TITLE IV-E CHILD WELFARE WAIVER DEMONSTRATION PROJECT FOR THE STATE OF FLORIDA

INITIAL DESIGN AND IMPLEMENTATION REPORT

As required in Section 2.3 of the Terms and Conditions, the Department of Children and Families (DCF) hereby submits the Initial Design and Implementation Report for the five year extension period.

I. Overview

The overall goals of the state's waiver demonstration are to:

- 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.

Florida's waiver demonstration project was designed to determine whether increased flexibility of Title IV-E funding would support changes in the state's service delivery model, maintain cost neutrality to the federal government, maintain safety, and improve permanency and well-being outcomes.

1. Over the life of the demonstration project, fewer children will need to enter out-of-home care.

2. Over the life of the demonstration project, there will be improvements in child outcomes, including child permanency, safety and well-being.

3. Waiver implementation will lead to changes in or expansion of the existing child welfare service array for many, if not all, of the lead agencies. Consistent with the CBC model, the flexibility of funds will be used differently by each lead agency, based on the unique needs of the communities they serve.

4. Expenditures associated with prevention and in-home services will increase, although no new federal dollars will be spent as a result of waiver implementation.

Theory of Change

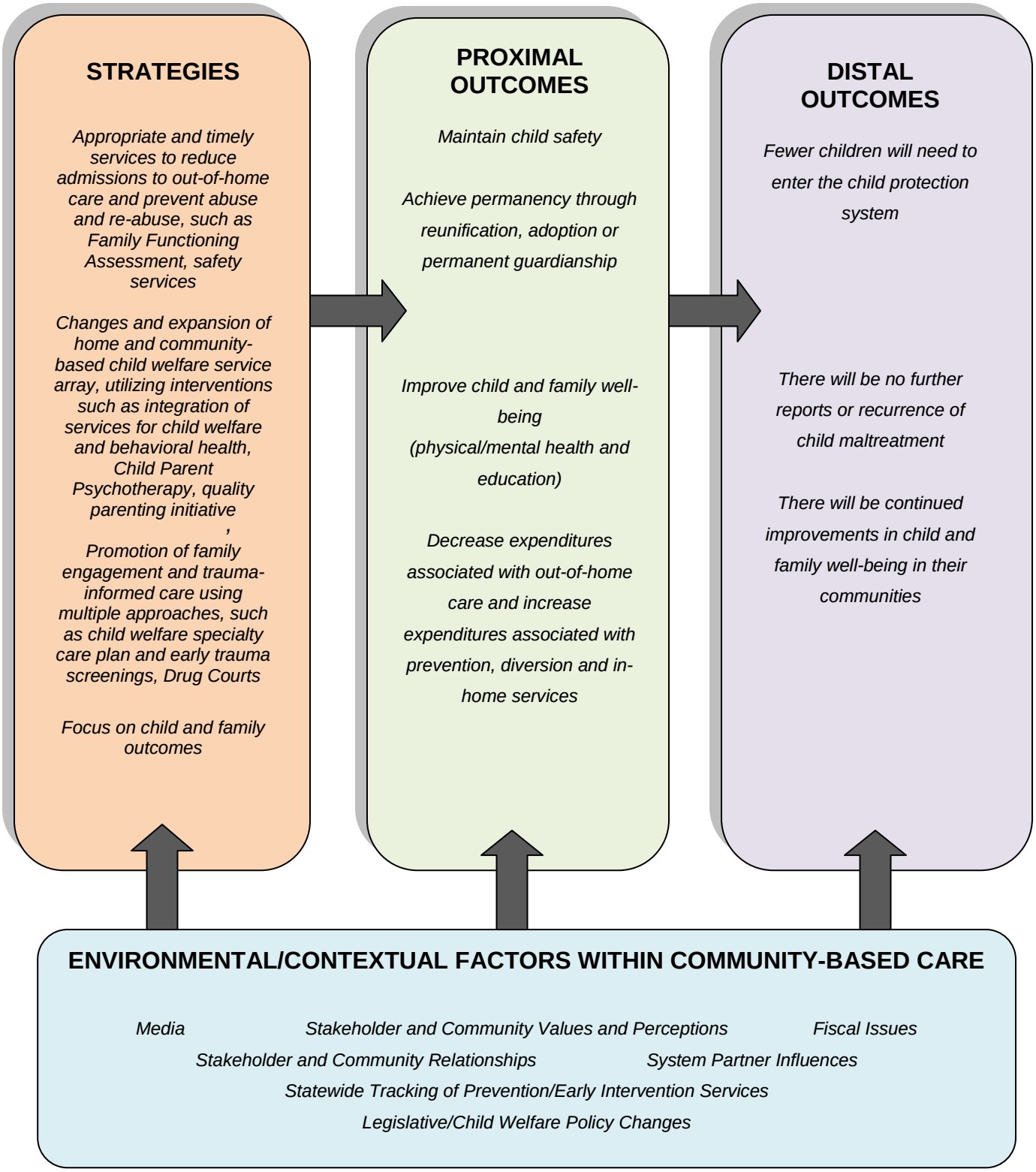
The theory of change is based on federal and state government expectations of the intended outcomes of the waiver demonstration implementation, and the hypotheses about practice changes developed from knowledge of the unique child welfare service arrangements throughout the state.

- Waiver implementation will continue to result in increased flexibility of IV-E funds, which have historically been earmarked for out-of-home care services. The flexibility will allow these funds to be allocated toward services to prevent or shorten the length of child placements into out-of-home care or prevent abuse and re-abuse.
- It is expected that the flexibility of funds will continue to be used differently by each lead agency, based on the unique needs of the communities they serve. However, it is

expected that over the long haul waiver demonstration implementation will lead to changes and expansion of home and community-based child welfare service array for lead agencies.

- A consistent focus on family centered practice and trauma informed care is expected to affect child outcomes, including child permanency, safety, and well-being.
- Over the life of the demonstration project, it is expected that fewer children will need to enter out-of-home care, resulting in fewer total days in out-of-home care. Therefore, costs associated with out-of-home care are expected to decrease following implementation, while costs associated with prevention and in-home services will increase, although no new dollars will be spent as a result of waiver demonstration implementation.

Theory of change model for Florida's IV-E Waiver demonstration



Child safety remains Florida's number one goal before decreasing out-of-home care placements. In addition, achieving permanency through reunification, permanent guardianship, or adoption is stressed as another very important proximal outcome. Another change is that child well-being is considered both a proximal and distal outcome rather than viewing it simply as a long term outcome. Well-being focuses on a child's physical and mental health status as well as their school performance. While, over the long term, family well-being within the community focuses on no further reports and recurrence of maltreatment.

Florida's demonstration does not contain the measurement of a waiver group and a control/comparison group. Rather, the measurement of success uses the comparison of child and family outcomes at periods before and throughout the waiver period, as well as maintaining cost neutrality over the five years with a capped allocation of Title IV-E foster care funds. Children and families benefit from a wide array of services and resources as a result of the Title IV-E waiver. Restrictions were removed that prevented a child and his/her family from receiving critical services in the home, and they were replaced with the flexibility to provide targeted in-home services where it was possible to do so and still maintain child safety.

Florida's waiver serves all children already known to the child protective system, as well as new cases reported for alleged maltreatment throughout the life of the project. While major progress has been made in many key areas of child welfare across Florida, there are areas where we must focus increased attention.

The state's demonstration is a flexible funding project that includes:

- Foster care maintenance payments.
- Foster care administration and related costs, excluding State Automated Child Welfare Information System (SACWIS) development and operational costs and state and training costs.

The flexibility allows for a broader array of services, many of which employ research or evidence-based practices for this population. However, these practices are not available statewide. We intend to maintain and expand the array of community-based services and programs provided by lead agencies or other contracted service providers using Title IV-E funds pursuant to this waiver.

II. Clearly Defined Target Population

Target Population

- The target population for Florida's demonstration is all families and children presenting to Florida's child welfare system through a report of alleged maltreatment. The target population includes sub-groups of individuals: all Title IV-E eligible and non IV-E eligible children, ages 0 – 17, who are receiving in-home or out-of-home services from a Community-Based Care lead agency and all new families with a report of alleged child maltreatment during the course of the demonstration project. Waiver funds may also be used for prevention and intervention for children and families identified as being at risk of maltreatment. The project is statewide.

Because the demonstration is statewide with evaluation based on program outcomes, the protocols associated with child welfare demonstrations that involve specific counties or identification of treatment and control groups are not applicable to this demonstration. However, the Department is open to the possibility of one or more sub-studies of specific waiver funded interventions.

- What are the specific child, placement, and family characteristics of your target population that result in the needs your demonstration aims to address (check all that apply), and your evidence that each checked characteristic is associated with those needs?

