DSD training archive page to view past webinar and training information and materials.
OBRA level II for people with developmental disabilities

• An encore playback from the 10/31/19 presentation is available until 1/31/20.

• The updated presentation (PDF) for the session is available on our training archive page.

• Dial 1-855-859-2056 and enter conference ID 8754977
Employment-focused training for service providers

eList Announcement 10/3/19

The Department of Human Services has added access to the College of Employment Services Plus content to its DirectCourse offerings. People who have completed all College of Employment Services courses successfully may apply to take the CES Plus courses. Space is limited to the first 100 applicants. Read the full announcement at Enhanced online employment-focused training for service providers.

• Questions: DSD.EmploymentFirst@state.mn.us
Email:

DSD.RRS@state.mn.us or
DSD.ResponseCenter@state.mn.us

Phone:

651-431-4300 or
866-267-7655 (toll free)
Orientation

Collaborative Safety Model

Kelly Knutson, MSW
Kenny Weaver, M.Sc. Candidate
Disability Service Across the U.S.

Media Portrayal
SUFFERING IN SECRET:
Illinois hides abuse and neglect of adults with disabilities
Tina Marie Douglas, a 48-year-old woman who had a history of running away from a group home in Lockport, right, was fatally struck by a vehicle in 2013 when she fled the facility. (John J. Kim / Chicago Tribune)
Failures of care
Incidents and System Responses
Four State workers arrested, accused of leaving disabled man in van behind at repair shop

"Any neglect of individuals in our care is completely unacceptable. The four staff involved in this incident were immediately placed on administrative leave without pay. All OPWDD staff in contact with individuals receiving services are being retrained on transportation safety protocols that require a sweep of each vehicle before the driver exits to ensure all individuals have exited and verification that individuals have arrived at their intended location. OPWDD will work closely with the Justice Center and law enforcement to ensure that this incident is fully investigated, appropriate disciplinary action is taken, and future incidents of this nature are prevented." says Jennifer Sullivan, Director of Communications.
Incident

State lawmaker alarmed by number of Greene Valley abuse, neglect cases

By Nate Morabito
Published: February 8, 2016, 6:00 pm | Updated: February 8, 2016, 6:06 pm

GREENE COUNTY, TN (WJHL) Of the 250 substantiated cases of abuse, neglect and exploitation at Greene Valley Developmental Center since 2002, Rep. David Hawk, (R) – District 5, says at best, he can only remember ever hearing of one of those cases.
System Response

"What we see is a system that works really hard to identify egregious acts and remove bad actors from the system," she said.

Several cases results in employees losing their jobs and Kumari says every case resulted in corrective action.
Incident

Hidden camera leads to charges against 17 workers at nursing home

Rachel Kingston, News 4 Reporter
Published: April 25, 2014, 9:35 pm

The 17 employees are charged with first degree falsifying business records, first degree endangering the welfare of an incompetent or physically disabled person and willful violation of public health laws.
System Response

The facility at Michigan Avenue and High Streets in Buffalo’s Medical Corridor, is operated by Kaleida Health and serves both adult and pediatric patients.

Kalieda Health said in a statement Thursday that it "has terminated 17 employees for neglectful care of one resident. This behavior, and lack of appropriate care, is unacceptable and will not be tolerated. When we were made aware of the situation, we took action." Kaleida Health, through its office of internal Audit and Compliance, has been working cooperatively with the Attorney General’s office on this investigation.”
Incident

• At a Springfield home owned by Sparc, a caregiver forgot to give a man his anti-seizure medication before sending him to a day program. The man suffered a major seizure, turned blue and was treated at a hospital.
System Response

• Sparc's chief operating officer, Ryan Dowd, said his company fired the caregiver and added more surveillance cameras in its group homes and added electronic medication records in addition to paper.
Incident

• UCP group home resident attending the company's day program in Springfield choked to death on a marshmallow that a caregiver handed out as a treat.

• The individual had dysphagia, putting him at high risk of choking, and a diet that consisted of pureed or finely chopped foods only.
System Response

• UCP Seguin CEO Voit said his organization, one of the state's largest group home providers, has dismissed the caregiver, retrained staff on choking risks and revised safety protocols.
Tennessee
December 2012
Coalition media group files lawsuit against DCS to obtain information relating to child death cases, garnering national media attention.

