



CONTINUOUS QUALITY IMPROVEMENT REPORTS

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Continuous quality improvement (CQI) is a structured, ongoing, data-driven process used for improving practice at a systems level.



METHODOLOGY



Quarterly Reviews

Sample data pulled from six months prior to dates review occurs, on a quarterly basis



Mixed-Methods

Reviews rely on multiple forms of knowledge (administrative data, case record review, interviews, observation)



Feedback Loops

DCFS receives consistent, timely feedback on findings to support practice improvement

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CQI TO DATE

Two Review Periods, Six Months of Practice



HOTLINE

27,077 Referrals Analyzed

125 Case Record Reviews

3 Observation Days



INVESTIGATIONS

12,305 Investigations Analyzed

100 Case Record Reviews

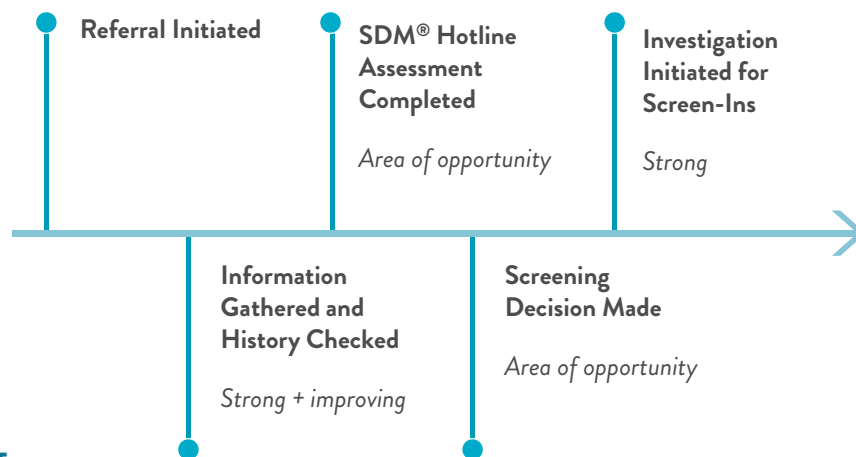
72 Interviews

Current data reflect practice from October 2025 to March 2026

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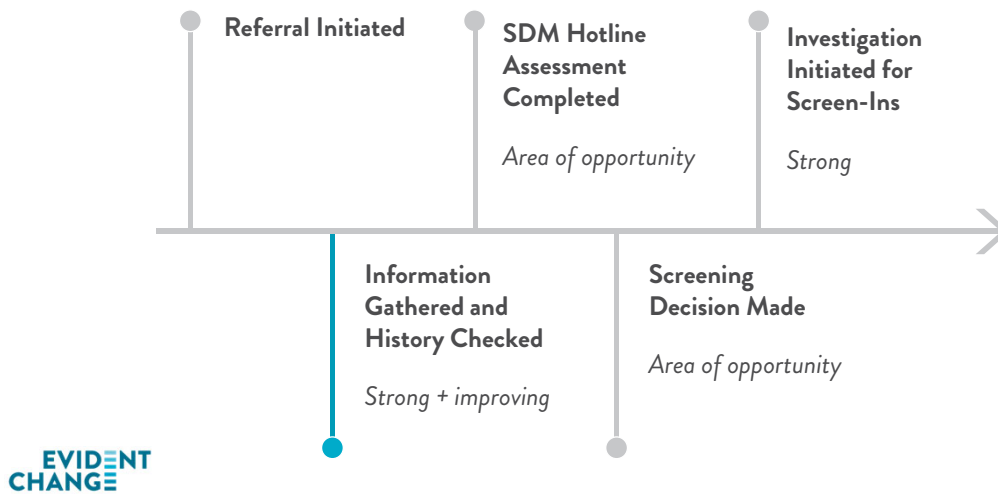
HOTLINE REPORT

