CBC FINANCIAL VIABILITY EFFECTIVE PRACTICES

Benchmarking CBCs with high performance on drivers of financial viability

April 2018

Office of CBC and ME Financial Accountability

Florida Department of Children and Families

Packet Contents

I. How were these CBCs selected for benchmarking?

II. White Paper on % of children served in-home
- *Family Support Services of North Florida – 8 pages*

III. White Papers on % of children in out-of-home care in relative or non-relative placements
- *Heartland for Children – 15 pages + one 4-page attachment*
- *Kids First of Florida – 9 pages*

IV. White Paper on % of children in licensed out-of-home placements that are group (vs. foster)
- *Family Support Services of North Florida – 8 pages + three 1-page attachments*

V. White Papers on discharge rate per 100 children in out-of-home care
- *Partnership for Strong Families – 9 pages*
- *Devereux CBC – 8 pages*

I. How were these CBCs selected for benchmarking?

A financially viable CBC was included in this project if it was at least one standard deviation beyond the statewide mean in the "good" direction for an identified volume metric, while also maintaining standards set for the associated safety metric. The CBCs were identified in November 2017 using SFY16/17 data.

Process Used	Summary
Identification, Validation, and Documentation of Practices	
1. Identify primary drivers of desired outcome	***Drivers of CBC financial viability:*** *1. Out-of-home populations* *2. Licensed care populations* *3. Group care populations*
2. Identify measures of performance for those drivers	***Volume metrics:*** *1. % of children served in-home (vs. out-of-home)* *2. Discharge rate per 100 in out-of-home* *3. % of out-of-home care in relative or non-relative (aka, non-licensed) placements* *4.% of licensed out-of-home placements in group vs. foster* *Paired with* ***Associated safety metrics:*** *% not abused during in-home services* *% not abused after case mngd services* *Rate of abuse in out-of-home placements*
3. Identify highest performers on those measures	***Identified Highest Performers:*** *1. % in home: Family Support Services of NFL* *2. Discharge rate: Partnership for Strong Families, Devereux* *3. % in relative or non-relative: Heartland for Children, Kid's First of Florida, Family Integrity** *4. % in group vs. foster: Family Support Services of NFL, Kid's First of Florida*
4. Identify key practices/processes put in place to achieve high performance	*Regions worked with the identified CBCs to produce white papers of key practice elements that contributed to higher performance.* *They were asked to document:* *- The core elements of their practices* *- Barriers they encountered in implementation* *- Resources used to implement practices* *- Feedback from staff on the practices* *- A real-life example of the practice* *- Their results (financial and programmatic data to support effectiveness)*
5. Validate and document key practice elements and data to support their effectiveness	
Sharing and tracking practices	
6. Review performance data with all CBCs in light of highest performers on identified measures	*All white papers shared at the Quarterly PoE in Tampa on April 20, 2018.* *They can also be viewed at* *http://apps.dcf.state.fl.us/profiles/index.asp?path=CBC%20FV%20White%20Papers* *Dashboards with the data used are in development and will also contain hyperlinks to these papers.*

The scope of this project was limited to the SFY16/17 performance of four key metrics that can gauge drivers of CBC finances. Other measures also have financial implications, such as permanency within twelve months, children not re-entering care within 12 months of permanency, the CLS timeliness metrics, and overall % changes in out-of home populations, licensed care populations, and group care populations.

Note: Some data elements shown in the following papers, including those used to benchmark the CBCs in November 2017, differ slightly from the data currently shown on the Child Welfare dashboard. This is due to adjustments made during the migration of FSFN to the cloud in December 2017. Additionally, one metric used to benchmark the CBCs (rate of abuse stratified by various out-of-home placements) is currently under review.

**Family Integrity Program declined to produce a white paper.*

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Office of CBC and ME Financial Accountability

CBC Financial Viability Effective Practices

Family Support Services of North Florida:
Providing intensive family preservation services within the home setting

11-13-2017

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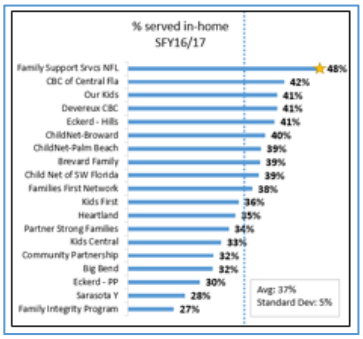
Practice Summary

Statewide, the general practice for in-home case management is to refer families to services provided outside of the home (e.g., to appointments in an office or a classroom). Family Support Services of North Florida (FSSNF) has transitioned from this service referral model to a service delivery model that directly provides the majority of services within the family's home by a wrap-around team of professionals. Only a subset of cases (est. 20% or fewer) require a referral to a community provider for more specialized services such substance abuse treatment. Since the implementation of this program (called "FAST"), FSSNF has seen a sustained increase in the percent of children served in home, a sustained reduction in removal rates, and a sustained reduction in their out-of-home population. In SFY16/17 more than 60% of cases with a safety determination of "unsafe" were served in-home rather than out-of-home (for more detail, see "Results"). [1]

In SFY16/17, FSSNF served 48% of children in their system of care in-home; 2 standard deviations above the statewide mean



CBC Context

FSSNF serves two counties in the Northeast Region; Duval, an urban county with approximately 930K residents, and Nassau, a rural county with approximately 79K residents.

All in-home cases in both counties are served under the same home-based service delivery model. For SFY16/17 in Duval, 1601 children were served in-home by 30 in-home case managers.[2] In Nassau, 138 children were served in-home by 3 in-home case managers.[3]

Practice Detail

This section contains three parts; a description of the core elements of the practice, a description of barriers encountered and ways they are addressed, and the resources used to implement the practice.

Core elements

1. A core wrap-around team of professionals is assigned to each family to provide their in-home services. The in-home case manager is a certified case manager, enabling them to continually evaluate safety, maintain dynamic safety plans, and directly provide services to caregivers and children within the home setting. Each unit of five case managers has both an assigned therapist who provides therapeutic services within the home and a Family Intervention Specialist (FIS) who provides substance abuse assessments and some treatments within the home. Each CMO also has access to a health-care coordination FSSNF staff-person (accessed by a no-waitlist referral process).

[1] This home-based care is also available for children under a safety plan in a relative or non-relative placement.
[2] For SFY16/17 in Duval, an average of 735 children were served in-home and 788 in out-of-home each month. (CW Dashboard)
[3] For SFY16/17 in Nassau, an average of 65 children were served in-home and 81 in out-of-home each month. (CW Dashboard)

Services provided within the home setting:	*Resources*
Parenting	*Nurturing Parenting training*
Behavior Modification	*Behavior Modification training*
Ages and Stages Questionnaire	*Free training (assessment generates free community referrals)*
Budgeting	*Free training to case managers*
Therapy	*Contracted CMO staff therapists assigned to units*
Health-care coordination	*FSSNF staff health-care coordinators are available to all units*
Project Healthy Homes	*Intensive SAMH services delivered by SAMH provider network*
Family Intervention Services	*Substance abuse assessments and treatment services delivered within the home (with some more intensive treatments referred out to other services).*
Family Intensive Treatment Teams	*FITT is a DCF-funded program with contracted staff provided by the ME. Teams are composed of a co-occurring therapist, case manager, and peer support.*

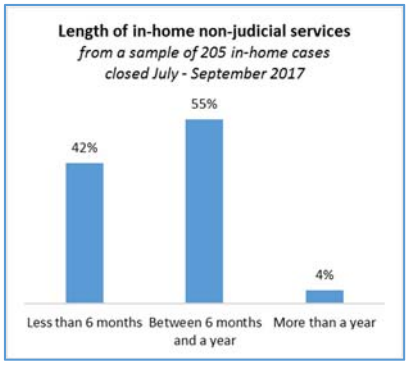
Outside services provided by referral include:

Services provided outside the home	*Resources*
Substance Misuse Treatment	*Income-based sliding scale*
Domestic Violence Services	*Free at local domestic violence center*
Domestic Violence Service Advocacy	*FSSNF has contracted for a DV advocate just for in-home cases. The advocate provides services at neutral locations.*
Homeless Temporary Housing	*FSSNF has contracted rooms at a local homeless shelter*
Human Trafficking Service Coordination	*FSSNF pays safe harbor rate for placements (uses 100/806 funds when applicable)*
Batterers Intervention Program	*Approx. $9 per session at a community provider (such as Salvation Army)*
Psychological Evaluations	*Varies per doctor's fee*

2. Practices are in place to ensure client access to and awareness of services. If possible, the in-home case manager provides transportation to services provided out of the home; otherwise they provide bus passes and then follow-up to ensure the services were provided. FSSNF provides a comprehensive community resource directory to its case management organizations with updates sent each quarter.
3. Standard processes are in place to engage the parents and increase their degree of accountability. Parents or caregivers sign an agreement at the initiation of on-going in-home services that acknowledges their responsibilities after extensive conversation with the case manager. The case manager references to this agreement as necessary to remind caregivers of their expectations.
4. An approach to safety management anticipates the potential of a case transferring to case management and enables a smooth transition for the family. In-home case management staff fill the safety management function where required for investigations, making a joint visit with the CPI within 24 hours of referral (or at discretion of the CPI)[4]. If the CPI determines that the safety of the child can be effectively managed in the home and transitions the case into ongoing in-home treatment services, the same case manager remains with the family to ensure continuity of care.

[4] Safety Management can be available within 2 hours if necessary.

5. Standards are in place to ensure manageable workloads for case managers: Each in-home case manager carries a maximum caseload of 20 children for on-going services and up to two Safety Management cases. They do not carry out-of-home cases. The average in-home case lasts between 6 and 8 months. Cases exceeding 12 months are rare and typically relate to substance abuse or human trafficking. The unit supervisor reviews safety plans biweekly and cases monthly (or at critical junctures). As of this report, there are no capacity issues or wait times for in-home services.



Barriers encountered and methods to address

Barriers encountered	Addressed by:
Some clients do not engage in services	The original CPI will return with the case manager for a joint home-visit to assist with re-engagement.
Some clients could feel overwhelmed by the variety of people in their home	"Warm hand-off" protocol: The case manager completes all initial joint visits with other in-home providers and the family to ensure that there is a "success bridge" built between the family and all the professionals that enter their home.
Issues of scheduling and communication between DCF and the CBC	Case management and protective investigative staff were moved to work in co-located offices.
	Monthly sharing of success stories: CMOs send "success stories" to CPIs with pictures of children who have been safely served in-home. Helps to "close the loop" for investigators and promote confidence in in-home services.
Issues of case progression/ resolving the present danger threats	Monthly internal team staffing of open cases at the co-located offices: in-home case managers, their supervisors, and any other service providers discuss identified families' safety plans, danger threats, behavior changes, conditions for return, etc. Ideas are shared to eliminate barriers and determine next steps. Any cases can be scheduled, but all are staffed at 5, 8, 11, and 12+ month intervals.
Issues of program consistency between CMOs and units	Establishment of an oversight coordinator: FSSNF staff position that provides quality assurance oversight and training. Facilitates program coordination/problem solving between parties.
Issues of caseload coordination between CMOs and services	Establishment of a centralized intake specialist: FSSNF staff position that reviews and assigns all incoming service referrals. Ensures equitable balance of CMO active caseloads.
Issues of communication and collaboration within the System of Care	Bi-weekly "Barrier Breakers" meetings: Leadership from FSSNF, DCF, the ME, the CMOs and other service providers meet to discuss resolve issues within their system of care. Also used to develop joint communications and messaging, negotiate service rates, etc.

Resources used to implement

FSSNF contracts for in-home case management by "business unit." One business unit funds 15 certified in-home case manager FTEs and 3 supervisors, as well as ten support workers, an associate director, and part of a director position. One business unit can serve approximately 450 children annually at a cost of $1.425M. The

CMOs determine staff salaries and how to best allocate the support positions. In-home case worker salaries range from $30-40K depending on certification and experience.

Additionally, FSSNF incurs annual program oversight costs totaling $520,746 that include the allocation of salary and benefits for the Vice President of Case Management, the Director of Family Preservation, three Oversight Coordinators, and three Community Resource Specialists. Other overhead (for rent, supplies, software, insurance, professional fees, etc.) totals $31K annually.

Staff Feedback

Feedback supports that this approach has proven effective and is the preferred approach by staff. CPIs and case management staff report that the wraparound in-home service model effectively engages families and successfully improves the conditions that resulted in the abuse or neglect report.

CMO feedback: “It’s one-on-one engagement. Because the services are in the home, our staff are truly able to assess the physical environment and the ways that the family interacts. I believe this is the model for behavioral health integration; we’re not sending them out to therapy, we’re bringing it to them. Our case managers are doing true social work and they see every day the ways that they are helping families.” (Stephanie Metzger, In-home Case Management Supervisor, Jewish Family and Community Services)

CPI feedback: “I am confident that when we refer a family to ongoing in-home services, they will be provided with the appropriate services based on that family’s needs that will enhance caregiver protective capacities to keep children safe.” (Dionne Danner, Family Safety and Preservation Services Program Administrator, DCF NER)

Statement from CBC leadership: “It is critical that as leaders we do everything in our power to allow a child to remain safely in their home. There is nothing as traumatic to a child as being separated from their parent. We have a responsibility to the children we serve to preserve the family unit whenever possible. We must give the Child Protective Investigators viable alternatives to removal.” (Lee Kaywork, CEO, FSSNF)

Practice Example

Renee is a 17-year-old female who had been hospitalized for unmanaged Type 2 diabetes. She was not doing blood sugar checks, managing her diet, taking medications, or attending medical appointments. She had lost her mother to complications from diabetes but did not understand the harmful effects of not managing her condition. The child did not have a legal guardian and was living with a relative.

An initial joint visit between the CPI and the in-home case manager was completed on April 25 during the safety management phase (eight days after report intake). The child was determined to be “unsafe” by the CPI for reasons of medical neglect and was referred in early June to ongoing home-based in-home services.

The case manager determined after several visits with the child that she was not engaging in the recommended services (in-home therapy and health-care coordination for appointments and diabetes education). To re-engage the child, the case manager held two joint home visits in mid-July; one with the original CPI and their supervisor (calling the diabetes medical office with the child present), and the other with the therapist and health-care coordinator nurse.

After these joint visits, each time the case manager, therapist, and health-care coordinator were present at the home on their weekly visits, they would have the child check her blood sugar levels and then notify the other parties. The case manager would upload the meter readings into FSFN after each visit for the health-care coordinator to review. The case manager, therapist, and health-care coordinator would also share "ad-hoc" successes and updates with one another while interacting at their co-located office space. The relative that the child was living with served as a safety manager, also helping her monitor her blood sugar levels and navigate the medical system.

When the child saw a team of people working diligently over time to ensure her welfare, she began to understand the criticality of her condition. She began to attend medical appointments, check her blood sugar, and refill her own medications. Her last medical appointment showed that she had lost weight and her A1C levels were within normal limits.

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Results

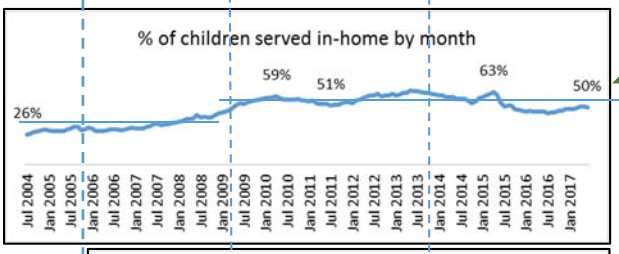
Primary benefits: **62% (1251 of 2011) children determined as "unsafe" by the CPI in SFY16/17 were transferred to ongoing in-home case management rather than removed from the home.** Of these, 90% (1129 of 1251) continued to remain safely in the home (i.e., they were not later removed from those in-home services).

Since the implementation of this program, FSSNF has seen a measurable and substantial increase in the percent of children served in-home (rather than removed), which is mirrored in a decrease in numbers of children in out-of-home care and a decrease in payments for licensed care placements. A common conception is that the degree of services necessary to keep children safely in their homes costs more than removing children from the home. However, FSSNF financial results indicate that the opposite is true.

SFY2005/2006: *Duval County implements new intensive in-home family preservation services for safe, but high very-high risk families.*

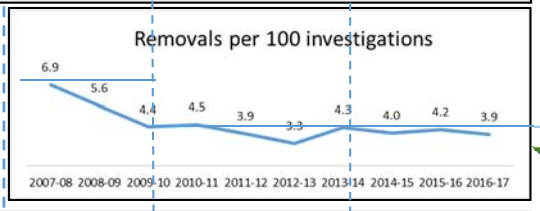
SFY2008/2009: *Nassau County implements intensive in-home family preservation services for safe, but high or very-high risk families.*
Duval County implements new enhanced, intensive in-home voluntary program for unsafe children (following the implementation of an comprehensive communication plan to all stakeholders: CBC, DCF, CMO, community partners, and the public).

SFY2013/2014: Nassau County implements new enhanced, intensive in-home voluntary program for unsafe children.



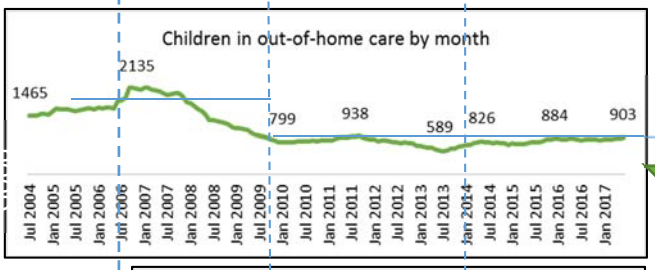
Good

Prior to January 2009, the average percent served in home was 33%. The average for the years following Duval implementation is 55%; an **increase of 22 percentage points**.



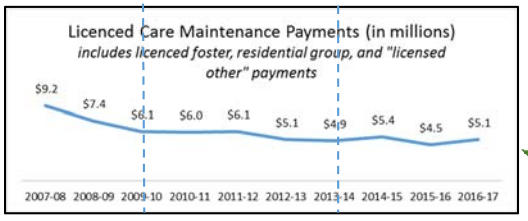
Good

The average annual removal rate per 100 investigations prior to January 2009 was **6.3**. The average for the years following Duval implementation is **4.1**.



Good

The average monthly out-of-home care prior to January 2009 was 1,691. The average for the years following Duval implementation is 827; **864 fewer each month.**



Good

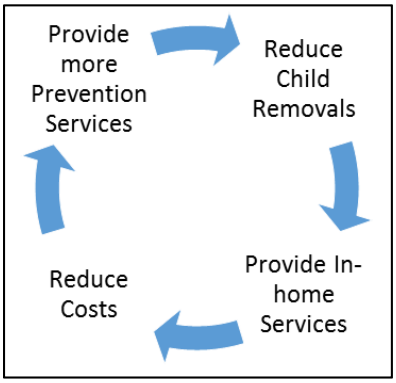
The average annual licensed care room and board prior to SFY08/09 was $8.3M. The average for the years following Duval implementation is $5.4M; **a reduction of $35%**

Since SFY08/09, FSSNF has averaged an annual carry-forward balance of $2.25M. They have never applied for Risk Pool funding.

Secondary benefits: An additional benefit realized by the team approach to care has been a decrease in workforce turnover. In particular, case workers who staff and manage out-of-home cases turn over at an approximate rate of 45%, whereas those managing in-home cases within an experienced wrap-around team turn over at a rate of 15%.