**Media groups file lawsuit against Tenn. children's agency**

Dec. 19, 2012

NASHVILLE, Tenn. (AP) — A coalition of media organizations is suing the Tennessee Department of Children's Services, alleging the agency is violating the law by not providing details about 31 children it had investigated and who died during the first six months of this year.

The lawsuit filed Wednesday is spearheaded by The Tennessean (http://tune.ws/ZPaBPX), which has repeatedly asked DCS for the information. To date, the agency has only provided brief summaries of the deaths.

The lawsuit asks the court to order the agency to explain why the records were not provided. It also asks that the department immediately give those records to the court so a judge can review them and redact any confidential information and for the records to then be opened to the public for review.
January 2013
State legislators call for DCS to be investigated in wake of agency not releasing child death records sought in media coalition lawsuit.

Rep. Mike Turner demands investigation into DCS, cites 'secrecy'
'It is well past time that we have a full accounting of problems,' he says

Jan 11, 2013

One of the state's top-ranking lawmakers has called for an immediate investigation into the Department of Children's Services, saying the matter is urgent and citing the department's refusal to release records concerning the deaths of children in its care.

Thirty-one Tennessee children died in the first half of 2012 after coming to the attention of the state's child protective agency.

On Thursday, House Democratic Caucus Chairman Mike Turner sent letters to Gov. Bill Haslam, House Speaker Beth Harwell and Lt. Gov. Ron Ramsey — the state's top three
February 2013

DCS Commissioner Kate O’Day resigns amidst continuing controversy over agency’s handling of child death cases.

DCS commissioner O’Day resigns amid scrutiny of deaths

Updated: Tue 12:32 PM, Feb 05, 2013

NASHVILLE, Tenn. (WVLT/AP) -- The commissioner of the Tennessee Department of Children’s Services has resigned amid scrutiny of how her agency was handling cases of children who died after investigations of abuse and neglect.

“Kate has informed me that she felt the time was right to step down,” Haslam said. “Gov. Bill Haslam announced in a news release Tuesday that Kate O’Day had decided to resign because of concerns that she had become the focus of attention rather than the children the agency is meant to serve.”

I appreciate Kate’s service to this administration and to our state. She has done a lot of good work in identifying longstanding problems that have hampered the department, and we will build on those efforts as we move forward.”
NASHVILLE - Gov. Bill Haslam on Tuesday named Jim Henry as the permanent head of the state's troubled Department of Children's Services.

Henry has been working as acting commissioner after the abrupt departure in February of then-Commissioner Kate O'Day, whose department has been engulfed in controversies over inadequate protections for children, children's deaths and questions about how investigations have been handled.

Henry, a former state lawmaker, already was commissioner of the Department of Intellectual and Developmental Disabilities and has been holding down a dual role at Children's Services as well as Intellectual and Developmental Disabilities, working to bring order back to DCS operations.

The governor today also named Debra Payne as the new commissioner of intellectual and Developmental Disabilities. Payne is a department veteran and has been serving as deputy...
What’s Next?
Time for Something New
Tennessee child welfare officials draw on lessons from aviation, call for "safety culture"
Collaborative Safety Model

- Moves away from blame and toward a system of accountability that focuses on identifying underlying systemic issues for improvement
- Used by other Safety Critical Industries such as Aviation, Nuclear Power, and Healthcare
- Based in Human Factors and Systems Safety (Safety Science)
  - Integrates Behavioral Analysis, Forensic Interviewing, and Trauma Informed Science
- Includes a robust, scientific, trauma-informed review process
- Review process is embedded within a larger transitional framework to support and advance a safety culture system wide.
Contrasting Reviews

Turkish Air flight TK1951 received erroneous information from the plane’s radio altimeter system. The crew’s response resulted in a fatal crash that claimed the lives of 4 crew members and 5 passengers.
Contrasting Reviews

• A woman with an intellectual disability and autism dies after choking on a large piece of carrot.
Expert Findings

• The Captain had close to 11,000 hours on the Boeing 737 alone. This combination of training standards and experience is apparently not enough to protect crews from the subtle effects of automation failures during automated, human-monitored flight.

