Phase 7- Florida Title IV-E Demonstration Evaluation Semi-Annual Progress Report (10/2017-03/2018)

Mary I. Armstrong
Amy Vargo
Areana Cruz
Melissa Johnson
John Robst
Svetlana Yampolskaya

Louis de la Parte Florida Mental Health Institute
University of South Florida

Submitted: April 10, 2018

Resubmitted: April 30, 2018

The authors gratefully acknowledge the assistance provided by the Florida Department of Children and Families and the following individuals: Sallie Bond, JoShonda Guerrier, Mark Shults, Alissa Cross, Ginger Griffeth, Mark Mahoney, Barney Ray, Keith Perlman, David Fairbanks, and Amy Kelly. The authors wish to thank CBC lead agencies and Case Management Organization leadership and staff for their participation.

Table of Contents

List of Figures

List of Tables

Phase 7- Florida's Title IV-E Demonstration Evaluation
Semi-Annual Progress Report (10/2017 – 03/2018)

Executive Summary

Background

On October 1, 2006 Florida was granted a Waiver to certain provisions of Title IV-E of the Social Security Act of 1935. The Waiver allowed the State to use certain federal funds more flexibly, for services other than room and board expenses for children served in out-of-home care. The Florida Title IV-E Waiver was granted as a Demonstration project, and required the State to agree to a number of Terms and Conditions, including an evaluation of the effectiveness of the Demonstration. The Terms and Conditions explicitly state three goals of the Demonstration project:

- Improve child and family outcomes through the flexible use of Title IV-E funds;
- Provide a broader array of community-based services and increase the number of children eligible for services; and
- Reduce administrative costs associated with the provision of child welfare services by removing current restrictions on Title IV-E eligibility and on the types of services that may be paid for using Title IV-E funds.

As specifically required by the Terms and Conditions under which the Demonstration extension was granted (October 1, 2013 through September 30, 2018), this evaluation seeks to determine, under the expanded array of services made possible by the flexible use of Title IV-E funds, the extent to which the State was able to:

- Expedite the achievement of permanency through either reunification, adoption, or legal guardianship.
- Maintain child safety.
- Increase child well-being.
- Reduce administrative costs associated with providing community-based child welfare services.

The Terms and Conditions of the Demonstration require a process, outcome, and cost analyses. Primary data was collected for this semi-annual report via interviews with and survey responses from lead agency leadership. Secondary data analysis was performed for this report with extracts from the Florida Safe Families Network (FSFN, Florida's statewide SACWIS

system), Florida Continuous Quality Improvement (CQI)[1], Florida Medicaid, and the Substance Abuse and Mental Health Information System (SAMHIS).

Findings

Implementation analysis. The goal of the implementation analysis is to describe the implementation of the Demonstration extension. This semi-annual report includes findings from a set of key stakeholder interviews conducted with 11 leadership teams at Community-Based Care lead agencies (CBCs) during the reporting periods of October 2017 through March 2018. The interviewees represented 13 circuits. The interviews focused on successful services, the use of rapid safety feedback reviews, and the ending of the Demonstration.

Service array. Interviewees reported several family support services that have been successful for the families they serve. Responses ranged from co-locating staff to the use of California Clearinghouse evidence-based practices. Successful services reported were: Nurturing Parenting, Nurturing Fathers, Wraparound family support models, Behavioral Educational Therapy, and a Family In-Home Research Support Team. Respondents from 10 circuits reported offering evidence-based or promising practices incuding: Wraparound Family Support Model, Family Connections Program, Nurturing Parenting, Nurturing Fathers, the C.A.R.E.S. model, MST, Home Builders, Family Builders, and Children to Action Teams. Respondents also reported that there is fidelity monitoring conducted with their evidence-based and promising practices.

Respondent unanimously stated that they offer both formal and informal safety management services. Formal safety management services included crisis management teams, safety management services teams, mobile response teams, Family Builders, ERAT (Emergency Response Action Team; available to CPIs), House Next Door (available to case managers), and SMART (program for CPIs designed in partnership with CPIs). Informal safety management services included faith-based community programs, relationships with learning coalitions, and supports identified by case managers.

Regarding which treatment services were perceived as having the most success for families, respondents talked about the importance of a wraparound approach with families. Second, respondents discussed the positive impact of co-locating services for families, as seen in the Kids in Distress model where services inclusive of parent education, domestic violence intervention, substance abuse outpatient treatment, and mental health counseling and therapy are coordinated for families. Third, respondents discussed the value of behavioral analysis

[1] Specifically, Florida data used for this report comes from the Federal Onsite Review Instrument (OSRI) and Online Monitoring System (OMS).

being included in programs. Fourth, the importance of services that "put trauma first" was discussed. Substance abuse programs, in particular, were perceived as having more success if they placed emphasis on dealing with the role of previous trauma in addictions treatment. Fifth, the practice of having a behavioral health consultant work with CPIs was mentioned as being successful. Sixth, successful substance abuse treatment services such as the FIT (Family Intensive Treatment) program, substance abuse call centers, and residential substance abuse treatment programs (particularly residential treatment programs that allow a baby or young child to stay with mom at the residential center) were identified by interviewees.

Emergent themes regarding successful child well-being services included improvements in dental care, discussion of the impact of the Child Welfare Specialty Plan, use of non DCF or Medicaid resources to fund well-being services, more trauma informed services, behavioral services geared toward the younger population, teams of nurses, and educational mentors.

Stakeholders were also asked to discuss how the Rapid Safety Feedback reviews have improved practice for their CBC, if they have. The majority of respondents felt that the reviews were helpful and useful. Reasons given for this included the ability to address safety concerns in real time, being able to focus on the most vulnerable population (0-3 years with substance abuse and domestic violence allegations), having another learning tool to support the coaching process between supervisors and case managers, and simply having "another set of eyes" on randomly selected cases. An additional strength identified by respondents included the reviews providing staff with a better understanding of family and cultural dynamics as they relate to high risk and abuse situations. Lead agencies described staff looking deeper at parent's protective capacities as a result of the review process.

Demonstration impact. There was consensus among the interviewees that the loss of the Demonstration funds would be irreplaceable and would have a highly detrimental impact on Florida's child welfare system of care. There was consensus across participants that prevention services and programs would be highly vulnerable to elimination or reduction with the loss of Demonstration funds, although most interviewees did identify alternative funding sources that could partially make up for the loss of Demonstration funds. During the interviews that occurred after passage of the Family First Services Prevention Act, there was cautious optimism about the future including the decision that prevention dollars will be "separate" and not require the IV-E eligibility requirements. Respondents also voiced concerns about some of the limitations in the new federal language, such as the restrictions on federal funding of residential group care.

Services and practice analysis. The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration,

including the implementation of evidence-based practices and programs. For the current report, a status update is provided regarding the implementation of the evidence-based practice fidelity assessment. There are 14 lead agencies (77.8%) that currently include Wraparound as part of their service array, and nine lead agencies (50%) that include the Nurturing Parenting Program. Six lead agencies reported that they offer both services as part of their service array. Furthermore, only one lead agency reported providing neither of these two services. The evaluation team is still determining to what extent agencies currently assess practice fidelity to these EBPs.

Outcome analysis: safety outcome. The outcome analysis tracked changes in five successive exit cohorts (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15 and SFY 15-16) of children who were followed from the time they either exited out-of-home care or their in-home services were terminated. The indicator *Proportion of all children who were NOT reported as the victims of subsequent verified maltreatment within six months of termination of services* was calculated by circuit and statewide, and cohorts were constructed based on state fiscal year.

Compared to the national standards that refer to similar indicators, the state of Florida maintained a relatively high proportion of children who did not experience verified maltreatment after either in-home or out-of-home services were terminated. On average, this proportion remained higher than 95% across the examined state fiscal years. However, not all circuits had proportions of children without verified maltreatment within six months of service termination higher than 95%. For some Circuits (e.g., 3 and 7) the proportions of children without verified maltreatment were equal to or lower than 95% across all examined fiscal years. When the impact of child and family characteristics on the recurrence of maltreatment within six months of service termination was examined, results showed that neglect, parental substance abuse, and history of domestic violence were the strongest predictors for repeated verified maltreatment.

Outcome analysis: child and family well-being. The constructs of child and family well-being were examined per the applicable Florida CQI items. These outcomes focus on improving the capacity of families to address their child's needs; and providing services to children related to their educational, physical, and mental health needs. Overall, ongoing reviews indicate that Circuit 19 demonstrated the most improvement across outcomes and performance items. Other circuits showed marked improvement from baseline to ongoing review, most notably Circuits 8, 13, and 18. At the state-level the changes from baseline to ongoing review varied among the well-being outcomes and performance items, however none of the state findings were found to be statistically significant. Each quarter, DCF meets with Quality Assurance Managers from the Regions, CBCs, and Sheriffs that conduct investigations

to review the CQI process, progress, improvements, data, and to discuss improvement activities. At these meetings members from CBCs, DCF, and Sheriff's offices share current initiatives in place to improve outcomes. The most notable initiatives discussed at the March 2018 quarterly meeting were initiatives to increase family engagement.

Cost analysis. The cost analysis in this report examined aggregated expenditure data from SFY 04-05 through SFY 15-16. Compared to the pre-Demonstration period, expenditures for front-end prevention services increased during the initial Demonstration and have continued to increase during the Demonstration extension. Consistent with one of the goals of the Demonstration, the ratio of expenditures for licensed foster care to expenditures for front-end prevention services has trended downward over time. This report also examined child-level data on costs as reported by fiscal agencies, and examined the relationship between specific child and parent characteristics to the likelihood of a child having a high-cost case. Overall, a high cost case tends to involve an older child that is more likely to be a victim of sexual abuse and/or neglect, with parents that were more likely to abandon the child or be unable to provide care. However, parental substance abuse or domestic violence in the household is less common. Such children are more likely to have very severe behavioral problems perhaps reflecting the severity of the maltreatment and/or the severity of the child's mental health problems.

Sub-study one: cross-system services and costs. The goal of the cross system services and cost sub-study is to better understand the Medicaid-funded services received by youth before and after entering out-of-home care. The majority of youth that receive in-home child welfare services are Medicaid enrolled and used Medicaid-funded services. SAMH was not a substantive funding source for these youth. More youth used Medicaid-funded services after in-home child welfare services began, although use declined over the duration of in-home child welfare services. More specifically, there was increased use of physical and behavioral health outpatient services, targeted case management, and treatment planning services. Medicaid-funded service use was not associated with the reason for in-home child welfare services. Further research is needed to determine if the decline in service use during in-home services is medically warranted, why the reasons for the receipt of in-home services were not associated with Medicaid-funded services, and whether Medicaid- and/or SAMH-funded services enable the children to remain in the home and avoid the need for out-of-home placement.

Sub-study two: services and practice analysis/outcome analysis for safe, but high risk for future maltreatment. For this report sub-study included a set of case file reviews,

within Eckerd Community Alternatives provider network. Eckerd Community Alternatives (Circuit 6) was selected for this analysis by identifying the number of cases from each agency that met the intervention criteria and selecting the agency with the highest number of qualifying cases. For the majority of the nine cases reviewed, children were determined to be safe but high or very high risk, and thus appropriate for Family Support Services.

With regard to family assessment, three of the cases reviewed did not have an initial Family Functional Assessment (FFA) in the file, although it is entirely possible that the FFA was completed and simply was absent from the case management case files. For all six cases, the FFA-initial included an assessment of the caregivers' protective capacities, safety, risk, and the family's needs. The services provided to families varied depending on their particular needs, but frequently included services such as individual and/or family counseling, parenting and life skills education, psychoeducation regarding children's mental/behavioral health needs, and assistance with basic needs such as daycare and affordable housing. All cases included referrals to formal services, which generally (though not always) matched the identified family needs. The majority of cases (n = 6) did contain some indicators of ways in which case managers are responsive to family concerns and new or changing needs, as evidenced by the case manager's documentation of concerns expressed by the family or the identification of new needs arising over the course of the case and follow-up with service referrals. Additional strengths evidenced in these cases were that all the families appeared to have participated in the recommended services and many families expressed satisfaction with the services they received according to family surveys included in the files.

Introduction

The Florida Department of Children and Families (the Department or DCF) has contracted with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF) to develop and conduct an evaluation of Florida's IV-E Demonstration Project extension (Demonstration) that is effective through September 30, 2018. Florida's original five-year Demonstration Project was implemented in October 2006. The contract for Florida's IV-E Demonstration extension evaluation was executed in January of 2015 with the University of South Florida (USF). This semi-annual progress report provides an update of evaluation components completed during the reporting period of October, 2017 through March, 2018.

The context for Florida's Demonstration extension includes the implementation of Florida's Child Welfare Practice Model (child welfare practice model), which provides a set of core constructs for determining when children are unsafe, the risk of subsequent harm to the child, and strategies to engage caregivers in achieving behavior change. Child protective investigators (CPIs), child welfare case managers, and community-based providers of substance abuse, mental health, and domestic violence services share these core constructs. The goal is that implementation of the child welfare practice model will support decision making of CPIs, child welfare case managers, and their supervisors in assessing safety, risk of subsequent harm, and strategies to engage caregivers in enhancing their protective capacities, including the appropriate selection and implementation of community-based services.

Other key contextual factors for the Demonstration include the role of Community-Based Care (CBC) lead agencies as key partners, as well as the broader system of partners including the judicial system. Community-Based Care (CBC) lead agencies are organized in geographic Circuits, and they provide foster care and related child welfare system services within those circuits.

It is expected that the Demonstration extension will continue to result in the flexibility of IV-E funds. The flexibility allows for these funds to be allocated toward services to prevent or shorten the length of child placements into out-of-home care, prevent abuse, and prevent re-abuse. Consistent with the CBC model, the flexibility of the Demonstration has been used differently by each lead agency, based on the unique needs of each community. The Department has developed a typology of Florida's child welfare service array that categorizes services into four domains: family support services, safety management services, treatment services, and child well-being services. The typology provides definitions and objectives for the four domains as well as guidance regarding the conditions when services are voluntary versus when services are mandated and non-negotiable.

Evaluation Plan

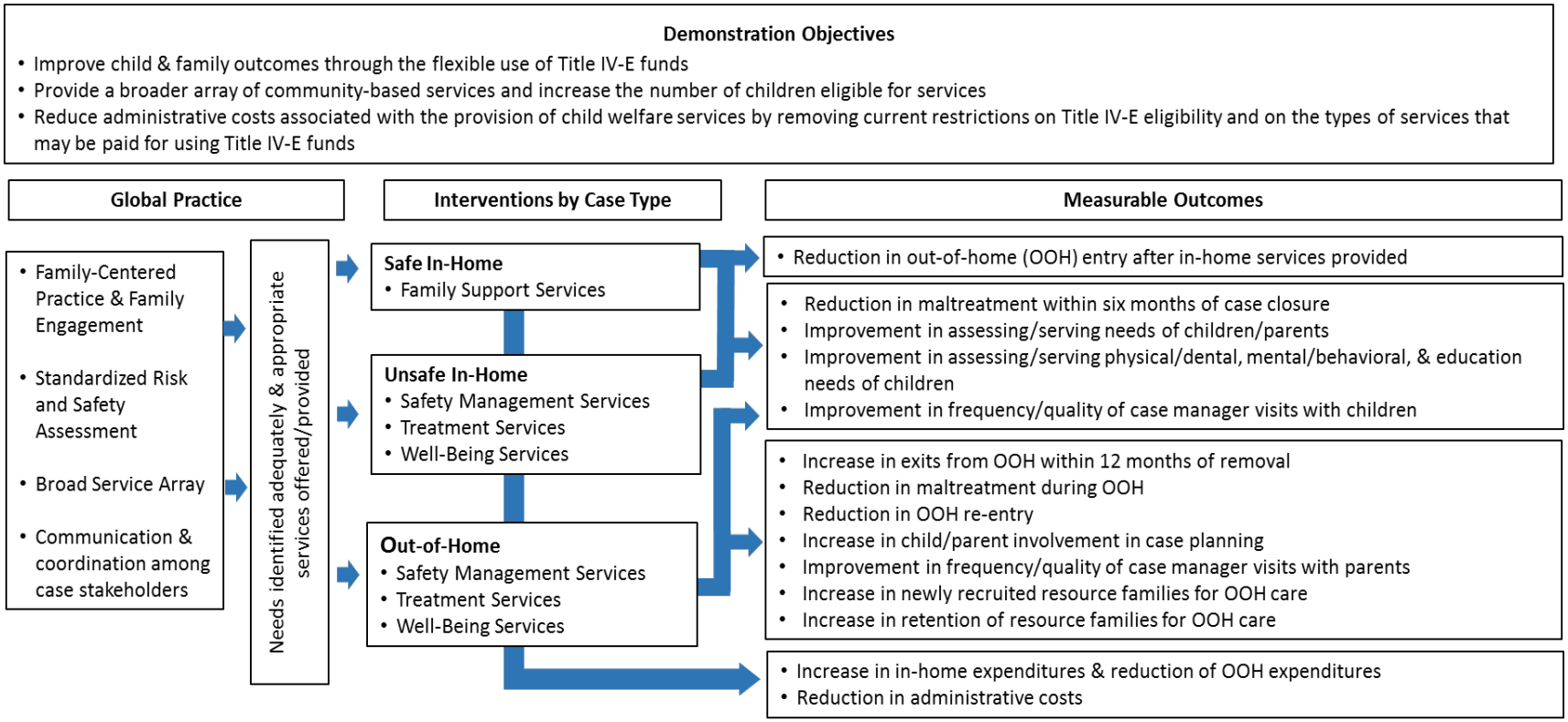
The goal of Florida's Demonstration extension is to impart significant benefits to families and improve child welfare efficiency and effectiveness through greater use of family support services and safety management services offered throughout all stages of contact with families. The evaluation design and outcome variables were selected for purposes of examining these aspects of Florida's child welfare system. The Administration for Children and Families has outlined Terms and Conditions for the Demonstration's extension. The Terms and Conditions include a requirement that the Demonstration evaluation be responsive to the hypotheses that an expanded array of community-based care services be available through the flexible use of Title IV-E funds will:

- Improve physical, mental health, developmental, and educational well-being outcomes for children and their families,
- Increase the number of children who can safely remain in their homes,
- Expedite the achievement of permanency through either reunification, permanent guardianship, or adoption,
- Protect children from subsequent maltreatment and foster care re-entry,
- Increase resource family recruitment, engagement, and retention, and
- Reduce the administrative costs associated with providing community based child welfare services.

The above listed outcomes are not addressed in every semi-annual report, but will continue to be addressed periodically throughout the evaluation of the Demonstration extension.

The Evaluation Logic Model (see Figure 1) displays the Demonstration objectives and how the implementation of the child welfare practice model can yield measurable outcomes for the Demonstration project.

Figure 1. IV-E Demonstration Project Evaluation Logic Model



Definitions:

Safe In-Home: The investigator determines that children are safe from impending danger but are at high or very high risk for maltreatment based on the completed Risk Assessment.

Unsafe In-Home: The investigator determines that there are present danger threats to the children, but there is at least one caregiver with sufficient protective capacities to maintain the children safely in the home with an active safety plan.

Out-of-Home: The investigator determines that there are present danger threats to the children and there is no caregiver with sufficient protective capacities to maintain the children safely in the home. Children are removed and placed in out-of-home care, and conditions for return that address the immediate danger threats to children are established.

The evaluation is comprised of four related components: (a) a process analysis containing an implementation analysis and services and practice analysis, (b) an outcome analysis, (c) a cost analysis, and (d) two sub-studies. The goal of the implementation analysis is to identify and describe implementation of the Demonstration extension. The services and practice analysis includes an examination of progress in expanding the array of community-based services, supports, and programs provided by CBC lead agencies or other contracted providers, as well as changes in practice to improve processes for identification of child and family needs and connections to appropriate services. The outcome analysis tests the relevant hypotheses listed in the amended Florida Demonstration Terms and Conditions by examining a variety of child-level outcomes that are expected to result from the extension of the Demonstration project. The cost analysis examines the relationship between Demonstration implementation and changes in the use of child welfare funding sources

One of the primary goals of the Demonstration is to provide greater flexibility in the use of funds to meet the needs of youth and families. To an important degree, such needs are addressed through federal and state-funded services brokered by CBC Lead Agencies. However, the SAMH and Medicaid programs are also important funding sources to address the needs of families in the child welfare system. To better understand the behavioral health care services received by children receiving in-home child welfare services, sub-study one performed a secondary data analysis to examine SAMH and Medicaid-funded services received by children in the child welfare system who have remained in the home.

The second sub-study examines the child welfare practice, services, and several safety outcomes for children who are deemed safe to remain at home, yet are at a high or very high risk of future maltreatment in accordance with the child welfare practice model and are offered voluntary Family Support Services.

The USF Institutional Review Board (IRB) has approved the evaluation plan. All study activities are conducted in accordance with the applicable regulations, laws, and institutional policies to ensure safe and ethical research and evaluation practice and to preserve the integrity and confidentiality of study participants and data. Informed consent is obtained from all participants. Electronic documents containing identifying information are password protected and stored on a secure drive accessible only to evaluation staff. Hard copies of documents are kept in locked filing cabinets when not in active use. When applicable, evaluation staff will obtain review and approval from state and lead agency IRBs.

This semi-annual report includes the results from aspects of the Demonstration evaluation. The implementation analysis component includes an analysis of stakeholder

interviews with leadership at Community-Based Care lead agencies. The services and practice analysis component provides a status update regarding the implementation of the evidence-based practice fidelity assessment, as well as, proposed changes to the service array assessment and next steps for the practice analysis. The outcomes analysis includes the examination of the proportion of all children who did not experience maltreatment within six months of case closure through several successive state fiscal years (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, and SFY 15-16), and findings related to well-being indicators. The cost analysis examines the trends in the numbers of youth receiving out-of-home, in-home, and adoption services, and the costs for those services. Sub-Study One looks at children and youth who receive in-home child welfare services and examine their health care utilization before and during in-home child welfare services. Sub-study Two describes findings from a set of case file reviews.

Process Analysis

The process analysis is comprised of two research components: an implementation analysis and a services and practice analysis. Descriptions of these components (goal, methods, and findings) are provided below.

Implementation Analysis

The goal of the implementation analysis is to describe the implementation of the Demonstration extension. This semi-annual report includes methods and findings from a set of key stakeholder interviews conducted with leadership at Community-Based Care lead agencies (CBCs) during the reporting periods of October 2017 through March 2018.

Methods. Eleven semi-structured stakeholder interviews were conducted via telephone with leadership at CBCs (see Appendix A for interview protocol). The interviewees represented 13 circuits. Interviews ranged from one to five participants. The interviews focused on successful services, the use of rapid safety feedback reviews, and the ending of the Demonstration.

Members of the Demonstration evaluation team at the University of South Florida conducted the interviews. The interviews were audio-recorded with the permission of the participants. Audio files were uploaded to a secure, shared site and files were then transcribed. The same project team members who conducted the interviews completed the coding and data analysis. All participants provided fully informed consent according to University Institutional Review Board policy (see Appendix B for informed consent document).

Data analysis. Interview data were coded using two overarching domains that provide a framework for conceptualizing systems change: service array and Demonstration impact. Data was analyzed with ATLAS.ti 6.2, a qualitative analysis computer software program. Interviewee responses were classified into codes that comprehensively represent participants' responses to each question. Three team members participated in an interrater reliability process that achieved a reliability score of 73%. Axial coding in ATLAS.ti 6.2 was used to group codes by domain and to see how ideas and emergent themes clustered. Selective coding was applied to pull specific examples from transcripts that were illustrative of key points (see Appendix C for code list). This semi-annual report includes the most commonly found patterns and themes from the interviews.

Findings.

Family support services. Interviewees were asked to describe the most successful family support services for families served by their CBC. Family support services were defined as: voluntary, supportive family services to prevent future child maltreatment among at-risk

families. The successful services reported ranged from co-locating staff to the use of California Clearinghouse evidence-based practices. At least 13 different family support services were reported as being the most successful for families across circuits. Successful service providers reported were Boys Town, Camelot, Behavior Basics, Castle, and C.A.R.E.S. Successful services were: Nurturing Parenting, Nurturing Fathers, Wraparound family support models, Behavioral Educational Therapy, and a Family In-Home Research Support Team. One interviewee stated,

> We subcontract now with a single agency, which is Boys Town, for family support services. And they do intensive in-home case management and linkage on safe high-end, very high at-risk kids and it's been successful, in the sense of keeping families together and not ultimately having future formal entry into the dependency system.

All interviewees reported using family support services that were successful in diverting children and families from entering out-of-home care.

Respondents were also asked if their family support service array included any evidence-based or promising practices. Respondents from 10 circuits reported offering evidence-based or promising practices. The reported practices and programs include: Family Connections Program, Nurturing Parenting, Nurturing Fathers, the C.A.R.E.S. model, MultiSystemicTherapy, Home Builders, Family Builders, and Children to Action Teams. Two programs with high success rates were Behavior Basics and Castle. Behavior Basics and Castle were described as providers of in-home programs for families deemed safe with high or very high risk. Castle was described as using three evidence-based models in their service delivery. One interviewee described the success rate of the two programs,

> Behavior Basics has, for three years running, like a 98 percent success on the outcome of families who successfully complete the program, don't have any verified abuse and neglect within 12 months following services, and Castle is close behind with 96 percent.

Another evidence-based practice that was reported by interviewees was the wraparound family support model. One respondent stated that they were not seeing the outcomes they wanted with a previous family support service array, so they came together to decide on and implement a new wraparound family support model,

> We went through a process by which we had our existing providers trained and certified by the national center for innovation and excellence in the wraparound model and that is the service line now that we are using on our safe but high and very high risk families. And we're finding so far that those services are much more successful, we're able to actually measure six, 12, and 18 months post services, we're not quite to the 18 month

> mark yet but we're seeing across all providers, one in each county, that very few folks that have actually successfully complete the entire wraparound support process are not coming back.

The C.A.R.E.S. model was also reported as a “level three” California Clearinghouse evidence-based practice that is a wraparound approach being used for family support services (a specific example of the success of this model is described in the *Impact* section of the implementation analysis). Respondents also reported that there is fidelity monitoring conducted with their evidence-based and promising practices. For example, Circuit Seven reported using the “NCFIE” (National Center for Innovation and Excellence) to ensure fidelity. The NCFIE was described as a

> Team of people that work with us to ensure fidelity with a model. Everybody has to be trained for the model, and there’s weekly supervision training and there’s the supervision guidance feedback and, everything else is directly related to the fidelity in the model. Then we have to submit outcomes related to the fidelity [of the] model as well. So, the whole program [is] based on this two-step fidelity model.

Safety management services. Interviewees were also asked to describe which safety management services have been the most successful for the families served by their agency. Safety management services were defined as: safety services actions, tasks, activities, and other imposed situations that may be formal or informal and provided by professionals and non-professionals for the purpose of managing or controlling impending danger threats and documented in a safety plan. Safety services must be capable of having an immediate effect, must be immediately available, must always be accessible, and must be sufficient to control impending danger. Interviewees were also asked if they provide both formal and informal safety management services, and if the services were offered to both CPIs and case managers.