Cost savings with the approach used by FSSFN have been used to expand front-end prevention services to those within the child welfare system and to the community at-large. Below is a list and description of prevention services provided by FSSFN.:

1. *A 90-120 day prevention program for safe children with a varying level of risk for re-abuse. Co-located staff provide in-home services that include evidence based parenting, behavior modification, budgeting, connection to community resources, and case management.*
2. *A therapeutic in-home infant mental health program. The service provides in-home behavioral health and social services to children 0-5 years of age and their caregivers. High-Risk Newborn (HRN) serves young children who may be at risk for developing more severe mental health disorders and helps parents learn how to build stronger bonds to their children.*



3. *The Integrated Practice Team (IPT) consists of specialized community service providers that offer knowledge and expertise as they partner with parents to assist in identifying barriers that would prevent children from remaining safely in the home. The Integrated Practice Team (IPT) is available to Duval and Nassau Counties. IPT has impacted our community by planning and integrating services to prevent child removal, shorten removal time and ensuring safeguards are in place for successful reunifications. Because the IPT helps to empower, strengthen and promote healthy families, the family supports and family members attend the IPT staffing's. In SFY16/17, out of the 251 IPT's staffed, from the table 236 were diverted from removal recommendation and/or re-engaged with community services, while 15 required immediate court intervention.*
4. *Community Resource Specialists (CRS) who are co-located with DCF, schools and a community center. They provide community referral assistance to families that are in need and provide additional support to DCF workers. CRS Workers are also an intricate part of the Parent in Need of Assistance process.*
5. *Parent In Need of Assistance referrals come from the Florida Abuse Hotline and 24 hour assistance is provided to parents in need where there is no abuse or neglect present i.e. Emergency housing, service needs, connection to community financial assistance, etc.*

Office of CBC and ME Financial Accountability

CBC Financial Viability Effective Practices

Supporting home based placement types within the child welfare system, Heartland for Children and the Department of Children and Families, Circuit 10

2-23-2018

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Practice Summary

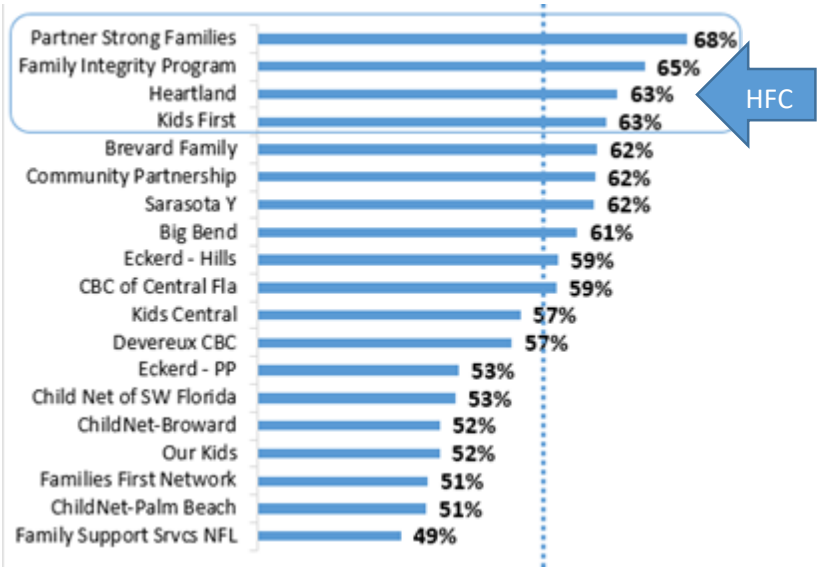
Across the state, when children are removed from their parents due to child safety concerns, there are a wide variety of placement options available for child protective investigators and case managers to consider. These options range from out of home relative/non-relative placements to licensed settings such as foster homes or residential group care. In all out of home removal scenarios, efforts and considerations are given to non-custodial parents, followed by a home based relative/non-relative placement, and lastly the option of a licensed care setting such as a foster home or residential group home would be considered.

Heartland has implemented a number of kinship care support initiatives and enhancements that have shown tangible costs savings, operational workload savings, quality child placements and improved outcome measures (see "Results" section). Although the enhancements occurred at times of increasing workload increase on CPI and case management, they were accomplished without any additional resources or increase of FTEs in the system.

At 63% for relative/non-relative placements, Heartland for Children is a state-wide high performer on the percent of children in out-of-home care who are in a safe, stable relative/non-relative placement.

In SFY16/17, Heartland for Children served 63% of children in their system of care in relative/non-relative placements

Statewide Average= 58%, Standard Deviation = 5%



CBC Context

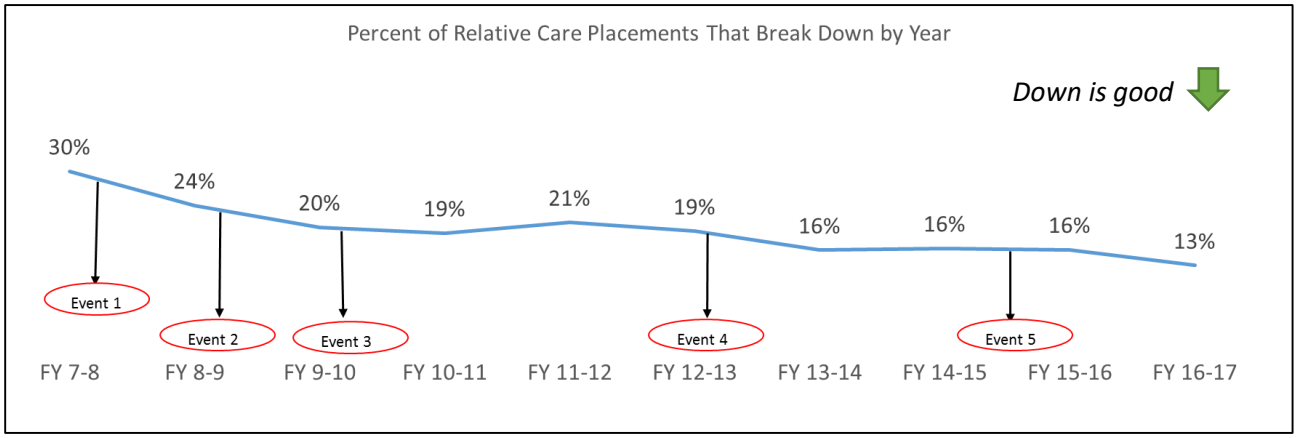
In 2003, Heartland for Children (HFC) was selected to provide services for a wide array of child welfare needs from foster care to adoptions to prevention and family support services. HFC has historically contracted with 4 case management organizations: Children's Home Society, Gulf Coast Jewish Family and Community Services (GCJFCS), Devereux Advanced Behavioral Health, and One Hope United. HFC serves three rural counties in the Central Region of Florida-Polk, Highlands and Hardee counties. Polk is the largest county in Circuit 10 with approximately 650,000 residents and encompasses the majority of the child welfare caseloads in this circuit. Highlands County is the second largest county with approximately 99,000 residents and Hardee County is the third largest county with approximately 27,000 residents.

Practice Detail

Core Elements

Impetus for change and initiation of the Guardians as Parents (GAP) Program

Early identification of emerging trends and issues and a strong finger on the pulse is the key to being proactive in the child welfare system. The below timeline and corresponding narrative outlines Heartland's identification of kinship care placement disruptions, the GAP Program support services put in place to address the issue and the resulting outcomes from those efforts.



Source: Initial Placement Status Listing Report – OCWDRU Report #1153

(Timeline Event 1) Creation of systematic supports for initial placement needs of kinship caregivers: In July 2007, Heartland recognized the need to provide support services for kinship caregivers and created the Guardians as Parents (GAP) team. The intent of the program was to assist kinship caregivers in receiving the benefits that they were entitled to at the time of initial placement. These benefits, which include Medicaid and food stamps as well as relative caregiver funds, were not systematically being offered or discussed with the caregivers. In addition, GAP would also provide assistance to make sure that daycare referrals were completed by the Child Protective Investigator (CPI) or case manager in a timely manner. Essentially, the GAP team would become the point of contact and support when caregivers had questions or would run into issues with those benefits. Since Devereux case management held HFC's Devereux Kids prevention contract which funded community facilitators, HFC first considered ways to better utilize those positions and serve families more efficiently. As a result, GAP services were added to the existing Devereux Kids prevention services contract, for a total contract amount of $458,853.66. Since its inception, the scope of the GAP program has been scaled back from primarily prevention services to more focus on relative and non-relative support, resulting in funding and programmatic changes to the contract. The current contract amount is $150,004.80 which supports 2 FTEs.

Devereux has helped design a strength-based, relational practice model that would quickly bring resources to kinship caregivers. There were four community facilitator positions in the Devereux prevention contract when HFC added the kinship caregiver support tasks to the contract. Those

community facilitator positions performed the added kinship caregiver support tasks as part of their normal job duties (part-time). As the focus shifted more and more to kinship caregivers support, and as positions vacancies occurred in the contract, the contract gradually changed programmatically over the years to where it is today, which is 2 dedicated full time employees performing only GAP activities. The program has been able to remain at 2 FTEs despite an increasing CPI workload Throughout its evolution in the HFC system of care, that model is still in place today and fosters the community support that is essential to its success. The many community resources that have come on board through the years are the result of using this model design and the focus on the families that is inherent in that design. It is the solidity of that essential design that has allowed the program to continue on the journey detailed below.

(Timeline Event 2) Implementation of a Placement Evaluation Tool to identify the underlying family dynamics of placements:

The creation of GAP began a journey and an evolution toward the practices HFC uses today. After the GAP program was contracted through Devereux, the next major step in the journey began in fiscal year 2008-2009. The impetus for that step began with the discovery of an issue that, at first blush, may have appeared to be somewhat unrelated to placement stability. The issue was discovered through the transfer of adoption cases from traditional case management units to specialized adoptions units. More often than not, these cases involved a kinship care placement made at or near the time of removal. Upon receiving the case, the adoptions unit identified previously undiscovered barriers to adoption finalization, and these barriers were largely tied to ineffective and/or inadequate assessment of the placement early on in the case.

As an initial step toward addressing these factors that were preventing adoption, HFC case management developed the attached Placement Evaluation Tool (PET), designed to delve into the underlying dynamics of the placement. The tool was initially piloted by GCJFCS and, during its first year of use in FY08-09, was shared with other case management organizations. It eventually found widespread use in the HFC system of care. Case managers found the tool had uses beyond determining long term placement viability and permanency. It proved to be a tool that could also help case managers with understanding not just caregivers' needs and concerns, but also with understanding family dynamics and predicting where possible issues with the placement might arise in the future. In this role, the PET became immediately useful in driving placement stability through creating relationship and understanding between the case manager and the caregivers.

(Timeline Event 3) Research into kinship caregiver dynamics:

Following the PET tool implementation, additional research was undertaken to understand the dynamics of kinship care and the experiences of kinship caregivers. That research eventually led to the work of Dr. Joseph Crumbley. Dr. Crumbley has a doctorate in Social Work from the University of Pennsylvania. Using many of the principles and ideas detailed in Dr. Crumbley's work, which include understanding role shifts of family members as well as the changing dynamics of the family in kinship care placements, HFC began development of an educational effort designed to assist everyone in the system of care who had involvement with kinship care to gain a more in-depth understanding and view of kinship situations.

(Timeline Event 4) Development of research-based kinship caregiver training:

The workshop that resulted from those efforts "The Psychological Impact of Kinship Care on Families", was initially presented to case management staff during FY 12-13 following over 2 years of development and pilot trainings . As a result of its popularity across the state, the workshop has been presented at

various conferences and events, including the Dependency Summit and Florida's Foster Parent Association annual conference. It has since been presented in 2016 and 2018 at the Kempe Center International Conference on Family Group Decision Making in Vail, CO, as well as in 2018 at Youth Village's National Conference in Memphis, TN. The workshop is currently used by Heartland on an as-needed basis to train case managers.

(Timeline Event 5) Redesign of Guardian Assistance Program to provide ongoing/comprehensive kinship caregiver support:

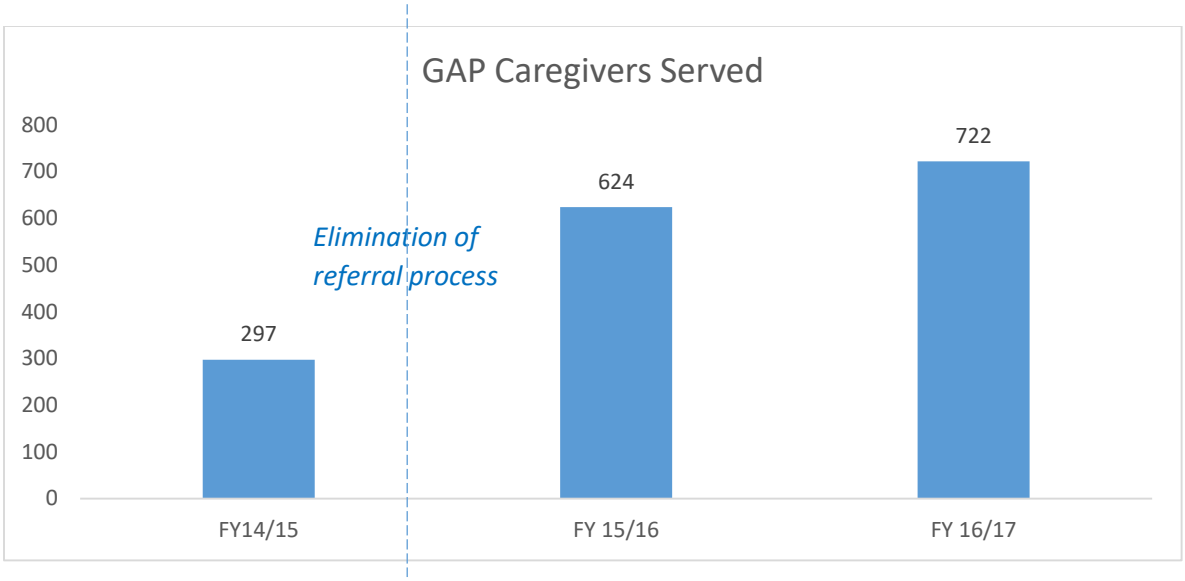
As Heartland's system of care learned more about the dynamics of kinship families and the unique struggles they sometimes face in caring for the children in their homes, they also began to realize that they required much of the same level of support that is provided for licensed foster homes. Although the GAP program was in place to assist caregivers with initial placement needs, such as benefit acquisition, there really was no formal structure in place for ongoing kinship caregiver support. In addition, the existing process required that a referral be sent to the GAP team prior to them making contact with the caregiver. The referral form appeared too unnecessarily long and complicated, and it was not unusual for GAP employees to return incomplete or incorrectly completed referrals to case managers and ask them to make corrections. Heartland saw incidents where referrals were going back and forth between GAP and case management. All of this contributed to some undesirable outcomes, such as delayed services, untimely assessment of needs, eventual breakdown due to financial and emotional gaps, and overwhelmed caregivers.

First, the system was entirely dependent on a case manager recognizing that he or she needed to send a referral to the GAP team. Absent that recognition, and absent the caregiver understanding that they were entitled to benefits, some caregivers went unserved by the program. Additionally, the level and type of support that GAP was designed to provide to caregivers often fell short of caregiver's needs. This tended to be particularly true of issues that involved complicated family dynamics and/or behaviors by children with intensive trauma histories. While there was an improved educational effort around kinship care, there really was not a well-organized and orchestrated system of support for caregivers to turn to, both of crisis situations and for ongoing support. HFC recognized that, in order to provide the support to caregivers that was truly required, the GAP program model would need to be revisited.

In 2015, HFC revised the GAP role in their system of care (Timeline Event 5) in the following ways:

- Change 1: The referral process was eliminated completely and replaced with proactive contacts driving by data.

  GAP employees were asked to monitor incoming kinship placement via weekly review of the CARS report in FSFN. Whenever a placement is discovered on the CARS report that is not currently being served by the GAP team, the team reaches out proactively to the caregiver with an offer of support and service. In addition to the CARS report, the GAP team receives the Initial Placement Form from the HFC Placement Team. The receipt of this form further assists the team with reaching out to caregivers as soon as possible. To also generate a case, case managers and others are still able to make referrals through a simple email to GAP. The GAP team handles all paperwork and record keeping. The chart below, which depicts the increases in number of GAP Caregivers served since the referral process change, demonstrates the tangible results of this effort:



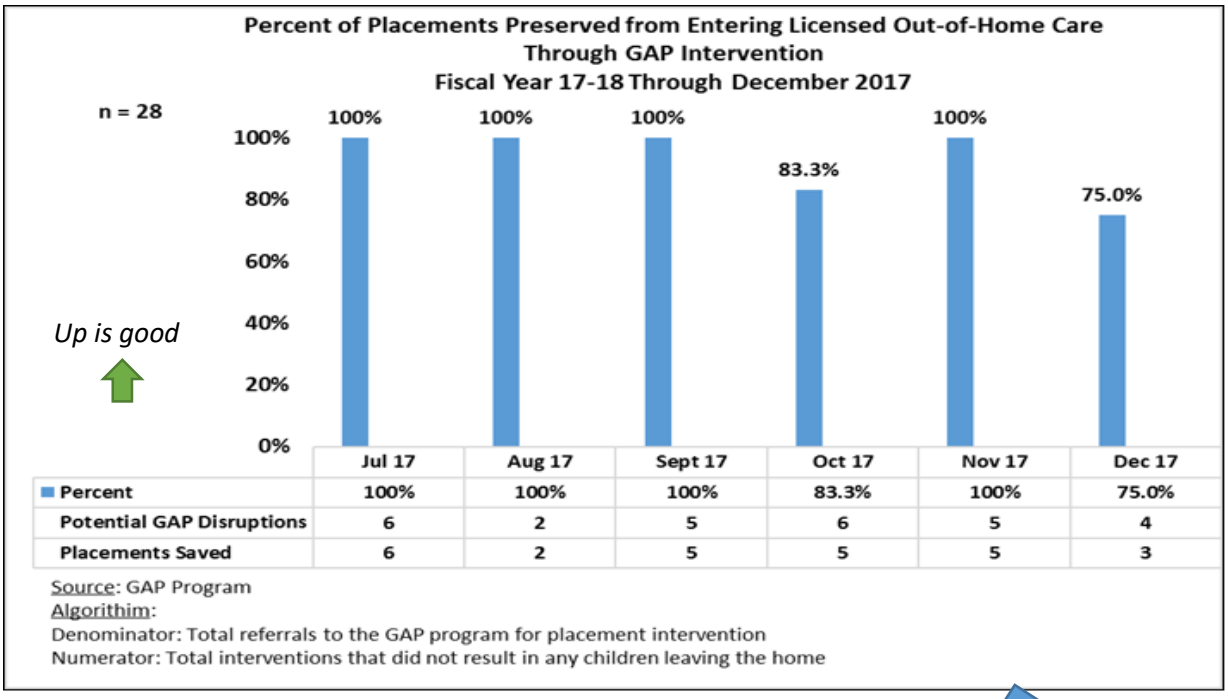
Source: HFC Data as of 1/12/18

- Change 2: Established support networks for caregivers and children in caregiver placements:
  HFC asked the GAP team to begin developing a more robust support network for the caregivers. GAP responded with two primary efforts. First, they formed a network of support groups around the circuit. These were designed to provide face to face support between the GAP team and the caregivers, as well as providing the caregivers an opportunity to form an informal network of supports for each other. There are five separate support groups covering all areas of Circuit 10 and it is very common for attendance to equal as many as 25 caregivers at any one group. In addition to education and social support, including discussions on caregiver finances, access to provider services, coping with adult children and mental health or addictions (oftentimes these are the parents of the relative placements) and long-term support options for children and families outside of child welfare. The GAP team also arranges for donations of food and other physical support items such as diapers, clothing, discount cards and after school activity options. Caregivers are showing more and more inclination to take leadership roles in these groups and as a result, the groups are becoming more self-supporting.

  Recently, the GAP team has expanded the support groups to include afterhours groups for the convenience of working caregivers. Additionally, a children's support group has been added and is beginning to gain popularity among the children placed in kinship care homes.

- Change 3: Established annual events for caregivers to network and learn:
  The GAP team began holding two annual events, an annual picnic and an annual conference. Each of these efforts have proven to be very successful with each having over 100 attendee's year over year. Caregivers are given the opportunity to connect to the larger support network in a low-key atmosphere that features food, prize giveaways, and educational speakers. The GAP team, with the support of HFC, will be continuing to expand the network of caregiver supports through support groups, partnership events, and ongoing individual support. The 4th annual caregiver's conference, to be held in April of 2018, is well underway.

- Change 4: Established processes to provide direct, in-home interventions for caregiver placements at risk of disruption:
  In July 2017, the GAP team also began direct placement intervention. Case management now has the ability to enlist the GAP team at any time there appears to be a potential placement disruption. GAP responds through direct contact with the caregiver and in home assistance to support the caregivers and child. In July 2017, HFC began tracking the effectiveness of the GAP team in intervening into the kinship care disruption: **During the first six months of the fiscal year, the GAP team has been asked to intervene in 28 placements. In 26 of those interventions the GAP program was able to successfully maintain the kinship placement (see chart with results below).**



GAP intervention prevented 93% of potential caregiver placement disruptions

From July 2017 to December 2017, 93% (26 of 28) of potential GAP disruptions were preserved through keeping the children in their relative placements. Using a FY16-17 average monthly cost of $1561 per child for a child in a HFC's licensed care placement, and assuming the child would have been placed in a licensed care setting (foster home or residential group care) as a result of the disruption, the **amount of savings for the 26 placements that were preserved totaled $142,051 for the six-month period of July to December 2017.**

Additional enhancements to the system of care

Following the implementation of the "psychological impact on kinship care for families" and the roll out of the required PET tool in 2013, it was evident that, in order for both DCF and HFC to successfully transition through the newly developed child welfare methodology process, every opportunity to strengthen relationships between not only DCF and HFC, but all community providers, would need to be

taken advantage of. During this time, many of these providers operated in silos and struggled to reach around the arm of their day to day task oriented responsibilities. To align adequate information gathering in not only the investigative teams, but also the case managers and provider agencies, we would need to approach all child welfare activities within the circuit as a team. One team, one goal and joint decisions- that was clear to everyone. Among many areas of focus during this time, one that stood out for the newly formed partnership between HFC and DCF was the overall relative/non relative placement performance.

In response to improving adequate placement decisions, both HFC and DCF had to instill a strong desire among the workforce that encouraged creative options outlined below in identifying and supporting non-licensed placements.

1. In order to support families caring for family members, one must identify appropriate family caregivers and provide a clear understanding of the caregiver expectations and possible outcomes along the child welfare case journey. Below are the search functions utilized by the Child Protective Investigations and Case Management staff throughout the life of a case.