• The documentation and training available for flight crews of the Boeing 737NG leaves important gaps in the mental model that a crew may build up about which systems and sensor inputs are responsible for what during an automatically flown approach.

(Dekker, 2009)
Expert Findings

• The person’s staff provided the carrot but **did not** monitor the eating
• The person’s main caregiver **should have** followed the meal plan restrictions
• The staff in the home **should have** identified the signs of choking sooner
• Staff **should have** administered the Heimlich prior to the resident falling to prone position
• Staff **should have** called 911 immediately
Developing a Safety Culture

7 Transitions to a New View of Safety
Transition 1. Blame to Accountability

To understand how to learn and improve as an organization.
Blame – Brené Brown
Transition 2. Applying quick fixes to understanding underlying features
To make meaningful change and address the real problems.
Transition 3. Operating as though systems are perfect to understanding systems are imperfect.
To learn the role of the system on organizational outcomes.
Trauma Informed

• How do we change the question – “What is wrong with you?” in trauma informed practice?

• Safety Critical Industries and Critical Incidents
  – Not because of you, but to you

• Second Story
Transition 4. First Stories to Second Stories

To dive beneath surface level descriptions of events and understand the true sources of failure and success.
Transition 5. Employees are a Problem to Control to Employees are a Solution to Harness

To make use of the most powerful resource an organization has, its people.
Transition 6. Accountability up to Responsibility Down

Shifting from a focus on compliance to support.
Transition 7. Simple to Systemic Accident Models

*To use accident models that are compatible with the complex world we work in.*
Systemic Critical Incident Review
Critical Incident Identified

Debrief on Learning Points

Invite Staff to be Debriefed

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other

Identify Learning Points

Systems Analysis Tool: Systemic Themes

Recommendations

Invite Staff to be Debriefed

Narrative Creation

Mapping

Debrief on Learning Points

Critical Incident:
- Staff Sleeping
- Wheelchair Safety
- Use of Prone Restraint
- Elopement
- Medication Error

Data Collection:
- Incident Report
- Service Plan
- Note Entries
- Medical Records
- Other

Identify Learning Points

Recommendations

Invite Staff to be Debriefed

Debrief on Learning Points
Critical Incident

- Identified by Agency
- MN DHS – DSD Pilot Categories
- 245-D Screened out for Maltreatment
  - Staff Sleeping
  - Wheelchair Safety
  - Use of Prone Restraint
  - Elopement
  - Medication Error
  - Termination of Services
Data is collected

Debrief on Learning Points

Invite Staff to be Debriefed

Mapping

Narrative Creation

Identify Learning Points

Recommendations

Systems Analysis Tool: Systemic Themes

Critical Incident:
Staff Sleeping
Wheelchair Safety
Use of Prone Restraint
Elopement
Medication Error

Data Collection:
Incident Report,
Service Plan, Note
Entries, Medical
Records, Other
Data Collection

• Incident Report
• Relevant Case Information
  – Examples
    • Service Plans
      – Behavior, Nursing, Dietary, etc.
    • Note Entries
    • Medical Records
    • Other

• Conducted by Safety Analyst
Learning points identified

Debrief on Learning Points

Invite Staff to be Debriefed

Data Collection:
- Incident Report
- Service Plan
- Note Entries
- Medical Records
- Other

Identify Learning Points

Systems Analysis Tool:
- Systemic Themes

Recommendations

Invite Staff to be Debriefed

Debrief on Learning Points

Narrative Creation

Mapping
Identification of Learning Points

• Based on Incident Review
• Will typically be consistent with incident
• Example Learning Points:
  – Wheelchair seatbelt not applied
  – Dispensed the wrong medication
  – Staff did not maintain sight supervision
  – Staff sleeping on duty
  – Prone restraint applied
Staff debrief

Debrief on Learning Points

Invite Staff to be Debriefed

Identify Learning Points

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other

Recommendations

Mapping

Narrative Creation

Systems Analysis Tool: Systemic Themes

Critical Incident: Staff Sleeping
Wheelchair Safety
Use of Prone Restraint
Elopement
Medication Error

