

Office of the Auditor General
Performance Audit Report

Office of Family Advocate
Michigan Department of Health and Human Services

April 2025

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution



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Report Summary

Performance Audit

Office of Family Advocate (OFA)

Michigan Department of Health and Human Services (MDHHS)

Report Number:
491-2201-24

Released:
April 2025

MDHHS's OFA, within Children's Services Administration, oversees independent Safe Systems Reviews (SSRs) of selected cases with a child fatality and recent involvement with MDHHS's child welfare system to help identify and communicate opportunities for systemic improvements. OFA also serves as the MDHHS liaison with Office of the Child Advocate (OCA) and is responsible for communicating and coordinating MDHHS's responses to OCA's findings and recommendations. In addition, OFA addresses constituent concerns and/or complaints related to the child welfare process or specific cases. Further, OFA is responsible for maintaining MDHHS's child fatality registry and tracking and timely notifying OCA, the Michigan Public Health Institute, select legislators, and MDHHS leadership of child fatalities with recent MDHHS child welfare involvement.

Audit Objective			Conclusion
Objective 1: To assess the sufficiency of OFA's efforts to identify and communicate opportunities to improve MDHHS's child welfare activities.			Sufficient, with exceptions
Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
OFA excluded 150 MDHHS child death notifications from its SSR evaluation process and did not complete SSRs for 135 death notifications meeting SSR criteria. Also, almost 30% of SSR information reviewed had some inaccuracies related to information OFA uses for preparing its annual report of SSR demographic data and systemic improvement recommendations. Further, OFA did not consistently distribute its most recently completed SSR annual report to all key areas within MDHHS supporting child welfare system activities (Finding 1).	X		Agrees

Audit Objective			Conclusion
Objective 2: To assess the sufficiency of OFA's efforts to provide selected child fatality information to intended parties.			Sufficient, with exceptions
Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
See Finding 1, part d.			
For periods subsequent to calendar year 2022, OFA had neither reported applicable data in the child fatality registry nor updated the registry's historical information for known discrepancies as of December 2024 (<u>Finding 2</u>).	X		Agrees

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Office of the Auditor General
201 N. Washington Square, Sixth Floor
Lansing, Michigan 48913

Doug A. Ringler, CPA, CIA
Auditor General

Laura J. Hirst, CPA
Deputy Auditor General



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Office of the Auditor General

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Doug A. Ringler, CPA, CIA
Auditor General

April 10, 2025

Elizabeth Hertel, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Director Hertel:

This is our performance audit report on the Office of Family Advocate, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler
Auditor General

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OFFICE OF FAMILY ADVOCATE

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

IDENTIFY AND COMMUNICATE OPPORTUNITIES TO IMPROVE MDHHS's CHILD WELFARE ACTIVITIES

BACKGROUND

The Office of Family Advocate (OFA) is responsible for oversight of the Safe Systems Review (SSR) process; serving as the liaison between the Michigan Department of Health and Human Services' (MDHHS's) Children's Services Administration (CSA) and the Department of Technology, Management, and Budget's (DTMB's) Office of the Child Advocate (OCA); and addressing constituent concerns and/or complaints.

MDHHS joined with the National Partnership for Child Safety to create MDHHS's SSR process in 2020. In 2022, OFA began completing SSRs to help identify and communicate systemic barriers which may have impacted child welfare case practice. All SSR reviewers must complete required training prior to conducting an SSR.

An SSR includes examining the history of a child death case, encouraging collaboration across ranks and disciplines to seek solutions to problems, and promoting a blame-free environment in which child welfare professionals can report errors or near misses without fear of reprimand or punishment. Potential recommended actions following each SSR can include departmental policy changes, staff training, strengthened collaboration, and/or public outreach and education. In addition, OFA summarizes its SSR results for the child deaths during a reporting year to provide MDHHS key areas with identified improvement opportunities for the cases reviewed and systemic improvement recommendations.

