Wisconsin Department of Children and Families

IMPROVING YOUTH AND FAMILY CENTERED CARE THROUGH SAFETY CULTURE, SAFETY ORGANIZING AND SYSTEMS THINKING

UK Center for Innovation in Population Health

THE johnpraed FOUNDATION

Wisconsin Department of Children and Families

Center for Innovation in Population Health

Katie Davis, MS, MPA (She/Her)
Child Welfare Licensing Manager

Jamie Gennrich (She/Her)
Deputy Director
Bureau of Permanence and Out of Home Care

Jeannette Paules, MSW (She/Her)
Program and Policy Analyst-Advanced

Dr. Tiffany Lindsey, LPC-MHSP (She/Her)
Assistant Professor, Safe Systems Team

Jordan Constantine, M.A. (He/They)
Senior Policy Analyst, Safe Systems Team

Wisconsin Department of Children and Families

Center for Innovation in Population Health

How our partnership started…

Child Welfare Strategic Plan and Transformation Initiative

Vision: All Wisconsin children are safe and loved members of thriving families and communities

Shared Child Welfare System Purpose: Strengthen all Wisconsin families to support their children **because** children belong with their families

Strategic Priorities

We build local prevention services to support families in their home

Safely transform the child welfare and youth justice system to dramatically increase the proportion of children supported in their homes and communities

Nurture and develop a continuum of prevention and family preservation services to support families and, where necessary, prevent a child's removal to keep families together

We keep children in family-like settings whenever possible

Identify, recruit and support relative and like-kin caregivers, in support of children and youth who cannot be safely maintained in their home

Elevate and support the role of individuals with lived experiences to inform system changes

We improve our group care system

Engage with providers across the state to elevate the quality of group care through trauma-informed, child-centric, and treatment-oriented approaches

Utilize short-term group care stays for children with complex needs to get kids back to family-like settings

Support group care providers in meeting the needs of children and youth with complex needs closer to home

We support our workforce with solutions and improvements

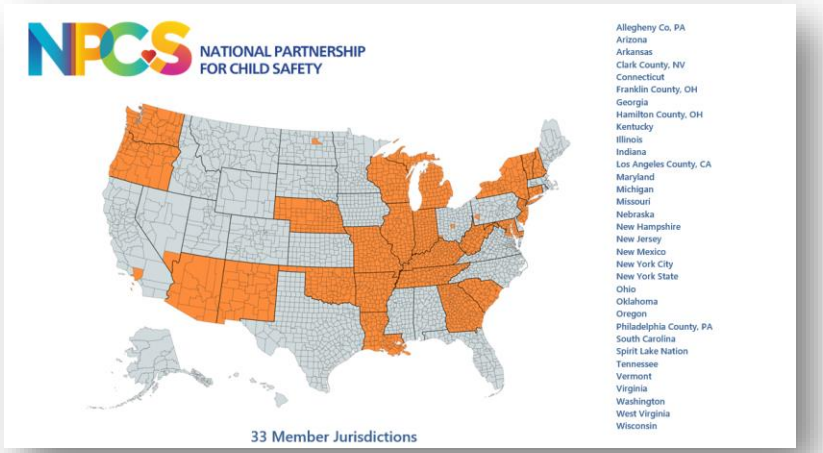
Invest in improvements in training, technology, and practices and processes to maximize time with families

Design a caseworker training model based on the needs of the workforce and the system

Enhance infrastructure to support youth justice initiatives and increase cross-system collaboration

Statement of Diversity, Equity and Inclusion

We include diverse perspectives through engaging a wide range of voices in shaping our child welfare transformation; and strive for fairness and justice in our child welfare system thru addressing racism, inequities and barriers to inclusion.



NPCS NATIONAL PARTNERSHIP FOR CHILD SAFETY

33 Member Jurisdictions

Establish Minimum Standards of Care in Wisconsin

The right child in the right placement and for the right time

Improved stakeholder trust in congregate care system

Improved system transparency and public trust

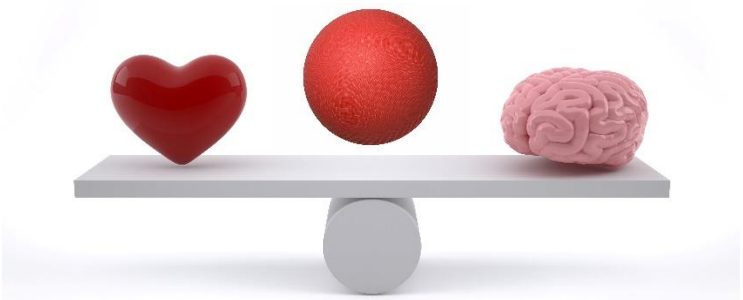
Improved system efficiency and partnerships

ACHIEVING QUALITY AND SAFETY IN WISCONSIN'S CONGREGATE CARE

You will…

- Learn how WI DCF Licensing team and Provider Agencies are collaborating to strengthen peer learning and innovate how to achieve quality, equity, experience, and efficacy.
- Learn how Safety Culture is being built in Congregate Care through safety organizing, psychological safety, and systems thinking to improve systems and outcomes for youth and families.
- Receive curated, field-tested safety organizing practices grounded in psychological safety and a tool to support systems learning and improvement after serious incidents (e.g., restraints, runaways)
- Participate in activities that demonstrate safety organizing

Staying in the Safety Zone



MINDFUL ORGANIZING

MANAGE PROFESSIONALISM

The Red Ball

- Ball is too high = Stress and anxiety are high
- Ball is too low = Exhausted, resigned, or frustrated
- Throw the ball at others = Aggressive, yelling, blaming
- Hold ball too tight = Guarded, isolating, "putting up walls"

*Adapted from the Team First Field Guide (Cull, & Lindsey 2019)