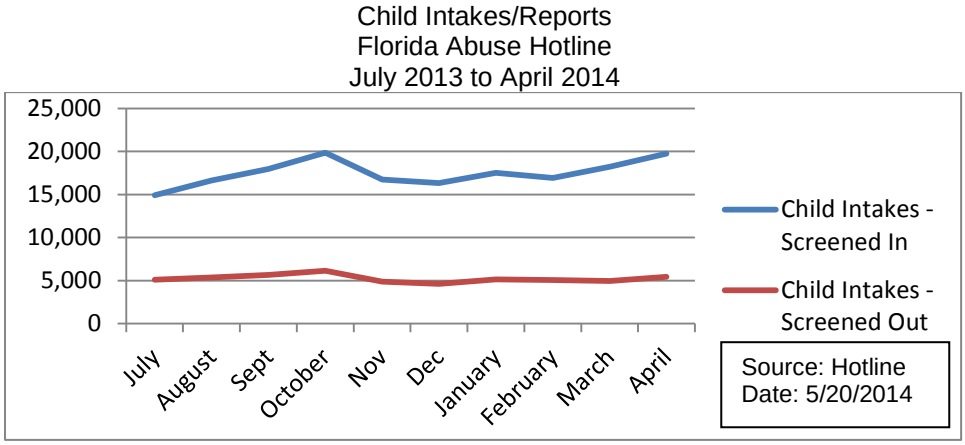
Specify target population: The target population is all children and families presenting to Florida's child welfare system through a report of alleged maltreatment.		
Characteristic	**Check if applicable**	**Evidence**
Child characteristics:		
Age of child	√	The disproportionate number of investigations received, allegations verified and removals of children in the age groups of 0 to 4 and 5 to 9 depicts the need to provide prevention, intervention, safety and in-home services. The need for in-home and permanency services for youth ages 15 to 17. These youth remain in out-of-home care for longer periods of time. DCF Child Fatality Trend Analysis addressing child fatalities shows the need to focus on prevention, safety and in-home services.
Race or ethnicity of child	√	Disproportionality of removals by race of child shows the need to focus out-of-home and in-home services by race. (Percent of Children by Event trend report Feb 2014)
Gender		
Sexual orientation/gender identity		
Developmental disability		

Specify target population: The target population is all children and families presenting to Florida's child welfare system through a report of alleged maltreatment.		
Characteristic	**Check if applicable**	**Evidence**
Mental health diagnoses/problems	√	FSFN psychotropic medication report shows that there has been a substantial decline in the number of children on psychotropic medications between July 2009 and July 2013 except for the age 0 to 5 population. The number of younger children on psychotropic medication has risen. Need to improve child (mental) health well-being and focus services on results of child's mental/behavioral health assessment. In state fiscal year 2012/2013, statewide quality assurance data shows that 81% of children received appropriate services based on the mental and behavioral health assessment.[i]
Medical problems	√	Need to improve availability and accessibility of physical and dental health care services for children in care or under protective supervision. In state fiscal year 2012/2013, statewide quality assurance data shows - a child's health care needs are assessed initially and on an on-going basis in 83% of cases. - concerted efforts were made to provide appropriate services to address the child's physical health needs in 81% of the cases. - concerted efforts were made to address dental health care needs in 73% of cases - appropriate services were provided to address the dental health care needs in 71% of cases. Also, Florida's Child Welfare Services Gap Analysis, April 2014, confirms the need to improve availability and accessibility of physical and dental health care services.
Internalizing/externalizing behaviors		

Specify target population: The target population is all children and families presenting to Florida's child welfare system through a report of alleged maltreatment.		
Characteristic	**Check if applicable**	**Evidence**
School problems	√	Need to provide education supports to improve a child's educational outcome. Florida NYTD results show that 64% of former foster care youth ages 18 to 22 years have a diploma or GED. QA data for 2012-13 shows that - 82% of children had their educational needs assessed on an ongoing basis - necessary educational services were engaged in 82% of cases.
History of child abuse/neglect	√	Need to provide safety and in-home services to address recurrence of maltreatment and improve safety, permanency and well-being outcomes. FSFN report on Number and Percent of Children Returning to Foster Care within one year of Reunification shows children reentering care (April 2014) -11.30% within 0 to 2 months -17.75% within 3 to 5 months -18.72% within 6 to 8 months -16.73% within 9 to 11 months Florida's CFSR Data Profile dated 4/13/2014 shows absence of recurrence of maltreatment in 94.1 % of cases and absence of child abuse and /or neglect in foster care at 99.02%.
Substance abuse		(see under Family Characteristics)
Homelessness/housing instability		
Poverty/resource insufficiency		
Other (specify):		
Placement characteristics:		

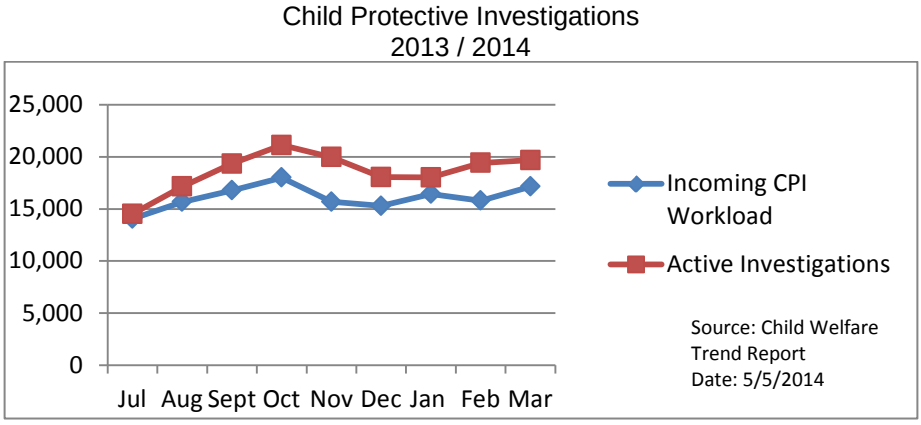
Specify target population: The target population is all children and families presenting to Florida's child welfare system through a report of alleged maltreatment.		
Characteristic	**Check if applicable**	**Evidence**
Initial reason for removal	√	Top three verified maltreatment allegations are family violence threatens child, inadequate supervision, substance misuse. (Spinner CPI Trend Report- April 2014)
Type of removal (court/voluntary)		
Number of prior removals		
Type and number of living arrangements		
Other (specify):		
Family characteristics:		
Family structure		
Siblings		
Parent competency		
Developmental disability		
Mental health diagnoses/problems		
Medical problems		
Substance abuse	√	During the first seven months of SFY 2013/2014, 21-24% of allegations were "substance misuse."
Homelessness/housing instability	√	During the first seven months of SFY 2013/2014,13% of the allegations were of environmental hazards.
Parenting attitudes		
Lack of social support		
Other (specify): Family Violence	√	During the first seven months of SFY 2013/2014, over 20% of the allegations each month involved "family violence threatens child."
Other (specify): Parent in need of Assistance	√	During calendar year 2013, the hotline received 3,018 "Parent in Need of Assistance" reports. The need is for family support services to prevent involvement of child welfare system.

- During this state fiscal year, the number of intakes or reports received by the Florida Abuse Hotline has increased 29% since July 2013. This trend indicates that the number of reports or intakes will continue to rise.



2013/2014	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Child Intakes - Screened In	14,924	16,621	17,979	19874	16725	16335	17539	16916	18228	19755
Child Intakes - Screened Out	5,104	5,380	5,652	6156	4887	4639	5142	5051	4965	5437

Since July 2013, the number of incoming investigations has fluctuated. The trend for the first three months of calendar year 2014 shows a slight increase in the number of incoming investigations.

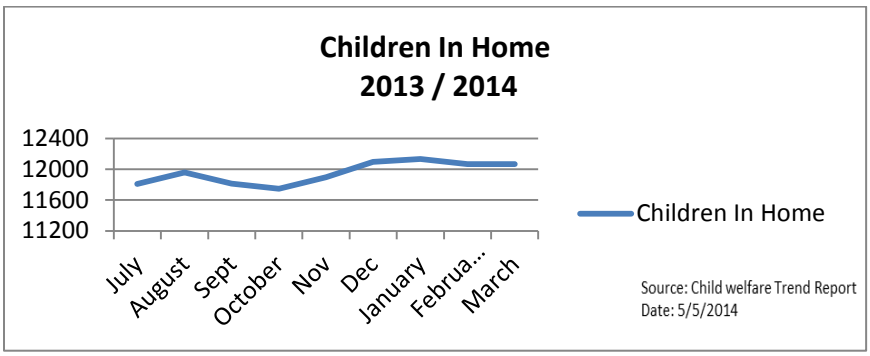


2013-2014	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Incoming CPI Workload	14,061	15,675	16,775	18,010	15,695	15,285	16,445	15,795	17,151
Active Investigation	14,522	17,150	19,348	21,125	19,981	18,059	18,030	19,419	19,676

During the first seven months of SFY 2013/2014, the count of initial plus additional investigations received ranged from about 14,000 to over 18,000(Weekly key indicator report 5/5/2014). Of these, 18-21% resulted in a most serious finding of "verified." During this same time frame, over 20% of the allegations each month involved "family violence threatens child;" 21-24% of allegations were "substance misuse;" and 16 to 18% were inadequate supervision.

The age of the child is also a factor; during FY 2012/2013, 44% of the children who were victims of verified abuse were ages 0-4 (or 21,478 children, as reported in the 2013 Annual Report of the Office of Adoption and Child Protection).

It appears that the number of children receiving in-home services has remained relatively flat. However, the balance of the children and families served in-home versus out-of-home is in flux due to implementation of new child safety and risk interventions.