Respondents unanimously stated that they offer both formal and informal safety management services. The interviewees also noted that the contracted providers offering safety management services have identified and expanded the informal safety supports for families. Formal safety management services included crisis management teams, safety management services teams, mobile response teams, Family Builders, ERAT (Emergency Response Assessment Team; available to CPIs), House Next Door (available to case managers), and a SMART program (for CPIs designed in partnership with CPIs). One respondent reported on the successes of a formal safety management service that was implemented after the implementation of the child welfare practice model,

> Once we had switched over to the new practice model, we created the safety management services team. And that was in April of 2015. We started it as a pilot, and it was very successful. We started one team, and then, we expanded to two teams, and it's been well-received and utilized by the CPIs.

Informal safety management services included faith-based community programs, relationships with learning coalitions, and supports identified by case managers. One respondent highlighted some of the faith-based programs available to the families served by their agency, "So, informal, we use, there's a program called GRIP, and it's God Raising Incredible Parents. And also, BAANK. It's B-A-A-N-K…It's faith-based, but they do some respite and supervised visits."

Treatment services. Leadership at lead agencies were asked which treatment services they had found to be the most successful for parents and caregivers served by their CBC. Treatment services were defined as specific, usually formal, services/interventions to achieve fundamental change in functioning and behavior associated with the reason that the child is unsafe.

First, respondents talked about the importance of a wraparound approach with families, as seen in the Placement Partnership Program, which was described as being very family-centered, where informal supports were valued as much as formal supports. Second, respondents discussed the positive impact of co-locating services for families, as seen in the Kids in Distress model where services inclusive of parent education, domestic violence intervention, substance abuse outpatient treatment, and mental health counseling and therapy are coordinated for families.

Third, respondents discussed the value of behavioral analysis being included in programs, as happens in Parenting for Success. For example, if caregivers are having trouble maintaining a placement due to behavioral issues, there is an in-home component of behavioral analysis where they go in and give them child-specific assistance with creating a behavior plan and helping the caregiver to monitor that plan and to understand the child's behaviors and be able to manage it and keep the child stable. In addition, a nine-hour behavior training for caregivers is offered that helps supplement original foster parent training in cases where a child's behaviors may be more intense than the original training covered.

Fourth, the importance of services that "put trauma first" was discussed. A stakeholder explained,

> If you can get practitioners and/or service programs or service arrays that truly are trauma integrated and addressing the multiple generations of trauma that our families

> bring, those are the services that can actually bring about sustainable changes and really life altering changes for our families.

This process was perceived as focusing less on DSM (Diagnostic and Statistical Manual) diagnoses and more on the actual trauma history and helping parents come to terms with what they had been through in their lives and how to put that into perspective and be able to begin to heal from it and move forward so that the trauma is not being acted out through addictions and inappropriate and unhealthy interpersonal relationships. Substance abuse programs, in particular, were perceived as having more success if they placed emphasis on dealing with the role of previous trauma in addictions treatment. Another specific example provided was a trauma informed parenting class. An interviewee described,

> They use the nurturing parenting curriculum, but when a parent comes in, they do a trauma screening on them to see, the specific track is for parents that have had past trauma that might be affecting their parenting. Then they would receive concurrently or perhaps in order some trauma treatment by a licensed provider.

Fifth, the practice of having a behavioral health consultant work with CPIs was mentioned as being successful. These consultants work to help investigators identify parents with mental health issues. A stakeholder explained,

> We've found that to be an issue in our integration meetings, is that oftentimes the [C]PIs didn't feel comfortable identifying mental health issues of the parents, and by having behavioral health consultants as part of that team, they're able to early identify parents that might need some ongoing mental health services which we then work with our partners to ensure families are engaging in those.

Sixth, programs treating substance abuse were discussed. The FIT (Family Intensive Treatment) program was identified as being a successful treatment option, although respondents noted that an increase in capacity of the FIT services was needed. Key aspects of this program's success were that it was voluntary (so that it tended to draw parents seeking a change) and that it was offered in the home so that parents did not have to depend on transportation or scheduling to get to a provider agency. An interviewee described, "The FIT program integrates both child welfare and substance abuse behavioral health side in order to wrap around the family and ensure that they're receiving services in home." The second substance abuse service mentioned was a substance abuse call center. This program originated due to a problem in families being referred for substance abuse treatment, but quickly dropping out due to a lack in engagement early on. An interviewee explained,

> So, what we designed with our managing entity was called the substance abuse call center. So, you have a PI who's working, or a case manager for that matter, who's working with the family. They're identifying if there is potential substance abuse treatment needs. They're able to pick up the phone if managed by our local 211, call 211, and get connected with a specific department within 211 that connects them immediately with a substance abuse assessment. The call center line actually makes that appointment with and for the family while they're on the phone together and then does follow up to ensure that they've not had any barriers to keeping that appointment. We've seen our engagement rate of families actually getting to the treatment providers go up significantly since we put this into place.

The third substance abuse program mentioned as being successful was residential substance abuse treatment. A component of the residential treatment allows the mom to take the baby or young child with her into the residential program, which was perceived as critical to families entering and staying in treatment and getting good outcomes.

Finally, gaps in treatment services were addressed by a few respondents. Most prominent was the need for more substance abuse services. A stakeholder described, "We do have FIT, but the availability of timely substance abuse services remains a significant issue." Another frustration expressed was that while services had improved significantly for children, particularly with the integration of substance abuse and mental health, services in the adult arena had remained painfully siloed, such that getting responsive and timely services for parents was very challenging. An interviewee articulated,

> I don't know that we're any more likely to get a parent of a child in foster care timely and effective behavioral health interventions today as we were ten years ago. I think that's unfortunate and should remain a key priority. We've got waiting lists, we've got duplicative assessments and confusion for the parents; all of the ground that we have covered on integrating the children's intervention, I think we've done a lousy job of really making system reform as it relates to the parent.

Child well-being services. Leadership at CBCs were asked which child well-being services such as educational, physical health, dental health, and behavioral health they found to be the most successful for children served by their CBC. Child well-being services were defined as specific, usually formal, services/interventions utilized to assure the child's physical, emotional, developmental, and educational needs are addressed. The assessment of the child strengths and needs indicators is used to systematically identify critical child well-being needs that should be the focus of thoughtful, case plan interventions. Emergent themes included

improvements in dental care, discussion of the impact of the Child Welfare Specialty Plan, use of non DCF or Medicaid resources to fund well-being services, and expansion of the service array.

Several lead agencies spoke about improvements in dental health. One interviewee stated that it was now twice as likely that a child involved in Florida's child welfare system would receive routine dental care compared to a child in the general Medicaid population. The concept of a mobile dental care clinic was being utilized in some parts of the state to get care to areas that did not have established pediatric dentists. As part of this discussion it was also acknowledged that dental care had been an indicator in the past that lead agencies had struggled the most with. A stakeholder summarized, "kids in foster care over the last seven years have gone from being 20 or 30 percent likely to get a routine dental checkup, to more than 70 or 80 percent, which is comparable to the general population." Another stakeholder expanded this to mental and physical health stating, "if a child has a mental health, substance abuse, or a [physical] health related incident, I think they get better and more timely care in Florida than we have ever delivered."

In keeping with this discussion was the role of Sunshine Health in providing the Child Welfare Specialty Plan, which provides coverage for most mental and physical health care and dental services. Overall, impressions of the Plan were positive, with the caveat that more expansion of services was needed. A stakeholder commented, "the availability of a child welfare specialty plan under Medicaid has helped overall child well-being dramatically." Another shared, "we have several providers that are very accessible, that we have great working relationships with." The Plan was cited with being very helpful with everything from routine immunizations to complex medical needs and orthodontics. Another success factor shared was that lead agencies had become more adept at insuring that every dependent child was Medicaid eligible to maximize the benefits provided by the Plan.

Third, there was discussion about services and material items provided to children that increased their well-being, which were not funded by DCF or Medicaid. These experiences included everything from extracurricular activities, sports, art, music, musical instruments, sports gear, prom dresses, tutoring, and mentoring. Anything that would create more normalcy and inclusion in a child's life was seen as beneficial to improving child well-being. While some of these items were billed to DCF, there were also examples of community funded initiatives to provide such goods and services. Another important resource mentioned were foster care support groups for children in the community that provided youth with ongoing support and services after they had left the formal child welfare system. Educational mentoring and tutoring

was again highlighted as a key aspect to these types of supports. Educational mentors that would stay with a child even if they moved counties were mentioned as a successful support of child well-being.

Fourth, lead agencies mentioned that behavioral health services becoming more trauma-informed had supported and improved child well-being. One stakeholder stated, "we've seen very promising outcomes with our early childhood court program and that CCP mode of counseling has been a big factor in our success." Another interviewee believed that their agency's Medicaid providers had gradually become more trauma-informed over time, and there was mention of becoming a more trauma-informed system of care overall. Finally, one lead agency interviewee stated, "if we've got people who are understanding of complex developmental trauma and what it takes to help children through that, those are the most effective interventions and services that we're seeing."

Additional themes around behavioral health services included therapists who focused on the younger age range and play therapy, and the importance of comprehensive behavioral health assessments. One interviewee stated,

> They are a huge piece in our system and really identify a lot about the child's needs in all areas, whether it is behavioral, physical, educational or whatever. Obviously, those are extremely important to us in identifying what we need to do for the kids.

One lead agency mentioned that getting behavioral analysis services covered by Medicaid had been critical. In addition, behavioral health coordinators were mentioned. An interviewee explained,

> We have one behavioral health coordinator and one clinical services specialist that sits with any child that needs a higher level of care or that perhaps case management just needs some advice on which direction to go on clinical services.

Another staff position that had been created was a psychotropic medication specialist who worked on the front end when a child is sheltered and on psychotropic meds. The medication specialist reaches out to the caregiver and to the parent, coordinates an initial visit with the psychiatrist so that they can get parental consent, and encourages parental involvement (as opposed to trying to get court orders for the child to be on meds). The medication specialist goes to the appointment with the caregiver and the parent. In cases where the parent is not present, the specialist makes phone contact from the doctor's office, so that the parent is included and has an opportunity to know what's going on with their child. Finally, the medication specialist works with case management on any issues that they have on psychotropic medications during the lifespan of the case.

Nursing staff teams were mentioned as a key service to supporting child well-being. An interviewee explained, “We have a nurse care coordinator supervisor along with four other nurses.” Under this model, when a child transitions over to a lead agency from CPI the nurse immediately reaches out to identify who the child’s medical providers are, obtain medical records, contact the caregiver, ensure a child wellness and dental exam is done, and ensure that any follow-up needs for the child are being met or services are scheduled to meet them. Also, under this model, a nurse with tenure is specifically assigned to all of the medically-complex youth, conducting periodic reviews of their files and ongoing follow-up. In addition, when a child comes in for medical neglect, a nurse care supervisor sits in on the case transfer staffing between the CPIs and the case manager to make sure that if the child’s coming in with significant medical needs that haven’t been addressed that the lead agency is addressing those needs.

Stakeholders were also asked to describe any gaps that existed in child well-being services in their area. Two themes emerged. First, in some geographic areas, medical and dental service provider networks were simply too thin and needed developing/expanding. Second, expanding residential care, specifically, was raised. Regarding this, there was a perceived need to better serve children requiring a higher level of care than typical residential care, but whom did not qualify for SIPP (Statewide Inpatient Psychiatric Program) placements via the suitability assessment. The suggestion was made that another level of care be added to residential care that would include children with developmental disabilities, behavioral challenges, crossover youth (in both the child welfare and juvenile justice system), and sexually reactive youth. Examples were given of having to place children out of state to find suitable residential placements, with the desire and hope expressed that Florida would develop these types of placements so that this type of cross country placement did not happen. An interviewee commented, “the notion that we can't find those things in Florida really troubles me.”

Rapid safety feedback reviews. Stakeholders were also asked to discuss whether the Rapid Safety Feedback reviews have improved practice for their CBC. First, as part of this discussion several interviewees detailed how the Rapid Safety Feedback reviews occurred at their agency. Typically, agencies completed at least 10 reviews per quarter. Interviewees described the target population as cases with very young children (e.g. 0-3 years). Files meeting inclusion criteria were selected randomly. Immediately subsequent to the review (24-48 hours), a consultation occurs with the case manager and their supervisor. When immediate safety concerns are identified, a Request for Action is issued and tracked until follow up results

in the danger threat being sufficiently managed. This information is also shared with the Department, and then the results are aggregated at the Statewide level.

The majority of respondents felt that the reviews were helpful and useful. Reasons given for this included the ability to address safety concerns in real time, being able to focus on the most vulnerable population (0-3 years with substance abuse and domestic violence accusations), having another learning tool to support the coaching process between supervisors and case managers, and simply having "another set of eyes" on randomly selected cases, causes new and different issues to be brought to the attention of the lead agencies. A stakeholder commented, "I think it gives us a better idea of looking at a variety of different cases, not just the ones that are being brought to our attention." Additional strengths included the reviews providing staff with a better understanding of family and cultural dynamics as they relate to high risk and abuse situations. Lead agencies described staff looking deeper at parent's protective capacities as a result of the review process. One stakeholder commented, "I guess it really puts the social work back in the process [of casework]."

There was a perception among some interviewees that the reviews had increased the quality and frequency of family visits. One respondent discussed increased focus on talking to youth alone and talking about a child's plan at every visit, in addition to getting fathers more involved in the process of visiting. Another respondent discussed the impact of meeting in person to discuss the case rather than over the phone. Additionally, there was the perception that the reviews had helped staff create improved sufficiency. An interviewee described,

> I believe that the rapid safety tool has helped us to focus in on what creates sufficiency and how it needs to be followed up to make sure that the safety plan is being followed by the providers that are supposed to be providing it.

A limited number of interviewees felt that the review process was flawed. Reasons for this included some lead agencies not having enough of the target population to support a sufficient sample size, which has led to some lead agencies expanding the population age range upward. Another concern expressed was the low level of inter rater reliability. These respondents were quick to clarify that the review process was better than those in the past:

> I think most of the historic federally pushed quality reviews are not effective. They tend to be far too retrospective and far too, random to really have a timely impact on services and systems. And I think a move to more timely feedback is helpful.

Other comments included the review process still being too compliance driven and proscriptive. Within this discussion the suggestion was made that Rapid Safety Reviews occur earlier. An interviewee detailed,

> I think, typically what I've seen is from the reviews, they're picking up items that, in child welfare in 45 days everything is stale and a lot of times to go back to collect something or do something that should've been done in the first three weeks of the case, so if that process could be a little bit earlier I think it would be most helpful.

The suggestion was made that Reviews occur when a case is still with CPI and that outstanding items identified could be transferred to the CBC.

Demonstration impact. The final set of interview questions for the implementation analysis for this report addressed issues related to the ending of the federal Demonstrations. The questions included perceptions about the overall impact on CBCs that would occur when the Demonstration in Florida ends, including the effects on overall service capacity, and the specific challenges related to funding of innovative services, prevention services, and services designed to prevent child removals. The final question was about alternative revenue sources that could replace IV-E funds. It is important to note that some interviews occurred before passage of the Family First Services Prevention Act and some took place after its passage.

There was consensus among the interviewees that the loss of the flexibility of the Demonstration funds would be irreplaceable and would have a highly detrimental impact on Florida's child welfare system of care. Responses to this question included: "I think that that's an absurd question," "None of it will replace federal participation," and "Revenues locally are so limited that it would in no way be able to support or sustain all the programs to any kind of capacity." Several interviewees also noted that state general revenue resources in Florida are "scarce" for human services such as child welfare, mental health, and substance use services. The example of one respondent was that currently Demonstration funds represent about 75% of the cost of their service array, at an annual cost of $3,000,000. Without the Demonstration, "you restrict it to eligibility, to only those people who are in out of home care."

Another theme that emerged from the interview data was the loss of the child welfare system of care that CBCs gradually built over the course of Florida's two Demonstrations. "I would just say that we changed the nature of child welfare in the state of Florida with the IV-E Waiver. Our capacity to build individualized services around families started with that Waiver." As another respondent reflected, CBCs across Florida have capitalized on the Demonstration's potential by keeping the focus on the front-end of the system and therefore reducing the number of children being removed and the number of children coming into the formal dependency system. In addition, despite challenges that have occurred such as the recent opioid crisis, Florida today has fewer children in foster care than in 2006 when the Demonstration began. One example of this incremental evolution is Brevard C.A.R.E.S., a program that is now on the

California Evidence-Based Clearinghouse for Child Welfare. This model was initiated in 2004 and over time has become a robust prevention and diversion model for at-risk families "before they reach the threshold of abuse." C.A.R.E.S. uses a wraparound approach with access to the full continuum of services that are available for families in the dependency system. The example below, taken from a recent C.A.R.E.S newsletter, illustrates the strengths of their model.

> *We recently received a homeless family in desperate need of permanent housing and stability after being homeless and living in their car for over a year. The team consisted of a mother, father, and their two daughters, one of whom had Down's syndrome.*
>
> *Added to the team were: a DCF Child Protective Investigator, who was able to get his Priest to pay for a night hotel stay as well as personal hygiene products for the family, a Brevard C.A.R.E.S. Housing Specialist, who secured a foster home for the family cats, as these were vital to the family's well-being, a Hope Village Manager, who provided shelter support for five days until housing could be established, a General Manager at Walmart provided the family with a $25 gift card to purchase any essential items after he heard the story of the family and felt compelled to assist, a Care Coordinator, a Family Partner who facilitated the family team meetings and provided a referral for family counseling with Caribbean Community Connection of Orlando to further assist the family with their emotional needs, as well as the friends/family that have assisted with hotel rooms, temporary shelter, and food.*
>
> *Although the family continues to have challenges, the strength of the team continuing to meet weekly with the family to help them press towards the goal of self-sufficiency is commendable. Everyone has come together as one to help fight alongside this family and I am extremely proud of this team who have exemplified the "Whatever It Takes" attitude.*

During this discussion about the theme of loss, another interviewee noted,

> We've taken advantage of the Waiver from the day one and evolved and refined our service array for at risk families over time…As of four years ago; we're investing 10% of our total budget to family support services. We were able to do that because we had seen a reduction in out-of-home care, so we reinvested, as the Waiver allows, to the front end.

In this discussion, some respondents noted that with the implementation of the child welfare practice model, there was a need to re-examine and adapt what CBCs offer both to families and to CPIs. Again, the funding flexibility made possible by the Demonstration allowed for this

adaptation to a more evidence-based and targeted approach. Another interviewee noted that the child welfare practice model can be a vehicle for the Department and CBCs to rethink the concept of diversion so as to keep children with their families without bring them into dependency case management:

> We have a lot more ability to meet families where they're at whenever they are served outside of the formal dependency system. Once they are in the formal dependency system, this really is a legal process and that drives what gets in the case plan.

The process can be much more consumer driven outside of the court system using family engagement tools such as family group decision-making. In summary, one respondent observed,

> We've taken full advantage of the Waiver and we are continually reflecting on and adapting our front-end service end service array and continually looking at how we can make it more effective to support these families and safely prevent removal.

In the discussion about use of Demonstration funds to prevent out-of-home placements, one CBC has implemented an intensive family services team model that works in collaboration with CPIs to maintain children in the home. The team does case management with the family for six to nine months to ensure that the children are safe and that families are getting the supports and services needed. Recently the CBC has added a master's level certified addictions professional that meets with the parents wherever they are, including in jail, and attempts to engage them in community substance abuse supports such as Alcohol Anonymous, Narcotic Anomymous, 12-step programs. The CBC is also starting a new opioid abuse support group to address this growing concern. Another focus of this CBC is lockout calls where a child with high needs is being discharged from a crisis unit or DJJ and the family is struggling. A family preservation specialist works with the family, community providers, and DJJ to prevent child placement. Finally, the CBC has created a Kinship Unit made up of certified case managers with some additional training. A team member attends all shelter hearings and works closely with families to identify relative or nonrelatives that could care for the children rather than a foster family placement. The team does the home study to try to expedite child placements into kinship-type settings, either relatives or non-relatives. Family Finders is the model for the unit but the new intervention takes several steps beyond Family Finders by making a recommendation about whether the family would be a suitable placement or a good connection for the child. The CBC also sends a resource packet of information to kinship families that focuses on funding resources for the kinship caregivers. All of these programs were possible because of the funding flexibility that comes with the Demonstration. One irony noted was that

the CBCs most successful in maintaining a reduction of placements through these programs will be the organizations most affected by loss of Demonstration funds because funds will be limited to children in out-of-home care.

Respondents also noted that the Demonstration's funding flexibility allows an immediate response to concrete needs and crises that families sometimes experience. Examples included repairs on houses with hazardous conditions, paying for a new water heater, and working with landlords on arrangements such as the CBC paying a family's rent for a few months. "I would rather fix the house than, remove children and put them through the system due to parents' financial inabilities."

Regarding the impact on innovative services, two CBC respondents identified community resource centers as innovations. Partnership for Strong Families, e.g., worked with Casey Family Programs to plan and implement three resource centers, two in Alachua County and one in Levy County, that are freestanding centers where community members can come to access concrete supports and services. These centers are partially funded with Demonstration dollars and may need to close or be scaled back. The Sarasota YMCA has an innovative funding arrangement with a local foundation and county governments in Manatee and Sarasota that funds a new early childhood court. The funding arrangement includes the CBC, the Brunswick Foundation, the Children's Services Council in Manatee County, and Sarasota County local government. The funding covers two physicians, a therapist, and a community coordinator for the new court.

There was consensus across participants that prevention services and programs would be highly vulnerable to elimination or reduction with the loss of Demonstration funds. Respondents identified many examples of violence prevention programs, family preservation services, mentoring, immediate response crisis intervention, teenage pregnancy prevention using evidence-based approaches, deployment of specialized personnel to child protective investigation units, assisting families with transportation and housing issues, and safety management services. For example, one CBC has a program called Measuring for Educational Success that is a partnership with the Bachelor's level and Master's level social work programs at Gulf Coast University. Students are paired with youth in foster care and in in-home care for a 10-week period where the focus is helping youth to understand how important education is to their future success. Another example is a partnership with United Way where together, the YMCA and the CBC recruit and train volunteers and match the volunteers to families at the point of reunification. The volunteer assists the family during post placement; the relationship sometimes continues beyond case closure.

Six participants mentioned Children's Services Councils (CSC) as a resource for prevention programs. For example, ChildNet has a relationship with the CSC in Palm Beach County and the two share the cost of Triple P, an evidence-based parent education program that is available to families in the dependency system.

On the other hand, most interviewees did identify a number of alternative funding sources that could partially make up for the loss of Demonstration funds. One theme that emerged from several participants was the goal of diversification of funding sources. Examples included contracts with county governments and state contracts, HUD funds through the local homeless services network, contracts with Career Source, use of Medicaid providers for substance use and mental health treatment services, and use of mental health and substance use block grant funds. Potential local resources included local United Ways, Children's Services Councils, private foundations and donors, and pursuit of opportunities jointly with Casey Family Programs.

Another potential funding source was re-visiting Medicaid targeted case management including the wraparound billable codes that some Medicaid managed care organizations in Florida are using. One of the challenges of this strategy is the need to use general revenue funds as a match. However, an advantage noted is that it would be a step towards the integration of child welfare and behavioral health funding streams. Mention was also made of the potential of a one-year extension of the Florida Demonstration as a short-term solution and, the Family First Services Prevention Act once implemented and the existing candidacy provision in IV-E language for children at imminent risk of removal.

A strength noted by some participants regarding the identification of future alternative funding is the strength of the partnership today between the Department, the Florida Coalition for Children, and the CBCs. The Department is actively engaging the Coalition on several priorities such as the ending of the Demonstration, the parental services array project, and the children's services array project. Despite the optimism regarding this partnership there was realism about not being able to fully replace Demonstration funds,

> I know that the Coalition for Children is working closely with DCF trying to guard this program or any way that other federal dollars could be brought in, but I don't think it will be able to fill the hole.

During the interviews that occurred after passage of the Family First Services Prevention Act[2], there was cautious optimism about the future including the decision that prevention dollars will be "separate" and not require the IV-E eligibility requirements. Participants also voiced concerns about some of the limitations in the new federal language, such as the restrictions on federal funding of residential group care.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. For the current report, a status update is provided regarding the implementation of the evidence-based practice fidelity assessment, as well as proposed changes to the service array assessment and next steps for the practice analysis.

Methods. Previously, two surveys were administered to CBC lead agencies to gather information about child welfare services provided throughout the state: a service array survey and an evidence-based practice (EBP) survey. As described in prior reports, both surveys were administered via *Qualtrics*, a web-based survey program, using a five-wave mailing strategy to follow up with non-responders (Armstrong, Vargo, Cruz et al., 2017). During the current reporting period, additional follow up was conducted by email with lead agencies who had not responded to the evidence-based practice survey to identify which agencies provide the two selected EBPs (Wraparound and Nurturing Parenting Program). Once responses were received from all lead agencies, the evaluation team began reaching out to those agencies who reported that they include either of the two EBPs in their service array to discuss their potential participation in the fidelity assessment study. The evaluators are currently conducting calls with lead agencies and providers to learn more about how these services are used, what if any data is currently collected, and explain what the options are for participating in the statewide fidelity assessment.

Findings. All 18 CBC lead agencies have responded regarding their inclusion of Wraparound and Nurturing Parenting Program as part of their child welfare service array. Table 1 provides the full list of lead agencies and which of these services they offer. There are 14 lead agencies (77.8%) that currently include Wraparound as part of their service array, and nine lead agencies (50%) that include the Nurturing Parenting Program. Six lead agencies reported

[2] "On February 9, 2018, President Trump signed into law the landmark bipartisan Family First Prevention Services Act, as part of Division E in the Bipartisan Budget Act of 2018 (H.R. 1892). Family First includes long-overdue historic reforms to help keep children safely with their families and avoid the traumatic experience of entering foster care, emphasizes the importance of children growing up in families and helps ensure children are placed in the least restrictive, most family-like setting appropriate to their special needs when foster care is needed." (Children's Defense Fund, 2018, p.1)

that they offer both services as part of their service array. Furthermore, only one lead agency reported providing neither of these two services. The evaluation team is still determining to what extent agencies currently assess practice fidelity to these EBPs.

Table 1

Provision of Wraparound and Nurturing Parenting by CBC Lead Agencies

Circuit	CBC Lead Agency	Wraparound	Nurturing Parenting
1	Families First Network	Y	-
2 & 14	Big Bend Community Based Care Inc.	Y	-
3	Partnership for Strong Families	-	Y
4	Family Support Services of North Florida	Y	Y
4	Kids First of FL, Inc.	Y	-
7	Community Partnership for Children, Inc.	Y	-
7	Family Integrity Program (St. Johns County)	Y	Y
6	Eckerd Community Alternatives (Pinellas/Pasco)	Y	-
12	Sarasota Family YMCA, Inc.	Y	-
13	Eckerd Community Alternatives (Hillsborough)	-	-
20	Children's Network of SW FL	-	Y
5	Kids Central Inc.	Y	Y
9 & 18	Community Based Care of Central FL	Y	Y
10	Heartland for Children	-	Y
18	Brevard Family Partnership	Y	Y
15 &17	ChildNet, Inc.	Y	-
19	Devereux Community Based Care	Y	-
11 & 16	Our Kids of Miami-Dade/ Monroe	Y	Y
Total # of lead agencies offering service		14	9

Next Steps. The evaluation team will complete planning calls with lead agencies to gather information about their provision of the two EBPs and current fidelity measurement by May 2018 and begin implementing protocols for the statewide fidelity assessment. Agencies that already collect fidelity data will be able to simply provide their data to the evaluation team.