TRADITIONAL SEARCH FUNCTIONS	ENHANCED LOCAL OPTIONS	MOST DEPENDABLE & ACCURATE SEARCH
Reporter and sources listed on abuse report intake	Child Support	Family Finders -accessible to CPI and CM's.
School/Daycare	DAVID – driver's license	Social media such as Facebook due to relationship status'.
Neighbor/Property Manager	Clerk of Courts/Post office	On site clerical staff are all trained in the Florida system to access application information.
Vital Statistics	US Department of State	DCF Regional Criminal Justice Coordinator is accessible for additional search options-EBT use.
Prior abuse report history	Accurint -multiple levels used	Doc Imaging through ACCESS
Property Appraiser	Out of state social services	FMMIS-AHCA

Once the child welfare professional(s) has located a willing and capable kinship caregiver, the level of adequacy and ability to care for the children is the next level of evaluation. All child protective investigators are trained by the Family Safety Program Office to engage with kinship caregivers in making safe and effective placement decisions. Child Protective Investigators are also highly trained on how to complete a qualitative and holistic approach to caregiving by way of the home study document. The technical aspects of a home study on a kinship caregiver are ingrained within a CPI, but there are other factors needing review to ensure a strong placement. These include the assessment of the caregiver's alignment with the child and their ability to provide a safe and nurturing home for the child on a financial, emotional, and physical basis. CPIs discuss with the caregivers the resources that are available to help them adjust to the idea of being a long-term placement for the child, in the event that reunification does not happen. The Family Safety Program Office provides training to investigation staff on the diligent search efforts (refer to chart above - search functions chart) that need to be conducted and a variety of efforts utilized in locating non-licensed care placement. Additional training is offered to CPIs regarding motivational interviewing

techniques which utilizes a client centered approach, and emphasizes the use of empathetic skills and higher level interviewing skills (use of reflective and validation statements) which can help with engagement when talking to parents and families. By having increased engagement with the client and the family, there is decreased resistance in working with the investigator to identify potential placements.

To ensure that the secondary half of the case was fully engaged in the action of gathering information from relative caregivers, each case management agency is fully trained in the art of family team conferencing, with this process being required on every case assigned to the Case Management Organization. This is a process where a facilitator develops relationships with all the case participants – the child, parents, family members, caregivers, guardian ad litem, the case manager, school, mental health staff, and DJJ, if applicable. The family team conference process also uses family finders to locate other family members who can be a source of support and assistance to the family. This process has been so successful in Circuit 10 that the next step will be for HFC and DCF to partner in training the investigations staff in completing this step during the investigation phase.

2. In an attempt to strengthen partnerships and relationships between HFC and DCF, the twice-monthly shelter review process was created. This review process includes an array of partners within the child welfare system, to include CLS, HFC, DCF, safety management and diversion (Medicaid approved) SAMH providers. These reviews would bring forth the opportunity to consider and approve necessary caregiver supports that had surfaced, appropriate interventions that could lead to a condition for return scenario for the family or strengthen the training focus in discussing the removal reason and barriers to any in home options.

   During the initial meetings, it was apparent that each agency had a lot to learn cross programmatically and each agency admittedly worked towards a better understanding of the other programs. The initial search for caregivers ranked top of the list when it came to next steps and subsequently the services needed to support them was second in line. This workgroup team won the *Excellence in Child Welfare Award* at the 2016 Dependency Summit.

3. As a result of these review sessions, multiple agencies were asked to enhance the services they offered to fill the gap in support services for kinship caregivers. The Guardians As Parents (GAP) Kinship services program, Serving Children and Reaching Families (SCARF) and Neighbor to Families (NTF) were all additional creative solutions for supporting relative/non-caregivers prior to and immediately after placement in their homes. These services provide access, stability and long-term support to families caring for their relative minors. The services of SCARF and NTF are only available for non-judicial cases and are not able to be used for children in out of home care as it is considered a duplication of services.

   Serving Children and Reaching Families (SCARF), provides enhanced diversion services aimed at stabilizing the crisis which places children at imminent risk for out of home placement or moves. SCARF's contract with HFC is currently $275,000. The intent of the program is to reduce the number of children being staffed over to case management by engaging families early in the investigation and providing access to a variety of necessary assessments, even if the initial risk level appears high. After the assessments are completed, SCARF provides the needed services, including the ability to

provide Medicaid billable wraparound services, to keep the children safely in their homes. SCARF is also working with families on legal solutions, such as custody documents (rather than a notarized power of attorney letter) when there are no safety concerns to avoid situations that would previously have resulted in a removal episode. The SCARF program also includes a component for caregivers to apply for available funds to support outside service options in keeping children safe. SCARF's contract began in FY17-18 and has served 306 children thus far and has prevented 297 children from entering the system of care.

The goal of the Neighbor to Family (NTF) program is to ensure early identification and treatment of families at risk of child abuse and neglect and to prevent children from eventually entering HFC's System of Care and/or out-of-home care. The NTF contract is $1,365,188 which covers the full array of services they provide. Many of our caregivers and families live in a constant state of crisis because they experience and perceive many of the daily events in their lives as threatening, overwhelming, or out of their control. Once a family's strengths, needs and support system have been identified, the Neighbor to Family program provides short-term and long-term support services through a purpose-driven plan that is child and family-centered. The program offers a supportive, empowering and respectful relationship with families with the ultimate goal to preserve family unity and prevent removal. NTF began working in Circuit 10 in 2014. Since the FY 2014-2015, NTF diversion program services have prevented 1,291 children from entering the system of care and served 1,343 children through December 2017. Through the safety management program with NTF, 1,039 children have been served. Their program prevented 984 children who did not have to be removed from their parents and were considered safe to remain in the home. (Source: NTF data obtained 3/9/18)

Staff Feedback

Actual client stories from staff show how successful the GAP Program is for clients and how frontline staff are supported in their efforts to do the best they can for the families they serve.

Sandi Denmark, former Case Manager Supervisor, current Case Management Trainer

Sandi reports that the GAP program is "super helpful" and marvels at the resources GAP coordinator Harvey Simmons can tap into. She says that, in her time as a supervisor, the GAP services were invaluable in reaching the caregivers quickly and providing crucial support to the families. Sandi notes that often the families do not know how to navigate the complex system of programs such as food stamps and Medicaid, and that to have someone provide the guidance to the caregiver is very important. Sandi shared a story about a caregiver who was struggling with a high needs child and who was ready to give the child up to foster care. Although that was an option, Sandi wanted to try one more thing first. She referred the caregiver to the GAP program, who shared information about the support groups with the caregiver. The caregiver attended the support group meeting, and found some companionship there and realized there were other families who were in her same situation. The placement was stabilized, preventing the child from going into licensed care.

Welda Bernadi, Case Manager Supervisor, Devereux

Welda, a case manager supervisor in C10 for two years, believes GAP is very important to the success of the kinship caregivers in Circuit 10. She says that they do not have the same level of program services in

other areas. She shared a story of a recent case where the home study was denied by investigations, in large part due to finances, but overturned by the judge. The GAP program was critical in helping the caregiver apply for public assistance programs as well as helping pay for daycare for the caregiver. The case involved a large sibling group and this ensured that the children could stay together.

Vanessa Young, Case Manager Supervisor, Devereux

Vanessa, a current case manager supervisor, shared that often caregivers do not realize how long they will be caring for children. Many times, the caregiver thinks that the process will be short, and that surely the parents will do what is needed quickly to be reunified. This is a typical response, even though investigations staff and case management attempt to give a more realistic picture of the judicial process. Once the reality of the situation sets in, caregivers realize that this is quite a challenging situation. Vanessa shared a story of a sibling group of 6 children, being cared for by a non-relative, who thought that it would surely only be a couple of months. The caregiver needed help with basics for the children such as food and clothing. The GAP program and the support group has provided a resource for the caregiver so that they can hear of other stories and share their experiences.

Angela Lewis, CPI since 2016 and currently in the Children's Advocacy Center Unit in the Lakeland Service Center (a specialized unit accepting the most severe allegations in a service center)

Angela recently recalled a case where "GAP is the only reason the placement worked with this particular family". There were a number of school age children and the parents were arrested due to operating a drug operation out of the home. The children were removed, and we wanted to place with a relative caregiver. The home was fine, and the caregiver was aligned with the children; but their funds were very limited, and they were just breaking even without the additional strain of providing for multiple children. The CPI reached out to GAP program coordinator via email, and GAP Coordinator Harvey Simmons was "super proactive" with the caregiver. The GAP funds were crucial to stabilizing the relative placement. GAP helped the caregiver apply for the necessary programs, and it provided enough support that the children are still with the relative and did not have to utilize foster care for the placement.

Practice Examples

The importance of the GAP program in the lives of kinship caregivers is highlighted by the caregiver testimonials below *(names are pseudonyms)*.

Julie, relative caregiver:

Julie and her husband have custody of their two grandsons who are 13 and 15, who they have cared for since 2007. Julie values the support of other people who are in similar situations which is why she and her husband remain involved with the GAP program, even though their case closed to Permanent Guardianship since 2008. She notes that most of their friends are looking at their retirement years and fail to understand the challenges that their family faces. Experiencing the highs and lows of being a caregiver, Julie has found the GAP support group provides a great place for her to share those experiences as well as hear that she is not alone. She finds the support group provides a great way make friendship connections with others. She said many of their friends have drifted away over the years, but the friendships from the support group have formed lasting bonds for her and her husband, as well as the children. There are many times that the families will make plans to meet and have social

interaction outside of the support groups. The GAP program has also provided food and clothing on numerous occasions, which she says has been so helpful. As both the children are special needs, the support group has helped provide resources to manage their behaviors as well as make contact with other programs to help address different issues with the children. Julie said she can't imagine being the caregiver of the children without the help of the GAP program over the last several years.

Susie, relative caregiver:

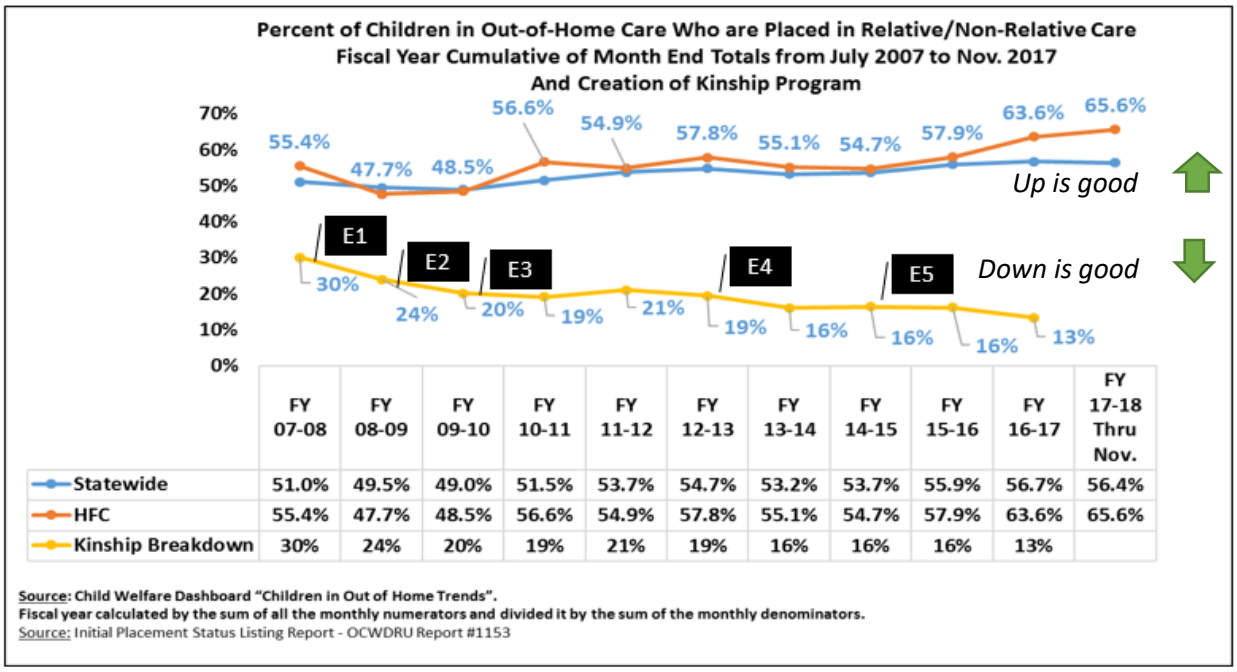
Susie is a grandmother raising her grandchild. Susie's sister, who resides in another home, has the sibling. Susie says that while the children are small and really still babies, the GAP program has been important to her. The support group has helped to hear what other families are going through on this "roller coaster of a process". The children's case is still open after two years, but it does appear to be moving towards adoption as the case closes. Susie said she would still like to be able to attend the support group even after the case closed as she has formed relationships in the group that are important to her. Susie shared that she has enjoyed working with Harvey and Debbie and that they have both helped her get past roadblocks.

Results

The benefits of the kinship care initiatives and enhancements in Heartland's system of care include tangible costs savings, operational workload savings, quality child placements and improved outcome measures. Although the enhancements occurred at time of increasing workload increase on CPI and case management, they were accomplished ***without any additional resources or increase of FTEs in the system.***

Increase in Kinship Care Placements While Decreasing Kinship Care Breakdowns

Since the GAP Program inception, the percentage of children in kinship care placements has risen while the breakdown in those placements has concurrently decreased (see chart with phase lines below).

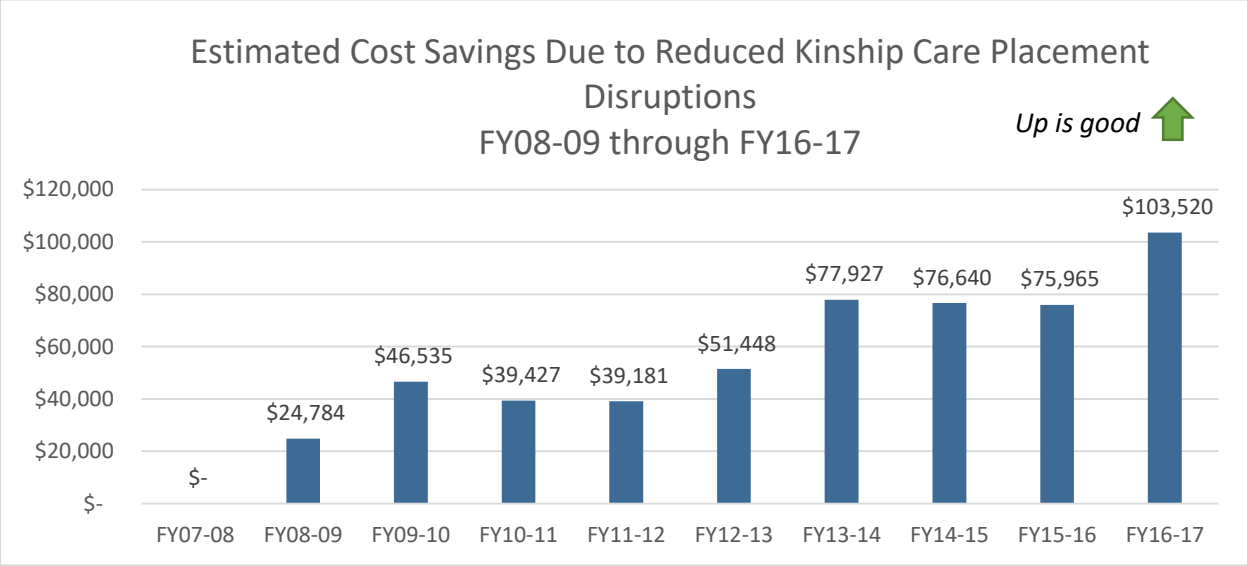


	FY 07-08	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18 Thru Nov.
Statewide	51.0%	49.5%	49.0%	51.5%	53.7%	54.7%	53.2%	53.7%	55.9%	56.7%	56.4%
HFC	55.4%	47.7%	48.5%	56.6%	54.9%	57.8%	55.1%	54.7%	57.9%	63.6%	65.6%
Kinship Breakdown	30%	24%	20%	19%	21%	19%	16%	16%	16%	13%	

Source: Child Welfare Dashboard "Children in Out of Home Trends".
Fiscal year calculated by the sum of all the monthly numerators and divided it by the sum of the monthly denominators.
Source: Initial Placement Status Listing Report - OCWDRU Report #1153

- Event 1 (E1) - GAP is created
- Event 2 (E2) -The issue of ineffective placement evaluation is discovered and the PET tool is developed.
- Event 3 (E3) - Research is undertaken in the interest of developing a more robust understanding of Kinship dynamics
- Event 4 (E4) - The educational initiative, "The Psycholocical Impact of Kinship Care on Families" is launched
- Event 5 (E5) - The GAP contract is revised, the referral process is eliminated, and the support structure for kin caregivers is radically enhanced

The estimated cost savings from reducing replacement reductions from 30% in FY07-08 to 13% in FY16-17 is estimated to total $535,427.00. Almost 20% of these estimated savings were realized in just the last SFY:

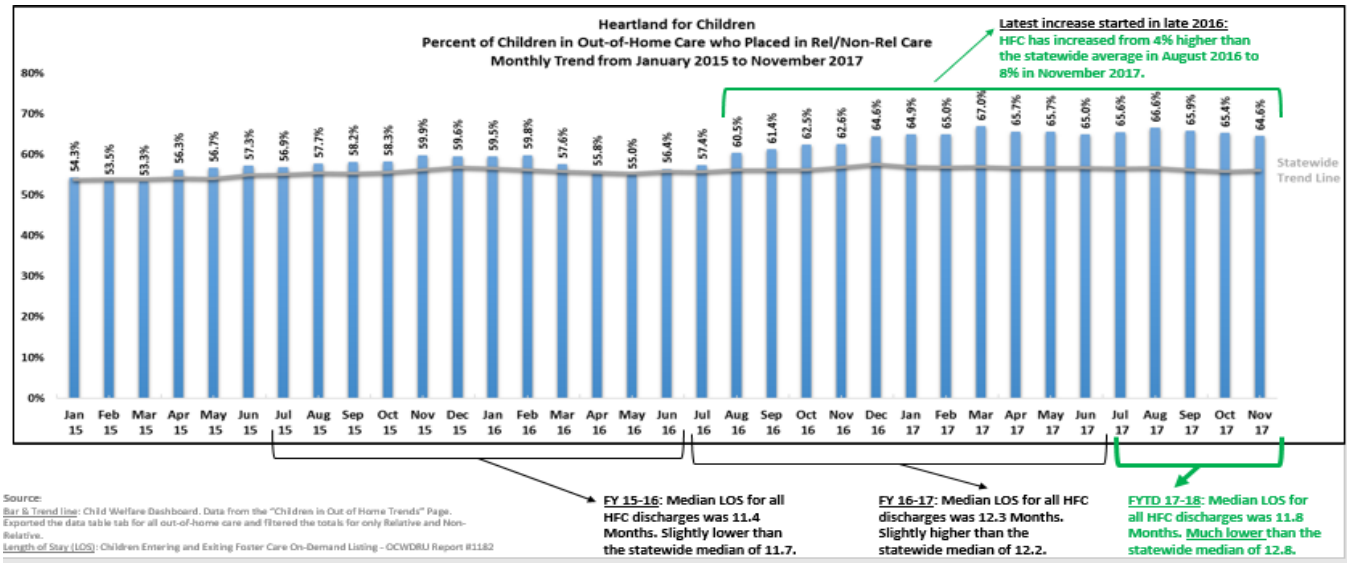


Source: Heartland for Children CO view, November 2017, Client Trends and Indicators tabs. Based on actual placement breakdown rate applied to an average number of relative placements per fiscal year at a per fiscal year average cost for licensed care cost vs. baseline of 30% relative placement breakdown rate across all fiscal years.

Reduced Length of Stay

Another benefit to the system of care since full implementation of all program enhancements has been a reduced length of stay for children placed in kinship care. Prior to the program enhancements, homes that would not be approved for adoptions were not identified as problematic until very late in the process. With the program enhancements, those were identified earlier in the process. In addition, services that could also help with caregivers being long term placement were implemented. Covering the period January, 2015 to November, 2017, the chart below shows the median length of stay by fiscal year for children placed in kinship care specifically for FY15-16, FY16-17 and for the first five months of FY17-18.

In FY 17-18 through November 2017, the median Length of Stay for all children discharged by HFC was 11.8 months, while the statewide median was 12.8 (1 entire month less). From FY15-16 to FY17-18, while the percent of children in relative or non-relative care increased, the median Length of Stay for those placements progressively decreased.



