

New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Oversight of Critical Foster Care Program Requirements

Office of Children and Family Services



Report 2015-S-79

July 2017

Executive Summary

Purpose

To determine whether the Office of Children and Family Services (OCFS) has effective controls in place to ensure that foster homes meet required criteria prior to their certification or approval for the placement of foster children, and to determine whether casework contacts occur as required for these children. Our audit covered the period April 1, 2012 through March 22, 2017.

Background

OCFS regulates and supervises child welfare services, including foster care and adoption, through its Division of Child Welfare and Community Services. Regional Offices oversee the entities that provide child welfare services, including voluntary agencies (VAs) and local Departments of Social Services (counties). These entities administer the foster care program, including placing children in foster care settings, certifying and approving certain foster homes, and providing casework services to children and families. OCFS and these entities use the CONNECTIONS system to document information about service delivery, including assessments and case plans for families and children.

Key Findings

- At each of the ten sites we visited, foster home records lacked evidence that counties or VAs met certain critical foster home certification/approval and recertification requirements, thus increasing the risk of placing children in an unacceptable environment. The problems we identified included missing home visits and no record that background checks for criminal history and/or child abuse history were done for foster home residents.
- Casework records lacked evidence that caseworkers made required contacts with foster children, foster parents, and parents. For example, for 150 children we selected for review, casework records for 33 lacked evidence that caseworkers had two contacts with the child within the first 30 days of placement, as required. For one of the 33 children, it took more than 60 days to make the initial contacts, and 14 were not visited in the foster home within the first 30 days of placement.
- For 30 of 150 children selected for review, we determined that 162 contacts were not entered within OCFS's 30-day limit. For example, for one child, 23 contacts were entered anywhere from 35 to 244 days after they took place.
- Inconsistencies and errors exist among different sources of foster care data, which may compromise its integrity and usefulness.

Key Recommendations

- Identify and implement strategies to improve county and VA compliance with requirements for the certification and approval of foster homes, promptness and frequency of casework contact services, and timely entry of casework contact progress notes.
- Identify and correct the inconsistencies and errors in foster care population data, and take prompt steps to address those that may compromise its completeness and/or accuracy.

Agency Response

In response to the draft report, OCFS officials stated that they “reject” our findings and characterized our recommendations as “irrelevant” and “nonsensical.” In part, officials argued that it is inappropriate for auditors to gauge performance without specific law or regulation specifying minimum performance standards. However, OCFS officials overlooked their own internal operating standards, which auditors used to assess OCFS’s performance. With specific regard to entering data about casework contacts, which are face-to-face visits done to assess the child’s safety or adjustment to foster care, OCFS officials “would consider entry within 30 days to be a reasonable standard.”

OCFS officials also asserted that supplemental information (records) they accumulated, and provided to us as much as six months after we issued our preliminary findings, disputes at least one error that we cited for half of the children in our tests and one-third of the individual findings overall. However, some of these records indicated that certain requirements were met after and in response to our preliminary audit results. For example, in one case, 427 days elapsed between the July 2015 casework contact and the September 2016 date when information about this visit was finally entered, which was nine days after OSC’s site visit. When records are not contemporaneous with the events in question, they are of limited evidentiary value. Also, OCFS officials did not account for the other half of the sampled children, for whom they did not provide evidence of the required oversight and supervision. Nor did OCFS officials provide evidence for the remaining two-thirds of the individual findings we cited. Consequently, we maintain that this report provides a reasonable basis for its findings and conclusions.

OCFS is responsible for the safety, permanency, and well-being of many of society’s most vulnerable youth. Timely, complete, and accurate management information is needed to ensure compliance with prescribed protocols (including supervisory visits) designed to protect youth placed in OCFS programs. However, OCFS’s defensive and dismissive response is not indicative of an appropriate agency control environment, particularly given the nature of the youth OCFS must protect. Consequently, we urge OCFS officials to reconsider the audit’s findings and recommendations with more open minds, to better enable OCFS to fulfill its vital mission.

Other Related Audit/Report of Interest

[New York City Administration for Children’s Services: Administration of Non-Competitive and Limited-Competition Contracts \(2013-N-2\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

July 21, 2017

Ms. Sheila J. Poole
Acting Commissioner
Office of Children and Family Services
52 Washington Street
Rensselaer, NY 12144-2834

Dear Ms. Poole:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Oversight of Critical Foster Care Program Requirements*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

In New York State, the child welfare system is State-supervised and locally administered. The Office of Children and Family Services (OCFS) regulates and supervises child welfare services, including child protective services, foster care, and adoption, through its Division of Child Welfare and Community Services. OCFS's mission is to promote the safety, permanency, and well-being of children, families, and communities. OCFS Regional Offices oversee the entities that provide child welfare services. These entities include voluntary agencies (VAs) and local Departments of Social Services (counties). Outside of New York City, counties sometimes work with VAs to secure placement services. When children are either placed directly by the county in a foster home certified or approved by the county, or placed in a foster home certified or approved by a VA, they are in the temporary custody of the county commissioner. During that time, the county is responsible for seeing that their needs are met and planning for their futures. OCFS and these entities use the CONNECTIONS system to document information about service delivery, including assessments and case plans for families and children.

Children are placed in foster care either because their parents are willing to have them cared for temporarily outside the home (voluntary) or by order of a court (involuntary). A voluntary placement occurs when parents are temporarily unable to care for their child for reasons other than abuse or neglect, such as when a family is experiencing a serious medical or financial problem. Parents sign a voluntary placement agreement that specifies the responsibilities of both the parents and the agency during the child's placement. Parents (or guardians) can request that the child return by a specific date, event, or circumstance; or the date for return may be indefinite. An involuntary placement occurs when a child has been abused or neglected, or may be at risk of abuse or neglect, by his or her parent(s) or someone else in the household, or because a court has determined that the child is a "person in need of supervision" or a juvenile delinquent. The court orders the child removed from the home, and determines the length of the placement or sets a date for its further review.

In foster care, the general rule is to place the child in the least restrictive, most family-like environment appropriate to meet the child's needs. According to OCFS officials, most of these children are in foster homes. Placement in foster homes can be with a relative (homes that require approval) or non-relative (homes that require certification). State statute requires that counties consider the availability of relatives as a placement resource, either as direct custodians or foster parents, prior to placing a child with a non-relative.

VAs and counties must evaluate prospective foster homes to ensure they meet basic physical, health, and safety requirements prior to certifying or approving them and placing children there. These requirements include a home study to determine if the foster home environment meets the child's needs, an evaluation of the physical and mental health of foster family members, and character references. They also include a determination of whether prospective foster parents and any person aged 18 years or older living in the home are the subject of an indicated child abuse maltreatment report on file with the State Central Register of Child Abuse and Maltreatment (SCR), as well as criminal history record checks by the New York State Division of Criminal Justice

Services (DCJS) and the Federal Bureau of Investigation (FBI). Additional requirements effective in June 2013 require county and VA personnel to check with the State Justice Center for the Protection of People With Special Needs to determine if prospective foster parents and any person aged 18 years or older living in the home appear on the Staff Exclusion List (SEL), which contains the names of individuals found responsible for serious or repeated acts of abuse and neglect in certain programs and deemed ineligible to work in a position involving regular and substantial contact with a service recipient.