The expectation is that aggregated fidelity data from participating agencies will be available to provide in the next semi-annual report.

With regard to the larger service array assessment, some proposed changes have been discussed with the Department. It was agreed that the original service array survey was too broad in scope, which caused too great of a burden on lead agencies and led to a poor response rate. Moving forward, the evaluation team proposed to focus data collection on the two selected EBPs, rather than request data on all services that child welfare-involved families may receive. Thus, in addition to measuring fidelity for the two EBP programs, evaluation team members will gather data from lead agencies on how many families were referred to and received each EBP service, the average duration of services, and processes for determining eligibility and making referrals. This will be much more feasible for lead agencies than attempting to collect such data on every child welfare service that is provided. This data will be collected over the next few months and reported in the next semi-annual report.

Finally, a second round of child protective investigator and case manager focus groups will be conducted in the upcoming months to look at any changes in practice and the service array from the perspectives of front-line workers. The evaluation team will select six circuits to participate (ensuring that they are not the same circuits that participated in the first round of focus groups). In an effort to be representative of different areas of the state, one circuit will be randomly selected from each of the six regions. Focus groups will be completed during the summer of 2018.

Outcome Analysis

Safety Outcome

One of the goals of the Demonstration extension is to improve safety outcomes for children. Specifically, it is expected that the increased funding flexibility and expanded child welfare services will reduce the risk of re-abuse and reentry into out-of-home care. Enhanced and extended services provided to families after reunification should significantly reduce the number of children who experience another child protection investigation, recurrence of maltreatment, or who reenter out-of-home care. The focus of this report is on the outcome of recurrence of maltreatment after termination of services.

Methods. The outcome analysis tracks changes in five (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15 and SFY 15-16) successive exit cohorts of children who were followed from the time they either exited out-of-home care or their in-home services were terminated. The indicator *Proportion of all children who were NOT reported as the victims of subsequent verified maltreatment within six months of termination of services* was calculated by circuit and

statewide, and cohorts were constructed based on state fiscal year (the description of the indicator is in Appendix D, Measure 1). The data used to calculate this indicator cover the time period of SFY 11-12 through SFY 16-17, therefore children in all five exit cohorts were followed for at least 6 months.

The predictor variables used in this analysis are:

- Child age
- Child race
- Child gender
- Family structure
- Presence of child emotional problems
- Presence of child physical health problems
- Presence of child behavioral problems as a reason for out-of-home placement
- Child maltreatment history
  - Neglect
  - Sexual abuse
  - Physical abuse
  - Threatened harm
- Caregiver loss
- Parental substance abuse
- History of domestic violence in the family
- Placement in out-of-home care

***Data sources*.** The data sources used were data abstracts taken from the Florida Safe Families Network (FSFN).

***Analytical approach*.** Statistical analyses consisted of life tables (a type of event history or survival analysis[3]) and Cox regression analyses (Cox, 1972). All analyses were conducted using SPSS software.

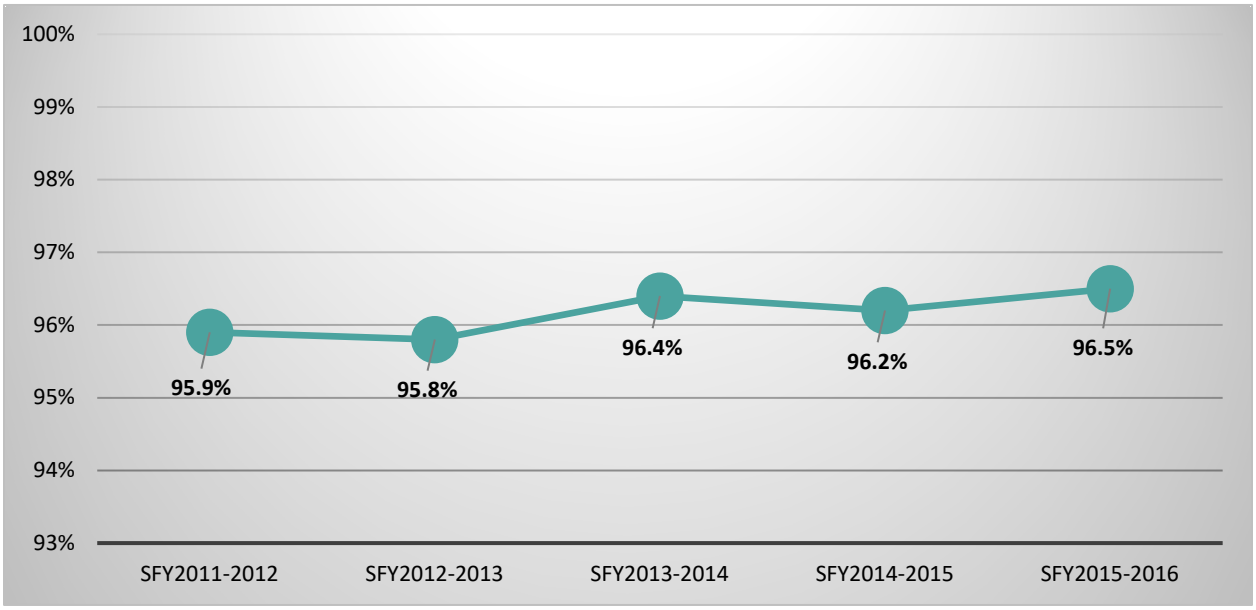
Findings.

***Proportion of all children who did NOT experience maltreatment within six months of case closure by State Fiscal Year*.** As shown in Figure 2, the proportion of children

[3]Survival analysis, referred to here as event history analysis, is a statistical procedure that allows for analyzing data collected over time as well as for utilizing information about cases where the event of interest did not occur during data collection (e.g., children who did not exit out-of-home care during the 12-month period). This technique allows for calculation of the probability of an event occurring at different time points (e.g., in 12 months after entering out-of-home care).

who did NOT experience verified maltreatment within 6 months of service termination slightly increased from 95.9% in SFY 11-12 to 96.5% in SFY 15-16. Federal standards that refer to similar indicators (i.e., Absence of Abuse within 6 months, or absence of maltreatment recurrence within 12 months) are 94.6% and 99% (HHSD, 2014). Although there was a trend indicating an increase in the number of children who did not return to the child welfare system after their services were terminated, the results of Cox regression analysis identified no statistically significant difference in maltreatment recurrence over time.

Figure 2. Proportion of all children who did NOT experience maltreatment within six months of case closure by State Fiscal Year



***Proportion of all children who did NOT experience maltreatment within six months of case closure by the Circuit*.** Figures 3-7 below represent findings by circuit for the proportion of children that were not maltreated after services were terminated. The proportions shown across all circuits slightly differ from the proportions shown for the whole state of Florida in Figure 2 because cases with a missing county of residence cannot be assigned to a specific circuit and are not included in the totals in Figures 3-7.

Figure 3. Proportion of Children Who Were NOT Maltreated After Termination of Services During SFY 11-12

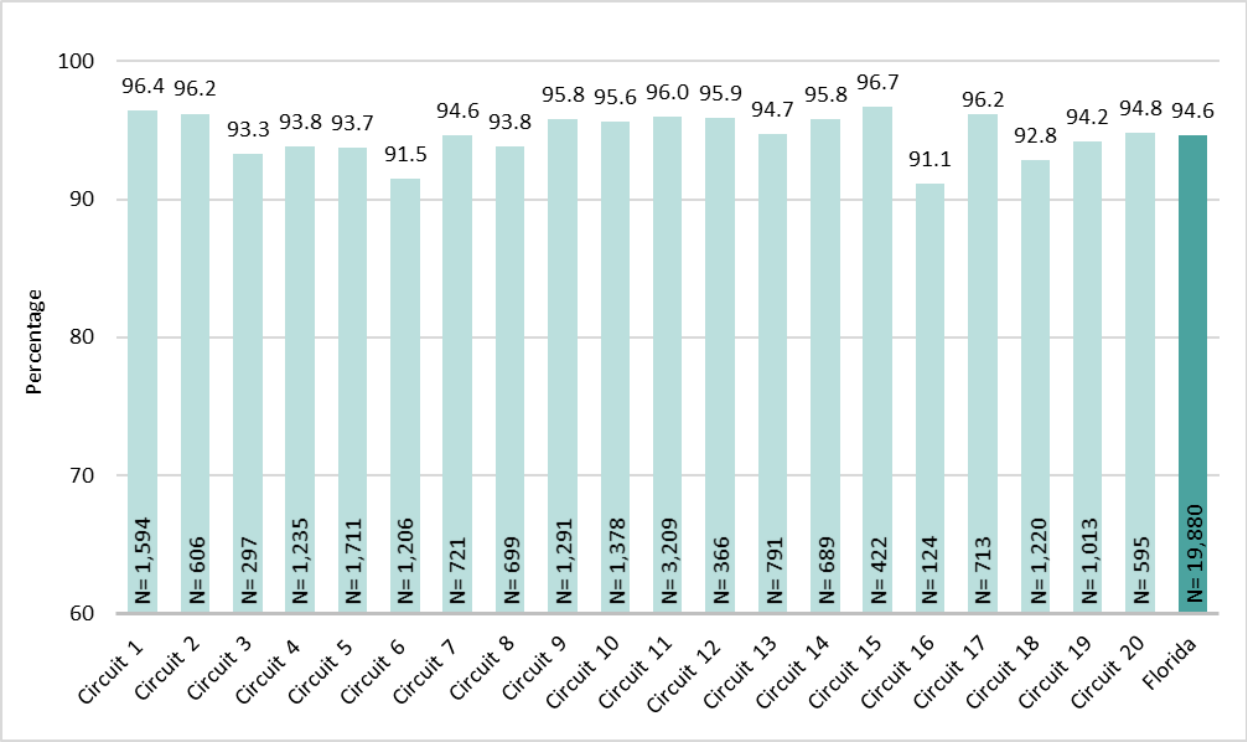


Figure 3 shows the proportions of children who were NOT maltreated after termination of services anytime during SFY 11-12 by circuit. As indicated in Figure 3, the proportion of children who were NOT maltreated after termination of services during SFY 11-12 ranged from 91.1% (Circuit 16) to 96.7% (Circuit 15) with the average of 94.6% across the circuits. Circuits 15 and 1 have the highest proportions of children who were NOT maltreated after termination of services (96.7% and 95.4%, respectively) and Circuits 16 and 6 had the lowest proportions of children who were NOT maltreated after termination of services (91.1% and 91.5%, respectively).

Figure 4. Proportion of Children Who Were NOT Maltreated After Termination of Services During SFY 12-13

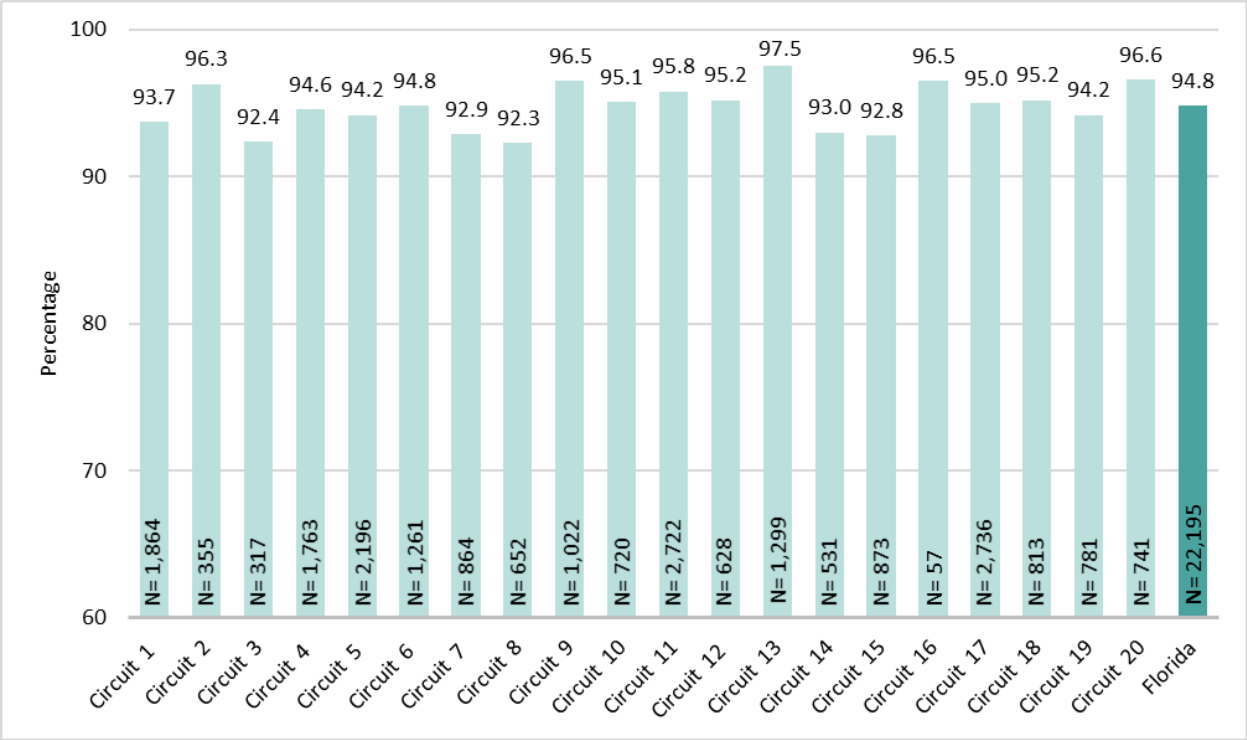
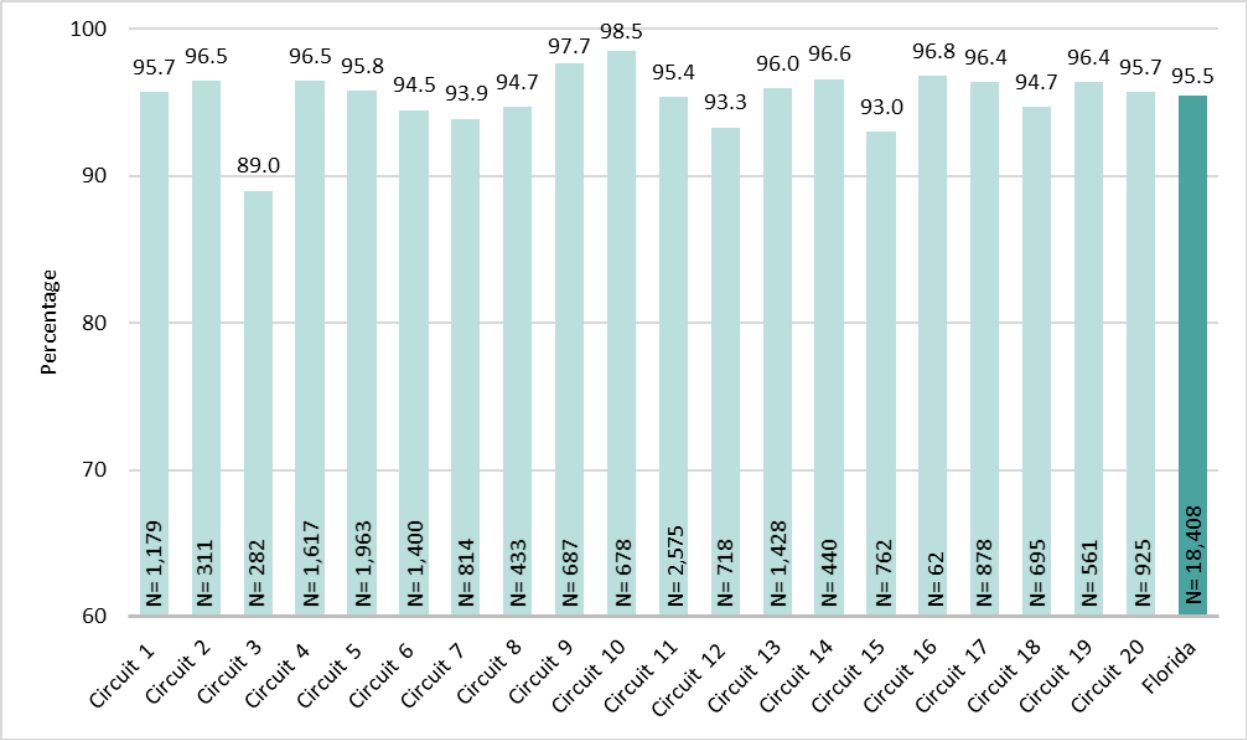


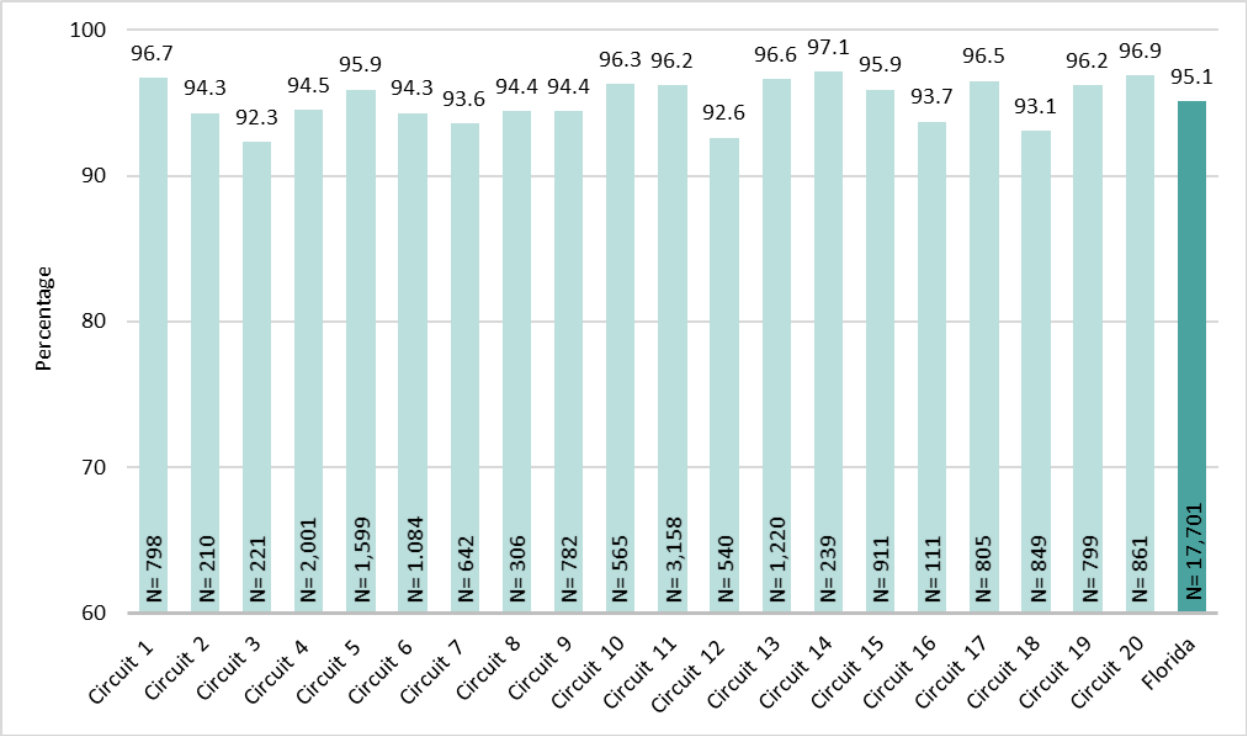
Figure 4 displays the proportions of children who were NOT maltreated after termination of services anytime during SFY 12-13 by circuit. As shown in Figure 4, Circuit 13 had the highest proportion of children who were NOT maltreated after termination of services – 97.5%, and Circuits 8 and 3 had the lowest proportions of children without maltreatment recurrence (92.3% and 92.4%, respectively). The average proportion (across circuits) of children who were NOT maltreated after in-home or out-of-home services were terminated, across circuits was almost 95.0%.

Figure 5. Proportion of Children Who Were NOT Maltreated After Termination of Services During SFY 13-14



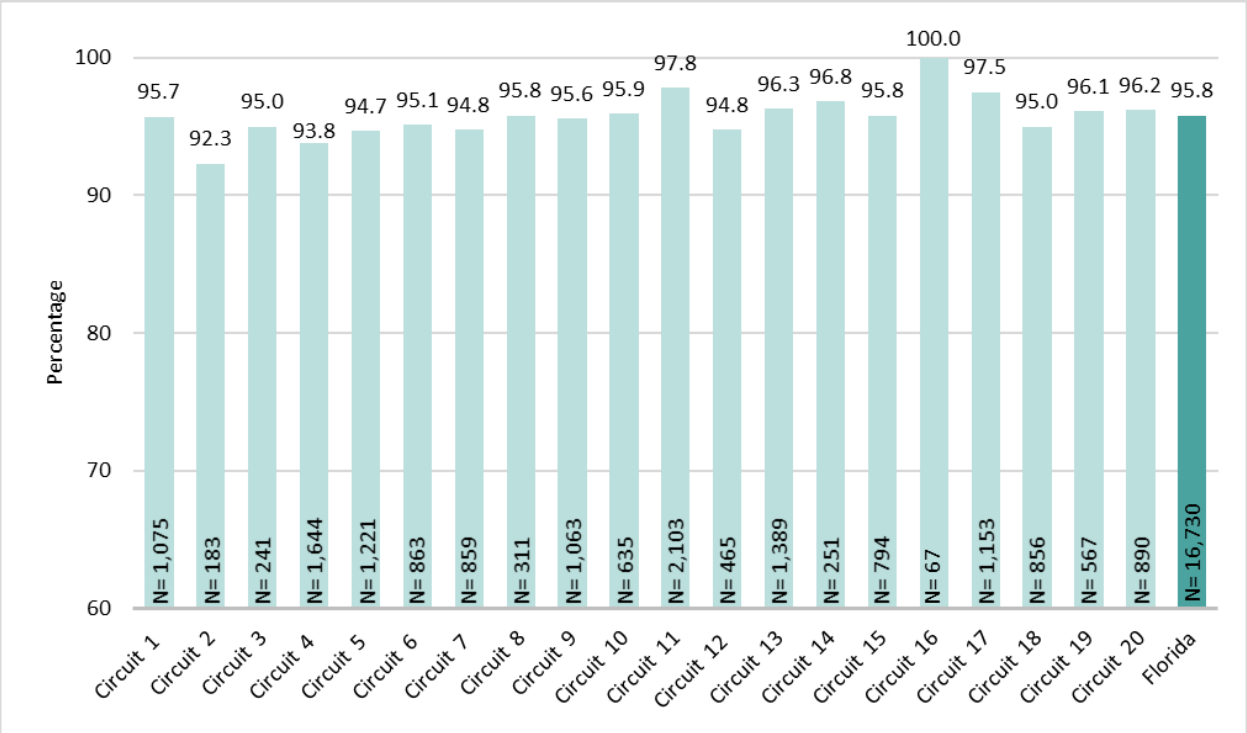
When the proportions of children who were not reported as victims of verified maltreatment during SFY 13-14 were examined, the results indicated that Circuit 10 had the highest proportion– 98.5%. Compared to the previous year, Circuit 3 continues to be the circuit with the lowest proportion (89.0%) of children without maltreatment recurrence. The average proportion of children who were NOT maltreated after in-home or out-of-home services were terminated did not change since SFY 12-13 and was equal to 95.5%.

Figure 6. Proportion of Children Who Were NOT Maltreated After Termination of Services During SFY 14-15



The proportions of children who were not reported as victims of verified maltreatment during SFY 14-15 are displayed in Figure 6. During SFY 14-15 Circuit 14 had the highest proportion of children whose services were terminated and who did not experience recurrence of maltreatment – 97.1%. Compared to the previous year, Circuit 3 continues to be the circuit with the lowest proportion (92.3%) of children without maltreatment recurrence. The average proportion of children who were NOT maltreated after in-home or out-of-home services were terminated slightly increased in SFY 14-15 compared to SFY 13- 14 and was equal to 95.1%.

Figure 7. Proportion of Children Who Were NOT Maltreated After Termination of Services During SFY 15-16



As shown in Figure 7, the proportion of children who did NOT experience verified maltreatment after their in-home or out-of-home services were terminated during SFY 15-16 were the highest for Circuits 11 (97.8%) and 16 (100.0%). Circuit 2 had the lowest proportion of children who did not experience maltreatment after service termination and was equal to 92.3%. The average proportion of children who were NOT maltreated after in-home or out-of-home services were terminated in SFY15-16 was 95.8%.

The effect of child and family characteristics on recurrence of maltreatment within 6 months after termination of services. Although the majority of children did not experience maltreatment after services were terminated, approximately 5% of children did become victims of verified maltreatment within 6 months of termination of services. It is important to examine child and family characteristics associated with adverse outcomes in order to focus prevention efforts. When child demographics were examined, Cox regression analysis indicated that age and racial category were associated with recurrence of maltreatment. Compared to White children, children who were African American were less likely to experience recurrence of maltreatment after services were terminated. Younger children were more likely to become victims of maltreatment after services were terminated, and age corresponds to this outcome in

such a way that being one year younger increases the chances of becoming a victim of verified maltreatment by 5%. Single female parent family structure also was found to relate to recurrence of maltreatment. However, the size effect was very small (Odds Ratio of 1.09) suggesting that this association is very weak.

Among child maltreatment variables, only neglect and physical abuse were significantly associated with maltreatment after services were terminated. Children who were physically abused were 15% more likely to become victims of verified maltreatment within 6 months after services were terminated and children who were neglected were 33% more likely to experience this adverse outcome (see Table E2, Appendix E). In addition, children who lost their caregivers were 17% more likely to experience recurrence of maltreatment after termination of all services.

Placement in out-of-home care was examined because it was hypothesized that children who were placed in out-of-home care represent more difficult and more complex cases. Therefore, they are at higher risk for maltreatment recurrence after termination of services. However, results of the Cox regression analysis indicated that placement in out-of-home care was not associated with recurrence of maltreatment.

The strongest predictors for verified maltreatment within 6 months after service termination however, were parental substance use and history of domestic violence. Children who came from a family with a domestic violence history were 46% more likely to become victims of verified maltreatment within 6 months of service termination. Children whose parents had substance abuse problems were 37% more likely to experience recurrence of maltreatment after termination of services.

Summary. Compared to the national standards that refer to similar indicators, the state of Florida maintained a relatively high proportion of children who did not experience verified maltreatment after either in-home or out-of-home services were terminated. On average, this proportion remained higher than 95% across the examined state fiscal years. However, not all circuits had proportions of children without verified maltreatment within 6 months of service termination higher than 95%. For some Circuits (e.g., 3 and 7) the proportions of children without verified maltreatment were equal to or lower than 95% across all examined fiscal years. In addition, there is considerable variation in the performance of circuits over time. For example, some Circuits (6, 8, and 16) considerably improved their performance in relation to maltreatment

recurrence after termination of services while there is a downward trend observed for others (Circuits 2 and 12).

When the impact of child and family characteristics was examined, results showed that neglect, parental substance abuse, and history of domestic violence were the strongest predictors for repeated verified maltreatment.