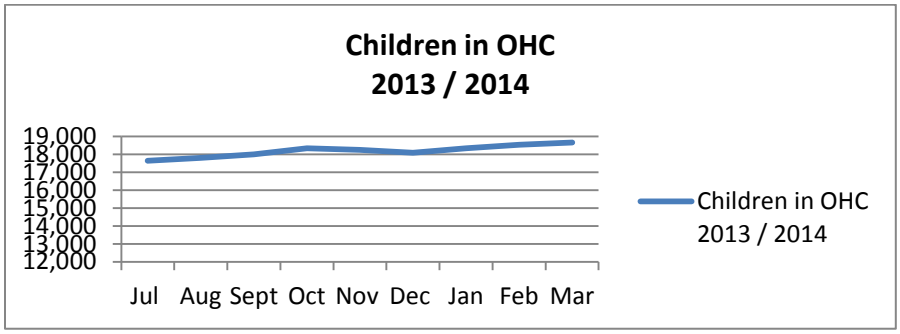
2013/2014	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Children In Home	11,811	11,960	11,812	11,748	11,896	12,095	12,132	12,067	12,066

As depicted below, the proportions of children in their own homes by age and race has remained consistent. There is no reason to anticipate any variation in this pattern.

Children Served By Age, Race, and Hispanic Ethnicity				
	In-Home Services			
Age:	November 2012		January 2014	
0-2 Years	2,770	24.75 %	2,730	25.53%
3-5 Years	2,570	22.96 %	2,390	22.35
6-9 Years	2,699	24.11 %	2,565	23.98
10-13 Years	1,861	16.62	1,810	16.92
14-17 Years	1,170	10.45	1,121	10.48
18+ Years	124	1.11	79	0.74
Race:				
White	7,306	65.30	6,893	64.52
Black	4,060	36.29	3,975	37.21
Other	259	2.31	260	2.43
Hispanic Ethnicity	1,904	17.02	1,888	17.67

Note: Race and Ethnicity numbers and percents are greater than the total number of children served because a child may have multiple races and/or ethnicities
SOURCES: DCF's Florida Safe Families Network (FSFN) monthly reports *Demographics of Children Receiving In-Home Services* and *Demographics of Children Receiving Out-of-Home Services*.

Since July, 2013 the number of children residing within Florida's out-of-home care system at the end of each month has started to increase. The state has experienced a 6% increase in the number of children residing in out-of-home at the end of the month between July 2013 and March 2014.



Number of Children in Out-of-Home Care as of the End of the Month								
Jul 13	Aug13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
17,633	17,803	18,003	18,328	18,236	18,091	18,331	18,533	18,665
Data Source: Florida Department of Children and Families, Office of Child Welfare, Child Welfare Trend Report, Number of Children in Out-of-Home Care as of the End of the Month								

In addition to the total number of children who were residing in out-of-care as of the end of the month, the disproportionality of this population by race has also remained relatively static.

Number of Children in Out-of-Home Care as of the End of the Month by Race									
	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Black	5,755	5,812	5,898	5,967	5,965	5,959	6,101	6,223	6,326
Other	1,202	1,209	1,244	1,272	1,266	1,244	1,270	1,256	1,276
White	10,676	10,782	10,861	11,089	11,005	10,888	10,960	11,054	11,063
Total	17,633	17,803	18,003	18,328	18,236	18,091	18,331	18,533	18,665
Data Source: Florida Department of Children and Families, Office of Child Welfare, Disproportionality of Children in Out-of-Home Care Trend Report									

Finally, the percentage of children by age group that received out-of-home care services at some point during the month indicates that 49% of out-of-home care services recipients are age 5 or younger.

Percentage of Children that Received Out-of-Home Care Services March 2014					
0-2	3-5	6-9	10-13	13-17	Total
27.9%	21.1%	20.2%	14.0%	16.8%	100.0%
5,514	4,162	3,996	2,759	3,329	19,760
Data Source: FSFN, Demographics of Children Receiving Out-Of-Home Services, Statewide, For the Period between 3/1/2014 and 3/31/2014.					

The single entry point to child welfare services in Florida is the Florida Abuse Hotline. All child abuse and neglect allegations received through the centralized Florida Abuse Hotline occur twenty-four hours a day, seven days a week. Some situations reported to the Florida Abuse Hotline include such circumstances that do not rise to the level of a protective investigation may be addressed as a "prevention referral." These situations, called "Parent in Need of Assistance" in Florida's SACWIS system, are more appropriately addressed by a less adversarial

assessment of needs and offer of services outside of the child welfare system. Engaging families in a less threatening way, when the situation does not warrant a formal investigation, increases the likelihood a family will acknowledge problems and agree to receive recommended services. This practice component is designed to give the Department an opportunity to help communities identify and provide services for families in order to avoid formal entrance into the child welfare system. The Department tracks and monitors such prevention referrals. During calendar year 2013, the hotline received 3,018 "Parent in Need of Assistance" reports that would be eligible to receive referrals for family support services.

Based on the above data, DCF Child Fatality Trend Analysis, January 1, 2007 through June 30, 2013 (Attachment 1), and Florida Child Welfare Services Gap Analysis Report, April 2014 (Attachment 2), special attention must be given to services necessary to meet the unmet needs that affect child safety. There are gaps in safety management services (services that should be in place in order to respond and manage threats to child safety) and in services known to be effective in the prevention and treatment of child abuse and neglect. This is especially true as we work to meet the needs of the younger children ages 0 to 4 and 5 to 9 years. Data shows that these two age groups of children are over represented as they comprise the majority of removals. Of particular note, the DCF Child Fatality Trend Analysis emphasizes the importance of in-home services. This trend analysis depicts that prior in-home services are shown to reduce the odds of death by 90%.

There are also identified gaps in assessment services such as mental health assessments for adults and children. Although a multitude of necessary services are available at the community level, many are perceived as inaccessible. This may be due to a lack of public transportation, hours of operation, waiting lists, etc.

While Florida has made substantial progress on improving educational outcomes for children in care, the K-12 Report Card, the plans for 67-counties' local agreements with local school boards and Department of Education partners, and electronic data sharing agreement are each important initiatives. Educational services that further impact a child's educational success are needed. For example, training on the relationships between the trauma of abuse and neglect and behavioral and emotional disabilities for educational decision-makers for children under protective supervision. This training will enhance the educational decision-makers ability to effectively advocate for the children.

- What are the key systemic barriers to achieving your identified outcomes that especially affect your target population? Check all that apply. Note that the following lists are not exhaustive.

  <u>Staffing barriers</u>
  √ Staff recruitment restrictions
  √ Hiring qualifications
  __ Training
  √ Caseload sizes
  __ Staff attitudes
  __ Other (specify):

  <u>Organization support/service barriers</u>
  √ Availability of appropriate family homes

√ Absence of permanency planning services
√ Lack of physical health services
√ Lack of behavioral health services
__ Other (specify):

Leadership barriers
√ Agency
__ Legislature
__ Courts
__ Inter-agency collaborations
__ Provider agencies
__ Other (specify):

__ Other systemic barriers (specify):

- What are the current numbers of children in your target population? If your demonstration involves multiple geographical service areas, answer separately for each designated geographical service area.

Target population	**Measurement basis of numerical information***	**Number of children in target group using the measurement basis**
All children and families who come to the attention of child welfare through a report of alleged child maltreatment	220,814 Children in active investigations (DCF Quickfacts Jan 2014) 12,066 In-Home 17,718 Out of Home Care (DCF Quickfacts Jan 2014) 14,680 Prevention/ Intervention (Source: Florida NCANDS FFY 2013)	Estimate 265,279 children and families will be served under the demonstration annually.

*E.g., number in the system at a point-in-time, in an entry cohort such as at case opening or foster care placement, ever served in a year, etc.

III. Clearly Defined Demonstration Components and Associated Interventions

The Department is currently undergoing a statewide structured implementation of a new child welfare practice model. As embodied in Florida's Child Welfare Practice Model, the vision is rooted in principles and practices that are safety-focused, family centered and trauma informed. Florida's practice model focuses on seven general professional practices and directed toward the major outcomes of safety, permanency, and child and family well-being.

- Engage the family;
- Partner with all involved;
- Gather information;

- Assess and understand information;
- Plan for child safety;
- Plan for family change;
- Monitor and adapt case plans.

Interventions:

1) Safety Methodology

This intervention is a very broad, integrated approach that affects child safety through increased intake analyst (Hotline) and child protective investigator ability to identify, assess, and make decisions about potentially unsafe children. It also includes aspects of case management and services for permanency and well-being.

Florida's integrated approach to:

- Initial identification of potentially unsafe children by the Florida Abuse Hotline;
- Further assessment of safety and safety decision making by investigators;
- Ongoing safety management and service provision to enhance parental protective capacities (emotional, cognitive and behavioral), address and enhance child well-being needs (emotional, behavioral, developmental, academic, relationships, physical health, cultural identity, substance abuse awareness, and adult living skills); and
- Providing a framework for safe reunification (conditions for return) or decision-making points for other needed permanency options by case managers.

The Safety Methodology also incorporates the classification of risk for safe children that results in appropriate community referrals and family support services for safe children at high risk of abuse in the future. The function of risk assessment is to ensure that families at risk of future maltreatment are identified and served. The Department has identified actuarial risk tools known as Structured Decision Making® (SDM), developed by the Children's Research Center (CRC) as the preferred option available for assessing risk. By utilizing the risk assessment tools, agency resources are targeted to higher risk families with a greater potential to reduce subsequent maltreatment. Using a statewide, evidence based actuarial risk assessment tool will help investigations and supervisors identify family risk levels using consistent constructs and language and will allow us to standardize prevention programs, allowing for evaluation of program effectiveness. This supports replication of best practice programs from community to community.