Foster home certifications or approvals must be renewed annually. The county or VA must document renewal with a written evaluation using the same criteria used for initial certification or approval, and include an evaluation of the care provided to children in the home. Criminal history record checks are done for each person aged 18 or over who is currently living in the home and has not been previously checked. At the time of renewal, these entities are also required to inform foster parents that foster youth aged 14 and older will be given the opportunity to respond to Youth Voice Questions about the safety and quality of life in their foster home. The OCFS Directive requires caseworkers or case planners to offer this opportunity at least once each year, as part of regular casework contacts with the child. Further, there must be at least one progress note entry, pursuant to regulation, indicating that the caseworker met with the youth and asked the questions and, when applicable, that the youth refused to respond to any or all of the questions.

Audit Findings and Recommendations

We found that foster home records lacked evidence that counties or VAs met certain critical foster home certification/approval and recertification requirements at each of the ten sites we visited. The problems we identified included missing home visits, background checks, and child input in the recertification process. We also found that casework contact records lacked evidence that caseworkers met contact requirements with the child, foster parent, and parent. In addition, we identified instances in which caseworkers did not enter casework contact information into CONNECTIONS timely. Finally, there were inconsistencies among different sources of foster care data that may compromise its integrity and usefulness.

Certifying and Approving Foster Homes

We used foster care population data provided by OCFS to select a sample of six counties (Erie, Ontario, Schenectady, Tompkins, Wayne, and Westchester) and four VAs (Buffalo Urban League, Cayuga Home, House of the Good Shepherd, and Kidspace) to visit and review selected records. In total, we reviewed the certification or approval files for the most recent foster home placement for 150 children to determine whether the homes met placement criteria. We found instances where key foster home certification/approval and/or recertification requirements were not met at every county and VA we visited, including missing home visits, missing background checks, and lack of evidence that caseworkers offered youth aged 14 or older the opportunity to respond to Youth Voice Questions. In response to our preliminary findings, OCFS provided additional documentation for some of the homes and placements we tested. Where applicable, we adjusted our results accordingly.

Of the foster home files for the 150 children in our sample, three lacked evidence that a required home study was done to assess the foster home environment. We also identified several home files that lacked evidence that key criminal and abuse records checks were done. For example:

- Two home files were each missing one or more required DCJS and FBI background checks. One of the two home files was also missing an SCR check, and the other was also missing one or more SEL checks.
- Three home files lacked evidence that county or VA personnel had done necessary safety assessments when foster home residents were found to have a criminal record, including one that also lacked an SEL check.

In addition to these cases, records on the homes of 24 other sampled children were also missing one or more SCR or SEL checks. Furthermore, recertification information for 23 of 48 applicable homes did not include evidence that children aged 14 or older provided input about their care in the foster home by responding to Youth Voice Questions, or that they were offered the opportunity to do so, as required by both regulation and OCFS Directive. In addition, personnel at two entities we visited stated that they were unaware of the requirement to offer an opportunity for youth to give input about their care. These two entities accounted for 18 of the 23 foster children whose records lacked evidence that caseworkers sought child input. All of these circumstances increase

risk that vulnerable children could be placed in environments that might not have met minimum standards for suitability and safety.

Providing Critical Casework Services to Children and Families

OCFS regulations require counties and VAs to provide casework contact services to the child, the child's foster parents or caretakers, and the child's parents or relatives. Casework contacts are face-to-face visits conducted for the purpose of assessing the child's current safety and well-being, obtaining information about the child's adjustment to foster care, facilitating the foster parents' role in achieving the course of action specified in the services plan, and assessing whether the child would be safe if he or she were to return home. These contacts are an integral part of obtaining firsthand information about the circumstances affecting foster children in their current and future environment. We found that foster care records lacked evidence that caseworkers made the minimum contacts with the foster children, as well as with their foster parents and parents. (See Exhibit A at the end of this report for results by entity.)

Caseworkers must make contact with the foster child at least twice in the first 30 days of placement, including at least once at the child's placement location, and at least once per month thereafter. A minimum of two contacts every 90 days must be made at the child's placement location. Of the records we reviewed for 150 children, 33 lacked evidence that caseworkers had two contacts with the child within the first 30 days, including one for whom it took more than 60 days to make initial contact and 14 who were not visited in the foster home within the first 30 days. In addition, available records indicated that caseworkers did not meet requirements for monthly contacts after the first 30 days for 18 children, and 39 children did not receive two contacts in the foster home every 90 days.

Caseworkers must also meet with foster parents at least once in the first 30 days, with the child's parents at least twice during that same period, and at least once per month with each thereafter. In general, at least one of the contacts during the first 30 days, and at least one contact every 90 days thereafter, with both foster parents and parents, must be in the child's placement location or the parents' home (if applicable), respectively. However, county and VA records lacked evidence that caseworkers met these requirements. Of the case files we reviewed for the 150 children we selected:

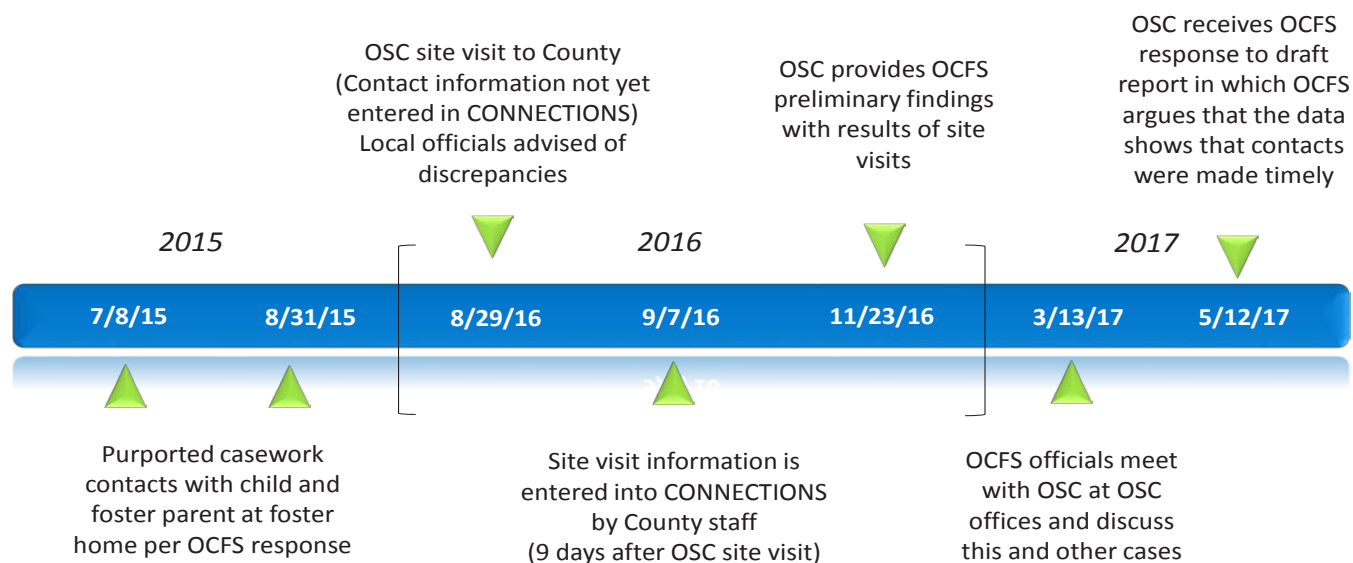
- 15 lacked evidence that there was contact with the foster parents within 30 days of placement, including files for four children for whom it took more than 60 days for the initial contact with the foster parent;
- 50 lacked evidence that there were two contacts with parents within the first 30 days, including files for ten children for whom it took more than 60 days for the initial contact with the parents to occur and files for 23 children for whom neither of the first two parent contacts occurred within the first 30 days;
- There was no evidence that 12 foster parents were visited in the foster home, or that 81 parents were visited in their homes, within the first 30 days;
- Caseworkers also did not meet requirements for monthly contacts after the first 30 days for 55 foster parents and 60 parents; and

- At least one visit every 90 days was not conducted in the foster home or parent's home for 17 foster parents and 100 parents, respectively.

