Why Can't We Get Timely Child Welfare Information?

The federal Department of Health and Human Services (DHHS) and the Minnesota Department of Human Services (DHS) just released 2020 child maltreatment reports, more than a year after the reporting periods. They showed wide variations among states and counties.

The delays are due largely to an unwieldy federally-mandated IT system known generically as SACWIS (don't ask) and as SSIS in Minnesota. States estimate that social workers spend 70% of their time feeding data into this system.

Conversely, the variations are because DHHS doesn't have the authority to mandate *program* standards among states. As a result, for example, findings of maltreatment ranged from 1.9 to 19 per 1,000 children nationally, and from 2.2 to 17 per thousand among Minnesota counties.

The saying goes "If you can't measure it you can't manage it." We have work to do before we can manage child welfare.

Narrative for podcast on federal and state child maltreatment reports

Just last month, in January, the federal Department of Health and Human Services and the Minnesota Department of human services both released their annual child maltreatment reports for 2020. This was for the federal fiscal year ending September 30th, 2020 and for the state year ending December 2020. There are links to both federal and state reports in the blog.

The overall reports were unsurprising. All of the major indicators were down significantly from prior years, including the number of maltreatment reports, open cases, findings of maltreatment, and entries into foster care. If you are interested in digging into the federal report, I recommend that you first read the latest addition of the child welfare on her, a block that is produced periodically by Marie Cohen. You can find it at childwelfaremonitored.org.

In the blog we focused on some of the high-level management issues regarding the lateness and variability of federal reports on child maltreatment. We will get to that shortly, the first part of this podcast is going to be pretty geeky because before we go into the management issues I want to first dive into some of the rather mind-numbing but important statistics both nationally at the Minnesota state level.

These reports have consistently been difficult to use because of the wide variation among states nationally, and among counties in Minnesota. For example the number of maltreatment reports per 1000 children ranges nationally from 19 in Hawaii to 127 in Alaska and 138 in Vermont. Then, the number of reports that were actually screened in for child protection services ranges from 17% to 98% nationally. The *average* number of reports screened in nationally was 54%. This compares by the way to 43% of reports being screened in in Minnesota and I will talk more about that in a moment.

The Minnesota numbers show some interesting trends. While we are still below the national average in terms of the percentage of maltreatment reports that were screened in, the gap is closing. In 2015 only 28% of maltreatment reports in Minnesota were screened in for child protection services. Then, the reforms produced by the Governor's Task Force on the Protection of Children required all the counties to follow a common set of state promulgated standards for responding to the initial maltreatment report, which accounts for why the percentage of reports screened in increased from 28% to 43%. During that same period, the national average went down from 62% to the current 54%. The net result is Minnesota is now considerably closer to looking like the rest of the country.

There is still a lot of variation however. As of 2020 there were a few small Minnesota counties that screened in fewer than 20% of reports, and a few counties, notably St. Louis at 64%, were higher than the average. The overall the consistency statewide however is much greater than in the past. Most counties now are within 15% of the average whereas prior to 2015 they could range much more broadly. Perhaps more significantly for child safety in Minnesota, a number of the large counties including Hennepin, and Ramsey are near the national average of 54%. In Hennepin County this may be largely due to the impact of a 2019 class action lawsuit, which required significantly tightened overall standards for the program. The outlier in terms of larger counties is Olmsted, which has long had a strong pro-family bias, or we would say pro- parent, and only screens in 33 ½% of maltreatment reports.

There is a lot of room for interpretation in terms of the number of children who are screened in for a child protection assessment or investigation. There may be valid reasons that smaller counties are outliers, simply because of the small number of cases that the process.

So perhaps a more reliable indicator of a state or county's response to maltreatment reports is the number of children per 1000 who are screened in. They corollary is the number of children per thousand where there is a finding of maltreatment. A warning here is that the language both in the federal and state reports is very confusing. The federal term used for children who are reported is "referrals", and only maltreatment reports that are screened in are called reports. The term victims is used inconsistently across the states. Then in Minnesota the term "victims" is used for the number of children who are screened in rather than those for whom it has been determined that they were abused or neglected. The term for children who were investigated and ended up with a determination that they were maltreated is a "determined victim". If you can keep all that in mind, good for you. I have to write it down every time. If you are interested in the details about determined maltreatment reports per 1000 among Minnesota counties, this is shown in table 12 of the state report.

For our purposes the concern within Minnesota is the variation in the number of determined cases of maltreatment on a per capita basis. Statewide the figure is 4.8 per 1000 children according to the DHS report but 5.1 per 1,000 in 2020 in the federal report. Either way, this compares to a national average of 8.4 per thousand, as shown on p. 16 of the federal report and also Exhibit 3/C on p. 21. Compared to this a number of counties including Anoka, Blue Earth, Carver, and Cass have between two and three findings of maltreatment per 1000 children. In contrast St. Louis County has 16.9 and Freeborn County has 19.3. Of special note is the Leech Lake tribe of Ojibway which has 0.5 findings of maltreatment per 1000 children despite a very

high rate of screened in reports. Ramsey and Hennepin counties are close to the statewide average.