Data Collection:
Incident Report,
Service Plan,
Note Entries,
Medical Records,
Other

Identify Learning Points

Invite Staff to be Debriefed

Debrief on Learning Points
Invite Staff for Debriefing

- Based on staff connected to identified Learning Points
- Includes Safety Analyst and:
  - Direct Care Staff or
  - Supervisor or
  - Other relevant staff
Critical Incident: Staff Sleeping Wheelchair Safety Use of Prone Restraint Elopement Medication Error

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other

Identify Learning Points

Systems Analysis Tool: Systemic Themes

Recommendations

Invite Staff to be Debriefed

Narrative Creation

Mapping

Debrief on Learning Points
Human Factors Debriefing

• Conducted by Safety Analyst
• Characteristics of Debriefing
  – Voluntary
  – Supportive
  – Safe
• Uses Human Factors Techniques
  – Understands decisions made in context
  – Explores Local Rationality
    • Attentional Dynamics
    • Knowledge Factors
    • Strategic Factors
Mapping

Debrief on Learning Points

Invite Staff to be Debriefed

Identify Learning Points

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other

Critical Incident: Staff Sleeping, Wheelchair Safety, Use of Prone Restraint, Elopement, Medication Error

Systems Analysis Tool: Systemic Themes

Recommendations

Narrative Creation

Mapping

Debrief on Learning Points
Systems Mapping

• Facilitated by Safety Analyst
• Multidisciplinary
• Based on AcciMap model
• Explores identified Learning Points and their influences at different levels of the system
  – Frontline
  – County
  – State
  – Provider
  – Other External
  – Government/Legislative
Safety Systems Map: Client Choking Death

Case No.: 000001

**Government and Regulatory bodies**

- Decreased availability of advanced first aid training

**External Entities**

- New HCBS waiver reduced daily rate by 15%

**Organizational Factors (Central)**

- First aid training was for neurotypical populations
- No advanced training for choking victims on their backs
- Fiscal/Management notices to decrease unnecessary costs

**Organizational Factors (Regional)**

- Hx of Bx outburst
- Coworkers reprimanded for unnecessarily calling 911

**Conditions, Processes and Actor Activities**

- Finding 1: Heimlich maneuver was not immediately provided to person choking
- Choking signs misinterpreted as Bx outburst
- Staff unaware how to perform intervention with unconscious choking victim.

**Outcome**

- Choking Death

Policy Interpretation

Finding 2: Regional management was called before 911
The narrative
Debrief on Learning Points
Invite Staff to be Debriefed

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other
Identify Learning Points

Critical Incident: Staff Sleeping Wheelchair Safety Use of Prone Restraint Elopement Medication Error

Systems Analysis Tool: Systemic Themes
Recommendations
Invite Staff to be Debriefed

Identify Learning Points
Mapping
Debrief on Learning Points

Narrative Creation
Narrative Creation

- Created by Safety Analyst
- Derived from Mapping process
- Turns Mapping product into contextual narratives
- Scored with Systems Analysis Tool

Example Narrative
Narrative Example

• Event: A person served choked on a burrito
• Learning Point 1: Heimlich maneuver was not immediately provided to person choking
• Learning Points were debriefed with direct care staff and mapped in a mapping session
Narrative Example

The delay in the application of the Heimlich maneuver was influenced by the direct care staff interpreting signs of choking as a behavioral outburst. This was further supported by the person having a history of behavioral outbursts and engaging in the same target behavior of physically aggressing toward staff at the beginning of the choking incident. Therefore, the first sign of choking recognized was the person turning blue. As soon as the direct care staff recognized the person was choking, they attempted to administer the Heimlich maneuver, however, the person became unconscious and fell to the floor compromising the effectiveness of the intervention. Once the person was on the floor, the direct care staff was unaware of how to apply the Heimlich as they were not currently trained on interventions for choking victims lying on their backs.
Debrief on Learning Points

Invite Staff to be Debriefed

Critical Incident: Staff Sleeping, Wheelchair Safety, Use of Prone Restraint, Elopement, Medication Error