Limitations. It is important to note a few limitations in conducting this outcome analysis. First, the study design did not include a comparison group (e.g., counties where the extension of the Demonstration was not implemented) because the Demonstration was implemented statewide. Because a comparison group was not available, longitudinal comparison was performed using exit cohorts. No time by group interaction was examined. Second, due to data limitations, predictor variables were limited to child demographic characteristics, presence of child physical health problems, child maltreatment history, and only three family characteristics: (a) family structure, (b) presence of domestic violence in the family and (c) parental substance abuse. Finally, the findings do not account for the effects of the lead agency characteristics or characteristics of the circuits.

Next Steps. Future evaluation activities will include further examination of permanency indicators and safety indicators controlling for the data structure – children nested within circuits. Factors associated with child outcomes will be examined and potential recommendations will be discussed.

Child and Family Well-Being

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews, adopting use of the Child and Family Services Reviews (CFSR) into Florida's continuous quality improvement reports (CQI), which reflect federally-established guidelines to conduct ongoing case reviews (U.S. Department of Health and Human Services, 2014). Through these CFSRs, CBCs review cases to ascertain the quality of child welfare practices relevant to the safety, permanency, and well-being of children. Florida's CQI Child and Family Well-Being Outcomes 1, 2, and 3 are rated as Substantially Achieved (SA), Partially Achieved (PA), or Not Achieved (NA); accompanying performance items are rated as either a strength or an area needing improvement. Performance item ratings are used to calculate a summated rating of the performance items addressing each outcome. The CFSR Onsite Review Instrument and Instructions (USDHHS, 2014) include details regarding the review process. Table 2 below shows the child well-being outcomes and performance items that have been reviewed for this report.

Data source. The data utilized for this report were derived from the CFSR Online Monitoring System.

Table 2

CFSR Well-Being Outcomes and Performance Items

CFSR Well-Being Outcome 1 Families have enhanced capacity to provide for their children's needs	
Performance Item 12	Needs and Services of Child, Parents, and Foster Parents
Performance Item 13	Child and Family Involvement in Case Planning
Performance Item 14	Case Worker Visits with Child
Performance Item 15	Case Worker Visits with Parents
CFSR Well-Being Outcome 2 Children receive appropriate services to meet their educational needs	
Performance Item 16	Educational Needs of the Child
CFSR Well-Being Outcome 3 Children receive adequate service to meet their physical and mental health needs	
Performance Item 17	Physical Health of the Child
Performance Item 18	Mental/ Behavioral Health of the Child

Data analysis. The following results show the number of cases reviewed that have been rated as substantially achieved for well-being outcomes and rated as a strength for performance items by Circuit. Results reported below represent finalized CFSR data submitted on or before March 19, 2018 for the period under review (PUR) for SFY 15-16 through Quarter 1 (ending March 19, 2018) of SFY 17-18. It is important to remember that the PUR is 12 months prior to review of the case. As such, the PUR for the first quarter of SFY 15-16, is the first quarter of the previous fiscal year.

Previous reports (Phases 5 and 6) detailed baseline CFSR ratings for in-home cases separately from foster care cases to allow for comparisons to be made between the two. Findings reported here compare baseline data to ongoing CFSR ratings for both in-home and foster care cases. To assess for significant differences between baseline data and that obtained through ongoing review, Wilcoxon matched-pairs signed-rank test was used. This is a non-parametric statistic used to compare ratings when the samples are not independent. This

is the most appropriate test because ongoing review ratings include data reported at baseline. Significant differences are only assessed for statewide ratings.

Findings.

CFSR well-being outcome 1. The first well-being outcome pertains to enhancement of the family's capacity to provide for the needs of their children. Four performance items (12-15) encompass the first well-being outcome. Performance item 12 is further disaggregated into sub-items 12A, 12B, and 12C to assess how the needs of the child(ren), parents, and foster parents, respectively, were addressed.

Performance item 12. As shown in Table 3, ongoing review shows the percentage of cases rated as a strength statewide improved from 60% at baseline to 62% during ongoing review for in-home cases and remained consistent at 67% from baseline to ongoing review for foster care cases. At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, the percentage of cases rated as a strength improved for most circuits with the most recent data. For foster care cases, the percentage of cases rated as a strength decreased for most circuits with the more recent data. Most notably, Circuits 8, 13, and 19 showed marked improvement[4] from baseline to ongoing review for in-home cases. For foster care cases, Circuits 18 and 19 showed marked improvement from baseline to ongoing review.

Table 3

Performance Item 12: Needs and Services of Child, Parents, and Foster Parents

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	22% (n=7)	75	19% (n=14)	46	39% (n=19)	107	36% (n=38)
C 2	9	89% (n=8)	18	78% (n=14)	18	78% (n=14)	53	77% (n=41)
C 3	12	17% (n=2)	25	12% (n=3)	17	24% (n=4)	33	15% (n=5)
C 4	47	53% (n=25)	104	56% (n=58)	78	68% (n=53)	179	67% (n=120)
C 5	23	61% (n=14)	58	47% (n=27)	49	61% (n=30)	117	54% (n=63)
C 6	26	69% (n=18)	66	67% (n=44)	44	73% (n=32)	110	70% (n=77)
C 7	35	71% (n=25)	90	76% (n=68)	63	79% (n=50)	145	72% (n=104)
C 8	16	6% (n=1)	32	16% (n=5)	21	29% (n=6)	51	29% (n=15)
C 9	30	57% (n=17)	66	59% (n=39)	49	63% (n=31)	128	69% (n=88)
C 10	33	67% (n=22)	70	71% (n=50)	46	72% (n=33)	110	75% (n=83)
C 11	31	52% (n=16)	63	46% (n=29)	42	60% (n=25)	99	52% (n=51)
C 12	10	70% (n=7)	12	75% (n=9)	33	79% (n=26)	121	74% (n=89)

[4] For the purposes of this report marked improvement refers to an increase of at least 10% from baseline to ongoing review for the percentage of cases rated as a strength

C 13	15	60% (n=9)	57	86% (n=49)	55	62% (n=34)	116	68% (n=79)
C 14	14	93% (n=13)	18	94% (n=17)	25	96% (n=24)	51	96% (n=49)
C 15	33	79% (n=26)	71	85% (n=60)	51	86% (n=44)	112	88% (n=99)
C 17	28	89% (n=25)	67	85% (n=57)	39	85% (n=33)	101	77% (n=78)
C 18	22	59% (n=13)	65	65% (n=42)	30	50% (n=15)	104	62% (n=64)
C 19	32	59% (n=19)	69	70% (n=48)	48	67% (n=32)	106	77% (n=82)
C 20	35	69% (n=24)	82	63% (n=52)	52	65% (n=34)	119	74% (n=88)
State	485	60% (n=292)	1110	62% (n=686)	806	67% (n=538)	1963	67% (n=1314)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Performance item 12A. For sub-item 12A, the State increased slightly in the percentage of cases rated as a strength for addressing the child's needs from baseline (83% for in-home and 87% for foster care) to ongoing review (84% for in-home and 88% for foster care) for both in-home and foster care cases (See Table 4). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. Circuit 2 remained consistent (meaning the % rated as a strength did not change from baseline to ongoing review) in the percentage of cases rated as a strength (89% from baseline to ongoing review) for in-home cases. Circuits 1 and 14 remained consistent in the percentage of cases rated as a strength (70% and 100%) for foster care cases from baseline to ongoing review. For in-home cases, Circuits 3, 8, and 18 showed marked improvement from baseline to ongoing review. For foster care cases, Circuit 8 showed marked improvement from baseline to ongoing review.

Table 4

Performance Item 12A: Needs Assessment and Services to Child

	In-Home Cases				**Foster Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	59% (n=19)	75	53% (n=40)	46	70% (n=32)	107	70% (n=75)
C 2	9	89% (n=8)	18	89% (n=16)	18	89% (n=16)	53	92% (n=49)
C 3	12	25% (n=3)	25	44% (n=11)	17	47% (n=8)	33	55% (n=18)
C 4	47	87% (n=41)	104	85% (n=88)	78	87% (n=68)	179	88% (n=157)
C 5	23	83% (n=19)	58	79% (n=46)	49	82% (n=40)	117	54% (n=63)
C 6	26	81% (n=21)	66	80% (n=53)	44	89% (n=39)	110	87% (n=96)
C 7	35	89% (n=31)	90	94% (n=85)	63	94% (n=59)	145	91% (n=)132
C 8	16	25% (n=4)	32	53% (n=17)	21	43% (n=9)	51	61% (n=31)
C 9	30	87% (n=26)	66	89% (n=59)	49	86% (n=42)	128	91% (n=117)
C 10	33	91% (n=30)	70	94% (n=66)	46	87% (n=40)	110	93% (n=102)
C 11	31	84% (n=26)	63	76% (n=48)	42	86% (n=36)	99	77% (n=76)
C 12	10	80% (n=8)	12	83% (n=10)	33	94% (n=31)	121	91% (n=110)

C 13	15	87% (n=13)	57	96% (n=55)	55	91% (n=50)	116	92% (n=107)
C 14	14	93% (n=13)	18	94% (n=17)	25	100% (n=25)	51	100% (n=51)
C 15	33	94% (n=31)	71	96% (n=68)	51	94% (n=48)	112	96% (n=107)
C 17	28	96% (n=27)	67	97% (n=65)	39	95% (n=37)	101	91% (n=92)
C 18	22	73% (n=16)	65	85% (n=55)	30	93% (n=28)	104	90% (n=94)
C 19	32	100% (n=32)	69	99% (n=68)	48	90% (n=43)	106	93% (n=99)
C 20	35	89% (n=31)	82	84% (n=69)	52	90% (n=47)	119	91% (n=108)
State	485	83% (n=401)	1110	84% (n=937)	806	87% (n=698)	1963	88% (n=1719)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Performance item 12B. For sub-item 12B, the State remained consistent in the percentage of cases rated as a strength for addressing the parent's needs from baseline (66% for in-home and 70% for foster care) to ongoing review for both in-home and foster care cases (See Table 5). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. Circuit 10 remained consistent in the percentage of cases rated as a strength (76% from baseline to ongoing review) for in-home cases. For in-home cases, Circuits 13 and 19 showed marked improvement from baseline to ongoing review. For foster care cases, Circuits 18 and 19 showed marked improvement from baseline to ongoing review.

Table 5

Performance Item 12B: Needs Assessment and Services to Parents

	In-Home Cases				**Foster Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	25% (n=8)	75	21% (n=16)	35	40% (n=14)	85	42% (n=36)
C 2	9	100% (n=9)	18	83% (n=15)	12	83% (n=10)	41	80% (n=33)
C 3	12	17% (n=2)	25	20% (n=5)	11	9% (n=1)	23	13% (n=3)
C 4	47	60% (n=28)	104	61% (n=63)	64	73% (n=47)	137	70% (n=96)
C 5	23	70% (n=16)	58	53% (n=31)	29	66% (n=19)	82	57% (n=47)
C 6	26	81% (n=21)	66	76% (n=50)	35	74% (n=26)	95	74% (n=70)
C 7	35	74% (n=26)	90	78% (n=70)	57	81% (n=46)	129	74% (n=95)
C 8	16	6% (n=1)	32	16% (n=5)	15	27% (n=4)	39	26% (n=10)
C 9	30	63% (n=19)	66	64% (n=42)	44	75% (n=33)	110	73% (n=80)
C 10	33	76% (n=25)	70	76% (n=53)	37	70% (n=26)	90	74% (n=67)
C 11	31	65% (n=20)	63	59% (n=37)	37	73% (n=27)	77	64% (n=49)
C 12	10	80% (n=8)	12	83% (n=10)	26	85% (n=22)	95	82% (n=78)
C 13	15	67% (n=10)	57	88% (n=50)	44	66% (n=29)	93	69% (n=64)
C 14	14	100% (n=14)	18	100% (n=18)	17	100% (n=17)	42	98% (n=41)
C 15	33	85% (n=28)	71	87% (n=62)	39	92% (n=36)	85	93% (n=79)
C 17	28	93% (n=26)	67	87% (n=58)	27	85% (n=23)	74	84% (n=62)
C 18	22	64% (n=14)	65	69% (n=45)	22	36% (n=8)	83	60% (n=50)

C 19	32	59% (n=19)	69	71% (n=49)	42	62% (n=26)	88	74% (n=65)
C 20	35	69% (n=24)	82	68% (n=56)	45	71% (n=32)	101	79% (n=80)
State	485	66% (n=319)	1110	66% (n=737)	638	70% (n=446)	1570	70% (n=1106)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Performance item 12C. For sub-item 12C, the State remained consistent in the percentage of cases rated as a strength for addressing the needs of foster parents from baseline to ongoing review (89%) for foster care cases (See Table 6). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. Circuit 8 showed marked improvement from baseline (55%) to ongoing review (72%). The percentage of cases rated as a strength increased with the more recent data for most circuits.

Table 6

Performance Item 12C: Needs Assessment and Services to Foster Parents

	In-Home Cases				**Foster Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	--	---	--	---	46	63% (n=29)	105	70% (n=73)
C 2	--	---	--	---	17	100% (n=17)	51	96% (n=49)
C 3	--	---	--	---	17	47% (n=8)	33	55% (n=18)
C 4	--	---	--	---	78	87% (n=68)	175	87% (n=152)
C 5	--	---	--	---	47	82% (n=41)	111	86% (n=95)
C 6	--	---	--	---	43	98% (n=42)	107	92% (n=98)
C 7	--	---	--	---	61	95% (n=58)	142	92% (n=131)
C 8	--	---	--	---	20	55% (n=11)	50	72% (n=36)
C 9	--	---	--	---	44	84% (n=37)	118	90% (n=106)
C 10	--	---	--	---	43	98% (n=42)	103	99% (n=102)
C 11	--	---	--	---	41	83% (n=34)	97	72% (n=70)
C 12	--	---	--	---	32	94% (n=30)	113	92% (n=104)
C 13	--	---	--	---	53	94% (n=50)	109	96% (n=105)
C 14	--	---	--	---	22	95% (n=21)	46	98% (n=45)
C 15	--	---	--	---	46	96% (n=44)	104	97% (n=101)
C 17	--	---	--	---	35	97% (n=34)	90	89% (n=80)
C 18	--	---	--	---	28	100% (n=28)	102	94% (n=96)
C 19	--	---	--	---	43	98% (n=42)	99	98% (n=97)
C 20	--	---	--	---	51	90% (n=46)	115	90% (n=103)
State	--	---	--	---	766	89% (n=682)	1871	89% (n=1662)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19. 2018

Performance item 13. This item pertains to efforts made to involve the parents and children (if developmentally appropriate) in case planning processes. Ongoing review shows the percentage of cases rated as a strength statewide declined slightly from 60% at baseline to 58% during ongoing review for in-home cases and improved from 66% at baseline to 67% for foster care cases (See Table 7). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, the percentage of cases rated as a strength decreased for most circuits with the more recent data. For foster care cases, the percentage of cases rated as a strength increased for most circuits with the more recent data. For both in-home and foster care cases, no circuit showed marked improvement in the percentage of cases rated as a strength. However, for in-home cases, Circuit 17 showed a marked decline[5] in the percentage of cases rated as strength from baseline (82%) to ongoing review (69%).

Table 7

Performance Item 13: Child and Family Involvement in Case Planning

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	22% (n=7)	75	19% (n=14)	43	35% (n=15)	100	38% (n=38)
C 2	9	56% (n=5)	18	56% (n=10)	14	86% (n=12)	49	86% (n=42)
C 3	12	33% (n=4)	25	20% (n=5)	14	21% (n=3)	30	17% (n=5)
C 4	47	66% (n=31)	104	66% (n=69)	75	72% (n=54)	169	71% (n=120)
C 5	23	61% (n=14)	58	55% (n=32)	35	69% (n=24)	95	63% (n=60)
C 6	26	69% (n=18)	66	68% (n=45)	36	86% (n=31)	99	87% (n=86)
C 7	35	74% (n=26)	90	74% (n=67)	60	60% (n=36)	138	62% (n=86)
C 8	16	13% (n=2)	32	22% (n=7)	16	19% (n=3)	46	26% (n=12)
C 9	30	40% (n=12)	66	33% (n=22)	48	60% (n=29)	120	57% (n=68)
C 10	33	61% (n=20)	70	59% (n=41)	42	76% (n=32)	100	81% (n=81)
C 11	31	32% (n=10)	63	32% (n=20)	39	46% (n=18)	89	40% (n=36)
C 12	10	70% (n=7)	12	75% (n=9)	29	83% (n=24)	109	86% (n=94)
C 13	15	73% (n=11)	57	70% (n=40)	51	84% (n=43)	106	75% (n=80)
C 14	14	79% (n=11)	18	83% (n=15)	20	85% (n=17)	46	85% (n=39)
C 15	33	97% (n=32)	71	94% (n=67)	48	88% (n=42)	106	93% (n=99)
C 17	28	82% (n=23)	67	69% (n=46)	32	75% (n=24)	89	75% (n=67)
C 18	22	64% (n=14)	65	58% (n=38)	28	46% (n=13)	99	52% (n=51)
C 19	32	53% (n=17)	69	51% (n=35)	48	67% (n=32)	101	71% (n=72)
C 20	35	71% (n=25)	82	72% (n=59)	49	63% (n=31)	113	72% (n=81)
State	485	60% (n=290)	1110	58% (n=643)	727	66% (n=483)	1805	67% (n=1218)

[5] For the purposes of this report marked decline refers to a decrease of at least 10% from baseline to ongoing review for the percentage of cases rated as a strength

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Performance item 14. This performance item considers the sufficient frequency and quality of visits between caseworkers and children to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. Ongoing review shows the percentage of cases rated as a strength at the state-level increased slightly from 59% at baseline to 60% during ongoing review for in-home cases and decreased from 69% at baseline to 68% for foster care cases. At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 2 and 12 showed marked improvement from baseline to ongoing review. For foster care cases, Circuit 1 showed marked improvement from baseline to ongoing review. For in-home and foster care cases, the percentage of cases rated as a strength decreased for most circuits with the more recent data (See Table 8).

Table 8

Performance Item 14: Case Worker Visits with Child

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	16% (n=5)	75	21% (n=16)	46	20% (n=9)	107	34% (n=36)
C 2	9	33% (n=3)	18	50% (n=9)	18	56% (n=10)	53	57% (n=30)
C 3	12	17% (n=2)	25	20% (n=5)	17	29% (n=5)	33	30% (n=10)
C 4	47	62% (n=29)	104	60% (n=62)	78	67% (n=52)	179	63% (n=112)
C 5	23	61% (n=14)	58	57% (n=33)	49	73% (n=36)	117	70% (n=82)
C 6	26	81% (n=21)	66	76% (n=50)	44	91% (n=40)	110	89% (n=98)
C 7	35	54% (n=19)	90	62% (n=56)	63	65% (n=41)	145	58% (n=84)
C 8	16	13% (n=2)	32	28% (n=9)	21	29% (n=6)	51	31% (n=16)
C 9	30	43% (n=13)	66	39% (n=26)	49	43% (n=21)	128	51% (n=65)
C 10	33	82% (n=27)	70	86% (n=60)	46	89% (n=41)	110	95% (n=104)
C 11	31	55% (n=17)	63	49% (n=31)	42	71% (n=30)	99	55% (n=54)
C 12	10	60% (n=6)	12	75% (n=9)	33	88% (n=29)	121	69% (n=84)
C 13	15	87% (n=13)	57	88% (n=50)	55	93% (n=51)	116	91% (n=105)
C 14	14	86% (n=12)	18	78% (n=14)	25	92% (n=23)	51	80% (n=41)
C 15	33	91% (n=30)	71	89% (n=63)	51	86% (n=44)	112	93% (n=104)
C 17	28	93% (n=26)	67	82% (n=55)	39	95% (n=37)	101	92% (n=93)
C 18	22	55% (n=12)	65	54% (n=35)	30	60% (n=18)	104	56% (n=58)
C 19	32	31% (n=10)	69	38% (n=26)	48	50% (n=24)	106	55% (n=58)
C 20	35	69% (n=24)	82	63% (n=52)	52	77% (n=40)	119	76% (n=91)
State	485	59% (n=287)	1110	60% (n=661)	806	69% (n=557)	1963	68% (n=1326)

Note. Figures may not total to 100% due to rounding.

Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Performance item 15. This performance item considers the sufficient frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring child safety, permanency, and well-being. Ongoing review shows the percentage of cases rated as a strength statewide increased slightly from 44% at baseline to 45% during ongoing review for in-home cases and increased from 36% at baseline to 39% during ongoing review for foster care cases (See Table 9). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home and foster care cases, the percentage of cases rated as a strength increased for most circuits with the more recent data. For in-home cases, Circuits 4, 14, and 19 showed marked improvement from baseline to ongoing review. For foster care cases, Circuits 17, 18, and 19 showed marked improvement from baseline to ongoing review.

Table 9

Performance Item 15: Case Worker Visits with Parents

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	19% (n=6)	75	16% (n=12)	36	28% (n=10)	86	35% (n=30)
C 2	9	67% (n=6)	18	44% (n=8)	11	64% (n=7)	38	53% (n=20)
C 3	12	8% (n=1)	25	4% (n=1)	11	0% (n=0)	23	0% (n=0)
C 4	47	49% (n=23)	104	60% (n=62)	63	51% (n=32)	140	52% (n=73)
C 5	23	26% (n=6)	58	28% (n=16)	26	31% (n=8)	74	30% (n=22)
C 6	26	54% (n=14)	66	52% (n=34)	32	59% (n=19)	92	55% (n=51)
C 7	35	46% (n=16)	90	48% (n=43)	55	24% (n=13)	123	27% (n=33)
C 8	16	6% (n=1)	32	13% (n=4)	14	7% (n=1)	38	13% (n=5)
C 9	30	30% (n=9)	66	32% (n=21)	43	30% (n=13)	107	35% (n=37)
C 10	33	70% (n=23)	70	57% (n=40)	37	43% (n=16)	91	46% (n=42)
C 11	31	26% (n=8)	63	30% (n=19)	38	26% (n=10)	76	18% (n=14)
C 12	10	50% (n=5)	12	58% (n=7)	24	71% (n=17)	92	60% (n=55)
C 13	15	80% (n=12)	57	75% (n=43)	45	40% (n=18)	93	46% (n=42)
C 14	14	79% (n=11)	18	89% (n=16)	16	56% (n=9)	41	54% (n=22)
C 15	33	55% (n=18)	71	62% (n=44)	38	50% (n=19)	83	57% (n=47)
C 17	28	64% (n=18)	67	66% (n=44)	24	29% (n=7)	71	39% (n=28)
C 18	22	55% (n=12)	65	46% (n=30)	22	14% (n=3)	83	29% (n=24)
C 19	32	31% (n=10)	69	43% (n=30)	42	19% (n=8)	88	36% (n=32)
C 20	35	40% (n=14)	82	34% (n=28)	44	25% (n=11)	97	29% (n=28)
State	485	44% (n=214)	1110	45% (n=504)	621	36% (n=221)	1537	39% (n=605)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System

Date retrieved: March 19, 2018

Well-Being outcome 1 ratings. Table 10 details ratings for this outcome pertaining to families having the enhanced capacity to provide for their children's needs. The ratings shown are a compilation of the ratings for performance items 12 through 15. The State remained consistent in the percentage of cases rated as a strength for addressing the parent's needs from baseline (45%) to ongoing review (45%) for in-home cases. The percentage of cases rated as a strength statewide increased slightly from 53% at baseline to 54% during ongoing review for foster care cases. At the state-level, the changes from baseline to ongoing were not found to be statistically significant. Circuits 1, 2, 3, 8, and 11 remained consistent in the percentage of cases rated as a strength for in-home cases. Circuits 6 and 18 remained consistent in the percentage of cases rated as a strength from baseline to ongoing review for foster care cases. For in-home cases, Circuit 13 showed marked improvement from baseline (60%) to ongoing review (70%). For foster care cases, Circuit 19 showed marked improvement from baseline (50%) to ongoing review (61%).

Table 10

Well-Being Outcome 1: Family's Enhanced Capacity to Provide for Children's Needs

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths SA**	**N**	**% Strengths Baseline**	**N**	**% Strengths SA**
C1	32	9% (n=3)	75	9% (n=7)	46	28% (n=13)	107	27% (n=29)
C 2	9	44% (n=4)	18	44% (n=8)	18	61% (n=11)	53	60% (n=32)
C 3	12	8% (n=1)	25	8% (n=2)	17	18% (n=3)	33	9% (n=3)
C 4	47	43% (n=20)	104	45% (n=47)	78	54% (n=42)	179	58% (n=104)*
C 5	23	39% (n=9)	58	31% (n=18)	49	55% (n=27)	117	44% (n=52)
C 6	26	62% (n=16)	66	52% (n=34)	44	66% (n=29)	110	66% (n=73)
C 7	35	46% (n=16)	90	52% (n=47)	63	48% (n=30)	145	45% (n=65)
C 8	16	6% (n=1)	32	6% (n=2)	21	24% (n=5)	51	22% (n=11)
C 9	30	37% (n=11)	66	29% (n=19)	49	39% (n=19)	128	41% (n=52)
C 10	33	48% (n=16)	70	54% (n=38)	46	61% (n=28)	110	69% (n=76)
C 11	31	29% (n=9)	63	29% (n=18)	42	36% (n=15)	99	33% (n=33)
C 12	10	50% (n=5)	12	58% (n=7)	33	73% (n=24)	121	67% (n=81)
C 13	15	60% (n=9)	57	70% (n=40)	55	58% (n=32)	116	61% (n=71)
C 14	14	71% (n=10)	18	78% (n=14)	25	84% (n=21)	51	76% (n=39)
C 15	33	79% (n=26)	71	80% (n=57)	51	73% (n=37)	112	82% (n=92)
C 17	28	82% (n=23)	67	78% (n=52)	39	72% (n=28)	101	69% (n=70)
C 18	22	50% (n=11)	65	45% (n=29)	30	40% (n=12)	104	40% (n=42)
C 19	32	34% (n=11)	69	38% (n=26)	48	50% (n=24)	106	61% (n=65)
C 20	35	49% (n=17)	82	43% (n=35)	52	56% (n=29)	119	61% (n=73)

State	485	45% (n=219)	1110	45% (n=501)	806	53% (n=429)	1963	54% (n=1064)

Note. Figures may not total to 100% due to rounding.
Note: SA= Substantial Achievement
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

CFSR well-being outcome 2. The second well-being outcome pertains to receipt of appropriate services to meet the educational needs of children. Only one performance item (Performance item 16) encompasses this outcome which evaluates efforts made to assess children's educational needs and appropriately address those needs. Only the results of Well-Being Outcome 2 will be shown due to the fact that the data from Performance Item 16 mirrors the data for Well-Being Outcome 2. Also, due to the few number of applicable in-home cases at the circuit level, caution should be taken when interpreting results for in-home cases.

Well-Being outcome 2 ratings. Table 11 details ratings for this outcome pertaining to receipt of appropriate services to meet the educational needs of children. The State increased slightly in the percentage of cases rated as a strength from baseline (64% for in-home and 81% for foster care) to ongoing review (66% for in-home and 83% for foster care) for both in-home and foster care cases. At the state-level, the changes from baseline to ongoing were not found to be statistically significant. Circuits 2, 3, 5, 7, 9, and 14 remained consistent from baseline to ongoing review in the percentage of cases rated as a strength for in-home cases. Circuits 13 and 15 remained consistent in the percentage of cases rated as a strength from baseline to ongoing review for foster care cases. For in-home cases, Circuits 1, 10, 15, 18, and 20 showed marked improvement from baseline to ongoing review. For foster care cases, Circuits 1, 8, and 20 showed marked improvement from baseline to ongoing review.