The risk assessment is built around two indexes, one for abuse and one for neglect; but only the total risk level matters. The instrument will not tell you if the family is at higher risk for abuse or neglect. The family risk level is based on the highest score of the two indexes and has policy overrides built in as well. In effect, based on the family's characteristics (not risk factors), how likely are they to abuse or neglect their children in the next 12 to 24 months? This concept of risk supports child welfare to allocate resources more effectively to people who have identifiable characteristics that more regularly present with difficulties.

To address long-term permanency, the safety methodology utilizes a structured assessment tool known as the Family Functioning Assessment – Ongoing, which is used to assess:

- Are danger threats being managed with a sufficient safety plan?

- How can existing protective capacities be built upon to make changes?
- What is the relationship between danger threats and the diminished caregiver capacities - What must change?
- What is the parent's perspective or awareness of his/her caregiver protective capacities?
- What are the child's needs and how are the parents meeting or nor meeting those needs?
- What are the parents really and willing to work on in the case plan to change their behavior?
- What are the areas of disagreement with the parents as to what needs to change?
- What change strategy will be used to address diminished protective capacities?

The Family Functioning Assessment – Ongoing (FFA-O) is the first formal intervention during on-going case management. It begins at the point the CPI worker transfers a case to ongoing case management. The assessment is a collaborative process that will result in identifying specific change strategies. However, the bulk of the conversation during the assessment is concerned with having caregivers recognize and identify protective capacities associated with impending danger and seek areas of agreement regarding what must change to eliminate or reduce danger threats and sufficiently manage threats to child safety.

The philosophy behind this assessment tool is that safety is paramount and is the basis for the intervention; however, the case planning process and interventions can be more clearly defined around the use of safety concepts and behavior change. The FFA-O also sets up conditions of return. These conditions of return are simply the conditions that must exist for children in-out-home care to return to the home safely. That is, what it would take to have children safely maintained in their own home. These conditions are derived from the safety analysis questions used to create the out of home safety plan. Reconciling information gathered during the on-going case management intervention against the existing safety analysis questions is the foundation to creating and analyzing the conditions for return, thus facilitating permanency through reunification.

Lastly, the progress evaluation, or Progress Update, is an on-the-record assessment that involves focused information collection and standardized decision making while case managers are considering progress for change and safety plan sufficiency. The formal intervention occurs at least at 90 days and at critical junctures. It is precise, fair and objective, reflected in progress measurements of no progress, minimal progress, significant programs and outcome achieved. Areas of assessment during the evaluation are caregiver protective capacities, child needs, family time and visitation, and case plan outcome evaluations. These measurements are connected to assessment driven actions: No Change, Change in case plan, Change in safety plan and Change in visitation plan (if the child is removed).

The assessment of well-being and the attention to children's strengths and needs is included in every FFA-O and Progress Update. Child strengths and needs items measure the extent to which certain desired conditions are present in the life of the child within a recent timeframe. The child indicators are directly related to a child's well-being and success (emotion, behavior, family and peer relationships, development, academic achievement, life skill attainment). When the Department is involved with families whose children are unsafe, the case manager is responsible for assuring that the child's physical and mental health, development and educational needs are addressed by their caregivers as well as other caregivers when the child

is in an out of home setting. The information gathered through assessment of these indicators is used to systematically identify critical child needs that should be the focus of thoughtful case plan interventions. The information needed by the case manager to complete the assessment will be gathered from the child, parent and other caregivers, and collateral source such as child care providers, teachers and/or other professionals. The scaling constructs for measuring the strength or need are as follows:

A=Excellent: Child demonstrates exceptional ability in this area

B= Acceptable: Child demonstrates average ability in this area

C= Some attention needed: Child demonstrates some need for increased support in this area

D=Intensive support needed: Child Demonstrates need of intensive support in

An implementation journey guided by implementation science and the support of national experts from Casey Family Programs, the National Resource Center for Child Protection and the Children's Research Center is in the initial implementation stage. The utilization of the Safety Methodology is being woven into all critical areas of practice and policy and supported by a statewide steering committee and various subcommittees with key stakeholder representation.

When child protective investigation indicates that parents or guardians can't, don't or won't protect their children, the Department quickly steps in to help, providing a full spectrum of services from in-home supervision services to referrals for parenting classes and child care, to foster care placement in a licensed home or placement with a relative. In-home services are emphasized in order to keep children in their own families whenever possible and safe to do so.

For the most part, in-home protective services are intended to support families with strengthening caregiver protective capacities while at the same time implementing in-home, agency directed and managed safety plans. Below is a brief description of in-home safety services that may be offered, and a list of examples of each. Availability of each type of service depends on the local CBC service structure and system of care to address community needs and population differences.

Safety Plan Service: Behavioral Management. Behavioral management is concerned with applying action (activities, arrangements, services, etc.) that controls (not treats) caregiver behavior that is a threat to a child's safety. While behavior may be influenced by physical or emotional health, reaction to stress, impulsiveness or poor self-control, anger, motives, perceptions and attitudes, the purpose of the services are only to control the behavior that poses a danger threat to a child. Services are concerned with managing any aggressive behavior, passive behavior or absence of behavior which threatens a child's safety.

Safety Plan Service: Supervision and Monitoring. Supervision and monitoring is the most common safety service in safety intervention. It is concerned with caregiver behavior, children's conditions, the home setting, and the implementation of the in-home safety plan. Child welfare professionals oversee people and the plan to manage safety. Supervision and monitoring is almost always used when other safety services are employed.

Examples: Case Manager visits, professional monitoring (e.g., drug testing for compliance with substance abuse treatment), Domestic Violence Specialist visits.

Safety Plan Service: Stress Reduction. Stress reduction is concerned with identifying and alleviating stressors occurring in the caregiver's daily experience and family life that can influence or prompt behavior that the in-home safety plan is designed to manage.

Examples: Changing work schedule/amount of hours, re-aligning household responsibilities.

Safety Plan Service: Behavior Modification. Safety management services or activities are not concerned with changing behavior; they are focused on immediately controlling threats. Safety management service is an attempt to limit and regulate caregiver behavior in relationship to what is required in the in-home safety plan. Modification is concerned with influencing caregiver behavior: a) to encourage acceptance and participation in the in-home safety plan and b) to assure effective implementation of the in-home safety plan.

Examples: Parent calls an informal safety support (family member, friend); or, under certain circumstances, parent lives temporarily away from the home.

Safety Plan Service: Crisis Management. Crisis is a perception or experience of an event or situation as horrible, threatening, or disorganizing. The event or situation overwhelms the caregiver's and family member's emotions, abilities, resources and problem solving. A crisis for families child welfare professionals serve is not necessarily a traumatic situation or event in actuality. A crisis is the caregiver's or family member's perception and reaction to whatever is happening at a particular time. With respect to safety management, a crisis is an acute matter to be dealt with so that present or impending danger is controlled and the requirements of the in-home safety plan continue to be carried out. The purposes of crisis management are crisis resolution and prompt problem-solving in order to control present danger or impending danger.

Safety Plan Service: Social Connection Social connection is concerned with present danger or impending danger that exists in association with or influenced by caregivers feeling or actually being disconnected from others. The actual or perceived isolation results in non-productive and non-protective behavior. Social isolation is accompanied by all manner of debilitating emotions: low self-esteem and self-doubt, loss, anxiety, loneliness, anger, and marginality (e.g., unworthiness, unaccepted by others).

Florida will use this safety category alone or in combination with other safety categories, such as Supervision and Monitoring, in order to reinforce and support caregiver efforts, and to evaluate how the caregiver is doing with behavior management is a secondary value of social connection. (See Behavior Management – Supervision and Monitoring.)

Safety Plan Service: Friendly Visiting. Friendly visiting is an intervention that was among the first used in social work history. The original intent of friendly visiting was essentially to provide casework services to the poor. In safety intervention, friendly visiting is directed purposefully at reducing isolation and connecting caregivers to social support.
Friendly visiting can include professional and non-professional safety management service providers, and other resources or support networks. When informal providers make arrangements for friendly visiting, it is necessary for child welfare professionals to direct and coach them in terms of the purpose of the safety management service and how to proceed, set expectations, and seek their accountability.

Examples: Healthy Families, Early Head Start, family members or friends, children's school teachers, clergy members.

Safety Plan Service: Basic Parenting Assistance. Safety intervention is concerned with parenting behavior that is threatening to a child's safety. Basic parenting assistance is concerned with developing specific, essential parenting that affects a child's safety. This safety management service is focused on essential knowledge and skills a caregiver is missing or failing to perform. Typically these are skills related to caring for children with special needs (e.g.,

infant, disabled child). Building support persons into the in-home safety plan can become a significant social connection to help parents/caregivers with challenges they have in basic parenting behavior, which is fundamental to the children remaining in the home.

Examples: Child-specific medical training, breastfeeding support (e.g., La Leche League), parenting mentors.

Safety Plan Service: Supervision and Monitoring as Social Connection. Some in-home safety plans will require social connection and behavior management, specifically supervision and monitoring. Supervision and monitoring occurs through conversations during routine safety management service visits, along with information from other sources. The point here is to promote achievement of objectives of different safety categories and safety management services when the opportunity is available. (See Supervision and Monitoring.)

Safety Plan Service: Social Networking. In this safety management service, child welfare professionals are facilitators or arrangers. Social networking as a safety management service refers to organizing, creating, and developing a social network for the caregiver. The idea is to use various forms of social contact, formal and informal; contact with individuals and groups; and use of contact that is focused and purposeful.