SCREENING PROCESS



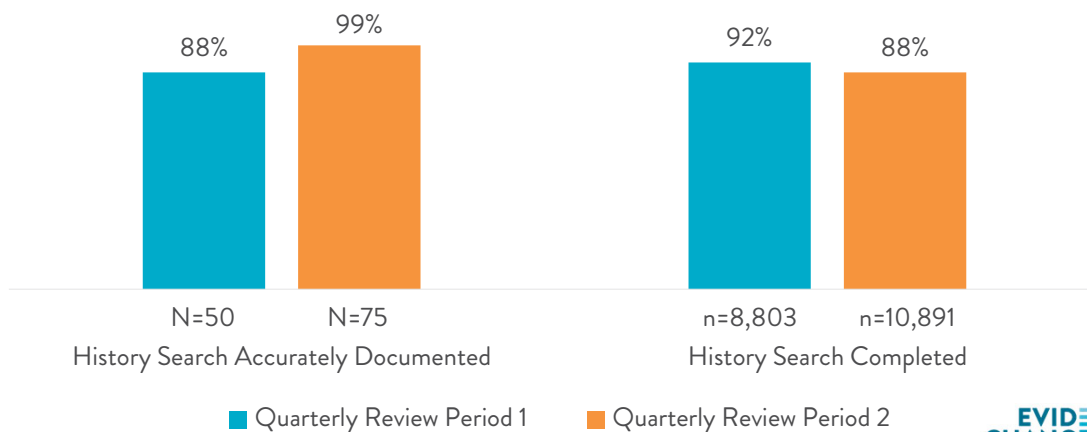
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SCREENING PROCESS



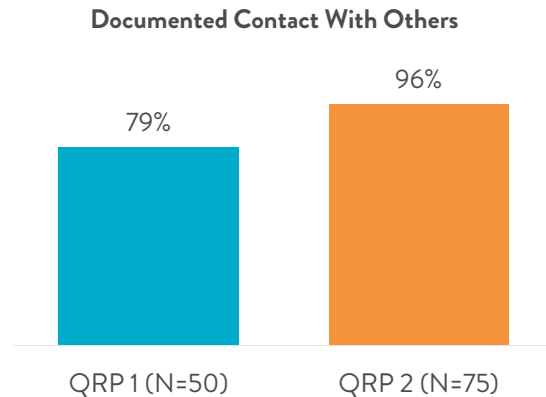
STRENGTH: HISTORY SEARCH

Accurate history search on new referrals is high and accurately documented.

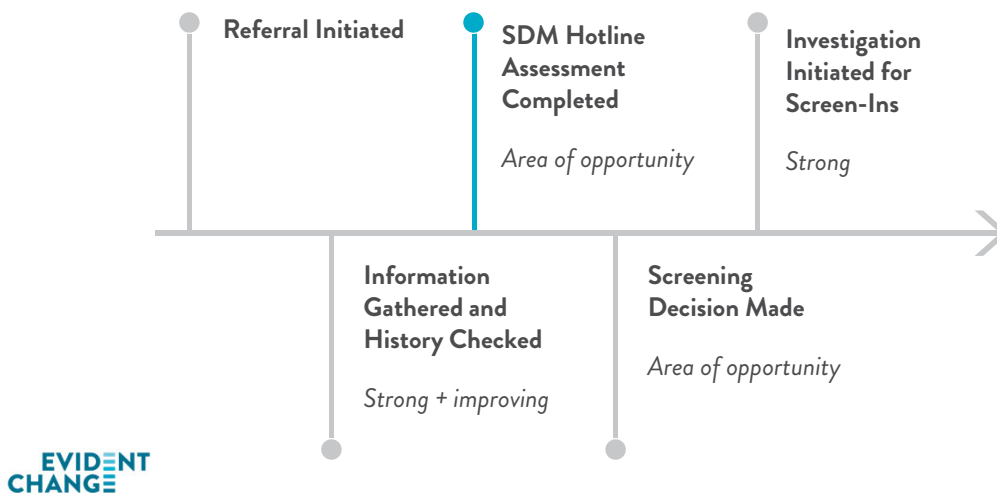


IMPROVEMENT: INFORMATION GATHERING

Operators are **more frequently** reaching out to others who may have relevant information about family circumstances or allegations.