In some cases, the responsible county or VA not only failed to meet several different requirements related to casework contact services with the child, foster parent, and/or parent, but also failed to fulfill one or more of the certification/recertification and approval requirements for the child's foster home. For example:

- A Wayne County child was placed in foster care in June 2015. However, although casework contacts with the child occurred, none were at the foster home, as required, for the ten-month period from August 2015 through May 2016. Further, there were no records of monthly contacts with the child's foster parent for the four-month period from October 2015 through January 2016, in addition to two months outside that period. Thus, there were no records of contact with the foster parent for six of the 11 months we reviewed. Finally, there were no records of monthly contact with the parent for five of 11 months we reviewed, nor was there any contact in the parent's home within the first 30 days, as required. Foster home records also lacked evidence that, at time of recertifying this home, county personnel met the requirements to evaluate the child's care and obtain input from the child regarding the care provided and improvements that could be made in care. In essence, this child's foster care placement went unmonitored for several months, followed by incomplete recertification of the foster parent's home for continued program suitability.
- For a child from Schenectady County placed in June 2015, the first casework contact with this child did not occur until 91 days after placement, which was also the date of first contact with the foster parent. The second contact with the child occurred 112 days after placement. Contact with the parent was similarly late, with the first contact occurring 76 days after placement and the second 135 days after placement, neither of which occurred in the home. We also found no record of monthly contacts with the foster parent for three of 11 months reviewed, and none with the parent for two of 11 months reviewed. Finally, the home certification/approval file lacked evidence that two SCR checks requested by the county were done, and it lacked a required medical report. (Note: The medical report was later obtained as a result of our audit.) OCFS states that casework contacts for this child met requirements. However, at the time of our site visit, a record of these contacts was not provided to our auditors. Further, information OCFS provided in response to our findings indicated that these contacts were likely entered into case records after we communicated the deficiencies. An example of one such case is illustrated in the following timeline. As such, we stand by our findings, noting that certain case records were updated well after the purported events took place.

Timeline – Example Casework Contact Entry Schenectady County



{ **427 days elapsed between July 2015 contact and September 2016 data entry** }

These examples demonstrate that OCFS needs to strengthen controls to provide adequate assurance that its local partners ensure foster homes meet requirements prior to placing foster children with them and casework contacts actually occur as required. In response to our findings, OCFS officials said they have provided direct guidance to caseworkers and supervisors addressing the timeliness of casework contacts by distributing a monthly report about the percentage of contacts made. However, they did not provide us any additional information, such as actions taken when contact percentages are low.

Issues related to the certification and approval of foster homes and completion of casework contacts have been identified previously. The U.S. Department of Health and Human Services' Children's Bureau (Bureau) conducts Child and Family Services Reviews every seven years to assess child welfare agency performance in achieving positive specified outcomes for children and families in the areas of safety, permanency, and well-being. The Bureau's last report for New York, issued to OCFS in 2009, identified several concerns related to foster care, including unclear standards for licensing foster family homes that resulted in inconsistent interpretations and applications of such standards in different areas of the State. The report also cited concerns with the frequency and quality of casework visits with both children and parents.

Entering Casework Contacts

OCFS regulations require that casework contact progress notes (casework contacts) be entered

into CONNECTIONS “as contemporaneously as possible with the occurrence of the event,” and OCFS officials cite 30 days as the maximum time allowable. During our site visits, we determined that most of the counties and VAs that we reviewed entered their casework contacts timely for the 150 children in our sample. However, 162 contacts (for 30 of the 150 children) were not entered within the 30-day standard. At one county, a total of 71 casework contacts were entered late for seven of the ten children we reviewed. For one child, 23 contacts were entered 35 to 244 days after the date of the contact. For another child, 11 contacts were entered 87 to 317 days after date of contact.

In response to the draft report, OCFS asserts that the 30-day time frame is “only an OCFS recommendation for best practice,” and that, because there is neither a statute nor a regulation establishing the number of days within which to record these contacts, OSC went beyond its authority in making findings on caseworker practice. In fact, however, OSC applied the standard set forth by OCFS representatives. Specifically, with respect to casework contacts, OCFS officials “would consider entry within 30 days to be a reasonable standard.” Thus, the 30-day time frame was considerably more than simply a “best practice.”

Moreover, OCFS officials overlooked the severity of the cases we found, instead ostensibly disclaiming responsibility for the timely data entry of caseworker contacts. Absent a specific law or regulation to direct them, OCFS officials demonstrated little apparent concern that caseworkers took more than a month to record contacts for 20 percent of the children we sampled, and some purported contacts took as long as ten months to be posted. Consequently, we maintain that material deficiencies in case record maintenance diminish OCFS’s ability to provide adequate case management of youth placed in foster care programs.

Our findings related to foster homes and casework services indicate an increased risk that entities subject to OCFS oversight could place a child in a dangerous or unsuitable environment. Access to current casework contact progress notes to monitor individual children’s well-being, adjustment, and progress toward permanency goals, where applicable, is equally important. Delays in entering casework contacts compromise the value of information that caseworkers rely on to make informed and appropriate decisions about the children who depend on their services.

Recommendation

1. Identify and implement strategies to improve county and VA compliance with requirements for the certification and approval of foster homes, promptness and frequency of casework contact services, and timely data entry of casework contact progress notes.

Other Matters

OCFS Oversight Tools

OCFS, through its Regional Offices, uses various quality improvement methods in its foster care-related oversight and monitoring of both county and VA foster care programs. For example,

Permanency Round Tables are meetings to develop strategies to assess and expedite permanency for selected children. OCFS Regional Office and home office personnel also provide technical assistance, training, and support to county and VA personnel. These methods do not entail reviewing records on site to evaluate compliance with foster home certification or casework requirements.

In contrast, reviews such as Safety and Permanency Assessments (SPAs) and Voluntary Agency Reviews (VARs) are done on site, and are intended to identify strengths and areas needing improvement related to the safety, permanency, and well-being of children in foster care. Where applicable, Performance Improvement Plans are required. SPAs are specific to counties and are done on a four-year cycle for counties OCFS classifies as large or medium (small counties do not receive SPAs). SPAs focus on certain practices, including: whether a safety assessment is in place for the child; the appropriateness of the permanency goal; the frequency of caseworker contacts; and foster parent and discharge resources. They do not include reviewing foster home certification and approval records.