As the liaison to OCA, OFA's primary responsibility is to facilitate MDHHS's responses to OCA's findings and recommendations (F&R) report. OFA receives an F&R report from OCA, obtains relevant information from applicable local MDHHS offices, compiles and organizes MDHHS's response, and provides a response to OCA within 60 days. Between January 1, 2023 and June 30, 2024, OFA received 8 F&R reports from OCA.

OFA also receives complaints via e-mail or phone from constituents, such as family and community members, legislative offices, or other MDHHS staff, regarding the child welfare process or actions taken on a specific case. OFA's complaint review may include:

- Conducting a case review.
- Contacting the county/Private Agency Foster Care (PAFC) for more information.
- Researching policy regarding the concern.
- Consulting with the OFA manager regarding the circumstances.

OFA communicates completed complaint review information to the constituent and to MDHHS management as necessary. Between October 31, 2022 and June 30, 2024, OFA received 97 constituent complaints.

AUDIT OBJECTIVE

To assess the sufficiency of OFA's efforts to identify and communicate opportunities to improve MDHHS's child welfare activities.

CONCLUSION

Sufficient, with exceptions.

**FACTORS
IMPACTING
CONCLUSION**

- OFA timely responded to and ensured MDHHS's CSA management approved responses for 100% of OCA's F&R reports reviewed.
- OFA ensured all reviewers assigned to an SSR during the audit period completed required training prior to performing an SSR and the SSR process included collaboration with all applicable individuals for 100% of the reviewed SSRs.
- OFA timely and reasonably addressed and performed follow-up actions, as applicable, for over 90% of sampled constituent complaints reviewed.
- OFA prepared an annual report of its 2022 SSRs during the audit period for distribution to applicable areas of MDHHS.
- Material condition* related to needed improvements in OFA's SSR process (Finding 1).

* See glossary at end of report for definition.

FINDING 1

Improvements needed in the SSR process.

OFA needs to improve its SSR process to help ensure it evaluates all applicable MDHHS child death notifications, completes an SSR when required, accurately collects SSR information, and appropriately communicates recommendations for needed improvements. Doing so would strengthen OFA's assurance it consistently identifies needed changes in MDHHS's child welfare activities and fully and timely conveys its recommendations to advance more positive outcomes for children and families.

MDHHS's stated goal* for the SSR process is system transformation to advance family well-being. MDHHS's SSR protocol indicates an SSR will be completed when a child dies and one or more of the following criteria are met:

- The child was a member of an open foster care case at the time of the fatality, or within the six months preceding the child's date of fatality.
- The Children's Protective Services was involved with either the child or any immediate family member of the child victim at the time of the incident or within the six months preceding the child's date of fatality.
- MDHHS's director, the CSA director, or a Business Service Center director requests a review of a child fatality.

OFA's SSR process begins when OFA receives a child death notification, typically through MDHHS's Michigan Statewide Automated Child Welfare Information System (MiSACWIS) system alerts and vital record matches. OFA is responsible for evaluating the circumstances of each child death notification to determine whether OFA must complete an SSR.

OFA completes and documents its SSRs using the Safe Systems Improvement Tool (SSIT) and prepares and distributes its annual report of SSR systemic improvement recommendations and demographic data collected based on its completed reviews.

Our review of OFA's SSR process noted:

- a. MDHHS child death notifications were not always considered and evaluated to determine whether circumstances surrounding the child's death warranted an SSR. We compared MiSACWIS child welfare records with the MDHHS child death notifications OFA evaluated for an SSR. We identified 150 child deaths with recorded dates of death in MiSACWIS between January 1, 2023 and June 30, 2024 which OFA did not include in its SSR evaluation process.

OFA did not evaluate 150 child deaths to determine whether circumstances called for an SSR.

* See glossary at end of report for definition.