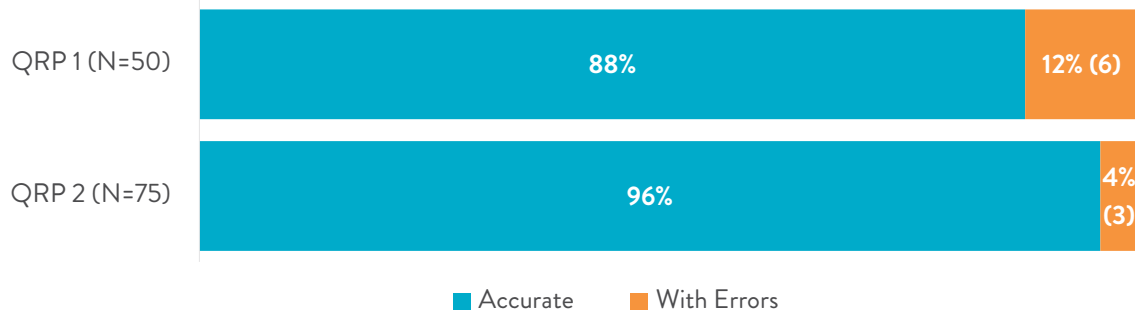


SCREENING PROCESS



IMPROVEMENT: ACCURATE COMPLETION OF SDM HOTLINE ASSESSMENT

Accurate completion **increased** between review periods.



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SELECTING ITEMS WITHOUT SUPPORTING DOCUMENTATION

CASE EXAMPLE

Medical neglect was selected on an assessment, but there was no documentation of medical concerns in referral notes.

SCREENING IMPACT

The referral was ultimately screened in through a second SDM hotline assessment with documented medical concerns.

PRACTICE IMPLICATION

Work is duplicated, using multiple assessments instead of one to reach screen-in.

Case example from October – December 2025 sample.

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NOT SELECTING ITEMS WHEN DOCUMENTATION SUPPORTS IT

CASE EXAMPLE

A referral was screened for neglect concerns; however, documentation indicated potential sexual abuse specific to child exposure to sexual activity.

SCREENING IMPACT

The referral was screened in; however, a selection of neglect allows for the screening decision to forgo supervisor review.

PRACTICE IMPLICATION

Incorrect selection meant supervisor did not review, which could have caught the error. The result is potential incorrect agency assignment or priority response time.

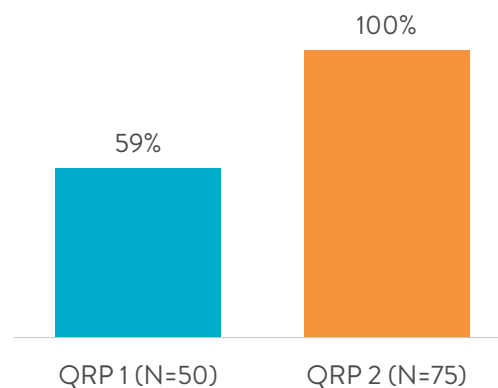
Case example from October – December 2025 sample.

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IMPROVEMENT: SUPERVISOR REVIEW

A significant increase in documented supervisor review, when relevant, was seen between review periods.