Table 11

Well-Being Outcome 2: Appropriate Services to Meet Children's Educational Needs

	In-Home Cases				**Foster Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths SA**	**N**	**% Strengths Baseline**	**N**	**% Strengths SA**
C1	6	17% (n=1)	17	29% (n=5)	36	69% (n=25)	78	81% (n=63)
C 2	3	100% (n=3)	3	100% (n=3)	16	100% (n=16)	43	98% (n=42)
C 3	0	---	0	---	11	55% (n=6)	26	58% (n=15)
C 4	8	63% (n=5)	18	72% (n=13)	61	89% (n=54)	142	91% (n=129)
C 5	5	80% (n=4)	5	80% (n=4)	39	85% (n=33)	90	82% (n=74)
C 6	14	71% (n=10)	27	63% (n=17)	33	76% (n=25)	81	84% (n=68)
C 7	3	100% (n=3)	4	100% (n=4)	45	80% (n=36)	115	84% (n=97)
C 8	2	0% (n=0)	6	33% (n=2)	14	29% (n=4)	40	45% (n=18)

C 9	3	67% (n=2)	9	67% (n=6)	38	92% (n=35)	106	89% (n=94)
C 10	7	43% (n=3)	13	69% (n=9)	35	94% (n=33)	90	97% (n=87)
C 11	22	77% (n=17)	39	72% (n=28)	35	77% (n=27)	91	71% (n=65)
C 12	6	67% (n=4)	8	75% (n=6)	26	81% (n=21)	102	83% (n=85)
C 13	7	86% (n=6)	19	84% (n=16)	47	79% (n=37)	92	79% (n=73)
C 14	0	---	0	---	22	100% (n=22)	44	93% (n=41)
C 15	7	71% (n=5)	17	88% (n=15)	44	91% (n=40)	91	91% (n=83)
C 17	1	100% (n=1)	4	75% (n=3)	38	74% (n=28)	100	75% (n=75)
C 18	3	67% (n=2)	5	80% (n=4)	26	77% (n=20)	88	86% (n=76)
C 19	2	0% (n=0)	5	40% (n=2)	41	76% (n=31)	82	77% (n=63)
C 20	7	14% (n=1)	12	25% (n=3)	42	71% (n=30)	92	83% (n=76)
State	107	64% (n=68)	213	66% (n=141)	649	81% (n=523)	1593	83% (n=1324)

Note. Figures may not total to 100% due to rounding.
Note. SA= Substantial Achievement
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

CFSR well-being outcome 3. The third well-being outcome pertains to receipt of adequate services to meet the physical and mental health needs of children. Results of the performance items for this outcome are shown in Tables 12 and 13. Again, due to the few number of applicable in-home cases at the circuit level, caution should be taken when interpreting results for in-home cases.

Performance item 17. This performance item addresses accurate assessment and receipt of appropriate services for the physical health needs of children. This item also addresses children's dental health needs. For both in-home and foster care cases, the percentage of cases rated as a strength increased for most circuits with the more recent data. Ongoing review shows the percentage of cases rated as a strength statewide remained consistent at 64% for in-home cases from baseline to ongoing review and increased slightly from 77% at baseline to 78% during ongoing review for foster care cases (See Table 12). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 5, 6, 10, 19 and 20 showed marked improvement from baseline to ongoing review. For foster care cases, Circuits 3, 7, 18, and 20 showed marked improvement from baseline to ongoing review.

Table 12

Performance Item 17: Physical Health of the Child

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	7	43% (n=3)	25	40% (n=10)	46	59% (n=27)	107	64% (n=68)
C 2	1	100% (n=1)	2	100% (n=2)	18	100% (n=18)	53	92% (n=49)
C 3	1	100% (n=1)	1	100% (n=1)	17	47% (n=8)	33	58% (n=19)
C 4	11	82% (n=9)	25	80% (n=20)	78	97% (n=76)	179	92% (n=164)
C 5	4	25% (n=1)	10	50% (n=5)	49	82% (n=40)	117	84% (n=98)
C 6	20	55% (n=11)	31	68% (n=21)	44	91% (n=40)	110	87% (n=96)
C 7	7	86% (n=6)	17	82% (n=14)	63	59% (n=37)	145	70% (n=101)
C 8	6	0% (n=0)	10	30% (n=3)	21	57% (n=12)	51	61% (n=31)
C 9	10	90% (n=9)	18	78% (n=14)	49	92% (n=45)	106	89% (n=94)
C 10	8	75% (n=6)	27	89% (n=24)	46	93% (n=43)	110	95% (n=104)
C 11	26	69% (n=18)	42	52% (n=22)	42	74% (n=31)	99	64% (n=63)
C 12	6	100% (n=6)	8	100% (n=8)	33	70% (n=23)	121	70% (n=85)
C 13	7	43% (n=3)	22	45% (n=10)	55	85% (n=47)	116	85% (n=99)
C 14	0	---	0	---	25	92% (n=23)	51	90% (n=46)
C 15	3	67% (n=2)	7	71% (n=5)	51	71% (n=36)	112	76% (n=85)
C 17	1	100% (n=1)	6	83% (n=5)	39	72% (n=28)	101	72% (n=73)
C 18	5	60% (n=3)	8	50% (n=4)	30	67% (n=20)	104	78% (n=81)
C 19	3	33% (n=1)	6	50% (n=3)	48	60% (n=29)	106	61% (n=65)
C 20	5	40% (n=2)	14	50% (n=7)	52	71% (n=37)	119	82% (n=98)
State	132	64% (n=84)	280	64% (n=179)	806	77% (n=620)	1963	78% (n=1540)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Performance item 18. This performance item addresses accurate assessment and receipt of appropriate services for the mental and behavioral health needs of children. For foster care cases, the percentage of cases rated as a strength increased for most circuits with the more recent data. For in-home cases, the percentage of cases rated as a strength decreased for seven circuits, increased for six circuits, and remained consistent for six circuits from baseline to ongoing review. Ongoing review shows the percentage of cases rated as a strength statewide decreased for in-home cases from 71% at baseline to 69% during ongoing review and increased slightly from 73% at baseline to 75% at ongoing review for foster care cases (See Table 13). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 7 and 19 showed marked improvement from baseline to ongoing review. For foster care cases, Circuits 1, 7, and 10 showed marked improvement from baseline to ongoing review.

Table 13

Performance Item 18: Mental/ Behavioral Health of the Child

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	17	47% (n=8)	42	48% (n=20)	27	44% (n=12)	54	59% (n=32)
C 2	0	---	0	---	14	93% (n=13)	32	91% (n=29)
C 3	1	100% (n=1)	4	100% (n=4)	11	27% (n=3)	21	29% (n=6)
C 4	19	79% (n=15)	39	77% (n=30)	45	84% (n=38)	112	87% (n=97)
C 5	6	33% (n=2)	12	17% (n=2)	20	85% (n=17)	55	75% (n=41)
C 6	14	79% (n=11)	32	69% (n=22)	22	91% (n=20)	61	89% (n=54)
C 7	12	92% (n=11)	40	85% (n=34)	31	65% (n=20)	89	81% (n=72)
C 8	6	50% (n=3)	14	50% (n=7)	8	0% (n=0)	29	38% (n=11)
C 9	13	77% (n=10)	27	78% (n=21)	23	83% (n=19)	64	70% (n=45)
C 10	14	71% (n=10)	23	78% (n=18)	22	68% (n=15)	62	89% (n=55)
C 11	20	75% (n=15)	36	69% (n=25)	28	89% (n=25)	73	78% (n=57)
C 12	3	100% (n=3)	4	100% (n=4)	22	77% (n=17)	65	77% (n=50)
C 13	6	67% (n=4)	18	72% (n=13)	37	68% (n=25)	68	72% (n=49)
C 14	3	100% (n=3)	3	100% (n=3)	17	94% (n=16)	30	87% (n=26)
C 15	17	82% (n=14)	39	87% (n=34)	33	85% (n=28)	73	85% (n=62)
C 17	4	75% (n=3)	12	58% (n=7)	28	71% (n=20)	75	75% (n=56)
C 18	6	67% (n=4)	9	67% (n=6)	15	73% (n=11)	51	55% (n=28)
C 19	4	50% (n=2)	21	71% (n=15)	34	62% (n=21)	62	69% (n=43)
C 20	13	54% (n=7)	33	45% (n=15)	27	67% (n=18)	60	63% (n=38)
State	178	71% (n=126)	408	69% (n=280)	464	73% (n=338)	1137	75% (n=852)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Well-Being outcome 3 ratings. CFSR Well-Being Outcome 3 pertains to receipt of adequate services to meet the physical and mental health needs of children. Caution should be taken when interpreting the results for in-home cases due to the low number of applicable cases for many circuits. Ongoing review shows the percentage of cases rated as a strength statewide decreased for in-home cases from 65% at baseline to 64% during ongoing review for in home cases and remained consistent at 70% from baseline to ongoing review for foster care cases (See Table 14). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 8, 10, and 19 showed marked improvement from baseline to ongoing review. For foster care cases, Circuit 7 showed marked improvement from baseline to ongoing review.

Table 14

Well-Being Outcome 3: Appropriate services to meet children's health needs

	In-Home Cases				Foster Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths SA**	**N**	**% Strengths Baseline**	**N**	**% Strengths SA**
C1	21	48% (n=10)	52	42% (n=22)	46	48% (n=22)	107	54% (n=58)
C 2	1	100% (n=1)	2	100% (n=2)	18	94% (n=17)	53	89% (n=47)
C 3	2	100% (n=2)	5	100% (n=5)	17	24% (n=4)	33	33% (n=11)
C 4	25	80% (n=20)	54	76% (n=41)	78	88% (n=69)	179	85% (n=152)
C 5	8	25% (n=2)	19	26% (n=5)	49	80% (n=39)	117	78% (n=91)
C 6	24	58% (n=14)	47	62% (n=29)	44	89% (n=39)	110	84% (n=92)
C 7	15	87% (n=13)	51	82% (n=42)	63	54% (n=34)	145	65% (n=94)
C 8	10	20% (n=2)	20	35% (n=7)	21	43% (n=9)	51	47% (n=24)
C 9	18	83% (n=15)	37	78% (n=29)	49	86% (n=42)	128	77% (n=98)
C 10	19	68% (n=13)	42	81% (n=34)	46	85% (n=39)	110	91% (n=100)
C 11	29	59% (n=17)	50	48% (n=24)	42	74% (n=31)	99	58% (n=57)
C 12	6	100% (n=6)	8	100% (n=8)	33	67% (n=22)	121	66% (n=80)
C 13	8	50% (n=4)	27	52% (n=14)	55	69% (n=38)	116	72% (n=83)
C 14	3	100% (n=3)	3	100% (n=3)	25	92% (n=23)	51	86% (n=44)
C 15	17	82% (n=14)	40	85% (n=34)	51	69% (n=35)	112	71% (n=80)
C 17	5	80% (n=4)	16	69% (n=11)	39	59% (n=23)	101	60% (n=61)
C 18	9	56% (n=5)	14	50% (n=7)	30	63% (n=19)	104	61% (n=63)
C 19	6	50% (n=3)	23	65% (n=15)	48	50% (n=24)	106	56% (n=59)
C 20	16	50% (n=8)	40	50% (n=20)	52	63% (n=33)	119	70% (n=83)
State	243	65% (n=157)	551	64% (n=353)	806	70% (n=562)	1963	70% (n=1378)

Note. Figures may not total to 100% due to rounding.
Note: SA= Substantial Achievement
Data Source: CFSR Online Monitoring System
Date retrieved: March 19, 2018

Summary. Overall, ongoing reviews show that Circuit 19 showed the most improvement across outcomes and performance items. Circuit 19 showed marked improvement from baseline to ongoing review for both in-home and foster care cases in Performance Items 12, 12B, and 15, marked improvement in foster care cases for Well-Being Outcome 1, and marked improvement among in-home cases only for Performance Items 17 and 18 and Well-Being Outcome 3. Other circuits showed marked improvement from baseline to ongoing review, most notable Circuits 8, 13, and 18. At the state-level the changes from baseline to ongoing review varied among the outcomes and performance items. None of the state findings were found to be statistically significant.

Each Region (See Table 15 for Regions and Circuits) meets quarterly to review the CQI process and data. At these meetings members from CBCs, DCF, and Sheriff's offices share

current initiatives in place to improve outcomes. The most notable initiatives discussed at the March 2018 quarterly meeting were initiatives to increase family engagement. The Southeast region reported working closely with training departments, operating a second Family Finding Bootcamp, a Kinship workgroup, monthly calls with ACTION, and the creation of a new QA (quality assurance) position just for data analysis. The Suncoast region reported utilizing black belt information to make improvements, having a watchlist to discuss counter measures, applying for grants from the ELC (Early Learning Coalition), having a QA position for compliance, and increasing Rapid Safety Feedback Reviews. The Central region reported improvements in achieving permanency timely and staffing out-of-home care children every month. The Central region also reported working on parent engagement, timeliness, and internal QA reviews. The Northeast region reported working on family engagement, conducting trauma-informed care training for Foster Care parents and case managers, having a quality foster parent workgroup in progress, having innovation staffings to address cases at a standstill, working on home visit sheets, employed a family resource advocate to stabilize placement, created a position to assist crossover kids/ DJJ, and creating a Kinship navigator position that looks for relatives, and also having a greenbelt project regarding placement timeliness. The Northwest region also reported working to improve family engagement. The Northwest region also reported holding a small summit with 125 participants from CLS (Children's legal services), GALs (Guardian ad Litems), the courts, and substance abuse and mental health providers. Members from each county that attended the summit decided on an initiative to work on.

Table 15

DCF Regions and Circuits

Region	**Circuit**	**CBC**
Northwest	1	Families First Network
	2	Big Bend Community Based Care, Inc.
	14	Big Bend Community Based Care, Inc.
Northeast	3	Partnership for Strong Families
	4	Family Support Services of North Florida Inc. (Duval and Nassau County) Kids First of Florida, Inc (Clay County)
	7	Community Partnership for Children, Inc (Flagler, Volusia, & Putnam County) St Johns County Board of County Commissioners (St. John's County)
	8	Partnership for Strong Families
Central	5	Kids Central, Inc
	9	Community Based Care of Central Florida
	10	Heartland For Children
	18	Community Based Care of Central Florida (Seminole County) Brevard Family Partnership (Brevard County)

Suncoast	6	Eckerd Community Alternatives
	12	Sarasota Family YMCA, Inc.
	13	Eckerd Community Alternatives
	20	Children's Network of SW Florida
Southeast	15	ChildNet Inc.
	17	ChildNet Inc.
	19	Devereux CBC.
Southern	11	Our Kids of Miami-Dade/Monroe, Inc
	16	Our Kids of Miami-Dade/Monroe, Inc

Next steps.

Subsequent reports will continue to disaggregate well-being outcome findings to allow for comparisons between in-home and foster care cases. Although the baseline data reported here will carry forward into the next report, findings from ongoing review will consist of the most recent Florida CQI data available at that time (the PUR for SFY 15-16 through the most recent FL CQI data available at the time).

Cost Analysis

The cost analysis for the Demonstration evaluation examined changes in costs over time, and how costs have changed for specific services (e.g., out-of-home versus in-home) (e.g., Armstrong, Vargo, Cruz et al., 2016a, 2016b, 2017). The analysis in this report extends prior evaluation work in two ways.

First, the analysis examined aggregated expenditure data from SFY 04-05 through SFY 15-16. Analysis of these data provided information on patterns across time-periods that includes a pre-Demonstration period, the initial Demonstration period, and the Demonstration extension period. While this analysis was performed in Armstrong et al. (2017), the method used to compute licensed foster care expenditures has been revised to be consistent with the evaluation of the initial Demonstration (Armstrong et al., 2012). In addition, trends in the ratio of licensed foster care expenditures to expenditures for front-end prevention services are reported. One of the goals of the Demonstration was to increase the use of front-end prevention services in order to avoid the need for out-of-home care. As such, the ratio was expected to decline with the implementation of the Demonstration.

Second, while aggregated data provide important information, this report also examined child-level cost data reported by lead agencies through the Florida Safe Families Network (FSFN). Child-level data on costs are available from SFY 13-14 onward, and an analysis in this report examines child characteristics for children with the highest costs. In addition, Medicaid-funded services costs and Substance Abuse and Mental Health (SAMH) costs are compared for

high cost and lower cost children. Given the high cost for children that have complex needs, the question becomes whether new programs could be developed that use the flexibility provided in the Demonstration to provide parents with the needed support to maintain the child in the home. For example, if children who have high child welfare costs also have high Medicaid costs, a potential intervention could provide an integrated and intensive support and treatment framework and remain cost-effective.

Research Questions

1 – How did costs change over time? More specifically, how did costs for licensed foster care and front-end prevention services change between the pre-Demonstration period, the initial Demonstration, and the Demonstration extension?

2 – How did the ratio of expenditures for licensed foster care to expenditures for front-end prevention services change over time?

3 – What was the distribution of child-level costs during SFY 13-14 through SFY 16-17?

4 – What child/family characteristics were associated with having high costs (defined as costs in the top decile)?

5 – What were the Medicaid and SAMH expenditures and services received by high cost children compared to lower cost children?

Data Analysis

Aggregated time series data. The analysis begins with an assessment of time series data for costs from SFY 04-05 through SFY 15-16. Including data from SFY 04-05 onward allows the analysis to have a true 'pre' Demonstration period. Much of the Demonstration extension evaluation has focused on comparing a time-period prior to the extension to the time after the implementation of the extension. However, there was a Demonstration Project already in place during the time-period prior to the implementation of the Demonstration extension. Prior semi-annual reports have primarily considered whether the Demonstration extension changed costs and outcomes relative to the original Demonstration (e.g., Armstrong, Vargo, Cruz et al., 2016a 2016b). The inclusion of earlier data enables comparison of three time-periods: pre-Demonstration (SFY 03-04 through SFY 05-06), during the initial Demonstration (SFY 06-07 through SFY 12-13), and during the Demonstration extension (SFY 13-14 through SFY 15-16).

FSFN cost data. In addition to examining aggregate data, child level data were available from SFY 13-14 through SFY 16-17 (although data from May and June 2017 were incomplete). The data included child identifiers (DCF child ID, social security number, name, and date of birth), fiscal agency (typically the lead agency), service batch, service type and

payment. Service batch is a broad service category (e.g., out-of-home care), while service type is a detailed descriptor of the service. Child level data enables examination of the wide variety of questions related to costs and outcomes. There are two primary limitations with these data. First, the data are limited to a time-period after the implementation of the Demonstration extension. Second, the data do not include dependency case management or prevention services. Thus, it does not provide a complete picture of the expenditures on each child.

Medicaid data. Medicaid claims and encounter data included all fee-for-service claims and encounters from the Statewide Medicaid Managed Care (SMMC) program. In 2014, most Medicaid recipients were transitioned to the SMMC program that became responsible for both physical and behavioral health care. In addition, a specialty SMMC plan (Sunshine Health Child Welfare Specialty Plan) was created that focuses on providing services to children and youth in the child welfare system. Children in the child welfare system are enrolled in either a standard managed care plan or the specialty plan. Medicaid data provided information on each service received by children and youth. Data were available on the dates of service, diagnoses, and expenditures for each service. Expenditures denoted the amount paid to the provider of service by the Medicaid program (when the child was enrolled in the fee-for-service program) or to the managed care organization (when the child was enrolled in a SMMC plan). Services were classified as physical or behavioral health based on the primary diagnosis on the claim or encounter. Health care utilization was examined from SFY 13-14 through SFY 16-17.

SAMHIS data. The Substance Abuse and Mental Health Information System (SAMHIS) provides data for substance abuse and mental health services paid through the State's SAMH program. Information included the dates of service, diagnosis, and expenditures for each substance abuse or mental health service. Services received from SFY 13-14 through 16-17 were included in the analysis.

Findings

Trends in expenditures. Expenditures for licensed care and front-end prevention services are shown in Table 16. Average annual expenditures are reported for three periods; pre-Demonstration, the initial Demonstration, and the Demonstration extension. Expenditures for front-end prevention services have increased from $16.8 million per year prior to the Demonstration, to $52.3 million per year during the Demonstration extension. Expenditures for licensed care have exhibited less variation; increasing from $154 million per year to $164 million per year during the initial Demonstration, before declining to $151 million per year during the Demonstration extension. Trends in the expenditures for other child welfare services, including adoption services (services associated with the adoption, e.g., legal), adoptions (maintenance

adoption subsidies), case management, and independent living, were reported in Armstrong et al. (2017).

Table 16

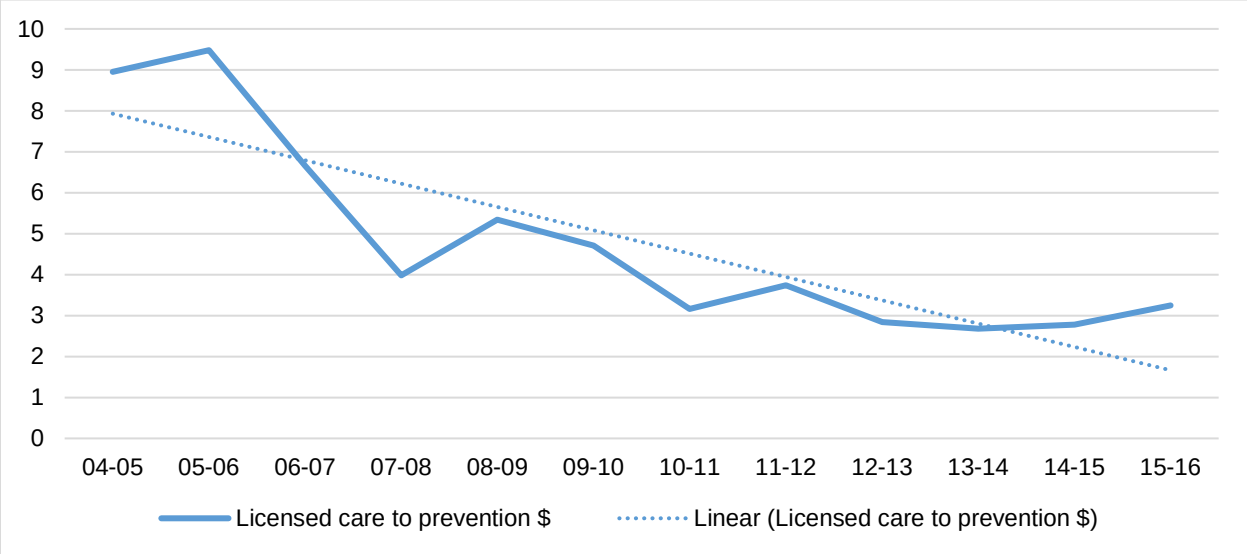
Licensed care and front-end prevention expenditures before and during Demonstration

Service	Pre-Demonstration	Initial Demonstration	Demonstration Extension
Licensed Care	154,939,869	164,041,988	151,854,992
Front-end Prevention Services	16,813,031	39,648,052	52,325,056

Note. Data Source: DCF Office of Revenue Management, Run date: 03-29-2018.

Figure 8 contains the ratio of costs for licensed care to costs for prevention services. The IV-E Demonstration was expected to provide greater emphasis on in-home child welfare services, avoiding the need for some children to be removed from their home. Prior to the original Demonstration (SFY 04-05 and 05-06), the ratio was between 9 and 10. In other words, expenditures for licensed care were 9-10 times larger than for prevention services. The ratio declined with the implementation of the Demonstration reaching 4.0 in SFY 07-08. The ratio remained in the 4-5 range until SFY 10-11 when the ratio fell below 4. The ratio has remained near 3.0 since SFY 12-13.

Figure 8. Ratio of licensed care to front-end prevention service expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 03-29-2018.

High cost children. In order to examine child characteristics, a cohort of children removed from the home in SFY 13-14 was examined. In Armstrong et al. (2017), the characteristics of children in the top quartile were examined. In this report, children in the top decile of costs were classified as high cost to focus more on youth with the highest costs. The characteristics of children in the top decile of expenditures were compared to the remaining 90% of children. FSFN data provided information on child age, race (Asian, White, Black; in some cases multiple categories were selected and in some cases none were selected), and gender, as well as substance abuse for parent child, domestic violence, reasons for removal and other household characteristics. In addition, there was information on child outcomes (reunification, guardianship, adoption, remained in out-of-home care, or aged out of the child welfare system).

The first step was to examine the distribution of child welfare costs. Total costs were computed for each child in the SFY 13-14 cohort through SFY 16-17. Thus, total costs include the costs during the out-of-home stay that began in SFY 13-14. In addition, for children were discharged from the SFY 13-14 out-of-home stay but had subsequent re-entry into out-of-home care, the total costs would include the costs from the subsequent out-of-home care as well. Table 17 contains the distribution of child-level costs. Ten percent of children had costs below $292, while 25% of children had total costs below $1,197. Children at the 90th percentile had costs greater than $51,628. Children with costs above $51,628 were classified as high cost, while children below $51,628 were classified as lower cost.

Table 17

Distribution of Costs

	Percentile				
	10	25	50	75	90
Total cost	292	1,197	6,950	19,790	51,628

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Child and household characteristics for high and lower cost children are provided in Table 18. Children in the top decile of costs had average costs of $93,170 compared to $9,810 for the other 90% of children. Thus, among children with total costs above $51,628, the average cost was $93,170. Children with high costs were older with an average age of 12.3 years compared to 5.6 years for other children. Children who were Black were more likely to be in the high cost group compared to Whites. Thirty-eight percent of the lower cost group was Black compared to 48.8% of the high cost group. Interestingly, parental drug abuse and

domestic violence in the household were associated with a lower probability of being in the high cost group. Over 40% of the low cost group involved parental substance abuse compared to 17.4% of the high cost group. Children in the high cost group were more likely to be the victims of sexual abuse or an absence of care (e.g., due to parent incarceration, death, abandonment of child, or relinquishment of custody). Children in the high cost group were also more likely to have reported behavioral problems (14.3% versus 3.5%).

Table 18

Child Characteristics

		Lower cost (n=7,983)	**High cost (n=887)**
		%/mean	**%/mean**
Total cost		9,810	93,170
Males		50.2%	51.5%
Age		5.6	12.3
White		66.8%	54.6%
Black		37.6%	48.8%
Physical health problems		0.8%	3.0%
Single parent - Female		52.3%	51.8%
Single parent - male		4.0%	9.8%
Two parent family		44.3%	40.4%
Reasons for service			
Parental substance abuse		44.1%	17.4%
Domestic violence		15.0%	6.5%
Sexual abuse		3.6%	8.2%
Physical abuse		14.4%	16.0%
Neglect		42.3%	43.1%
Absence of care		23.8%	42.5%
Child behavioral problems		3.5%	14.3%
Threatened harm		1.2%	1.2%

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Table 19 compares the types and duration of placements for high cost children compared to other children. The number of days in each placement type were computed from the removal date in SFY 13-14 through 16-17. High cost children spent much more time in residential settings and spent much less time with relatives. Other differences (e.g., RTC level of care, corrections) also point towards greater complexity of needs for high cost youth.