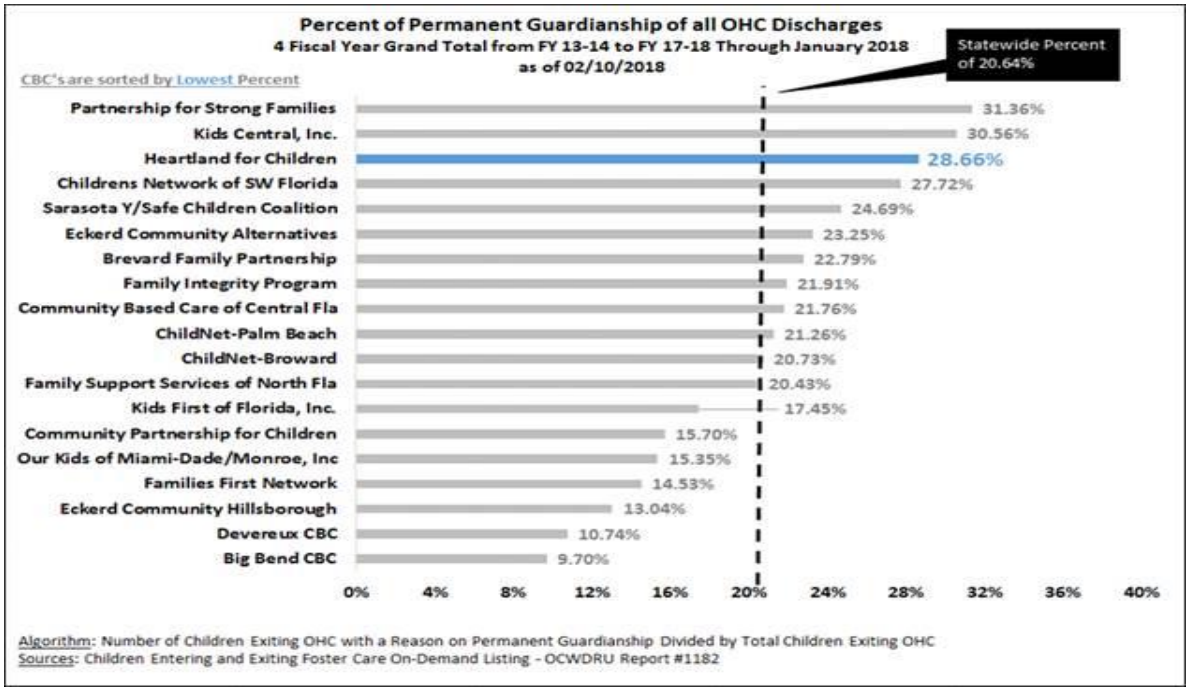
This one-month reduction in the Length of Stay, is projected to save Heartland for Children approximately $54,854.25 in case management costs[1] for FY17-18. In addition to the cost savings, this shortened path to permanency has a positive effect on the children such as increased educational opportunities, health benefits, medical dental immunization, reduction in children's medical emergency health events and juvenile arrest incidents.

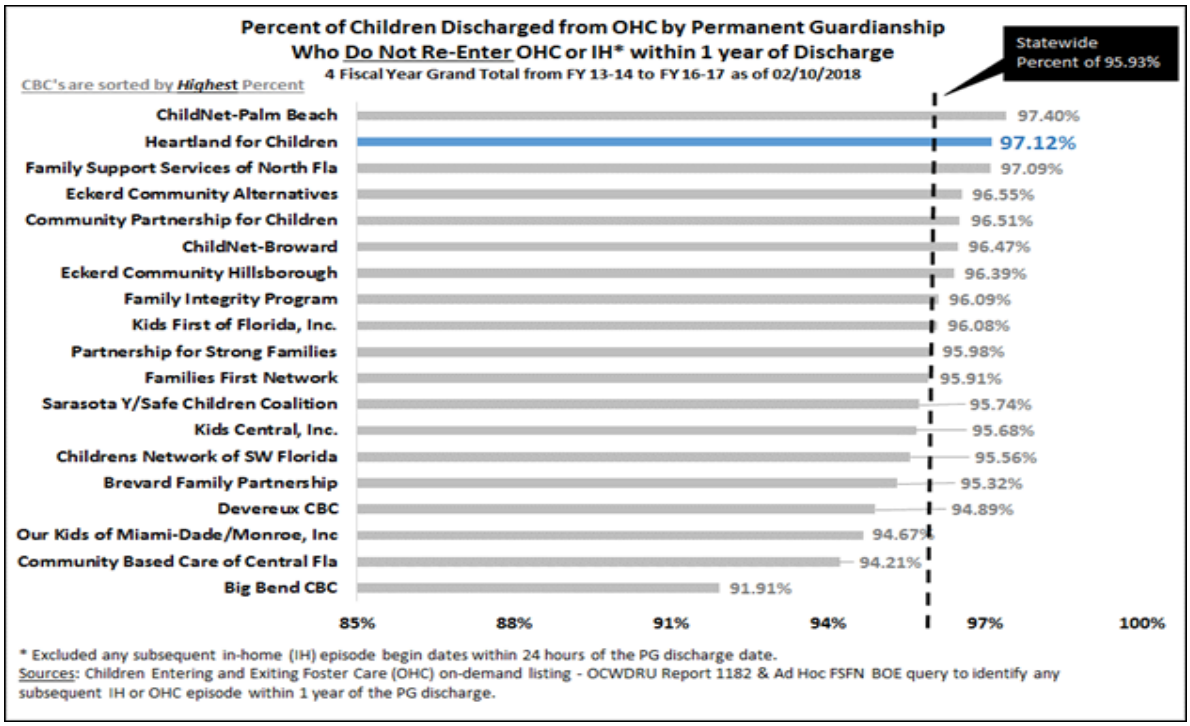
[1] *Source: Heartland for Children CO view, December 2017, Client Trends, and Average Cost Per Client Tabs. Average number of FY17-18 relative placements through December multiplied by FY17-18 case management average cost per client through December and divided by 12.*

Increased Permanency for Permanent Guardianship Discharges

From fiscal years 2013/2014 to 2016/2017, when compared to all other CBC lead agencies statewide, HFC achieved the 3rd[nd] highest percentage of discharges to Permanent Guardianship *while* achieving the 2[nd] highest percentage of permanent guardianship discharges who continue to maintain safely in the home (see the two charts below). Most children discharged to permanent guardianship come from

stable kinship placements. By coordinating support activities for caregivers, this has increased kinship stability, which has led to more children being able to be with kinship caregivers and achieving permanency in Permanent Guardianship.





In closing, the benefits of the kinship care initiatives and enhancements in Heartland's system of care as reflected in the information above include tangible costs savings, operational workload savings, quality child placements and improved outcome measures.

Attachment 1

Placement Evaluation Tool

PET

Developed by Bill Nunnally

This tool is designed to give the user essential insight into the dynamics of the placement, its viability, and potential issues that may need to be addressed before they become more difficult to manage. It should not be viewed as all-inclusive or as needing to be used in its entirety.

Once you have completed the tool, it is recommended that you complete a written evaluation of the information that you collect and staff the case with your immediate supervisor for further decision making.

1. Home Study
    a. Do we have a correctly completed home study from the CPI? If there are any questions as to the validity or thoroughness of the CPI home study, or if we do not have that home study, then the case manager must complete a new home study immediately.
    b. If the home study is believed to be complete and accurate, all areas of this guideline, starting with Section 2, should be covered with the caregivers, even if that information is part of the home study.
2. Budget
    a. Is there enough money to support the family along with the additional child(ren)? This should not include subsidies such as relative caregiver funding.
    b. If there is a shortfall, how will that difference be made up?
    c. If the expectation is that we will subsidize the family, what would be the alternative plan in the event that the child remains there permanently?
3. Condition of the home
    a. Is there adequate space for our child(ren)?
    b. Is there an anticipated need for more space in the future – as in an infant who will need his/her own room at one year of age?

c. What is the impact to children already in the home? Example – a child already there who had his/her own room/space and will now have to share that to accommodate a sheltered child.

d. Is any child in the home going to be expected to be in a space not previously intended as a bedroom area? For example, a section of a living room is now set up as a sleeping area.

e. Is the home safe and free of hazards?

f. Is the furniture in good repair and safe? Is there adequate furniture for all of the occupants or will we be asked to buy furniture and/or appliances for the home?

g. What is the neighborhood like? Is it safe for children of the age we are placing? How many callouts have there been to this home within the past year? How many callouts have been to the immediate neighborhood (6 square blocks surrounding the home) in the past year?

4. Who lives here and/or comes and goes frequently? Is anyone showing resistance to providing necessary information for background screening?

5. Caregivers' health

    a. Does anyone in the home have a chronic health condition that requires regular medical intervention?

    b. Are there any health/age conditions that might interfere with the caregivers' ability to interact in a nurturing and healthy way with the child?

6. Caregiver's position in the case and personal history

    a. What is the history with this caregiver's relationships with the birth parents?

    b. Under what circumstances did this caregiver agree to take custody of this child or children? Describe the caregiver's account of first contact and drop off.

    c. Were any promises of adoption or assistance of any kind made to this caregiver upon placement? These may be either from the CPI or the Case Manager.

    d. What is this caregiver's position on the child's potential for future interaction with the birth parents?

    e. Does the caregiver acknowledge any issues or problems that might not appear as part of the researchable public record? For example, a prior substance abuse history which is not documented in the case record.

    f. What is the marital status of this caregiver?

g. If the caregiver is married, what are the acknowledged relationship issues that exist today or have existed in the past?

h. What have we observed, if anything, that might give us concern about the current stability of the marriage?

i. Has the caregiver had other marriages? How many? If so, do we know why those marriages dissolved?

j. What is the caregiver's current view toward parental reunification?

    i. If they do not expect reunification, what points do they make to support that view?

k. What is the caregiver's view toward providing a permanent home for the child(ren) if that is required.

    i. Do they see themselves as an Adoptions placement?

    ii. Permanent Guardianship?

    iii. What do they say to explain their position regarding permanency?

l. Visitation

    i. Will the caregiver help to facilitate or supervise visitation? If not, why not?

    ii. Will they transport the child to visitation? If not, why not?

    iii. Will they allow the birth parent to visit the child in their home? If not, why not?

m. Transportation

    i. Does this caregiver have reliable transportation?

    ii. Do they have the financial ability to repair or replace their vehicle if need be?

    iii. Are they willing to transport the child to appointments? If not, why not?

    iv. Are they willing to transport the child to allow him/her to participate in extracurricular activities? If not, why not?

    v. Are they willing to transport either or both birth parents to assist with care plan completion? If not, why not?

n. Normalcy

    i. Do they understand normalcy? If not, the case manager must be able to explain it to them during this conversation.

ii. Are they willing to support normalcy? If not, why not?

iii. What sort of normalcy activities is the child already involved in?

o. Medical/Dental

i. Do they understand the child's need for regular medical and dental care?

ii. What behavior by the caregiver demonstrates their willingness and ability to ensure regular medical and/or dental care for the child?

p. Education

i. Does the caregiver appear to understand the importance of education in the child's life (if age appropriate)?

ii. What behavior by the caregiver demonstrates their willingness to support the child educationally?

iii. Is the child lagging behind peers educationally?

1. If so, what has the caregiver done to assist the child? Tutoring? Seeking assistance from school personnel? Etc.

q. Special Needs

i. Does this child have any educational, medical, behavioral or developmental special needs?

ii. Is the caregiver fully aware of those needs?

iii. Does the caregiver have an understanding of the special services that will be required for the child?

iv. What behaviors by the caregiver demonstrate their efforts to address the child's special needs?

CBC Financial Viability Effective Practices

Providing Services that promote, maintain, and strengthen relative/non-relative care placements

Date of Report: February 16, 2018

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Practice Summary

The statewide average for children in out-of-home relative and non-relative care was 58% in the state fiscal year (SFY) 16/17, while KFF's was 63% (one standard deviation above the mean). KFF has increased the number of children in relative and non-relative care by utilizing supports and services that help maintain and strengthen the placement until the child can achieve permanency.

The Relative Caregiver Support Model is successfully utilized by KFF to safely place and maintain a child in a relative or non-relative placement rather than a licensed family foster home or non-family-foster placement (such as group care, residential treatment home). KFF diligently identifies the needs and then wraps supportive services around the child and caregiver to support and strengthen the placement.

When a child is initially removed from their home, the Department of Children and Families Child Protective Investigator makes every attempt to locate relative and non-relative caregivers who are fit and willing to care for the child. On occasion, due to factors such as parental non-compliance with providing information, relatives are not able to be located immediately. When that occurs, the child will be placed in a foster home. However, the search for relatives and non-relative caregivers will continue even when DCF transfers the case to Kids First of Florida (KFF) for ongoing services. This process begins with the KFF Placement Coordinator and continues throughout the life of the case with the KFF Family Services Counselor (FSC) who has the support of the Administrative Assistant who is responsible for coordinating the diligent search process.

This supportive approach safely reduces the cost and number of children in licensed family foster homes and non-family-foster placements. The 2017 base licensed family foster room and board rates range from $448 to $538 per month, depending on the age of the child. The average group home cost per child (excluding APD and treatment placements) was $3,708 in May 2017. Diverting one child from group could save $44,496.00 per year.

Besides the cost savings, relative and non-relative placements are more advantageous than licensed placements (particularly when it comes to group care, residential treatment and "other" placements) because the child has a prior relationship with the caregiver which helps to maintain the child's connections in out-of-home care and, if a child cannot be reunified, relative/non-relative placements have a better chance of leading to the child being adopted and achieving permanency.

Substantial social science research indicates that relative placement had advantages for the children. Research reveals that:

- Children in relative care tend to be just as safe as, or safer than, children placed in foster care.
- Relative placements provide more stability than placement with foster families, and if the child has to move, it is likely he or she will move from the home of one relative to another.
- Siblings more often remain together in relative care and are more likely to visit one another even if they reside in separate relative homes.
- Relative caregivers are more likely to continue the ties with the child's birth family.
- Children in relative care are more likely to remain connected to their community, including their school.
- Relative caretakers facilitate parent-child visitation more easily since the caregivers will likely favor reunification and will be less likely than foster parents to compete with the parents for permanent custody of the child.

- Relatives are more likely to invest time and care for a child who shares a blood tie. This includes a willingness to care for the child for as long as needed.
- Placement with relatives will generally be less traumatic than placement in an unfamiliar home because the children will be living with someone they know and trust, particularly if the non-relative differs racially or ethnically from the child.
- Placement with relatives supports the transmission of a child's family identity, culture, and ethnicity.
- Placement with relatives eliminates the unfortunate stigma that many foster children experience.
- Children fare better in relative care than in foster care along numerous axes.
- The child placed with relatives knows his or her own family, sees family resemblances, and understands how he or she fits into it.

(Hon. Leonard Edwards, Judge-in-Residence, Center for Families, Children and the Courts, California Administrative Office of the Courts, "Examining the Benefits and Challenges of Placing Children with Relatives")

CBC Context

KFF is the CBC agency for Clay County. Clay County is in Northeast Florida, south of Jacksonville. The county is spread over 604 miles. The county's population was 208,311 in 2016, with a population of 346.7 per square mile. Clay County is largely a suburban area; however, many parts of the county remain quite rural. In SFY 16/17, KFF served 820 children and young adults.

Practice Detail

Core Elements:

The Relative Caregiver Support Model is utilized by KFF to safely place and maintain a child in a relative or non-relative placement rather than a licensed family foster home or non-family-foster placement (such as group care, residential treatment home).

KFF utilizes the Family Team Conference and multi-disciplinary team processes to identify all needs and then wraps supportive services around the child and caregiver to support and strengthen the placement. The approach incorporates the formal and informal supports of the child, including current and previous caregivers, Guardian Ad Litem, teachers, extended family, friends, etc., KFF staff and community stakeholders.

Through a team approach, the child, the caregiver, the child's support system, KFF staff, and stakeholders come together and assess and identify the strengths and needs of the child and caregiver and the supports and services that can assist them with meeting objectives, obtaining appropriate supports and services and overcoming placement barriers, mental health issues, or any other identified need. The KFF Family Services Counselor (FSC) ensures that all identified supports and services are provided. KFF currently has 28 primary FSC positions. The primary FSC is responsible for all case coordination and works directly with the biological parents, children, and caregivers. Their average

caseload is approximately 12 families and the primary FSC is responsible for visiting each child every 30 days, as well as ensuring that all supportive services (for parents, child and caregiver) are coordinated.

Supportive Services can include, but are not limited to, the following:

1. Transitional Trauma Therapy (TTT): To reduce the emotional impact related to the child's removal from the home and placement changes, Clay Behavioral Health Center's TTT services (counseling) are provided to the child, caregiver and family at removal, through the adjustment of the child in the out-of-home care setting and during placement changes while in out-of-home care. This service was added in SFY 12/13. A TTT therapist is present with the DCF Child Protective Investigator at every removal and assists the child and family with the emotional aspect of the event. The child's trauma is addressed utilizing Trauma Focused Cognitive Behavioral Therapy. These services help to reduce the likelihood of a placement disruption.

2. Medicaid Funded Services: Medicaid funded services (office as well as home based services) assist in meeting the child's physical, emotional, and developmental needs including physical, dental, audio and visual assessments and services, counseling and therapy, mental health treatment, substance abuse treatment, case management, behavioral analysis and assessments and evaluations used to facilitate treatment. KFF has a unique partnership with Clay Behavioral Health Center, the community mental health and substance abuse counseling and treatment provider in Clay County. The uniqueness, which consists of a shared CEO as well as co-location, assists in efficiency in both access of services and communication regarding compliance, barriers, and progress in clients receiving services.

3. Grants and Aids – Purchase of Therapeutic (Mental Health) Services for Children (aka 100806 Funds): 100806 funds can be used for a child who has a qualifying mental, emotional or behavioral disorder and a functional impairment which interferes with, or limits the child's role or functioning in family, school, or community. These funds provide:
   - A comprehensive array of services and informal supports tailored to the individual needs, strengths and developmental level of the child;
   - Innovative and specialized treatment approaches and support services not funded by Medicaid or other funding sources; and
   - Opportunities to further develop self-regulation and positive relational skills through age appropriate enrichment activities.

4. Resource Support: Resource support is utilized to assist caregivers in meeting the concrete needs of the child and caregiver. Through the assigned KFF FSC, caregiver needs are assessed and identified at each monthly home visit. If added supports are identified, the FSC will coordinate the delivery of the needed resource. KFF is responsible for assisting with securing funding if needed. These supports may include financial/income/employment assistance, housing assistance, household goods, food, clothing, and home furnishings. The supports can be provided by KFF or a community provider.

5. In-Home Parent and Education and Support: Clay Behavioral Health Center's In-Home Parent Education and Support is an in-home program designed to build parenting skills (behavior

management, child development and caregiver-child communication) and locate and access community services and supports. This resource is available for all parents and caregivers (relative/non-relative/licensed caregivers) if needed. Funding will be provided by KFF if parents/caregiver does not have the ability to pay for the service.

6. Childcare and Educational Services: Educational services such as tutoring are utilized to assist the child in improving school performance. Childcare and afterschool care is provided, as needed, through the various daycares and schools in the community.

7. Natural Support System: KFF works with the child and caregiver to strengthen their natural support system as necessary. This assistance includes encouraging the caregiver to be involved in the child's education and maintaining contact with the child's family and social connections, when appropriate.

Barriers encountered and methods to address:

A primary barrier is that many relative caregivers do not believe that they need the assistance of a formal program such as KFF. KFF has addressed this barrier by consistently communicating information via a newsletter, through the monthly FSC visits, and involving the relative caregivers in KFF events. Often times, relative/non-relative caregivers do not realize how much of an impact caring for the child will have on their family.

Resources used to implement:

Many of the services associated with the wrap-around approach are paid for through other funding sources such as Medicaid, 100806 funds, etc. and therefore it is more cost effective for the Community Based Care Agency.

Support or Service	Provider	Cost	Est % of children who receive this service
Medicaid Funded Services	Medicaid Providers Within the Community	Medicaid Funded (Sunshine Health Agreement)	100%
Trauma Treatment Services	Clay Behavioral Health Center	$75.00/hour-1st Session None to CBC-Additional Sessions (Safe and Stable Families Funding and General Revenue)	100%
Children's Mental Health Services (100806 Funds)	Providers Within the Community	Various (100806 Contracted funding)	60%
Resource Support	Clothes Closet, Miriam's Basket, etc.	Community Volunteers	100%
	KFF Finance Department	Various (Prevention, General Revenue)	60%

In-Home Parent and Education and Support	Clay Behavioral Health Center	$50.00/hour (Safe and Stable Families Funding and General Revenue)	60%
Childcare and Educational Services (including Tutoring)	Episcopal Children's Services, Schools, etc.	Episcopal Funding, General Revenue	50%
	Afterschool Programs	Varies	30%
	First Coast Behavior Solutions-Tutoring	$40.00/hour, General Revenue	20%
Natural Support System	Caregivers, Guardian Ad Litems, teachers, extended family, friends, etc.	None to CBC	100%

Staff Feedback

KFF staff feels that a supportive approach is helpful and effective because it helps to alleviate the stress that the caregiver is experiencing when the caregiver feels supported. It is especially helpful when the caregiver has not cared for a child previously or the child has behavioral issues. The approach makes for a smother and organized transition for the caregiver and child.

CBHC staff commented that the approach is effective because TTT services are provided whenever needed. While TTT is designed to establish a relationship with a child and family at the onset of removal, the TTT team assists as part of the ongoing process to strengthen a family system in order to maintain a placement. CBHC also likes the team approach in which the FSC, child, caregiver, service providers and supports work together to meet the child's needs and maintain placement stability.