Safety Plan Service: Resource Support. Resource support refers to safety category that is directed at a shortage of family resources and resource utilization, the absence of which directly threatens child safety.

Services/Examples:

Activities and safety management services that constitute resource support used to manage threats to child safety or that are related to supporting continuing safety management include:

- Resource acquisition related specifically to a lack of something that affects child safety.
- Transportation services particularly in reference to an issue associated with a safety threat.
- Financial/Income/Employment assistance as an assistance aimed at increasing monetary resources related to child safety issues.
- Housing assistance that seeks a home that replaces one that is directly associated with present danger or impending danger to a child's safety.
- General health care as an assistance or resource support that is directly associated with present danger or impending danger to a child's safety.
- Food and clothing as an assistance or safety management service that is directly associated with present danger or impending danger to a child's safety
- Home furnishings as an assistance or safety management service that is directly associated with present danger or impending danger to a child's safety.

Safety Plan Service: Separation. Separation is a safety category concerned with danger threats related to stress, caregiver reactions, child-care responsibility, and caregiver-child access. Separation provides respite for both caregivers and children. The separation action creates alternatives to family routine, scheduling, demand, and daily pressure. Additionally, separation can include a supervision and monitoring function concerning the climate of the home and what is happening. Separation may involve anything from babysitting to temporary out-of-the-home family-made arrangements to care for the child or combinations.

Examples of actions that could be taken in this category include:

- Planned absence of caregivers from the home.
- Respite care.
- Day care that occurs periodically or daily for short periods or all day long.
- After school care.
- Planned activities for the children that take them out of the home for designated periods.
- Family-made arrangements to care for the child out of the home; short-term, weekends, several days, few weeks.

Because the Safety Methodology is focused on safely maintaining children in their own homes whenever possible, and facilitating reunification based on improving caregiver protective capacities and effecting behavior changes, demonstration funds will be used to support services provided through the new practice model.

2) Increase availability and access to services.

This intervention challenges CBC lead agencies and local communities to increase availability and access to services based on the needs of children and families at the local level. An area that has not developed as widely as we had hoped is service array and evidence-based family support services across the state. Florida is a large state with a diverse population with varying needs. Casey Family Programs in partnership with the University of South Florida conducted a statewide electronic survey in January and February 2014 to examine service gaps in Florida's child welfare system. The purpose of the survey was to conduct a comprehensive gap analysis of services available at the community level for families at risk of involvement or involved with Florida's child welfare system. The final report was issued April 8, 2014.

Overall, a wide range of services were rated between occasionally or usually available and accessible. A small number of key service gaps do exist. The respondents identified 13 services as critical unmet needs that affect child safety. Four of these: (1) crisis management, (2) behavior management- in-home supervision and monitoring, (3) in-home crisis intervention, and (4) after school care are safety management services. Three of these are in-home services: (1) behavior management- in-home supervision and monitoring, (2) Safe at Home, and (3) in-home crisis intervention. Two of the services are evidence-based practices: (1) Safe at Home, and (2) Parent-Child Psychotherapy. The recommendations from the final report will serve the regions and CBCs well as they work with local community providers and funders to further develop service network within the local community.

Moreover, CBCs are required by contract to provide services and programs that are evidence-based. Below is the excerpted language from the CBC contract:

"The Lead Agency agrees to expand the array of community-based services and programs using title IV-E funds as outlined in the Waiver Terms and Conditions. Expanded services, supports, and programs may include, but are not limited to:

- Early intervention services in situations of developing family need to prevent crises that jeopardize child safety and well-being;
- One-time payments for goods or services that reduce short-term family stressors and help divert children out-of-home placement (e.g., payments for housing, child care, etc.);
- Evidence-based, interdisciplinary, and team-based in-home services to prevent out-of-home placement;
- Services that promote expedited permanency through reunification when feasible, or other permanency options as appropriate;
- Enhanced training for child welfare staff and supervisors in service delivery and supervisory practices;
- Improved needs assessment practices that take into account the unique circumstances and characteristics of children and families; and
- Long term supports for families to prevent placement recidivism."

3) Integration of Services for Child Welfare and Behavioral Health

Behavioral health concerns are among the most common involved in allegations of child abuse and neglect. In a nod to the psychological concept defined by one source as "the organization of the psychological or social traits and tendencies of a personality into a harmonious whole," the Department's Offices of Child Welfare, Substance Abuse and Mental Health participate in several integration initiatives to address issues for shared clients in order to bring processes and policies into a "harmonious whole" across the programs. These integration approaches involve children and their families; that is, adult behavioral health and child behavioral health are both involved. Though many of these efforts also involve child and family well-being, first and foremost is their impact on the ability of the Department to promote child safety.

Assessment in children and families involved with child welfare are often related to behavioral health (substance abuse or mental health). By increasing the skills and knowledge of child welfare professionals about behavioral health, and by pursuing integration of practice and services, the Department can address these critical factors in a holistic manner across the two systems.

Integration of services for child welfare, mental health, substance abuse and domestic violence is another intervention component. Integrated services will ensure early identification of the needs of the family and timely access to necessary interventions, resulting in an improved response to issues such as, developmental disabilities, substance-exposed newborns, and domestic violence.

Some integration efforts are short term, such as presentations at joint conferences or particular media campaigns (notably the joint "Who's Watching Your Child" campaign). However, there are several initiatives that are significant, long term, and will affect the overall ability of the child welfare program to achieve the broad goal of increasing safety for children. These include:

- A behavioral health initiative affecting child welfare that involves the implementation of Managing Entities within the Substance Abuse and Mental Health program. The Department contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the Department's funding to be tailored to the specific behavioral health needs

in the various regions of the state. There are seven Managing Entities that "develop, implement, administer, and monitor a behavioral health Safety Net" throughout the state.

Managing Entities (ME) are under contract with the Department to manage the day-to-day operational delivery of behavioral health services. The ME must ensure that resources are community focused and build on the unique strengths and meet the specific needs of the local communities.

- Provision of training in the area of trauma-informed care for staff and caregivers, specifically as part of the pre-service curriculum and on-line training developed by the Florida Certification Board, and in alignment with the child welfare Practice Model;
- Care coordination/case management program inclusion of behavioral health and trauma-informed care under the Child Welfare Specialty Plan under Medicaid Managed Care (refer to Florida CFSP 2015-2019, Health Care Oversight and Coordination Plan) and local coordination of child welfare agencies with services provided by the Behavioral Health Managing Entities;
- Florida Children's Mental Health System of Care Expansion Grant and Integration with Child Welfare;
- Project LAUNCH (Linking Actions to Unmet Needs in Children's Health), a five-year grant from the Substance Abuse and Mental Health Administration (SAMHSA). This grant is grounded in the public health approach and works towards coordinated programs that take a comprehensive view of health by addressing the physical, emotional, social, cognitive and behavioral aspects of well-being.
- The Substance Abuse Mental Health Program will provide content expertise on prescription drug treatment and prevention, Family Intervention Specialists (FIS), and child welfare issues related to substance abuse and mental health. The SAMH Program is also partnering with the Florida Alcohol and Drug Abuse Association to develop and deliver seven webinars to train Child Protective investigators and FIS staff in the recognition and assessment of behavioral health disorders.
- A critical part of the child welfare/behavioral health integration process is the role of FIS. As appropriate, child welfare policies and procedures have been revised to include the FIS services. Further, FIS protocols have been developed which delineate the service delivery process to this population. It is significant to note that FIS are co-located with the child welfare staff to promote communication, easy access and improved continuity of care.

Other integration components concern administration and oversight of psychotropic medication for children in foster care. Florida has made positive efforts to address the overutilization of psychotropic medications in foster care. Psychotherapeutic medications are to be provided to the child only with the express and informed consent of the child's parent or legal guardian. Court authorization, after consultation with the prescribing physician, must be sought if parental rights are terminated, the whereabouts of the child's parents are not known, or a parent declines to give express and informed consent. A mandatory pre-consent review by a child psychiatrist contracted by the Department is required prior to prescription of a psychotropic medication for any child between the ages of birth through five (5) years who is in the custody of the Department in out-of-home care.

The Department works closely with Agency for Healthcare Administration (AHCA) to ensure oversight of psychotropic medication. The oversight of prescription medicines, including

psychotropic medications, is critical to safeguard appropriate practice of management and administration of medication to children placed in out-of-home care. Medication information is required to be documented in the Florida Safe Families Network (FSFN) in data fields that can be easily queried and analyzed. Among others, the data fields include the name of the medication, the condition(s) the medication addresses, and whether or not the medication is psychotropic, and whether the medication is administered for psychiatric reasons.

- AHCA contracts with the University of South Florida for the Medicaid Drug Therapy Management Program (MDTMP) for Behavioral Health to maintain and develop evidence based guidelines for the use of psychotropic medications for children. This program includes the development of Florida-specific best practice guidelines and their dissemination through a variety of methods created and implemented by the prescriber community. These treatment guidelines will represent a consensus of the prescriber community and will reflect the best available scientific information.

- The MDTMP also includes a claims review process and educational mailings to inform physicians of prescribing behavior that may be worth reviewing. The mailings, containing patient-specific prescription information and clinical considerations, are designed to reduce the frequency of practices that are inconsistent with the guidelines. National experts, Florida physicians, AHCA, and DCF staff meet biennially to update medication guidelines.