Table 19

Placements

	Lower cost (n=7,983)	High cost (n=887)
	Mean	**Mean**
Days in foster care - non-relative	235.6	180.6
Days in RTC	1.7	23.3
Days in correctional	4.4	34.8
Days in licensed care	0.5	23.7
Days in non-relative care	62.9	28.7
Days in relative care	201.3	50.5
Days in residential	23.8	345.1
Days in independent living	0.0	0.0
Number of placements	2.3	3.0

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Child outcomes are provided in Table 20. Children in the high cost group had very different outcomes than other children. Discharge from out-of-home care was less likely for children in the high cost group. In particular, reunification with the parents and adoption were less likely. Reunification occurred for 29.7% of children in the lower cost group, compared to 15.3% of the high cost group. Adoption was the outcome in 37.1% of cases in the lower cost group compared to 8.5% of the high cost cases. Rates of guardianship were also lower for children in the high cost group (4.5% versus 13.0%). A higher percentage of children in the high cost group aged out of the child welfare system (17.2% versus 2.8%). Clearly, the lower likelihood of achieving permanency led to longer lengths of stay and higher costs.

Table 20

Child Welfare Outcomes

	Lower cost		High cost	
Number of children discharged	6,665		409	
Number of children in sample	7,983		887	
% discharged	83.5%		50.6%	
Permanency time (in months)	22.0		35.8	
	% of discharged	**% of all youth**	**% of discharged**	**% of all youth**
Adoption	44.4%	37.1%	18.3%	8.5%
Age of majority/child turned 18/emancipation	3.5%	2.9%	38.1%	17.5%
Death of child	0.0%	0.0%	0.2%	0.1%
Guardianship	15.6%	13.0%	9.8%	4.5%

Living with other relatives	0.1%	0.1%	0.0%	0.0%
Reunification	35.6%	29.7%	33.3%	15.3%
Transfer to another agency	0.8%	0.7%	0.2%	0.1%

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Medicaid-funded service use is reported in Table 21. The mean and median expenditures are reported for high cost and lower cost children and by service type. The distinction between high and lower cost continued to be based on child welfare costs. Thus, the purpose was to examine Medicaid-funded service use among children who had high costs in the child welfare system. Nearly all youth in the SFY 13-14 out-of-home cohort used some Medicaid-funded services between SFY 13-14 and 16-17. Average Medicaid costs for the 876 high cost children that used Medicaid-funded services were $39,902 compared to $17,102 for the 7,983 lower cost children that used Medicaid services. A higher percentage of high cost youth received Medicaid-funded out-of-home care (e.g., Statewide Inpatient Psychiatric Program, SIPP; Specialized Therapeutic Foster Care, STFC; or Specialized Therapeutic Group Homes, STGH). Twenty percent of high cost children received Medicaid-funded out-of-home services while 7.9% of lower cost children received Medicaid out-of-home services. In addition to being more likely to use specific services, high cost children also had higher Medicaid costs for most services. Notable differences include Medicaid-funded out-of-home care ($65,920 versus $41,256) and outpatient services ($12,388 versus $7,040).

Table 21

Medicaid-Funded Service Use

	Lower cost (n=7,983)			**High cost (n=887)**		
	# Children	**Mean**	**Median**	**# Children**	**Mean**	**Median**
Children that used any service	7,874	17,102	5,570	876	39,902	17,091
Assessment	5,883	558	462	835	832	700
Crisis care	64	185	128	12	179	159
Developmental disability care	706	226	196	33	77	27
Emergency room	6,045	884	537	762	1,747	874
Inpatient	2,526	15,713	3,901	450	17,457	6,156
Other	37	2,597	1,800	21	5,400	3,848

Out of home	632	41,256	26,365	182	65,920	47,127
Outpatient	7,811	7,040	3,142	876	12,388	8,543
Targeted case management	2,403	1,672	624	367	5,020	1,968
Treatment planning	4,060	246	194	759	346	291

Note. Data Source: DCF Office of Child Welfare, DCF Office of CBC/ME Financial Accountability, and Agency for Health Care Administration. Run date: 03-29-2018.

SAMH-funded service use is reported by SAMH cost center in Table 22. Fewer youth in the SFY 13-14 out-of-home cohort used some SAMH-funded services between SFY 13-14 and 16-17. Average SAMH costs for high cost children were $2,453 compared to $1,855 for lower cost children. A higher percentage of high cost youth received crisis support/emergency services and residential services, although neither was utilized by a large number of children.

Table 22

SAMH Funded Service Use

	Lower cost (n=7,983)			**High cost (n=887)**		
	N	**Mean**	**Median**	**N**	**Mean**	**Median**
Children that used any service	1,416	1,855	402	431	2,453	702
Assessment	220	428	86	90	189	172
Case management	597	480	148	151	647	316
Crisis support/emergency	279	559	98	149	1,178	310
In-home and on-site services	171	1,284	513	32	1,622	772
Intervention	285	658	329	116	372	202
Medical services	195	1,647	739	70	1,240	942
Outpatient	628	535	262	193	591	264
Residential level 1	70	13,009	5,919	33	12,557	7,309
Substance abuse detox	35	1,687	842	18	1,379	1,025
Tx Alt for Safe Cities (TASC)	103	458	200	43	696	247
Non-contract services	31	258	50	22	95	50

Note. Data Source: DCF Office of Child Welfare, DCF Office of CBC/ME Financial Accountability, and DCF Substance Abuse and Mental Health. Run date: 03-29-2018.

Discussion

This report examined the trend in costs for licensed foster care and front-end prevention services. The analysis used data that covered a pre-Demonstration period, the initial Demonstration, and the Demonstration extension and updated some results from Armstrong et al' (2017). Compared to the pre-Demonstration period, expenditures for front-end prevention services increased during the initial Demonstration and have continued to increase during the Demonstration extension. Consistent with one of the goals of the Demonstration, the ratio of expenditures for licensed foster care to expenditures for front-end prevention services has trended downward over time.

This report also examined child-level data on costs as reported by fiscal agencies, and examined the relationship between specific child and parent characteristics and the likelihood of a child being a high cost case. Overall, a high cost child tends to be older, more likely to be a victim of sexual abuse and/or neglect, with parents that were more likely to abandon the child or be unable to provide care. However, parental substance abuse or domestic violence in the household is less common. Such children are more likely to have very severe behavioral problems perhaps reflecting the severity of the maltreatment and/or the severity of the child's mental health problems.

Children that had high child welfare costs also tended to have high Medicaid costs. This finding reinforces the idea that cross-system children, who receive services from multiple public sector agencies, should be emphasized in research efforts. The importance of cross-system children is not new. In September 2015 the Governor of Florida issued Executive Order 15-175 directing the Department of Children and Families to conduct a comprehensive review of local, state, and federally funded behavioral health services and to analyze how those services are delivered and how well they are integrated with other similar and/or interdependent services within a community. The report examined how children with behavioral health needs used behavioral health services, and were also involved with multiple systems including Medicaid, SAMH, child welfare system, and juvenile justice (Boaz, Robst, Christy, & Teague, 2016). The combined public sector costs are substantial for youth with complex behavioral health needs, and efforts are necessary to ensure that these youth receive the most appropriate treatment.

The results in this report have implications for the Demonstration. Given the high cost for children that have complex needs, the question becomes whether new programs could be developed that use the flexibility provided in the Demonstration to provide parents with the needed support to maintain the child in the home. Most parents of high cost children do not appear to have substance abuse problems or domestic violence in the household. High cost

children are more likely to receive out-of-home care due to an absence of care, and childhood behavioral problems. Given the high costs to the child welfare and Medicaid programs, such an intervention could provide an intensive support and treatment framework and remain cost-effective.

Next Steps

An essential question is whether the type and amount of child welfare services, Medicaid services, and SAMH services are associated with better outcomes (e.g., permanency, reunification, guardianship, and adoption) for high cost children in child welfare. This question is important, yet challenging to answer. It is necessary to examine Medicaid and SAMH services for youth that have similar needs. Services can differ for youth with similar needs due to a variety of factors including geographic location (urban versus rural) and availability of specific services.

Sub-Study One: Cross-System Services and Costs

Medicaid and SAMH service use among children receiving in-home child welfare services

Many children involved with the child welfare system are not removed from their families; instead children are receiving services in their homes and communities. Families whose children remain in the home after a maltreatment investigation typically have substantial service needs (U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, 2013). In-home child welfare services play an important role in children's safety, permanency, and well-being.

The receipt of in-home services indicates the youth remained in the home and was not placed in relative or non-relative foster care. It does not indicate the timing of child welfare (or other) services. In-home child welfare services might be offered to families if a maltreatment allegation is substantiated but the child is deemed safe, if the child is being reunified but the family continues to need services, and in some cases when the maltreatment allegation is not substantiated but the family needs services. The trauma and negative outcomes associated with a child's removal from his or her family highlights the importance of having effective in-home services to stabilize and strengthen the family to prevent the need for out-of-home care. Indeed, one of the primary goals of Demonstration projects nationwide is to provide greater resources for States to increase the likelihood of a youth being able to remain in the home, and to decrease the use of or length of stay in out-of-home services.

Research findings emphasize the reasons for a greater focus on services received by children remaining in the home. Children receiving in-home services have physical, developmental, and mental health needs that are similar to youth in out-of-home care (Leslie, Gordon, Memeken, et al., 2005). Similarly, children remaining in the home were just as likely to score in the clinical range of the Child Behavior Checklist, but were less likely to receive mental health services (Burns, Phillips, Wagner, et al., 2004). Thus, given a similar level of child need, lead agencies and case managers should work with parents/caregivers to ensure that children remaining in-home are getting the services they need to address physical and behavioral health needs.

As reported in earlier evaluation reports, the State has used the flexibility of the Demonstration to increase funding for preventive in-home services (e.g., Armstrong, Vargo, Cruz et al., 2017). However, IV-E funds are only one source of funds for services needed by children and families. An optimal in-home services program would ensure that both children and parents access available services to minimize the needs for out-of-home placement. Such services include those funded by IV-E and other child welfare funding sources, but also include

physical and behavioral health services available through Medicaid and Substance Abuse and Mental Health (SAMH) programs. Children have high rates of mental health problems and medical needs. The purpose of this report was to look at children and youth who receive child welfare in-home services and examine their health care utilization before and during in-home child welfare services. Medicaid and SAMH data were used to determine the health care services received, and whether the receipt of child welfare in-home services affected health care service use.

Research Questions

This report addressed the following research questions.

1. What proportion of children who received in-home child welfare services were Medicaid enrolled?
2. How many children who received in-home child welfare services used Medicaid-funded services? What were the average expenditures for each child that used services?
3. Did Medicaid-funded service use decline as the child spent more time in child welfare?
4. What types of Medicaid-funded services did youth use? What were the average expenditures for each service category?
5. How many children received SAMH-funded services? What were the average expenditures for each child that used services? What types of SAMH-funded services did children receive?
6. Were expenditures for Medicaid-funded services affected by the reason the child received in-home child welfare services? Youth receiving in-home child welfare services due to medical neglect should see an increase in physical health services, while youth with potential trauma due to sexual abuse should see an increase in behavioral health services.

Data

The sample was identified from the Statewide Automated Child Welfare Information System (SACWIS), which in Florida is the Florida Safe Families Network (FSFN). Subjects were children and youth, ages 0-18, who received in-home child welfare services from July 1st, 2015 to June 30th, 2016. Because the goal is to examine the use of health care services, a minimum duration for in-home services was set to 31 days. Given the lags that often occur in receiving treatment, children receiving child welfare in-home services for less than a month may not have the opportunity to access health care resources before the end of in-home services.

FSFN data was the source of demographic variables (age, race, ethnicity, gender), as well as the date the child started in-home services and the reason the children received in-home

services. Reasons for entering in-home services included abandonment, alcohol abuse by child, alcohol abuse by parent, caregiver unable to care for child, child behavior problems, child disability, domestic violence in the household, drug abuse by child, drug abuse by parent, emotional abuse or neglect, inadequate housing, inadequate supervision, medical neglect, parents incarcerated, physical neglect, relinquishment of custody, requested services, or sexual abuse. Several reasons for services, including abandonment, parental incarceration, parental death, and relinquishment of custody may seem inconsistent with the child remaining in the home. This likely reflects a more inclusive concept of family and the role of extended family. As noted by Landsman (2015), the distinction between keeping children at home and keeping children with family is not always clear. In other words, the receipt of in-home services does not necessarily indicate the youth remained in the same home, as they move to live with another parent or family members.

Medicaid claims and encounter data included all fee-for-service claims, and encounters from the Statewide Medicaid Managed Care (SMMC) program. In 2014, most Medicaid recipients were transitioned to the SMMC program that became responsible for both physical and behavioral health care. In addition, a specialty SMMC plan (Sunshine Health Child Welfare Specialty Plan) was created that specializes in providing services to children and youth in the child welfare system. Children in the child welfare system are enrolled in either a standard managed care plan or the specialty plan. Medicaid data provided information on each service received by children and youth. Data were available on the dates of service, diagnoses, and expenditures for each service. Expenditures denoted the amount paid to the provider of service by the Medicaid program (when the child was enrolled in the fee-for-service program) or the managed care organization (when the child was enrolled in a SMMC plan). Services were classified as physical or behavioral health based on the primary diagnosis on the claim or encounter. Health care utilization was examined in the year prior to starting in-home services and during the time the child received in-home services. The duration of child welfare in-home services can be more or less than one year.

The Substance Abuse and Mental Health Information System (SAMHIS) provides data for substance abuse and mental health services paid through the State's SAMH program. Information included the dates of service, diagnosis, and expenditures for each substance abuse or mental health service.

Findings

Table 23 contains descriptive statistics for the sample of youth. There were 11,594 children that started child welfare in-home services during SFY 15-16. The children averaged 6

years of age, and slightly more than half were males. The majority of the sample was White (59.7%). The reason for in-home services is reported for 86% of the children, with domestic violence (25.4%) and parental drug abuse (21.1%) being the most common.

Table 23

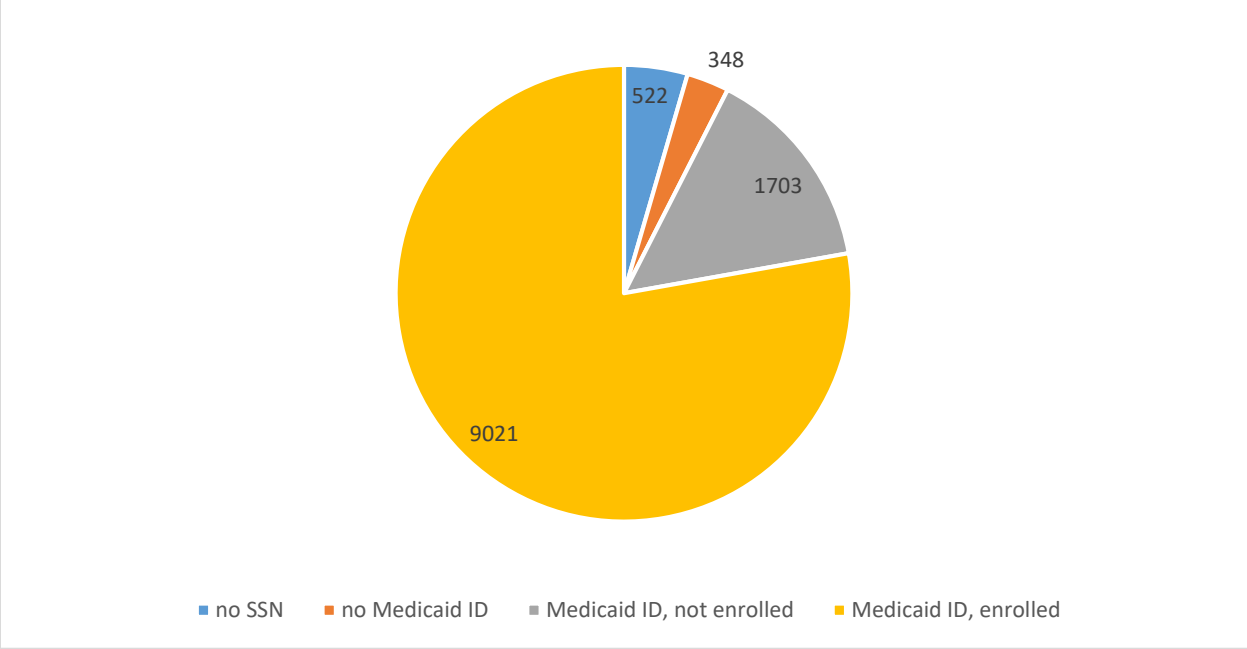
Descriptive Statistics

	Children	**%/Mean**
Age (in years)	11,594	6.24
Gender		
Female	5,623	48.5%
Male	5,910	51.0%
Unknown	61	0.5%
Race		
Black	3,744	32.3%
White	6,916	59.7%
Other	934	8.1%
Ethnicity		
Hispanic	1,980	17.1%
Reason for in-home services		
Abandonment/Relinquishment	126	1.0%
Alcohol abuse child	12	0.1%
Alcohol abuse parent	786	6.8%
Caregiver unable to care for child	556	4.8%
Child behavior problems	116	1.0%
Child disability	35	0.3%
Domestic violence	2,950	25.4%
Drug abuse child	84	0.7%
Drug abuse parent	2,444	21.1%
Emotional abuse/neglect	451	3.9%
Inadequate housing	389	3.4%
Inadequate supervision	1,000	8.6%
Medical neglect	264	2.3%
Parents incarcerated/death	174	1.5%
Physical neglect	96	0.8%
Requested services	313	2.7%
Sexual abuse	156	1.4%

Research question one. What proportion of children who received in-home child welfare services were Medicaid enrolled?

Figure 9 provides a summary of the steps taken to determine Medicaid enrollment during in-home child welfare services. Table 23 contains a starting point for this study, the number of children in the FSFN data that began in-home child welfare services in SFY 15-16. Of the 11,594 children, 522 did not have a valid Social Security Number (SSN) reported in FSFN and were not matched to Medicaid data. Extracting Medicaid claims and encounter data was performed in three steps. First, the FSFN data had information on child SSN, but Medicaid claims and encounter data use the Medicaid ID. The Medicaid recipient file contains both the child SSN and Medicaid ID. Of the 11,072 children with valid SSNs, only 348 did not match to the Medicaid recipient file based on SSN and thus did not have a Medicaid ID number. Second, Medicaid enrollment data were used to determine if the child was enrolled in the Medicaid program during in-home child welfare services. There were 9,021 youth enrolled in the Medicaid program during in-home child welfare services, while 1,703 youth with a Medicaid ID were not enrolled during in-home child welfare services; enrollment either ended before the start of child welfare in-home services or did not start until after services ended. Third, Medicaid claims and encounter data were extracted for the 9,021 children who were Medicaid enrolled during child welfare services.

Figure 9. Matching between FSFN and Medicaid (n = 11,594)



Research question two. How many children who received in-home child welfare services used Medicaid-funded services? What were the average expenditures for each child that uses services?

There were 7,659 children that used Medicaid-funded physical and behavioral health services in the year prior to starting in-home child welfare services. That represents 66% of the 11,594 children in the sample and 85% of children who were Medicaid enrolled during child welfare services. The use of a before period enables determination of whether Medicaid service use increased, decreased, or remained the same after the child began child welfare services. There were 7,428 children who received Medicaid-funded services during in-home child welfare services. That represents 64% of all children in the sample, and 82% of Medicaid enrolled children.

Table 24 contains the distribution of monthly expenditures for Medicaid services. Because the duration of in-home services varies across youth, expenditures are reported on a per user per month basis. As is typical with health care expenditure data, the distribution is highly skewed. The median monthly expenditures were $91 in the year prior to child welfare services and $89 during child welfare services. Thus, half of the children had monthly expenditures below $91 in the year prior to child welfare services. However, the 90th percentile was $976 and $517 respectively. Children in the top decile of monthly expenditures had expenditures greater than $976.

Table 24

Users of Medicaid Services and the Distribution of Monthly Expenditures

	Users of Medicaid services	**% of all children**	**% of Medicaid enrolled**	**Distribution of monthly expenditures for users of services (percentile)**				
				10th	**25th**	**50th**	**75th**	**90th**
Before	7,659	66%	85%	10	28	91	267	976
During	7,428	64%	82%	11	33	89	215	517

One challenge with the comparison in Table 24 is that the length of time a child received in-home services varies. While the before period was defined to be one year (365 days), on average, children received in-home services for 226 days. In addition, the range was from 31 to 837 days. Thus, for children that received in-home for less than a year, the observation window was shorter during in-home services than before. For youth that received in-home services for more than a year, the observation window was longer during child welfare services. The

number of children that use Medicaid-funded services depends on the length of exposure. In other words, children observed for a longer time are more likely to use some services. Given the duration of in-home services averaged less than a year, the comparison of the number of service users may be misleading. In order to account for differing exposure times, services were examined for the same time before and during in-home services. For youth that received in-home services for less than a year, the length of the pre-period was reduced to match the time in in-home services. For youth that received in-home services for more than a year, the length of the during-period was reduced to one year. In this way, the analysis compares Medicaid services for each child received in the same number of days before and during child welfare services .

Table 25 contains the proportion of youth that used Medicaid-funded services as well as the distribution of monthly expenditures. Accounting for the time that a youth received in-home services led to a clearer picture. More youth received Medicaid-funded services during child welfare in-home services than before the start of child welfare in-home services. In addition, the distribution of expenditures suggests that among children that received Medicaid-funded services, most children received more services during in-home child welfare services than before. For example, the median expenditures were $61 per month prior to the start of in-home services and $87 per month during in-home services.

Table 25

Users of Medicaid Services and the Distribution of Monthly Expenditures: Equal pre- and during Time Periods

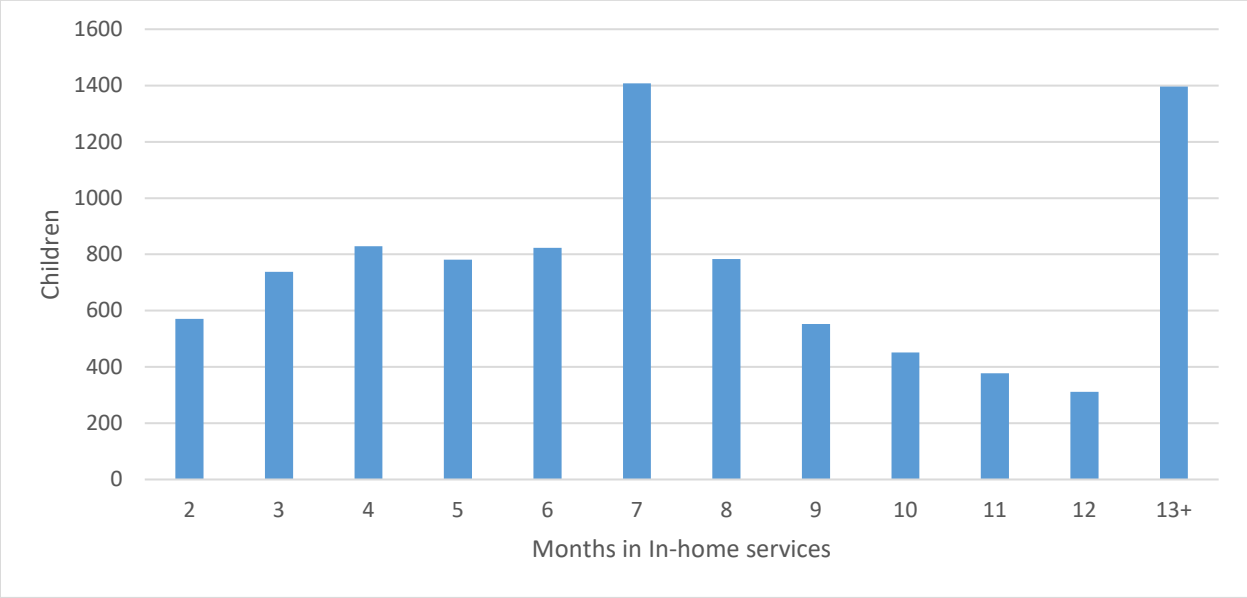
	Users of Medicaid services	**% of all youth children**	**% of Medicaid enrolled**	**Distribution of monthly expenditures for users of services (percentile)**				
				10th	**25th**	**50th**	**75th**	**90th**
Before	6,957	60.0%	77.1%	6	17	61	196	820
During	7,394	63.8%	82.0%	11	31	87	211	509

Research question three. Did service use decline as the child spent more time in child welfare?

Medicaid-funded services are an important source of physical and behavioral health care for children in the child welfare system. Another question is whether services were provided on an ongoing basis or whether there was a big push at the beginning of child welfare services followed by a decline as time passed.

This research question was answered in three steps. First, Figure 10 provides a simple chart to highlight the duration of in-home services. All children received in-home services for at least 31 days because 30 days or more of in-home services was required to be in the sample. Treatment lasted between 1 and 2 months for 571 children. The largest spike was in the seventh month when 1,408 children left in-home services. There were 1,396 children who received in-home services for more than one year.

Figure 10. Duration of In-Home Services



Second, the proportion of children that were enrolled in Medicaid during a month that received services was computed. Thus, for each month of the first year, it was determined how many children were Medicaid enrolled at the end of the month. Of those youth, it was determined how many used services in that month. The percentages are reported in Table 26 and indicate that 44-51% of youth used services in a given month. The percentage was stable from months 1 to 8, but began to decline over the last few months.

Table 26

The Percentage of Children who are Medicaid Enrolled that use Services in each Month

Month receiving in-home services	**Number of Medicaid enrolled children at end of month**	**Number of children that used Medicaid services**	**% of children that used services**
1	9,021	4,341	48.1%
2	8,450	4,079	48.3%
3	7,712	3,645	47.3%

4	6,883	3,305	48.0%
5	6,102	2,892	47.4%
6	5,279	2,485	47.1%
7	3,871	1,968	50.8%
8	3,088	1,473	47.7%
9	2,535	1,155	45.6%
10	2,084	941	45.2%
11	1,707	745	43.6%
12	1,396	608	43.6%

Third, in order to examine how expenditures changed over time, an individual fixed-effects model, sometimes referred to as a within-person model, was estimated. Separate observations were created for each month that the child received in-home services. The dependent variable was the Medicaid expenditures during that month. The independent variables were the month in in-home services (ranging from 1 to 28), and dummy variables for each youth in the data. We also explored whether the effect of time was linear by including a variable denoting months squared. This regression approach controlled for variation in service use across children and focused on the change in expenditures for each child over time. The results are in Table 27 and specification #1 indicates that expenditures declined by about $9 per month; although the coefficient was not significant at the $p<.05$ level. While the coefficient may seem small, the median expenditure during in-home services was $89. Specification #2 suggests that the decline was non-linear where there was a steeper decline during the early months with the decline moderating as months passed.

Such a decline may be appropriate. At the start of in-home services, youth may need assessments, treatment planning, and both physical and behavioral health treatment to address on-going issues. The question is whether the decline in Medicaid-funded services was medically warranted due to an improvement in the youth's condition, or whether it reflected time limits imposed by a managed care organization, or some other non-medical reason. This analysis of administrative data cannot answer this question.