Referrals With Documented Supervisor Review



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RECOMMENDATIONS FOR IMPROVING ACCURATE COMPLETION OF SDM HOTLINE ASSESSMENT

Relevance: Ensure alignment between SDM hotline assessment and practice/policy

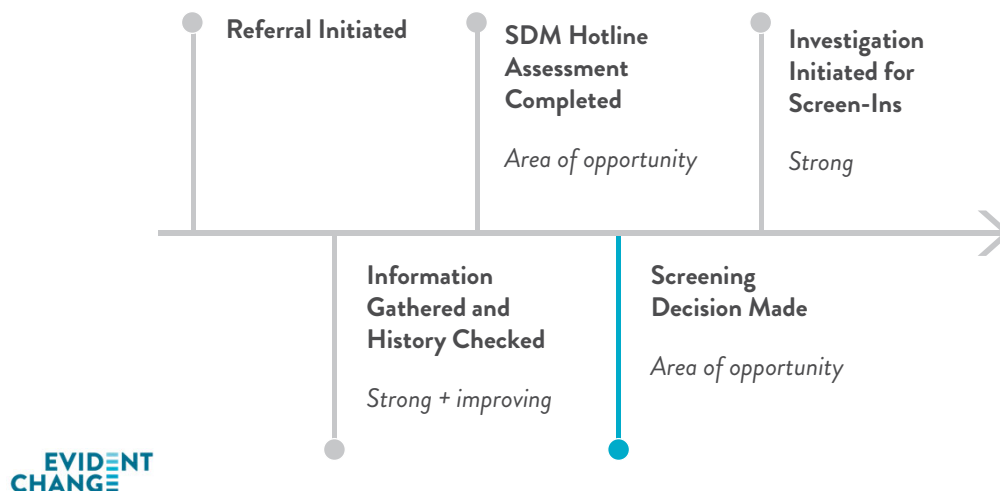
Improve accurate selection: Ensure staff trained on the SDM hotline assessment and its applicability to information-gathering processes

Topic focus: 38% (n=3) of screenings with errors (n=13) had concerns related to sexual abuse

Documentation support: Provide guidance on best practices for documenting decision rationale

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SCREENING PROCESS

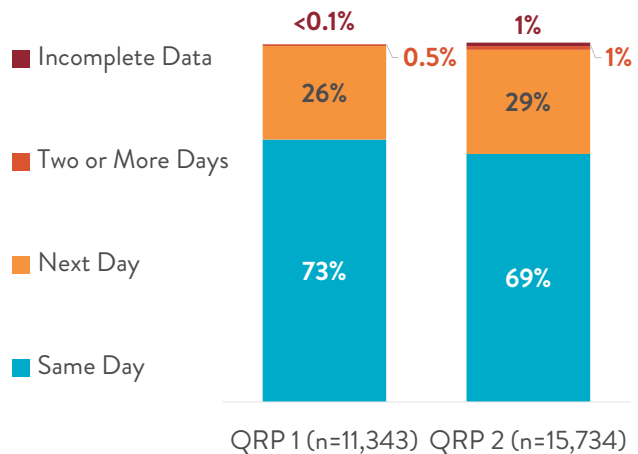


OPPORTUNITY: REDUCE TIME BETWEEN REFERRAL AND DECISION

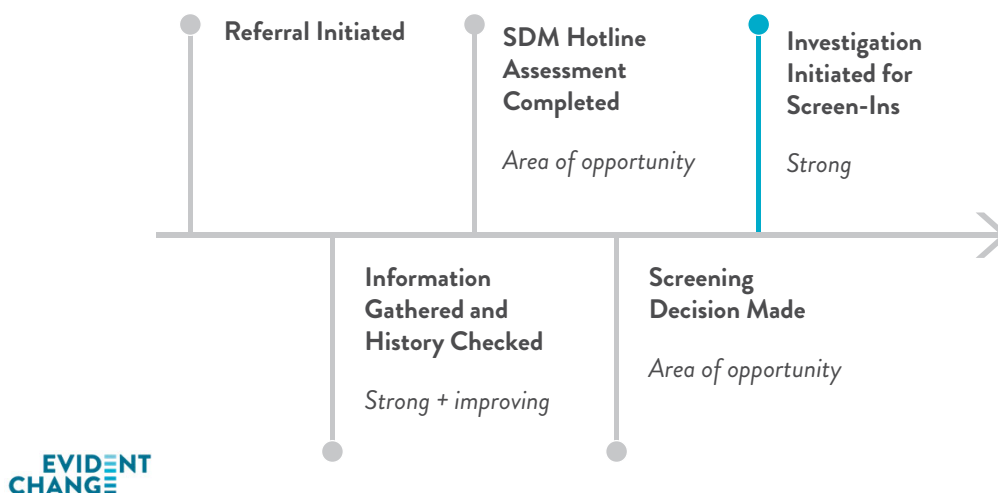
Most screening decisions were made the same day, as expected. Some referrals made through the Mandated Reporter Portal are entered into the system later, resulting in a “next day” time stamp.