MINDFUL ORGANIZING

MANAGE PROFESSIONALISM

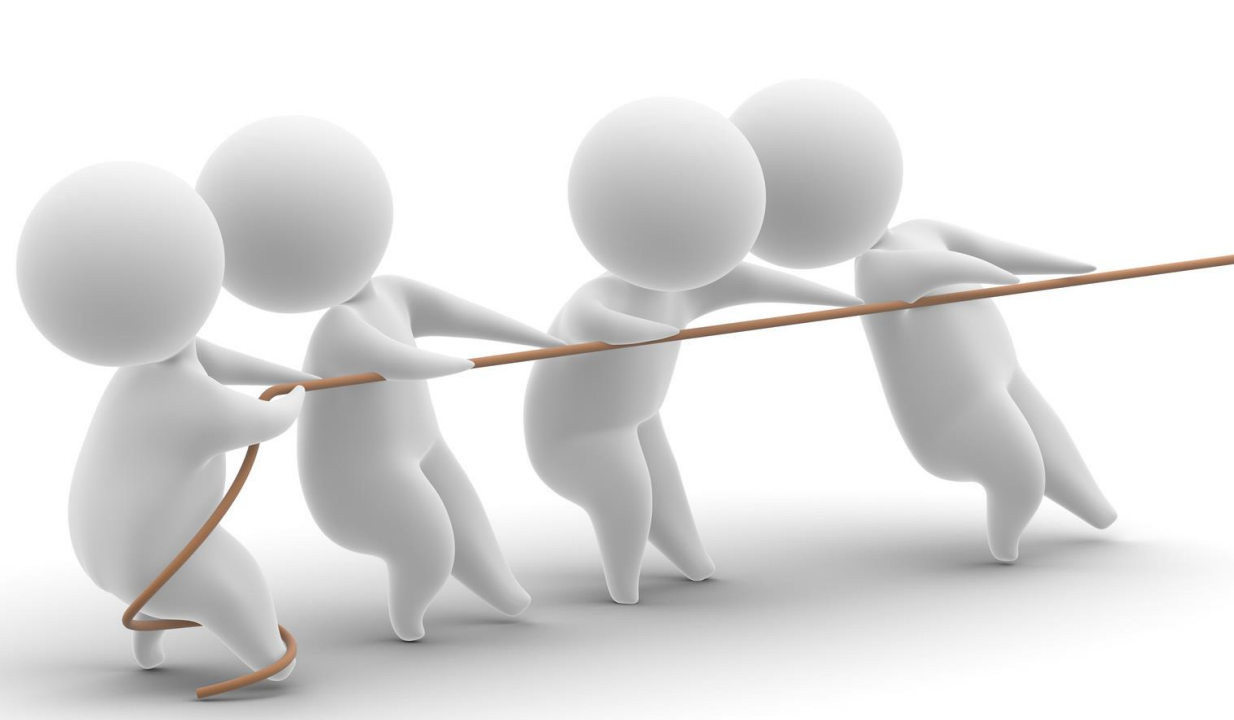
The Red Ball

STRATEGIES FOR KEEPING OUR RED BALL IN THE BALANCED ZONE BETWEEN OUR HEAD AND OUR HEART:

- Create distraction-free zones (e.g., quiet spaces)
- Listen to music
- Go for walks outside
- Open windows (if able); have pictures of nature in your space
- Stretch (e.g., yoga)
- Structure for increased teamwork during high-stress moments (i.e., avoid overtaxing any one team member)
- Verbally acknowledging the Red Ball and responding mindfully to teammates

*Adapted from the Team First Field Guide (Cull, & Lindsey 2019)

The worst teams
make it harder
to do the best work



The best teams
make it easier
to do hard work

In the BEST team you've worked on...

- ALWAYS
- SOMETIMES
- RARELY
- NEVER

If you made a mistake, it was not held against you

The people on the team valued each other's unique skills and talents

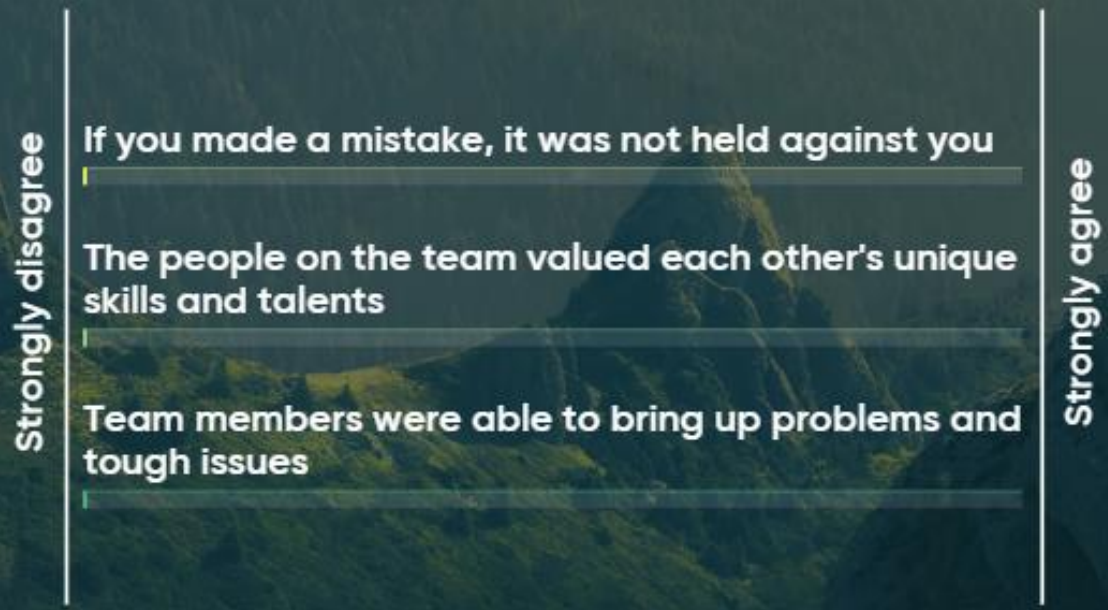
Team members were able to bring up problems and tough issues

In the WORST team you've worked on...

Go to **www.menti.com** and use the code **95 15 45 1**

Mentimeter

Rate these statements based on your experience in the BEST team you've worked on...



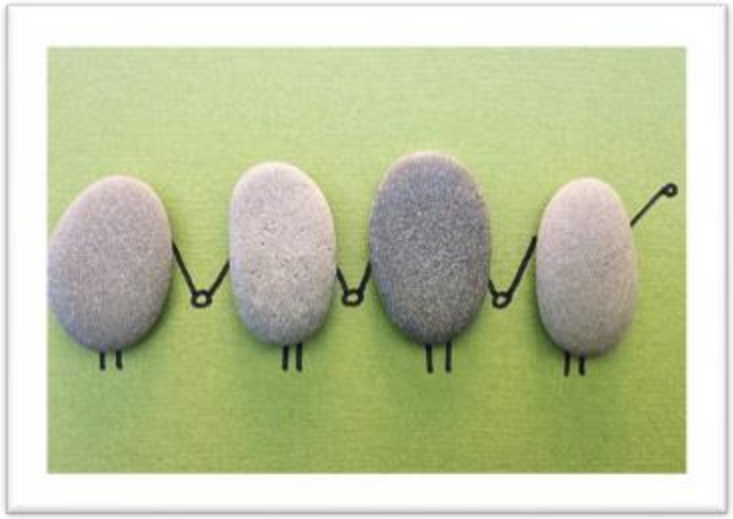
Safety Culture

High Risk, High Impact Service

Our work changes the course of youth and families' lives. Even with good intention things go wrong and we embrace a mindset of constant growth and learning. We practice conscious inquiry into human error and unintended outcomes to learn about our systems and how they might improve