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other

Identify Learning Points

Recommendations

Invite Staff to be Debriefed

Debrief on Learning Points

Systems Analysis Tool: Systemic Themes

Narrative Creation

Mapping
Systems Analysis Tool Application

• Scored by Safety Analyst
• Identifies Underlying Systemic Themes
  – Examples:
    • Communication/Teamwork
    • Service Array
    • Policies
    • Supervisory Support
• Targets resources and interventions during recommendation process
Recommendations

Debrief on Learning Points

Invite Staff to be Debriefed

Mapping

Narrative Creation

Critical Incident: Staff Sleeping Wheelchair Safety Use of Prone Restraint Elopement Medication Error

Data Collection: Incident Report, Service Plan, Note Entries, Medical Records, Other

Identify Learning Points

Systems Analysis Tool: Systemic Themes

Recommendations

Transaction on Learning Points

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Recommendation Development

• Based on Systems Analysis Tool
• Created by Safety Action Group
  – Comprised of:
    • Agency Leadership
    • Critical Incident Review Team Representative (Safety Analyst)
• Designed for System-Wide change
  – Examples:
    • Policy
    • Resource Allocation
    • Collaboration/coordination within and outside agency
    • Fiscal acquisition processes
Culture Change
Agency Response Example

Case: Social workers charged with child abuse in case involving torture and killing of an 8-year-old boy

- Four County social workers have been charged with felony child abuse in connection with the 2012 death of the 8-year-old, who was tortured and killed even though authorities had numerous warnings of abuse in his home.
- County prosecutors allege that county Department of Children and Family Services employees allowed a vulnerable boy to remain at home and continue to be abused.
Agency Response Example

• **Director Statement:** “In our rigorous reconstruction of the events surrounding the boys death, we found that four of our social workers had failed to perform their jobs. I directed that all of them be discharged. I want to make it unambiguously clear that the defendants do not represent the daily work, standards or commitment of our dedicated social workers, who, like me, will not tolerate conduct that jeopardizes the well-being of children.”
Agency Response Example

Case: Three male children — ages 2 months old and 5 and 8 years old were found in a closet full of miscellaneous items.

• The youngest boy's body was in a suitcase.
• The children appeared to have been stabbed to death and parts of their bodies dismembered.
• DCS agency had multiple contacts with the family of the 3 slain boys
Agency Response Example

- **Director Statement:** “It is a sad day as we reflect on the gruesome nature of what occurred. We grieve as a community, trying to understand why three innocent souls have been taken. We grieve as an organization, suffering the loss of children whom we knew. When a child is murdered, it's common to ask if something could have been done to prevent such a tragedy. At DCS, we ask ourselves those questions because we take the responsibility of protecting children very seriously. But our powers are limited; we cannot predict the future; and people, can at times, do awful things. We offer our deepest sympathies to the family and pray for the peace of the departed. I ask all of us to respect, support, and commend the dedicated men and women of DCS and Law Enforcement who do the unimaginable. Who do, when no one else can or will. Who comfort the afflicted, protect the weak, and wipe the tears; who then go find a private place to shed their own.”
Building a Safety Culture

Collaborative Safety Model
Safety Culture Model

• Core Elements
  – Build the Systemic Review Process
  – Align staff throughout the agency on the review process and associated science and values
  – Embed safety science into everyday management, supervision and frontline work
  – Engage external stakeholders (oversight entities, legislature, media, etc.) in the review process
  – Support agency responses to high profile events
  – Evaluation and Sustainability
Systemic Critical Incident Review

• Departs from Blame
• Integrates safety science into the learning process
• Establishes an environment that promotes staff engagement
• Values staff perspective
• Compatible with complexity of work
Integration of Safety Science into Daily Operations

- Management and supervision guided by Safety Science

- Changes how we:
  - Talk about work
  - Support quality work
  - Meet metrics
  - Treat staff
  - Support Teamwork
  - Promote psychological safety
Top to Bottom Alignment

- Executives
- Leadership/Management
- Supervisors
- Frontline Staff
- External
  - Oversight Entities
  - Legislature
  - Media
  - Key Partners
    - Law Enforcement
    - Providers
    - Courts
Data
Retention
Turnover / Retention