- Florida has a Florida Pediatric Psychiatry Consult Hotline. This service is administered by the Florida Medicaid Drug Therapy Management Program for Behavioral Health located at the Florida Mental Health Institute (FMHI) at the University of South Florida. The Florida Pediatric Psychiatry Hotline, a network of regional children's behavioral health consultation teams, is designed to help primary care clinicians meet the needs of children with psychiatric conditions. The goals of the program are to provide consultation about psychotropic medications for children with psychiatric illness and promote a primary care clinician's and child psychiatrist's collaborative relationship. Currently there are three consultation hotlines (University of Florida Division of Child and Adolescent Psychiatry in Gainesville; University of South Florida Division of Child and Adolescent Psychiatry in the Department of Pediatrics, Rothman Center for Neuropsychiatry in St. Petersburg; and Florida International University).

4) Child Welfare and Physical Health Assessments

Although Florida has increased timeliness of medical and dental services, we still have considerable way to go in completing comprehensive health care assessments when children come into care, and in following periodicity schedules for immunizations and well-child checkups. The well-being standards do not demonstrate improvements in the percent of children receiving the services identified through assessments. This includes lags in physical and dental health particularly.

Another collaborative partner, Agency for Healthcare Administration (AHCA), has placed the 72 hour screening requirement in all contracts for Medicaid Managed Assistance (e.g., Sunshine Health and other plans). Effective 7/1/14, the 72 hour screening will be a requirement in Florida statutes. This requirement is addressed in the Protective Custody Coverage Provisions of the managed care contract and requires the following:

Child Heath Check Up Age of Child
birth
2-4 days
2 months
4 months
6 months
9 months
12 months
15 months
18 months
Once every year for ages 2-20

The Managed Care Plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter or the foster care program by DCF.

a) The Managed Care Plan shall provide these required examinations without requiring prior authorization, or, if a non-participating provider is utilized by the Department of Children and Families, approve and process the out-of-network claim.

c) For all Child Health Check Up Screenings for children/adolescents whose enrollment and Medicaid eligibility are undetermined at the time of entry into the care and custody of the Department, and who are later determined to be enrollees at the time the examinations took place, the Managed Care Plan shall approve and process the claims. All children must have ongoing assessments following the Child Health Check-up periodicity schedule. The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

Furthermore, AHCA will monitor performance through the contract performance measures required within the Child Welfare Specialty Plan contract. AHCA has adopted a set of quality metrics that sets targets on the metrics that equal or exceed the 75th percentile national Medicaid performance level. In addition, these metrics will be used to establish plan performance, improvement projects focusing on areas such as improved prenatal care and well child visits in the first 15 months and better preventive dental care for children.

5) Education Information and Service Integration for Child Well-being

The Department and its various educational partners, particularly the Department of Education, local school boards, post-secondary institutions, foster parents and caregivers, continue to develop methods and approaches to working together toward common goals for educating children and youth.

Interagency agreements are a normal method of defining these methods, at the state and local levels. Some of these are very broad, such an agreement among the Department of Children and Families, Department of Education, Department of Juvenile Justice, Agency for Persons with Disabilities, and the agency for Workforce Innovation to coordinate educational and vocational services. Others have more narrow topical focus, such as data sharing agreements or for coordinating services in a specific county. These interagency agreements not only support coordination, but they provide a platform whereby resources and knowledge can be shared and made more efficient and effective.

It became clear that the impetus for improving each child's educational success needed to come from the local partners, as our case management agencies are the ones interacting with individual children, as well as with the local schools. As such the following are being implemented:

Data Exchange: The long-term objective of the data exchange pilot project, as well as incorporating educational data elements into FSFN, is to create baseline data against which

subsequent data will be measured to assess the strengths and challenges of our children's educational success. Once systemic challenges are identified, the objective is for Community-Based Care (CBCs) agencies, working with their individual school districts, to develop local interventions to respond to these challenges.

School Stability: The Department has been working with the Florida Department of Education and with CBC agencies to move toward greater stability in school placements.

- The component involves completion, execution and implementation of the joint memorandum with Florida Department of Education on the applicability of McKinney-Vento to children in the child welfare system. This memo will clarify that children who are initially removed from their families and placed into shelter care are "children awaiting foster care placement" such that they have the right to remain in their schools of origin, should that be in their best interest, and will delineate when each school district will be required to transport the children back to their original schools.
- The Department will also distribute a guide for determining if remaining in the school of origin is in each sheltered child's best interest. This guide is currently being used by the Children's Legal Services attorneys, in their discussions of school stability with child protective investigators and case managers whenever a placement change is brought to the attention of CLS prior to the move.
- Another component is inclusion of educational placement stability as one of the issues to be addressed in transition planning when a child is moved from one placement to another. The specific goal of this component is either for children to remain in their schools of origin until the end of the school year, when that is in their best interests, or to time the transfer to a new school to a scheduled break in the academic year so as to minimize the difficulties for the students and to maximize the transfer of school credits and the students' ability to make a seamless transition to the new school and classroom.

  To achieve this component, the Department will train community based care managers and its protective investigators, both through direct training and by providing "train the trainer" sessions. Because this transition plan is developed for a court proceeding, the Children's Legal Services' attorney handling the case is in a good position to encourage and remind the professional social workers to include this educational issue in the transition plans that are provided to the dependency courts.
- Another component is the designation of an education liaison in most of the community-based care agencies, and a designation of a foster care liaison within the majority of Florida's local school districts. In school districts with larger populations of children in foster care, these foster care liaisons are often in court daily, and assist with educational stability issues.

6) Quality Parenting Initiative

The Quality Parenting Initiative (QPI) integrates practice across various systems to ensure foster families are provided the support they need to provide high quality care to children.

The Quality Parenting Initiative (QPI) is one of Florida's approaches to strengthening foster care, including kinship care. It is a process designed to help a site develop new strategies and practices, rather than imposing upon it a predetermined set of "best practices." If a child's own parents are unable to safely care for him or her, the system must ensure that the foster or

relative family caring for the child provides the loving, committed, skilled care that the child needs, while working effectively with the system to reach the child's long term goals.

QPI recognizes that the traditional foster care "brand" has negative connotations and this deters families from participating. QPI is an effort to rebrand foster care, not simply by changing a logo or an advertisement, but by changing the core elements underlying the brand. When these changes are accomplished, QPI sites are better able to develop communication materials and to design recruitment training and retention systems for foster parents. The key elements of the QPI process are:

- To define the expectations of caregivers;
- To clearly articulate these expectations; and then
- To align the system so that those goals can become a reality.

The major successes of the project have been in systems change and improved relationships. Sites have also reported measurable improvement in outcomes such as:

- Reduced unplanned placement changes;
- Reduced use of group care;
- Reduced numbers of sibling separation: and
- More successful improvements in reunification.

QPI currently is established in 18 of 19 CBC lead agencies, covering 19 of 20 Circuits in the state. The goal is to expand QPI to the last remaining circuit in 2014-15.

7) Trauma Informed Care

Florida's child welfare system recognizes that children who have experienced maltreatment and have been removed from their homes face considerable trauma. These children must be protected from events that may add to the traumatic experiences and must receive the necessary early intervention and trauma informed therapeutic treatment. Caregivers struggling with their own history of trauma may also need specialized treatment to build and enhance parental capacity. A trauma informed system recognizes the impact of trauma on staff and those it serves, provides respect, information, collaboration, hope, and works to identify and change policy or procedure that has the potential to be traumatizing. To this end, Florida seeks to:

- Provide statewide training for new hires and technical assistance on trauma informed care.
- Integrate trauma informed care screening practices to help identify, assess, and refer parents and children in need of specialized treatment.

Florida is working to improve its system of "trauma-informed care" to ensure children experiencing trauma are quickly recognized and treated. The state uses standardized assessments as part of the Child Behavioral Health Assessment (CBHA). CBCs have developed and implemented treatment and service interventions that reflect strong partnerships and networks. The Child Welfare Pre-service Curriculum includes training to help professionals identify and address childhood trauma. In April 2014, the Florida Association for Infant Mental Health sponsored a conference "Many Paths to Enhancing Parent-Child Relationships-Innovative Approaches to Providing Infant Mental Health, Home Visiting, and Part C Services"

which highlighted trauma informed care. Some examples of trauma informed care services or initiatives provided through Community-Based Care lead agencies include:

Circuit 19 – Devereux CBC: All Devereux CBC staff were trained on trauma informed care principles in November 2013. The pre-service for case managers has trauma informed focus imbedded throughout, as does Devereux's foster parent curriculum. Devereux CBC believes that trauma focus should permeate the entire system, and work to reinforce with staff and providers alike the practice of trauma sensitive approaches in services to children, as well as the parents of the children, who are in many cases victims of trauma themselves. Devereux CBC ensures trauma principles are routinely reinforced through in-service training that occurs approximately twice yearly.

Circuit 12 – Sarasota YMCA: The Sarasota Y/Safe Children Coalition uses multiple approaches to identify children who may be in need of trauma-informed care. Comprehensive Behavioral Heath Assessments (CBHA) are completed on all children who are sheltered and based on the recommendations of the assessment, children are referred to clinicians for further evaluation if warranted. All children, five years of age and younger, are referred to Florida Center for Early Childhood for the completion of their CBHA as our local Infant and Early Childhood Mental Health provider. The Florida Center for Early Childhood utilizes specific assessment tools to provide a clear recommendation for the younger children in the child welfare system of care. All of the local mental health agencies have trauma-informed therapists on staff.