Practice Example

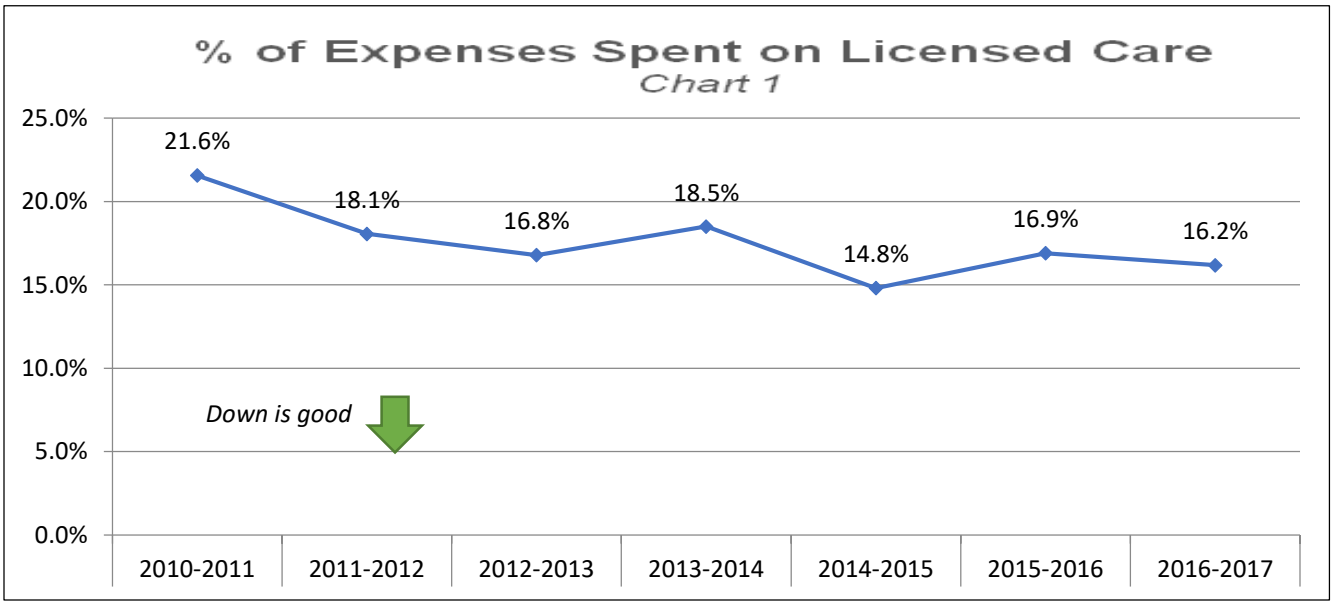
J.D. is an 8-year-old, hearing impaired boy who was removed from his mother's care due to medical neglect and inadequate supervision. Although J.D. was originally placed in a foster home, his grandmother was located and expressed an interest in caring for the child. However, there was concern that she could not manage his behavior. J.D. has tantrums and runs away from others when he gets upset; a behavior that has increased danger due to his hearing impairment.

To assist the grandmother and the child with preparing for the placement, the FSC, foster parent, grandmother and school personnel met to discuss needed supports and services. Arrangements were made to ensure his educational, medical and mental health needs were discussed and that his grandmother had been educated and trained in his care. Additional supports such as after school care and tutoring and an in-home behavior analyst were added to ensure J. D.'s transition and placement would be successful. J. D. is currently scheduled to be placed with his grandmother with the necessary supports in place.

Results

KFF enhanced the supportive approach in SFY 12/13 with the addition of Transitional Trauma Therapy and Florida's Child Welfare Practice Model (formerly known as the Florida Safety Decision Making Methodology).

The percentage of expenditures spent on licensed care has decreased since SFY 10/11. When comparing the overall expenditures in SFY 16/17, KFF spent 5.39% or $471,699.75 less on licensed care (including family foster homes, group care, residential treatment and "other") than in SFY 10/11 (see chart 1).



KFF began approaching the SFY 16/17 statewide average for the % of relative and non-relative placements in 2011 and exceeded the SFY 16/17 statewide average in 2014. As of the end of September 2017, 185 children or 65% of children served in out-of-home care by KFF were placed in relative or non-relative care, rather than licensed care (including family foster homes, group care, residential treatment and "other"), well below the statewide average of 58% (see figure 1).

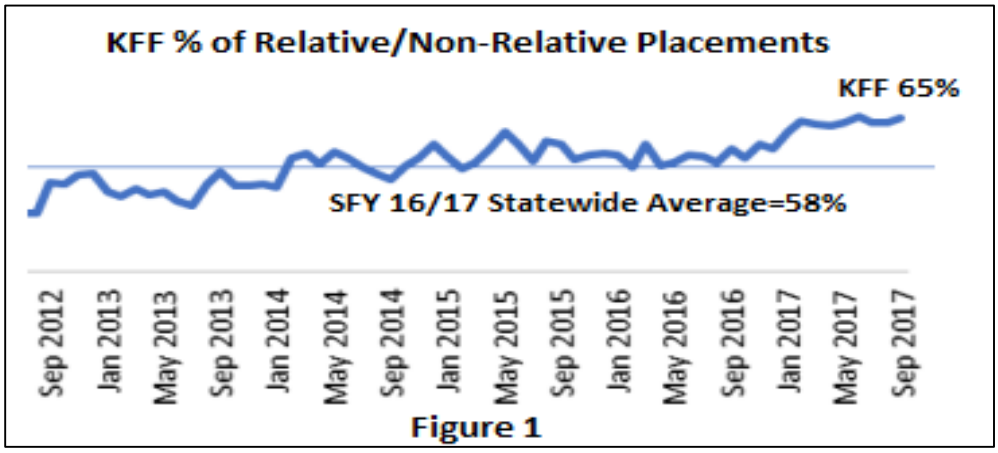


Figure 1

In September 2017, KFF was 7% above the statewide average for the number of children in relative and non-relative care. That 7% translates to 20 children served through KFF. If those 20 children remained in relative or non-relative care for one year as opposed to a licensed family foster home with a room and board rate of between $448 to $538 per month, the savings to KFF would be between $107,520.00 and $129,120.00. Based on the average monthly group home cost per child (excluding APD and treatment placements) of $3,708 in May 2017, diverting one child from group care to relative or non-relative care could save $44,496.00 per year.

KFF reduced the % of licensed out-of-home placements in non-family foster placements (including group care, residential treatment and "other") in 2012 and was significantly below the statewide average of 32% in September 2017 (see figure 2). In addition, KFF has the lowest rate of placement moves for children in out-of-home care according to the CBC Scorecard measure "Placement moves per 1,000 days in foster care. Last SFY, KFF's rate of placement moves was 1.640, while statewide the rate was 4.410.

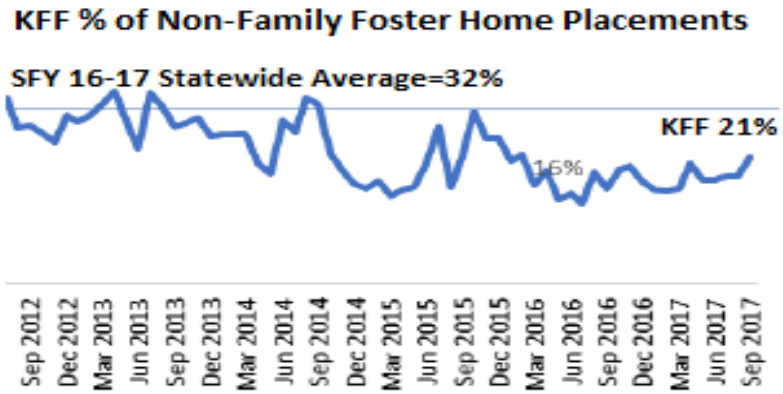


Figure 2

Placement Moves per 1,000 Days in Foster Care For Children Entering Care

CBC Lead Agency	10/1/14 - 9/30/15	1/1/15 - 12/31/15	4/1/15 - 3/31/16	7/1/15 - 6/30/16	10/1/15 - 9/30/16	1/1/16 - 12/31/16	4/1/16 - 3/1/17	7/1/16 - 6/30/17	10/1/16 - 9/30/17	1/1/17 - 12/31/17
Big Bend CBC	4.07	3.64	3.70	3.38	3.65	3.37	3.63	3.45	3.20	4.04
Families First Network	4.47	4.92	5.02	5.62	5.90	6.10	6.50	6.06	6.19	5.71
Community Partnership for Children	3.21	3.42	3.31	3.14	3.10	3.14	3.48	3.55	3.64	3.39
Family Integrity Program	2.81	2.45	2.28	2.74	2.91	3.02	3.29	3.71	5.49	5.51
Family Support Services of North Fla	2.80	3.38	3.46	3.82	3.77	4.08	4.07	3.94	3.66	3.14
Kids First of Florida, Inc.	2.87	3.04	2.92	2.47	1.79	1.72	1.65	1.40	1.95	2.34
Partnership for Strong Families	3.70	3.79	3.50	3.25	3.64	3.33	3.35	4.10	3.99	3.99
Brevard Family Partnership	3.11	2.97	2.64	3.44	4.18	3.92	3.76	3.24	3.16	2.85
Community Based Care of Central Fla	3.91	3.66	4.16	3.49	3.60	3.89	4.13	4.80	5.03	4.75
Community Based Care of Central Fla (Seminole)	4.13	3.49	3.44	3.63	3.74	3.24	3.73	3.23	3.24	3.78
Heartland for Children	3.37	2.87	2.70	3.05	3.73	3.48	3.13	2.83	2.99	3.14
Kids Central, Inc.	3.98	3.46	3.44	3.65	4.21	4.40	4.14	4.47	3.98	3.84
Childrens Network of SW Florida	5.39	5.02	5.29	5.45	6.39	6.31	6.48	6.40	5.81	5.45
Eckerd Community Alternatives	3.65	3.71	3.48	3.65	3.86	4.03	4.07	4.41	4.36	4.32
Eckerd Community Hillsborough	4.59	4.54	4.91	5.53	5.58	5.55	5.58	5.28	5.70	6.29
Sarasota Y/Safe Children Coalition	4.20	3.95	4.32	4.27	4.68	4.55	4.48	4.29	4.18	4.23
ChildNet-Broward	3.25	3.14	3.12	3.46	3.46	3.38	3.52	3.34	3.18	2.98
ChildNet-Palm Beach	3.00	2.96	3.10	3.23	3.54	3.58	3.80	3.50	4.02	4.56
Devereux CBC	4.57	3.94	3.93	3.54	4.53	4.11	4.06	3.96	3.79	3.74
Our Kids of Miami-Dade/Monroe, Inc	5.09	4.95	4.88	5.16	5.62	5.63	5.76	5.14	5.13	5.23
Statewide	**3.94**	**3.80**	**3.83**	**4.03**	**4.37**	**4.38**	**4.47**	**4.39**	**4.36**	**4.35**
National Standard	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12

Good

KFF: lowest in the state

Source: FSFN OCWDRU Report #1102: "Placement Moves Per 1,000 Days in Foster Care"

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Office of CBC and ME Financial Accountability

CBC Financial Viability Effective Practices

Providing training, support, and enhanced service provision to foster parents and teens in the most family like setting

02/14/2018

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Practice Summary

Statewide, the general practice is to utilize residential group homes for teen placements. Family Support Services of North Florida's (FSSNF) philosophy ensures the best interest of children are served in the least restrictive placement. At the forefront of this philosophy is "if a home is not good enough for your own family then it is not good enough for our children". With every placement FSSNF considers the trauma to which children have been exposed and puts an emphasis on child-specific placement matching in the least restrictive setting using assessment and teamwork. Through the use of training, supports, and an enhanced service provision FSSNF has maximized the utilization of family foster homes while decreasing the use of residential group homes.

CBC Context

FSSNF serves two counties in the Northeast Region; Duval, an urban county with approximately 930K residents, and Nassau, a rural county with approximately 79K residents.

FSSNF has developed extensive relationships with formal and informal service providers to create a comprehensive array of services that meet the needs of children and families in the communities we serve. FSSNF continues to place a strong emphasis on utilizing prevention services to effectively manage the "front door" while safely reducing the number of children who enter the formal child welfare system. FSSNF has developed a strong network of services in Duval and Nassau counties that ensures the continuity of care from entry to exit which includes, but not limited to Family Preservation, a department within FSSNF that provides services to safe and unsafe children while keeping the family together when possible; Out-of-Home Care, and Post-Placement Services.

Practice Detail

This section contains three parts; a description of the core elements of the practice, a description of barriers encountered, ways they are addressed, and the resources used to implement the practice.

Core elements

1. **FSSNF takes a collaborative team approach to placement matching in a family like setting by identifying appropriate supports and services to be implemented into family foster homes.** In order to achieve this, FSSNF has restructured its Kids Central Placement Department to now include the following

   3 Placement Specialists
   1 Lead Placement Specialist
   1 Intake Specialist
   1 Behavioral Health Care Coordinator
   1 Children's Health Specialist
   1 Education Liaison
   1 Out of County Services/Interstate Compact for Placement of Children (OCS/ICPC) Specialist
   1 Department Manager

   When a placement request is received to the department, a multi-disciplinary team staffing is scheduled and facilitated by a placement specialist. Depending on the circumstances and the anticipated needs of the child(ren) needing placement, other members of the placement team may participate in the multi-disciplinary team staffing and assessment. For all children who may have mental health or behavioral health needs, the Children's Health Specialist and Behavioral Health Care Coordinator participate in the call to assess for a higher level of care and any services that could be offered to the child and foster home to assist in making the placement successful and to address the needs of the child. The Education Liaison participates in school stability staffings and any staffings where the child has educational needs that need to be addressed. Enhanced placement board rates are utilized when necessary and are based on strict criteria (see attached foster care enhanced rate criteria) with supervisory approval.

The OCS/ICPC liaison assists with the transition of children in or out of the county or state needing placement. All team members are available for consultation for high risk placements.

2. Quality parenting recruitment, training, and expedited licensing process. FSSNF has improved all processes related to foster home management by taking a strong customer service approach to the Quality Parenting Initiative (QPI) recruitment, PRIDE training, streamlined licensing procedures, and new ways to retain our foster homes to ensure better outcomes and stability for our foster children. FSSNF regularly recruits for foster parents using various community venues, media communications techniques and social marketing. Our dedicated FSS Recruitment and Retention Specialist utilizes targeted recruitment efforts to increase the number of quality foster homes who will serve specialized populations such as teens, LBGTQ youth, and large sibling groups. Outreach efforts are varied and focus on creating an interest in caring for our community's children. This is done through various means targeting different groups such as corporate, faith – based, lifestyle- focused events, our website, and media and social contacts.

   FSSNF has developed a unique, enhanced foster parent training class structure to supplement the standard Parent Resources for Information, Development and Education (PRIDE) curriculum. The FSSNF Pride Training Specialist coordinates CPR and first aid training during the course, invites child welfare and community guests such as Children's Medical Services, Foster Closet, Neighbor to Family, and other providers. The curriculum is based on trauma informed care techniques and meets the statewide Quality Parenting Initiative standards. Topics range from trauma-informed care, attachment disorder, co-parenting, transition planning, bonding and positive behavior management to name a few.

   During PRIDE class, the licensing packet is initiated by the Licensing Coordinator to start the licensing paperwork process to support the prospective foster parents while training. This results in the licensing packets being submitted to DCF for approval usually within 3-4 weeks after the PRIDE class is completed, successfully reducing the licensing time from 25 weeks to 14 weeks from when a family expresses interest in fostering to actually receive placement into their newly licensed home.

   The permanent FSSNF Licensing Counselor is assigned to the family foster home prior to graduation to ensure any issues that need to be addressed are being handled immediately. Retention efforts are significantly increased as Licensing Counselors work closely with newly licensed parents to ensure their experience with fostering is well supported by ongoing trainings, individualized support and services plans, and facilitation of both verbal and written communication.

3. Enhanced service provision and supports for foster parents.
   FSSNF has standard processes in place to gather data and feedback from foster families; a 30-day survey followed by a 90-day survey for newly licensed foster parents, exit interviews, and FSC review of foster homes in order to gather information from foster parents, children, and case management to improve quality standards and supports for caregivers. Through feedback from the surveys and exit interviews, FSSNF focused on providing trauma informed training to our foster parents. Tri-annual trainings are provided in addition to camps, enrichment activities, and events for our foster parents.

   FSSNF contracted with Children's Home Society to develop an Acute Intervention Team that provides after-hours in-home therapeutic crisis response services within 1 hour . This service can be utilized from the hours of 3 pm to 3 am and is coordinated by the on call FSSNF placement specialist who works directly with the foster parent and Acute Intervention Team to de-escalate any situations in the

foster home.

The Acute Intervention Team utilizes masters level clinicians trained in trauma informed care to assist foster parents with de-escalation and behavior management techniques and provide on-going therapeutic wraparound services. The Acute Intervention Team has the ability to Baker Act to avoid use of law enforcement to reduce further trauma to the child. Since implementation of the Acute Intervention Team in September 2017, FSSNF has seen a reduction in placement disruptions in the middle of the night as well as a reduction in the need for emergency respites after hours. Of the 35 crisis calls that the team has responded to since September, only 4 children had to be Baker Acted after hours, 1 call resulted in an incarceration and 6 placements were disrupted. Of the 6 placements that ultimately disrupted, all placements were stabilized for the night or weekend and did not have to be re-placed until the next business day.

Foster parents have access to the Acute Intervention Team and other emergency assistance via the Kids Central on call service. This on call service is a company contracted by FSSNF and operates from the hours of 5 pm to 8 am to relay messages and calls to the FSSNF Kids Central Placement Specialist on call. The foster parent, case manager or DCF Child Protective Investigator only has to call one after-hours number to reach the designated on call placement specialist with FSSNF. The on call placement specialist then reaches out to the foster parent and the Acute Intervention Team to coordinate services directly or assist in any other emergency needs of the foster parent and child.

FSSNF also employs a dedicated foster Family Resource Advocate (FRA) that is referred by Kid's Central for foster parents receiving placement from DCF, or newly licensed foster parents receiving their initial placement, as well as foster parents in need of additional supports to maintain child placement. The FRA assists with communication, navigation and education of dependency system, provision of basic needs, and assistance with referrals and community resources. FRA is available for after-hours crisis response and has a 3 hour response time[2]. When the FRA position was first implemented in 2016-2017, placement stabilization rate of the 45 referrals received as at 56%, meaning that 56% of the placements were saved and the youth was able to remain in the home without placement disruption. For 2017-current, placement stabilization rate is currently at 65% among the 45 referrals submitted for assistance.

FSSNF contracted with Justice Works Youth Care program to provide intensive wrap-around case management services to high risk cross-over teens. Justice Works utilizes bachelors level Family Resource Specialists to work with the adolescent and foster parent in the home and in the community for a minimum of 6 hours per week. The intensive case management services provide support to the teen and foster parent to stabilize behaviors and decrease risk or recidivism[3].

4. Intensive wraparound services, supports, and enrichment programs for teens. FSSNF utilizes the teen umbrella services to include the FSS Family Resource Advocate, Justice Works Youth Care program, Children's Home Society Acute Intervention Team as well as FSS teen enrichment programs such as SPLASH, The Challenge, Tour de TRAILS, and Just Like Me to provide enhanced services based on child specific needs. The teen umbrella provides services to promote positive development and well-being, pro-social skills, life skills instruction, mentoring, and educational supports. The enhanced service provision provides supports necessary to stabilize high risk behaviors that could hinder permanency and safety.

Services provided within the licensed home setting:	*Resources*
Parenting	*Nurturing Parenting training*
Behavior Modification	*Behavior Modification training*
Biopsychosocial Assessment	*Mental health assessment tool to evaluate trauma*
Mentoring	*Mentor Matters program and secondary case*
Trauma Therapy	*Contracted CMO staff therapists assigned to teens*
Crisis Response & De-escalation	*MSW therapists provide in-home therapeutic supports*
Anger Management	*Evidenced based program materials*
Targeted Case Management	*Contracted case management organization certified staff*
Life Skills Instruction	*Contracted service providers & FSS staff*

[1] Children's Home Society Acute Intervention Team available within 1 hour of call to Kid's Central
[2] Family Resource Advocate available for crisis response within 3 hour of call to Kid's Central
[3] Justice Works Youth Care available for crisis response within 3 hour of call to Kid's Central

Standards are in place to ensure manageable workloads for support services:

- Licensing Counselors maintain a 1 to 40 foster home case ratio that is monitored by supervisors and program manager.
- Children's Home Society Acute Intervention Team assigns therapists for wraparound case management services as necessary and caseloads are monitored by program director.
- FSS Family Resource Advocate maintains open referrals for 30-60 days of short term support and carries a maximum of 10 open referrals.
- Justice Works Youth Care Family Resource Specialists maintain a maximum of 8 cases per each FTE (2 contracted FTE) due to working with the youth for 4-6 months on average.

Barriers encountered and methods to address

Barriers encountered	Addressed by:
Lack of foster homes willing to take high risk teen placements.	FSSNF uses targeted recruitment strategies to include communication of services and in-home wrap around supports available for foster parents who are willing to take this population of children.
Issue of communication between foster parents and other parties to a child's case and concern that the foster parents' voice is heard.	FSSNF takes a QPI team approach with foster parents to increase transparency and communication between all parties. FSSNF licensing and placement staff utilize team emails between FSSNF, CMO, GAL, foster parents, and any other parties to ensure everyone is kept up to date on case activities. FSSNF also utilizes supports and services plans in writing to the foster parents for clear and direct communication. FSSNF conducts foster parent surveys to get direct feedback. Foster parents participate on the FSSNF board, are represented on the QPI steering committee, and run the FAPA groups.