Some of this variation may be due to differences in demographics. Poverty has been shown to be a significant driver of child maltreatment, so perhaps it is reasonable that suburban or exurban counties that have more wealth actually have less maltreatment. But we suspect from experience and talking with experts that some of this is giving wealthier parents the benefit of the doubt in maltreatment cases. So the bottom line is, as in other areas, we need better information in order to make a reasonable judgment about how much maltreatment actually exists.

Nevertheless, the overall numbers for Minnesota cannot be explained away readily by differences in demographics. The federal report shows Minnesota lagging by about three children per thousand, or roughly 1/3 behind the national average for child victims from 2016 to 2020, which raises the question of whether children are overall significantly less safe in Minnesota than in the country as a whole.

Now, if you are still with me, let's move on to some of the management questions. As indicated in the blog, there is a curious combination of over and under-regulation that contributes to the difficulty of getting timely and high-quality national data on child welfare. The overregulation comes in the form of the federally required computer system. The feds back in the 1990s reimbursed 90% of the cost to states to build a child welfare information system, with the requirement that they not create one from scratch, but use an existing model from another state that met all the federal reporting requirements. This process called technology transfer did not work very well. I was the project member on a couple of project teams to adapt similar systems, and the cost of tweaking and then some quotes one system to make it work in a different state was typically as or more costly than it would've been to simply build them from scratch according to federal specifications. There were so many workarounds in trying to map existing routines and subroutines onto a system that would interface with the rest of the IT systems in a particular state, that it was a breakeven or net loss proposition. What states ended up with was Frankenstein systems that neither worked well with the federal government or with their other state systems, such as payroll, general ledger, civil service etc.

Now, more than 30 years down the road, the systems are still living along and causing expense and operational difficulties for Minnesota and other states

At one point I did a survey for a national child welfare policy group of state experiences with the federal system, which I as mentioned in the blog this is known as SACWIS, or State and County Welfare Information System. This system is known by different names in different states, and in Minnesota it is SSIS, or Social Services Information System. The fact that this system has the term "welfare" in it rather than child welfare shows how old it is. SACWIS-slash-SSIS has never been user friendly, and it took years to work the bugs out. As an example, I once was on assignment in the District of Columbia working on their child welfare class action lawsuit and on two occasions I saw two social workers quit on the spot. In both cases it was because they had spent long periods of time, one worker mentioned two days, trying to get their SACWIS system

to accept information, at the end of which process the system crashed and they lost all of their data. I won't repeat what they said on the way down the elevator.

Additionally, I once did a survey for a client of about 15 states on their experience with SACWIS. They consistently reported that workers spend 70 or 75% of their time just trying to get information to "take" in the system. I pushed back pretty hard on that, I couldn't believe that this number was correct. But in circling back to people who had a national perspective and a number of credible state managers I knew, I came over time to believe that this was the case. In addition, in Minnesota, supervisors and managers still report approximately the same percentage of their workers time being spent on the care and feeding of SSIS. It currently takes approximately one days to simply do the paperwork to close out the case.

There is currently some renewed interest in making an overhaul of this IT system a priority. This has always been a tough sell since there is hardly anything less appealing politically than spending money on a computer system. But things have gotten to that point where it could become a public issue if the system is not overhauled, because systems like this tend to break down in a very traumatic and politically troublesome way. From my experience doing IT projects and with Business Process Redesign, I know that it is not at all unusual for a redesign of an IT system to reduce the amount of work or time spent maintaining it by 50% or more. What is important here is that all of this time saved would go directly into casework, which would effectively increase the number of caseworkers in Minnesota but one third or more. I did a little work a few years ago and estimated that a relatively small contract, say $100,000, would enable the state DHS to develop a roadmap for a complete overhaul of SSIS, which would probably cost in the neighborhood of $3 million to $5 million. It would be so much cheaper than building a system from scratch and such a great investment in the workforce that it is clearly worth the expense.

In contrast, looking at this from a program perspective, the federal Department of Health and Human Services has never had sufficient authority to standardize definitions or practices among the states. As a result, both at the national level and in Minnesota states and counties have used what is called here "community standards". Deciding what this means in practice is that whether children are being abused and taking action to protect them depends on where they live. This has caused great concern over time, great variation in the number of children who were maltreated and killed in Minnesota, and is the primary focus of our reform efforts at Safe Passage for Children.

Another major aspect of this is the timeliness of the data. If you want to use information to better manage programs it is critical that you have it in as close to real time as possible. Neither the federal nor the state reports do very much good in this respect. In addition the information needs to be at a level where it is actionable. National statistics are not actionable by anyone. In Minnesota it would be somewhat helpful to at least have the data in the annual state report available to county managers on a monthly basis. Better yet, Utah has a process where they give monthly reports on key data items to workers on their own caseloads. As a result they have been able to improve performance on basic metrics such as monthly visits with children in foster care and timely court appearances from an average of 60% to 90% compliance.

The overall picture here is that the data collected at the federal and state levels is not very useful for improving the management of the program. We need to address the two headed monster here of simultaneously decreasing federal micromanagement in certain areas, particularly IT systems, while at the same time increasing federal oversight and standard-setting in other areas such as requiring common definitions and standards for the various aspects of the child protection system.

Rich Gehrman

Executive Director, Safe Passage for Children of Minnesota

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