VARs are specific to VAs, are done on a three-year cycle, and include a case record review for seven modules, such as family engagement throughout the life of the case and safety and quality of daily living in out-of-home care. Additional modules are added where applicable and may include reviewing certification and approval records. We reviewed 20 SPAs and 85 VARs to assess OCFS oversight of the entities that certify and approve foster homes and arrange for casework services for children in foster care.

Of the 57 counties in New York (excluding New York City), 32 (or 56 percent) were subject to SPAs, including nine large- and 23 medium-population counties. Of the 32 counties, 13 did not receive a full SPA within the four-year cycle covering calendar years 2012-2015. In response to our report, OCFS states that alternate monitoring activities, such as Permanency Round Tables and Onsite Review Instruments, are approved substitutes for SPAs. However, unlike the SPA, the Permanency Round Table does not include case record reviews. Further, although seven counties received one of these alternate activities, six were not subjected to such alternate monitoring during the four-year cycle.

In addition, OCFS's SPA procedures require the Regional Office to complete a desk review and to provide the county with information about which records they plan to review four weeks in advance of their visit. The practice of providing a sample this far in advance increases the risk that records might be altered prior to the SPA. We also examined 85 VARs for 78 VAs outside of New York City and identified two VAs that were not reviewed during the three-year cycle covering calendar years 2013-2015. In one instance, an alternative review was done in place of the VAR; in the other instance, OCFS personnel said a VAR was scheduled for late 2016.

We also reviewed the corrective action plans for the SPAs and VARs, which must be done when there are any recommended and required actions, and found 19 instances (including three SPAs and 16 VARs) where the SPA or VAR contained recommended and required actions and, where applicable, areas for improvement. However, the corrective action plans did not address these items. Because SPAs do not address compliance with foster home certification and approval

requirements, and because not all counties are subject to SPAs, there is risk that problems in this important area may not be detected, corrected timely, and prevented in the future. In response to our preliminary findings, OCFS officials said they will be adding smaller counties to the SPA cycle beginning in 2017. Given these results, OCFS may benefit from assessing how these oversight tools might work to better identify and address problem areas in foster care oversight.

Data Inconsistencies

As part of our audit, OCFS provided State foster care population data, sorted by VA and by county (excluding counties in New York City), for the period April 1, 2012 through June 25, 2016. During our visits, we also obtained foster care data from the counties and VAs we visited, and reviewed records for 334 children to arrive at our adjusted sample of 150 children. Of the 334 records, we identified eight potential errors representing eight children. These included: three children who OCFS data indicated were placed locally, but county/VA officials said were placed out-of-state or outside of that county; two children who were not in foster care during our audit period; two children who were placed by a county or VA that differed from OCFS data; and one child who the county indicated was never in foster care. In response to our preliminary findings, OCFS officials provided information regarding potential explanations for the data differences. However, officials did not provide explanations for the specific discrepancies we identified and detailed.

We also compared foster care population data from five entities we visited – Erie, Ontario, and Westchester counties and the Buffalo Urban League and Kidspace VAs – to OCFS population data to assess whether the information was consistent, after allowing for possible timing differences. We identified a total of 135 children who were on county or VA lists, but were not on OCFS's list, including 58 children at Erie County, 26 children at Buffalo Urban League, 12 children at Kidspace, 25 children at Westchester County, and 14 children at Ontario County.

In response to our preliminary findings, OCFS acknowledged errors regarding four of the aforementioned children, and provided explanations to address the other 131. According to the OCFS information, 73 of the 131 children did not appear in the data we requested because they were entered in CONNECTIONS late at the county or VA level. However, the information OCFS provided did not enable us to verify this. We also note that, according to OCFS officials, entities must enter child information into CONNECTIONS to receive payments related to that child, and are expected to enter all foster care movements within 30 days of the event.

OCFS officials also provided explanations for the other 58 children who appeared on county or VA records but not on OCFS's records. However, despite the extensive amount of time we allowed OCFS to provide explanations, we were unable to reconcile the discrepancies. According to OCFS officials, certain children were not in foster care during the period, and others had no foster care record. Officials also asserted that still other children were in OCFS data; nonetheless, we were unable to locate them using the OCFS-established Child Identification Numbers. Under these circumstances, there are limitations in the reliability and usefulness of data used by both OCFS and the counties, which could hinder their respective foster care oversight and monitoring efforts.

Recommendations

2. Formally assess potential steps to improve the effectiveness of SPAs and VARs and implement steps as warranted. Steps for consideration should include, but not be limited to:
 - Withholding sample details until time of site visits;
 - Monitoring corrective action plans to ensure they address recommended and required actions; and
 - Incorporating a review of certification and approval requirements at the counties.
3. Identify and correct the inconsistencies and errors in foster care population data, and take prompt steps to address those that may compromise its current and future completeness and accuracy.

Audit Scope, Objectives, and Methodology

Our performance audit determined whether OCFS has effective controls in place to ensure that foster homes meet the required criteria prior to certification or approval for the placement of foster children and whether casework contacts occur as required for these children. The audit covered the period April 1, 2012 through March 22, 2017.

To accomplish our objectives, we reviewed relevant laws and regulations as well as OCFS policies and guidance related to areas of foster care under audit. We held meetings with OCFS personnel to better understand their role in overseeing county and VA activities related to foster care. We also met with personnel from selected counties and VAs that we visited. We became familiar with OCFS internal controls as they relate to its oversight of the entities that certify and approve foster homes and provide casework services to children in foster care and the families involved in their care. We performed certain tests to assess the sufficiency of these controls.

To identify a population of children in foster care for purposes of our audit, in October 2015 we requested that OCFS provide a list of children, sorted by county and VA (excluding New York City), who had been in foster care at any time during the period April 1, 2012 through June 25, 2016. We asked that the data include only the most recent placement type (e.g., certified foster home or approved relative foster home) for each child, and that it include the entity responsible for the last placement type for each child. After negotiating a confidentiality agreement with OCFS and clarifying information about the data we were seeking, we received usable data from OCFS in June 2016. We used this data to select samples to test areas under audit and to assess aspects of its reliability.

We analyzed the data to select a judgmental sample of ten entities to visit: six counties (Erie, Ontario, Schenectady, Tompkins, Wayne, and Westchester) and four VAs (Buffalo Urban League, Cayuga Home, House of the Good Shepherd, and Kidspeace). In selecting our sample, we considered factors such as geographic coverage, representation of both counties and VAs, and results of prior regional office monitoring efforts. We selected a judgmental sample of 10 or 20 children

at each location whose records we planned to test during our visits. After reviewing information in CONNECTIONS during our site visits, we removed certain children from our selection who had not been in foster care long enough to enable us to adequately test our objectives. We removed others, such as those who had been adopted, and replaced them as needed. In total, we reviewed records for 334 children to arrive at our adjusted sample of 150 children. In addition, we reviewed records for 46 VA employees to determine if they contained required documentation, such as criminal background checks. In evaluating compliance, we reviewed supporting documentation related to certification and approval of foster homes and casework contacts. We communicated our findings to OCFS management and considered information OCFS provided in response through March 20, 2017.