High turnover and high caseloads of caseworkers at the Case Management Organizations.	FSSNF regularly monitors caseloads of the CMOs by analyzing data of caseloads per FTE and each agency. This is presented and assessed during barrier breaker meetings, DCF/CBC partnership meetings, CMO CEO meetings and various other avenues to constantly monitor and evaluate.
	Current Data: Total number of dependency case managers= 117, **cumulative turnover rate: 15.57%** (avg weighted); **case managers with <1 year experience: 37.61%** (avg. weighted). **Average kids per worker caseload is 12.89.**
Lack of training for foster parents to handle the trauma and behaviors associated with high risk youth placements.	FSSNF conducts tri-annual trainings for foster parents and kinship caregivers. FSSNF brings in outside expert trainers for different topics presented in order to provide caregivers with quality training and support. FSSNF contracts with Anna Farin to train on trauma informed care in every PRIDE class of new foster parents. In addition, FSSNF will put together specific training for the foster parent through the use of a support and services plan, when appropriate, to address any specialized placements in their home.
Issues of communication and collaboration within the system of care.	FSSNF participates in bi-weekly "Barrier Breaker" meetings with DCF, CMO, GAL, Medical Examiner and other stakeholders to strategically address any issues that may be affection the successfulness of the system of care between DCF and the CMOs. In addition, FSSNF facilitates monthly CMO director and supervisor meetings to discuss any placement barriers, new rules, and new services to be utilized to help with foster family placements.

Resources used to implement

- FSSNF contracts for in-home after-hours therapeutic crisis response with Children's Home Society at $62,598.00 for 365 days per year. Therapeutic wraparound services not eligible for Medicaid reimbursement are invoiced to FSSNF at the Medicaid rate. The non-reimbursable expenses would be in addition to the contracted rate of $62,598. At this time there have been no additional, non-Medicaid eligible expenses.
- FSSNF contracts for in-home secondary wraparound case management services with Justice Works Youth Care at $14,000.00 per month for 2 FTE Family Resource Specialist.
- FSSNF employs 1 FTE Family Resource Advocate at $56,253.00 (amount includes benefits). Teen enrichment activities are supported through donations, grants and state funding at a total annual approximate cost of $74,000.

Staff Feedback

Feedback from critical stakeholders and partners support that our approach has decreased stress and improved moral for Kid's Central placement staff as well as Family Service Counselors assigned to high risk teens. The Licensing Counselors have also expressed gratitude for the additional supports that they are able to share with foster parents.

CMO feedback: "We have Justice Works assigned to 2 of our teens and they have been incredible! They truly have been a help in transporting our kids to appointments and really trying to work with them to participate and actually go to the appointments. It's really a benefit to communication, as we all know these teens can be a handful for our case managers and the support programs have alleviated some of that stress off of the workers! I love love love the programs!" (M. Oxford, Dependency Case Manager Supervisor, Children's Home Society)

Department of Juvenile Justice Probation feedback: “So far, the Justice Works program has been working well for the kids on my caseload. I have found it very helpful for them to have someone that is continuously present in their progress. Working with Justice Works has been a pleasure. I appreciate the updates and it helps to have that extra hands to ensure things are getting done. All of my youth that are in the program have reported to me that they do like their Justice Works Manager. From my behalf, I would say – so far, so good. And, Thank you for recognizing the need.” (A. Santiago, Juvenile Probation Officer, Circuit 4)

Foster parent feedback: “It is so nice to know that if I have a problem in my home I can call Kid’s Central and access services. So often in the past I have tried to deal with situations on my own and I have felt overwhelmed and even frightened at times. Having the crisis response team available and the Resource Advocate has not only provided support but has helped me to learn new skills.” (K. Thomas, FSSNF teen foster parent)

Statement from CBC leadership: "From a community- based care perspective it is essential that our foster teens are provided a family-centered, collaborative environment to live rather than a residential group home setting. If they can be placed in specialized, quality (or traditional) foster homes with caring people that are trained to understand and handle the specific behavioral issues affecting these youth, and supported by the appropriate wraparound services, they are afforded better opportunities to have positive, long- term outcomes." (Bob Miller, CEO of Family Support Services)

Practice Example

GH is a 17 year old female in foster care. Since coming into care November 2016 until September 2017, the child had 9 placement disruptions along with multiple Baker Acts, arrests, and runaway episodes. There were concerns as her high risk behaviors continued to increase in frequency and she started hanging out with other children who were negatively influencing her. As a result, the child was placed on probation through the Juvenile Justice System.

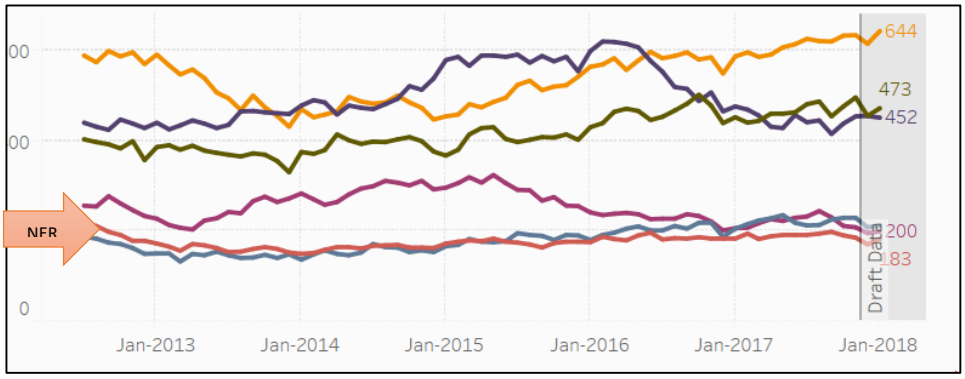
In September 2017, Kids Central called the CHS Acute Intervention Team (CHS AIT) over a weekend to stabilize the placement that was disrupting in the current foster family home in efforts to save this placement, as it was her 8th. The CHS AIT went to the foster home multiple times over the weekend often speaking to the child directly when she felt like she wanted to run away and could not cope with issues in the foster home. The team took the child out of the environment for lunch and to walk around at the mall to help calm her down. The CHS AIT worked closely with the foster parents, the child, and Kids Central and kept her stable throughout the weekend. CHS AIT built a rapport with GH who still continues in her placement to date. Additionally, GH was referred for the Justice Works program in October 2017 for support to the child and foster parent.

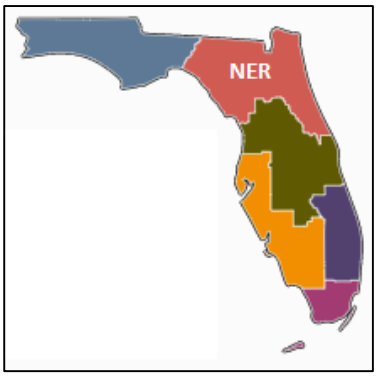
Since the implementation of both the CHS AIT and Justice Works team, GH has been stable in her placement and has made positive changes in all areas of her life. There have been no new arrests, Baker Acts or run episodes since being in this placement. Justice Works continues to monitor GH on a weekly basis.

Results

Through assessment, evaluation and oversight of the FSS placement program, we have seen a measurable and substantial increase in the number of children placed in family foster home settings compared to historic residential group care settings. The chart below shows that the Northeast Region has the lowest number of children in group care compared to other regions across the state.

Children in Group Home by Region as of January 2018 *(Source – Child Welfare Dashboard):*





Currently, 86% of the children in licensed care are placed in family foster homes. We are consistently more than one deviation above the statewide goal for placement moves per 1,000 children. This is indicated on the most recent FSFN OCWDRU report and shows consistency in this measure since 2014.

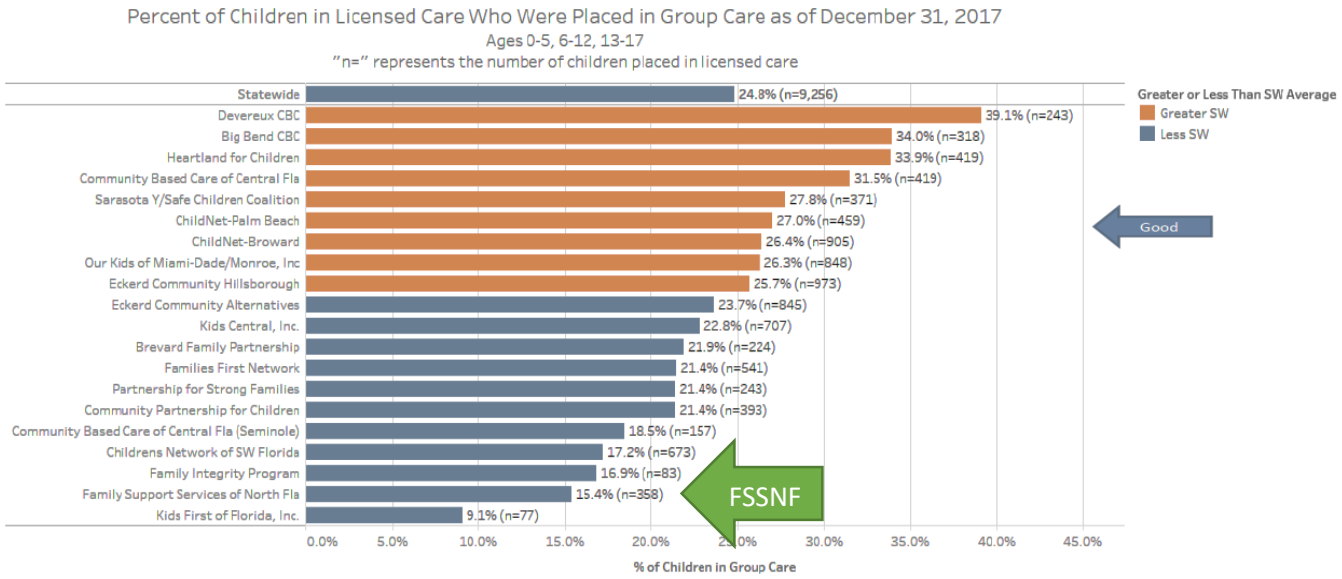
Placement Moves per 1,000 Days in Foster Care For Children Entering Care

CBC Lead Agency	10/1/14 - 9/30/15	1/1/15 - 12/31/15	4/1/15 - 3/31/16	7/1/15 - 6/30/16	10/1/15 - 9/30/16	1/1/16 - 12/31/16	4/1/16 - 3/1/17	7/1/16 - 6/30/17	10/1/16 - 9/30/17	1/1/17 - 12/31/17
Big Bend CBC	4.07	3.64	3.70	3.38	3.65	3.37	3.63	3.45	3.20	4.04
Families First Network	4.47	4.92	5.02	5.62	5.90	6.10	6.50	6.06	6.19	5.71
Community Partnership for Children	3.21	3.42	3.31	3.14	3.10	3.14	3.48	3.55	3.64	3.39
Family Integrity Program	2.81	2.45	2.28	2.74	2.91	3.02	3.29	3.71	5.49	5.51
Family Support Services of North Fla	2.80	3.38	3.46	3.82	3.77	4.08	4.07	3.94	3.66	3.14
Kids First of Florida, Inc.	2.87	3.04	2.92	2.47	1.79	1.72	1.65	1.40	1.95	2.34
Partnership for Strong Families	3.70	3.79	3.50	3.25	3.64	3.33	3.35	4.10	3.99	3.99
Brevard Family Partnership	3.11	2.97	2.64	3.44	4.18	3.92	3.76	3.24	3.16	2.85
Community Based Care of Central Fla	3.91	3.66	4.16	3.49	3.60	3.89	4.13	4.80	5.03	4.75
Community Based Care of Central Fla (Seminole)	4.13	3.49	3.44	3.63	3.74	3.24	3.73	3.23	3.24	3.78
Heartland for Children	3.37	2.87	2.70	3.05	3.73	3.48	3.13	2.83	2.99	3.14
Kids Central, Inc.	3.98	3.46	3.44	3.65	4.21	4.40	4.14	4.47	3.98	3.84
Childrens Network of SW Florida	5.39	5.02	5.29	5.45	6.39	6.31	6.48	6.40	5.81	5.45
Eckerd Community Alternatives	3.65	3.71	3.48	3.65	3.86	4.03	4.07	4.41	4.36	4.32
Eckerd Community Hillsborough	4.59	4.54	4.91	5.53	5.58	5.55	5.58	5.28	5.70	6.29
Sarasota Y/Safe Children Coalition	4.20	3.95	4.32	4.27	4.68	4.55	4.48	4.29	4.18	4.23
ChildNet-Broward	3.25	3.14	3.12	3.46	3.46	3.38	3.52	3.34	3.18	2.98
ChildNet-Palm Beach	3.00	2.96	3.10	3.23	3.54	3.58	3.80	3.50	4.02	4.56
Devereux CBC	4.57	3.94	3.93	3.54	4.53	4.11	4.06	3.96	3.79	3.74
Our Kids of Miami-Dade/Monroe, Inc	5.09	4.95	4.88	5.16	5.62	5.63	5.76	5.14	5.13	5.23
Statewide	**3.94**	**3.80**	**3.83**	**4.03**	**4.37**	**4.38**	**4.47**	**4.39**	**4.36**	**4.35**
National Standard	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12

Good

FSSNF

As noted earlier in the report, matching and success for children in their initial foster placement is paramount to success. FSSNF is amongst the leaders in diverting all ages of children from entering residential group care settings.



Justice Works and CHS AIT

Nine cross-over kids referred to Justice Works in October 2017 were averaging 2 placement disruptions per month. As of December 2017, the same group averaged .25 placement disruptions per month.

Similarly, nine high-risk teens referred to the Acute Intervention Team in September 2017 were averaging 2 placement disruption per month. As of December 2017, the same group averaged .22 placement disruptions per month.

Attachment 1

Placement Process:

- Check out on event on the CoBris board based on the placement specialist rotation.
- Send an email/call the FSC/CPI to staff the case.
- ID services for placement stability.
- Find least restrictive placement near removal address.
- Determine if child needs to be referred for a medical foster home or a therapeutic foster home. See appropriate sections for more information.
    - If a therapeutic foster home will be requested, please contact Amy Hood and Dieulise Lambert at FSS to schedule an MDT staffing. An STFC referral form will need to be completed as well. Gather as much information as possible from the CPI or FSC.
- Check home for adequate sleeping arrangements, genders/ ages of all children in the home (to include foster, adopted, biological), foster parent's licensed capacity, and review Child Placement Agreement log for any restrictions.
    - See over cap section if:
    - Placing an infant in a home that already has 2 children under the age of 2 years old.
    - Placing a 6th or more child in a home that already has a total of 5 children in the home.
    - Placing a child in a home that is already at their licensed capacity.
- ID if *child placement agreement* is needed and notify worker to send to safety.plan@fssnf.org. Child Placement agreement needs to be signed within 5 days of placement.
- Foster parents are given all important information on the children to include sexual issues, medications and any behavioral issues. Note conversation with foster parent in CoBris note.
- If you are unable to identify a placement for a sibling group to remain all in the same home, attempt to identify two or more placements in the same area of town. Please see separated sibling section for more information.
- If it determined that an enhanced rate is needed for the placement, review the *Enhance Rate Criteria Form* to determine the rate. The foster parent must be notified of why the enhanced rate is being given and expectations of what the enhanced rate it to be used for. Document this conversation in the event.
- Send an email/call the FSC/CPI with the placement information. Attach dl_licensing when placement is in a FSS home. Include any applicable documents such as a child placement agreement and/or FSC review/ Exit Interview.
- School Stability Checklist form must be completed to determine whether or not child will remain in removal school. If it's determined that the child will remain in current school, send a transportation request to Gail Cook and contact at Duval Schools.
- ID if an exit interview is needed and notify the FSC to send it to exit.interview@fssnf.org
- ID if a bed hold is needed. If so, put a reminder on calendar to re-staff with placement supervisor on the 3rd business day from the start of the bed hold. For foster parents receiving enhanced rates, ALL BEDS HOLDS ARE AT BASIC RATE.
- If placement is in a NTF home, notify SPOA at time of placement.

Attachment 2

FSSNF Staffing Form

Date: _____

Conference Line:
Participant #:
Host:

Case Name/ Child:
Agency:
FSC/ FSCS:
GAL:
AAL:
FSS Placement:
FSS Licensing:
DCF:

Current Placement:

Reason for staffing:

Safety concerns?

Child's current school/grade/ IEP:
Diagnosis/ medications:

Behaviors (runaway, DJJ, etc.):

Current services:

Current safety plan? If yes, what are the restrictions?

Current case plan goal:

Parents case plan compliance:

Visitations with parents:

How does the child feel?

What does the agency want?
NEXT STEP:

Attachment 3

Foster Care Enhanced Rate Criteria
(As of 01/12/2015)

	A	B	C	D	E
1	STANDARD	MILD	MODERATE	SEVERE	SERIOUS
2	Rate: $15.36 (0-5)	Range: $16-$21	Range: $22-$32	Range: $33-$53	Range: $54-above
3	Rate: $15.36 (6-12)	Range: $16-$21	Range: $22-$32	Range: $33-$53	Range: $54-above
4	Rate: $17.41 (13-17)	Range: $18-$23	Range: $24-$34	Range: $35-$55	Range: $56-above
5	Basic Living skills	Has behavioral, medical, or developmental needs that require care above basic living skills.	Has complex behavioral, medical, or developmental needs that require medication management, therapeutic services, and/or physical and occupational therapy.	Has deteriorating behavioral, medical, or developmental needs that pose a threat to the child, vulnerable children in the home, and/or caregiver.	Has history or demonstrating serious behavioral , medical, or developmental needs that pose a threat to the child, all children in the home, and/or caregiver.
6	Child can meet basic daily living skills for age	Child needs assistance to meet basic daily living skills for age.	Caregiver needs outside assistance to meet child's basic daily living skills.	Child doesn't have ability or is defiant in meeting basic daily living skills.	Child doesn't have ability or is oppositional defiant and threatening to caregiver when trying to meet basic daily living skills.
7	Follows rules at home and outside of home	Needs redirection outside of the norm.	Needs constant redirection but will comply with rules.	Needs constant redirection but will only comply with rules sometimes.	Child outright defiant and refuses redirection.
8	No Sexual abuse	Previous sexual abuse history as a victim but not exhibiting any acting out behaviors due to abuse. Doesn't require counseling or successfully completed counseling.	Previous sexual abuse history as a victim that requires counseling to address abuse and compliant with counseling.	Previous sexual abuse history or current sexual abuse as a victim and/or perpetrator that requires counseling and not compliant with counseling.	Previous sexual abuse history or current sexual abuse as a victim and/or perpetrator that requires counseling and/or DJJ invlovement due to it and not compliant or refusing counseling.
9	No runaway problems	Doesn't always meet curfew but doesn't have runaway problems.	Frequently misses curfew and has runaway episodes for short periods of time.	Breaks curfew regularly and has frequent runaway episodes for short periods of time or long runaway episodes.	Refuses to abide by curfew and is a chronic runaway.
10	No DJJ involvement	Some past history with DJJ.	Past history and/or current involvement with DJJ but meeting all DJJ requirements.	Past history and/or current involvement with DJJ and not meeting DJJ requirements.	Past history and/or current involvement with DJJ and blatant refusing to comply with DJJ requirements.

Office of CBC and ME Financial Accountability

CBC Financial Viability Effective Practices

Partnership for Strong Families:
Twelve months to Permanency

2-9-2018

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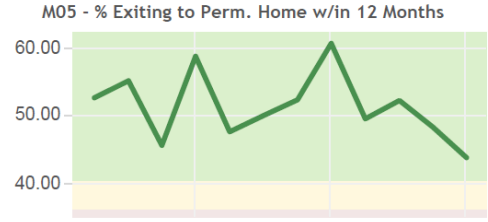
Practice Summary

Percent of children exiting foster care to a permanent home within twelve (12) months of entering care (M05): The percentage of children who entered foster care during the report period where the child achieved permanency within twelve (12) months of entering foster care. This measure is similar to the federal indicator, Permanency Performance Area 1: Permanency in 12 Months for Children Entering Foster Care.

Time is of the essence for permanency of children in the dependency system. Partnership for Strong Families (PFSF) combines routine permanency staffings with multi-stakeholder safe reduction workgroups to identify and address local, systemic barriers to permanency. This work has allowed PFSF to maintain consistent, sustained high performance on permanency over time.



PSF performance between SFY 2014-2015 Quarter 2 to SFY 2017-2018 Quarter 1. CBC Scorecard Performance Measure Trends, Child Welfare Dashboard.

PFSF has always had a strong staffing protocol to review cases for permanency prior to the first and second judicial review hearings. Permanency Staffings are scheduled for cases with length of out of home care stay at 4 months and 8 months. The Permanency Staffings focus on Conditions for Return to identify cases that can be reunified with a safety plan. If cases are not able to reunify, action steps to address barriers and preparation for a goal change are identified so recommendations regarding a change in permanency goal can be made at the earliest opportunity before the court.