Blameless Candor and Respect

We can't fix what we don't know. Secrets and hidden problems don't help and sometimes even hurt those we serve. We embrace vulnerability and humility, share stories, respond with empathy and practice conscious inquiry



Collaborate and Commit

No single one of us has all the answers. In a safety culture we seek multiple perspectives and leverage the expertise of those closest to the work. We collaborate to innovate new solutions to system problems

Cull, Epstein, O'Day & Rzepnecki, 2013

Accountability in a Safety Culture

Retributive

Asks Who and Why?
Who broke which rule and why??
How serious is the violation?
What is the proportional punishment?
Individual blame for unwanted outcomes
Fear and compliance mindset
Believe blame and threat of sanctions increase safety
Assumes mistakes and errors are due to bad professionals
Achieves accountability through sanctions and fear

Restorative

Asks What and How?
Who was harmed?
What do they need now?
Whose responsibility is it to help?
Shared accountability for unwanted outcomes
Learning and growth mindset
Believe psychological safety and safety organizing increase safety
Assumes mistakes and errors occur due to complexity
Achieves accountability through repair, prevention, and learning

Safety Culture and System Resilience

LEADERS IN A SAFETY CULTURE

- Strive to balance systems and individual accountability
- Value open communication, transparency, and continuous learning and improvement

TEAMS IN A SAFETY CULTURE

- Monitor themselves, their colleagues, and their systems for stress.
- Communicate honestly and often, share work equitably, and promote accountability.
- Anticipate and respond to unexpected events as a unit

The shared belief team members are accepted, respected, supported and able to disclose a concern or make a mistake

Psychological Safety

It’s not this…

- A lack of accountability
- A guarantee of comfort during hard conversations
- Experienced at the interpersonal level like trust
- Free from vulnerability

It’s this…

- Shared accountability that’s constructive, just and kind
- Foundational to candor and respect in hard conversations
- Experienced at the group level and situational
- Built through measurable habits and behaviors

PSYCHOLOGICAL SAFETY IS NOT AT ODDS WITH HAVING TOUGH CONVERSATIONS. IT IS WHAT ALLOWS US TO HAVE TOUGH CONVERSATIONS.

– Amy C. Edmondson

What gets us there?

- Building new habits
- Small behavioral changes
- Asking more questions
- Empathy
- Humility
- Vulnerability

What gets in the way of Psychological Safety?

HOW psychological safety RELATES TO PERFORMANCE STANDARDS

AMY EDMONDSON

COMFORT ZONE

People are open and collegial but not challenged. On teams, they fail to make major strides.

LEARNING ZONE

People collaborate and learn in the service of high performance, getting complex and innovative work done.

APATHY ZONE

People show up at work with their hearts and minds elsewhere; choosing self protection over exertion.

ANXIETY ZONE

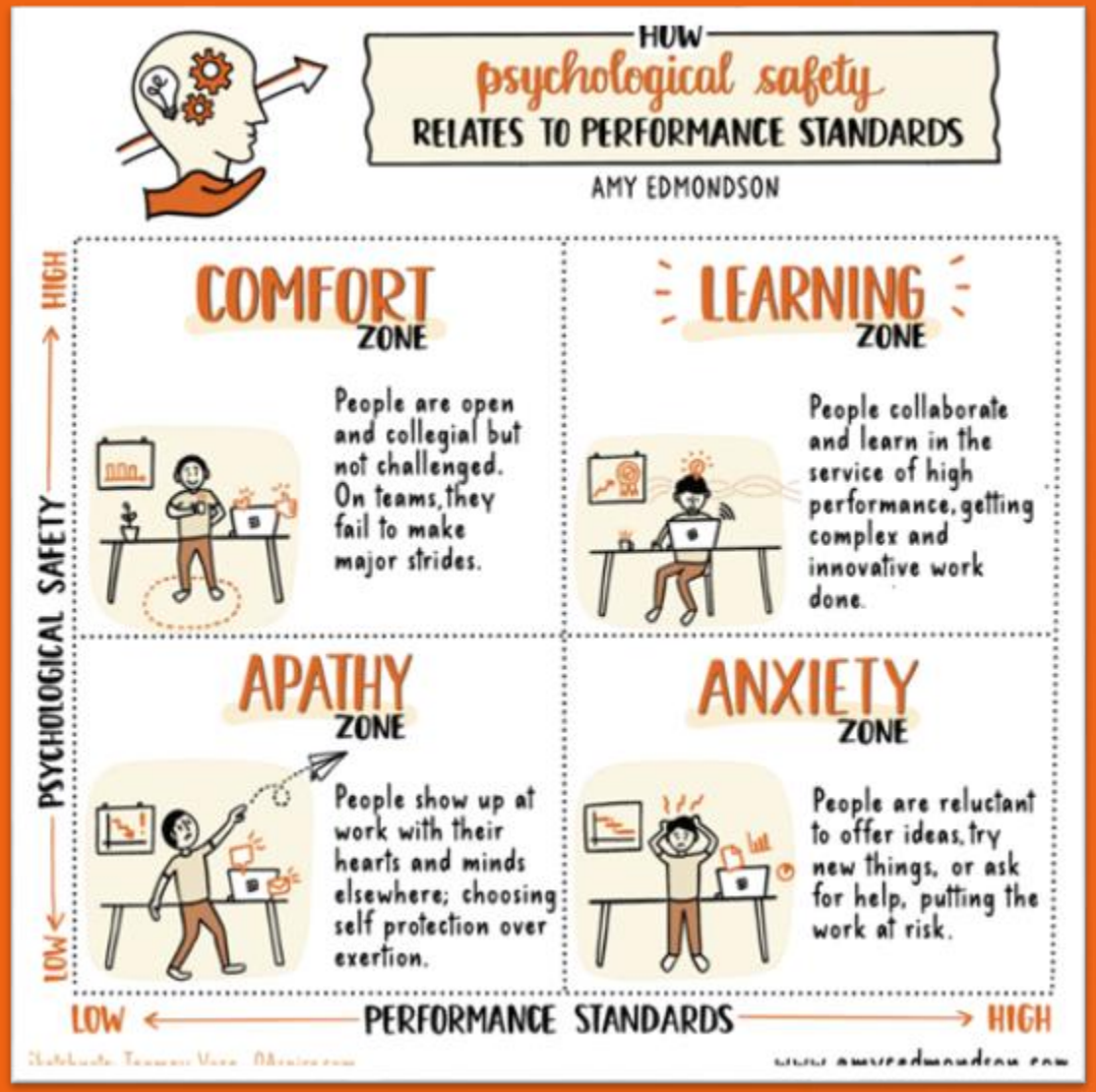
People are reluctant to offer ideas, try new things, or ask for help, putting the work at risk.

PSYCHOLOGICAL SAFETY: LOW ↓ HIGH

LOW ← PERFORMANCE STANDARDS → HIGH

Sketchnote: Tanmay Vora, QAspire.com

www.amycedmondson.com



Perspective Taking

What kind of care might youth experience when your team is in these zones?

What specific behaviors do youth see when your team is in the learning zone?

Why Psychological Safety Matters

A growing evidence shows us psychological safety is related to…

- Decreased emotional exhaustion & secondary traumatic stress
- Increased workforce retention
- Increased workplace connectedness and mindful organizing
- Increased innovation

(NPCS data, 2021 and 2022; Vogus et al., 2016; Epstein et al., 2020; Edmondson 1999, 2022)

Mindful Organizing

How teams plan, innovate, learn, monitor and support one another

Mindful Organizing in Practice

- Teamwork rooted in care coordination and psychological safety by continuously PLANNING AHEAD and REFLECTING BACK
- The best outcomes for those we serve rely on intentional, healthy teaming habits
- Teams share accountability, promote equity, and respond to high-stress, high-consequence moments together
- Spend time identifying what could go wrong
  Talk about mistakes and how to learn from them

Healthy Teaming Habits

Plan forward

Reflect Back

Test Change

Communicate Effectively

Appreciation

Manage Professionalism

Mindful Organizing in other Safety-Critical Industries

A surgeon and medical team verbalize each step taken throughout the surgery to ensure everyone in the room is aware of each step taken during the procedure

A pilot and co-pilot run through a pre-flight checklist with the assigned air traffic controller before take-off

Mindful Organizing in Youth Centered Care

Why Mindful Organizing Matters

Early research tells us Mindful Organizing is related to:

Less emotional exhaustion & turnover in the child welfare workforce

(NPCS data, 2021; Vogus et al., 2016; Epstein et al., 2020)

Fewer placement disruptions for children in out-of-home placement

Vogus et.al. (2016); Epstein et al (2020)

More parent-child visitation for children in out-of-home placement

Vogus et.al. (2016); Epstein et al (2020)

Fewer care interruptions, patient falls, and medication errors in residential treatment centers and hospitals

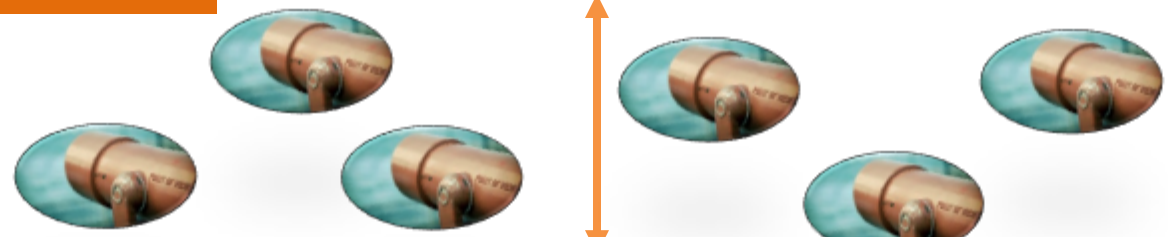
Epstein et al (2020); Vogus (2011)

3 Interrelated Strategies

Organizational Assessment

Systems-focused improvement

Tools for Teams*



SAFETY CULTURE SURVEY

SAFE SYSTEMS IMPROVEMENT TOOL (SSIT-CC)

TEAMFIRST FIELD GUIDE

*Cull, Rzepnicki, O'Day, & Epstein (2013)

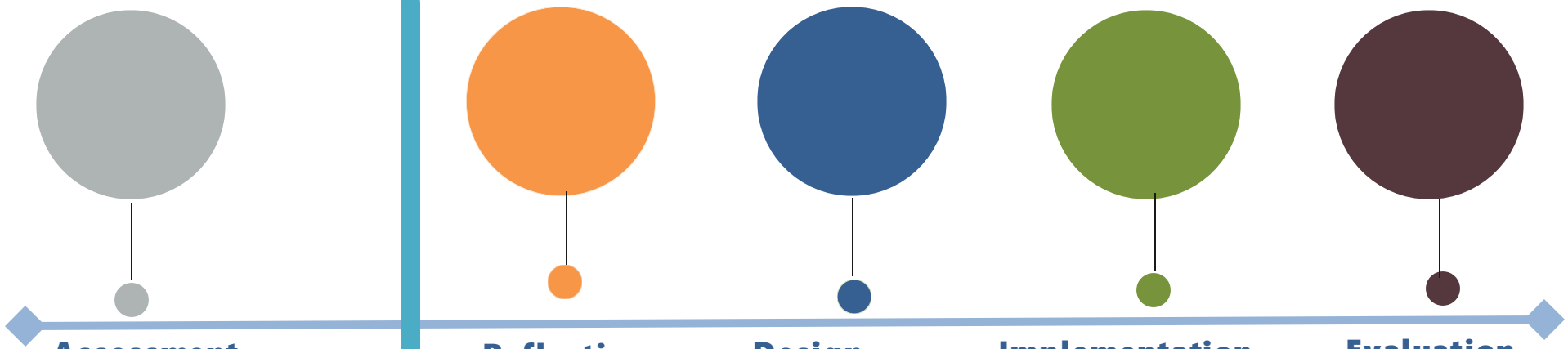
Wisconsin Department of Children and Families

WHAT WE DID...

Center for Innovation in Population Health

DCF is interested in overhauling the existing system to improve outcomes for children and families

DCF seeks to evaluate and make systemic changes to existing rules, policies, procedures and methods of work to establish a standard of care



Assessment

- Safety Culture overview for Providers
- Safety Culture Survey with Licensors and Providers
- Focus groups with Congregate Care Directors, Direct Care Teams and Licensors
- Review of current rules, policies, procedures
- Placement Data analysis
- CANS Data Analysis (LCA)

Reflection

- Sharing what we learned
- Collaborating on priorities
- Multiple perspectives

Design

- Data informed
- Co-design
- Collaboration
- Data informed
- Adopt-Adapt-Abandon

Implementation

- SSIT-CC Training, Coaching
- TA for pilot SSIT-CC implementation
- Bi-Monthly open attendance Learning Labs on requested topics
- Practice Community Cohorts (closed groups)

Evaluation

- SC Survey
- CANS and administrative data analysis
- Practice Community Post Assessment
- SSIT
- YOUTH VOICE

WISCONSIN Congregate Care:

Safety Culture Survey Results

The safety culture survey is an organizational assessment that examines aspects of an agency's workforce and culture.

169

EMPLOYEES FROM 33 GROUP HOMES COMPLETED THE SURVEY

213

EMPLOYEES FROM 16 RESIDENTIAL CARE CENTERS COMPLETED THE SURVEY

Psychological Safety - State

Here, think about how you feel about psychological safety related to the state/DCF.

	Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree	N/A or I don't know
If your facility makes a mistake, DCF Child Welfare Licensing often holds it against you.	○	○	○	○	○	○	○	○
DCF Child Welfare Licensing values each facility's unique skills and strengths.	○	○	○	○	○	○	○	○
Leadership at my facility are able to bring up concerns and challenges with DCF Child Welfare Licensing.	○	○	○	○	○	○	○	○
It is safe to take an interpersonal risk when working with DCF Child Welfare Licensing.	○	○	○	○	○	○	○	○
Even when operations are within the Administrative Rules and Statutes, DCF Child Welfare Licensing often rejects facilities for having different ideas.	○	○	○	○	○	○	○	○
It is difficult to ask DCF Child Welfare Licensing for help (i.e., DCF Child Welfare Licensing is not approachable).	○	○	○	○	○	○	○	○

Mindful Organizing

When completing this portion of the survey, think about your "unit/team" as the facility in which you work.

	Not At All	To A Very Limited Extent	To A Limited Extent	To A Moderate Extent	To A Considerable Extent	To A Great Extent	To A Very Great Extent
During a shift change, we usually discuss what to look out for	○	○	○	○	○	○	○
When discussing specific situations or processes in our work, my team spends time identifying things we do not want to go wrong.	○	○	○	○	○	○	○
My team discusses alternatives to improve how we go about our normal work activities.	○	○	○	○	○	○	○
My team has a good understanding of each other's skills and talents.	○	○	○	○	○	○	○
We discuss our unique skills with each other so we know who has relevant specialized skills and knowledge.	○	○	○	○	○	○	○
My team talks about mistakes and ways to learn from them.	○	○	○	○	○	○	○

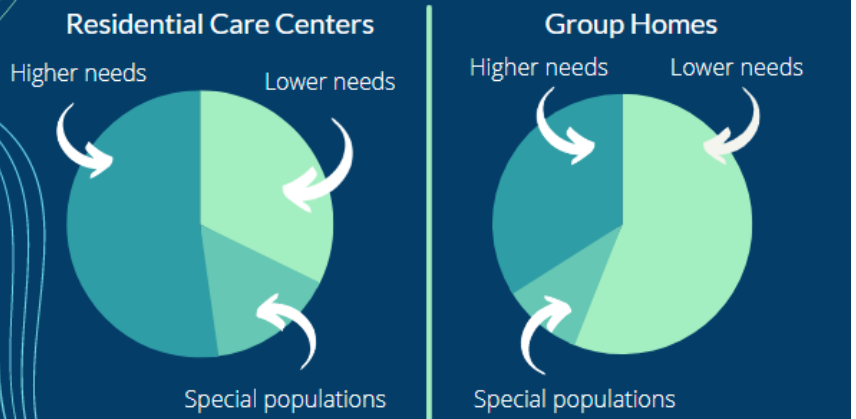
Congregate Care

Focus Groups

Focus group conversations with Group Home and Residential Care Center employees in August, 2021 and centered on:

- The gaps in CARE between what a youth needs and what they receive from an agency
- The gaps in SUPPORT between what an agency needs and what support they receive from DCF licensing

Characteristics of Youth Served in Congregate Care



Support from DCF

Residential Care Centers — Group Homes

Percentage of agency directors who say that DCF Child Welfare Licensing's enforcement process is beneficial to creating better practice. How can we bring this to 100%?

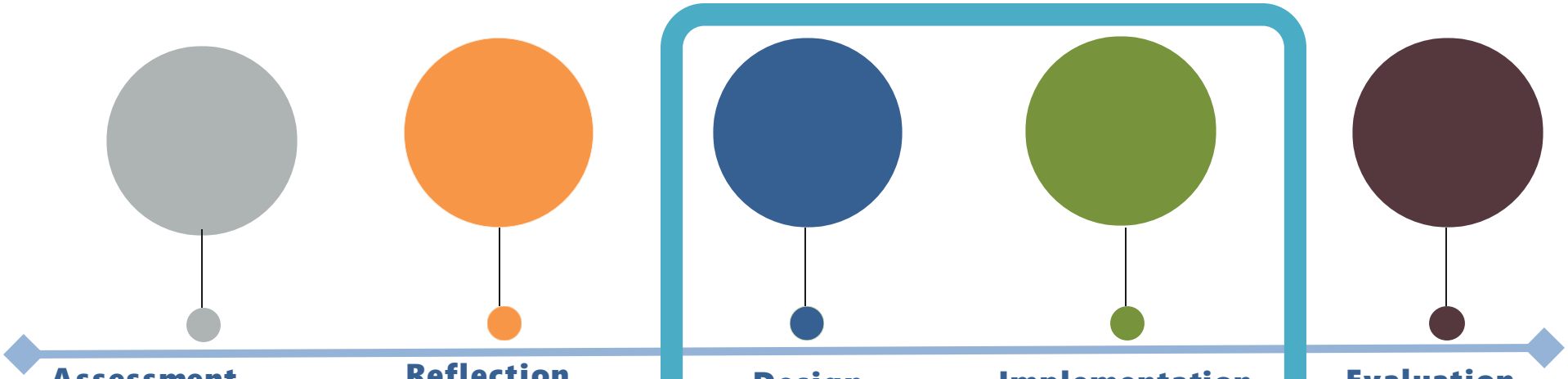
Wisconsin Department of Children and Families

WHAT WE DID...

Center for Innovation in Population Health

DCF is interested in overhauling the existing system to improve outcomes for children and families

DCF seeks to evaluate and make systemic changes to existing rules, policies, procedures and methods of work to establish a standard



Assessment

- Safety Culture overview for Providers
- Safety Culture Survey with Licensors and Providers
- Focus groups with Congregate Care Directors, Direct Care Teams and Licensors
- Review of current rules, policies, procedures
- Placement Data analysis
- CANS Data Analysis (LCA)

Reflection

- Sharing learning
- Collaborating on priorities
- Multiple perspectives

Design

- Data informed
- Co-design
- Collaboration
- Data informed
- Adopt-Adapt-Abandon

Implementation

- SSIT-CC Training, Coaching
- TA for pilot SSIT-CC implementation
- Bi-Monthly open attendance Learning Labs on requested topics
- Practice Community Cohorts (closed groups)

Evaluation

- SC Survey
- CANS and administrative data analysis
- Practice Community Post Assessment
- SSIT

- YOUTH VOICE

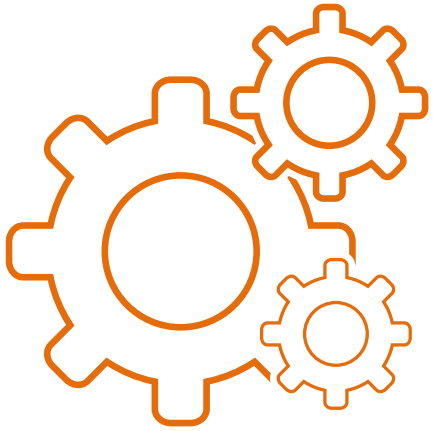
Safe Systems Improvement Tool for Congregate Care (SSIT-CC)

The SSIT-CC is an Information integration tool used to assess the strengths and challenges present within an agency's system, related to adverse youth experiences.

The underlying philosophy of shared accountability for youth experiences, supports a blameless, supportive inquiry, focused on learning and meaningful system improvement

It is grounded in:

- An action framework for learning and improvement
- Supportive inquiry across multiple disciplines
- Human Factors
- Systems thinking

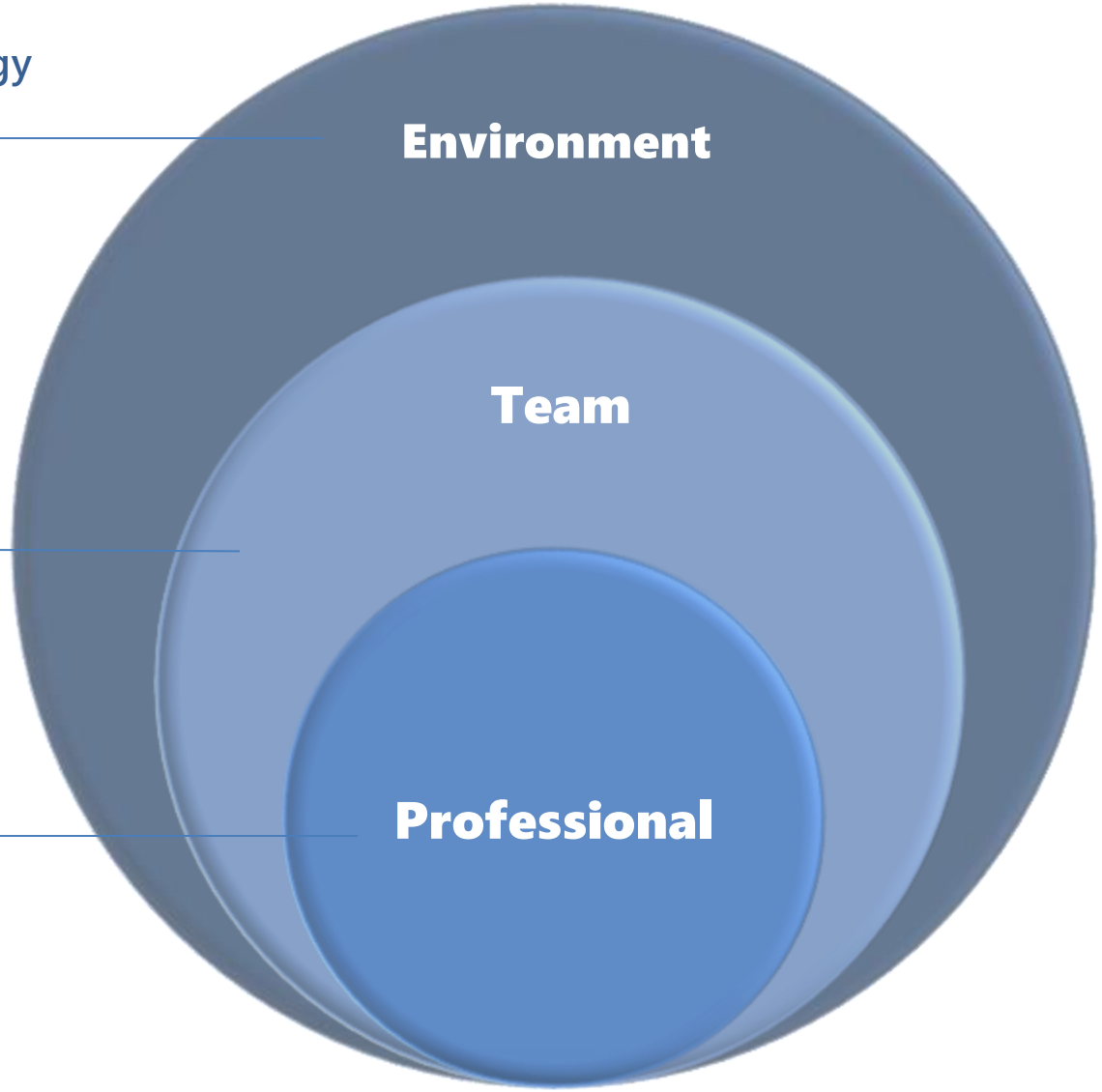


SSIT Nested Domains: Seek the Systems Story

ENVIRONMENT
Demand-Resource Match
Policy and Practice
Training
Physical Environment
Community Resources
Technology

TEAM
Preparing/Reflecting
Effective Communication
Professionalism
Supervisory Support
Workload
Practice Drift

PROFESSIONAL
Bias
Stress Management
Fatigue Management
Knowledge Base
Documentation
Information Integration



Learning Labs

Learning labs explore how a human factors, systems approach can support specific aspects of relational, person-centered youth care.

- Bi-monthly open sessions
- Facilitated peer learning and sharing
- Topics chosen by DCF and Providers

TOPICS

Affirming Care for LGBTQ+ Youth
Restraint Elimination
Medication Errors
Effective Communication Logs
Relational, person-centered behavior management
Responding to youth missing from care

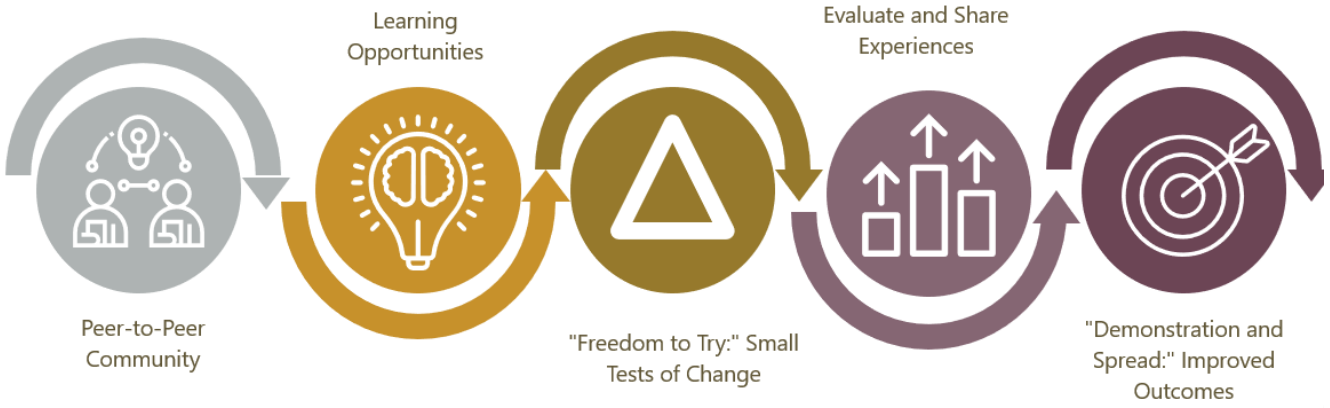
Practice Communities

Cohort One
June-December, 2022

Reducing Physical Interventions through Person-Centered Care

Group will reconvene quarterly in 2023

Practice Community: How it Works



A group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. (Wenger and Lave)

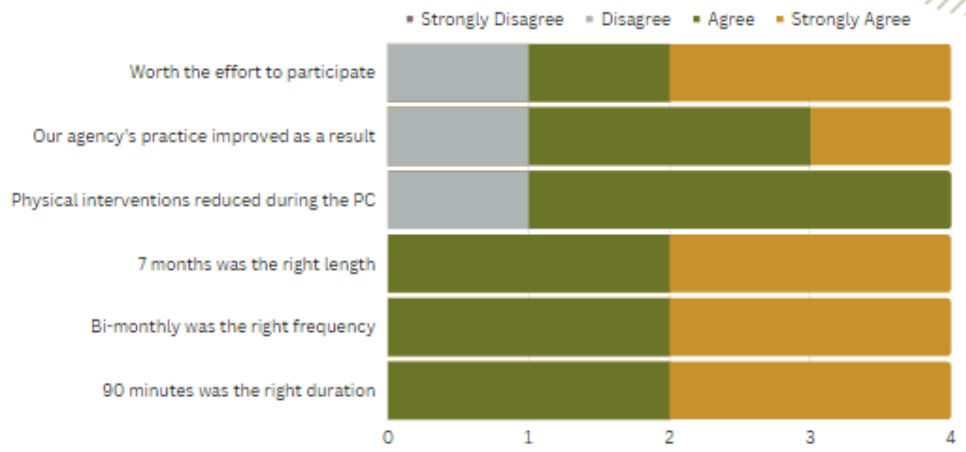
WHO TOOK PART?

11 Provider Teams attended the first session

6 Provider Teams completed all sessions

A range of RCC and Group Home Providers attended session 1. The 6 agencies who completed the Practice Community were RCCs.

WHAT THEY TOLD US ABOUT THE PRACTICE COMMUNITY



4 of the 6 Providers who completed the Practice Community submitted a post-assessment.

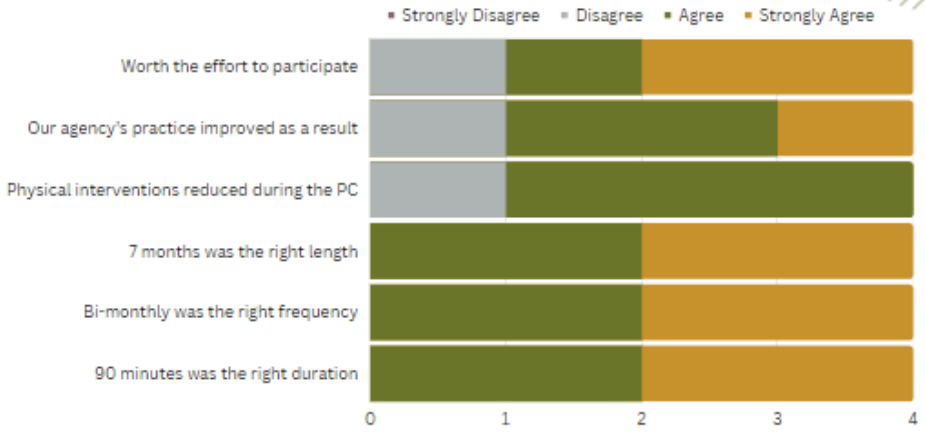
WHO TOOK PART?

11 Provider Teams attended the first session

6 Provider Teams completed all sessions

A range of RCC and Group Home Providers attended session 1. The 6 agencies who completed the Practice Community were RCCs.

WHAT THEY TOLD US ABOUT THE PRACTICE COMMUNITY



4 of the 6 Providers who completed the Practice Community submitted a post-assessment.

WHAT THE DATA TOLD US ABOUT PRACTICE

Agencies provided quantitative physical intervention data for the period prior to and during the Practice Community.

Pre-assessment data reported the number of physical interventions January - June and post-assessment data reported for the period from July - December while the Practice Community was convening.

4 of the 6 Provider Agencies who completed the Practice Community submitted quantitative post assessment data

2 of the 3 Provider Agencies who submitted quantitative pre and post assessment data reported a decrease in physical intervention.

The provider who did not provide quantitative data for the pre-assessment noted in the post assessment that physical interventions had trended down in July - December during the Practice Community

WHAT CHANGED AS A RESULT OF THIS PRACTICE COMMUNITY

Workplace culture. Collaboration. Openness and honesty in difficult conversations. The beginnings of creating a psychologically safe workplace. Inclusion. A mindset to dig deeper on why restraint and seclusion are being used. More in-depth admissions process to see if we are equipped to meet specific needs

We had already put into practice a lot of the information that came up in this practice community, so we did not gain anything that we were able to make changes with

Slight reduction in restraints. Created a draft plan for reducing /eliminating restraints, lots more discussion and awareness of the benefits of reducing restraints.

Our debriefing has improved immensely. And though our restraints spiked they have actually tapered off as of beginning December. Learning from the Practice Community definitely played a role in that. Staff are learning to see the "bigger picture" and think about antecedent events, biases etc.

WHICH ASPECTS OF THE PRACTICE COMMUNITY WERE MOST HELPFUL?

- Being held accountable for making changes or implementing new initiatives/practice.
- Discussing difficulties of addressing a difficult topic
- Presenters experienced in the field
- Resources!
- Discussions and learning from each other
- Connecting with other providers sharing information and experiences
- Presented as an environment for learning and that allowed providers to be honest and introspective
- Talking with facilities going through the same thing as us

2023 Practice Community April-October, 2023

From Universal Point Systems to Person-Centered, Relational Care

What we learned?

Wisconsin Department of Children and Families

Center for Innovation in Population Health

MINDFUL ORGANIZING STRATEGIES

REFLECT BACK

TALK ABOUT MISTAKES AND WAYS TO LEARN FROM THEM

Plus-Minus-Interesting

An activity where you look at an event or case retrospectively and think through the following questions:

Plus:
- What went well?
- What went according to plan?
- What did I/we do that worked so well and is there anything learned to apply again the next time?

Minus:
- What did not go well?
- Was there anything that should not be replicated in a future situation?
- What were the "lessons learned"?

Interesting:
- What things were learned that were previously unknown?
- Is anything unique or curious and worthy of sharing with others?

For example, a teammate uses PMI while mentoring a new employee to discuss what the new employee is learning from her fieldwork.

***Adapted from the Team First Field Guide (Cull, & Lindsey 2019)**

PLUS	MINUS	INTERESTING
WHAT WENT WELL AND ACCORDING TO PLAN? WHAT WOULD WE APPLY AGAIN NEXT TIME?	WHAT DIDN'T GO WELL? WHAT LESSONS DID WE LEARN AND WHAT WOULD WE NOT REPLICATE AGAIN?	WHAT DID WE PREVIOUSLY NOT KNOW? WHAT IS UNIQUE OR CURIOUS AND WORTH SHARING WITH OTHERS?

What Providers told us…

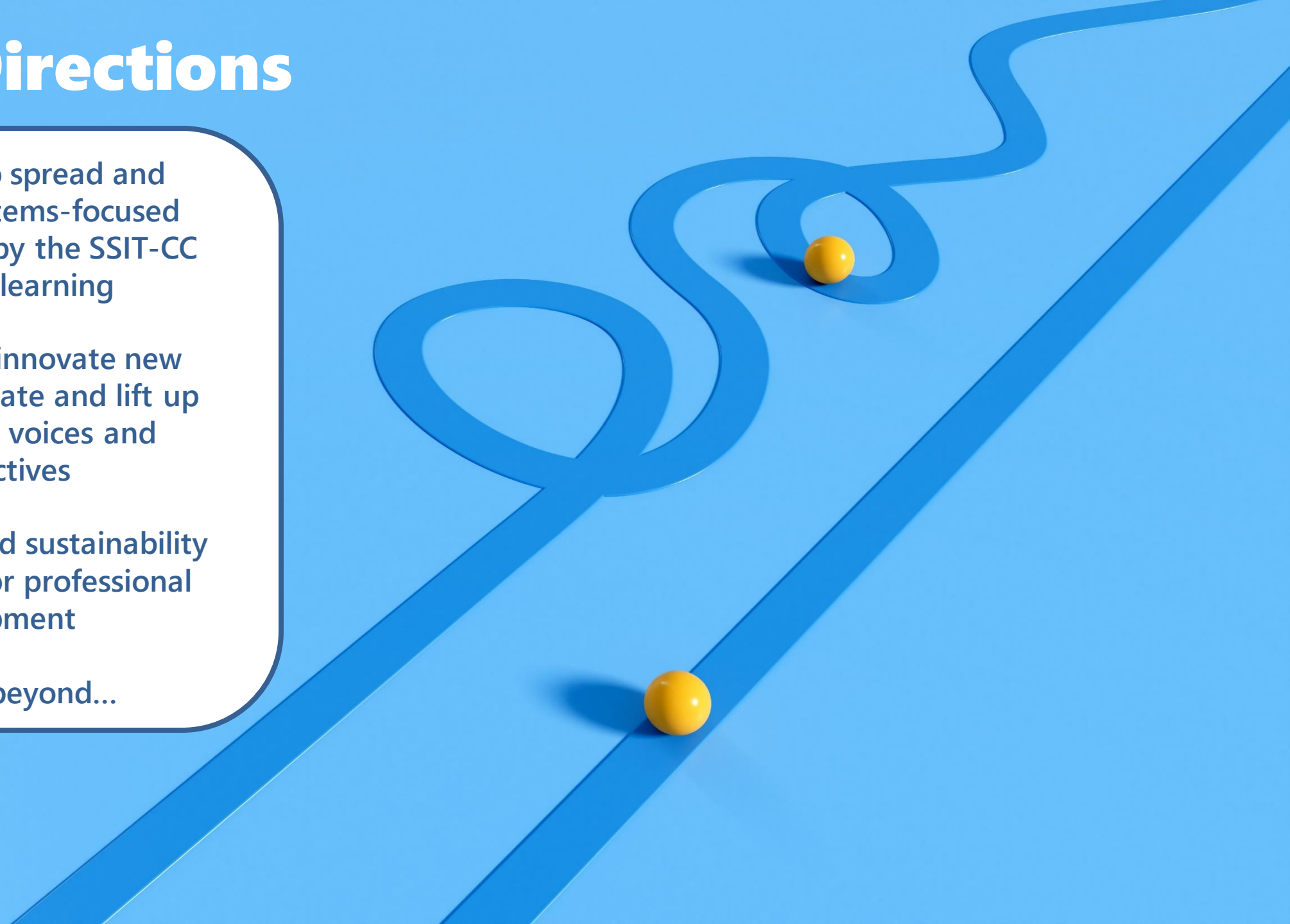
Future Directions

Collaborate to spread and strengthen systems-focused reviews guided by the SSIT-CC and share learning

Collaborate to innovate new ways to incorporate and lift up diverse youth voices and perspectives

Build capacity and sustainability through Licensor professional development

2024 and beyond…

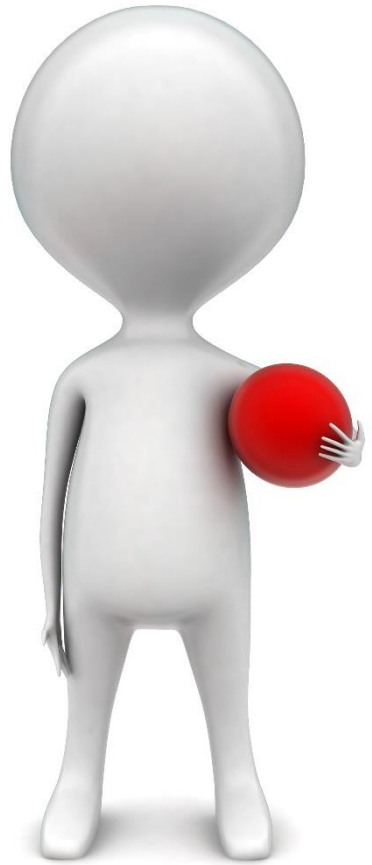


Safety is not the absence of threat

It is the presence of connection

Gabor Mate´ M.D.

What are you Taking Away?



SSIT-CC

TEAMFIRST FIELD GUIDE

SAFETY CULTURE SURVEY

Center for Innovation in Population Health

Wisconsin Department of Children and Families

Jamie.gennrich1@Wisconsin.gov
Katie.davis1@Wisconsin.gov
Jeannette.paules@Wisconsin.gov