We conducted our performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained during the audit provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating threats to organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

As is our normal practice, we requested that OCFS officials provide us with a letter of representation to affirm that they have made all relevant records and related data available for audit, and that they have complied with all applicable laws, rules, and regulations or have disclosed any exceptions and material irregularities to the auditors. The letter of representation is also intended to confirm any significant oral representations made to the auditors and thereby reduce the likelihood of misunderstandings. OCFS did provide us with a representation letter, but made purposeful changes to the document to limit the period of time covered by its representations only through June 25, 2016, thereby excluding several months during which it provided significant audit-related information, including the information that accompanied its response. As such, we deemed the letter unacceptable for the purposes of our audit and requested a revised letter. However, despite the auditors' multiple requests and reminders, OCFS officials declined to provide an acceptable representation letter. We therefore have limited assurance that the information provided to us during the course of our audit was reliable, accurate, and complete.

Authority

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Agency Response and Additional Reporting Requirements

We provided a draft copy of this report to OCFS officials for their review and formal written comment. We considered their comments in preparing this final report. In general, OCFS “rejects” our findings and characterizes our recommendations as “irrelevant” and “nonsensical.” In part, officials argued that it is inappropriate for an outside party to gauge their performance, if there were no specific laws or regulations specifying minimum performance standards. However, OCFS officials overlooked their own internal standards, which auditors used to assess performance.

OCFS officials also asserted that supplemental information they accumulated and provided to us, as many as six months after we presented findings to them, disputes at least one error we cited for half of the children in our tests and one-third of the individual deficiencies we cited. However, some portions of the supplemental information appear to have been created after and in response to our audit testing and site visits (and well after the corresponding events actually took place). When records are not contemporaneous with the events in question, they are of limited evidentiary value. Also, OCFS officials did not account for the other half of the sampled children, for whom they could not provide evidence of the required oversight and supervision. Nor did officials provide evidence for the remaining two-thirds of the individual deficiencies we cited. Consequently, we maintain that the audit provided a reasonable basis for the report’s findings and conclusions. Exhibit B is a timeline depicting key events in the audit process, including timing of OCFS responses to OSC preliminary reports and the extended time period during which our auditors considered information that OCFS provided.

OCFS is responsible for the safety, permanency, and well-being of many of society’s most vulnerable people. Timely, complete, and accurate management information is needed to ensure compliance with prescribed protocols (including supervisory visits) designed to protect youth placed in OCFS programs. However, OCFS’s defensive and dismissive response is not indicative of an appropriate agency control environment, particularly given the vulnerable youth OCFS must protect. Consequently, we urge OCFS officials to reconsider the audit’s findings and recommendations with more open minds, to better enable OCFS to fulfill its vital mission. In addition, OCFS’s response includes multiple misleading and/or inaccurate statements. Our rejoinders to those comments are included in the report’s State Comptroller’s Comments, which are embedded in OCFS’s response.

Also, with its response to the draft report, OCFS officials included more than 500 electronic files that were referenced as Attachments 1 through 3 to that response. Many of these files were replete with highly sensitive and confidential information about the health and welfare of specific foster children, their parents and foster parents, and the homes they lived in. Our normal practice is to attach the agency’s response in its entirety to the final report. However, we did not attach the files in question (Attachments 1 through 3) to this report due to their volume as well as their sensitive and confidential nature. For a limited period, those files will be retained by the Office of the State Comptroller, in a secure manner.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

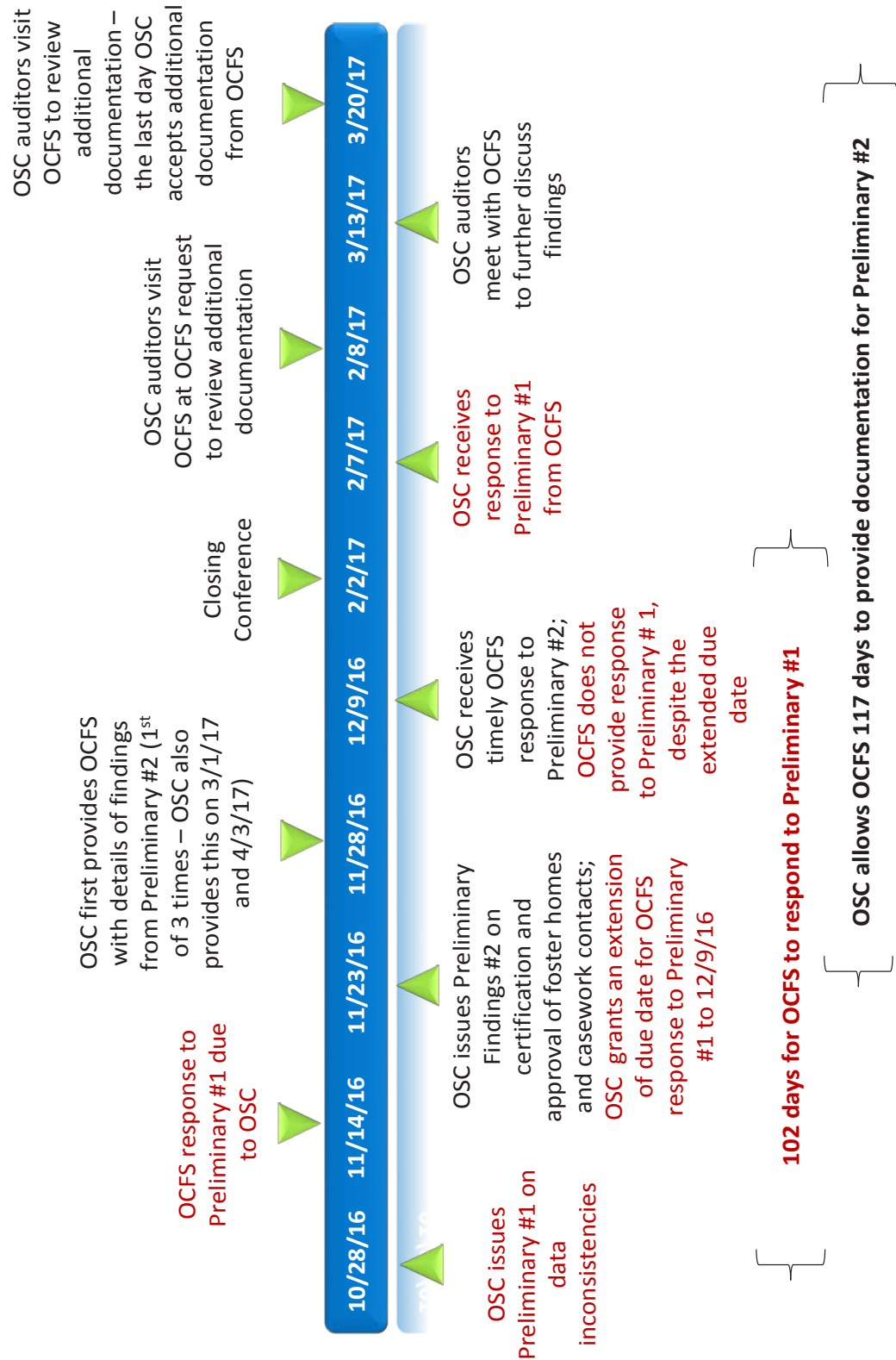
To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Exhibit A