OFA informed us that prior to February 2024, it included only child death notification information in its SSR tracking sheet when there was an allegation of abuse and neglect at the time of death. Because of this limited tracking, OFA did not evaluate these deaths to determine whether an SSR was warranted based on other circumstances (see part b.(2)).

b. An SSR was not always completed for MDHHS child death notifications meeting the SSR criteria. We noted:

(1) OFA selected 35 MDHHS child death notifications for SSRs rather than reviewing all 143 MDHHS death notifications meeting SSR criteria between January 1, 2023 and June 30, 2024. This practice was not consistent with MDHHS's SSR protocol indicating an SSR will be completed when a child dies and one or more of the SSR criteria are met. OFA informed us it sampled child deaths for SSRs because of the volume of cases and limited resources. In addition, OFA informed us a sampling plan and/or methodology was not included in its SSR protocol because some limited sample size information was included in its SSR tracking sheet and no State or federal mandates require SSRs. Because of the limited nature of the sampling information OFA provided, we were unable to confirm whether OFA followed a sampling selection criteria and/or evaluate the reasonableness of OFA's SSR sampling methodology.

(2) OFA did not conduct SSRs for 27 (18%) of the 150 MDHHS child death notifications identified in part a. as meeting SSR criteria, nor include these child deaths in its sampling process.

c. The SSR information OFA collected and used to prepare its annual report of demographic data and recommendations was not always accurate. We noted the SSIT for 6 (29%) of 21 selected SSRs contained inaccurate information including the children's gender, cause of death, and scoring information related to the determined level of quality improvement needed.

MDHHS informed us the data for cause and manner of death is manually compiled using various sources including child welfare records, medical records, autopsy results, or by death certificates, as well as information obtained during debriefs, and the inaccuracies were an oversight.

d. OFA did not always timely provide or distribute its SSR annual report to all key areas within MDHHS supporting the child welfare system. Our review noted MDHHS's

Almost 30% of SSRs reviewed had inaccurate information for OFA's annual SSR report, and the most recent report was inconsistently distributed to key MDHHS child welfare areas.

2022 SSR annual report was approved for distribution in May 2024. In July 2024, OFA provided the final report to MDHHS's CSA In-Home Services Bureau director. In November 2024, OFA provided the report to the CSA Administration Bureau director. However, as of February 11, 2025, OFA informed us although it provided high-level recommendation information to MDHHS's CSA Out-of-Home Services Bureau (OOHSB), it had not distributed the 2022 SSR report to OOHSB management or the CSA Business Service Center directors.

The 2022 SSR report outlines 163 identified improvement opportunities, including needed improvements in safety planning; developing collateral contacts for assessing child safety concerns; and providing supervisory support, training, and additional policies and guidance for child welfare staff. OFA's recommendations related to CSA included ones impacting its OOHSB and Business Service Center activities.

MDHHS informed us the SSR protocol did not have formal procedures for distributing the SSR report.

We consider this finding to be a material condition because of the number of child deaths not evaluated or reviewed and the potential impact on OFA's identification and communication of needed improvements in MDHHS's child welfare activities.

RECOMMENDATION

We recommend OFA improve its SSR process to help ensure it evaluates all applicable MDHHS child death notifications, completes an SSR when required, accurately collects SSR information, and appropriately communicates recommendations for needed improvements.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

OFA agrees with the finding and took immediate steps to enhance the SSR process. MDHHS has voluntarily partnered with the National Partnership for Child Safety as a continuous quality improvement venture to improve child safety. Through this partnership, MDHHS worked closely with the Center for Innovation in Population Health at the University of Kentucky to create the Safe Systems Review for further quality improvement and system reform efforts related to child welfare.

The OFA modified the MiSACWIS query language and enhanced the data validation process to improve the accuracy of the MiSACWIS data evaluated for a SSR Review, effective February 2024.

The OFA corrected the reporting inaccuracies identified during September 2024 and will secure access to the death certificate registry (EDRS) and amend the intra-agency agreement to ensure

accuracy of reporting. Additionally, the OFA has implemented bi-monthly technical assistance and fidelity reviews to ensure continuous education is provided on accurate scoring to the Safe System reviewers.

The OFA is in the process of updating the SSR protocol with a documented sampling methodology and reporting procedures that outline the annual report distribution process.