PRACTICE IMPLICATION

Decisions are made through an informal pre-screening instead of completion of the SDM hotline assessment.

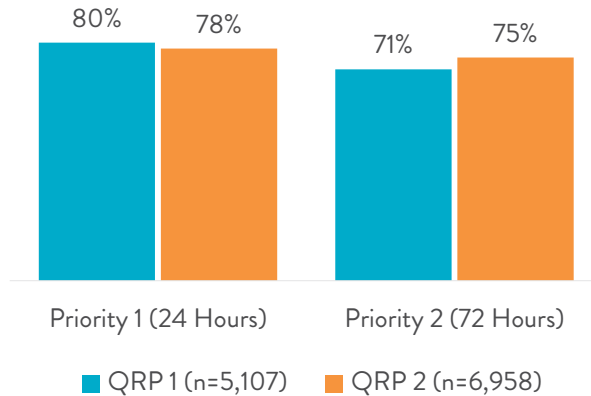


SCREENING PROCESS



STRENGTH: TIMELY INVESTIGATION INITIATION BY DCFS

Most investigations are initiated timely by DCFS, with Priority 2 timeliness increasing in the most recent review period.



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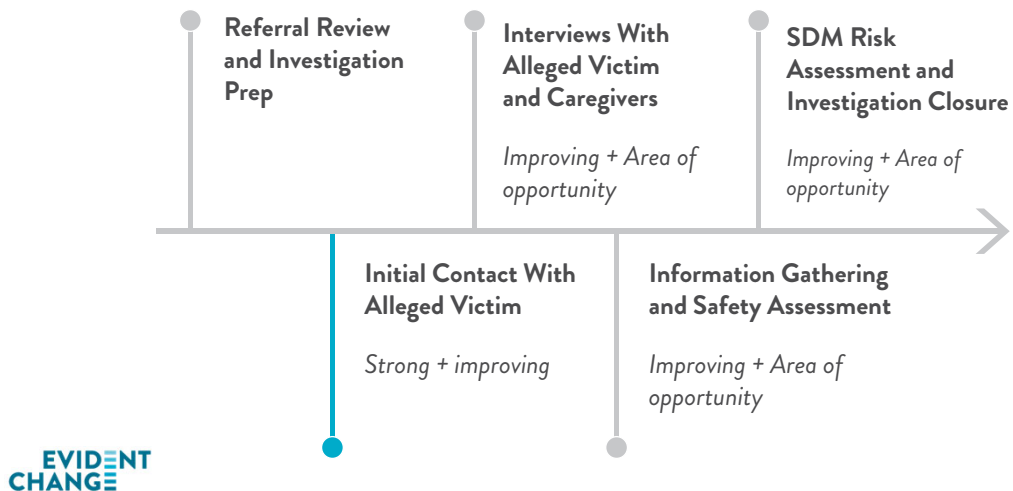
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INVESTIGATION REPORTS