All case management staff receive trauma-informed training during pre-service training and we have in-service trainings available for all staff. In the Spring of 2013 the focus of the SCC conference was trauma-informed care with experts providing training specific to trauma for the child welfare population – this was the topic for the full day's agenda.

Youth and Family Alternatives is the Case Management agency that provides oversight for the young children in Circuit 12. They require all case management staff to have additional training that specifically focuses on the target population of 0-5 years.

The foster parent pre-service training, Positive Parenting, is a trauma informed based curriculum. The Foster and Adoptive Parent Associations invite local experts to provide trauma informed care training as part of their Association meetings. Additionally foster parents are encouraged to view the on-line training provided through the Center for the Advancement of Child Welfare website.

Several lead agency and case management staff also are active members of the Circuit 12 Trauma-Informed Care workgroup which is facilitated by Central Florida Behavioral Health Network in partnership with local mental health providers, school representatives, Child Welfare Systems Advocate, DCF, and other community partners.

Circuit 4 - Kids First of Florida: Clay Behavioral has two Trauma Treatment Therapists (TTT) on-call 24/7 to assist with all placement changes and to assist the CPI's with initial removals. The TTTs work with the children for up to 26 weeks after the removal/placement change, or longer if needed. Also, if the child needs therapy due to any type of trauma, a referral to the TTT is made. All staff have been trained on the impact of trauma on a child a while back, but another training is needed for the new staff. The foster parents were trained about a year and a half ago on the impact of trauma on a child. Following this training, trauma informed care was incorporated into the PRIDE training class to assure all foster parents have this training

Circuits 3 & 8 - Partnership for Strong Families: Trauma informed care has been integrated into week 1 of Pre-service training. Robert Edelman has facilitated a training for staff last year and we continually offer other training opportunities on trauma informed care

Partnership for Strong Families (PSF) ensures that all child-specific needs are accounted for, and addressed, through the provision of services that are individually identified to meet a child's needs. Through PSF's Utilization Management Department, every child that is in need of services is screened, by a Family Services Facilitator (FSF), to ensure that there is adequate information and identification of child needs. Each of the FSFs has received Training for Youth Mental Health First Aid, which has a focus on identifying risk factors to facilitate early identification and intervention for Youth affected by trauma. The FSFs are considered service experts for the areas they serve. PSF also has an in-house trainer for Youth Mental Health First Aid. When children are determined to have a history of trauma, and are in need of trauma-specific services, the Family Service Facilitators are able to identify appropriate providers in the area who are able to deliver trauma-informed care services. These services include, but are not limited to, individual, group, and family therapies. One particular program specializing in Trauma is the FIT (Families in Transition) program. This program normally intervenes at the time of removal, and focuses heavily on the trauma that the child has experienced. Additionally, PSF partners with community agencies (such as Meridian Behavioral Healthcare, Inc., Child Advocacy Center, Village Counseling Center, Family Preservation Services, etc.) who have established tools for assessing and treating children with a history of trauma, and other specialized issues. Some of these community partners have also provided training, which has been available to staff and partner families.

Circuit 10-Heartland for Children: Heartland has evolved into a Trauma Integrated System of Care. Heartland has been at the forefront of Trauma Integration for the past four years. They have brought a number of well-known lecturers, trainers and consultants to work with Heartland and our partners as they have integrated trauma knowledge into their practices. The list of individuals includes, but is not limited to; Tonier Cain, Juli Alvarado, Dr. Wayne Duehn, and Dr. Bruce Perry. Through the provision of this expertise, over 1,700 people in circuit 10 (Case Management, Protective Investigators, Children's Legal Services, Guardian ad Litem, Department of Juvenile Justice, school employees, group home staff, Healthy Start, Healthy Families, mental health and substance abuse providers, as well as other community service providers) have been trained on understanding the impact of trauma. In addition to disseminating information on the body of research on the Adverse Childhood Experience Survey (ACES), Heartland is integrating the utilization of this knowledge in day to day decision making. Heartland has ensured that the CBHA providers now produce trauma informed comprehensive assessments that identify common behaviors associated with victims of trauma.

Heartland's case manager pre-service curriculum has been updated to include a trauma informed understanding of behavior. The adoptive parent and foster parent preparation classes have been revamped for the same understanding, with a special emphasis on becoming a caregiver to a victim of complex trauma. Additionally, Heartland for Children's new hire orientation contains a module on understanding the impacts of trauma. Monthly calls with Juli Alvarado for both caregivers and staff are utilized to continue to implement and integrate understanding of trauma into our day to day practice.

Heartland for Children staff participate in the Circuit 10 Trauma Informed Care Coordinating Council and are actively working to build capacity for trauma specific treatment through our training series with Dr. Bruce Perry and the Child Trauma Academy. Heartland has purchased a webinar series featuring Dr. Perry. The plan is to train 25 external stakeholders in neurodevelopmental principles. As the result of full integration of trauma knowledge and day to

day practice, no placement decision or provision of service is made without prior consideration of trauma and case specific implications. The thinking of Heartland for Children has shifted thinking from "what is wrong with you?" to "What happened to you?" and staff has a general understanding that trauma IS the problem.

Florida is committed to working in collaboration with the Children's Bureau and the demonstration waiver's evaluation contractor to expand on the efforts to improve measurement and outcomes related to well-being. These efforts will include the use of data from the family functional assessments as deployed through Safety Methodology.

IV. Assessing Readiness to Implement the Demonstration

The contract template for negotiations with Community-Based Care (CBC) lead agencies includes a comprehensive list of "Standards of Quality, Safety, and Practice Requirements". This Authority and Requirement attachment is part of the contract with all 18 CBC lead agencies. Included in the Authority and Requirements document are the following major requirements by category:

- Federal laws and policy regarding child welfare
- Florida laws regarding child welfare, substance abuse, mental health, and contracting requirements
- Florida administrative code chapters regarding child welfare (rules)
- Florida departmental operating procedures regarding child welfare and organization management and
- Federal cost principles.

As noted in Section V. Work Plan, the CBC lead agency agreements incorporate requirements related to the demonstration. This includes maintenance and improvements to the array of services provided by CBC lead agencies, issues related to use of funds, expenditure reporting, etc. The attachment 3 to this report, Authorities and Requirements, provides the current requirements.

V. Work Plan

In order to manage the demonstration, an oversight team has been established. This oversight group is composed of senior managers from DCF along with executive leadership from Community-Based Care (CBC) Lead Agencies. This group includes:

Emilio Benitez, Chief Executive Officer, Childnet, Inc.

Sallie Bond, Title IV-E Specialist, Office of Child Welfare, DCF

Glen Casel, ED., Chief Executive Officer, Community Based Care of Central Florida

Elisa Cramer, Director, Family and Community Services, DCF

Pete Digre, Deputy Secretary, DCF

Mark Mahoney, Assistant Staff Director, Office of Revenue Management, DCF

Lisa Peyton, Chief Operating Officer, IMPOWER

Cheri Sheffer, Chief Operating Officer, Devereux Community Based Care

Janice Thomas, Assistant Secretary for Programs, DCF

Sallie Bond will serve as primary point of contact with the Administration for Children and Families (ACF), Children's Bureau for matters related to the demonstration project.

The details of the implementation of the demonstration are being accomplished by work teams that include persons with the expertise in specific issues or practice areas. As the demonstration project proceeds, additional work groups may be formed as additional need for expertise is identified. For the demonstration, the following groups have been established to accomplish the tasks necessary for a successful demonstration:

Eligibility – This work group will review and modify procedures, as necessary, to ensure that IV-E eligibility determinations are made for all children who are involved in the demonstration project to ensure eligible children retain their eligibility after the demonstration ends and to ensure that IV-E eligibility can be properly determined for the purpose of Adoption Assistance Payments.

Fiscal Accounting and Reporting – This work group will address issues related to cost allocation, financial accountability and reporting related to the demonstration. The group will develop procedures to ensure that financial information related to the demonstration is reported on Form CB 496 and relevant attachments are completed in sufficient detail to assure that information needed for effective management of the demonstration is provided. This work group will also provide information necessary for preparation of the fixed schedule of payments for the five-year demonstration period as required by section 4 of the Terms and Conditions and recommend any subsequent modification to this schedule. This work group will also assure the cost neutrality provisions of section 4 of the Terms and Conditions are met.

Provider Relations/ Contract Provisions – This work group will develop or modify any necessary modifications or attachments to contracts between DCF and the CBC Lead Agencies in order to meet the requirements of section 2.1 of the Term and Conditions.

Array of Service/ Practice Issues – This work group will provide guidance and/or technical assistance on program practice in order to best use the flexibility of the demonstration to improve child welfare practice. This group will consider how the improved array of community-based services provisions of the demonstration in section 2.1 of the Terms and Conditions can be used to accomplish the permanency and safety outcomes for children and families and to improve the well-being of children and families.

Communication and Training– This work group will develop effective mechanisms to share information about the demonstration with stakeholders and interested parties. This group is also responsible for development and deployment of training material related to the demonstration.

Evaluation – This work group will assure that an independent evaluation is conducted that meets the requirements of the waiver terms and conditions. This will include procuring the evaluator, assuring that an evaluation design document is submitted for review and approval by the Children's Bureau, and ongoing coordination with the evaluator throughout the course of the demonstration. The Department anticipates having a third party independent evaluator secured by September 1, 2014. See timeframe for procurement below.