• Tennessee DCS Snapshot
  – Shelby County (CY 2014 – 2015)
    • 400% improvement in vacancy rate (turnover)
  – Mid Cumberland Region (CY 2014 – 2015)
    • 250% improvement in vacancy rate
  – Davidson County (Nashville) (CY 2014 – 2015)
    • 93% improvement in vacancy rate

• Heritage Christian Services Snapshot
  – 2017: 57% retention
  – 2019: 71% retention
Turnover / Retention

- Arizona DCS Snapshot
  - 2015: 50-60%
  - 2018: 20-25%

- Hennepin County HHS (Minneapolis) Snapshot
  - 2016: 20%
  - 2018: 7%

- Minnesota DHS, Child Safety & Permanency
  - 2016: 18%
  - 2019: 5%
Media

• Empirical Data
  – Qualitative Analysis
Minnesota...Then

Dayton called Pope County’s handling of Eric’s case a “colossal failure,” and said they should have followed through with the requirement to notify law enforcement of maltreatment reports.

“That’s just inexcusably and immorally negligent,” he said.
"County child welfare workers work hard to protect children every day, and strive to meet the best interests of children and their families. It is frustrating when the public only hears one side of the story." said Minnesota Department of Human Services Commissioner Emily Piper in a statement.

"I can say with confidence that county child welfare workers are doing their best, day in and day out," Piper said in her statement. “It’s a difficult situation to remove children from their parents’ custody and such decisions are not made lightly. The preference is to place children with family members when possible.”
Chanhassen shooting: Did mental health systems fail?

On Tuesday Minnesota Department of Human Services Commissioner Chuck Johnson released a statement on the call for an investigation into why the crisis team did not respond to Amorosi's request to help his son.

"A young person's death is a tragedy, and our hearts go out to the family and friends of this boy as they grieve his loss. DHS is committed to doing all we can to ensure that people with mental illness get the care they need.," Johnson wrote. "We understand and appreciate the concerns expressed by NAMI regarding the services provided by mental health crisis teams. We have reached out to NAMI and to Carver County to determine how we can help shed light on this particular case and work on improvements statewide so that crisis services are received when they are needed the most."
NYC Administration on Children Services

Life after Zymere: What it takes to keep NYC’s kids safe – NY Daily News By Editorial Board, September 26, 2019

• Zymere Perkins, only 6, succumbed two years ago today to fatal blows likely inflicted by his mother’s boyfriend. Shock, followed by aftershocks: Jayden Jordan, 3, caged and fatally beaten in Brooklyn. So jolting were these boys’ horrible ends, so evasive of accountability was Commissioner Gladys Carrión, that soon ACS had new leadership.

• Hats off to David Hansell for turning a bureaucratic corner. Bosses set the tone, but then and now, the crucial work of this vital agency is done by the agency’s front-line employees, including 2,100 child protective specialists.

• We at the Daily News rush to hold such men and women to account when they fail. We spend too little time and energy commending those who do the quiet, delicate, emotionally exhausting work well every day, making arduous judgments about when children are at such risk they should be pulled from their homes.
TN examines child deaths with more care

Tony Gonzalez, tgonzalez@tennessean.com 11:57 p.m. CDT May 7, 2014

Tennessee’s child abuse investigators, who confront life-or-death decisions about whether kids are safe in their homes, haven’t always been willing to talk when things go wrong — when children die or suffer severe injuries.

And for at least a couple of years, caseworkers didn’t have to say much of anything.

The Department of Children’s Services fell behind on internal reviews of child deaths. When they did look back, the reviews did little to explain what led to each incident, or what might save other children.

That’s changing.

The department recently completed its first year of new, more immediate and more exacting death reviews as required by a federal judge. A court order requiring changes followed a Tennessean
DCS makes 'massive turnaround,' nears end of 15-year case

Anita Wadhani, awadhani@tennessean.com  |  2:51 p.m. CT April 11, 2015

More than 15 years of federal court oversight of Tennessee's foster care system is nearing an end, with the Department of Children's Services demonstrating in court Monday that it has complied with all orders.

The case began in 2000, when attorneys for the New York-based advocacy agency Children's Rights filed suit over the state's treatment of kids in foster care. Named after "Brian A" — a 9-year-old boy
Arizona

How Arizona Fixed Its Broken Child Welfare System in 2 Years

The state attracted national attention for its failure to prevent and address child abuse and neglect. Since then, massive changes have led to massive improvements.