INVESTIGATION PROCESS

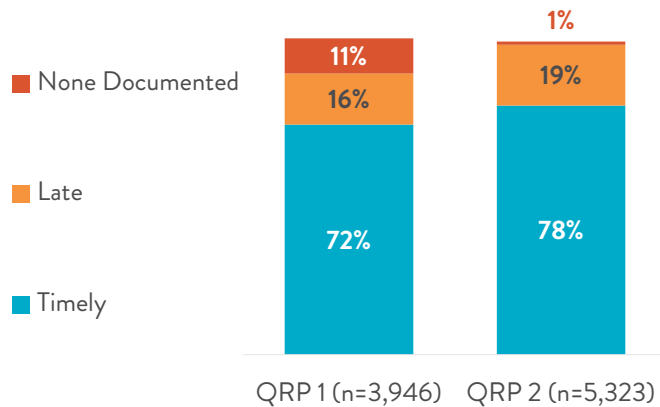


INVESTIGATION PROCESS

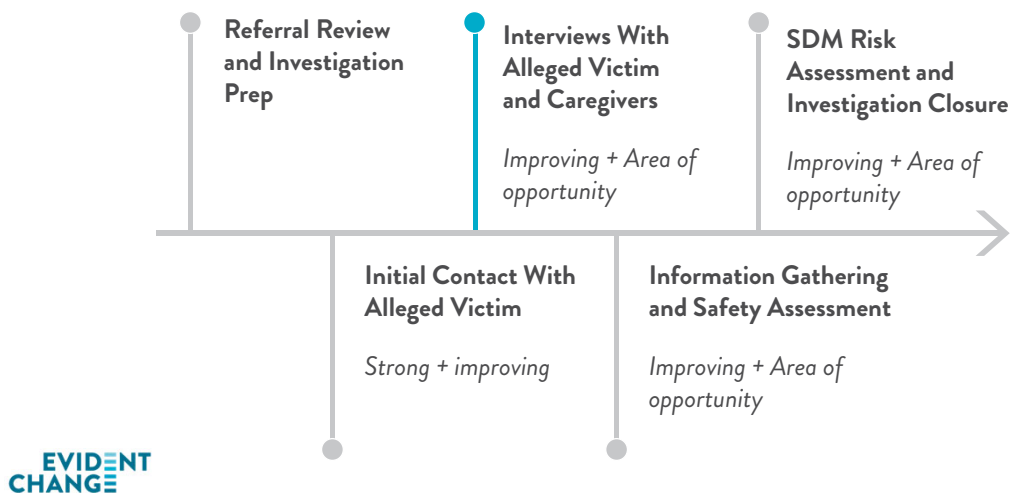


IMPROVEMENT: DOCUMENTATION OF INITIAL CONTACT WITH ALLEGED VICTIMS

The number of investigations with timely initiation has **improved**, and investigations with no initial contact documented **decreased**.