PROVIDE SELECTED CHILD FATALITY INFORMATION TO INTENDED PARTIES

BACKGROUND

OFA is responsible for providing and maintaining MDHHS's registry of select child fatality information, notifying specified parties of MDHHS child death notifications, assisting with Collaborative Case Assessments (CCAs) and furnishing the CCA reports to MDHHS management, and preparing an SSR annual report.

The Child Protection Law (Public Act 238 of 1975, as amended) requires MDHHS to establish and maintain a registry of statistical information regarding select children's deaths connected to child welfare cases that shall be accessible to the public. OFA uses data from MiSACWIS to populate the child fatality registry.

When a child dies under the care and supervision of MDHHS with recent child protective services involvement, including those ages 18 and over, OFA is required to:

- Notify the Office of Legislative Services (OLS), if the child was under court jurisdiction for abuse and neglect, within one business day.
- Provide electronic or written notification to OCA within one business day.
- Distribute a child death reporting form to notify MDHHS leadership and the Michigan Public Health Institute (MPHI) of the child's death.

From January 1, 2023 through June 30, 2024, OFA received notifications of 511 child deaths requiring notifications to these parties, as applicable.

OFA assists with MDHHS's CCAs. CCAs are held when an urgent review of a child welfare case is warranted because of a child's death, near-death experience, or serious physical injury; media involvement; and/or multiple referrals of allegations of child abuse and/or neglect. Requests for a CCA may be made by various areas within MDHHS, dependent upon the unique circumstances of the case. OFA is responsible for completing a case review for the CCA, attending the CCA meeting and documenting any action steps needed in the CCA report, submitting the report for management approval, and monitoring and tracking action steps when necessary. Between January 1, 2023 and June 30, 2024, OFA participated in 20 CCAs.

OFA's SSR annual report includes statistical information related to reviewed child death cases for the reporting year to provide to MDHHS areas administering and supporting the child welfare system.

AUDIT OBJECTIVE

To assess the sufficiency of OFA's efforts to provide selected child fatality information to intended parties.

CONCLUSION

Sufficient, with exceptions.

**FACTORS
IMPACTING
CONCLUSION**

- OFA established a public child fatality registry as required by law.
- OFA attended CCA meetings, prepared and submitted CCA reports for approval, and monitored and tracked action steps, when necessary, for 100% of the CCA meetings and associated reports we reviewed.
- OFA timely provided required notifications to MDHHS leadership, MPHI, OCA, and OLS for over 90% of MDHHS child death notifications we reviewed.
- Condition noted in Finding 1, part d., related to OFA's distribution of its 2022 SSR annual report.
- Material condition related to needed improvement in the validation and error correction process for MDHHS's publicly reported child fatality registry information (Finding 2).

FINDING 2

Improvements needed in child fatality registry data validation and error correction process.

OFA has not publicly reported child fatality data for periods after calendar year 2022 or updated the historical data for identified discrepancies.

OFA needs to improve its validation and error correction process for MDHHS's publicly reported child fatality registry information. Doing so would help OFA ensure MDHHS consistently provides timely and reliable child fatality information to the public and fulfills its statutory responsibilities related to the child fatality registry.

Section 722.627b(11) of the *Michigan Compiled Laws* requires MDHHS to establish and maintain a registry of statistical information regarding children's deaths that shall be accessible to the public, including:

- The number of children who died while under court jurisdiction for child abuse or neglect regardless of placement setting.
- The number of children who died as a result of child abuse or neglect after a parent had 1 or more child protective services complaints within the 2 years preceding the child's death and the category dispositions of those complaints.
- The total number of children as identified above who died in the preceding year.
- The child protective services disposition of the child fatality.

MDHHS established the child fatality registry to fulfill this mandate and used data queries to summarize applicable MiSACWIS information and publicly report it in the registry. OFA informed us that near the end of calendar year 2022, it began a process to validate the queried MiSACWIS data results used for the registry. In doing so, OFA noted concerns with the query language used to obtain the information from MiSACWIS and discrepancies between the MiSACWIS information and corresponding data contained in OFA's internal tracking records of child death notifications obtained from other sources. The noted discrepancies included, but were not limited to, duplicated child death information, erroneous dates of death, and inaccurate personal identification numbers.