In 2015, PFSF started the Safe Reduction Workgroup (SRW) that addresses barriers to permanency in the thirteen-county area. First implemented in Alachua county, the workgroups work through local systemic issues to further permanency options for children and address stakeholder barriers. Prior to the 2015 kickoff of the SRW, PFSF received technical assistance from Casey Families. SRW continues to this day addressing barriers, large and small, as they arise. Barriers addressed include ensuring service delivery to rural areas, slow judicial dockets, or strengthening stakeholder collaboration.

PFSF's performance in Exiting Children to Permanent Homes within 12 months reflects a focus on early permanency planning for children in out of home care and addressing those barriers early on within the local community.

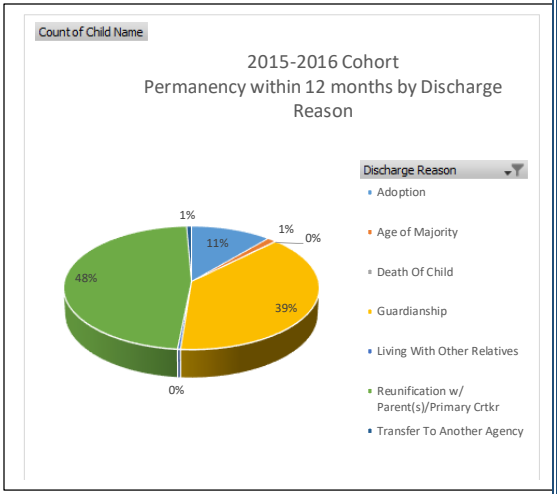
CBC Context

PFSF serves thirteen primarily rural counties over two judicial circuits in the Northeast Region. PFSF serves counties within two judicial circuits; Eighth Judicial Circuit: Alachua, Baker, Bradford, Gilchrist, Levy and Union; Third Judicial Circuit: Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, and Taylor. The service area covers a vast area over 8,000 square miles of predominantly rural territory serving a combined population of approximately 583,444. Approximately 45% of the population is in Alachua County with an estimated population of 263,496.

Practice Detail

This section contains three parts; a description of the core elements of the practice, a description of barriers encountered and ways they are addressed, and the resources used to implement the practice.

Core elements



1. <u>Permanency staffings are conducted for cases with length of stay at 4 months and 8 months</u>. They can be held daily, depending on the number of cases needed to be staffed that month. Staffings are attended by the case manager, case manager supervisor, and Operations manager, as well as family and other stakeholders and conditions within the case warrant. The Permanency Staffing focuses on Conditions for Return to assist in identifying early reunifications. Permanency Staffing agendas are generated based on length of stay at 4 and 8 months with a design to have the cases staffed prior to the judicial review milestones. The staffing focus on Conditions for Return helps to identify cases that are nearing readiness for reunification assessment and in home safety planning as well as identifying steps that would help prepare the case for a change in permanency goal should that become necessary. Beginning in 2014, Family Functioning Assessment Progress Updates are used to inform the discussion and decision making. Utilizing the formalized assessment work product streamlined the staffing preparation and focused the decision making on the ongoing case assessment regarding Conditions for Return. Including parents and caregivers in early Permanency Staffings helps establish reasonable efforts to engage parents in planning, services, and efforts toward reunification. Assisting parents and caregivers in understanding Conditions for Return requirements helps set shared expectations regarding what is necessary to move forward with reunification. Of children in the cohort for the calendar years 2015 and 2016, 71% of children who achieved reunification were reunited with their family prior to the end of the 9th month in out of home care. Of the children who achieved permanency through placement with a permanent guardian, 65% did so prior to the end of the 9th month in out of home care.

2. <u>Safe Reduction workgroups were established for each Judicial Circuit</u>. Participants from PFSF, the Department of Children and Families, Children's Legal Services, Regional Council, Guardian ad Litem and the Judiciary meet regularly to discuss and address systematic barriers to timely permanency. The Safe Reduction workgroups for each Judicial Circuit allow the local teams and stakeholder to identify and address county or circuit specific challenges. The workgroups improve communication and coordination for overall better permanency outcomes of children in the system. Through the workgroups, many systemic barriers were identified and addressed for overall system improvement. The Eighth Judicial Circuit Safe Reduction workgroup was established in 2015 and replicated in the Third Judicial Circuit in January, 2017.

Barriers to permanency identified by the Workgroups and methods to address

Barriers encountered	Addressed by:
Unclear paternity delayed permanency	Processes were implemented to ensure establishment of paternity is addressed early in the case, beginning with the shelter hearings. Establishment of paternity was determined to be a critical case factor that if not addressed early would likely result in permanency delays. CLS and the courts started routinely addressing

	paternity from shelter hearings forward. Clearing up paternity issues such as cases where the child has a legal and a biological father, or the father is undetermined with early DNA testing enables the court to make findings regarding paternity.
Starter tasks	Early identification of parent tasks that directly relate to an apparent deficit that lead to the removal. These starter tasks are immediately referred to in order to expedite getting the parent engaged in treatment. This practice allows for parents to begin working toward reunification prior to the court adopting a formal case plan.
Quality Provider Reports	Processes were implemented through PFSF's Utilization Management Department to ensure timely and quality provider information is available to the court for informed decision making.
Parent Readiness assessment	Parent Readiness assessment is conducted prior to referring clients for parenting classes. This enables clients to focus on their mental health or substance abuse treatments as a priority and only adding parenting training in when the client is ready. Delaying parenting services until other key services are complete, helps prevent overloading parents with tasks upfront in a case.
Tracking "Discretion to Reunify"	Case Management Agencies track cases that the court has granted the agency "discretion to reunify" to ensure steps toward reunification are taken at the earliest opportunity that an in home safety plan is deemed sufficient to manage the danger threat.
Concurrent Planning	Filing case plans with concurrent goals up front in the case enables case managers to work toward reunification while also taking steps toward alternative permanency outcomes.
Caregiver Participation	Lead agency staff invite licensed caregivers to participate in staffings. Case management agency staff invite parents and non-licensed caregivers to participate in staffings. Family and caregiver participation assist the professionals in making well informed recommendations regarding permanency.
Conditions for Return training	PFSF in conjunction with Children's Legal Services, provided training to Regional Counsel, GAL counsel, and private attorneys for parents on Conditions for Return. The intention of the training was to better enable defense counsel to consult with their clients about safety resources that could expedite in home safety planning.
Case scrub	CLS and Safe Reduction workgroup participants conducted case scrubs for cases 12 months and older in which permanency had not yet been achieved. The reviews focused on identifying and addressing specific case barriers as well as systemic barriers resulting in delays in permanency.

Resources used to implement

PFSF Lead Agency Quality Operations Managers (5 positions) chair and manage the Permanency Staffings as a part of their duties over 13 counties served by PFSF and account for 10% of their job duties throughout the month. Additionally, two Administrative Assistant positions provide assistance with scheduling and ensuring documentation generated is entered into FSFN. Oversight is provided by PFSF Director of Quality Operations (2 positions). Case Management Organization Program Directors, supervisors, and Family Care Counselors are critical partners in the staffings.

Stakeholder participation in a Safe Reduction Workgroup depends on the barrier being addressed, so the structure of the group can ebb and flow depending on which subject matter expert(s) are needed. Typically, a workgroup member can anticipate spending 1 to 5% of their time dedicated to the SRW and its outcomes.

Staff Feedback

Feedback supports that this approach has proven effective and helps to move cases to permanency outcomes efficiently.

CLS feedback: "The 4 and 8 month staffing schedule has changed Circuits 3 and 8 for the better. Since implementation, we have been more prepared walking into both the first judicial review and the first permanency hearing. We have been able to have much more robust discussions around Conditions for Return, reunification, and possible goal changes at much earlier junctures in our cases. We are consistently in the top 3 in the state in 15+ month reunification goals, which is likely a direct result of these staffings. Permanency for our children is a top priority of our child welfare system, and the process we have in place helps us achieve permanency in a timely and effective manner." (Francine Turney, Managing Attorney, Children's Legal Services for Circuits 3 & 8)

CMO feedback: "The 4 and 8 month staffing have been integral in not only showing us where the parent stands with services and behavior change but also showing the parents that this process is working for them and not against them. For the parents that hit the ground running and are engaged in services from the start of this case this will be a quicker process, and we might be able to say at 4 or 8 months that we are ready to move from supervised visits to unsupervised visits then eventually to reunification." (Jessica Eickstedt, Program Director, Camelot Community Care)

CMO feedback: "Maintaining a strong dedicated focus for each individual family allows for our agency to ensure that children achieve the timely permanency that they deserve. Group staffings and a team focus allows for each family to be seen via every possible solution aspect that can be reached. The timely permanency in a safe and healthy environment is the upmost important foundation that can be given to a child." (Dory Young, Program Director, Devereux)

Statement from CBC leadership: "When children are removed from their caregivers, we owe the family our best efforts to determine an appropriate case plan goal and achieve it as expeditiously as possible. By focusing on common barriers and emphasizing continual assessment of conditions for return, we have reduced the time a child is under supervision. Our objective is to achieve permanency more quickly regardless of whether the goal is reunification, permanent guardianship, or adoption. One process that has served us well is a "case scrub" by CLS and case management at twelve months for those cases that still have a goal of reunification. It has highlighted paternity determination, service provision, and obtaining trial time as elements that, when approached systemically, result in an overall reduction in time to permanency." (Stephen Pennypacker, CEO, Partnership for Strong Families, Inc.)

Practice Example

HH is a 17-year-old with autism. HH spent his entire youth as the only child with a single mother, who through the years has experienced her own set of mental and medical health issues. As HH grew older,

his outbursts and symptoms would worsen, to the point that his mother, Tabitha, would become unwilling (and at times, unable) to manage him, leaving him to his own will. HH would run away for hours, destroy property, and even become physical with his mother. Instead of seeking out for preventative help through community resources, Tabitha would have HH placed under Baker Acts as these would at least give her a few days of rest. This method was not working as upon one Baker Act in June 2017, Tabitha refused to pick HH up from the facility, leaving DCF with no option but to place HH in foster care. Paternity was established at the onset of the judicial case at the shelter hearing. Shortly after DCF identified present danger, a case manager was identified to provide safety management services. During this phase, the case manager met the mother and assessed for her overall functioning. It was evident that there was more than just inadequate supervision, abandonment, or any failure to protect. Tabitha was willing but was defeated by her inability to manage HH's regressing behaviors, largely because of how much his life triggered aversive memories of her own past trauma.

Through early initiation of services, to include therapeutic intervention, the two were able to address some of their own issues, to include how they interact with one another. One of the service providers brags about how Tabitha has made clear behavioral expectations and follows through with rewards and consequences for HH. Through services, they created a sleep cycle chart, where they found that the days when HH is extremely hyper, talkative and volatile are preceded by nights of minimal sleep. Discoveries (or breakthroughs, as we like to call them) such as this have given Tabitha some confidence in her ability to manage HH's inevitable behaviors and to minimize her own reactivity.

A permanency staffing was held in October, 2017, where the mother participated and was able to articulate how the aforementioned Conditions for Return were rectified. Thanks to the collaboration of the CPI and case manager, as well as the quick assessment and service provision to the family, it became clear that HH could return home to a calm, consistent environment with a sufficient safety plan and safety services in the home. Although the caregiver was unable to attend the permanency staffing to provide a formal input, the case manager was able to articulate in her FSFN notes as well as in person at the staffing the caregiver's concurrence with Tabitha's progress and ability to care for HH safely. HH spent just 4 ½ months in foster care before his reunification with his mother. Reunification was authorized by the court as of November 2, 2017 and following a transition period, HH finally returned home on November 22nd, right in time for the holidays!

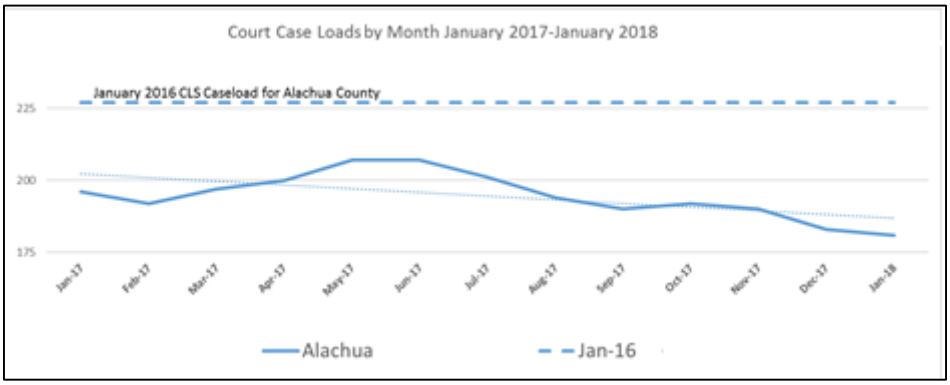
While post placement supervision is still ongoing, and HH continues to struggle to manage some of his impulses, it is clear that Tabitha's confidence as a mother has increased, as well as her ability to call for help and prevent future incidents from becoming dangerous situations for both HH and herself. Expediting critical services and the mother's participation in early permanency planning helped identify that Conditions for Return could be met with an in home safety plan allowing HH to be reunited with his mom.

Results

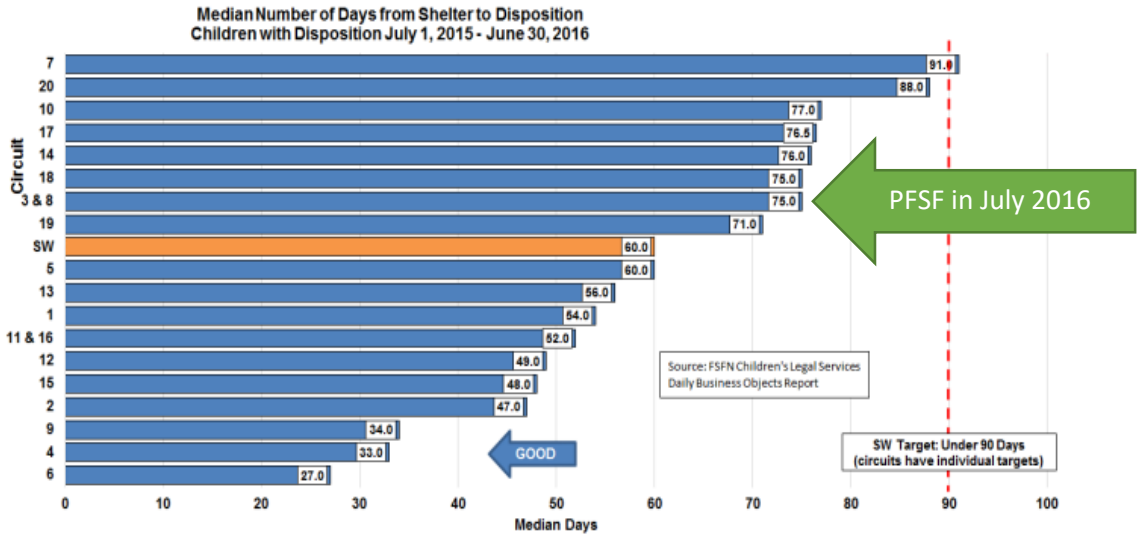
Primary benefits: PFSF performs consistency well on Federal Child Welfare Permanency Indicators (M03) Percent of children exiting foster care to a Permanent home within 12 months of entering care, (M04) Percent of children exiting foster care to a permanent home within 12 months for children in foster care 12 to 23 months and, (M05) Percent of children exiting to a permanent home within 12 months for those in care 24+ months. The focus on Conditions for Return not only helps the permanency outcomes for cases within 12 months, but also those cases with 12-23 and 24+ length of stay continue to see positive permanency outcomes.

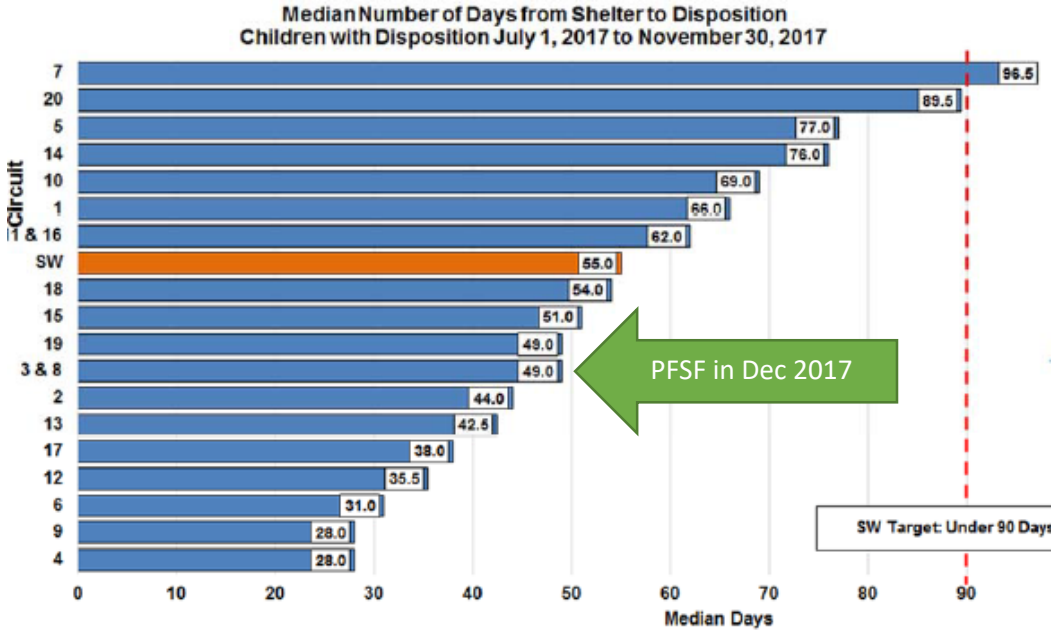
Federal Measure	FY 2015 Q4	FY 2016 Q1	FY 2016 Q2	FY 2016 Q3	FY 2016 Q4	FY 2017 Q1	FY 2017 Q2	FY 2017 Q3	FY 2017 Q4	FY 2018 Q1
M03: % of children exiting to a permanent home w/in 12 months of entering care	45.80	58.90	47.80	50.20	52.50	60.80	49.70	52.40	48.50	44.00
M04: % of children exiting to a permanent home w/in 12 months for those in care 12 to 23 months	64.10	69.80	68.80	64.10	63.20	56.70	58.80	58.00	64.90	71.00
M05: % of children exiting to a permanent home w/in 12 months for those in care 24+ months	30.70	36.90	32.70	31.80	31.60	34.90	37.50	37.60	30.60	35.40

The Safe Reduction workgroups with judiciary and local stakeholders helped identify and address barriers to permanency which resulted in overall lower numbers of court involved cases. Alachua dropped from 227 court cases in January, 2016 to 181 as of January, 2018. The Alachua reductions are indicated by the chart below. Columbia county also had a significant drop in court involved cases in the 2017 calendar year which in part can be attributed to resolving paternity establishment barriers identified through the case scrub reviews.



Through Safe Reduction workgroup efforts the Median Number of Days from Shelter to Disposition was reduced from 75 days in July 2016 (July 1, 2015-June 30, 2016) to 49 days as of December 2017 (July1, 2017-November 30, 2017). (Child Welfare Key Indicators Monthly Report)





Secondary benefits:

An early focus on permanency helps to ensure work is focused on reunification when possible and alternate permanency options when reunification is not possible. Children need stable nurturing relationships with a caregiver. Brain development science highlights how critically important stable nurturing relationships with at least one consistent adult is to a child's growth and development. PFSF consistently performs well on the measure Placement Moves per 1,000 days in Foster Care for children Entering Care. More stable placements contribute to better permanency outcomes with timely reunification or achievement of an alternate permanency goal prevents children from lingering in out of home care.