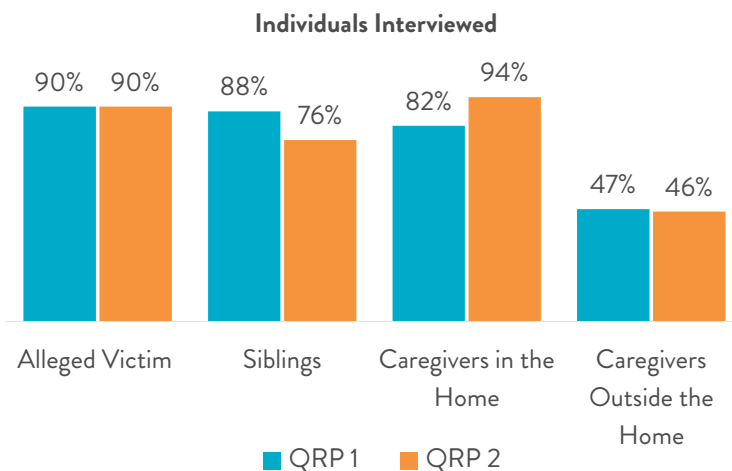


INVESTIGATION PROCESS

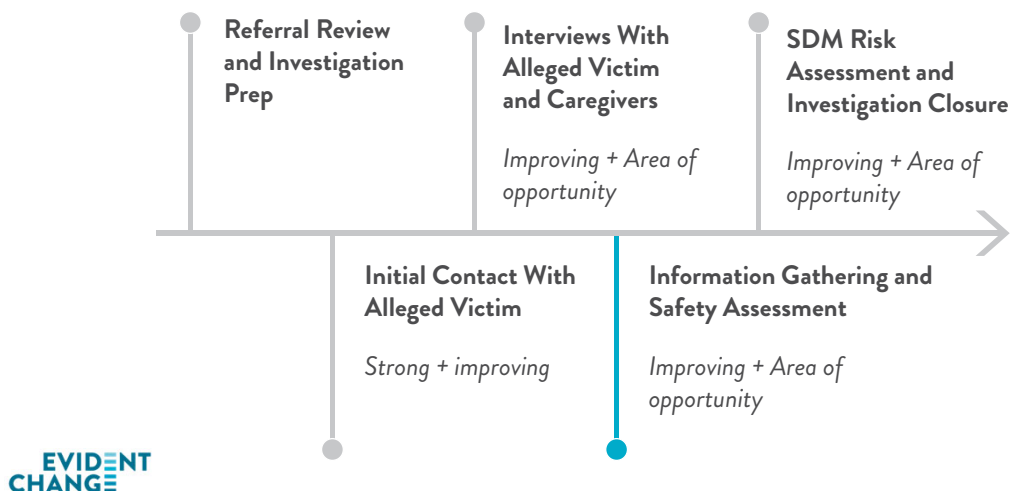


IMPROVEMENT: INITIAL INTERVIEWS

Interviews with alleged victims was **stable** between review periods and **increased** for caregivers in the home. Interviews with siblings decreased.

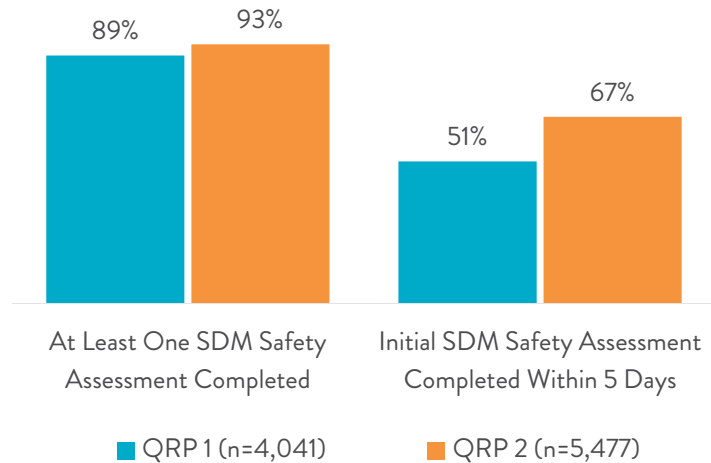


INVESTIGATION PROCESS



IMPROVEMENT: TIMELY COMPLETION OF SDM SAFETY ASSESSMENT

Completion of initial SDM safety assessments and timely completion within first five days of investigation have increased.

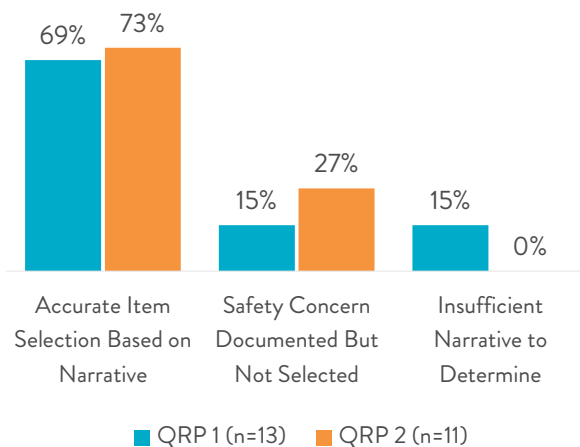


OPPORTUNITY: IMPROVE ACCURACY OF SAFETY THREAT SELECTION

Documentation of safety concerns improved, but a gap remains with accurate selection of these concerns on the SDM safety assessment.