OFA also informed us that although it continued its internal validation process which began in late 2022, it temporarily paused its public child fatality registry reporting to address the noted query language concerns and data discrepancies. We noted as of December 2024, OFA had neither updated its historical public child fatality registry information for identified discrepancies nor resumed its public reporting. Consequently, the reliability of MDHHS's publicized child fatality registry information at the time of our review was undeterminable, and information for periods subsequent to calendar year 2022 was not publicly available via MDHHS's child fatality registry.

We consider this finding to be a material condition because unreliable data hinders OFA's ability to meet its mandate under

State law for publicly reported child fatality information and could also negatively impact other stakeholders who may utilize the information.

RECOMMENDATION

We recommend OFA improve its validation and error correction process for MDHHS's publicly reported child fatality registry information.

**AGENCY
PRELIMINARY
RESPONSE**

MDHHS provided us with the following response:

OFA agrees with the finding and recognizes there are always opportunities for improvement. The OFA received legal input to ensure correct interpretation of the requirements within MCL Section 722.627b(11) and resumed public reporting of child fatality registry information during January 2025 after improving the validation process.

MDHHS modified the MiSACWIS query language to ensure accuracy of the MiSACWIS data used for the child fatality registry and the OFA will continue to conduct monthly review and validation of the query results. Monthly validation will be completed of child deaths reported to Centralized Intake to ensure that all deaths due to suspected child abuse and/or neglect are accounted for in the MiSACWIS data set.

The OFA has modified the master fatality tracking tool to ensure all sources of data reported to OFA are included and will continue to hand validate all data. The Data Management Unit will continue to send weekly and monthly child death data to OFA and any data concerns identified during the validation process will be promptly evaluated and resolved.

DESCRIPTION

MDHHS's OFA, within CSA, acts as an internal monitor for certain child welfare activities within MDHHS. OFA is responsible for:

- Overseeing the SSR process.
- Serving as the liaison between MDHHS's CSA and DTMB's OCA.
- Addressing constituent concerns and/or complaints.
- Providing and maintaining MDHHS's registry of select child fatality information.
- Notifying specified parties of child deaths.
- Assisting with CCAs and furnishing CCA reports to MDHHS management.
- Preparing the SSR annual report.

As of June 30, 2024, OFA had six full-time staff.

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine the records and processes of OFA. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those 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 provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our audit objectives and corresponding audit procedures were directed toward concluding on OFA's efforts to identify and communicate opportunities to improve child welfare activities and to provide selected child fatality information to intended parties and were not directed toward concluding on the accuracy or completeness of MDHHS's vital records.

As part of the audit, we considered the five components of internal control* (control environment, risk assessment, control activities, information and communication, and monitoring activities) relative to the audit objectives and determined all components were significant.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered January 1, 2023 through June 30, 2024.

METHODOLOGY

We conducted a preliminary survey to gain an understanding of OFA's processes, programs, and activities to establish our audit objectives, scope, and methodology. During our preliminary survey, we:

- Interviewed OFA management and staff.
- Reviewed applicable sections of the *Michigan Compiled Laws* and MDHHS policies, procedures, and memorandums of understanding related to OFA.
- Obtained an understanding of OFA's processes, tasks, and responsibilities.
- Performed preliminary examinations of:
 - Selected MDHHS child death notifications to determine whether OFA correctly assessed eligibility of the death for an SSR, followed its SSR protocol for any completed SSR, and timely notified required parties, as applicable.

* See glossary at end of report for definition.

- F&R reports to determine whether OFA responded timely and obtained approval from MDHHS management.
- Constituent complaints to determine whether OFA followed its complaint response process.
- CCAs to determine whether OFA completed and obtained approval of CCA reports.

OBJECTIVE 1

To assess the sufficiency of OFA's efforts to identify and communicate opportunities to improve MDHHS's child welfare activities.