Caseworker Contacts – Number of Sampled Children for Whom Contact Requirements Were Not Met													
County or Voluntary Agency (Number of Cases Reviewed)	Casework Contacts With Foster Child				Casework Contacts With Foster Parent				Casework Contacts With Parent or Relative				
	Two contacts within 30 days	Initial contact in foster home	Monthly contacts	Two contacts in foster home every 90 days	One contact within 30 days	Initial contact in foster home	Monthly contacts	One contact in foster home every 90 days	Two contacts within 30 days	Initial contact in parent home	Monthly contacts	One contact in parent home every 90 days	
Erie (20)	6	3	2	5	3	3	7	3	4	13	6	14	
Ontario (10)	1	1	3	4	-	1	7	-	3	4	7	6	
Schenectady (10)	2	-	1	1	2	1	4	-	3	2	2	4	
Tompkins (20)	6	1	2	9	3	2	8	2	10	11	9	14	
Wayne (10)	-	1	-	4	-	1	4	3	2	6	4	9	
Westchester (20)	9	4	2	5	3	3	7	3	9	12	12	18	
Buffalo Urban League (10)	1	-	1	2	0	-	2	-	1	9	1	7	
Cayuga Home (10)	5	1	3	4	3	-	5	-	5	6	4	4	
House of the Good Shepherd (20)	4	-	1	2	2	-	2	-	6	7	7	11	
Kidspeace (20)	-	3	4	4	-	1	10	6	8	11	9	13	
Total Exceptions	34	14	19	40	16	12	56	17	51	81	61	100	
Total Reviewed	150	150	150	150	150	150	150	150	133	128	129	127	
% Exception	23%	9%	13%	27%	11%	8%	37%	11%	38%	63%	47%	79%	

Exhibit B

Timeline – OCFS Responses to OSC Preliminary Reports and Additional Time OSC Allowed to Consider OCFS Information



Agency Comments and State Comptroller's Comments



Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Acting Commissioner

May 11, 2017

Mr. John F. Buyce, CPA
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th floor
Albany, NY 12236

Re: Oversight of Critical Foster
Care Program Requirements,
2015-S-79

Dear Mr. Buyce:

This letter constitutes the Office of Children and Family Services (OCFS) response to the Draft Report of the Office of the State Comptroller (OSC) audit on the Oversight of Critical Foster Care Program Requirements (Draft Report). OSC asserts the purpose of this audit was to determine whether: (i) effective controls are in place for proper certification or approval of foster homes; and (ii) whether voluntary authorized agencies (VAs) and Local Departments of Social Services (LDSS) made required contacts with foster children, foster parents and others (“case work contacts”).

OCFS strongly rejects OSC’s draft findings regarding the sufficiency of the foster home certification and approval process and the adequacy of casework contacts made by VAs and LDSS. There are multiple legal and factual inaccuracies in OSC’S Draft Report. Specifically, the Draft Report is rife with specious findings that make OSC’s recommendations at best irrelevant and at worst, nonsensical. Accordingly, OSC’s findings rely on OSC’s misapplication of relevant statutory, regulatory and policy requirements and OSC failing to rely on, or even acknowledge, relevant information documented in case records.

I. Errors in the OSC Auditing Process Taint the Draft Report Findings

At the outset, OCFS notes that the Draft Report is tainted as it relies on flawed audit processes. The primary flaws were OSC's failure to understand fully the foster home certification data it received, and the statutory and regulatory standards against which OSC should have been measuring the data.

OCFS informed OSC of these audit process flaws during the audit process, and requested additional time to analyze their implications to any potential findings. OSC rejected OCFS's request, failed to remedy the audit flaws identified prior to issuing the Draft Report, and did not afford OCFS any additional opportunity to review relevant documents that would have allowed both parties to more fully understand OSC's process flaws. Worse, the Draft Report fails to acknowledge any additional clarifying information provided by OCFS with respect to the OSC errors and misunderstandings.

State Comptroller's Comment – The audit team met and corresponded with OCFS throughout the audit, often with OCFS legal staff present or participating, to help ensure that OCFS personnel fully understood the audit process, including our application of audit criteria. We also granted OCFS officials multiple extensions of time to provide additional documentation in response to our preliminary findings, which were issued to OCFS in November 2016. OSC auditors reviewed and gave appropriate consideration to all the additional information provided by OCFS. OCFS's assertion that auditors failed to acknowledge such information is patently false. In fact, auditors adjusted both the draft and final audit reports to reflect the supplemental information, where relevant, that OCFS provided during a period of nearly 4 months following the issuance of the preliminary findings. After this period, our auditors notified OCFS officials that they should provide any and all additional documentation by March 20, 2017, so that OSC could proceed with the reporting phase of the audit in a timely manner.

As a result of OSC's flawed process, the Draft Report is rife with errors. For example:

- In over half of the cited error cases, OSC made at least one incorrect finding; and
- Over a third of the unique findings cited by OSC are inaccurate.

OCFS identified these errors in OSC's review by looking at each of the instances where OSC provided sufficient information for OCFS to analyze an alleged referenced deficiency. OCFS looked to, among other things, case notes on individual foster children and records on the certification or approval of the relevant foster homes. In the limited circumstances where OCFS found a potential problem concerning the certification or approval of a foster home, OCFS immediately contacted the applicable VA or LDSS to help review the accuracy of the finding and also required corrective action to resolve any issues in foster homes caring for children. (OCFS' detailed findings are set forth in Attachment 1). OSC failed to consider OCFS's information and rejected OCFS's efforts to work collaboratively to fix the process.

State Comptroller’s Comment – In November 2016, we provided OCFS with all pertinent information we developed regarding the deficiencies we identified in the foster home certification or approval process. We also had ongoing communications with OCFS staff to resolve outstanding issues and reviewed additional documentation provided by them over several months. However, some of this additional documentation was incomplete or not for the correct foster home, and other pieces were created or entered into case records after (or in response to) our field visits, thereby diminishing their evidentiary value. Further, OCFS’s Attachments 1 through 3 (which are discussed in more detail on Page 16 of this report) consist of supplemental information officials accumulated since November 2016, a period of about 6 months at the time OCFS responded to the draft report. In addition, some of this information appeared to have been created after and in response to our audit testing and site visits. OCFS contends that this information disputes at least one error we cited for half of the children in our tests and one-third of the individual findings overall. However, officials did not account for the other half of the sampled children. Thus, there is material risk that OCFS officials were unable to find any evidence demonstrating that these children received the required oversight and supervision. Nor did OCFS provide evidence for the remaining two-thirds of the individual findings we cited, and consequently, we dispute the assertion that this represented a lack of information in “limited circumstances.”

II. OCFS Adequately Regulates and Supervises VAs and LDSS in Certifying and Approving Foster Homes.

OCFS rejects OSC’s findings that OCFS does not adequately regulate and supervise VAs and LDSS. OCFS is responsible for the oversight and supervision of VAs and LDSS in certifying or approving foster homes. OCFS requires that VAs and LDSS follow relevant law, regulations and policy with respect to background checks and certification of foster homes. OSC found that OCFS’s supervision of VAs and LDSS was deficient, but that finding was based on a fundamental misunderstanding of statutory, regulatory and policy requirements regarding: (A) the timing of background checks; and (B) how foster children over age 14 may provide input into the foster care process.