B Y J. B. WO G A N | A P R IL 2 7 , 2 0 1 7

We’ve implemented what we call “a safety culture.” We’re not going to talk about people as failures as much as the systemic and process failures that lead to outcomes that we would like to be different. That’s had a huge impact. Our turnover rates are now in the mid-20s.

Greg McKay has been director of the Arizona Department of Child Safety since 2015. (AP/Ross D. Franklin)
Arizona's Governor

Arizona DCS
@ArizonaDCS

“The average caseload has dropped from 145 cases to 16. The backlog that plagued the agency for so long, has been eliminated. And since a year ago, we’ve found safety and permanency for nearly 11,000 children,” Governor Doug Ducey #AZService #AZKidsThrive

2:00 PM - 8 Jan 2018
Minnesota Disability Services Pilot Project
Discussion
Follow us on Instagram @collaborativesafety

Follow us on Twitter @collabsafety
Resources
Communications from DHS

**Bulletins**

Official policy communications to inform DHS business partners, about program changes and required actions

**E-List Announcements**

Official policy communications to inform Disability Services Division business partners, about program changes and required actions

Policy and general reference

**Community-Based Services Manual**

Online manual and reference tool for lead agencies who administer HCBS.

**CountyLink**

A website designed for counties administering all DHS programs that includes manuals, performance measurement data, training resources, and I.T. systems (including SSIS and MnCHOICES).
**Technical Assistance**

**DSD Response Center**

Phone or email connection to provide customer service for lead agencies, providers, consumers and other partners regarding technical assistance for HCBS programs.

DSD.ResponseCenter@state.mn.us

**Policy Quest**

The Disability and Aging PolicyQuest is an automated web-based system for designated lead agency staff to submit policy questions. The public can view the responses.

**Training**

**Upcoming DSD Training Opportunities**

Upcoming schedule of DHS provided training opportunities for lead agencies, providers, and other stakeholders. You can also visit our training archive to access materials from past trainings.

**DSD Training Archive**

Archived Trainings grouped by topic and date. Audio provided up to three months after initial training.

**Aging Training & Conferences**

The Aging and Adult Services Division and Minnesota Board on Aging offer training for lead agency staff and for those looking to learn more about how to better serve and support older adults more broadly.
**Advocacy**

**Ombudsman (LTC, DD/MH, MCO)**
Regional ombudsmen work to enhance the quality of life and services for people receiving services and supports by providing advocacy and other assistance.

**Specialized**

**Disability Hub MN**
Statewide information, referral and assistance service to connect people to community services.

**Senior Linkage Line**
Statewide information, referral and assistance service for seniors, caregivers, and Medicare beneficiaries.

**DB101.org**
Provides tools and information on employment, health coverage, and benefits to learn how work and benefits go together.

**Lead Agency Review Website**
The purpose of the HCBS Lead Agency Review website is to share information about the lead agency review process, including case file review and site visit protocols as well as our findings with lead agencies.
| **Person Centered Thinking Training** | Review learning objectives and register for Person Centered Thinking training as well as Picture of a Life – Person Centered Plan Facilitation Training. |
| **Person Centered Practices Webpage** | Overview of the Person-Centered practices initiative, including frequently asked questions, the Person-Centered, Informed Choice and Transition Protocol, as well information for providers and the public. Including an [FAQ Page](#). |
| **Olmstead Plan Webpage** | Minnesota’s Olmstead plan guides state agencies to ensure that all people having the right to make choices: where to live, to have a satisfying job, to attend classes and to be part of the community. |
| **Positive Supports Minnesota** | Positive supports are approaches that are used to help people using a variety of proven support strategies that do not include punishment or seclusion. Website includes policy, training, resources and examples. |
Please take a moment to let us know your thoughts.

• Take our Survey:

• http://surveys.dhs.state.mn.us/snapwebhost/s.asp?k=157410660133
Audio from today’s session will be available beginning tomorrow morning by dialing:

855-859-2056
Conference ID:
4761079

If you have questions following the session, email to DSD.ResponseCenter@state.mn.us
Thank you for attending!