Placement Moves per 1,000 Days in Foster Care For Children Entering Care

CBC Lead Agency	10/1/14 - 9/30/15	1/1/15 - 12/31/15	4/1/15 - 3/31/16	7/1/15 - 6/30/16	10/1/15 - 9/30/16	1/1/16 - 12/31/16	4/1/16 - 3/1/17	7/1/16 - 6/30/17	10/1/16 - 9/30/17
Big Bend CBC	4.07	3.64	3.70	3.38	3.65	3.37	3.63	3.45	3.20
Families First Network	4.47	4.92	5.02	5.62	5.90	6.10	6.50	6.06	6.19
Community Partnership for Children	3.21	3.42	3.31	3.14	3.10	3.14	3.48	3.55	3.64
Family Integrity Program	2.81	2.45	2.28	2.74	2.91	3.02	3.29	3.71	5.49
Family Support Services of North Fla	2.80	3.38	3.46	3.82	3.77	4.08	4.07	3.94	3.66
Kids First of Florida, Inc.	2.87	3.04	2.92	2.47	1.79	1.72	1.65	1.40	1.95
Partnership for Strong Families	3.70	3.79	3.50	3.25	3.64	3.33	3.35	4.10	3.5
Brevard Family Partnership	3.11	2.97	2.64	3.44	4.18	3.92	3.76	3.24	3.16
Community Based Care of Central Fla	3.91	3.66	4.16	3.49	3.60	3.89	4.13	4.80	5.03
Community Based Care of Central Fla (Seminole)	4.13	3.49	3.44	3.63	3.74	3.24	3.73	3.23	3.24
Heartland for Children	3.37	2.87	2.70	3.05	3.73	3.48	3.13	2.83	2.99
Kids Central, Inc.	3.98	3.46	3.44	3.65	4.21	4.40	4.14	4.47	3.98
Childrens Network of SW Florida	5.39	5.02	5.29	5.45	6.39	6.31	6.48	6.40	5.81
Eckerd Community Alternatives	3.65	3.71	3.48	3.65	3.86	4.03	4.07	4.41	4.36
Eckerd Community Hillsborough	4.59	4.54	4.91	5.53	5.58	5.55	5.58	5.28	5.70
Sarasota Y/Safe Children Coalition	4.20	3.95	4.32	4.27	4.68	4.55	4.48	4.29	4.18
ChildNet-Broward	3.25	3.14	3.12	3.46	3.46	3.38	3.52	3.34	3.18
ChildNet-Palm Beach	3.00	2.96	3.10	3.23	3.54	3.58	3.80	3.50	4.02
Devereux CBC	4.57	3.94	3.93	3.54	4.53	4.11	4.06	3.96	3.79
Our Kids of Miami-Dade/Monroe, Inc	5.09	4.95	4.88	5.16	5.62	5.63	5.76	5.14	5.13
Statewide	**3.94**	**3.80**	**3.83**	**4.03**	**4.37**	**4.38**	**4.47**	**4.39**	**4.36**
National Standard	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12	4.12

Source: FSFN OCWDRU Report #1102: "Placement Moves Per 1,000 Days in Foster Care"

Good

PFSF

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Devereux Community Based Care

CBC Financial Viability Effective Practices

Discharges from care

2-1-2018

CBC Contact:
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Table of Contents

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Cheri Sheffer, COO

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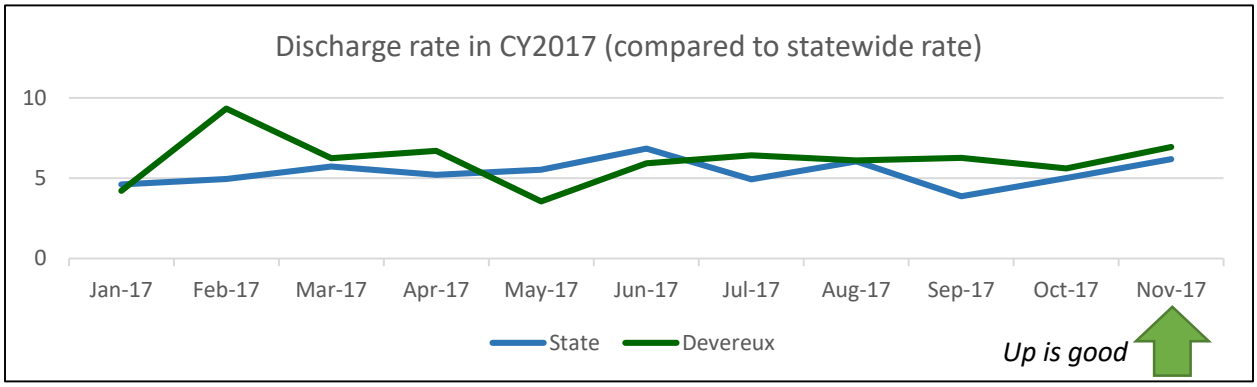
Practice Summary

Devereux Community Based Care (DCBC) uses a multi-faceted approach to managing the length of stay in out of home care, centered on early engagement with the family and our CLS and GAL partners, and early identification of and removal of barriers to permanency. The length of stay for children in care is a driver of caseload size. Longer lengths of stay also impact the utilization of group and shelters when higher numbers of children are requiring licensed care than available foster homes can accommodate. Increased caseload size and high use of group and shelter are drivers of financial instability.

CBC Context

Devereux Community Based Care (DCBC) covers Circuit 19, a four-county area: Indian River, Martin, Okeechobee, and Saint Lucie Counties. While Okeechobee is very rural, the other three are a mix of urban and rural. Historically, Circuit 19 has exceeded the state average for removals per 100 children. Therefore, maintaining a healthy discharge rate is critical. DCBC serves an average of 786 unduplicated children in out of home care each year.



When DCBC assumed lead agency operations on November 1, 2013, the discharge rate was in its second year of an all-time low and adoptions were practically non-existent in Saint Lucie County, where case management caseloads were approximately 25:1 and turnover was at an all-time high (88%). High court expectations in St Lucie County, which accounts for 50% of our cases, resulted in continued hearings, limited availability of court time and inability to move cases to permanency. Children's Legal Services (CLS) and the Guardian ad Litem (GAL) programs were impacted as well in what could be accomplished. The working relationships between the three were ~~as~~ struggling. With a change in the judiciary in Saint Lucie County in January 2014 and a renewed sense of determination among the three groups, we began to work together to plan improvement strategies.

Re-establishing trusting relationships with our CLS and GAL partners as well as the judiciary were key to implementation of several strategies:

1. re-establishing the stipulation process
2. instituting a locally designed process for rapid family engagement
3. redesigning the case transfer process
4. unit-specific monthly out of home care reviews led by the DCBC CEO and COO
5. streamlining the adoption process
6. establishing monthly Permanency Roundtable (PRT) meetings

In additions, we have established a monthly meeting with the leadership from Children's Home Society (CHS), Devereux Community Based Care (DCBC), Childrens Legal Services (CLS), Dept of Children and Families (DCF), Guardian AdLitem (GAL) and Dept of Juvenile Justice (DJJ) to maintain an ongoing dialogue and address barriers or concerns that may arise.

Practice Detail

Core elements

1. Re-established the stipulation process

   DCBC implemented partnership meetings with CLS and GAL, and with the support of these partners and the parent's attorneys, was able to implement a stipulation process for motions that streamlined and prioritized which issues needed to go to court for a hearing, and which could be agreed upon through stipulation therefore avoiding the need for hearings. Stipulations involve motions agreed upon by the parties so that a full hearing does not have to be held.

   Stipulation was agreed to circuit-wide but had the most impact in Saint Lucie County where the previous judge required that every motion be heard even if all parties agreed. The implementation was planned and implemented from January through March of 2014 and continues today.

2. Implemented Rapid Family Engagement.

   The strategy allows for Conditions for Return to be discussed with the family within five days of shelter, provides for early engagement in the case planning process and relationship building between the parent and the Dependency case manager.

   Implementation has been county-specific; Saint Lucie in October 2015, Martin and Okeechobee in March 2016, while Indian River County has not yet begun.

3. Implemented county-specific intake and operations case transfer process

   Families are invited to participate in the case transfer staffing. Because the initial FFA is completed prior to transfer, this setting lends itself to clear dialogue with the family regarding strengths and stressors, as well as service needs. Standard case transfer staffing processes were established in each county in 2014.

4. Monthly out-of-home care reviews

   Each child who is in a licensed care setting is reviewed monthly at a series of county-specific meetings, with the DCBC CEO, COO, County Director, CHS or DCBC program director and case management supervisors in attendance. Barriers to reunification and/or other permanency options are discussed and plans to address are determined at the meetings.

   Information is gathered that further assists the team in determining specific factors that are contributing to inability to secure placement in a foster home, if the current placement is in group, and to support our targeted recruitment initiative for foster homes, if indicated. If assistance is

needed from CLS or the GAL program, or barriers such as ICPC which need to be brought the attention of DCF in Tallahassee, or delays in service or treatment delivery, those connections are followed up by the CEO, COO or County staff and tracked for the following month's meeting.

DCBC began these reviews in October 2014. As of November 2017, we have added to these reviews all children in relative or non-relative placement for longer than two years. Recognition must be given to DCF Southeast Region Child Protective Investigations for the excellent job they do in finding relatives and non-relatives, which averages in the mid-50 percentile, for children coming into care.

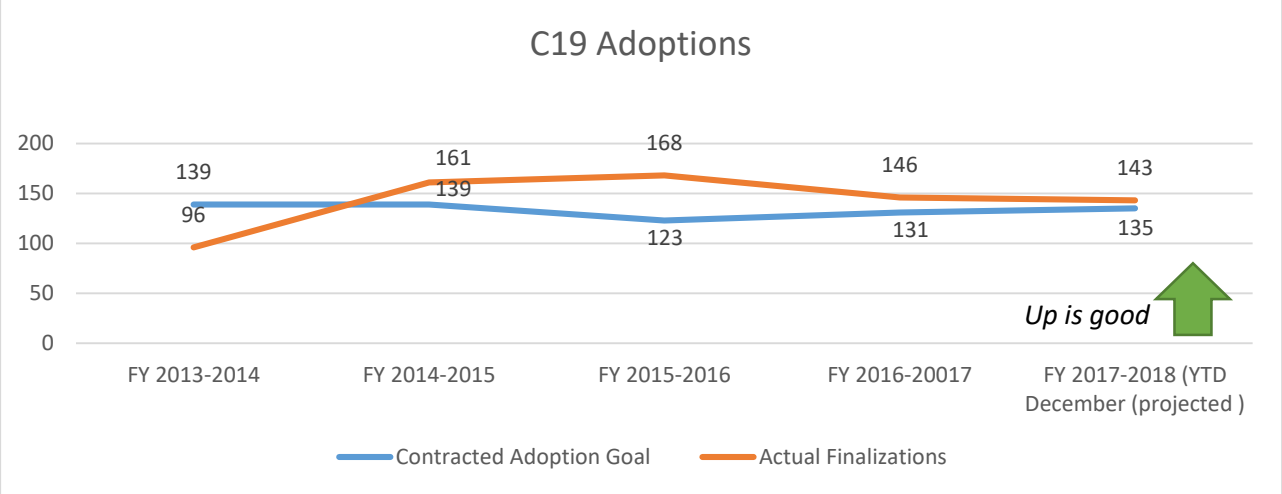
5. <u>Reorganize adoption workload to maintain continuity for children and reduce time to adoption</u>

In previous years the C19 practice had been to transfer primary case responsibility to CHS adoptions at Termination of Parental Rights (TPR). In April 2013 this was changed to allow Adoption specialists to be assigned as secondary, and Dependency case managers remain as primary worker through adoption finalization. In addition to providing case manager continuity for children, this allows adoption case management to focus on the adoption elements of the case rather than the day-to-day case management activities.

In addition, court expectations for casework that was duplicative contributed to limited availability of court time and inability to conduct other required case management tasks. In some cases, these were the key factors delaying permanency. For example, prior to January 2014 the Saint Lucie County court required their own version of the adoption home study be completed; adoption counselors were having to do two versions of the home study, taking up more valuable time. With the support of CLS and the GAL program we were able to change the Court's perspective and complete the one state-required version.

DCBC further enhanced these adoption workload efforts in January 2014 by funding a recruitment specialist so that CHS adoptions could focus on more targeted recruitment efforts for children without identified homes.

These practice changes are believed to have contributed to the substantial increase in adoption finalizations identified in the chart below.



6. Permanency Round Table (PRT) Process

With the oversight of the Casey Foundation and the strong commitment by CLS and the GAL program leadership, DCBC began the Permanency Roundtable Process (PRT) in May 2014. PRT is a process started by the Casey Foundation for children for whom permanency challenges are discussed by all parties involved with their case. Strategies are created to hopefully move them closer to permanency. To date we continue to meet monthly. In attendance are the CLS managing attorney, the GAL supervising attorney, a GAL practicing attorney, and the child's GAL. The GAL program director, the DCBC CEO and COO, along with the unit supervisor and case manager of the child being discussed attend as well as the DCBC clinical staff. The child's therapist and AAL are invited and usually attend usually by phone.

We have had much success with the PRT process due in large part to the continued support and participation of the CLS and GAL programs. Since inception, 97 children who have been in care for higher than average lengths of time have been reviewed through the PRT process, with a 38% success rate in achieving permanency as a result.

It is critical to ensure that any permanency achieved is both safe and sustainable. DCBC contracts for post-reunification safety management services through Boys Town and Behavior Basics. Staff go into the home to ensure the safety plan is being following and to provide in-home services to the family. Devereux also reviews any re-entries at our monthly scorecard meeting down to the unit level and discuss the causes of re-entry (such as the relapse of substance abuse or domestic violence).

Barriers encountered and methods to address

The environment that had been created prior to DCBC beginning operations in November 2013 was unfortunately dysfunctional. In Saint Lucie County (SLC) these was almost a paralysis of discharges or adoptions. Turnover was exceptionally high both for case management and CLS. The initial change was an agreement to work together to create the trusting relationships with our CLS and GAL partners that are needed for a successful system of care. Locally, we established in the first quarter of 2014 a monthly leadership meeting with CLS, DCF and the GAL program. County Directors now attend, and we have added the Circuit 19 Chief Probation Office to the group to address barriers or concerns that may arise across disciplines. The lines of communication are open and planning together to address barriers is the accepted practice.

Resources used to implement

The investment was in terms of human resources in time and commitment. While tracking systems were created for the out-of-home (OHC) reviews (weekly pulls created from FSFN and an Excel tracking sheet for notes) there was no financial investment. For the Case Transfer process and the Rapid Family engagement, protocols and a few forms were developed to guide the processes.

Staff feedback

In conversations with staff who have been involved with the changes we have received only positive feedback. RFE and stipulations have allowed us to get to disposition much more quickly and therefore to permanency. Standardized OHC reviews have helped to identify and address barriers to permanency which staff believe have helped case managers in knowing they are helping families. Program Directors like the process as it helps then educate staff but also gives then the ability to assess what case managers and supervisors know about their cases and what issues they may be a struggle and are needing leadership's assistance.

Practice Example

One success story that resulted specifically from the Permanency Round Table process is that of a 16 year old girl who had been in care since the age of eight. Her mother had been sent to prison for the abuse and all parental rights had been terminated. However, all the girl wanted was to go back to her mother. The PRT attendees agreed that they would attempt to locate the mother. When she was found, they found that the mother had turned her life around and was thrilled to learn that her daughter wanted to reunite.

After months of family therapy and visits, the mother and daughter were reunited. Six months later, before the case closed, Devereux CBC had an adoption ceremony to make the reunification permanent. The adoption took place two years ago and things are still going well.

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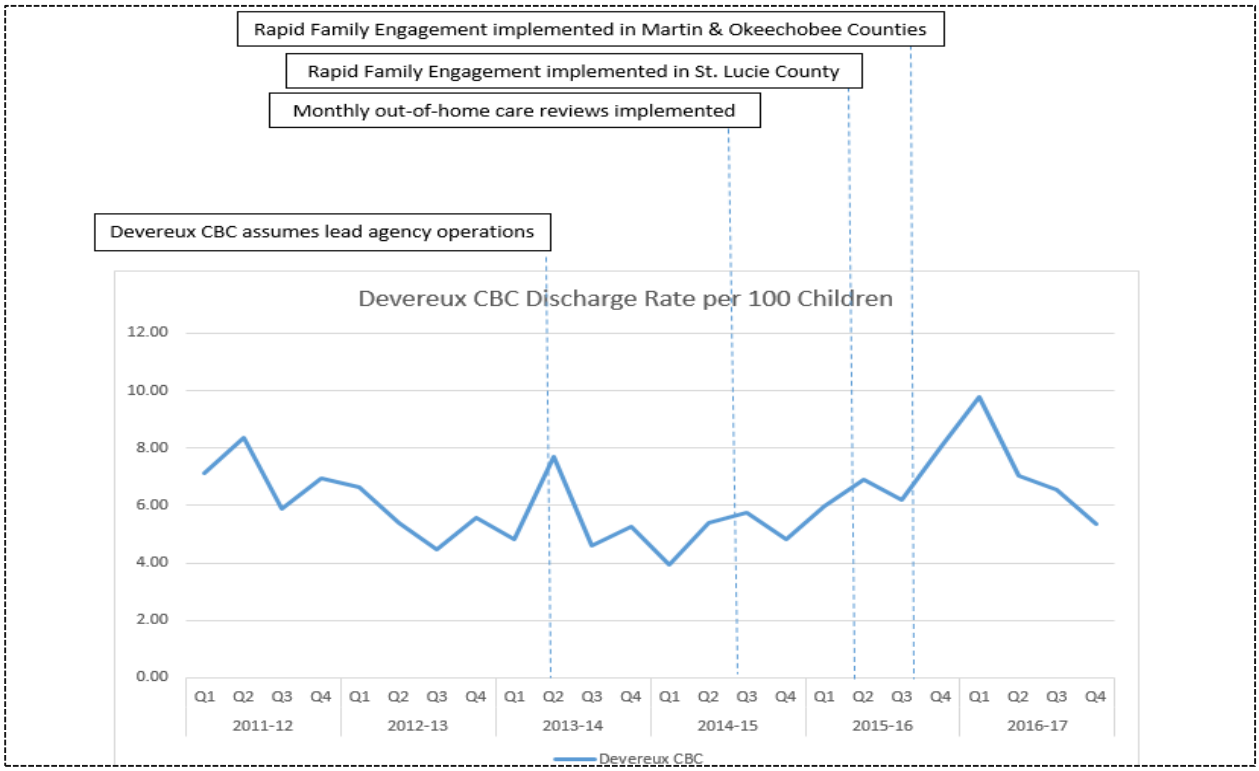
Results

Attempts to isolate and track the impact of each specific strategy has resulted in the conclusion that all the strategies are inextricably linked. However, we view the combination of strategies that involve executive-level stakeholder commitment to addressing permanency barriers, engagement of relevant court partners in strategies to streamline court processes, and early engagement of parents in case planning to have had a collective impact. The drop in discharge rate from the 2nd quarter of 16/17 to the 4th quarter has much to do with the increase in intakes, but we are still discharging in higher numbers than when we began the six practice changes in 2014.

Below is a depiction of implementation timelines for our core practice elements and other relevant systemic influences. *Note: Januarys are low as we push for discharges at holiday time and again in May as we are waiting for the end of the school year.*



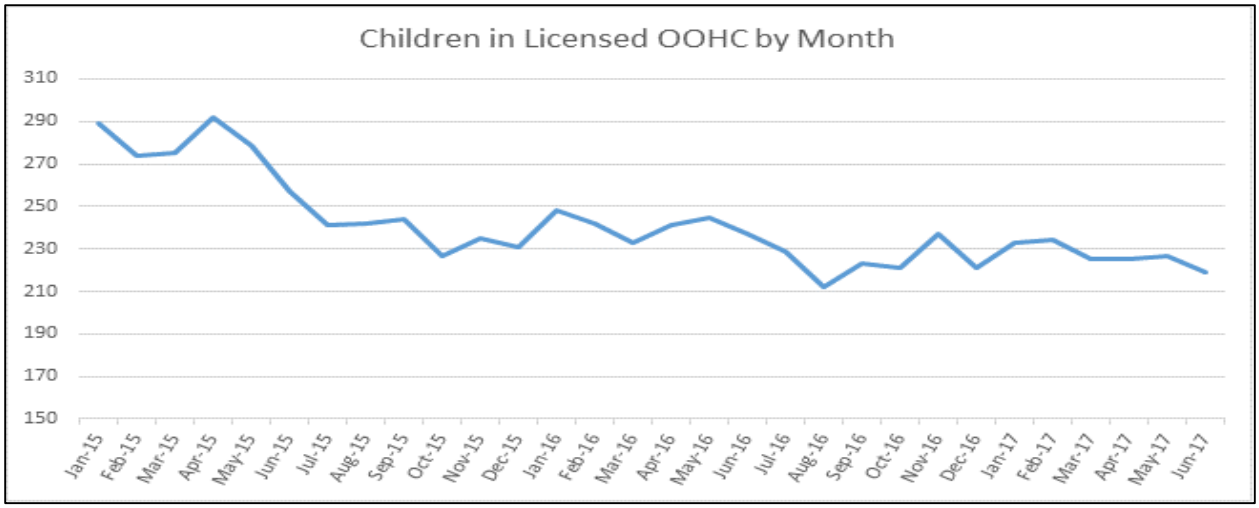
Primary Benefits

The primary benefit is the trust and teamwork that has been created between the partners, allowing for mutual planning and potential disagreement resolution. Despite continued increase in intakes, we have been able, using the processes described above, to maintain a healthy discharge rate, leading to fewer children in the system.

Secondary Benefits

Having fewer children in the system allows for lower caseloads, more ability for case managers to focus on permanency, and finally, it has resulted in fewer children in licensed OHC. The cost of licensed care is

a major factor in any CBC budget, and this reduction has had a positive impact on our financial stability. Every fiscal year since Devereux assumed the lead agency in FY 14-15 we have ended the year in the black; in the last year our carry-forward exceeded $900,000.



A benefit to the reduction in OHC is the emphasis it allowed us to focus on foster placement versus group placement. The incorporation of discussion regarding reasons for placement in group through our OOHC reviews has fueled another initiative, our Targeted Recruitment List (TRL), in which we identify children in licensed group care who can be potentially matched with available foster families, and present for placement in our monthly meetings with our four child placing agencies. While we continue to be the highest in the state for children in group care and the number varies from month to month, there has been a 23% reduction in use of group care from January 2015 to January of 2018.

The six strategies have, we believe, created a culture shift to focus on the urgency of actions and permanency, and increased the routine use and benefit of Accurint for successful relative searches. An overarching benefit has been our improved partner relationships, which have continued to expand into every area of our system, supporting our efforts to more deeply engage a broader spectrum of community partners in strengthening of our community's ability to meet the needs of children in Circuit 19.