A. OSC Incorrectly States the Foster Home Renewal Background Check Requirements.

OSC incorrectly states that all of the background checks required when foster homes are first certified or approved also apply at each annual renewal of the homes. Draft Rep. at 6. However, the relevant State statutes in sections 378-a and 424-a of the Social Services Law only authorize more limited background checks when homes are renewed.

State Comptroller’s Comment – We have clarified language in the Background section of our report to state that certain background checks are done at renewal only when needed.

Although the Draft Report suggests there were some missing background checks for a few homes, OSC failed to provide sufficient detail about those homes for OCFS to determine whether OSC applied the correct statutory requirements in those cases. Regardless of the lack of useful information from OSC, OCFS, in conjunction with the Office of Information Technology Services (ITS), strengthened the statewide comprehensive child welfare management system (CONNECTIONS) so that VAs and LDSS are precluded from issuing foster home certifications, approvals or renewals unless system based documentation of the required background checks is completed.

B. OSC Incorrectly Determined that Input from Foster Children is Required before Recertification of a Foster Home.

OSC incorrectly states that input from foster children over 14 years of age is required during the foster home renewal process. However, there is no statutory or regulatory requirement for such input by foster children. OCFS, through policy directive [10-OCFS-ADM-09](#), requires that the VA or LDSS, as part its regular casework contacts, provide older foster youth a yearly opportunity to complete a questionnaire that, among other things, asks about the child's care in the foster home. Participation by the foster child is voluntary. If a foster child responds, the VA or LDSS must consider the information when evaluating whether to renew the foster home. However, the policy directive expressly states that the renewal process must not be held up to wait for a foster child to complete the questionnaire (which is the only logical process since participation by the foster child is voluntary, and not required). Accordingly, the lack of documentation of a particular older foster child's input during the renewal process does not demonstrate any inappropriate action by a VA or LDSS.

State Comptroller's Comment – We clarified language in the Background of this report to state that caseworkers are only required to offer youth an opportunity to provide input about the safety and quality of life in their foster home. Nevertheless, the policy directive OCFS cites does, in fact, require caseworkers to document that they offered this opportunity and, where applicable, that the youth refused to respond to any or all of the questions. During our fieldwork, we accepted information in any format that would substantiate that caseworkers had made these efforts. Our findings represent cases where the VA or county provided no such information and OCFS did not provide relevant support as well. As such, we maintain that corrective action is warranted.

III. OSC Misunderstands the Casework Contacts Standards.

OSC's findings that VAs and LDSS were deficient in the level of contacts they made with foster children as well as the time within which they document such contacts were based on OSC's misunderstanding of OCFS's regulations in this area. OCFS rejects OSC's conclusions regarding the sufficiency and timeliness of casework contacts.

A. Timing and Frequency of Casework Contacts is Based on the Date of the Foster Child's Placement.

OSC misapplied the casework contacts standards at 18 NYCRR 441.21 in thirty-eight (38) of the cases it cited for errors based on the frequency of casework contacts during the first 30 days of placement. Many of the misapplications were cited based on a flawed understanding of the term “placement”. OCFS and its predecessor, the New York State Department of Social Services, define the term “placement” as the removal of the child from his or her parent or relative when the child initially enters foster care (See [82-ADM-37](#) and [15-OCFS-ADM-18](#)). The CONNECTIONS system defines the term “placement” as when “the child is removed from the home and placed in the care and custody” of the LDSS Commissioner or the Commissioner of OCFS. (see [OCFS Glossary of CONNECTIONS and Frequently Used IT Terms](#) and [CONNECTIONS Tip Sheet](#)). During the first 30 days of placement, the regulations require at least two casework contacts. After that initial period, one casework contact per month, including when a foster child has been transferred to another foster home, is required. OSC erroneously applied the casework contacts requirement for new foster care placements to situations where existing foster children moved to different foster care settings. Thus, OSC’s finding of insufficient contacts is erroneous because it lacks foundation in regulation.

State Comptroller’s Comment – Because of restrictions OCFS imposed on our direct access to data, for each and every case that we examined, we obtained placement date information from the on-site county or VA personnel. We communicated all of these findings in detail to OCFS in November 2016, including information on the placement dates used, and we continued communications with OCFS about these findings on multiple occasions through March 2017 (via phone calls, emails, and visits to OCFS to review additional records). It was not until April 2017, more than six months after we communicated these findings, that OCFS raised the placement date as a possible area of disagreement. Given our lack of direct access to information to verify OCFS’s assertion about the date, we cannot assess the extent of its accuracy. However, placement dates aside, our findings related to caseworker contacts still show deficiencies for more than half of the children whose case records we reviewed.

Similarly, OSC misapplied the requirement for casework contact with relatives and caregivers for foster children who were in care for more than 30 days.¹ OSC refused to modify its findings even after OCFS notified OSC of these mistakes. As such, OSC findings on frequency of casework contacts in these cases are legally baseless, and lack substantive foundation.

OCFS has well-established processes to assist VAs and LDSS in monitoring whether their staff are complying with the required casework contacts. As OSC notes in the Draft Report, OCFS issues a monthly report on the percentage of contacts made. Draft Rep., at 9. Additionally, OCFS provides VAs and LDSS access to additional reports on casework contacts where the data can be organized by worker, by child, by parent or by foster parent. This system has proven to be successful for OCFS at monitoring compliance with the laws and regulations that apply in these circumstances.

B. OSC Overstates the Requirement for Data Entry of Casework Contacts.

Neither OCFS regulation nor applicable law set for a minimum time frame for entering casework contacts into the CONNECTIONS system. Yet, OSC incorrectly states that OCFS regulations require VAs and LDSS to enter casework contacts into CONNECTIONS within 30 days of the casework contact being recorded. This is simply not legally or factually accurate. The CONNECTIONS system supports multiple ways of gathering data about case contacts. The system both allows for contemporaneous recording of progress notes and casework contacts, and also allows data entry of such activities any time after the event occurs prior to the closing of the applicable case stage. The 30-day timeframe is only an OCFS recommendation for best practice. Neither statute nor regulation establish a specific number of days for VAs or LDSS to enter casework contacts.

State Comptroller's Comment – We are disappointed that OCFS officials not only fail to acknowledge or comment on the severity of the cases we found, but attempt to disclaim responsibility for meeting (or having) a requirement for timely recording of casework contacts, despite the potential negative effects on case management efforts and the youth OCFS serves. Given the vulnerable nature of these children, we are troubled by OCFS's tacit approval of caseworkers taking more than a month to record their contacts with children (and sometimes taking as long as ten months). Further, as an agency charged with protecting vulnerable youth, OCFS's contention that there is no basis for evaluating casework practices, unless a specific minimum performance standard is imposed by law or regulation, demonstrates management's misunderstanding of responsibility and accountability for government program administration. Moreover, it overlooks guidance from OCFS officials who "would consider entry within 30 days to be a reasonable standard."

¹ The requirement regarding casework contacts with the child's parents or relatives is found at 18 NYCRR 441.21(b)(2) and contact with the child's caregiver (foster parent) is detailed at 18 NYCRR 441.21(d)(2).