To accomplish this objective, we:

- Compared vital records and child welfare records with recorded dates of the child deaths in MiSACWIS from January 1, 2023 through June 30, 2024 with OFA's internal tracking of MDHHS child death notifications to assess if OFA considered and evaluated all MDHHS child death notifications in MiSACWIS for an SSR.
- Judgmentally and randomly selected 21 of the 35 SSRs completed between January 1, 2023 and June 30, 2024 to evaluate the accuracy of the data reported in the SSIT and to evaluate if OFA completed the SSRs in accordance with its procedures.
- Reviewed the training records of all reviewers assigned to an SSR during the audit period to determine if they had completed the required training prior to performing an SSR.
- Verified OFA prepared the 2022 SSR annual report during the audit period and assessed its distribution of the report information to MDHHS's areas administering and supporting the child welfare system.
- Reviewed all 8 F&R reports sent to OFA from OCA between January 1, 2023 through June 30, 2024 to evaluate whether OFA's F&R responses were timely and approved by MDHHS management.
- Randomly selected a sample of 14 of 97 constituent complaints received between October 31, 2022 and June 30, 2024 to determine whether OFA timely and reasonably addressed the complaint and performed follow-up actions as applicable.

Our random samples were selected to eliminate bias and to enable us to project the results to the respective populations. We selected other samples judgmentally based on risk and could not project those results to the respective populations.

OBJECTIVE 2

To assess the sufficiency of OFA's efforts to provide selected child fatality information to intended parties.

To accomplish this objective, we:

- Judgmentally and randomly selected 48 of 511 MDHHS child death notifications OFA received between January 1, 2023 and June 30, 2024 to evaluate the timeliness of OFA's required child death notifications to MDHHS leadership, MPHI, OCA, and OLS, as applicable. Also, we compared vital records and child welfare records with recorded dates of death in MiSACWIS from January 1, 2023 through June 30, 2024 to OFA's internal tracking of child death notifications to identify potential child fatalities with recent child protective services involvement not considered for communication to required parties.
- Randomly sampled 6 of 20 CCA meetings completed between January 1, 2023 and June 30, 2024 to determine whether OFA attended CCA meetings, prepared and submitted CCA reports for approval, and monitored and tracked action steps, when necessary.
- Assessed OFA's process to maintain and provide child death information through MDHHS's child fatality registry for periods subsequent to calendar year 2022 through December 2024.
- Verified OFA distributed the 2022 SSR annual report prepared during the audit period to MDHHS areas administering and supporting the child welfare system.

Our random samples were selected to eliminate bias and to enable us to project the results to the entire population. We selected other samples judgmentally based on risk and could not project those results to the respective populations.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions or reportable conditions*.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 2 findings and 2 corresponding recommendations. MDHHS's preliminary response indicates it agrees with both of the recommendations.

* See glossary at end of report for definition.

The agency preliminary response following each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 3, Section 100) require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

GLOSSARY OF ABBREVIATIONS AND TERMS

CCA	Collaborative Case Assessment.
CSA	Children's Services Administration.
DTMB	Department of Technology, Management, and Budget.
F&R	findings and recommendations.
goal	An intended outcome of a program or an entity to accomplish its mission.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, strategic plan, goals, and objectives. Internal control includes the processes for planning, organizing, directing, and controlling program operations. It also includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.
material condition	A matter, in the auditor's judgment, which is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. Our assessment of materiality is in relation to the respective audit objective.
MDHHS	Michigan Department of Health and Human Services.
MiSACWIS	Michigan Statewide Automated Child Welfare Information System.
MPHI	Michigan Public Health Institute.
OCA	Office of the Child Advocate.
OFA	Office of Family Advocate.
OLS	Office of Legislative Services.

OOHSB CSA Out-of-Home Services Bureau.

performance audit An audit which provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.

reportable condition A matter, in the auditor's judgment, less severe than a material condition and falls within any of the following categories: a deficiency in internal control; noncompliance with provisions of laws, regulations, contracts, or grant agreements; opportunities to improve programs and operations; or fraud.

SSIT Safe Systems Improvement Tool.

SSR Safe Systems Review.



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