Table 27

Regression Results: Expenditures and Time in In-Home Services

	Specification #1			Specification #2		
	Coef	**Std err**	**p value**	**Coef**	**Std err**	**p value**
Intercept	240.9	1629.9	.910	357.9	1631.1	0.826
Month	-9.3	7.5	0.215	-40.4	19.0	0.034
Month squared	--			1.9	1.0	0.076
Individual fixed effects	Yes			Yes		
R squared	0.339			0.340		

Research question four. What types of services did youth use? What were the average expenditures for each service category?

Table 28 contains the mean and median expenditures by type of service. In order to compare the pre- and during periods, the pre- and during periods were set to be equal duration for each youth. Three services, outpatient, inpatient, and emergency room, were divided into physical health and mental health services based on the primary diagnosis. Inpatient stays that encompassed the child's birth were placed in a separate category due to the large number of children and high average expenditure. Fewer children used physical health inpatient services during child welfare in-home services than before child welfare services began, while the use of physical and behavioral health outpatient services, targeted case management, and treatment planning services all increased. However, emergency room visits for physical health reasons also increased. It is also worth noting that, unlike children entering out-of-home care, most youth who received child welfare in-home services did not receive behavioral health assessments.

Table 28

Mean and Median Monthly Expenditures by Medicaid Service

	Before In-home Services			During In-home Services		
Service	**Number of children**	**Mean ($)**	**Median ($)**	**Number of children**	**Mean ($)**	**Median ($)**
Assessment	1,801	60	36	2,151	34	10
Developmental Disability Care	130	22	16	143	35	20

ER - BH	90	34	16	70	95	18
ER - PH	2,716	48	21	3,032	69	36
Inpatient - BH	140	1,030	249	123	1,172	363
Inpatient - PH	646	2,378	393	402	2053	493
Inpatient - Birth	783	12,441	509	--		
Out of Home	57	1,604	887	15	2137	413
Outpatient - BH	6,072	135	22	6,539	184	36
Outpatient - PH	1,753	119	29	2,611	171	66
Targeted Case Management	451	77	21	695	114	29
Treatment Planning	764	11	8	1,449	28	14

Research question five. How many children received SAMH-funded services? What were the average expenditures for each child that used services?

This question examined service use paid by the Substance Abuse and Mental Health system in Florida. The FSFN file with child identifiers was matched to SAMHIS service data based on Social Security Numbers. Youth do not enroll in the SAMH program like Medicaid. Rather data were available only for youth who receive services through the system.

Table 29 contains the proportion of children that received SAMH services, as well as the distribution of monthly expenditures for users of services. Less than 3% of youth that received in-home child welfare services used SAMH funded services. Even among users, the distribution suggests that most youth did not receive a sizable number of services. The Medicaid program appears to provide the vast majority of behavioral health services to youth receiving in-home child welfare services. For example, over 6,000 children received Medicaid behavioral health outpatient services, well in excess of the number of children that received any SAMH funded service..

Table 29

Users of SAMH Services and the Distribution of Monthly Expenditures

	Users of SAMH services	% of all children	Distribution for users of services				
			10th	25th	50th	75th	90th
Before	331	2.9%	2	6	12	35	101
During	277	2.4%	2	5	14	45	160

Table 30 contains the utilization of specific SAMH funded services. Services are reported by SAMHIS cost center with some cost centers combined due to small sample sizes. The most notable services provided through SAMH were case management and outpatient services. However, the 105 children that received case management services prior to in-home services represented less than 1% of the sample. A similarly low percentage received outpatient services.

Table 30

Mean and Median Expenditures by SAMH Cost Center

	Before			During		
Cost Center	N	Mean	Median	N	Mean	Median
Assessment	45	93	7	33	13	6
Case Management	105	38	11	91	30	8
Crisis Support/Emergency	54	32	5	23	25	9
In-Home & On-Site Services	28	37	29	17	91	39
Intervention	55	56	20	43	71	22
Medical Services	17	44	31	11	22	15
Non-Contractual Services	<10	40	14	<10	23	16
Outpatient	131	13	7	141	32	12
Residential/Detox	<10	773	408	<10	627	544
TASC (Tx Alt for Safe Cities)	<10	13	5	<10	53	10

Research question six. Was the reason the child received in-home child welfare services associated with expenditures for Medicaid-funded services?

The last research question examined whether there was a relationship between the reason for in-home child welfare services and the receipt of Medicaid services. Given the declining Medicaid service use over the duration of in-home services time, two different time frames were considered; the first six months of in-home services and the duration of in-home services. A linear regression was estimated where the dependent variable was the average monthly expenditures for the child during in-home services. The independent variables included demographic variables (age gender, race, and ethnicity), the reason for in-home child welfare services (abandonment, alcohol abuse by child, alcohol abuse by parent, caregiver unable to care for child, child behavior problems, child disability, domestic violence in the household, drug abuse by child, drug abuse by parent, emotional abuse or neglect, inadequate housing, inadequate supervision, medical neglect, parents incarcerated, physical neglect, relinquishment of custody, requested services, or sexual abuse), average monthly expenditures in the year prior to in-home services beginning, the length of time receiving in-home services, whether the child was born in the prior year, and an interaction between being a prior year birth and prior year expenditures. In order to achieve a parsimonious model, a stepwise approach was utilized that only retained coefficients significant at the $p<.05$ level. Distinguishing newborns was important because of the high prior year expenditures and the expectation that expenditures remained elevated for some period. The interaction between prior year birth and prior expenditures accounted for the fact that the relationship between prior year and current expenditures may differ for newborns compared to other children.

The regression results are in Table 31. The results were very similar for the first six months of in-home services, and for the duration of in-home services. The first noteworthy result is that none of the reasons for in-home services were significantly associated with Medicaid expenditures during in-home services. It was expected that youth who received in-home services due to medical neglect would have increased physical health services, while youth with sexual abuse histories required behavioral health services. However, no reason was significantly associated with average monthly expenditures during in-home services. Prior year expenditures were positively associated with Medicaid expenditures during in-home services. Time in care was negatively associated with monthly Medicaid expenditures. This reflects the decline in service use over time, leading to lower average monthly expenditures. Newborns had higher expenditures while in in-home services. However, as expected, the relationship between prior monthly expenditures and expenditures while receiving in-home services was weaker.

Table 31

Regression Results

	First Six Months			Duration of In-Home Services		
	Coef	Std err	p value	Coef	Std err	p value
Intercept	193.30	37.96	<.0001	144.50	38.61	0.0002
Prior year expenditures	0.58	0.03	<.0001	0.71	0.03	<.0001
Time in-home care	-0.68	0.14	<.0001	-0.41	0.14	0.0032
Prior year birth	420.41	59.00	<.0001	426.05	60.01	<.0001
Prior year expenditures*Prior year birth	-0.37	0.03	<.0001	-0.46	0.03	<.0001
R squared	0.0637			0.0814		

Discussion

This sub-study examined Medicaid and SAMH service use for children that received in-home child welfare services. The majority of youth that receive in-home child welfare services are Medicaid enrolled and used Medicaid-funded services. SAMH was not a substantive funding source for these youth. More youth used Medicaid funded services after in-home child welfare services began, although use declined over the duration of in-home child welfare services. More specifically, there was increased use of physical and behavioral health outpatient services, targeted case management, and treatment planning services. Medicaid-funded service use was not associated with the reason for in-home child welfare services. This was a surprising result given that one of the reasons for in-home services is medical neglect.

Further research is needed to determine if the decline in service use during in-home services is medically warranted, why the reasons for receipt of in-home services were not associated with Medicaid-funded services, and whether Medicaid- and/or SAMH-funded services enable the children to remain in the home and avoid the need for out-of-home placement.

Sub-Study 2: Services and Practice Analysis/Outcome Analysis for Safe, but High Risk for Future Maltreatment

Practice analysis

The practice analysis includes two components: a set of case file reviews, followed by corresponding interviews with case managers and parents. The original intent of this analysis was to compare a set of cases that received Family Support Services under the child welfare practice model (intervention group) with a set of cases that received voluntary services under the old practice model (comparison group) to examine practice changes implemented under the child welfare practice model and the impact that such changes have had on family engagement and participation in voluntary services. There were some unexpected challenges that have altered the approach somewhat, in that the evaluation team was unable to draw a comparison group as initially proposed. As a result, the team was only able to review a set of cases that met the intervention group criteria and thus can only provide a descriptive analysis of FSS practice rather than a comparative analysis. Findings from the case file reviews are described in this report.

Methods. As described in previous reports, one lead agency, Eckerd Community Alternatives (Circuit 6) was selected to conduct case file reviews for this sub-study (Armstrong, Vargo, Cruz et al., 2017). Eckerd was selected because they had the greatest number of cases that met the intervention criteria (n = 1,584), which were cases assessed as safe but high or very high risk that received Family Support Services. There were some difficulties in drawing the sample, as discussed in prior reports. Ultimately, a sample of intervention cases was drawn, but a comparison group could not be drawn because the case numbers from FSFN did not match any of the lead agency's records. When asked if the lead agency could draw a sample from their files using the comparison group criteria, the agency reported that it was unable to do so. A decision was made to proceed with the intervention group case file reviews, and the reviews were completed in early December 2017. A case file review protocol was developed to capture data from the files (see Appendix F). The protocol included a combination of closed- and open-ended response items and gathered both quantitative and qualitative data.

A sample of nine cases that received Family Support Services were reviewed using the case file review protocol. Descriptive statistics were produced using SPSS for data that was appropriate for quantitative analysis (e.g. frequencies, means, and medians). This includes information about the family composition, abuse allegations, safety and risk determinations, and various components of case practice that were assessed using a binary Yes/No checklist. Open-coding was performed on the qualitative data to identify key themes and patterns

emerging form the data. This analysis further entails looking at how different pieces of data within a case file relate to one another; for example, do the services provided to the family align with the needs identified in the family assessment?

Findings. The number of children involved in the cases reviewed ranged from two to five, with a median of three children per case. The children ranged in age from younger than one year to 17 years. The mean age of the youngest child in the household was 2.8 years, while the mean age of the oldest child in the household was 12.1 years. Eight of the nine families had at least one child under the age of five. Just under half (n = 4) of the cases were a single-parent household headed by the biological mother. A third of the cases (n = 3) were two-parent households composed of both biological parents, while one case was a two-parent household comprised of the biological mother and her current spouse (the children's step-father). The final case was a relative caregiver who had legally adopted the children in her care. Just under half of the caregivers (n = 4) were in their mid-to-late 20s (ages 25-29), a third (n = 3) were in their 30s, and two were over the age of 40.

Most cases included more than one abuse allegation, and all but one case had at least one substantiated allegation. The most common allegations included environmental hazards, inadequate supervision, domestic violence, substance abuse, and parental mental health problems (see Table 32). Additionally, trouble meeting basic needs (e.g. food, clothing, and housing due to poverty) and uncontrolled child mental health problems were significant identified needs on several cases. For the majority of cases, the children were determined to be safe but high or very high risk, and thus appropriate for Family Support Services. On three cases, however, the CPI assessment in the file indicated that children were determined to be unsafe, although the information included in the family assessments did not necessarily support such conclusions. For example, one case had no substantiated allegations, but the children were still determined to be 'unsafe' by the CPI. On another case, the CPI concluded that "domestic violence in the home poses threat to child safety," but the information gathered by the CPI indicated that the father was threatening to harm himself and no one else, and the children were not present when the incident occurred. These findings indicate some inconsistencies with the child welfare practice model, since families with a determination of 'unsafe' are not eligible for Family Support Services and should always be provided with mandatory child welfare services, and since the information included in the assessments does not appear to support some of the safety determinations. Furthermore, the findings are inconsistent with the data that was pulled from FSFN, since inclusion criteria used to select the cases were limited to families that were assessed as safe but high or very high risk. Thus, it appears that in some

cases the assessment results entered into FSFN by caseworkers do not necessarily align with the assessments in the case files.

Table 32

Child Abuse and Neglect Allegations and Findings from Investigation (n = 9)

Allegation	Substantiated (# cases)	Unsubstantiated (# cases)	Total # Cases
Environmental hazard	2	1	3
Inadequate supervision	1	2	3
Threatened harm to child	1	1	2
Medical neglect	0	1	1
Sexual abuse	0	1	1
Domestic violence	1	2	3
Substance abuse	3	0	3
Parental mental health	0	3	3
Child mental health	0	2	2
Basic needs	0	2	2

With regard to family assessment, three of the cases reviewed did not have an initial Family Functional Assessment (FFA) in the file, although it is entirely possible that the FFA was completed and simply was absent from the case management case files. All but one of the cases had at least one updated family assessment competed by the case manager in the file, although for two of the cases it was not the official Department FFA, but a different assessment used by the case management agency. Of the six cases that had a FFA-initial on file, most (n = 5) indicated that interviews were completed with the mother, with additional relatives and/or adult household members, and with other collaterals (such as school personnel, doctors, neighbors, etc.). Two-thirds of these cases (n = 4) indicated that interviews were completed with at least some of the children. Some children were too young to interview, but in some cases children who were old enough were not interviewed. Only two cases indicated that interviews were completed with the biological fathers. Although the biological fathers did not live in the same household as the children in several cases, the FFA in the files provided no indication of whether or not these fathers had any involvement with their children or whether any attempts were made to contact them. Additional sources of information noted in the files for completing the FFA included police reports, prior abuse reports and/or child welfare cases, observations of the family, and medical records. For all six cases, the FFA-initial included an assessment of the caregivers' protective capacities, safety, risk, and the family's needs. On the other hand, they did not all include an assessment of the family's strengths or the family's perspective of their needs and strengths. These findings are summarized in Table 33.

Table 33

Areas Addressed by the Initial Family Functional Assessment (n = 6)

Key Elements Assessed	Proportion of Cases
Caregivers'/parents' capacity to protect and nurture the children.	100%
Observations of interactions between the children and household members.	83.3%
Whether the children can live safely in the current home or placement.	100%
Factors that may place the children's safety at risk.	100%
As assessment of the family's strengths and resources.	66.7%
An assessment of the family's needs that hinder providing a safe and stable home.	100%
The family's perspective of their needs and strengths.	33.3%

After being referred to case management for Family Support Services, the duration of cases ranged from as little as one month up to five months, with the median service duration being about three months. The majority (n = 6) of cases were staffed roughly every two weeks, with two cases that were staffed weekly and one case that was staffed less frequently (roughly once per month). Case documentation indicated that for most cases (n = 7) the caregivers participated in the staffings at least some of the time, with three cases indicating consistent family participation in staffings. The same seven cases also included documentation of the inclusion of family voice and perspectives during staffings, such as asking family members to report their perceived needs, services they would like to receive, and how they feel about the services they have received. All nine cases showed evidence that family needs and the identification of services to address those needs were discussed during staffings, as documented in case staffing notes. Some staffing notes also indicated discussion of family strengths, but needs were more often the focus.

The services provided to families varied depending on their particular needs, but frequently included services such as individual and/or family counseling, parenting and life skills education, psychoeducation regarding children's mental/behavioral health needs, and assistance with basic needs such as daycare and affordable housing. All cases included referrals to formal services, which generally (though not always) matched the identified family needs. On the other hand, fewer cases incorporated the use of informal supports, although some cases did make use of these. Examples include referring a caregiver to a local parent

support group and engaging relatives who are local in the family care plan. In a few cases, there appeared to be services provided that did not match the family's needs, such as one case in which the parents were referred to substance abuse services despite the fact that the substance abuse allegations were unsubstantiated. Another example was a case in which the primary need identified was for safe and stable housing, but the services provided were counseling and parenting skills, which did nothing to address the family's need for affordable housing and did not appear to be related to any of the allegations in the case. There were a few cases in which some of the family's identified needs appeared to be unmet by the services provided, although it is possible that families were connected to other resources not formally documented in the case files. For the majority of cases (n = 7), most or all of the family's identified needs appeared to be addressed by the services provided.

Aspects of case practice that were more difficult to assess from the case files include case managers' contact and engagement with families and responsiveness to family needs over the life of the case. Most of the case files did not contain actual documentation of case manager home visits or contact with the family, however, the staffing reports did note the frequency with which the case manager is expected to conduct visits. All cases indicated a minimum of weekly visits; several cases specified at least two visits per week and one case indicated contact from the case manager or another support worker up to four times per week. Information about the substance of those visits, however, was not documented in the files. Strategies used by either case managers or CPI to engage families were also unclear and largely undocumented in the case files. Two cases noted the use of family team meetings to engage the family in service planning and identification of needs and strengths, but otherwise there was limited information about engagement processes. In fact, one case file explicitly noted the mother's limited engagement, but efforts to increase her engagement were not documented.

The majority of cases (n = 6) contained some indicators of ways in which case managers are responsive to family concerns and new or changing needs, as evidenced by the case manager's documentation of concerns expressed by the family or the identification of new needs arising over the course of the case and follow-up with service referrals. Most often, these issues were documented in the case staffing reports. For example, a staffing report for one case described how the mother expressed some concerns over new problematic behaviors that one of her children was exhibiting. According to the notes, the case manager discussed the concerns with the mother and was able to suggest some behavior management strategies as well as providing a referral for psychoeducation services. On another case, a staffing report

notes that the mother had a mental health breakdown one day and called the case manager, who was able to de-escalate the situation over the phone and referred the mother to a nearby mental health receiving facility. The case manager then met with the mother the following day to implement a safety plan.

Additional strengths evidenced in these cases were that all the families appeared to have participated in the recommended services and many families expressed satisfaction with the services they received according to family surveys included in the files. All files indicated that the families cooperated with services, and case closure was based on the family's progress and observed behavior changes for all but one case, which was discharged because the family moved to a different county. In this case, the case manager provided a list of resources for the family's new residence. On the other hand, some of the challenges that could be identified in the files included lack of transportation for some families, limited ability for some families to participate in case staffings (either due to scheduling conflicts or transportation issues), and the difficulty of managing serious mental and behavioral health problems of children. As noted earlier, the limited case notes and documentation included in these files greatly limits the extent to which case practice can be assessed. Thus, practice will be further explored through the upcoming interviews with families and case managers.

Summary. For this report sub-study included a set of case file reviews, within Eckerd Community Alternatives provider network. Eckerd Community Alternatives (Circuit 6) was selected for this analysis by identifying the number of cases from each agency that met the intervention criteria and selecting the agency with the highest number of qualifying cases. For the majority of the nine cases reviewed, children were determined to be safe but high or very high risk, and thus appropriate for Family Support Services. With regard to family assessment, three of the cases reviewed did not have an initial Family Functional Assessment (FFA) in the file, although it is entirely possible that the FFA was completed and simply was absent from the case management case files. For all six cases, the FFA-initial included an assessment of the caregivers' protective capacities, safety, risk, and the family's needs. The services provided to families varied depending on their particular needs, but frequently included services such as individual and/or family counseling, parenting and life skills education, psychoeducation regarding children's mental/behavioral health needs, and assistance with basic needs such as daycare and affordable housing. All cases included referrals to formal services, which generally (though not always) matched the identified family needs. The majority of cases (n = 6) did contain some indicators of ways in which case managers are responsive to family concerns and new or changing needs, as evidenced by the case manager's documentation of concerns

expressed by the family or the identification of new needs arising over the course of the case and follow-up with service referrals. Additional strengths evidenced in these cases were that all the families appeared to have participated in the recommended services and many families expressed satisfaction with the services they received according to family surveys included in the files. For this report sub-study included a set of case file reviews, within Eckerd Community Alternatives provider network. Eckerd Community Alternatives (Circuit 6) was selected for this analysis by identifying the number of cases from each agency that met the intervention criteria and selecting the agency with the highest number of qualifying cases. For the majority of the nine cases reviewed, children were determined to be safe but high or very high risk, and thus appropriate for Family Support Services. With regard to family assessment, three of the cases reviewed did not have an initial Family Functional Assessment (FFA) in the file, although it is entirely possible that the FFA was completed and simply was absent from the case management case files. For all six cases, the FFA-initial included an assessment of the caregivers' protective capacities, safety, risk, and the family's needs. The services provided to families varied depending on their particular needs, but frequently included services such as individual and/or family counseling, parenting and life skills education, psychoeducation regarding children's mental/behavioral health needs, and assistance with basic needs such as daycare and affordable housing. All cases included referrals to formal services, which generally (though not always) matched the identified family needs. The majority of cases (n = 6) did contain some indicators of ways in which case managers are responsive to family concerns and new or changing needs, as evidenced by the case manager's documentation of concerns expressed by the family or the identification of new needs arising over the course of the case and follow-up with service referrals. Additional strengths evidenced in these cases were that all the families appeared to have participated in the recommended services and many families expressed satisfaction with the services they received according to family surveys included in the files.

Next Steps. The next step with this sub-study is to conduct interviews with the families whose files were reviewed and interviews with case managers who work FSS cases to learn more about practice and services provided to these cases. Interview guides have been developed (Appendix F) and submitted to USF's Institutional Review Board for Approval. As soon as approval is received, the evaluation team will begin working with Eckerd Community Alternatives to contact potential participants. The interviews and analysis will be completed for the next semi-annual report. A site for the second round of case file reviews and interviews will also be selected prior to the next report.

Summary

This semi-annual progress report is for the period October, 2017 – March 2018 for Florida's Demonstration. The Demonstration evaluation includes four related components: (a) a process analysis comprised of an implementation analysis and a services and practice analysis, (b) an outcome analysis comprised of safety, permanency, and child well-being indicators, (c) a cost analysis, and (d) two sub-studies.

Implementation Analysis

The goal of the implementation analysis is to describe the implementation of the Demonstration extension. This semi-annual report includes methods and findings from eleven key stakeholder interviews conducted with leadership at Community-Based Care lead agencies (CBCs) during the reporting periods of October 2017 through March 2018.

Family support services. Interviewees reported several family support services that have been successful for the families they serve. Responses ranged from co-locating staff to the use of California Clearinghouse evidence-based practices. At least 13 different family support services were reported as being the most successful for families: Nurturing Parenting, Nurturing Fathers, Wraparound family support models, Behavioral Educational Therapy, and a Family In-Home Research Support Team. Respondents from 10 circuits reported offering evidence-based or promising practices including Family Connections Program, Nurturing Parenting, Nurturing Fathers, the C.A.R.E.S. model, Multisystemic Therapy, Home Builders, Family Builders, and Children to Action Teams.

Safety management services. Interviewees were also asked to describe which safety management services have been the most successful for the families served by their agency. Respondent unanimously stated that they offer both formal and informal safety management services. Formal safety management services noted included crisis management teams, safety management services teams, mobile response teams, Family Builders, ERAT (available to CPIs), House Next Door (available to case managers), and SMART (program for CPIs designed in partnership with CPIs). Informal safety management services included faith-based community programs, relationships with learning coalitions, and supports identified by case managers.

Treatment services. Leadership at lead agencies were asked which treatment services they had found to be the most successful for parents and caregivers served by their CBC.

First, respondents talked about the importance of a wraparound approach with families, as seen in the Placement Partnership Program, which was described as being very family-centered, where informal supports were valued as much as formal supports. Second,

respondents discussed the positive impact of co-locating services for families, as seen in the Kids in Distress model where services inclusive of parent education, domestic violence intervention, substance abuse outpatient treatment, and mental health counseling and therapy are coordinated for families.

Third, respondents discussed the value of behavioral analysis being included in programs, as happens in Parenting for Success. Fourth, the importance of services that "put trauma first" was discussed. Fifth, the practice of having a behavioral health consultant work with CPIs to help investigators identify parents with mental health issues was noted. Sixth, stakeholders noted programs treating substance abuse such as the FIT (Family Intensive Treatment) program.

Child well-being services. Leadership at CBCs were asked which child well-being services such as educational, physical health, dental health, and behavioral health they found to be the most successful for children served by their CBC. Emergent themes included improvements in dental care, discussion of the impact of the Child Welfare Specialty Plan, use of non DCF or Medicaid resources to fund well-being services, more trauma-informed services, behavioral services geared toward the younger population, teams of nurses, and educational mentors.

Rapid safety feedback reviews. Stakeholders were asked whether the Rapid Safety Feedback reviews have improved practice for their CBC. The majority of respondents felt that the reviews were helpful and useful. Reasons given for this included the ability to address safety concerns in real time, being able to focus on the most vulnerable population (0-3 years with substance abuse and domestic violence accusations), having another learning tool to support the coaching process between supervisors and case managers, and simply having "another set of eyes" on randomly selected cases as a vehicle for bringing new and different issues to the attention of lead agencies. For those respondents that did speak specifically to how the reviews had helped improve practice, there was a perception that the reviews had increased the quality and frequency of family visits. A limited number of interviewees felt that the review process was flawed. Reasons for this included some lead agencies not having enough of the target population to support a sufficient sample size, which has led to some lead agencies expanding the population age range upward. Another concern expressed was the level of inter rater reliability.

Demonstration impact. The final set of interview questions for the implementation analysis addressed issues related to the ending of the federal Demonstrations. There was consensus among the interviewees that the loss of the Demonstration funds would be

irreplaceable and would have a highly detrimental impact on Florida's child welfare system of care. Several interviewees also noted that state general revenue resources in Florida are "scarce" for human services such as child welfare, mental health, and substance use services. Another theme that emerged from the interview data was the loss of the child welfare system of care that CBCs gradually built over the course of Florida's two Demonstrations. CBCs across Florida have capitalized on the Demonstration's potential by keeping the focus on the front-end of the system and therefore reducing the number of child removals and the number of children coming into the formal dependency system. Respondents also noted that the Demonstration's funding flexibility allows an immediate response to concrete needs and crises that families sometimes experience. There was consensus across repsondents that prevention services and programs would be highly vulnerable to elimination or reduction with the loss of Demonstration funds. Respondents identified many examples of violence prevention programs, family preservation services, mentoring, immediate response crisis intervention, teenage pregnancy prevention using evidence-based approaches, deployment of specialized personnel to child protective investigation units, assisting families with transportation and housing issues, and safety management services.

On the other hand, most interviewees identified a number of alternative funding sources that could partially make up for the loss of Demonstration funds. One theme that emerged from several participants was the goal of diversification of funding sources. Examples included contracts with county governments and state contracts, HUD funds through the local homeless services network, contracts with Career Source, use of Medicaid providers for substance use and mental health treatment services, and use of mental health and substance use block grant funds. Potential local resources included local United Ways, Children's Services Councils, private foundations and donors, and pursuit of opportunities jointly with Casey Family Programs. A strength noted by some participants regarding the identification of future alternative funding is the strength of the partnership today between the Department, the Florida Coalition for Children, and the CBCs.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This report includes a status update regarding the implementation of the evidence-based practice fidelity assessment, as well as proposed changes to the service array assessment. All 18 CBC lead agencies have responded regarding their inclusion of Wraparound and Nurturing Parenting Program as part of their child welfare

service array. There are 14 lead agencies (77.8%) that currently include Wraparound as part of their service array, and 9 lead agencies (50%) that include the Nurturing Parenting Program. Six lead agencies reported that they offer both services as part of their service array. Only one lead agency reported providing neither of these two services. The evaluation team is still determining to what extent agencies currently assess practice fidelity to these EBPs.