Schedule of Events and Deadlines for Securing Evaluator

ACTIVITY	DATE	Status/Comments
RFP advertised and released on Florida VBS:	7/9/2014	
Solicitation Conference (Call) to be held:	7/16/ 2014	
Notice of Intent to Submit a Proposal to be received by the Department	7/16/2014	
Submission of written inquiries must be received by:	7/21/2014	
Deadline for Department's Response to Inquiries:	7/30/2014	
Sealed Proposals must be received by the Department:	8/5/2014	
Proposal Opening and Review of Mandatory Requirements:	8/15/2014	
Meeting of Department Evaluators	8/19/2014	
*Debriefing Meeting of the Evaluators and ranking of the proposals:	8/23/2014	
Anticipated Effective Date of Contract:	9/1/2014	

The following work plan shows the major tasks, deliverables and time frames for accomplishing the tasks as assigned to each of the work groups and oversight team. This work plan will be reviewed and updated as the demonstration progresses to assure that implementation of the demonstration proceeds in accordance with the Terms and Conditions. Each of the work groups as delineated on the work plan will develop detailed plans that provide description of key tasks, responsible parties, timeframes, and benchmarks of progress.

At this time, the cost of specific interventions and evidence-based practices is unavailable. The evaluator will assist with determining these costs for inclusion in future progress reports.

Key Tasks, Reporting Requirements, Timelines

Major Tasks/ Deliverables	Due/ Completed	Assigned/ Comments
1. Organize the activities necessary to prepare for implementation of the waiver during the renewal period. Establish a waiver management and support structure to guide the effort.	02/2014 Completed	Oversight Committee
2. Submit a document showing the fixed schedule of payments for the five year demonstration period.	03/2014 Completed	Oversight Committee
3. Submit an Initial Design and Implementation Plan/Report.	05/2014	Oversight Committee In progress. Final Draft submitted.
3.1. Eligibility	09/2014	Mukweso Mwenene (DCF & CBC)
3.1.1. Develop and update a plan in accord with the IDIR Outline posted on the Children's Bureau web site. 3.1.2. Complete review and modification of eligibility protocol, as appropriate.	08/2014	Eligibility work group
3.1.3. Implement revised eligibility protocol, if needed.	08/2014	Eligibility work group in coordination with communications and training work group
3.1.4. Incorporate revisions to eligibility into FSFN, as appropriate	12/2014	Eligibility work group

Major Tasks/ Deliverables	Due/ Completed	Assigned/ Comments
3.2. Fiscal Accounting and Reporting	09/2014	Mark Mahoney Barney Ray Allison Hill, Lake view John Aitken, Kids Central Pam Griffith or Nicole Strobel, Eckerd Bob Miller, Family Support Svcs of North FL Kellie Messer , Devereux
3.2.1. Develop and update a plan in accord with the IDIR Outline posted on the Children's Bureau web site.	05/2014 and ongoing	Fiscal accounting and reporting work group
3.2.2. Determine the federal reporting requirements for the Florida waiver through discussion with ACF Atlanta and Washington.	05/2014 and ongoing	
3.2.3. Revise State accounting codes necessary to capture data for the Federal report, State program modifications, State reports and internal reports.	08/2014	Fiscal accounting and reporting work group
3.2.4. Modify the GRANTS System to accommodate the changes necessary to correctly report expenditures by Federal grant based upon analysis of the Federal reporting requirements and program delivery modifications and changes.	08/2014	Fiscal accounting and reporting work group

Major Tasks/ Deliverables	Due/ Completed	Assigned/ Comments
3.2.5. Determine the elements of a revised Cost Allocation Plan for the Community-Based Care (CBC) projects.	09/2014	Fiscal accounting and reporting work group
3.2.6. Modify the CBC expenditure reports to reflect the elements contained in the new cost allocation plan, as appropriate.	09/2014	Fiscal accounting and reporting work group
3.2.7. Modify the CBC contracts for implementation of the waiver renewal.	ongoing	Contract provisions work group in coordination with fiscal accounting and reporting work group.
3.3. Contract Provisions		Cameo Bryant
3.3.1. Identify the specific Lead Agencies that will be involved in the provision of waiver-funded services, and the geographic region or regions served (per section 2.1of the T&C).	03/2014 Completed	See CBC Map in Attachment 4 The waiver is statewide.
3.3.2. Incorporate into the contracts with each Lead Agency provisions related to standards of quality, safety and practice requirements.	03/2014 Completed	Existing standards are summarized in section IV. of this report and the Attachment 3 titled, “Authority and Requirements”.

Major Tasks/ Deliverables	Due/ Completed	Assigned/ Comments
3.3.3. Incorporate provisions into Lead Agency contracts specifying payment rates, contact between case managers and children and their families, documentation and reporting requirements and mechanisms for regular review of progress towards achieving each child and family's safety, well-being, and permanency goals.	03/2014 Completed	Contract provisions work group See Attachment 5
3.3.4. Incorporate provisions into Lead Agency contracts specifying quality assurance responsibilities.	03/2014 Completed	Contract provisions work group See Attachment 3
3.3.5. Specify in the contract the responsibilities of the State in supporting Lead Agencies in providing services and supports to eligible children and families and in monitoring the contract.	03/2014 Completed	Contract provisions work group See Attachment 3
3.4. Array of Service/ Practice Issues		Ginger Griffeth
3.4.1. Develop and update a plan in accord with the IDIR Outline posted on the Children's Bureau web site.	08/2014	Array of service/ practice issues work group
3.4.2. Review and modify, as necessary, draft list of principles and values to guide further development of the array of services.	Ongoing	Array of service/ practice issues work group
3.4.3. Coordinate with Contract Provisions group to ensure consistency between needs of systems of care for flexibility in service planning and identification of supports.	Ongoing	Array of service/ practice issues work group and contract provisions work group

Major Tasks/ Deliverables	Due/ Completed	Assigned/ Comments
3.4.4. Coordinate with evaluation group to ensure that linkage between changes to services and supports and outcomes are incorporated into evaluation.	Ongoing	Array of service/ practice issues work group and evaluation work group
3.4.5. In conjunction with communications group, develop processes to share best practices among CBC Lead Agencies.	Ongoing	Array of service/ practice issues work group and communications and work group
3.5. Communication and Training		Ginger Griffeth Sandy Neidert
3.5.1. Develop and update a plan in accord with the IDIR Outline posted on the Children's Bureau web site.	Complete	
3.5.2. Establish an intranet site for collection and dissemination of information regarding demonstration.	Ongoing	Communications and Training work group Complete
3.5.3. Develop communications processes to ensure internal and external customers have appropriate information regarding demonstration.	ongoing	Communications and Training work group
3.5.4. Coordinate with other groups regarding development and deployment of training material related to the demonstration.	Ongoing	Communications and Training work group
3.5.5. Incorporate into pre-service and in-service training curriculum documentation requirements and mechanisms for regular review of progress towards achieving each child and family's safety, well-being, and permanency goal.	12/2014	Communications and Training work group Statewide Training Plan See CFSP 2015-2019

Major Tasks/ Deliverables	Due/ Completed	Assigned/ Comments
3.6. Evaluation	9/2014	Keith Perlman
3.6.1. Submit specifications or RFP for evaluation to ACF.	05/2014	Evaluation Work group Submitted draft specifications/RFP on 5/21/2014. Received ACF comments on 5/28/14. ACF/CB approved specifications on 6/17/2014. Complete.
3.6.2. Final draft of evaluation plan and related contract submitted to ACF.	09/2014	Evaluation Work group; evaluator
4. Submission of semiannual progress reports	10/30/2014 semiannually thereafter	Sallie Bond Oversight and coordination team

Phase Down Plan

As shown in task 3.1 of the work plan, key items of information required for title IV-E eligibility will be collected through a simplified eligibility protocol and checklist. This information will be available so that IV-E eligibility can be documented for purposes of adoption assistance. The information will similarly be available to permit transition from the demonstration to normal program requirements at the conclusion of the demonstration or in the event that the demonstration is terminated. In addition to information needed for title IV-E eligibility, information will be collected for eligibility for Temporary Assistance for Needy Families (TANF) funding and to permit children in out-of-home care to be placed on the Medicaid eligibility file.

Upon conclusion of the waiver, this information will be used to determine the IV-E eligibility status of all children in out-of-home care. These determinations will be made in year five of the waiver so that all children will have an updated eligibility determination prior to month 60 of the waiver. In the event that the waiver is terminated either by the Federal agency or the State agency pursuant to section 1.0 of the Waiver Terms and Conditions, the eligibility status of each child in out-of-home care will be updated within 90 days of the termination, so that title IV-E foster care funds can be properly claimed.

VI. Training and Technical Assistance Assessment

The waiver demonstration implementation is entering a new five-year extension period. The work teams identified in Section V may identify needs for training and technical assistance as

their work continues. At this time, there is no specific need identified where the state is not already receiving technical assistance. Florida is currently receiving technical assistance from several of the national resource centers: NRCs for Diligent Recruitment, Organizational Improvement, Youth Development, Permanency and Family Connections, and Child Protection Services.

VII. Anticipated Major Barriers and Risk Management Strategies

Florida does not anticipate major barriers at this time. The 2014 Florida Legislature passed a major child welfare bill that modifies how child welfare conducts its business and addresses accountability. There is greater emphasis on quality assurance; further professionalization of child protective investigator staff; and the creation of an Institute for Child Welfare.

[i] All children taken into state custody must have a comprehensive behavioral health assessment within 30 days of entering care. For in-home cases, a CBHA must be completed if mental/behavioral health issues are relevant to the reason for the Department's involvement.