Notwithstanding the lack of a thirty-day timeframe, OCFS has developed quality assurance reports to assist LDSS to monitor the performance of data entry by their staff and VA staff. In addition, OCFS, through quarterly meetings with VAs and LDSS, does and will continue to stress the importance of early data entry of progress notes. OSC however goes beyond its authority in making findings on caseworker practice when no such minimum standards exist in law or regulation.

C. OSC Made Significant Errors in its Specific Casework Contact Examples

OSC's errors in assessing the completeness of VAs and LDSS casework contacts are clearly visible in the examples provided in the Draft Report. On page nine (9) of the Draft Report, OSC provides specific case examples where it alleges casework contacts were not made in the correct location or with the correct frequency. However, OCFS' examination of the complete files for those specific cases demonstrates that many of OSC's findings in the Draft Report to be in error.

i. House of Good Shepherd (attachment 2):

- OSC erroneously states that casework contacts with the child and the foster parent took over 100 days to occur. OSC's count was incorrect by 90 days as contact with the foster child and the foster parents occurred on day 10 and again on day 17 after placement.
- OSC erroneously states that contact with the parent from which the child was removed did not occur until 106 days after placement. OSC's count was incorrect by 77 days as the parent was contacted on day 29.
- OSC erroneously states that there were a significant number of missing contacts between VA staff and the foster child in the first three 90-day periods (270 days). However, the records clearly demonstrate that contact was made each month during that period.
- OSC erroneously states that there were a significant number of missing contacts between the VA staff and the foster parent. Again, OSC is incorrect as the record demonstrates such contact was made monthly.

State Comptroller's Comment – Based on the additional documentation OCFS provided, we deleted the examples from the House of the Good Shepherd from the final report.

ii. Schenectady County (attachment 3):

- OSC erroneously states the first contact with the child and the foster parents did not occur until 91 days after placement. The first contact occurred 14 days after placement. OSC's count was incorrect by 77 days.

State Comptroller's Comment - Information OCFS provided in response to our findings indicated that these contacts were likely documented and entered into the case record after we communicated the deficiencies. As such, we could not place sufficient reliance on the information and therefore did not adjust our findings.

- Contact with the parent from which the child was removed was similarly timely with two contacts within the first two weeks of placement of the child. Subsequent monthly contacts with the parent did occur during the first three, 90-day periods (270 days) to the extent that parent cooperated with the contacts. During that time the parent was facing a number of crisis including a stay in a drug rehabilitation program. These types of complexities are common for parents whose children have been removed. While OCFS mandates that staff of VAs and LDSS make the contact with parents, OCFS has no authority to mandate that the parents cooperate. In all foster care cases, diligent effort to make the contacts is expected.

While OSC states the above examples “demonstrate that OCFS needs to strengthen controls”, OCFS finds no evidence to support that position. Given the number of errors OSC made in its assessment of these cases, the complex nature of the cases, and the detailed information found within the case notes, OCFS finds that staff of the VAs and LDSS have, on the whole, documented thoroughly the difficult and multi-layered work they do with foster children and their families.

IV. Data Consistency Issues Were Created by OSC Through a Disorganized Process of Requesting and Collecting Data from Multiple Sources.

OSC's concern in the Draft Report regarding the consistency between the foster care placement data accessible by OCFS and the information available at VAs or LDSS is unfounded. Many of the alleged inconsistencies were due to the different timeframes and definitions OSC had OCFS use to compile the samples and those used by the VAs or LDSS when the OSC auditors visited them; others resulted from delays in CONNECTIONS data entry by the VAs or LDSS.

State Comptroller's Comment – OCFS is incorrect in its assertion that our audit methodology was inconsistent. In fact, we requested the same information for the same time period at each entity we visited, describing in detail the population of data we sought, to ensure common understanding. Further, OCFS officials acknowledge that county and VA delays in entering data into CONNECTIONS contributed to some of the problems we identified in our report.

V. OCFS Provides Appropriate and Timely Oversight Activities of VAs and LDSS.

OSC conclusions regarding the frequency and extent of OCFS' oversight activities are inaccurate. Among other things, OSC incorrectly assessed whether OCFS timely completed county foster care Safety and Permanency Assessments (SPAs) which are assessments of county foster care activities. SPAs are specific to counties and are done on a four-year cycle for counties OCFS classifies as large or medium. OSC miscalculated the number of counties that were subject to a SPA by incorrectly identifying 33 counties that were eligible when there are only 32 such counties.

State Comptroller's Comment – We adjusted our report to reflect that only 32 counties were subject to this requirement.

Additionally, OSC incorrectly asserted that of the eligible counties 14 of those counties did not received timely SPA. This is a result of OSC failing to note which counties had an authorized alternate monitoring activity, in lieu of a SPA as authorized by OCFS policy. There are several approved monitoring activities in which counties may engage that can be substituted for a SPA, such as Permanency Round Tables (PRTs) and a full case record review with the Federal Administration for Children and Families (ACF) Onsite Review Instrument (OSRI). All of the counties that participated in the above alternate activities were not recognized by OSC.

State Comptroller's Comment – We revised our report to recognize that seven counties participated in these alternative activities, which we note are less intensive and do not involve a review of case records.

VI. Additional Initiatives to Enhance OCFS's Oversight of VAs and LDSS Foster Home Programs

OCFS has, and will continue its already stringent oversight of VAs and LDSS foster home programs. In addition, OCFS will continue to enhance these initiatives. First, OCFS is standardizing the home study application and recertification process to support further compliance with OCFS standards and promote best practices for all certified or approved foster homes.

Second, OCFS is also mandating that VAs and LDSS use the Foster and Adoptive Home Development (FAD) module within CONNECTIONS. This will enable OCFS Home Office to conduct desk audits to assess the quality and statewide consistency of the home study and certification and approval process. The OCFS Home Office will begin these desk audits by the summer of 2017.

Third, OCFS is revising and reissuing the Foster Boarding Home Licensing Standards Practice Guide, to be completed in September 2017, and holding a Home Finder

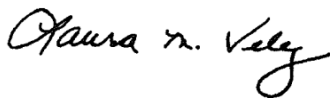
Summit for LDSS and VA, Home Finders and supervisors on August 8 – 9, 2017 to share information on recruitment, retention, and licensing best practices.

Finally, OCFS is centralizing, within the OCFS Home Office, the monitoring of the completion of corrective action plans resulting from various monitoring activities including SPAs and Voluntary Agency Reviews (VARs). OCFS is also expanding its application of the Continuous Quality Improvement (CQI) process within OCFS to confirm that corrective action plans adequately address areas needing improvement.

State Comptroller's Comment – Although OCFS officials initially characterized our recommendations as “irrelevant” and “nonsensical,” we are pleased that the initiatives they cite appear to address many of them. This includes: improving the certification process to better ensure compliance; system improvements to preclude certification without required background checks; increased monitoring to ensure consistency in certifications and renewals; and centralized monitoring of corrective action plans.

As set forth above, OCFS rejects the findings in OCS's Draft Audit Report as flawed, both in how information was obtained, and how it was evaluated. Please contact Laura Velez at (518) 474-3377 or e-mail to Laura.Velez@ocfs.ny.gov for additional inquiries or information.

Sincerely



Laura Velez
Deputy Commissioner
Division of Child Welfare and Community Services