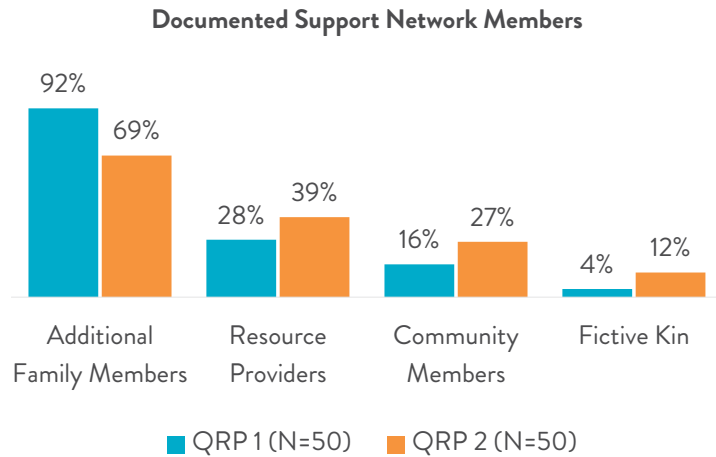
PRACTICE IMPLICATION

Selecting safety threats when warranted typically results in development of a *safety plan* to ensure a child can safely remain in the home, or removal when a safety plan is not possible.



OPPORTUNITY: DOCUMENTATION OF SUPPORT NETWORK DEVELOPMENT

On average, 51% of reviewed case records had documentation of support network development with families. Most often, these networks are additional family members.



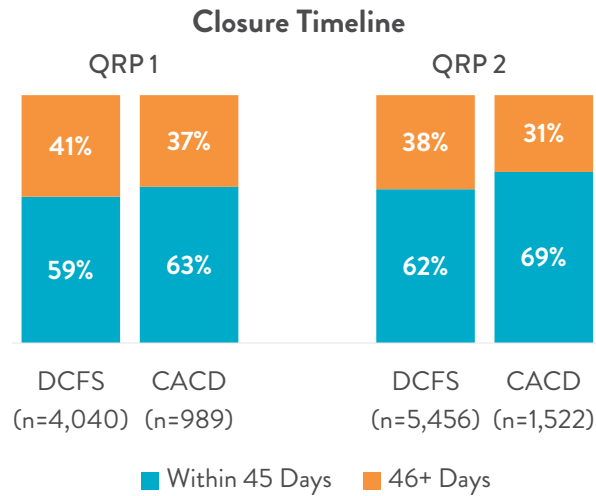
INVESTIGATION PROCESS



OPPORTUNITY: INCREASE CLOSURE WITHIN 45 DAYS

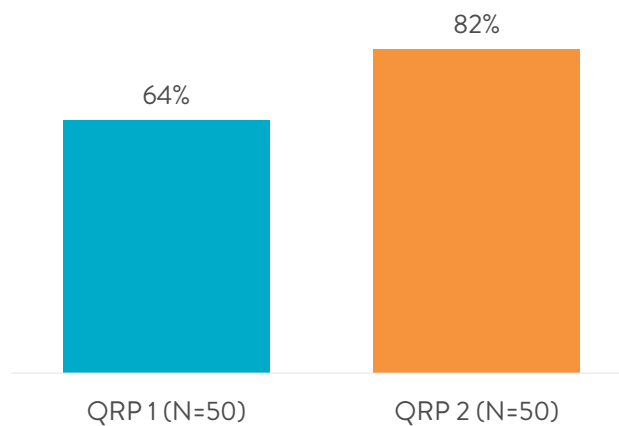
Over a third of investigations close outside of the expected 45-day window.

CACD completed investigations within the 45-day window at a slightly higher rate than DCFS.



IMPROVEMENT: DOCUMENTED SUPERVISOR SUPPORT

Documented supervisory support for investigations increased **18 percentage points** between review periods.



**THANK YOU &
QUESTIONS**

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