Outcome Analysis: Safety Outcome

The outcome analysis tracks changes in five (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15 and SFY 15-16) successive exit cohorts of children who were followed from the time they either exited out-of-home care or their in-home services were terminated. Compared to the national standards that refer to similar indicators, the state of Florida maintained a relatively high proportion of children who did not experience verified maltreatment after termination of either in-home or out-of-home services. On average, this proportion remained higher than 95% across the examined state fiscal years. However, for some Circuits the proportions of children without verified maltreatment were equal to or lower than 95% across all examined fiscal years. In addition, there is considerable variation in the performance of circuits over time. When the impact of child and family characteristics on one safety outcome, recurrence of maltreatment within 6 month of service termination was examined, results showed that neglect, parental substance abuse, and history of domestic violence were the strongest predictors for repeated verified maltreatment.

Outcome Analysis: Child and Family Well-Being

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews and adopted use of the Child and Family Services Reviews (CFSR)— federally-established guidelines to conduct ongoing case reviews (U.S. Department of Health and Human Services, 2014). Through these CFSRs, CBCs review cases to ascertain the quality of child welfare practices relevant to the safety, permanency, and well-being of children. The report examined the status of three CFSR outcomes that focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, mental health needs. The report compared baseline data to ongoing CFSR ratings for both in-home and out-of-home care cases.

Overall, ongoing reviews show that Circuit 19 demonstrated the most improvement across outcomes and performance items. Circuit 19 showed marked improvement from baseline to ongoing review for both in-home and foster care cases in Performance Items 12, 12B, and 15, marked improvement in foster care cases for Well-Being Outcome 1, and marked improvement among in-home cases only for Performance Items 17 and 18 and Well-Being

Outcome 3. Other circuits showed marked improvement from baseline to ongoing review, most notable Circuits 8, 13, and 18. At the state-level the changes from baseline to ongoing review varied among the outcomes and performance items. None of the state findings were found to be statistically significant.

Cost Analysis

The cost analysis for the report examined aggregated expenditure data from SFY 04-05 through SFY 15-16. Analysis of these data provided information on patterns across time-periods that included a pre-Demonstration period, the initial Demonstration period, and the Demonstration extension period. Compared to the pre-Demonstration period, expenditures for front-end prevention services increased during the initial Demonstration and have continued to increase during the Demonstration extension. Consistent with one of the goals of the IV-E Demonstration, the ratio of expenditures for licensed foster care to expenditures for front-end prevention services has trended downward over time.

Second, while aggregated data provide important information, this report also examined child-level cost data reported by lead agencies through the Florida Safe Families Network (FSFN) and the relationship between specific child and parent characteristics and the likelihood of a child being a high cost case. Overall, a high cost case tends to involve an older child, is more likely to be a victim of sexual abuse and/or neglect, with parents that were more likely to abandon the child or be unable to provide care. However, parental substance abuse or domestic violence in the household is less common. Such children are more likely to have very severe behavioral problems perhaps reflecting the severity of the maltreatment and/or the severity of the child's mental health problems. Finally, children that had high child welfare costs also tended to have high Medicaid costs.

Sub-Study One: Cross-System Services and Costs

This sub-study looked at children and youth who receive in-home child welfare services and examine their health care utilization before and during in-home child welfare services. Medicaid and SAMH data were used to determine the health care services received, and how the receipt of in-home child welfare services affected health care service use. Findings indicate that the majority of youth that receive in-home child welfare services are Medicaid enrolled and used Medicaid-funded services. SAMH was not a substantive funding source for these youth. More youth used Medicaid funded services after in-home child welfare services began, although use declined over the duration of in-home child welfare services. More specifically, there was increased use of physical and behavioral health outpatient services, targeted case

management, and treatment planning services. Medicaid-funded service use was not associated with the reason for in-home child welfare services.

Sub-Study Two: Services and Practice Analysis/Outcome Analysis for Safe, but High Risk for Future Maltreatment

Practice analysis. A sample of nine cases that received Family Support Services were reviewed using a case file review protocol. Descriptive statistics were produced using SPSS for data that was appropriate for quantitative analysis (e.g. frequencies, means, and medians). Open-coding was performed on the qualitative data to identify key themes and patterns emerging form the data. The number of children involved in the cases reviewed ranged from two to five, with a median of three children per case. The children ranged in age from younger than one year to 17 years. The mean age of the youngest child in the household was 2.8 years, while the mean age of the oldest child in the household was 12.1 years. Eight of the nine families had at least one child under the age of five.

Most cases included more than one abuse allegation, and all but one case had at least one substantiated allegation. The most common allegations included environmental hazards, inadequate supervision, domestic violence, substance abuse, and parental mental health problems. Additionally, trouble meeting basic needs (e.g. food, clothing, and housing due to poverty) and uncontrolled child mental health problems were significant identified needs on several cases

With regard to family assessment, three of the cases reviewed did not have an initial Family Functional Assessment (FFA) in the file, although it is possible that the FFA was completed and simply was absent from case files. All but one of the cases had at least one updated family assessment competed by the case manager in the file, although for two of the cases it was not the official Department FFA, but a different assessment used by the case management agency. Of the six cases that had a FFA-initial on file, most (n = 5) indicated that interviews were completed with the mother, with additional relatives and/or adult household members, and with other collaterals (such as school personnel, doctors, neighbors, etc.). Only two cases indicated that interviews were completed with the biological fathers. Additional sources of information noted in the files for completing the FFA included police reports, prior abuse reports and/or child welfare cases, observations of the family, and medical records. For all six cases, the FFA-initial included an assessment of the caregivers' protective capacities, safety, risk, and the family's needs. On the other hand, they did not all include an assessment of the family's strengths or the family's perspective of their needs and strengths.

All cases included referrals to formal services, which generally (though not always) matched the identified family needs. On the other hand, fewer cases incorporated the use of informal supports, although some cases did make use of these. Examples include referring a caregiver to a local parent support group and engaging relatives who are local in the family care plan. In a few cases, there appeared to be services provided that did not match the family's needs, such as one case in which the parents were referred to substance abuse services despite the fact that the substance abuse allegations were unsubstantiated.

The majority of cases (n = 6) contained some indicators of ways in which case managers are responsive to family concerns and new or changing needs, as evidenced by the case manager's documentation of concerns expressed by the family or the identification of new needs arising over the course of the case and follow-up with service referrals. Additional strengths evidenced in these cases were that all the families appeared to have participated in the recommended services and many families expressed satisfaction with the services they received according to family surveys included in the files. All files indicated that the families cooperated with services, and case closure was based on the family's progress and observed behavior changes for all but one case, which was discharged because the family moved to a different county.

Next Steps

For the implementation analysis, the remainder of the key stakeholder interviews with CBC leadership will be completed, and a set of interviews with CPI supervisors will be conducted. The analysis and findings from these interviews will be included in the next progress report.

For the services and practice analysis, the evaluation team will complete planning calls with lead agencies to gather information about their provision of the two EBPs and current fidelity measurement by May 2018 and begin implementing protocols for the statewide fidelity assessment. Agencies that already collect fidelity data can simply provide their data to the evaluation team. The expectation is that aggregated fidelity data from participating agencies will be available to provide in the next semi-annual report.

Finally, a second round of child protective investigator and case manager focus groups will be conducted in the upcoming months to look at any changes in practice and the service array from the perspectives of front-line workers. The evaluation team will select six circuits to participate (ensuring that they are not the same circuits that participated in the first round of focus groups). In an effort to be representative of different areas of the state, one circuit will be

randomly selected from each of the six regions. Focus groups will be completed during the summer of 2018.

Future outcome evaluation activities will include further examination of permanency indicators and safety indicators controlling for the data structure – children nested within circuits. Factors associated with child outcomes will be examined and potential recommendations will be discussed. Subsequent reports will continue to disaggregate well-being outcome findings to allow for comparisons between in-home and foster care cases. Although the baseline data reported here will carry forward into the next report, findings from ongoing review will consist of the most recent Florida CQI data available at that time (the PUR for SFY 15-16 through the most recent FL CQI data available at the time).

For the cost analysis, a next step is whether the type and amount of child welfare services, Medicaid services, and SAMH services are associated with better outcomes for high cost children in child welfare. Child outcomes that will be examined include permanency, reunification, guardianship, and adoption.

For Sub-Study 1, a next step is to determine if the decline in service use during in-home services is medically warranted, why the reasons for receipt of in-home services were not associated with Medicaid-funded services, and whether Medicaid- and/or SAMH-funded services enable the children to remain in the home and avoid the need for out-of-home placement.

For Sub-Study 2, the next steps are to conduct interviews with the families whose files were reviewed and interviews with case managers who work FSS cases to learn more about practice and services provided to these cases. Interview guides have been developed (Appendix F) and submitted to USF's Institutional Review Board for Approval. As soon as approval is received, the evaluation team will begin working with Eckerd Community Alternatives to contact potential participants. The interviews and analysis will be completed for the next semi-annual report. A site for the second round of case file reviews and interviews will also be selected prior to the next report.

References

Armstrong, M., Vargo, A., Cruz, A., Johnson, M., Landers, M., Robst, J, & Yampolskaya, S. (2016a). Phase 3-Florida's Title IV-E Demonstration Waiver Interim Evaluation Report (10/01/2013-03/31/2016). Retrieved from Florida's Center for Child Welfare Website: http://centerforchildwelfare.fmhi.usf.edu/Datareports/IVEReport.shtml

Armstrong, M., Vargo, A., Cruz, A., Johnson, M., Landers, M., Robst, J, & Yampolskaya, S. (2016b). Phase 4-Florida's Title IV-E Demonstration Waiver Interim Evaluation Report (04/2016-09/31/2016). Retrieved from Florida's Center for Child Welfare Website: http://centerforchildwelfare.fmhi.usf.edu/Datareports/IVEReport.shtml

Armstrong, M., Vargo, A., Cruz, A., Johnson, M., Landers, M., Robst, J, & Yampolskaya, S. (2017). Phase 6-Florida's Title IV-E Demonstration Waiver Interim Evaluation Report (04/2017-09/31/2017). Retrieved from Florida's Center for Child Welfare Website: http://centerforchildwelfare.fmhi.usf.edu/Datareports/IVEReport.shtml

Boaz, T., Robst, J., Christy, A., & Teague, G. (2016). Final Administrative Data Report, Reports to the Florida Department of Children and Families in Response to the Governor's Executive Order 15-175.

Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., Lansverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 960-970.

Children's Defense Fund. (2018). Families First prevention Services Act. Retrieved from: http://www.childrensdefense.org/policy/welfare/?gclid=CjwKCAjwwbHWBRBWEiwAMIV7E13NdGxu__EI7o8JmYHUTKz2ZvQK1fV_5Xk0HculiAPE_MQu_b-qkxoC8UYQAvD_BwE

Department of Health and Human Services. Administration for Children and Families. (2014). *Statewide Data Indicators and National Standards for Child and Family Services Reviews. Federal Register, 79,* 61241- 61260.

Landsman, M.J. (2015). The changing landscape of in-home child welfare services. *Journal of Public Child Welfare, 9*, 417-422.

Leslie, L.K., Gordon, J.N., Meneken, L., Premji, K., Michelmore, K.L., & Ganger, W. (2005). The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *Journal of Developmental and Behaviorial Pediatrics, 26*, 177-195.

U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation. (2013). Children placed outside the home and children who remain in-home after a maltreatment investigation have similar and extensive service needs. National Survey of Child and Adolescent Well-Being: Child Well-Being Spotlight.

Appendix A

Interview protocol

IV-E Waiver Stakeholder Questions

Thank you for taking the time to participate in this interview. We are going to begin by asking a few questions regarding the array of services available to families served by your agency. Specifically Family Support Services, Safety Management services, Treatment services, and Child Well-Being services.

The definitions for these service types are:

Family Support Services - Voluntary supportive family services to prevent future child maltreatment among at-risk families.

Safety Management Services – Safety services actions, tasks, activities, and other imposed situations that may be formal or informal and provided by professionals and non-professionals for the purpose of managing or controlling impending danger threats and documented in a safety plan. Safety service must be capable of having an immediate effect, must be immediately available, must always be accessible, and must be sufficient to control impending danger.

Treatment Services – Specific, usually formal, services/interventions to achieve fundamental change in functioning and behavior associated with the reason that the child is unsafe.

Child Well-Being Services – Specific, usually formal, services/interventions utilized to assure the child's physical, emotional, developmental, and educational needs are addressed. The assessment of the child strengths and needs indicators is used to systematically identify critical child well-being needs that should be the focus of thoughtful, case plan interventions.

1. Which Family Support Services have you found to be the most successful for the families served by your CBC? (Follow up: Are these services evidence-based or promising practices, how do you know they are implemented with fidelity?)

2. Which Safety Management services have you found to be the most successful for the families served by your CBC? (Follow up: Are you using both formal and informal Safety Management Services and if formal, are they available for use by the case managers?)

3. Which Treatment services have you found to be the most successful for parents and caregivers served by your CBC?

4. Which Child Well-Being services such as educational, physical health, dental health, and behavioral health have you found to be the most successful for children served by your CBC?

5. The Children's Bureau is interested in learning more about CBCs use of Rapid Safety Feedback reviews. Please tell us how the Rapid Safety Feedback reviews have improved practice for your CBC? Are you able to provide an example?

We would now like to transition into discussing the end of IV-E Waivers. We would like to gain your thoughts and perceptions on how your CBC will continue child welfare work when the Waiver ends.

6. What are some new innovative programs or services that have been introduced by your CBC (or Case Management Organizations providing case management services for your area) because of the Waiver? (capacity and funds invested)

7. What, if any, current services and supports available to prevent removals are at risk of being reduced or eliminated post Waiver?

8. What revenue sources are projected post Waiver by your CBC to support continuation/expansion of: in-home services, if any? Prevention (primary, secondary, or tertiary) services?

Appendix B

Verbal Informed Consent

Verbal Informed Consent to Participate in Research Involving Minimal Risk
Information to Consider Before Taking Part in this Research Study

Pro # __5830146300____

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called: **Title IV-E Waiver Demonstration Evaluation**

The person who is in charge of this research study is Mary I. Armstrong, Ph.D. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. Other research team members include Amy Vargo, Svetlana Yampolskaya, Melissa Johnson, John Robst, Monica Landers, and Areana Cruz.

The research will be conducted at child welfare agencies, stakeholder offices, and through phone interviews in Florida.

This research is being sponsored by The Department of Children and Families.

Purpose of the study
The purpose of this research study is to examine the process, effectiveness, and impact of Florida's IV-E Waiver Demonstration Project and Community-Based Care. Specifically, the study focuses on implementation, organizational characteristics, monitoring, accountability, child level outcomes, cost effectiveness, and quality of services. The findings from this study will help guide policy recommendations regarding Community-Based Care and the IV-E Waiver.

Why are you being asked to take part?
We are asking you to take part in this research study because you have a leadership position at a Community-Based Care lead agency within the FL child welfare system.

Study Procedures:
If you take part in this study, you will be asked to give us your opinions through an interview that will take about 30-45 minutes to complete. The interview will be audio-recorded (with your permission) to make sure our notes are correct.

Total Number of Participants
A total of 200 individuals will participate in the study at all sites over the next five years.
Alternatives / Voluntary Participation / Withdrawal
You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop

taking part in this study. Your decision to participate or not participate will not affect your job status in any way.

Benefits
There are no direct benefits anticipated as a result of your participation in this study. However, some personal positive aspects that you might experience are:

- You may enjoy sharing your opinions about this important topic.
- It may be beneficial that your responses could be combined with those of other individuals like yourself in a report that will be disseminated about the IV-E Waiver and Community-Based Care.
- You will help us learn more about the IV-E Waiver and Community-Based Care. What we learn from your input may help other areas as they refine their child welfare system.
-

Risks or Discomfort
This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study. Some people may get angry or excited when responding about some of their experiences. If you have any difficulty with a question, you may skip it and come back to it later. If necessary, you may choose not to respond to the survey and/or complete it at another time.

Compensation
You will receive no payment or other compensation for taking part in this study.

Costs
It will not cost you anything to take part in the study.

Privacy and Confidentiality
We will keep your study records private and confidential. Certain people may need to see your study records. Anyone who looks at your records must keep them confidential. These individuals include:

- The research team, including the Principal Investigator, study coordinator, and all other research staff.
- Certain government and university people who need to know more about the study, and individuals who provide oversight to ensure that we are doing the study in the right way.
- Any agency of the federal, state, or local government that regulates this research. This may include employees of the Department of Health and Human Services.
- The USF Institutional Review Board (IRB) and related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance.
- The sponsors of this study and contract research organization. The Department of Children and Families, the agency that paid for this study, may also look at the study records.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

You can get the answers to your questions, concerns, or complaints
If you have any questions, concerns or complaints about this study, or experience an unanticipated problem, call Mary Armstrong at 813-974-4601.

If you have questions about your rights as a participant in this study, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

Consent to Take Part in this Research Study

I freely give my consent to take part in this study. By participating in this interview, I understand that I am agreeing to take part in research. I have received a copy of this form for my records.

Appendix C

Florida IV-E Code List (03-15-18)

Practice and Service Array: service array resulting from, at least in part, implementation of Florida's IV-E Waiver, including review processes that are in place for child welfare cases

(FSS) Family Support Services- examples and descriptions of successful services

(FSSEBP) Family Support Services—evidence-based practices; examples and descriptions of successful services

(FSSPP) Family Support Services---promising practices; examples and descriptions of successful services

(FSSFID) Family Support Service Fidelity—issues measuring and/or achieving fidelity

(SMS) Safety Management Services- examples and descriptions of successful services

(ISMS) Informal Safety Management Services- examples and descriptions of successful services

(FSMS) Formal Safety Management Services- examples and descriptions of successful services

(TS) Treatment Services - examples and descriptions of successful services

(CWBS) Child Well-Being Services- examples and descriptions of successful services

(CWBSGAPS) Child Well-Being Service Gaps- any indications of gaps in child well-being services

(RSFR) Rapid Safety Feedback Reviews – Implementation and success of RSFRs

Impact: relevant impacts of the IV-E Waiver, or potential lack thereof in the future

(INNOVSERV) Innovative services - created as a result of Florida's IV-E Waiver flexible funding

(CAP) Capacity – increases or decreases in service capacity as a result of Florida's IV-E Waiver ending

(PREVSERV) Services/supports that prevent removals – created or enhanced as a result of Florida's IV-E Waiver

(ALTREV) Revenue sources to sustain changes without Waiver funding

(ALTREV-TCM) Discussion of pursuing targeted case management as a way augment funding

(WAIVEND) Impact of Waiver ending on the current child welfare system in Florida

(WAIVEND-MITFACT) Mitigating factors/context regarding how each lead agency's child welfare system might be impacted by the ending of Florida's IV-E Waiver (e.g., Florida's allocation formula)

Decision Rules for Coding

1. Don't double code
2. Don't code the actual protocol question in isolation or with the data, unless the data does not actually answer that question
3. Don't code things as Impact unless they have actually happened (e.g., hopes for impact might go under vision or goals)
4. Don't make a new global code for strengths/facilitators and barriers/challenges; please insert these two codes as needed at a third level underneath each topic

Appendix D
Safety Outcome

Measure 1

The number and proportion of all children who did NOT experience maltreatment within six months of case closure (i.e., termination of out-of-home services or in-home supervision).

> This measure is based on exit cohort. An exit cohort is defined as all children whose cases were closed (in-home or out-of-home services were terminated) during a given fiscal year and it is based on the date the cases were closed as indicated by an *End Date* in FSFN. Children were followed for 6 months from the date of service termination to determine whether they experience another verified maltreatment as indicated by *Received Date of First Intake with Verified Maltreatment in* FSFN.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[6] Because every child was followed for 6 months, this measure is identical to a percent where the numerator is the number of children who experienced verified maltreatment within 6 months after services terminated. The denominator is the number of children whose cases were closed (i.e., discharged from a removal episode or exited from in-home services) during a specific federal fiscal year.

[6] Event history analysis is a statistical procedure that allows for analyzing data collected over time as well as for utilizing information about cases where the event of interest did not occur during data collection (e.g., children who did not exit out-of-home care during the 12-month period). This technique allows for calculation of the probability of an event occurring at different time points, such as in 12 months after out-of-home care entry (Allison, 1984). This technique was chosen over a percent because (a) it represents the state of art for analyzing longitudinal data, (b) it allows to efficiently dealing with complex data, and (c) it allows estimating the probability of an event to occur beyond the study period.

Appendix E

Results of Statistical Analyses

Table E1

Results of Cox Regression. Children who did not Experience Recurrence of Maltreatment within 6 months of the Service Termination in the State of Florida by Cohort (State Fiscal Years 2011-2012 through 2015-2016)

	Children With Service Termination (*N* = 116,881)		
	β	**$\chi^2_{(1)}$**	**OR**
Cohort	0.01	0.21	1.01

Note. *$p < .05$

Table E2

Results of Cox Regression. Factors Associated With Recurrence of Maltreatment within 6 Months of the Service Termination

	Children With Service Termination (*N* = 94,608)		
	β	**$\chi^2_{(1)}$**	**OR**
Age	- 0.05	189.65*	0.95
Child gender	- 0.04	1.37	0.97
Race			
African American	- 0.15	20.83*	0.86
Asian	- 0.45	2.86	0.64
Hawaiian	- 0.25	0.38	0.78
Family Structure			
Single male family structure	0.03	0.14	1.03
Single female family structure	0.07	4.38*	1.09
Physical health problems	0.18	2.16	1.20
Emotional problems	- 0.45	1.60	0.64

Behavioral problems	- 0.12	3.24	0.89
Neglect	0.28	73.15*	1.33
Sexual abuse	- 0.06	0.30	0.95
Physical abuse	0.14	10.08*	1.15
Caregiver loss	0.15	16.70*	1.17
Parental substance abuse	0.32	91.69*	1.37
Domestic violence	0.38	141.27*	1.46
Placement in out-of-home care	0.01	1245.69*	1.00

Note. *$p < .05$

Appendix F

Case File Review Protocol

Date of Case Review _____ / ____ / _____ FSFN ID# _____

Reviewed by: _____

Part 1: Investigation	
1. Date case open to investigation: ____ / _____ / _____ 2. Assigned CPI: _____	
3. Gender of Child(ren) in family: Child 1: ☐Female ☐Male Child 2: ☐Female ☐Male Child 3: ☐Female ☐Male Child 4: ☐Female ☐Male Child 5: ☐Female ☐Male	4. Birthdates of Child(ren): Child 1: ____ / _____ / _____ Child 2: ____ / _____ / _____ Child 3: ____ / _____ / _____ Child 4: ____ / _____ / _____ Child 5: ____ / _____ / _____
5. Adults in household in relation to children: Adult 1: _____ Adult 2: _____ Adult 3: _____ Adult 4: _____	6. Birthdates of adults: Adult 1: ____ / _____ / _____ Adult 2: ____ / _____ / _____ Adult 3: ____ / _____ / _____ Adult 4: ____ / _____ / _____
7. Maltreatment allegations and findings from investigation:	

Allegation	Investigation findings	Result
1.		☐ Substantiated ☐ Unsubstantiated
2.		☐ Substantiated ☐ Unsubstantiated
3.		☐ Substantiated

		☐ Unsubstantiated
4.		☐ Substantiated ☐ Unsubstantiated
5.		☐ Substantiated ☐ Unsubstantiated
6.		☐ Substantiated ☐ Unsubstantiated

8. Identify who was included in the initial family assessment process, and how they were engaged by the investigator in this process:

Individual	Included?	If yes, how were they engaged? If no, provide any available information as to why not.
Mother/ female legal guardian	☐Y ☐N	
Father/ male legal guardian	☐Y ☐N	
Children	☐Y ☐N	
Other household members (please identify):	☐Y ☐N	

Other relatives/ extended family outside the household (please identify):	☐Y ☐N	
Other non-relative collaterals (e.g. neighbors, friends, school, health providers, etc. Please identify):	☐Y ☐N	

9. What other sources of information were used to complete the family assessment?

10. Did the family assessment contain the following elements:

Caregivers'/parents' capacity to protect and nurture the children. ☐Y ☐N

Observations of interactions between the children and household members. ☐Y ☐N

Whether the children can live safely in the current home or placement. ☐Y ☐N

Factors that may place the children's safety at risk. ☐Y ☐N

An assessment of the family's strengths and resources. ☐Y ☐N

An assessment of the family's needs that hinder providing a safe and stable home. ☐Y ☐N

Identification of special needs of the child and family. ☐Y ☐N ☐N/A

The family's perspective of their needs and strengths. ☐Y ☐N

11. What are the identified family strengths?
12. What are the identified family needs?
13. What were the safety and risk determinations? Case referred to FSS? ☐Y ☐N Date of referral: ____ / _____ / _____
14. Describe any strategies or practices evidenced in the file that were used to obtain family buy-in and encourage family engagement in services:
15. Any additional notes related to the investigation/ initial assessment process:
Part 2: Case Management
1. Date case open to FSS: ____ / _____ / _____ 2. Assigned CM: _____
3. If applicable, were updated family assessments completed to reflect current and relevant information impacting the child(ren)'s level of risk? ☐Y ☐N ☐N/A Date(s) of subsequent assessments: ___ /___ / ____ ___ /___ / ____ ___ /___ / ____ ___ /___ / ____

Is there evidence that the family was engaged in the ongoing assessment process? ☐Y ☐N

Explain/describe:

Was each updated assessment signed and approved by the CM supervisor? ☐Y ☐N ☐N/A

4. Additional notes related to family assessment:

5. List the name and date of completion for all other assessments of the child(ren) and family included in the file.

Name of assessment:	Purpose of assessment	Date of assessment:
		___ / ____ / ____
		___ / ____ / ____
		___ / ____ / ____
		___ / ____ / ____

6. List the type and date of any staffings/meetings held to discuss needs and service planning for the family and who attended. Include family team meetings/family group decision making meetings, if applicable.

Staffing type: _____ Date: ___ / ____ / ____

Who attended:

Staffing type: _____ Date: ___ / ____ / ____

Who attended:

Staffing type: _____ Date: ___ / ____ / ____

Who attended:

7. Is there evidence that the family *participated and was engaged* in the staffing(s)? ☐Y ☐N

Explain/describe:

8. Is there evidence that the voice of the family was considered during the staffing/service planning process?

☐Y ☐N

Explain/describe:

9. Were the needs and strengths of the family as identified through the assessment process discussed in the staffings/family meetings? ☐Y ☐N

Explain:

10. Were formal services and informal supports identified that match the needs and strengths of the family?

☐Y ☐N

List the identified services and supports:

11. Is there evidence of follow up by the CM on service recommendations, referrals, service receipt, and any challenges encountered by the family? ☐Y ☐N Explain/describe:
12. Is there evidence that the CM communicates with the family regarding their services and progress on a regular basis (e.g. at least every 30 days) ☐Y ☐N Explain/describe, including frequency of face-to-face and other contacts:
13. Is there evidence that the CM follows up with concerns expressed, questions asked, or additional needs identified by the family during home visits or other contacts? ☐Y ☐N Explain/describe:
14. Describe any strategies or practices evidenced in the file that were used to encourage family engagement in services:
15. Identify strengths of the case management process as evidenced in the file.
16. Identify challenges of the case management process as evidenced in the file.

17. Date case closed: ____/____/____ Summary/description of family progress and reason for case closure: