Phase 3-Florida's Title IV-E Demonstration Waiver Interim Evaluation Report (10/01/2013-03/31/2016)

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Background

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

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

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

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

The Terms and Conditions of the Demonstration require a process, outcome, and cost analyses. Primary data was collected for this interim report via interviews and focus groups with the Department of Children and Families (DCF), Community-Based Care lead agency, and case management stakeholders. Secondary data analysis was performed with extracts from the Florida Safe Families Network (FSFN) (Florida's statewide SACWIS system), and Florida's Continuous Quality Improvement -Child and Family Services Reviews (CFSR).

Findings

Implementation analysis. The primary goal of the implementation analysis is to describe implementation of the Title IV-E Demonstration Project (the Demonstration), to track changes, and to identify lessons learned that might benefit continued implementation of the Demonstration. Interview data were coded using five overarching domains that provide a framework for conceptualizing systems change: leadership, environment, organizational capacity/infrastructure, Demonstration impact, and lessons learned.

There was agreement among stakeholders that since the initiation of Florida's Demonstration in October 2006 there has been consistency over time in Florida's vision and goal for the Demonstration: to safely reduce the number of children in out-of-home care. Changes in leadership and policy direction at federal, state, and local levels have created new priorities that affect ongoing Demonstration implementation. Spikes in out-of-home care levels and contextual variables such as domestic violence, substance abuse, mental health, and human trafficking were challenging. Respondents discussed their perceptions of the role of the media in child deaths, Florida's practice model, turnover in child protective investigators (CPIs) and case managers, and changes in how CPIs conduct investigations as contributing factors to the increases in out-of-home care.

Funding flexibility made possible through the Demonstration and its relationship to successful implementation of Florida's practice model was raised as a key strength. A challenge to this funding flexibility is the fiscal impact of a greater number of children being removed from their families. This often means recruiting and certifying new foster families and increasing case management staff, diverting resources from creative prevention and diversion services intended to be at the heart of the Demonstration. Stakeholders also reported an increase in services such as safety management, family support, prevention, diversion, and in-home. Some stakeholders also appreciated having the opportunity and ability to transition to services that are evidence-based, and/or specialized for target populations.

Services and practice analysis. The purpose of the services and practice analysis is to assess progress in expanding the service array under the IV-E Demonstration extension. This includes implementation of evidence-based practices and programs, changes in practice to improve processes for identification of child and family needs, connections to appropriate services, and enhanced use of in-home services to increase successful family preservation and reunification. Preliminary findings are presented from a set of case management focus groups conducted in various areas of the state. Findings indicate several factors that affect child welfare practice and particularly the effectiveness of family preservation efforts. While case

managers overall value family preservation and perceive the use of an in-home service approach as potentially improving the ability to address family issues, they are concerned about the ability of the system under current practice to ensure child safety. The availability of adequate services and resources to support families is one of the greatest barriers experienced by case managers. The other major barrier experienced is a lack of system cohesion, whereby case managers reported poor communication and collaboration among the various agencies and stakeholders involved with child welfare cases. The result is that there is often disagreement over how to proceed with particular cases.

Permanency and safety indicators analysis. The outcome analysis tracked changes in permanency and safety indicators in three (SFY 11-12, SFY 12-13 and SFY 13-14) successive entry and exit cohorts of children who were followed from the time they either entered the child protection system or exited out-of-home care. All indicators were calculated by the Circuit and statewide, and cohorts were constructed based on a state fiscal year (SFY). The data used to produce these indicators covered the time period SFY 11-12 through SFY 14-15 so children in all three entry cohorts could be followed for 12 months. The data sources for the quantitative child protection indicators used in this report were data abstracts taken from the Florida Safe Families Network (FSFN).

Overall, there was considerable variability among Circuits. For example, Circuit 8 had the highest permanency rate throughout the three years (between 62% and 64%), one of the lowest lengths of stay, averaging 10 months, the highest proportion of children who acquired guardianship (25%), and is among the Circuits with the highest proportion of children with adoption finalized (73% for SFY 11-12 and 70% for SFY 12-13). In contrast, Circuit 7 had one of the lowest proportions of children exiting into permanency (between 39% in SFY 11-12 and 32% in SFY 13-14), one of the highest median lengths of stay (approximately 15 months across three entry cohorts), and the lowest proportion of children reunified (21% for SFY 13-14) or acquired guardianship within 12 months of the latest removal (6% for SFY 13-14).

Similarly, Circuits 10, 11, and 13 had the lowest maltreatment rates per 1,000 child population throughout the three years (between 7% and 11%). Circuit 5 had the highest proportion of children who did not enter out-of-home care after their dependent case was opened during the examined three years (approximately 95%). Circuits 4 and 8 had the highest proportion of children without re-entry during the study period ranging from 92% to 95%.

Overall, there were two observed trends. One trend indicates a decreasing proportion of children over time who experienced expedited permanency in general and who achieved permanency for reason of reunification, guardianship or adoption. The second trend indicates

improved performance statewide on child safety based on three out of four examined indicators. Specifically, there is a decrease in the number of verified child maltreatment cases per 1,000 child population over time, an increase in the proportion of children who remained home after their dependent case was opened, and there is an increase in the proportion of children with no verified maltreatment within 6 months of services termination. Re-entry into out-of-home care remained stable over time.

Child and family well-being analysis. The constructs of child and family well-being were examined according to the applicable CFSR outcomes and performance items. These outcomes focus on improving the capacity of families to address their child's needs; and providing services to children related to their educational, physical, and mental health needs. There was substantial variation across Circuits in achieving reasonable conformity for the three well-being indicators. A few Circuits, such as Circuits 2, 10, and 14 most notably, stand out as consistently obtaining strength ratings for the relevant performance items. Across well-being outcomes and performance indicators according to these reviews, Circuits 1, 3, and 8 appear to be less effective in the quality of child welfare practices relevant to the well-being of children. The performance item related to enhancement of a family's capacity to provide for the needs of their children is an area of concern**.** This performance item rates the frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. This item was rated as a strength in only about one-third of cases statewide, however, the consistency with which the Quality Assurance (QA) teams interpreted the items and sub-items varied across the state. As the state continues to utilize the CFSR tool, it is anticipated that the QA teams will become proficient and the inner-rater reliability will significantly improve.

Cost analysis. This component examines whether there were changes in lead agency appropriations by service type between the original Demonstration period and the Demonstration extension. Data for SFY 07-08 through SFY 14-15 was used to assess changes in costs. SFY 13-14 was the first year of the Demonstration extension. The trend away from dependency services and towards prevention services continued into SFY 13-14 but then reversed in SFY 14-15. Maintenance adoption subsidies have continued to increase while expenditures for independent living services have declined. Overall, appropriations for Community-Based Care have continued to increase. It is challenging to attribute any causal relationship between the Demonstration extension and changes in appropriations or expenditures.

Sub-study: cross-system services and costs. A sub-study specific to the cost analysis examined trends in service use and costs for youth served by the child welfare system and other state systems. Medicaid enrollment and claims/encounter data for youth that received out-of-home services were analyzed. The vast majority of youth that were enrolled in the Medicaid program after removal from the home were also enrolled prior to removal. However, service penetration was much higher after removal from the home. The pattern of service use also differed before and after removal. Physical health inpatient services were more common before removal, and were likely related to the reasons for removal. Behavioral health outpatient services were much more common after removal from the home.

Several differences across time were found with more youth being removed from the home after extension of the Demonstration. The service mix also changed after the extension of the Demonstration with inpatient physical health services prior to removal becoming less common. Finally, there were a number of differences in service utilization patterns across Circuits. Medicaid funded service utilization declined after removal from the home, particularly for physical health inpatient services. However, this trend was not apparent in all Circuits, and service penetration and changes in service use varied considerably across Circuits.

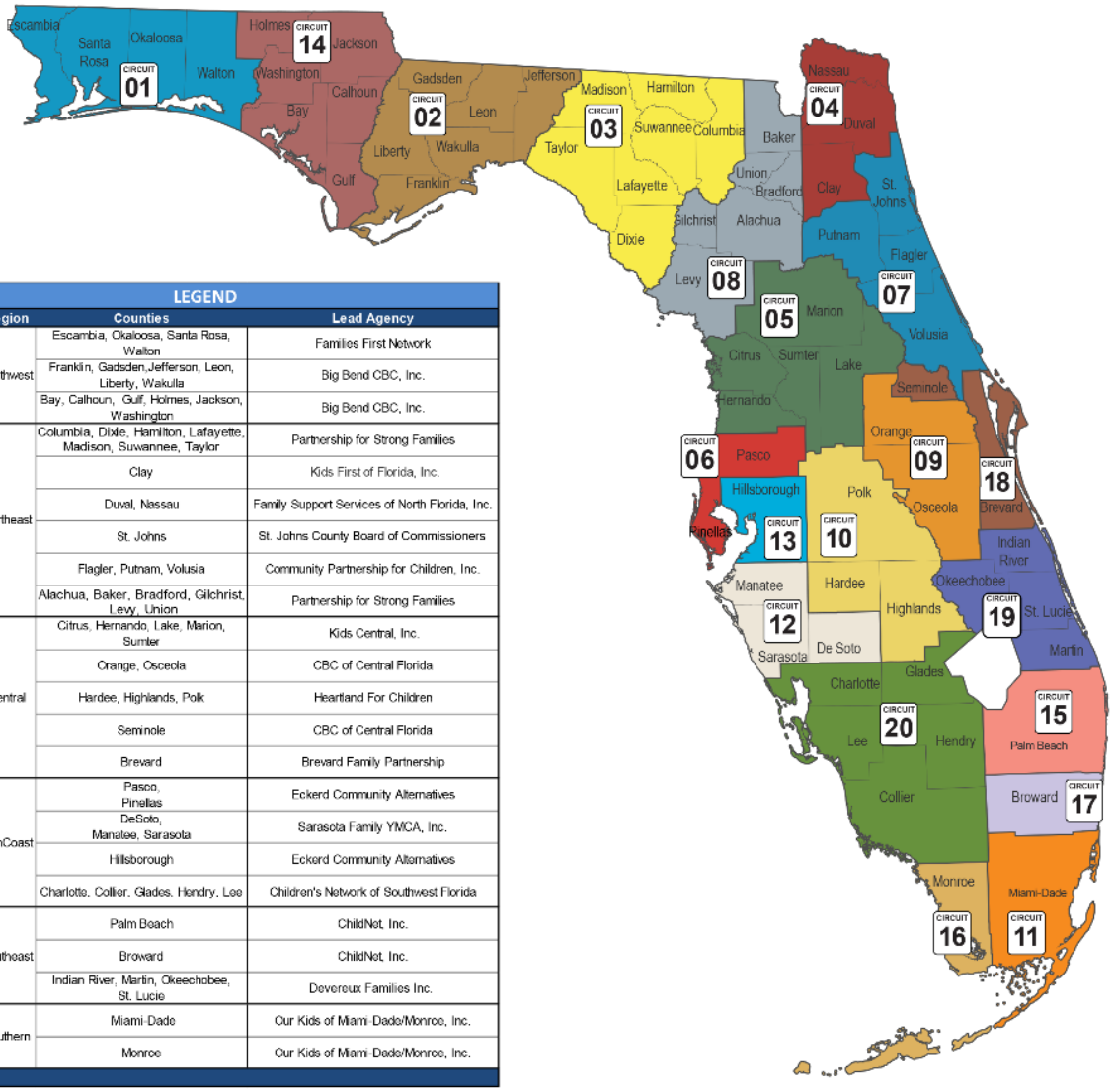
Introduction and Overview

The Florida Department of Children and Families (the Department or DCF) has contracted with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF) to develop and conduct an evaluation of Florida's Demonstration continuation that is effective through September 30, 2018. The Demonstration allows for flexibility in the use of federal IV-E funds granted to the state's child welfare agencies. The flexibility in funds allows child welfare agencies to develop and implement innovative programs that emphasize parental involvement and family connections while ensuring the safety and well-being of children.

Background and Context

The context for the Demonstration includes the recent implementation of Florida's Child Welfare Practice Model which provides a set of core constructs for determining when children are unsafe, the risk of subsequent harm to the child, and strategies to engage caregivers in achieving change. These core constructs are shared by child protective investigators (CPIs), child welfare case managers, and community-based providers of substance abuse, mental health, and domestic violence services. Other key contextual factors include the role of Community-Based Care (CBC) lead agencies as key partners with shared local accountability in the delivery of child welfare services as well as the broader system partners including the judicial system. Lead agencies are organized in geographic Circuits (see Figure 1 for the current CBC lead agency Circuit map).

Figure 1. Florida Community-Based Care Lead Agency Circuit Map



LEGEND				
Circuit	Region	Counties	Lead Agency
1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network
2		Franklin, Gadsden,Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.
14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.
3	Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families
4		Clay	Kids First of Florida, Inc.
4		Duval, Nassau	Family Support Services of North Florida, Inc.
7		St. Johns	St. Johns County Board of Commissioners
7		Flagler, Putnam, Volusia	Community Partnership for Children, Inc.
8		Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families
5	Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.
9		Orange, Osceola	CBC of Central Florida
10		Hardee, Highlands, Polk	Heartland For Children
18		Seminole	CBC of Central Florida
18		Brevard	Brevard Family Partnership
6	SunCoast	Pasco, Pinellas	Eckerd Community Alternatives
12		DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.
13		Hillsborough	Eckerd Community Alternatives
20		Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
15	Southeast	Palm Beach	ChildNet, Inc.
17		Broward	ChildNet, Inc.
19		Indian River, Martin, Okeechobee, St. Lucie	Devereux Families Inc.
11	Southern	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.
16		Monroe	Our Kids of Miami-Dade/Monroe, Inc.

Purpose of the Demonstration. The goal of the Demonstration continuation is to impart significant benefits to families and improve child welfare efficiency and effectiveness through greater use of family support services and safety services offered throughout all stages of contact with families. The evaluation design and outcome variables were selected for purposes of examining these aspects of Florida's child welfare system. The Administration for Children and Families have outlined Terms and Conditions for the Demonstration's continuation. The Terms and Conditions states that the Demonstration needs to be evaluated on the hypotheses that an expanded array of Community-Based Care services available through the flexible use of Title IV-E funds will:

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

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

Theory of Change

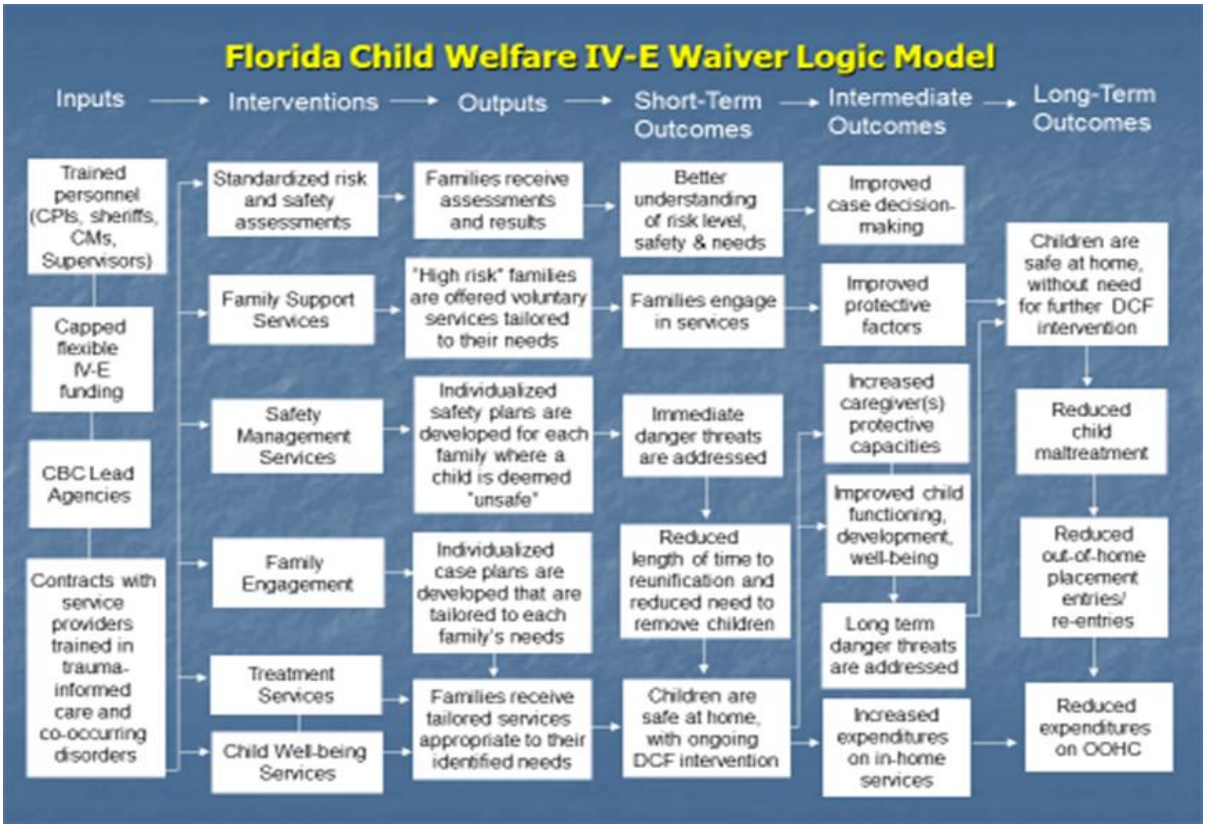
Florida's IV-E Demonstration extension is guided by a theory of change. The theory of change is based on federal and state expectations of the intended outcomes of the Demonstration, and the hypotheses about practice changes developed from knowledge of the unique child welfare service arrangements throughout the state (see Figure 2 for theory of change and logic model). The expectation is that the Demonstration extension will build on the lessons learned and progress made in Florida's child welfare system of care during the initial Demonstration period. The goals of the Demonstration are to:

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

Over the life of the Demonstration, it is expected that fewer children will need to enter out-of-home care and stays in out-of-home care will be shorter, resulting in fewer total days in

out-of-home care. Costs associated with out-of-home care are expected to decrease following Demonstration implementation, while costs associated with in-home services and prevention will increase, although no new dollars will be spent as a result of Demonstration implementation.

Figure 2. Florida Child Welfare IV-E Waiver Logic Model

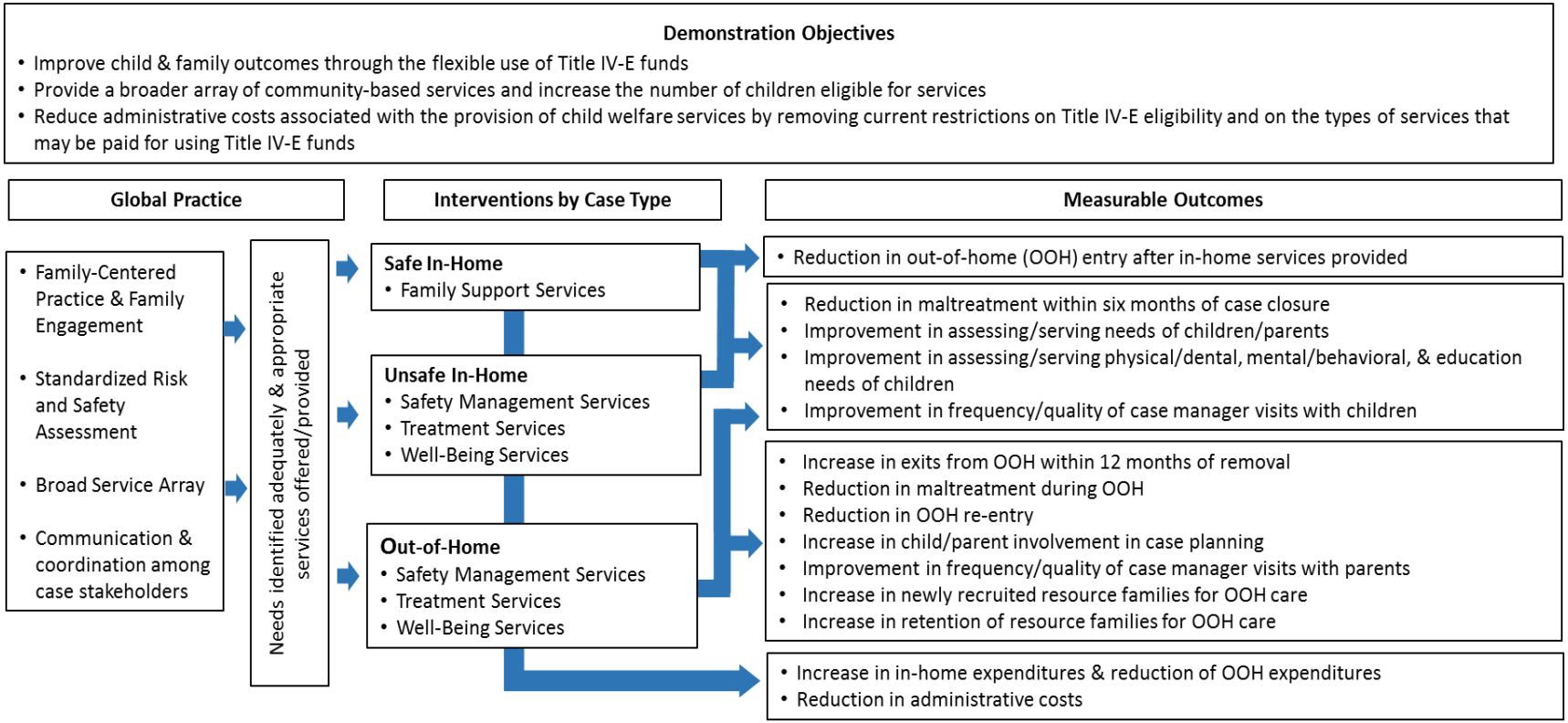


The Evaluation Framework

In addition to work completed on Florida's Theory of Change, Waiver logic model and Florida's Initial Design and Implementation Report (IDIR), USF constructed an evaluation plan for the Demonstration period and developed an evaluation specific logic model (Figure 3).

The evaluation is comprised of four related components: (a) a process analysis comprised of an implementation analysis and a services and practice analysis, (b) an outcome analysis, (c) a cost analysis, and (d) two sub-studies. The Evaluation Logic Model displays an overview of the Demonstration objectives and how the implementation of Florida's practice model can yield measurable outcomes for the Demonstration project. The four components of the evaluation and the two sub-studies are described below including key questions, data sources and data collection, and data analysis plans.

Figure 3. IV-E Waiver Demonstration Project Evaluation Logic Model



Definitions:

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

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

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

Process Analysis

The process analysis is comprised of two related research components: an implementation analysis and a services and practice analysis. Descriptions of these components are provided below.

Implementation analysis. Table 1 describes the key questions, data sources, and the projected timeline for the implementation analysis activities.

Table 1

Implementation Analysis Key Questions, Methods, and Timeline

Evaluation Questions	Methods	Timeline
1. What was the planning process for the Waiver demonstration extension?	Document review, observation	Ongoing.
2. Who was involved in implementation of the Waiver extension and how were they trained?	Document review, observation	Ongoing.
3. What were the implementation strategies used by the lead agencies (e.g., training, coaching) and the stakeholders' perceptions of success of these strategies?	Document review, observation, stakeholder interviews/focus groups	Baseline, mid-project, and final year.
4. Were the organizational supports (e.g., leadership, organizational policies, and quality assurance activities) in place to support implementation of the Waiver extension at the state and CBC levels? Were these resources utilized to implement an expanded service array?	Document review, stakeholder interviews/focus groups	Baseline, mid-project, and final year.
5. What were the confounding social, economic and political forces coinciding with implementation of the Waiver extension?	Stakeholder interviews/focus groups, logic model refinement	Baseline, mid-project, and final year.
6. What challenges were encountered during the Waiver extension implementation and how were they overcome?	Stakeholder interviews/focus groups	Baseline, mid-project, and final year.

Data analysis. Qualitative data analyses was performed to assess differences in implementation and organizational capacities during implementation of the initial Demonstration project and the extension of the Demonstration. Qualitative data was transcribed and analyzed with ATLAS.ti, a computer software program. The analysis was conducted by classifying responses into themes that comprehensively represent all participants' responses to every question. The themes were then analyzed in terms of their relation to other themes resulting in families of themes that are related in terms of topic. This process was reiterated until an overall structure is created that captures the participants' experiences as told during the interviews. The most commonly found patterns and themes are reported in the evaluation reports along with analysis of their relationships to each other. Direct quotations, when used in reports or other communications, will be edited for clarity and to remove identifying information.

Services and practice analysis. The services and practice analysis component includes a comparison of how services and practices under the Demonstration differ from those available prior to the change in Florida's practice model and Demonstration continuation period. Table 2 provides the key questions and data sources/ data collection methods.

Table 2

Services and Practice Analysis Key Questions and Methods

Evaluation Questions	**Methods**
1. What are the array of services available, including any evidence-based practices and programs?	Surveys, focus groups
2. What are the procedures for assessing child and family needs (including types of assessments used) and determining client eligibility?	Document review, focus groups
3. What are the referral processes and mechanisms?	Document review, surveys, focus groups
4. What practices are being used to effectively engage families in services?	Surveys, focus groups
5. What are the intended goals, types, and duration of services provided?	Surveys

6. What is the number of children and families served for each type of service (e.g. Family Support, Safety Management, Treatment, and Child Well-Being)?	Surveys, FSFN (to the extent that such data exist)
7. What evidence-based practices (EBPs) are being utilized, and to what extent have EBPs been implemented with fidelity?	Surveys, fidelity assessment TBD

Data analysis. The analysis includes an examination of progress in expanding the array of community-based services, supports, and programs provided by CBC lead agencies or other contracted providers, as well as changes in practice to improve processes for identification of child and family needs and connections to appropriate services.

Outcome Analysis.

The Demonstration project evaluation question(s) for each outcome focus area (child permanency, child safety, child and family well-being, and resource family recruitment and retention) are delineated in Table 3 below.

Table 3

Outcome Analysis Key Questions

Permanency Outcome Evaluation Questions

1. What is the number and proportion of all children exiting out-of-home care regardless of the reason for discharge within 12 months of the latest removal? (Entry cohorts SFYs 11-12 through 16-17)

2. What is the median length of stay for children in out-of-home care (i.e., the number of months at which half of the children are estimated to have exited out-of-home care into permanency)? (The full length of stay for every child in Entry cohorts for SFYs 11-12 through 16-17 will be utilized in the analysis. The median will be used as a summary statistic.)

3. What is the number and proportion of children who were reunified (i.e., returned to their parent or primary caregiver) within 12 months of the latest removal? (Entry cohorts SFYs 11-12 through 16-17)

4. What is the number and proportion of children who exited out-of-home care into permanent guardianship (i.e., long-term custody or guardianship by relatives or non-relatives) within 12 months of the latest removal? (Entry cohorts SFY 11-12 through 16-17)

5. What is the number and proportion of children with finalized adoptions (i.e., the date of the Court's verbal order finalizing the adoption) within 24 months of the latest removal? (This will be calculated by taking the number of children adopted within 24 months of the latest removal [numerator] and dividing by the total number

of children adopted [denominator] within the Exit cohorts for SFYs 11-12 through 16-17.)

Safety Outcome Evaluation Questions

6. What is the number and proportion of children who were removed from their primary caregiver(s) and were placed into out-of-home care within 12 months of the date their in-home case was opened? (Entry cohorts SFYs 11-12 through 16-17)

7. What is the rate of verified maltreatment as a proportion of the State's child population and/or as a proportion of the child population in each DCF Circuit? (All children in Florida that experienced verified maltreatment will be included in the numerator and all children in Florida will be included in the denominator for SFYs 11-12 through 16-17.)

8. What is the number and proportion of children that experience verified maltreatment while receiving out-of-home child welfare services? (Children served during SFYs 11-12 through 16-17)

9. What is the number and proportion of children that experience verified maltreatment within six months of case closure (i.e., termination of out-of-home services or in-home supervision)? (Exit cohorts SFYs 11-12 through 16-17)

10. What is the number and proportion of children who re-enter out-of-home care within 12 months of their most recent discharge from out-of-home care? (Exit cohorts SFYs 11-12 through 16-17)

11. What is the number and proportion of children that experience maltreatment while receiving child welfare services

Well-Being Outcome Evaluation Questions

12. Did the agency make concerted efforts (concerted efforts is determined by whether or not the agency made efforts to accurately assess children's educational needs for applicable cases? This would be noted by the presence of an educational assessment in a child's case file which includes the services provided to meet those needs as well as the services needed but not provided) to assess children's educational needs, and appropriately address identified needs in case planning and case management activities?

13. Did the agency address the physical health needs of children, including dental health needs?

14. Did the agency address the mental/behavioral health needs of children?

15. Did the agency make concerted efforts to assess the needs of and provide services to children, parents, and foster parents to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family?

16. Did the agency make concerted efforts to involve the parents and children (if developmentally appropriate) in the case planning process on an ongoing basis?

17. Were the frequency and quality of visits between caseworkers and children sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals? Sufficient is determined by the most typical pattern of face-to-face visitation between the caseworker and the child(ren) in the case. Response options for this item include more than once a week, once a week, less than once a week but at least twice a month, less than twice a month but at least once a month, less than once a month, or never. Sufficient is further determined by the quality of the visit which assesses whether the visit focused on issues pertinent to case planning, service delivery, and goal achievement.

18. Were the frequency and quality of visits between caseworkers and the mothers and fathers of the children sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals?

Resource Family Outcome Evaluation Questions

19. What is the number of new and active licensed foster families that have been recruited?

20. What is the number of licensed foster families that have remained in an active status for at least 12 months?

21. What is the average number of months licensed foster families remain in an active status?

Data sources. The outcome analysis tests the relevant hypotheses listed in the amended Florida Demonstration Project Terms and Conditions by examining a variety of child-level outcomes that are expected to result from the extension of the Demonstration project. A longitudinal design is utilized to track outcomes over the five-year extension period and focuses on the areas of child permanency, child safety, child and family well-being, and resource family recruitment and retention. Cases for seven cohorts of children will be examined. These will include five successive cohorts of children from birth to age 17 who are involved with the child welfare system during the course of the extended Demonstration period (federal fiscal years [FFYs] 13-14, 14-15, 15-16, 16-17, and 17-18), with cases for two cohorts of children from the last two federal fiscal years (FFYs 11-12 and 12-13) of the originally approved Demonstration serving as a baseline comparison. All cohorts are defined and identified using data available in the Florida Safe Families Network (FSFN).

Data analysis. Several analytic strategies have been used to answer the research questions relevant to the outcome analysis. First, multilevel Cox regression was used to answer all permanency outcome evaluation questions (with the exception of median length of stay for children in out-of-home placements) and for all safety outcome evaluation questions (with the exception of the rate of verified maltreatment as a proportion of the child population for which DCF reported data will be utilized). Multilevel Cox regression modeling is appropriate for

examining changes over time for time-to-event measures (e.g., exiting out-of-home care within 12 months and experiencing maltreatment within six months of case closure) (Cox, 1972; Singer & Willett, 2003; Muthén, & Muthén, 1998-2012). In addition, the use of multilevel Cox regression has accounted for geographic or contextual influences (i.e., DCF Circuits) on child outcomes. Multivariate analyses have been conducted to examine the effect of child demographic characteristics such as age, gender, race/ethnicity, geography (DCF Circuits), and as appropriate, placement types or settings. In addition, event history analysis using the Kaplan-Meier procedure (Kaplan & Meier, 1958) have been applied to calculate the permanency outcome of median length of stay for children in out-of-home care. Finally, Chi-square analysis has been conducted to answer the well-being evaluation questions to compare over time the proportion of cases where the efforts and activities related to each case management quality of practice standard were rated as a strength. All analyses have been done at statewide and Circuit levels.

As part of their quality assurance program, the Department is utilizing the federally-establish guidelines to conduct ongoing case reviews in accordance with the Child and Family Services Review (CFSR) process (U.S. Department of Health and Human Services, 2014). Therefore, the constructs of child and family well-being have been examined according to the applicable CFSR outcomes and performance items.

Cost Analysis.

The cost analysis examines the relationship between the Demonstration implementation and changes in the use of child welfare funding sources. The key questions and data sources are provided in Table 4 below.

Table 4

Cost Analysis Key Questions and Data Sources

Evaluation Questions	**Data Sources**
1. Was the Waiver implementation associated with a substitution from out-of-home expenditures to in-home prevention/early intervention/diversion expenditures using IV-E funding?	Florida Accounting Information Record (FLAIR), Florida DCF Office of Revenue Management, stakeholder interviews
2. How has the Waiver implementation impacted the use of other child welfare funding such as TANF and State funds?	FLAIR, Florida DCF Office of Revenue Management, stakeholder interviews
3. Is the increased flexibility of the Waiver associated with a reduction in administrative costs?	Florida DCF Office of Revenue Management

4. Was the Waiver implementation cost-effective? What services were most cost-effective?	Florida DCF Office of Revenue Management, FSFN, stakeholder interviews

Data analysis. The analysis for in-home (intervention) costs versus out-of-home service costs: (a) determines whether there is a change in expenditures between the two years immediately preceding the Demonstration extension and the five years during the Demonstration extension period, (b) determines whether there is a trend (increasing, decreasing, none) in annual expenditures from FFY 11-12 through FFY 17-18, and (c) includes data from the original Demonstration (FFYs 04-05 through 10-11) to determine whether the extended Demonstration was associated with a change in expenditure trends.

The analysis of cost neutrality is not a major component of the cost analysis. While cost neutrality is required under the Demonstration Terms and Conditions, payments under the IV-E Global Waiver program are predetermined and thus cost neutrality will be achieved under the terms of the payment methodology outlined in the Demonstration Terms and Conditions.

A cost-effectiveness analysis compares the costs of the intervention with the outcomes or "effectiveness" expressed in units that are more natural than dollars. In the analysis of cost effectiveness, the ratio of the change in costs for a type of service to the change in outcomes for each DCF Circuit is computed. The change is measured as the difference between the extended Demonstration implementation and original Demonstration implementation periods. The ratio of 'costs' to 'outcomes' will be compared across Circuits. It may be challenging to access data with sufficient detail (particularly for costs) at the Circuit level. As an alternative, costs and outcomes for all youth prior to the extended Demonstration implementation will be compared with costs and outcomes for youth after the extended Demonstration implementation.

Sub-Study 1: Cross-System Services and Costs – Cost Analysis

The first sub-study employs a cost analysis. It is important to examine how changes in the child welfare services provided to youth also affect service use and costs for other public sector systems. Specific public-sector systems that being examined are Medicaid, Juvenile Justice, and Baker Act (involuntary examinations). The analysis examines trends in service use and costs for youth served by the child welfare system and other state systems.

Sub-Study 2: Safe at Home and at High Risk for Future Maltreatment – Services and Practice Analysis/Outcome Analysis

This sub-study (not yet completed) will examine and compare child welfare practice, services, and several safety outcomes for two groups of children: (a) children who are deemed

safe to remain at home, yet are at a high or very high risk of future maltreatment in accordance with Florida's practice model (intervention group), and (b) a matched comparison group of similar cases during the two federal fiscal years immediately preceding the extension of the Demonstration (FFYs 11-12, 12-13), where the children remained in the home and families were offered voluntary prevention services. Voluntary services are/were offered to all families in both groups.

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

Implementation Status

This interim evaluation report includes findings from the process analysis (implementation analysis and services and practice analysis), outcome analysis (child safety, child permanency, and child and family well-being indicators), cost analysis, and the sub-study on cross-system services and costs. The implementation analysis summarizes finding from 21 stakeholder interviews conducted from January 2015-March 2016. The services and practice analysis section of the report summarizes the findings from the Department's Service Array Survey administered to CBC lead agencies, and preliminary findings are from 10 case management focus groups conducted in various areas of the state. The outcome analysis section of the report summarizes findings for a set of permanency and safety indicators that were selected in collaboration with the Department. The outcome analysis section also examines the status of three CFSR outcomes that focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, mental health needs. The cost analysis section summarizes findings from the cost-related results of several Demonstrations that have been evaluated across the country, and the findings from the examination of whether there were changes in CBC lead agency appropriations by type of service between the original Demonstration period and the Demonstration extension. Finally, this report includes a summary of the initial findings on the sub-study related to cross-system services and costs.

Evaluation Timeframe

The following paragraphs represent a timeline for future evaluation activities. The timelines listed below are tentative and subject to change if unanticipated delays occur in the data collection process. At this time, there are no known or anticipated challenges to completing the proposed evaluation objectives within the time frames presented.

During the next year of the Demonstration evaluation, team members will conduct additional stakeholder telephone interviews with judges, court personnel, Child Protective Investigators and their supervisors for the implementation analysis.

Completion of a set of focus groups with CPIs, full analysis of the case manager and CPI focus groups, and development and administration of the service array survey with CBC lead agencies is anticipated to be completed by September of 2016 for the services and practice analysis component of the evaluation. Development and completion of the service array survey is expected in October 2016. Anticipated completion of the survey administration is January 2017, with analysis of results expected to be complete by March 2017.

For the programmatic outcomes related to child safety and permanency, future data analysis will track progress over time on the child safety and permanency indicators that we examined for the baseline years. The effects of multiple child characteristics, such as demographics, health problems, and others that have been linked to child safety (Shaw, 2006; Yampolskaya, Armstrong, & King-Miller, 2011) and permanency (Choi & Ryan, 2007; Grella et al., 2009; McDonald et al., 2007) will also be examined. The profiles of children served in the child protection system will be examined as well, and the association between sub-groups of children with similar characteristics and child safety and permanency outcomes will be examined.

Regarding the child and family well-being outcomes, results from the ongoing Child and Family Service Reviews will be updated in each semi-annual progress report at the circuit level and statewide. The assessment of trends in CFSRs and progress towards achieving national standards for these outcomes at both the Circuit-level and the State-level will also be reported in future evaluation reports.

Future reports for the cost analysis will examine costs at the lead agency level. We will examine how the relative breakdown of the cost groups differs across lead agencies. In addition, we will assess whether such differences can be explained by differences in youth characteristics, and whether differences in costs across lead agencies for specific service groups are associated with differences in performance measures.

Future analysis for the cross-systems services and cost sub-study will examine the differences across time and across Circuits in more detail. In addition, we will examine State Substance Abuse and Mental Health Information System (SAMHIS) data to include services paid by funding sources other than Medicaid. Youth that only received DCF in-home services will also be included and compared to youth that received out-of-home services. Finally, we will examine whether service use patterns are associated with outcomes.

There have been two minor changes to the evaluation plan since the evaluation began. The first change was delaying the administration of the service array survey from year one to year two in order to eliminate redundancy with the service array survey that was being administered by DCF. The second change includes an addition of a new safety outcome (what is the number and proportion of children that experience maltreatment while receiving child welfare services) to the evaluation plan. While, completing Florida's IV-E Waiver Demonstration Evaluation Semi-Annual Evaluation Report (10/2015-03/2016) a team member recognized that the safety outcome was listed in the Terms and Conditions and not in the evaluation plan. This issue has since been corrected, and the outcome will be analyzed.

Process Analysis

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

Implementation Analysis

The goal of the implementation analysis is to identify and describe implementation of the Demonstration extension within the domains of leadership, environment, organizational capacity and infrastructure, Demonstration impact, and conclusions acquired throughout the process. This interim report includes methods for data collection and data analysis including a coding scheme, and findings from a set of key stakeholder interviews conducted during the reporting period of January 2015 through March 2016.

Key questions. The primary goal of the implementation analysis is to describe the implementation of the extended Title IV-E Waiver Demonstration and track changes regarding the following items identified in the amended Florida Terms and Conditions document:

- The planning process for the Demonstration, including whether any formal needs assessment, asset mapping, or assessment of community readiness was conducted;

- The organizational aspects of the Demonstration, such as staff structure, funding committed, administrative structures, and project implementation, including ongoing monitoring, oversight, and problem resolution at various organization levels;
- The number and type of staff involved in implementation, including the training they received, as well as their experience, education, and characteristics;
- The role of the courts in the Demonstration and the relationship between the child welfare agency and court system, including any efforts to jointly plan and implement the Demonstration extension;
- Contextual factors, such as the social, economic and political forces that may have a bearing on the replicability of the intervention or influence the implementation or effectiveness of the Demonstration extension. This discussion will note any possible confounding effects of changes in these systems, or changes resulting from other Demonstrations or reforms that were implemented during the Demonstration extension;
- The barriers encountered during the extended implementation, the steps taken to address these barriers, and any lessons learned during implementation.

Data sources and data collection. Twenty-one semi-structured stakeholder interviews were conducted via telephone with relevant stakeholders at both the lead agency and Department level in order to assess the contextual factors that may enhance or impede the implementation of the Demonstration (see Appendix A for interview protocol). Each interview was conducted with one to five stakeholders present, depending on the agency and individual preference. The interviews focused on implementation strategies, supports and resources that have been utilized, and contextual and environmental factors. Interview protocol questions were adapted slightly, in relation to the stakeholder's position, but the same domains were covered.

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

Interview data were coded using five overarching domains that provide a framework for conceptualizing systems change: leadership/commitment, environment, organizational capacity/infrastructure, Demonstration impact, and lessons learned. Data was analyzed with ATLAS.ti 6.2, a qualitative analysis computer software program. Interviewee responses were

classified into codes that comprehensively represent participants' responses to each question. Three team members participated in an interrater reliability process that achieved a reliability score of 65%. Axial coding in ATLAS.ti 6.2 was used to group codes by domain and to see how ideas and emergent themes clustered. Selective coding was applied to pull specific examples from transcripts that were illustrative of key points (see Appendix C for code list). This progress report includes the most commonly found patterns and themes from the current set of interviews.

Results.

Leadership. The first domain examined is leadership. Leadership is crucial in establishing and promoting the vision for change, creating a sense of urgency around this vision, and creating buy-in for the change effort at all levels of the system. Systems change is most likely to be successful when key leaders are committed to the change effort and share a common vision, a set of values, and accountability for achieving systems change outcomes (Armstrong et al. 2014: 104; Glisson, Dukes, & Green, 2006: 849). Interviews explored stakeholder perspectives regarding the inclusion of key leaders in the Demonstration, their commitment to the systems change effort, and the extent to which there is shared accountability across key stakeholder groups for child and family outcomes.

There was agreement among the interviewees that there has not been much change in Demonstration goals and vision since the extension. Rather the focus has been on sustaining and refining the original Demonstration intent: to safely reduce the number of children in out-of-home care. This purpose was described in various ways, such as an opportunity to keep children in the home and preserve families safely, the capacity to implement new evidence-based practices, and spending money at the front end for diversion services. One interviewee described the Demonstration as, "a paradigm shift: less about policy and procedure and more about changing the way people working in the child welfare communities are providing for the families that we serve." Similar to the views expressed by interviewees in previous Florida Demonstration evaluation progress reports, the Demonstration was characterized by one respondent as "just the way we do our work." Another respondent described the Demonstration as a tool that "enabled agencies to develop a customized system of care that is responsive to the local needs of their children and families."

When asked about the role of leadership in Demonstration implementation, respondents provided varying viewpoints. One shared viewpoint was that many individuals with consistent leadership roles in CBCs and DCF regional offices both understand and fully support the Demonstration's goals and intent. These individuals share and sustain a common vision of the

Demonstration's purpose. Another viewpoint is that changes in administration at any level create new priorities and initiatives. One example is the changes in emphasis and importance placed on reducing new entries into out-of-home care. At one point, both national and state leaders strongly supported this policy direction. Another respondent commented on the impact of changes in leadership in a local Sheriff's office that is responsible for child protective investigations. The new leader was described as "risk adverse" and there has been an increase in the number of children sheltered by investigators.

Stakeholders discussed leadership at the Department level. The current Secretary and his key staff have set a direction regarding an emphasis on ensuring the safety of children. A lead agency stakeholder described, "They [DCF leadership] have been plain that we need to do what's right for kids." A secondary emphasis was reducing out-of-home care placements where children could be safely maintained in the home. Some respondents contrasted this prioritization to the first five years of the Demonstration where they perceived more emphasis placed on decreasing out-of-home care populations across the state. From the Department's perspective priorities had not changed per se, but they had refined their methodology for determining which children were most appropriate to serve via in-home services versus out-of-home care. The point was also raised that implementation of Florida's practice model could have gone more smoothly if there had been consistency across priorities and direction between outgoing and incoming leadership of DCF.

Stakeholders were asked specifically about the past two years of the Demonstration continuation and whether there had been a clear vision for continued implementation of the Demonstration. A lead agency stakeholder commented, "I think for the most part it's pretty seamless." Interviewees agreed with this providing further clarification that there was not a lot of ongoing discussion about the Demonstration, because the Demonstration had become integrated into practice and policy. Another lead agency stakeholder commented:

> I knew that there was a lot of work done and that it was important that we got the Waiver, but it was presented in a much more holistic way of this is how we are going to treat families. Families are better off to be treated, with prevention and early intervention services that keep children in their homes.

It was at times challenging in the interviews for stakeholders to concretely describe "the Waiver" because it had served as a foundation for several years and was continuing to serve as a foundation for system wide practice change and philosophical change.

Environment. In the context of systems change, the environment refers not so much to the physical environment (which typically cannot be changed) but rather the political, social, and cultural environment in which services are provided. Building environmental capacity entails

ensuring that there is political will and community readiness and acceptance for the identified changes, and fostering an organizational and system culture that promotes open communication and creative problem solving to identify and address barriers, resistance, and conflict that may hinder successful implementation of the change effort. It includes development of system-wide structures to support implementation and shared accountability across system partners. Interviewees were asked about contextual variables that may affect the work that they do with children and families, reform efforts other than the Demonstration, and any service array or asset mapping completed in conjunction with the Demonstration. The common themes addressed by interviewees were contextual variables (domestic violence, substance abuse, mental health, and human trafficking), the impact of the media, perceptions of recent spikes in out-of-home care, reform efforts implemented in conjunction with the Demonstration, and the utilization of service array/asset mapping/needs assessments.

Interviewees spoke to a range of contextual variables including domestic violence, employment rates, human trafficking, immigration, the juvenile justice system, mental health, poverty, substance abuse, and unaccompanied minors. The contextual variables that stakeholders spoke to the most were substance abuse, mental health, domestic violence, employment, and poverty. An interviewee indicated that substance abuse with substances such as methamphetamines and heroin have led to an increase in domestic violence cases. Another respondent spoke about substances that have the largest impact on their community, “you know, heroin, there’s always been sort of your meth, your heroin, you know, your cocaine use, but probably the prescription drugs are the worst, the opiates.”

In regards to employment, stakeholders spoke to both high and low employment. One interviewee described the lack of employment opportunities and the repercussions of job loss, “…we were seeing families come to our prevention and diversion program that were not in the profile of the families that we had typically served as a result of their loss of jobs at the Space Center…” Stakeholders also noted that in some communities where the economy has improved, there are employment opportunities that could deter people from becoming an investigator or a case manager, “Alternatives for people who are in their early mid-20s, early 30s to do this work, versus going to do something that’s less stressful and pays more, when that wasn’t the case only three or four years ago, that’s had an impact.”

Some stakeholders reported that poverty has had a significant impact on their community. One interviewee mentioned that being in one of the poorest counties in the state of Florida results in a lack of safety nets and supports for families. Another interviewee stated, “I would say economic issues, particularly as it relates to families in rural areas; there may not

always be the availability of the needed services and they [the family] don't always have the means to access the services when they are available."

Substance abuse issues were indicated as a contextual factor by all respondents, but the issue was more prominent in some sites. One respondent commented on how parents with substance abuse issues are being addressed:

> "I think that the continued issue of having possibly not the right focus of services for substance abuse and mental health for the child welfare population is an issue for us. I think that both of those services often…….treat our child welfare population just like they do anybody else, anybody else that walks in the door without a full understanding of the urgency that we have because permanency is an issue and safety is an issue but also that their treatment needs to be more around helping parents build parental capacity not just fix their problem around substance abuse."

Some respondents reported that their community was experiencing an overwhelming increase in substance abuse issues:

> …We have a horrible, horrible epidemic going on with heroin in that county. So, you know, that's something I think's a barrier because our children are, you know, the children that we would get in before where we could reunify. We're actually getting children in care whose parents have overdosed and have passed away

Poverty issues were described in the general sense as a lack of understanding about how poverty might impact a family's ability to provide food and housing for their children, and that this inability to financially provide may sometimes be confused with child maltreatment. One respondent stated:

> I mean you definitely have to talk about poverty and education. And then homelessness; you have families that come to us because of homelessness and that has a very big impact on us and parents not being able to care for their children because they can't find employment and attain employment, so that is a very big impact on the people that we're dealing with.

Another respondent put the contextual variable of poverty in these terms:

> "You know, I certainly think that the lack of understanding of poverty plays a huge role, because it's not really just about money. It's much more. I think the lack of understanding about- true understanding, especially of generational poverty by legislators, by agency heads, by managers, by case managers, by CPIs… I think that is unfortunate that people don't have a better understanding including the educational system - you know, I could spend my career, the rest of my career, I think, if we just understood poverty, how much better our service delivery could be."

Respondents indicated that there was a deficit in effective approaches to treating mental health concerns throughout childhood and adolescence. An example of this concern was the

following:

> Particularly on the mental health side of things. The trauma that children incur as a result of removals and what they went through in their lives, the therapy that we apply to it, although effective, I think, for younger children, doesn't seem to be as effective with teenagers.

Another respondent stated:

> Some of the stuff just doesn't exist much. The trauma around teenagers and utilization of chemical control, for lack of a better word, as opposed to good therapeutic control, and I'm just not sure that we have, we have the adequate resources in the community to do all the things we need to do.

Based on the responses, there seems to be a lack of therapeutic resources for treating children and adolescents with significant mental health concerns.

In regards to the contextual variables of health insurance challenges some respondents indicated that they have already begun to address the issue:

> "We're having a lot of this conversation through the existence of the managing entity, that's been very helpful. The Medicaid reform and having the child welfare carved out - I think it's been helpful because really - especially now under the CBCIH, we're all partners with the organization that holds the contract with the HMOs. It really is focusing on mental health services, outcomes, and needs of the children in our care. It's going to be hard to see which part is the Waiver, and which is other reforms. We're all looking at all of these blueprints of wellbeing for children a whole lot more closely."

Another challenge is that Medicaid and managed care plans have a significant impact on the services that can be offered to families:

> "Definitely the changes to the MMA plans has impacted community mental health and substance abuse services both for children and families. We're finding shorter authorization coming through these private agencies, which then are leaving children with identified treatment needs, then again losing a funding source. So then again, you have kids who have a funding source and just because they're trying to maximize for profit gains, they become dependent because the child welfare system can access additional dollars."

These contextual factors suggest that the Demonstration can allow for growth in service delivery areas as well as engaging families, but that issues such as poverty, housing shortages, substance abuse, domestic violence, and mental health can only be lessened by collaboration between service systems at the community level.

The remaining contextual variables reported by interviewees were region-specific. Immigration and unaccompanied minors are concerns for areas like south Florida. Human trafficking is an issue that has become apparent in certain regions with some stakeholders reporting small numbers and others reporting larger numbers of cases. When stakeholders

spoke about the contextual variable of the juvenile justice system (JJS), responses ranged from agencies developing initiatives and collaboration efforts with the Department of Juvenile Justice (DJJ), and the challenge of having a large number of juvenile offenders in their region.

According to stakeholders, the most significant environmental factor affecting the child welfare system is the perceived rise in the number of children entering out-of-home care. Stakeholders noted that at the beginning of the Demonstration's implementation in 2006, there was a decrease in the number of children entering out-of-home care, but more recently, there are some major spikes in the number of children entering out-of-home care. While data indicates that the number of children in out-of-home care has decreased statewide since the implementation of the Demonstration in 2006, there has been a recent substantial increase in the number of children entering out-of-home care. One interviewee spoke to the recent rise in out of-home care and some of the implications it has had:

> I would say that we see an increase of about, I think our increase was about 88 percent [in terms of] children coming into care in the past year to year and a half. So, it's got a huge impact on caseloads, on the financial, financial aspect, and also on, it's really squeezed the service continuum as well.

Members of the evaluation team sought to confirm the widespread perception that number of children entering out-of-home care was increasing. As indicated in Table 5, the number of children that entered out-of-home care statewide has decreased (with minor increases recently) since the implementation of the Demonstration. The recent increases in out-of-home care cases are not at the level they were prior to implementation of the Demonstration.

Table 5

Number of Children that Entered Out-of-Home Care Statewide since Demonstration Implementation

SFY	Number of Children Entered OOH
2004-2005	20,987
2005-2006	20,980
2006-2007	18,003
2007-2008	15,057
2008-2009	13,704
2009-2010	13,841
2010-2011	15,217
2011-2012	15,664
2012-2013	13,705
2013-2014	15,665
2014-2015	16,563

Note. Data Source: Florida Safe Families Network
Note. Date: 03-03-2016

When asked what stakeholders believe (i.e., each stakeholder's perceptions of root causes) caused the spikes, responses ranged from factors such as the media, the amount of turnover among CPIs and case managers, and the implementation of Florida's practice model. One interviewee described the impact of the media:

> Well, it began when there were a couple of child deaths in Broward and elsewhere in the state that got some coverage in the media and particularly in the Miami Herald…We went from monthly removals typically in the low 50s to nearly 90 removals a month…

Respondents noted especially the Innocents Lost article and a series of articles run by the Miami Herald as the largest media impacts.

Another environmental variable was reform efforts (other than Florida's practice model) that agencies were able to implement in conjunction with the Demonstration extension due to the flexibility in funding they have because of the Demonstration. One respondent spoke to the expansion into trauma-informed care that they have been working on:

> We became a trauma sensitive organization, trauma sensitive community. And we worked specifically around identifying trauma triggers and working with, not just children that are traumatized by the system, but secondary and vicarious trauma that come upon the staff people working in social services.

Another respondent indicated how using data analytics is a new and exciting reform effort for the Department, "It's a very exciting time to be in child welfare. I think for the first time we're actually able to look to science in a way we haven't been able to before, using data analytics, which is a huge process that we're employing here in the Department of Children and

Families." Another respondent spoke to reform efforts that they have been able to accomplish by working with community partners:

> We work very closely with our community partners, for example United Way, where we work to establish different reforms that are specific to the community needs itself. We have some programs for example, we have a mentoring program that the state gave a onetime allocation and then they set up the program…

Indications of community support and political support varied by stakeholder. Some stakeholders reported a belief that they have political support, "we definitely have political support; our local representative and senator have been big advocates for the agency." Other stakeholders either did not address this issue or were less focused on the need for political support. A few stakeholders reported that some legislation is in need of an update or that legislation may have some unintended consequences.

Interviewees reported that since the implementation of the Demonstration they have built relationships with community partners. One interviewee spoke to the CBCs' impact within their communities:

> And then socially I do believe that the CBC has really had an impact in the community in terms of raising awareness and really being able to connect the community in a way that perhaps from a state perspective we haven't been able to do historically around child welfare.

Another interviewee commented:

> The community speaks to us as to what they want to see, what outcomes they want for the families, and where they feel like gaps in services present themselves. And so the Waiver allows us to be responsive to the community feedback and input and not to have to live, you know, within those silos of funding.

In order to facilitate positive collaboration with community partners, interviewees reported participating in active communication with judges, DCF stakeholders, and Children's Legal Services (CLS). One stakeholder spoke about their initiatives to increase collaboration:

> So, we've, you know, really try and ramp up and do what we can in working with children's legal services. We go out and we really promote our diversion services and try and make sure that everyone is very well educated on that and our opportunities for helping families outside of the child welfare system are helping to keep families together.

Stakeholders reported a variety of asset mapping and needs assessments that have occurred. Stakeholders at the Department level reported on a series of Regional Site Visits conducted in 2015:

> So those regional visits are probably one of the largest sort of needs assessments ever conducted. Before the regional visits occur, we actually did a sort of gap analysis… and we really focused on family support services and safety services.

In describing the supportive aspects of system collaboration, one respondent stated:

> We've been very fortunate this last year in getting the new funding in, but you know it takes all of our systems interfacing. Whether it's Department, juvenile justice, or child welfare, or early learning…our continuing need for organizations to work together for the funding that's needed for kids and their families.

Other respondents indicated that positive relationships with the judiciary system were supportive, as was being able to coordinate with staff in other child serving agencies that were aware of the Demonstration and its beneficial uses.

The Demonstration was seen as supportive in developing family safety services because agencies are able to use the flexibility of Demonstration funds to provide a more diverse set of services. One respondent had the following to say about family safety services and Demonstration funds:

> You know, with our new practice model, a large number of our cases are children who are found safe but have either high risk or very high risk. Whenever we are able to engage the family, which our practice model encourages, we can refer those families to family support services. They really are trying to prevent them from getting deeper into the system…So we definitely see one of the things that we think we can do is continue and increase the use of Waiver dollars to serve children in their own home - even the *unsafe* children.

Another respondent stated "The Waiver will allow us to use [service dollars] for safety services, so that will help a CPI make a determination that we can safely leave the kids at home. Or not have to shelter them." These responses indicate that the Demonstration has allowed agencies to develop more collaborative practices and allocate more funds to family safety practices that could result in fewer removals of children.

In high risk cases timing can be critical. One respondent stated "there are a couple of very big red flags in my mind. One of them very specifically is the timing at which community services are engaged with a family." Based on the responses there is a lack of agreement regarding the decision not to engage families until the assessment process is completed, rather than up front when an investigation is in process. Another respondent indicated the benefits of being able to engage high risk families sooner rather than later:

> Because we had the Waiver, we really were in a position to, with some tweaking of our existing diversion programs, retraining …we were able to stem the tide and, you know, get that back into place. And we used our diversion team as we implemented safety methodology to become the safety managers for the investigators. So now what we have is much better continuity because we're

actually engaged in a case a little sooner on the highest risk cases.

Lack of familiarity with Florida's practice model was identified as another primary barrier. The responses suggested that until CPIs and other stakeholders become familiar with Florida's practice model then there will be a tendency on the part of the CPIs to err on the side of caution and request removal, thereby bolstering a trend toward overall increases in the number of removals statewide. A specific example of this was the following response from one stakeholder:

> Right now, as I said. This whole new system process - The CPIs have to get comfortable with it. It's really not being followed the way it should. And so we're all getting like - When you're not sure what to do, you remove.

Another respondent explained how an increase in familiarity with the practice model could yield more favorable outcomes:

> …I think once we get our feet under us, with everybody becoming familiar with the new methodology, we'll be able to successfully [achieve some of the goals of the Demonstration] again. It's having to recraft the service to make sure that prevention and intervention services are meeting the needs that the CPI sees.

***Organizational capacity/infrastructure*.** This domain focuses on the organizational and system capacities that directly support the implementation and sustainability of the Demonstration. Analysis of capacity and infrastructure examines the development and implementation of policies and procedures that support effective practice, provision of training, skill-building, coaching, supervision, and technical assistance to support effective implementation of practice changes, and the availability and use of data and oversight processes to monitor implementation and support continuous quality improvement. The analysis identified strengths, challenges, and recommendations to improve organizational capacity.

When asked about organizational capacity, some CBC leaders raised issues related to funding. One issue is the funding flexibility offered by the Demonstration and its relationship to successful implementation of Florida's practice model. For example, funding is available to develop an array of safety management services to use during safety planning with a family, "now we're learning how to use safety management services, through Title IV-E funding to actually work with these families in the home on kids that we probably would have historically removed." Finally, stakeholders reflected on how the flexibility of the Demonstration has allowed CBCs to leverage other funds to expand their training opportunities, for example one CBC is utilizing "development coaches" to assist the new trainees coming out of a certification class.

A second issue is the fiscal impacts of more children coming into care that several lead agencies are experiencing. As one respondent noted, when more children come into care, increased foster home capacity becomes a focus, especially when ensuring that children are in an appropriate setting. In addition, caseloads become higher and there is a need for more case managers. A primary concern addressed in interviews was the perception that Florida had returned to a funding design that existed before the first five years (2006-2011) of the Demonstration implementation in Florida. A lead agency stakeholder described, "Florida's funding design has evolved to a place that mimics the old IV-E. The CBC allocation formula now and statutes are more about how many kids you have in care than anything else." From the perspective of lead agency interviewees, this seemed to be in stark contrast to the goals of IV-E in terms of eliminating funding incentives to bringing more kids into care than should be in care. According to the interviewees, those agencies who have kept their out of home care population down with an emphasis on prevention and diversion are more likely advocates of bringing Florida Statute and CBC allocation formulas back into alignment with the goals of the Demonstration. From the Department's perspective, although Statute and formulas have evolved over time (e.g., current law is s. 409.991, F.S., Allocation of funds for community-based care lead agencies) this remains a more complicated issue than the perception of some interviewees that a higher number of children in out of home care brings more funding to a lead agency. The evaluation will continue to delve into this area when follow up interviews are conducted with CBC and Department leadership at a later stage in the evaluation.

Many of the responses related to organizational capacity discussed the impact of the implementation of Florida's practice model, "we do better assessments, too. I was just thinking; that is one good thing is that you do better assessments. You know more about the children and you know more about the family and their functioning." Another interviewee noted that the rapid safety feedback tool was adopted that focuses on the assessment of present and impending danger and safety planning for children three and under. There was acknowledgement that the more in-depth functional family assessment process is "less incident driven" and examines the complex service needs of the entire family. Stakeholders discussed caseworker competence and skills related to caseworker knowledge about Florida's practice model and the Demonstration. Several respondents believe that the implementation of Florida's practice model is related to the spikes in out-of-home care, due to changes in how investigations are conducted, and the learning curve associated with line staff becoming familiar with a new model. Stakeholders also spoke to how some CBCs have renegotiated contracts in order to align with Florida's practice model:

> Many of the CBCs renegotiated existing contracts with their providers to align with the new practice model, to really be able to serve those safe but high risk children up front with prevention and diversion services. And then even the children that have been deemed unsafe, to have an array of safety management services that would allow them to be safely served in the home instead of having to come into care.

Several interviewees noted that the high turnover rate amongst investigators and case managers led to an inexperienced workforce that is unfamiliar with Florida's practice model. As one interviewee stated, "65 percent of your staff have been here less than a year, they're risk-adverse, and they're not willing to take a chance on a good intervention to keep a child home." There was some discussion about changes in CPS practice related to Florida's practice model including changes in how investigations are conducted, when families are offered services, and rates of child removals. There was some concern that early engagement with families by case managers was being lost. Previously, the practice was a face-to-face transition between the case manager and the investigator, while the investigation was still open. The case manager then began working with the family and connecting them with services. Under Florida's practice model, one perception was that since CPIs put in place the safety management services, there is a delay in ongoing services and the opportunity to intervene during the crisis is lost. One respondent spoke to the impact that turnover has had on CPIs' knowledge of available services:

> But we've gone out, we started doing it a quarter ago, we're trying to go out every quarter and have the same conversation again, because we get to see a bunch of new faces, and after we do it, we get a bump for a couple of weeks and then it tapers off again so, it's just one of the downfalls of too much work.

Stakeholders were asked how the role of the courts has changed. While most respondents indicated that the role of the courts had not changed since Demonstration extension, others indicated that the courts have had an impact. One respondent stated, "But judges pretty much look to the law as the end all, be all. And so I wouldn't say from their perspective their role has changed and I wouldn't say from our perspective their role has changed necessarily." Some respondents described strong collaboration with judges. One respondent indicated that in smaller counties the judicial collaboration might be more feasible than in larger counties:

> In our smaller counties, our judges are more aware and easier to work with, so they are well aware of our services that we also provide the prevention and intervention. And I would say that they utilize that and use that sometimes and order that to help families.

Interviewees were asked to discuss training and technical assistance that has been provided to prepare stakeholders to implement the Demonstration, as well as additional/on-going training and technical assistance needs. Approximately half of stakeholders who

participated in interviews did not feel that there were training needs specific to the Demonstration, with the belief that those previously trained were not experiencing any known issues with sustained implementation. Interviewees commented on the Demonstration supporting improvements in how families were engaged in services, and so from a service delivery and training level, trainings were more about the client-caseworker dynamic rather than the Demonstration. A Department stakeholder explained:

> I cannot remember training around the fact that it was IV-E Waiver. But, there has been a real emphasis on how to provide intervention services so that we don't have to remove children, which is the purpose of the Waiver.

Trainings that occurred with CPIs and Sheriff's Offices were also mentioned by stakeholders as being particularly helpful in engaging families at the front end of services and preventing families who are struggling with poverty from formally entering the child welfare system. "I think we've really tried to educate the investigators right up front to call us no matter what time, day or night, we have staff that work, you know, 24/7 just to alleviate situations like that." This stakeholder went on to describe fiscal accounts the lead agency maintained to support families in need of emergency assistance to pay for utilities and safe housing.

Interviewees were also asked to discuss processes for the collection and review of data relevant to the Demonstration. The most commonly expressed concern was continued tracking and documentation of Title IV-E eligibility. While lead agency stakeholders understood that the Federal government to have waived Florida's child welfare system from many of the IV-E reimbursement requirements, the Department is under the understanding that the Federal requirements have been maintained, and therefore view their directive to maintain eligibility compliance to be in keeping with the Federal government. A lead agency stakeholder said of the continued requirement for eligibility documentation, "I think this is one of the biggest detriments to the Waiver we have ever faced." Therefore, this issue may be more directly resolved in the immediate sense by facilitating dialogue on the topic between DCF and lead agencies, if the Federal requirement is unchanged. In addition, the Department recently launched an enhanced IV-E eligibility module that was of specific concern in terms of going against the intended flexibility of the Demonstration as well as intended reductions in administrative cost. Interviewees continued to discuss the time and staff demands related to the Department's requirement to track eligibility determination during the reporting period of 10/2015-03/2016. However, a new IV-E eligibility module in FSFN may reduce this perceived administrative burden for the CBCs.

Interviewees were asked to discuss issues pertaining to how, or to what extent or what

problems exist in the current system regarding family engagement. The primary area discussed within this topic was how families are engaged on the front end of services during the investigation process. Concern was expressed by lead agency stakeholders that practice had shifted from a more prevention/early intervention model where families are linked to immediate crisis services as soon as an investigator begins working with the family, to a model where a child and family assessment process needs to run its course before families can be offered services. From the Department's perspective, this is not the case, so the issue may be more easily resolved by improved communication and training. A lead agency stakeholder commented, "Everything that I know about human being's behavior tells me that the closer you get to the point of crisis the more likely you are to see change. I don't know why we would delay." The opposing viewpoint offered was that an assessment needs to be completed before it can be determined what services are needed. Interviewees talked about how that might make sense in theory but perhaps did not make sense in actual practice, suggesting that families might be more open to realizing that there is a problem and partnering with case managers on a voluntary basis rather than waiting until time has passed and an adversarial relationship may have set in.

***Demonstration impact*.** This domain examines ways in which the Demonstration extension affects Florida's child welfare system. The primary theme is that the Demonstration has become ingrained in the way that CBCs and case managers operate. Another major theme is that without the flexibility in funding provided by the Demonstration, CBCs would be very limited in what they could do for families and that the flexibility in funding has facilitated a variety of beneficial objectives including diversification and expansion of the service array.

When stakeholders addressed the organizational impact of the Demonstration, the conversation centered on how the Demonstration has become embedded into the everyday practice, and how not having the Demonstration would be detrimental to CBCs. It was commonly reported that the Demonstration has become an "invaluable" resource. One respondent spoke clearly to the true integration of the Demonstration into practice:

> Well, you know, it's kind of funny because we don't think about it as Title IV-E Waiver process. It is just the way we do our work. So it's wrapped up into everything we do around implementation of new practices, the way we look at, you know, service allocation, the way we look at budget, everything." Another respondent expressed this common sentiment: "…I think that the Waiver is almost a must to operate in our environment, with our business model, with Community-Based Care.

Another respondent said, "I can't overemphasize how critical the Waiver has been to our agency and I just think for the state of Florida. I just, I can't imagine states not having it, quite frankly."

Stakeholders were asked to comment on their perceptions of how the Demonstration affected removal decisions. One interviewee stated, “I think the Waiver has enabled us to truly keep children home who otherwise would be in care.” Stakeholders also responded to questions regarding whether or not the Demonstration had seemed to positively affect child level outcomes. An interviewee stated, “I think, yes, because more children are able to be served in their homes.” Another interviewee addressed how the numbers of children in out-of-home care has dropped since the implementation of the Demonstration:

> I'm sitting here looking at a statewide graph where we went from 29,255 kids in out-of-home care to 22,668 as of December 15. So obviously the, you know, 22 and a half percent reduction in total out-of-home care since December 2006.

The second greatest impact as reported by stakeholders was the diversification and growth of services that had occurred. The most common services mentioned were safety management, family support services, prevention services, diversion services, and in-home services. Some stakeholders also spoke to having the ability to transition to services that are evidence-based and/or specialized, “I think also the Waiver has allowed us to sub-contract out to professionals that have the expertise in the certain areas [where] services are needed. And we’re able to use that funding to pay for those services.” For example, one interviewee noted the value of utilizing behavior analysts to assist with maintaining placements for teens and pre-teens. Another described several unique programs such as self-esteem building among teens in foster care, a specialized scuba diving certification program, and an arts and performance camp.

Some CBCs have used the funding flexibility to leverage additional funding to implement strategies to keep the caseloads of case managers down. Keeping caseloads at a manageable level was perceived to help reduce the likelihood of turnover and increase the productivity of the case managers. One respondent stated, “We also have adopted a standard of 17 to 1 in terms of kids to caseworker ratio, which of course the flexibility and funding has allowed us to do.” Another respondent stated, “we are able to use part of that flexibility to take some of the case load off the case managers and create specialized units that can handle courtesy cases or other interstate compact cases…” Agencies have also expanded what their employees can do and what their requirements should be, “we have co-located staff at the protective investigators’ site, we just recently, probably like in the last 90 days, really, changed the core competencies required for the staff that were formerly resource coordinators.” One respondent emphasized the effects of not having the Demonstration on case management and the ability to provide services:

> [Without the Waiver] I would see an increase in the number of children per case manager. Right now we try to fund case management at the federal level of 1 to 12, 1 case manager per 12 children. You would see an increase in that so we would not beat that federal standard or it would be close to that federal standard. We probably will see more kids entering care because we wouldn't be able to provide diversion services upfront so that the children do not enter the formal child welfare system, and we wouldn't be able to provide reunification services so that children are reunified.

Reportedly, the Demonstration has had an impact on child safety and well-being by allowing agencies to be creative in the services they offer that might enable children to remain safely in the home. Respondents spoke about instances in which a CPI could have possibly removed the child, but the agency was able to step in and offer services that could keep the child safely in the home. One stakeholder stated, "I think overall kids are doing better as a result of the Waiver. Again, because it enables us to use the system in ways we otherwise wouldn't be able to do if we didn't have the Waiver." Another respondent indicated that the Demonstration has allowed them to communicate better with CPIs, so that CPIs can call if they are in a "questionable situation" regarding removing a child. A respondent noted a specific example of how the flexibility of the Demonstration makes the prevention of removals possible:

> …if we have a child that maybe was arrested through DJJ for touching his siblings, we will access those funds to put an alarm on the door so that the parents would know if the child's door opens in the middle of the night.

Other examples that were noted were putting barriers around pools, helping with means of transportation, and being able to adjust "service delivery based upon the incoming case."

The Demonstration has influenced how some CBCs are able to engage families in low-income communities. Stakeholders reported being able to target resources in counties identified as "hotspot communities" due to their high rates of crime, unemployment, and poor education outcomes. Other agencies have engaged external family supports that might be able to provide relative care for children. One respondent provided examples of strategies to engage families:

> …An anti-stigma campaign, we've built credibility with the protective investigators, we're able to engage families at the point that they experience stressors, we have probably about 15 to 20 percent of our referrals are families who are self-referring, they're calling themselves and saying, 'I need support, I need assistance.'

As noted earlier, flexibility in the utilization of funding is one of the primary themes surrounding how the Demonstration has affected lead agencies and the Department. Agencies have been able to expand their service array, utilize more family-focused services, meet a family's needs before they come into care, and provide more upfront services. One respondent

stated, “There were a lot of the changes when the initial Waiver happened, and that built a culture in the department and the lead agencies about the flexibility of funding in trying to meet the needs of families before they came into, maybe the formal system.” Another interviewee stated, “in my opinion one of the major advantages of having the Waiver is that it gives us the flexibility to purchase the services that we need based on the population shift and the need for services.” The Demonstration has also helped organizationally by allowing funds to be shifted to allow for spending in different areas such as hiring new staff and spending money on prevention programs. An interest in using IV-E funds for post adoption services was also expressed.

The Demonstration is also viewed as having an impact with judges. The interactions of child welfare caseworkers with judges appear to vary depending on the Circuit, because some judges are entering retirement and new judges are coming into the process. In general, interviewees reported that there is a positive relationship between the lead agencies and the judicial system. It was also reported that the judges may not have had enough training on the Demonstration. Respondents stated that judges know about the Demonstration and some of what it allows for, but this knowledge comes from conversations and not specific trainings on the Demonstration itself:

> A number of the justices are currently in learning mode on child welfare. We participated with the statewide court initiatives for parenting. I think that's been helpful. It doesn't directly address the Waiver. What it has enabled us to do is talk about how the outcomes that we're experiencing through our parenting programs can help facilitate more timely reunifications with children and their parents; and perhaps prevent some removals. So I don't know if we've had a conversation in the context of how the Waiver makes it possible to fund [these services].

Summary. The goal of the implementation analysis component is to identify and describe implementation of the Demonstration in terms of leadership, environment, organizational capacity and infrastructure, Demonstration impact, and conclusions. In regards to leadership, there was agreement among stakeholders that since the initiation of Florida’s Waiver in October 2006 there has been consistency over time in Florida’s vision and goal for the demonstration: to safely reduce the number of children in out-of-home care. One observation was that many individuals in leadership roles at both DCF and CBCs understand and have fully supported the Demonstration’s goals over time. There was also recognition of how changes in leadership and policy direction at federal, state, and local levels create new priorities and affect ongoing reforms such as Florida’s IV-E Demonstration.

Regarding environmental factors that influence the Demonstration, the most common factors noted by respondents were spikes in out-of-home care and contextual variables such as

domestic violence, substance abuse, mental health, and human trafficking. Regarding the reasons for increases in out-of-home care, respondents discussed their perceptions of the role of the media in child deaths, Florida's practice model, turnover in child protective investigators (CPIs) and case managers, and changes in how CPIs conduct investigations as contributing factors to the increases in out-of-home care.

Organizational capacity includes infrastructure characteristics that directly support the implementation and sustainability of the Demonstration. An organizational impact as reported by stakeholders is the diversification and growth of services that has occurred. The most common services mentioned were safety management, family support services, prevention services, diversion services, and in-home services. Some stakeholders also spoke to having the ability to transition to services that are evidence-based and/or specialized for target populations.

The most commonly expressed concern was continued tracking and documentation of Title IV-E eligibility; there was both confusion and frustration about this requirement. A key theme regarding the impact of the Demonstration was its impact on organizational structure. As noted earlier, the Demonstration has become an integral part of daily operations and has helped organizationally by allowing funds to be shifted to allow for spending in different areas such as hiring new staff and spending money on prevention and diversion programs.

Limitations. Two primary limitations exist with the implementation analysis data. First, interviews were done at the leadership level among lead agencies and Department upper level staff. The data does not yet reflect the views of stakeholders at the service delivery level or views of judges and court personnel. Second, interview data is largely based on each interviewee's perceptions of key issues. There may be instances where in a trend such as rising out-of-home care rates may be attributed to one factor specifically based on individual experience.

Services and Practice Analysis

The services and practice analysis is designed to assess progress in expanding the service array under the Demonstration extension, including the implementation of evidence-based practices and programs, and changes in practice to improve processes for identification of child and family needs and connections to appropriate services. The analysis will include a comparison of how services and practices under the extended Demonstration differ from those available prior to the extension, as well as a fidelity component once specific evidence-based practices are identified. The current report provides a review of evaluation activities and findings to date for this component of the process study.

Key questions. A comprehensive assessment of the service delivery system including changes in child welfare practice and the array of available services under the Demonstration extension is proposed for this component of the study. The services and practice analysis is guided by the following set of research questions:

1. What is the array of services available to children and families, including any evidence-based practices and programs, and what changes occur in the service array over time and across communities?
2. What are the procedures for assessing child and family needs (including types of assessments used) and determining client eligibility?
3. What are the referral processes and mechanisms?
4. What practices are being used to effectively engage families in services?
5. What are the intended goals, types, and duration of services provided?
6. What is the number of children and families served for service category (e.g. Family Support, Safety Management, Treatment, and Child Well-Being)?
7. What evidence-based practices (EBPs) are being utilized, and to what extent have EBPs been implemented with fidelity?
8. To what extent are children and families connected to appropriate services based on their identified needs?

Data sources and data collection. A mixed-methods approach has been proposed, which incorporates the administration of surveys with CBC lead agencies and case management agencies, focus group interviews with front-line staff (e.g. case managers and CPIs), observation of meetings and trainings that relate to practice and service provision, and review of relevant policy and practice documents. Evaluation activities completed thus far include review and analysis of data from a Service Array Survey administered by DCF and a series of focus groups with case managers across the state. These data sources, methods, and analyses are described in further detail for each component.

***Service array survey*.** A survey was conducted by DCF from roughly January to May of 2015 to collect data on the current array of available services across CBCs. A series of follow up site visits were also conducted by the Department with each CBC to discuss their service array and clarify responses from the survey. Originally, the evaluation plan included the administration of a service array survey during this same timeframe, but an agreement with DCF was reached to wait until Year 2 of the evaluation to administer this survey to the CBCs in order to eliminate redundancy. Members of the evaluation team also attended several of the site visits with the CBCs to observe the service array discussions. The data collected through the

DCF service array survey was shared with the evaluation team. This survey asked CBCs to provide information about Family Support Services and Safety Management Services provided in their communities, including the following:

- A description of each service provided,
- The level of evidence the service has received,
- Whether the service utilizes standardized assessments,
- Whether the service is evaluated for outcomes and effectiveness, and
- Whether the service delivery is trauma-informed.

Results were analyzed both qualitatively (e.g. content analysis) and quantitatively (frequencies of responses).

***Case management focus groups*.** Sites were selected for the focus groups at the Circuit level using a stratified random sampling process based on child removal rates (as reported in the CBC Lead Agency Trends and Comparisons Report, June 26, 2015). Circuits were stratified into three categories: low removal rates (less than five removals per 100 investigations), moderate removal rates (five to six removals per 100 investigations), and high removal rates (greater than six removals per 100 investigations). Next, two Circuits were randomly selected from each category using a random number generator. The six Circuits and corresponding CBC lead agencies selected through this process were as follows:

- Circuit 4 (Family Support Services of North Florida),
- Circuit 9 (CBC of Central Florida),
- Circuit 19 (Devereux Families, Inc.),
- Circuit 12 (Sarasota Family YMCA, Inc.),
- Circuit 11 (Our Kids of Miami-Dade/Monroe, Inc.), and
- Circuit 15 (ChildNet, Inc.).

Once sites were selected, the CEO of each CBC was contacted via email with an explanation of the evaluation activities and a request for their assistance in organizing the focus groups with their case management agencies. Five of the six CBCs responded to the request and facilitated arrangements for the focus groups with case management staff. The sixth CBC responded to the initial request, but did not respond to subsequent requests to identify a date and times for the focus groups, and therefore was unable to be scheduled within this reporting report. Focus groups were conducted from January to March of 2016. Two focus groups were conducted for each circuit to maximize the ability of case managers to participate. Focus groups varied in size from as few as four to as many as 12 participants and included case

managers who handle in-home, out-of-home, and mixed caseloads. A few of the focus groups also included other agency support staff, such as supervisors and court liaisons.

A semi-structured interview guide (see Appendix D) was used to facilitate the focus group sessions. The focus groups were audio-recorded with the permission of participants. Verbal informed consent was obtained from all participants prior to beginning the sessions. All audio files were transferred to a secure, password protected computer following the interviews and then immediately deleted from the recorder. The audio files were transcribed into a Word document and coded using ATLAS.ti 6.2, a qualitative data analysis software program. A grounded theory approach was used to identify key themes and concepts that emerged from the data. Resulting codes were further analyzed to examine their relation to one another in order to identify sets of codes that touch on similar or related topics or that frequently co-occur within the data set. This analysis is presently ongoing and currently includes case management perspectives only, so the results presented in the current report should be considered preliminary and not conclusive. Further analysis will be provided in a future report and will also include focus groups with Child Protective Investigators to provide a more balanced perspective.

Results.

***Service array survey*.** Results from the DCF service array surveys reveal a wide variety in the services provided across the state, but they also indicate considerable confusion on the part of the CBCs regarding the new service categories introduced by DCF as well as lack of understanding about levels of evidence for the programs provided in their communities. For example, of 275 services reported by the CBCs as “Family Support Services,” at least half did not actually fit the definitional criteria of Family Support Services as provided by DCF. A large number of services reported were Treatment Services (e.g. mental health assessments, counseling/therapy, domestic violence programs, etc.), as well as some Child Well-Being Services and other community resources, such as housing, which may be provided to the family using flexible IV-E funds but do not specifically qualify as a Family Support Service. Definitions were provided in the survey, so it is unclear precisely what the source of confusion was regarding the definitional criteria. The results also indicate the considerable overlap that may exist across some of the service categories, depending on the nature of the program; for example, some programs may meet the definitional criteria for Family Support Services as well as Safety Management Services, Treatment Services or Child Well-Being Services, creating a lack of clarity as to how such services should be categorized. Findings regarding Family Support Services and Safety Management Services are reported.

Family support services. There were 275 services across the responding CBCs that were identified by respondents as Family Support Services. Respondents indicated that the majority of the services identified (n = 206) are designed for families at all risk levels, based on the DCF family risk assessment. Thirteen services were reported to target families at High/Very High Risk only, 33 were reported to target families at Moderate to High/Very High Risk, and 8 services were reported to be for families at Low to Moderate Risk only. Responses to this question were missing for 15 of the reported services. Of the 275 services reported, respondents reported that 189 (68.7%) of these are documented in FSFN, although there does seem to be some variability in where staff are documenting this service delivery. Respondents indicated that 153 of these services are documented in the Family Support module. Case notes were the next most commonly reported place where service delivery is documented. It was reported that standardized assessments are used for 111 (40.4%) of these services, although many respondents indicated that they did not know whether or what kind of assessments are used (n = 139; 50.5%). Furthermore, respondents reported that only 92 (33.5%) of these services include an evaluation of client outcomes and service effectiveness by the provider. Respondents also reported that 151 (54.9%) of these services are trauma-informed in their delivery. Based on responses, it appears that a considerable number of providers require staff to complete trauma-informed care training. For 29 services, respondents either did not know if service delivery was trauma-informed or did not provide a response.

Finally, while respondents reported that 133 (48.4%) of these 275 services were "Supported-Efficacious" evidence-based programs, very few of the reported services actually included an identified program model, and only a small number of those that did identify a program model actually meet the criteria to be considered either "supported by research evidence" or a "promising practice." Level of evidence was assessed using the California Evidence-based Clearinghouse (2009) criteria, which range from Level 1 (Well-Supported by Research Evidence) to Level 5 (Concerning Practice). In reviewing the data, only 5 identified program models (reported across 7 CBCs) have sufficient research evidence to be considered supported or promising programs: Homebuilders (Level 2 Evidence: Supported by Research), Nurturing Parenting (Level 3 Evidence: Promising Research), Wraparound (Level 3 Evidence: Promising Research), Parents as Teachers (Level 3 Evidence: Promising Research), and Effective Black Parenting (Level 3 Evidence: Promising Research). Of these, Homebuilders, Nurturing Parenting, and Wraparound were the most frequently reported programs, although none of these programs appear to be implemented across significant areas of the state based on the survey responses. Since the vast majority of responses did not include sufficient

information to determine whether a manualized program model is being used, furthermore, it is difficult to fully assess the extent of evidence-based practice implementation at present.

Safety management services. There were 192 services identified across the responding CBCs as Safety Management Services. The most frequently reported services included crisis management (n = 26), supervision and monitoring (n = 25), resource support (n = 23), behavior modification (n = 21), and basic parenting assistance (n = 20). Respondents indicated that the majority (64%) of the available services are requested on a routine or consistent basis, with resource support appearing to be the least consistently requested service. These data are summarized in Table 6. Respondents further indicated that 136 (70.8%) of these services include an evaluation of client outcomes and service effectiveness by the provider, and 154 (80.2%) of the services were reported to be trauma-informed in their delivery.

Table 6

Types and Frequency of Safety Management Services Provided (n = 187)

	How often is the service requested?			
Safety Management Services	Consistently	Rarely or Never	Sporadic	**Total**
Basic Parenting Assistance	14	4	2	**20**
Behavior Modification	17	2	2	**21**
Crisis Management	15	4	7	**26**
Friendly Visiting	10	3	2	**15**
Resource Support	8	4	11	**23**
Separation	8	3	1	**12**
Social Connection	4	2	1	**7**
Social Networking	6	3	0	**9**
Stress Reduction	10	3	1	**14**
Supervision and Monitoring	21	2	2	**25**
Supervision and Monitoring as Social Connection	9	4	2	**15**
Total	**123**	**34**	**31**	**187**

Note. Data were missing for 5 of the 192 reported services
Note. Data Source: DCF Florida's Service Array Survey, 2015

Case management focus groups. Four overarching themes emerged from the analysis conducted thus far, each of which connects to a number of related codes and

concepts. These themes are as follows: 1) beliefs and values related to family preservation and the use of in-home services, 2) family assessment processes, 3) availability of community resources, and 4) lack of system cohesion. Preliminary findings related to each theme are discussed.

Family preservation. Overall case managers valued family preservation and believe that in most cases it is in the best interest of children. Most commonly, case managers referenced child well-being and the ability to better address family issues as the benefits of maintaining children in the home while working with families. Case managers unanimously emphasized the trauma that is caused by removing children, and saw preventing that trauma as the greatest benefit to in-home services. A number of case managers also expressed a sense that unnecessary removals do occur and that there is a need to prevent this from happening, although on the other hand, some case managers also perceived that there are cases in which children are kept in the home when it is not safe, and this was also a considerable concern. Child safety was the primary concern expressed by case managers regarding the use of in-home services. These concerns were also clearly connected to the liability they felt as case managers, and the perceived lack of accountability from other system partners. If anything happens to a child under their care, the case managers are the primary individuals held accountable, even though they do not have the authority to make removal decisions. If they feel that a danger threat is present, case managers must call a report in to the abuse hotline and allow CPI to assess the situation and decide whether a removal is necessary. In these situations, case managers felt that they are often ignored when they express concerns about a child's safety, but they are always the first ones held responsible if a child is harmed. These sentiments connect directly to the sense expressed across sites that there is a lack of system cohesion, discussed below.

Also frequently related to concerns about child safety were expressions of skepticism towards families. In nearly every focus group, case managers expressed doubts about the sincerity or motivations of families in complying with safety plans or case plans. Although some case managers expressed a belief that keeping children in-home served as motivation for parents in complying with services, many expressed the opposite belief and felt that, particularly on non-judicial cases, parents had no motivation to change because they still have their children in their custody and no court requirement to participate in services. Thus, there appears to be some belief that punitive actions are necessary to motivate parents to change. Many case managers were wary about the effectiveness of safety plans for ensuring child safety. However, a strategy commonly identified for helping to alleviate some of these concerns was the

incorporation of informal family supports who can help to monitor and manage safety. While there was still some skepticism expressed towards this strategy (e.g. is grandma going to be honest about the situation or is she going to cover for mom?), for the most part case managers felt that this was an appropriate approach for ensuring child safety *if* clients have family or friends available locally who can serve in this function.

Family assessment processes. The assessment of child safety, family needs, and progress and changes over time is a critical component of child welfare practice. Case managers noted that this is an ongoing process that typically incorporates various sources of information. While most noted that the assessment process begins with the allegations from CPI, many expressed that there is usually insufficient information in the allegations and further inquiry is necessary. Most frequently, case managers described the assessment of family needs as a process that includes soliciting input from the family, including extended family members when possible, and direct observation of the family. Related to this, some further noted that one of the advantages of in-home services is the ability to actually observe the family together in their natural environment, as opposed to observing them in an unnatural setting during supervised visitations. Finally, case managers emphasized that assessment and decision-making are collaborative, team-based processes that involve input from multiple stakeholders, including reports and evaluations from service providers, oversight from supervisors, and feedback from partners within the legal system (attorneys, GALs, judges, etc.). This can be a strength, since it ensures that decisions are never made in isolation, but case managers expressed that it can also be extremely challenging when all the various players are not on the same page; thus, these discussions also eluded to perceptions regarding a lack of system cohesion.

Availability of community resources. Community resources and services were simultaneously identified as one of the greatest supports and one of the greatest barriers for case managers. There was considerable variability across the participating sites in the availability of community resources. Some sites reported fairly good availability of services in their community and described strong relationships with their service providers. Among case managers in these communities, service providers were considered one of their best sources of support in their job. Providers that offer in-home services were identified as a particularly important and beneficial resource, especially for families with limited means of transportation, but not all communities have in-home service providers. Many case managers identified gaps in the availability of services in their community or limited variety of services, which make it difficult to provide services that meet families' individualized needs. Affordable housing and

transportation, in particular, were universally identified as critical resources that are lacking across communities. Availability of service providers that offer flexible appointment hours, such as evenings or weekends, was reported to be another significant challenge for families, particularly for parents trying to maintain full-time jobs. Even among communities that reported good availability of services, initiating services was frequently reported to be a problem, with many providers having insufficient capacity and long waitlists. Finally, most sites reported having at least some issues with poor quality of services and providers available in their community, and indicated that information about the effectiveness of various service interventions is generally not made available to them for informing decisions about what services to use.

Lack of system cohesion. Discussions at each of the sites indicated that one of the greatest barriers faced involves a lack of cohesion among the various partners and stakeholders that comprise the child welfare system. Case managers felt frustrated by poor communication and collaboration within the system, which they saw as a pervasive problem. They expressed that the various agencies and stakeholders with whom they must work (e.g. CPI, CLS, parents' attorneys, GALs, judges, etc.) are frequently not in agreement about how to proceed and often do not work well together. Across many of the sites, this was described as particularly prevalent with CPI. Case managers were especially concerned about the safety assessments and decisions made by CPIs, expressing that they often did not agree with these decisions and they felt the new child welfare practice model was not being implemented properly. Many case managers also reported concerns about the ways in which CPI engage with families, describing their interactions as often aggressive and disrespectful towards families, and that they often fail to adequately inform families about what to expect or in some cases actually misinform families about what will happen. Furthermore, case managers across the sites expressed that CPIs and other stakeholders (CLS, GALs, judges, etc.) often did not take their input, expertise, and opinions seriously. They perceived that they are treated with disrespect by various system stakeholders and their concerns about child safety and the families on their caseload are often disregarded, yet they are also the primary person held accountable for anything that happens on the case. This lack of cohesion across the system and the devaluation of case managers' work contribute to challenges in obtaining family buy-in, affecting the ability of case managers to engage effectively with the families on their caseload. Overall, case managers perceived that the system is experienced by families as confusing and not user-friendly, and this exacerbates the hostility and resentment frequently exhibited by system-involved families.

Summary. Findings from the service array survey administered by DCF indicated that at the time the survey was administered, there was not a clear shared understanding across CBC lead agencies of the new service categories introduced by the state, nor did lead agencies appear to have a strong understanding of how to assess the level of evidence associated with a particular practice or program. DCF did provide further clarification to lead agencies regarding the service categories during follow-up site visits. The findings also suggest that service utilization is not consistently entered into FSFN across the lead agencies. It is difficult to ascertain the extent to which evidence-based programs have been implemented statewide based on the survey results, since few respondents identified specific program models that are being used in their responses. Only five recognizable program models with an evidence-base, reported across seven lead agencies, could be identified from the survey responses.

The findings from the focus groups described here indicate several factors that affect child welfare practice and particularly the effectiveness of family preservation efforts. While case managers overall value family preservation and perceive the use of an in-home service approach as potentially improving the ability to address family issues, they are concerned about the ability of the system under current practice to ensure child safety. The availability of adequate services and resources to support families is one of the greatest barriers experienced by case managers. The other major barrier experienced is a lack of system cohesion among the various agencies and stakeholders involved with child welfare cases, which can serve to undermine the efforts of case managers in working with families to resolve child safety concerns. It must be emphasized that these results are preliminary, and represent the perspectives of case managers only.

Limitations. One limitation that should be noted for the services and practice analysis was the vast majority of responses in the service array survey did not include sufficient information to determine whether a manualized program model is being used, which enhanced the difficulty to fully assess the extent of evidence-based practice implementation at present. The overall lack of information provided by respondents about the program /service models being used was another primary limitation. Another limitation we would like to address is that the focus groups only consisted of case managers, which will be eliminated when evaluation team members conduct focus groups with CPIs.

Outcome Analysis

The major goals of the Demonstration extension are to improve outcomes for children, including safety, permanency, and child and family well-being. To achieve these objectives,

Florida has Demonstration authority to use funds for various services and the development of innovative strategies that would improve child outcomes including reduction of the risk for child re-abuse, achievement of timely permanency and promotion of child well-being.

Under the Demonstration extension, the state is able to implement and expand child welfare services and practices that would better meet the needs of children, youth, and families; implement individualized services; and use evidence-based interventions known to be effective in achieving better child safety, permanency, and well-being outcomes for children within the child welfare system. The outcome analysis for this report focuses on child permanency, safety, and well-being outcomes.

Safety and Permanency Indicators

Permanency is critical because it is inherent to the well-being of a child (U.S. Department of Health and Human Services [U.S. DHHS], 2014) and it is difficult to improve child well-being without achieving permanency. In addition, research has shown that children are at risk to experience a variety of adverse outcomes when permanency is not achieved (Aguiniga, Madden, & Hawley, 2015; Murphy, Zyl, Camargo, & Sullivan, 2012; Newton, Litrownik, & Landsverk, 2000; Zima, Bussing, Freeman, Xiaowei, Belin, & Forness, 2000).

Research also has shown that failed child safety including recurrence of maltreatment, and re-entry into out-of-home care, is associated with numerous adverse outcomes. For example, studies have demonstrated that child maltreatment is associated with poor health, mental health problems, substance abuse, juvenile delinquency, and peer rejection (Bolger and Patterson 2001; Hussey, Chang, Kotch, 2006; Kaplow & Widom 2007; Yampolskaya, Armstrong, & McNeish, 2011). Further, it negatively influences children's educational outcomes (Shonk & Cicchetti, 2001) and social skills (Rogosch & Cicchetti, 1994).

To better understand the extent to which child permanency is achieved and child safety is ensured, specific indicators were developed and calculated. The indicators were selected and developed in collaboration with DCF.

Key questions. The following permanency key questions were examined:

- What was the proportion of children who achieved permanency within 12 months of removal?
- What was median length of stay in out-of-home care?
- What proportion of children were reunified within 12 months of removal?
- What was the proportion of children who exited out-of-home care into permanent guardianship (i.e., long-term custody or guardianship by relatives or non-relatives) within 12 months of removal?

- What was the proportion of children who were adopted within 24 months of removal?

The following safety key questions were examined:

- What was the rate of verified maltreatment as a proportion of the State's child population?
- What was the proportion of children who were NOT removed from their primary caregiver(s) and were placed into out-of-home care within 12 months of the date their in-home case was opened?
- What was the proportion of children who did NOT re-enter out-of-home care within 12 months of discharge?
- What was the proportion of children who did NOT experience verified maltreatment within 6 months after either in-home or out-of-home services were terminated?

Data sources and data collection. The outcome analysis tracks changes in permanency and safety indicators in three (SFY 11-12, SFY 12-13 and SFY 13-14) successive entry and exit cohorts of children who were followed from the time they either entered the child protection system or exited out-of-home care. All indicators were calculated by the Circuit and statewide, and cohorts were constructed based on a state fiscal year (SFY). The data used to produce these indicators covered the time period SFY 11-12 through SFY 14-15 so children in all three entry cohorts can be followed for 12 months. The data sources for the quantitative child protection indicators used in this report were data abstracts taken from the Florida Safe Families Network (FSFN).

Data analysis. Statistical analyses consisted of life tables (a type of event history or survival analysis[1]), Cox regression analyses (Cox, 1972), and analysis of variance (ANOVA). All analyses were conducted using SPSS software.

Results.

Permanency indicators.

Proportion of children who exited into permanency within 12 months of the latest removal. The proportion of children who exited out-of-home care into permanency during the first 12 months was calculated for the three entry cohorts including SFY 11-12, SFY 12-13, and SFY 13-14. *"Exited into permanency"* is defined as an exit status involving any of the following reasons for discharge: (a) reunification with parents or original caregivers, (b) permanent guardianship (i.e., long-term custody or guardianship) with a relative or non-relative, (c)

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

adoption finalized, and (d) dismissed by the court (see the description of the indicator in Appendix E, Measure 1). The National Standard for Permanency in 12 months for children entering foster care is 40.5% (U.S. DHHS, 2015).

As shown in Table 7, for entry cohort SFY 11-12 Circuit 8 had the highest proportion of children exiting out-of-home into permanency within 12 months (61.8%). Circuits 7 and 19 had the lowest proportions of children exiting into permanency within 12 months (approximately 39% and 43%, respectively). The average proportion of children exiting out-of-home care into permanency within 12 months in SFY 11-12 for the state was 50.4%. For entry cohort SFY 12-13 Circuit 5 and Circuit 8 had the highest proportions of children exiting out-of-home into permanency within 12 months – approximately 60% and 61%, respectively, and Circuit 16 had the lowest proportion of children exiting into permanency – 41%. Finally, for entry cohort SFY 13-14 Circuit 8 had the highest proportion of children who achieved timely permanency (64%) and Circuit 7 had the lowest – 32%. The overall proportion of children who exited out-of-home care into permanency within 12 months for the state of Florida decreased from 50.4% for the cohort SFY 11-12 to 46.8% for the cohort SFY 13-14. Results of Cox regression analysis indicated that it was a significant decrease (see Table F1, Appendix F) although the proportion remains higher than the national standard of 40.5%.

Table 7

Number and Proportion of Children who Exited Out-of-Home Care for Permanency Reasons within 12 Months of Last Removal in the State of Florida by Cohort

Circuit	**Entry Cohort SFY 2011-2012**		**Entry Cohort SFY 2012-2013**		**Entry Cohort SFY 2013-2014**	
	Number of Cases	**Proportion Achieved Permanency (%)**	**Number of Cases**	**Proportion Achieved Permanency (%)**	**Number of Cases**	**Proportion Achieved Permanency (%)**
Circuit 1	1,053	54.3	679	47.9	860	44.2
Circuit 2	402	55.0	274	47.8	296	40.5
Circuit 3	251	56.6	265	53.6	286	44.8

Circuit 4	893	57.7	696	53.3	923	55.4
Circuit 5	1.035	57.1.0	886	59.9	904	52.5
Circuit 6	1,931	47.0	1,622	57.6	1,521	51.2
Circuit 7	1,030	39.3	765	42.9	672	32.4
Circuit 8	317	61.8	288	61.1	308	64.0
Circuit 9	818	48.2	729	46.7	822	39.5
Circuit 10	1,001	51.1	814	47.7	936	51.0
Circuit 11	1,188	48.7	1,180	44.3	1,708	44.2
Circuit 12	695	50.5	512	50.6	551	47.2
Circuit 13	1,233	53.8	1,144	51.8	1,150	54.9
Circuit 14	334	40.7	297	44.8	277	33.6
Circuit 15	741	47.0	780	47.6	1,121	52.8
Circuit 16	48	50.0	63	41.3	87	39.1
Circuit 17	803	51.1	945	45.9	1,103	38.1
Circuit 18	744	51.9	661	50.5	743	44.0

Circuit 19	500	42.6	457	44.2	472	41.3
Circuit 20	646	51.4	642	46.3	914	44.9
State of FL	15,664	50.4	13,705	49.9	15,656	46.8

Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Median length of stay for children who entered out-of-home care. Statewide performance on permanency, based on entry cohorts, was also examined by calculating the median length of stay in out-of-home care for children who exited out-of-home care, regardless of how permanency was achieved (see the description of the indicator in Appendix E, Measure 2). In fiscal year 2014, the median length of stay nationwide was 13.3 months (U.S. DHHS, 2015).

Table 8

Proportion and Median Length of Stay for Children in Out-of-Home Care in the State of Florida by Cohort

Circuit	**Entry Cohort SFY 2011-2012**		**Entry Cohort SFY 2012-2013**		**Entry Cohort SFY 2013-2014**	
	Number of Cases	**Median Length of Stay (in months)**	**Number of Cases**	**Median Length of Stay (in months)**	**Number of Cases**	**Median Length of Stay (in months)**
Circuit 1	1,053	11.6	679	12.6	860	13.4
Circuit 2	402	10.7	274	13.0	296	15.1
Circuit 3	251	10.6	265	11.5	286	13.4
Circuit 4	893	10.9	696	11.1	923	11.4
Circuit 5	1,035	10.7	886	10.4	904	11.5
Circuit 6	1,931	13.0	1,622	11.1	1,521	11.9

Circuit 7	1,030	14.2	765	13.7	672	17.8
Circuit 8	317	10.5	288	10.0	308	10.1
Circuit 9	818	12.6	729	12.9	822	15.4
Circuit 10	1,001	11.8	814	12.5	936	11.8
Circuit 11	1,188	12.4	1,180	14.3	1,708	13.8
Circuit 12	695	11.9	512	11.9	551	12.7
Circuit 13	1,233	11.5	1,144	11.7	1,150	11.5
Circuit 14	334	14.2	297	13.5	277	17.7
Circuit 15	741	12.7	780	12.6	1,121	11.5
Circuit 16	48	12.0	63	16.5	87	14.9
Circuit 17	803	11.9	945	13.5	1,103	16.2
Circuit 18	744	11.7	661	11.9	743	14.3
Circuit 19	500	14.7	457	14.4	472	14.2
Circuit 20	646	11.8	642	13.1	914	14.3
State of FL	15,664	11.9	13,705	12.0	15,656	13.0

Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Table 8 shows the median length of stay for children placed in out-of-home care in SFY 11-12, SFY 12-13, and SFY 13-14. As indicated in Table 8, children who entered out-of-home care in SFY 11-12 and who were served by Circuit 8 had the shortest median length of stay in out-of-home care (approximately 11 and a half months). Children who were served by Circuit 19 had the longest median length of stay in out-of-home care (over 14 months). The median length of stay for the state of Florida in SFY 11-12 (i.e., the number of months when 50% of children exited out-of-home care) was less than 12 months.

For SFY 12-13, Circuits 5 and 8 has the shortest median length of stay in out-of-home care (approximately 10 months) and children served by Circuit 16 had the longest median length of stay in out-of-home care (approximately 16 months). The number of months children

stayed in out-of-home care for the state of Florida for SFY 12-13 was approximately 12 months. During SFY 13-14 several Circuits, including Circuits 4, 5, 6, 8, 10, 13, and 15, had median length of stay in out-of-home care less than 12 months. The median length of stay for the state of Florida in SFY 13-14 was approximately 13 months, a significant increase compared to SFY 11-12 (see Table F2, Appendix F).

Proportion of children who were reunified with their original caregivers within 12 months. The proportions of children who entered out-of-home care in SFY 11-12, SFY 12-13, and SFY 13-14 and were discharged for reasons of reunification during 12 months after the latest removal was calculated for these entry cohorts (see the description of the indicator in Appendix E, Measure 3). There is no national standard for this indicator. As shown in Table 10, during SFY 11-12 Circuit 1 had the highest proportion of children reunified within 12 months (44%). Circuits 7 and 20 had the lowest proportions of children achieving reunification within 12 months (approximately 26%). The average proportion of children reunified within 12 months for SFY 11-12 in the state of Florida was 34% (see Table 9).

For entry cohort SFY 12-13, Circuit 13 had the highest reunification rate – 42%, and Circuit 7 had the lowest proportion of children reunified – approximately 25%. The proportion of children reunified within 12 months after placement into out-of-home care for the state of Florida during SFY 12-13 did not substantially change and remained close to 34% (see Table 9). When entry cohort SFY 13-14 was examined, Circuit 13 still had the highest reunification rate – approximately 46%, and Circuits 7 and 14 had the lowest reunifications rates (21% and 21.7%, respectively). The proportion of children reunified within 12 months of the latest removal for the state of Florida was 32.3% - a small but significant decline over time (see Table F3, Appendix F).

Table 9

Number and Proportion of Children who were Reunified within 12 Months of the Latest Removal in the State of Florida by Cohort

Circuit	**Entry Cohort SFY 2011-2012**		**Entry Cohort SFY 2012-2013**		**Entry Cohort SFY 2013-2014**	
	Number of Cases	**Proportion Reunified (%)**	**Number of Cases**	**Proportion Reunified (%)**	**Number of Cases**	**Proportion Reunified (%)**
Circuit 1	1,053	44.0	679	36.8	860	34.5
Circuit 2	402	34.3	274	35.0	296	31.1
Circuit 3	251	29.5	265	28.3	286	22.4
Circuit 4	893	31.7	696	28.6	923	25.0
Circuit 5	1,035	32.6	886	37.7	904	32.7
Circuit 6	1,931	30.4	1,622	36.4	1,521	34.3
Circuit 7	1,030	25.5	765	25.5	672	21.0
Circuit 8	317	31.6	288	26.7	308	26.3
Circuit 9	818	34.1	729	34.3	822	29.3
Circuit 10	1,001	34.1	814	30.0	936	30.8
Circuit 11	1,188	38.6	1,180	33.5	1,708	35.1
Circuit 12	695	33.4	512	29.1	551	28.3
Circuit 13	1,233	43.4	1,144	42.1	1,150	46.2
Circuit 14	334	27.5	297	33.0	277	21.7
Circuit 15	741	32.1	780	31.7	1,121	37.6

Circuit 16	48	31.3	63	33.3	87	31.0
Circuit 17	803	37.2	945	35.9	1,103	29.1
Circuit 18	744	40.5	661	37.1	743	32.2
Circuit 19	500	36.4	457	35.0	472	34.1
Circuit 20	646	25.9	642	26.3	914	31.2
State of FL	15,664	34.4	13,705	33.7	15,656	32.3

Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Proportion of children who acquired permanent guardianship within 12 months. Permanent guardianship was defined as discharge from out-of-home care for the following reasons: (a) guardianship to non-relative, (b) guardianship to relative, (c) long-term custody to relative, (d) living with other relatives, and (e) other guardianship (see the description of the indicator in Appendix E, Measure 4). There is no national standard for this indicator.

As shown in Table 10, the proportions of children who exited out-of-home care for permanent guardianship in SFY 11-12 ranged from 5% (Circuit 19) to 24% (Circuits 3 and 20). Similarly, for SFY 12-13 the proportion of children acquiring guardianship ranged from 6% (Circuits 2 and 16) to 25% (Circuit 8). For SFY 13-14 Circuit 8 had the highest proportion of children who exited out-of-home care for the reason of guardianship (28%) and Circuits 2 and 19 had the lowest (approximately 4%). The statewide proportion of children discharged into guardianship decreased from almost 13% in SFY 11-12 to 11% in SFY 13-14. The overall decrease in the proportion of children who acquired guardianship for the state of Florida was statistically significant (see Table F4, Appendix F).

Table 10

Number and Proportion of Children who Exited Out-of-Home Care into Permanent Guardianship within 12 Months of the Latest Removal in the State of Florida by Cohort

Circuit	**Entry Cohort SFY 2011-2012**		**Entry Cohort SFY 2012-2013**		**Entry Cohort SFY 2013-2014**	
	Number of Cases	**Proportion with Guardianship (%)**	**Number of Cases**	**Proportion with Guardianship (%)**	**Number of Cases**	**Proportion with Guardianship (%)**
Circuit 1	1,053	9.3	679	8.4	860	8.0
Circuit 2	402	13.2	274	6.2	296	4.1
Circuit 3	251	24.3	265	21.1	286	19.2
Circuit 4	893	11.7	696	8.6	923	11.2
Circuit 5	1.035	22.9	886	21.1	904	18.4
Circuit 6	1,931	14.8	1,622	19.0	1,521	13.7
Circuit 7	1,030	10.8	765	13.7	672	6.3
Circuit 8	317	21.1	288	25.0	308	27.9
Circuit 9	818	11.0	729	8.5	822	6.8
Circuit 10	1,001	15.4	814	14.4	936	16.6
Circuit 11	1,188	6.3	1,180	7.9	1,708	7.0
Circuit 12	695	16.6	512	19.9	551	17.8
Circuit 13	1,233	8.0	1,144	8.0	1,150	6.8
Circuit 14	334	11.1	297	6.7	277	9.0
Circuit 15	741	12.0	780	12.8	1,121	12.6
Circuit 16	48	18.8	63	6.4	87	5.8

Circuit 17	803	11.6	945	8.3	1,103	7.5
Circuit 18	744	9.5	661	11.5	743	9.0
Circuit 19	500	5.0	457	7.4	472	3.6
Circuit 20	646	23.8	642	17.8	914	12.6
State of FL	15,664	12.9	13,705	12.8	15,656	10.9

Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Proportion of children with adoption finalized. The proportion of children who entered out-of-home care and were discharged within 24 months after placement in out-of-home care because of adoption was calculated for the SFY 11-12 and SFY 12-13 entry cohorts. Entry cohorts for this indicator represents all children who were initially placed in out-of-home care and had *adoption* in their case plans as their primary goal. This indicator includes only one reason for discharge, which is "adoption finalized" (see Appendix E, Measure 5). There is no national standard for this indicator.

Table 11

Number and Proportion of Children with Finalized Adoptions within 24 Months of the Latest Removal in the State of Florida by Cohort

Circuit	**Entry Cohort SFY 2011-2012**		**Entry Cohort SFY 2012-2013**	
	Number of Cases	**Proportion with Finalized Adoption (%)**	**Number of Cases**	**Proportion with Finalized Adoption (%)**
Circuit 1	335	35.8	280	37.9
Circuit 2	93	52.7	97	53.6
Circuit 3	68	57.4	84	54.8
Circuit 4	352	74.4	313	70.3

Circuit 5	200	33.0	141	43.3
Circuit 6	547	41.0	419	39.9
Circuit 7	314	41.4	229	36.2
Circuit 8	102	72.6	104	70.2
Circuit 9	193	43.5	174	32.8
Circuit 10	180	31.1	158	50.0
Circuit 11	332	41.3	344	34.3
Circuit 12	168	35.7	158	44.9
Circuit 13	241	42.3	222	43.7
Circuit 14	109	41.3	116	44.0
Circuit 15	189	48.7	169	45.6
Circuit 16	10	20.0	11	36.4
Circuit 17	183	37.7	245	28.6
Circuit 18	147	35.4	128	18.8
Circuit 19	152	20.3	157	29.3
Circuit 20	177	36.7	198	33.3
State of FL	4,092	43.0	3,751	41.8

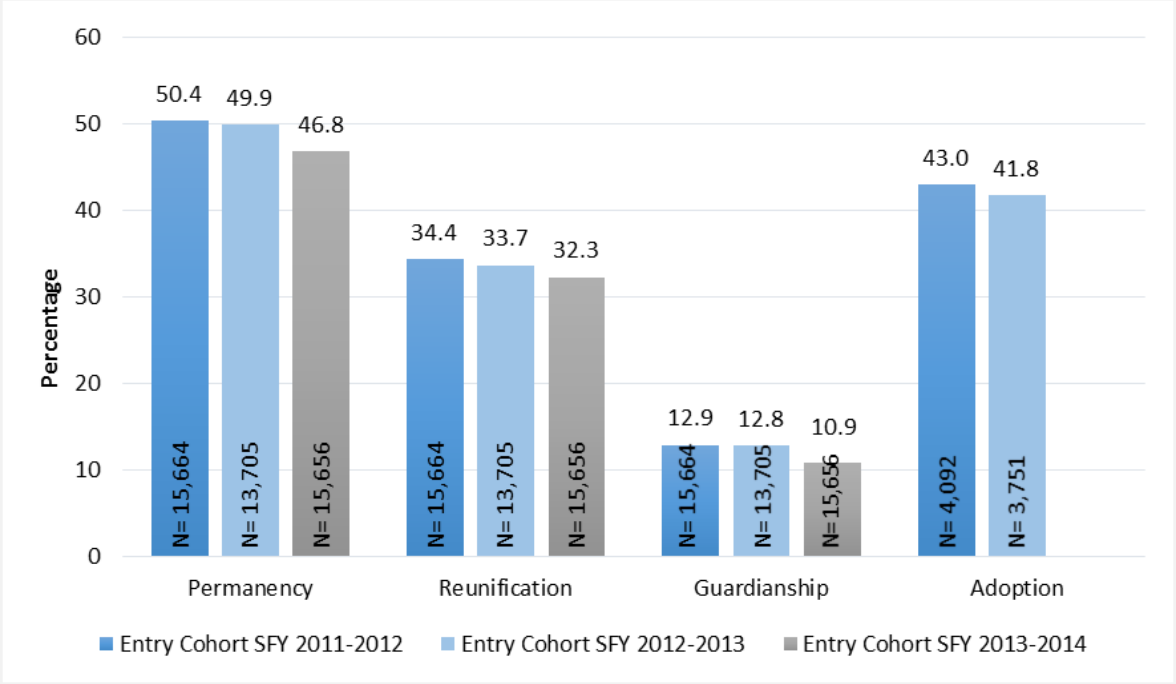
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Table 11 shows the comparison between proportions of children adopted within 24 months of their latest removal based on SFY 11-12 and SFY 12-13. For entry cohort SFY 11-12, Circuits 4 and 8 had the highest proportion of children with finalized adoptions (74.4% and 72.6%, respectively), Circuits 16 and 19 had the lowest proportions of children who exited out-of-home care because of adoption – 20%. For the entry cohort SFY 12-13, the highest proportion of children with finalized adoption was observed for Circuits 4 and 8 – 70%, and the

lowest proportion of children who were adopted after exiting from out-of-home care was observed for Circuit 18 – approximately 19%. The proportion of children with finalized adoption for the state of Florida slightly declined by 1%, but this decline was not significant (see Table F5, Appendix F).

There is an overall trend indicating a decreasing proportion of children over time including those who exited into permanency in general and who achieved permanency for reason of reunification, guardianship or adoption. This trend was observed for the majority of Circuits and for the state of Florida (see Figure 4).

Figure 4. Permanency Outcomes for the State of Florida



Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Safety indicators.

Rate of verified maltreatment as a proportion of the State's child population. This report provides an unduplicated count of children who were alleged victims of maltreatment in investigative reports received during SFY11-12 through SFY14-15 time period, broken down by their most serious investigative finding during the year. The number of maltreatment incidents was calculated per 1,000 children in the population. This measure was calculated by the Department. Because the measure consists of cross-sectional data, rates of verified

maltreatment were available for four state fiscal years (the description of the indicator is in Appendix E, Measure 6).

As shown in Table 12 for the cohort SFY 11-12, Circuit 8 had the highest proportion of child maltreatment victims per 1,000 children in the population (22.4%). Circuit 15 had the lowest proportions of victims per 1,000 children (10.0%). The average proportion of child maltreatment victims per 1,000 children in the population in SFY 11-12 for the state was 13.5%.

Table 12

Proportion of Children with Verified Child Abuse in the State of Florida by Cohort: Per capita rate/1000

	SFY 2011-2012	**SFY 2012-2013**	**SFY 2013-2014**	**SFY 2014-2015**
Circuit	**Child Abuse Rate (%)**	**Child Abuse Rate (%)**	**Child Abuse Rate (%)**	**Child Abuse Rate (%)**
Circuit 1	21.49	19.7	16.91	16.98
Circuit 2	14.01	9.92	10.89	8.94
Circuit 3	22.13	18.35	20.84	17.98
Circuit 4	14.14	14.68	14.35	11.21
Circuit 5	18.30	18.80	13.95	9.94
Circuit 6	21.15	20.19	17.59	16.75
Circuit 7	16.78	15.06	11.95	12.74
Circuit 8	22.43	21.91	19.56	13.90
Circuit 9	13.71	12.88	10.14	8.24
Circuit 10	11.32	11.54	10.18	8.74
Circuit 11	6.88	6.65	7.88	8.02
Circuit 12	18.19	15.69	13.30	15.75

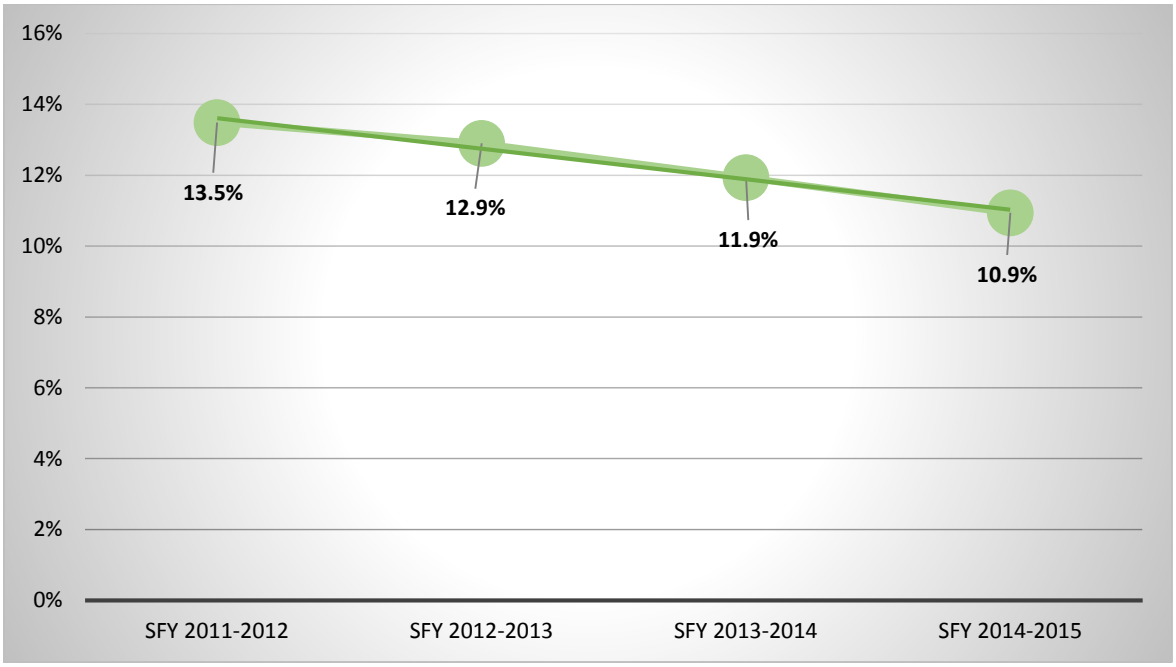
Circuit 13	10.75	10.77	10.35	9.91
Circuit 14	12.51	14.32	13.78	11.39
Circuit 15	9.97	9.86	13.14	7.24
Circuit 16	15.36	18.00	20.82	27.74
Circuit 17	13.23	12.92	12.54	13.11
Circuit 18	12.67	10.93	7.66	10.35
Circuit 19	14.73	11.70	10.11	12.60
Circuit 20	10.71	10.90	10.35	8.75
Sate of FL	13.5	12.90	11.93	10.94

Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

For the cohort SFY 12-13, Circuit 8 remained the highest in the ranking of the proportions of child maltreatment victims per 1,000 children in the population (21.9%). For the cohort SFY 13-14 Circuits 3 and 16 had the highest proportion of victims per 1,000 children (20.8%); Circuits 11 and 18 had the lowest proportions of victims per 1,000 children in the population (7.8% and 7.7% respectively). Circuits 3 and 16 were the areas with the highest proportions of child maltreatment victims per 1,000 children in the population (18.0% and 27.7%, respectively). Circuits 11 and 15 had the lowest proportions of victims per 1,000 children in the population in the SFY 14-15 (8.0% and 7.2%, respectively).

The average proportion of child maltreatment victims per 1,000 children in the population for the state was 13.5% in SFY 11-12, 12.9% in SFY 12-13, 11.9% in SFY 13-14, and decreased to 10.9% in SFY 14-15 (see Figure 5). Overall, there was a reduction in the proportion of child maltreatment victims per 1,000 children in the population by 2.6% from SFY 11-12 to SFY 14-15. The results of ANOVA indicated that this reduction is statistically significant (See Table F6, Appendix F).

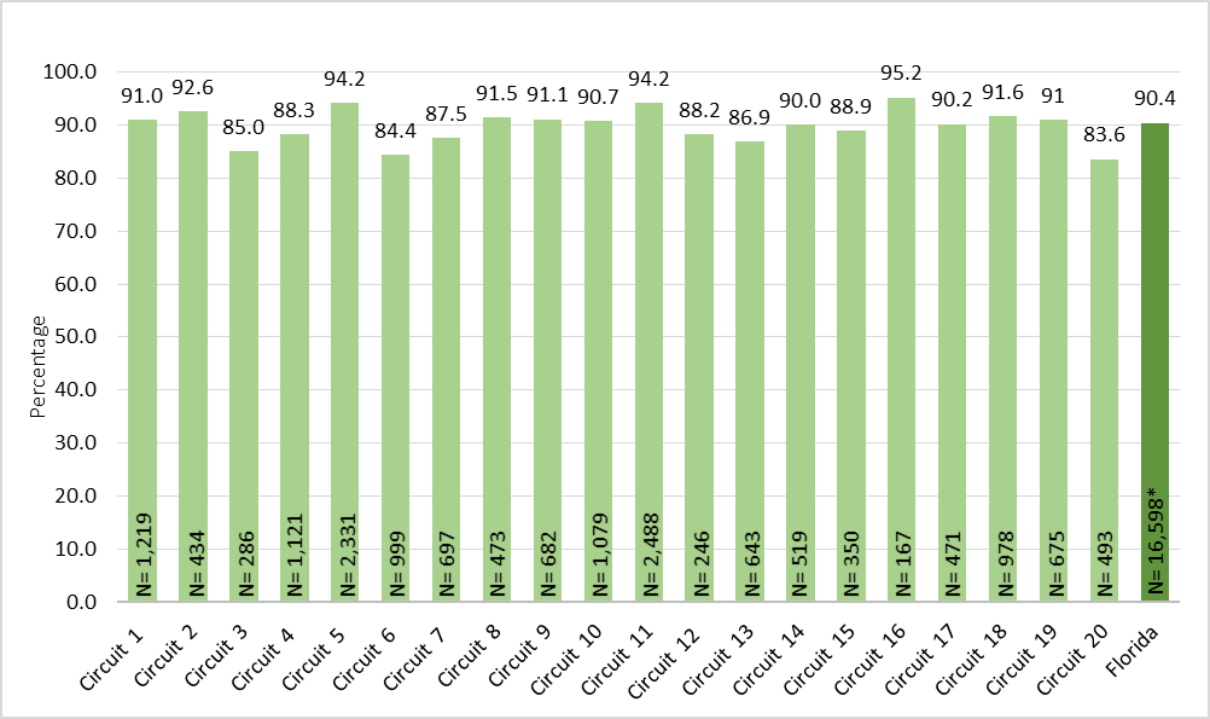
Figure 5. Proportion of Children with Verified Child Abuse in the State of Florida by Cohort: Per capita rate/1000



Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Proportion of children who were NOT placed into out-of-home care within 12 months of the date their in-home case was opened. The proportions of children who did not enter out-of-home care after initially receiving in-home services within 12 months were calculated for three state fiscal years (see the description of the indicator in Appendix E, Measure 7). As shown in Figure 6, during SFY 11-12 Circuits 5, 16, and 17 had the highest proportions of children who did not enter out-of-home care after initially receiving in-home services (approximately 95%). Circuits 3 and 6 had the lowest proportion of children who did not enter out-of-home care after initially receiving in-home services (88% and 89%, respectively). The average proportion of children who did not enter out-of-home care within 12 months after their dependent case was opened and they began receiving in-home services for the state of Florida was 92.4% (see Figure 9).

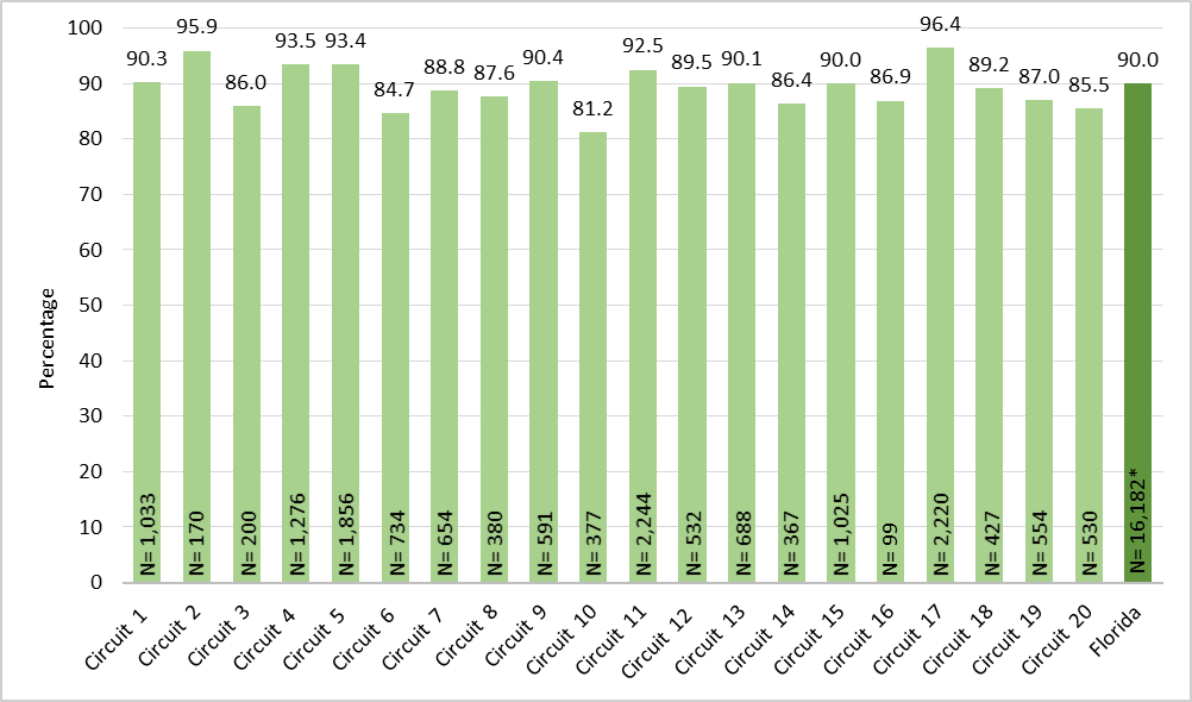
Figure 6. Proportion of Children Whose Case Was Open in SFY 11-12 and Who Did NOT Enter Out-of-Home Care within 12 Months suggest



Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

For entry cohort SFY 12-13, Circuits 2 and 17 had the highest proportions of children who did not enter out-of-home care after initially receiving in-home services (approximately 96%). Circuit 10 had the lowest proportion of children who did not enter out-of-home care after initially receiving in-home services (81%). The average proportion of children who did not enter out-of-home care within 12 months after their dependent case was opened and they began receiving in-home services for the state of Florida was 90.8%. Figure 7 displays the proportion of children that had a case opened in SFY 12-13 and did not enter out-of-home care within 12 months.

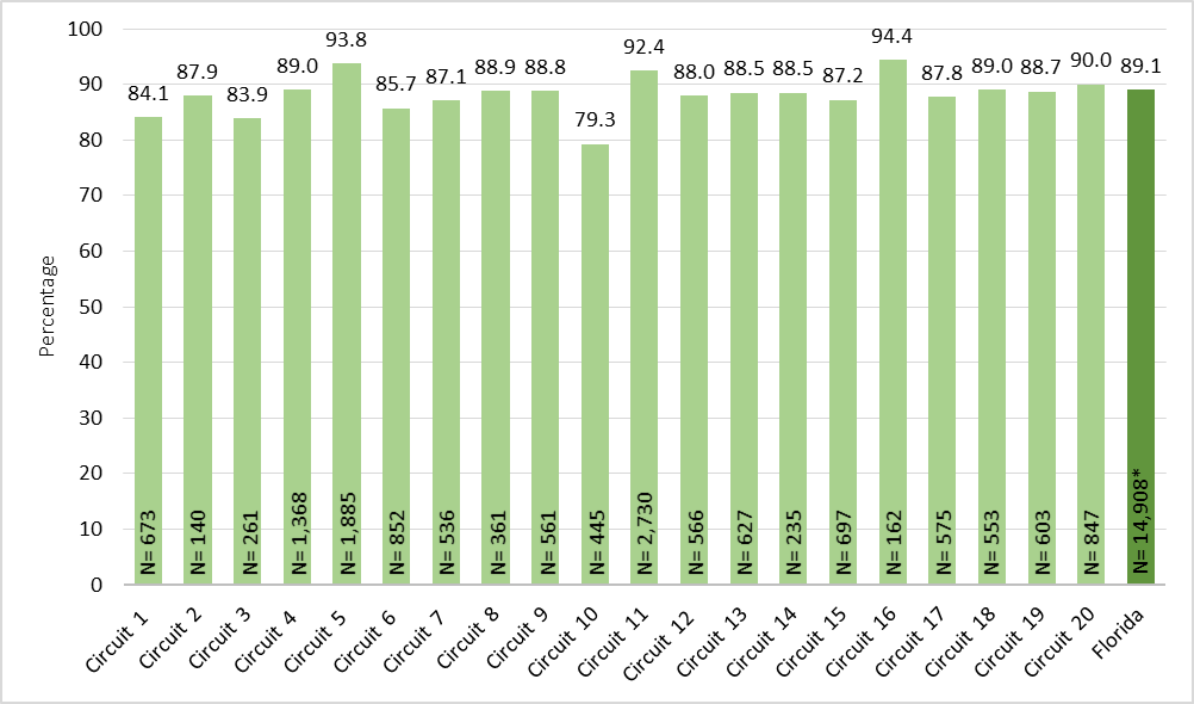
Figure 7. Proportion of Children Whose Case Was Open in SFY 12-13 and Who Did NOT Enter Out-of-Home Care within 12 Months suggest adding statewide data to the graph



Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

When the entry cohort SFY 13-14 was examined, Circuit 16 had the highest (94%) and Circuit 10 had the lowest proportion (79%) of children who did not enter out-of-home care after initially receiving in-home services (see Figure 8). The average proportion of children who did not enter out-of-home care within 12 months after their dependent case was opened and they started receiving in-home services for the state of Florida was 89.1% (see Figure 9).

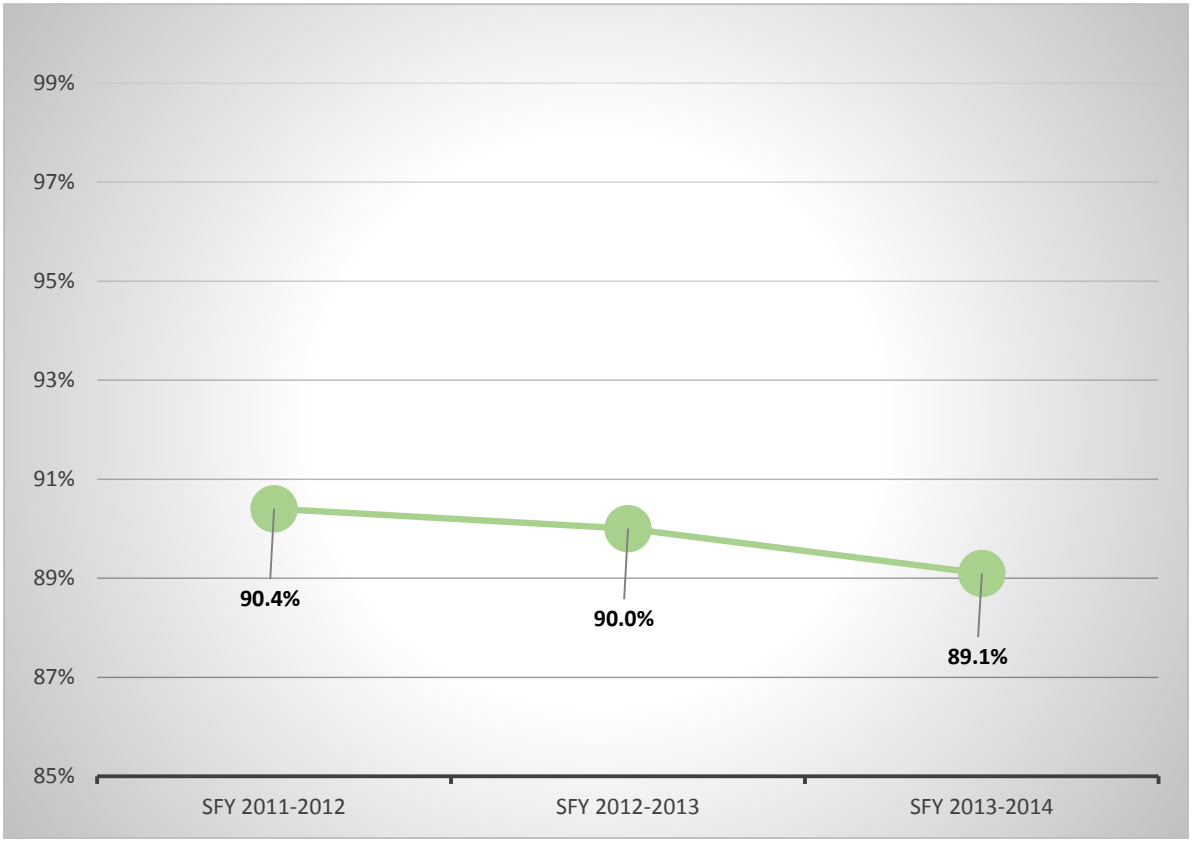
Figure 8. Proportion of Children Whose Case Was Open in SFY 2013-2014 and Who Did NOT Enter Out-of-Home Care within 12 Months



Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

As shown in Figure 9, the proportion of children who did not enter out-of-home care within 12 months after their dependent case was opened and who initially received in-home services dropped from 92.4% in SFY 11-12 to 89.1% in SFY 13-14, a statistically significant difference (see Table F7, Appendix F).

Figure 9. Proportion of Children in the State of Florida Who Did Not Enter Out-of-Home Care within 12 Months



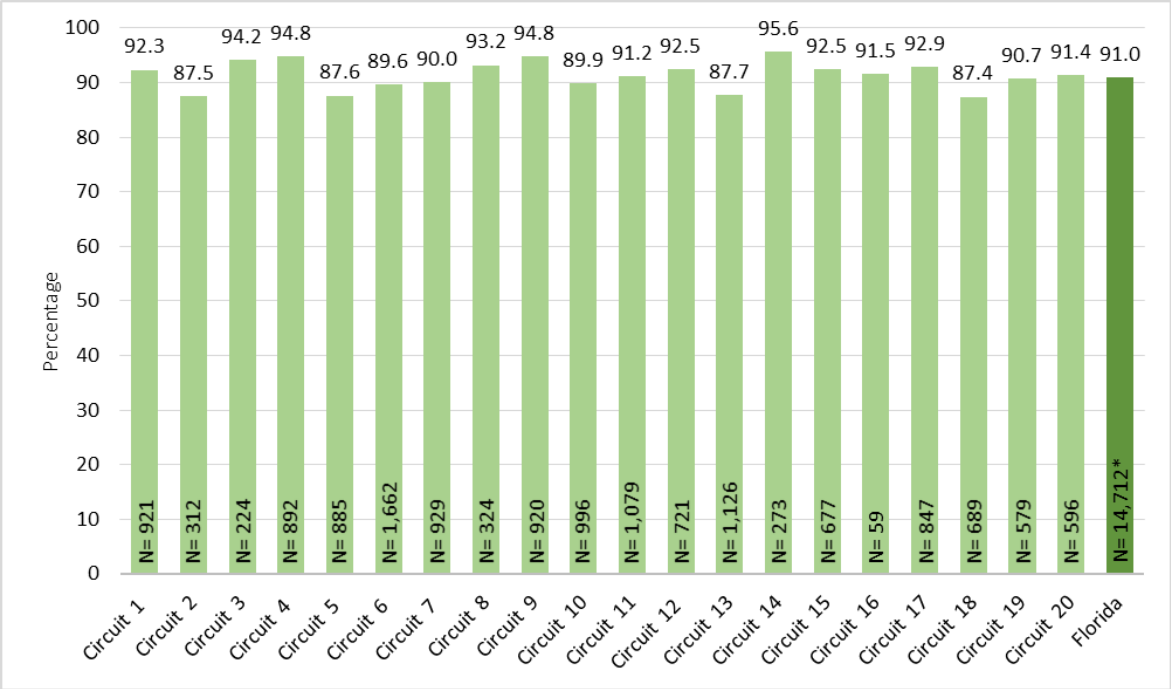
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

The number and proportion of children who did NOT re-enter out-of-home care within 12 months of their most recent discharge from out-of-home care for permanency reasons. Re-entry into out-of-home care was defined as all children who re-entered out-of-home care after exiting for permanency reasons during a given fiscal year (see description of the indicator in Appendix E, Measure 8).

As shown in Figure 10, the proportion of children who did not re-enter out-of-home care in SFY 11-12 ranged from 91.3% (Circuit 2) to 97.8% (Circuit 14). Similarly, for SFY 12-13 the proportion of children who did not re-enter out-of-home care ranged from 75.5% (Circuits 16) to 92.9% in Circuit 9 (see Figure 11). For SFY 13-14, Circuit 8 had the highest of proportion of children without re-entry into out-of-home care, and Circuit 2 had the lowest proportion of children without re-entry (see Figure 12). As shown in Figure 13, for the state of Florida the proportion of children without re-entry did not change over the three examined exit cohorts and

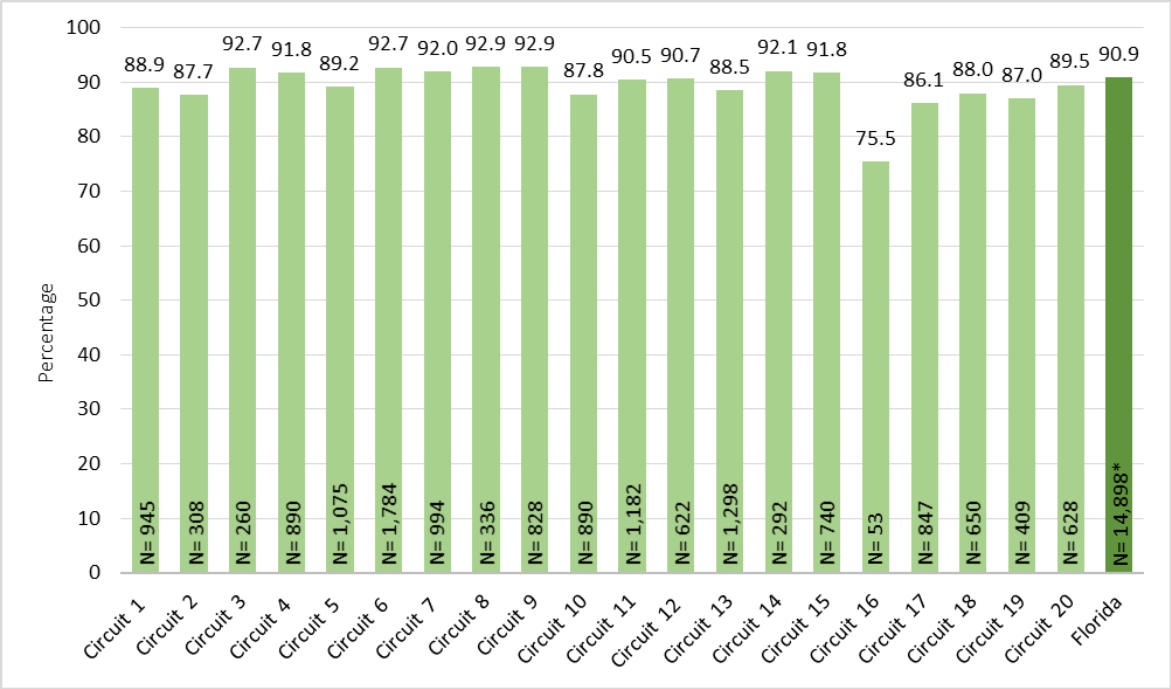
remained at approximately 91%. Results of Cox regression analysis indicated no statistically significant difference in re-entry into out-of-home care over time.

Figure 10. Proportion of Children Exited Out-of-Home Care in SFY 11-12 and Did Not Re-enter within 12 Months



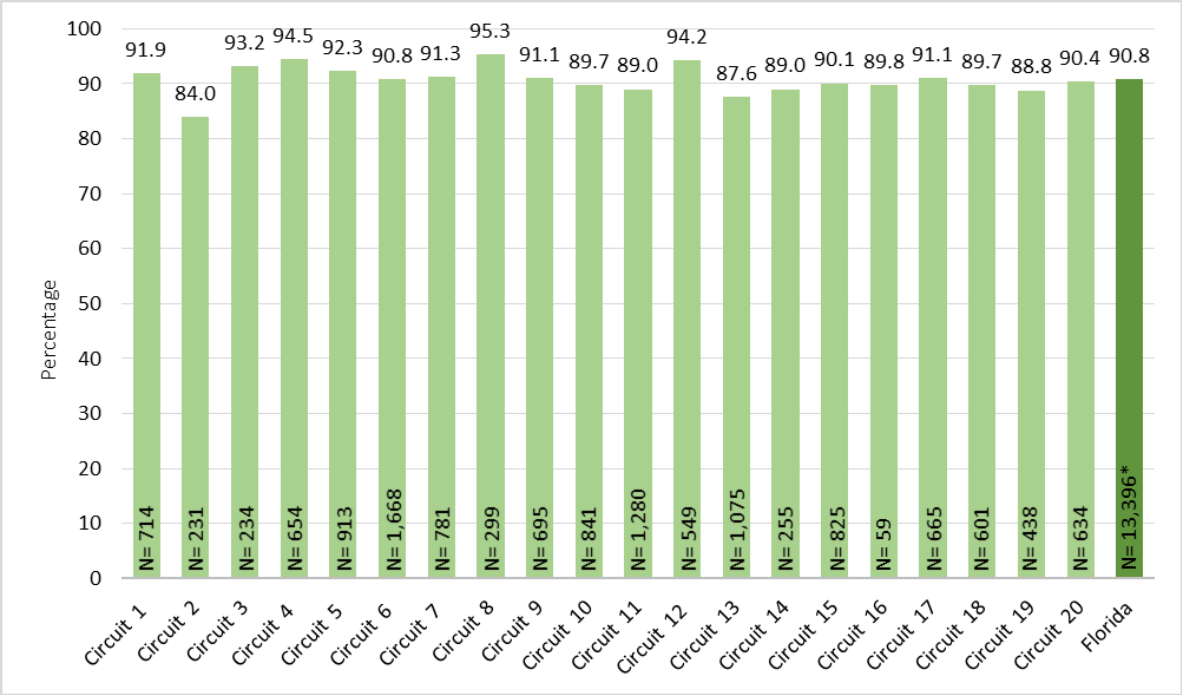
Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Figure 11. Proportion of Children Exited Out-of-Home Care in SFY 12-13 and Who Did Not Re-enter within 12 Months



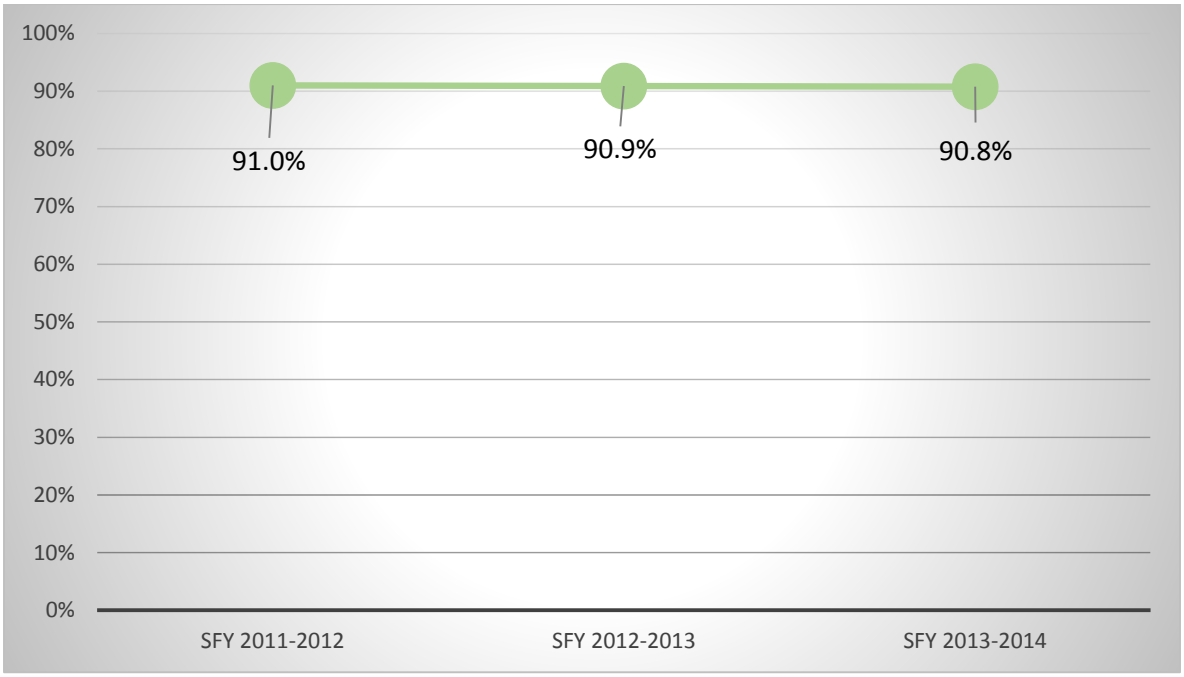
Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Figure 12. Proportion of Children Exited Out-of-Home Care in SFY 13-14 and Who Did Not Re-enter within 12 Months



Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

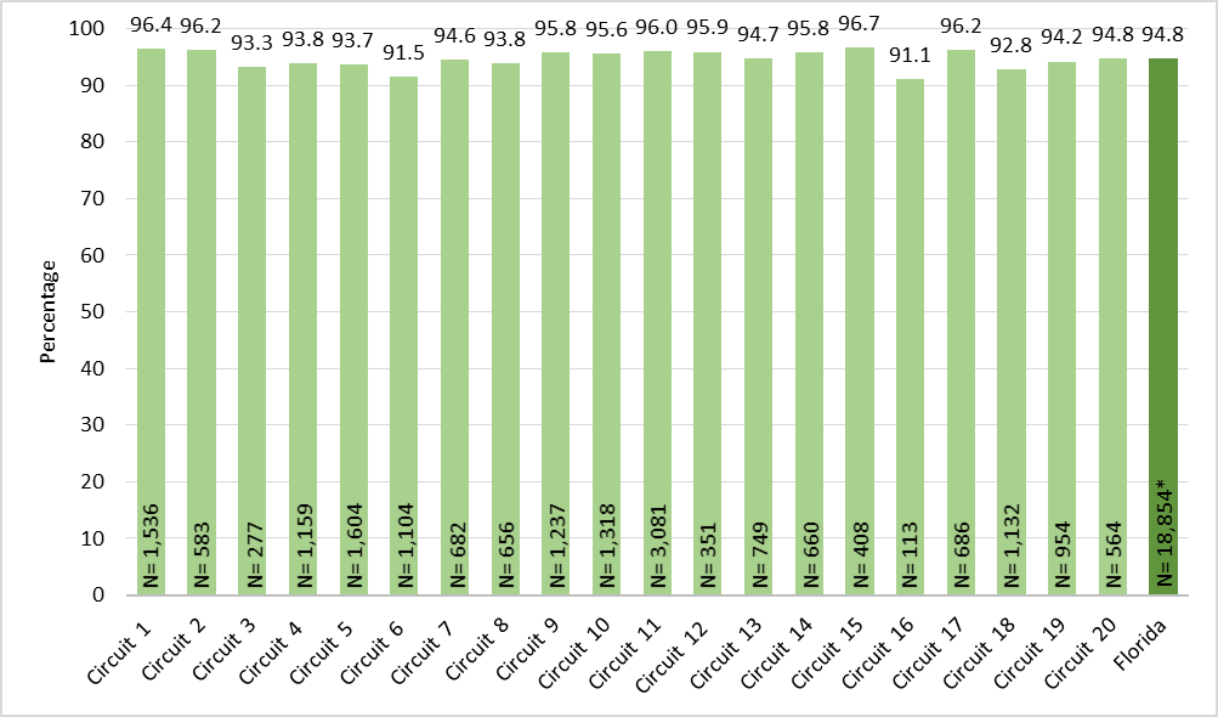
Figure 13. Proportion of Children Exited Out-of-Home Care and Who Did Not Re-enter within 12 Months



Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Proportion of children who did NOT experience verified maltreatment within 6 months after in-home or out-of-home services were terminated. Because this measure involves only 6 months follow-up, proportions of verified maltreatment within 6 months after services terminated were calculated for four state fiscal years exit cohorts (the description of the indicator is in Appendix E Measure 8). As shown in Figure 14, during SFY 11-12 Circuits 1, 2, 15 and 17 had the highest proportions of children who did not experience verified maltreatment within 6 months after either in-home or out-of-home services were terminated (slightly higher than 96%).

Figure 14. Proportion of Children Who Did NOT Experience Verified Maltreatment within Six Months of Service Termination in SFY 11-12

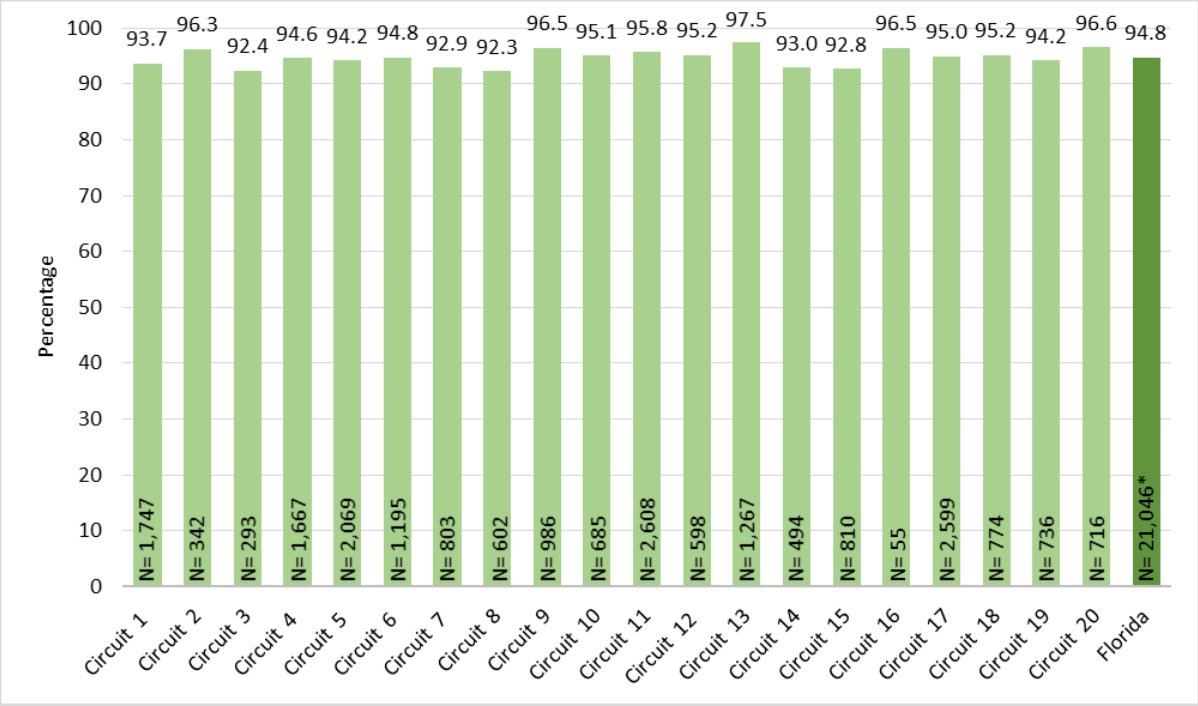


Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Circuits 6 and 16 had the lowest proportions of children who did not experience verified maltreatment within 6 months after services were terminated (91.5% and 91.1%, respectively). The average proportion of children who did not experience verified maltreatment within 6 months after either in-home or out-of-home services were terminated for the state of Florida in SFY 11-12 was almost 95% (see Figure 18).

As shown in Figure 15, for exit cohort SFY 12-13, Circuits 2, 9, 13, 16 and 20 had the highest proportions of children who did not experience verified maltreatment within 6 months after services were terminated (higher than 96%). Circuits 3 and 8 had the lowest proportions of children who did not enter out-of-home care after initially receiving in-home services (92.4% and 92.3%). The average proportion of children who did not experience verified maltreatment within 6 months after either in-home or out-of-home services were terminated for the State of Florida in SFY 12-13 remained the same (see Figure 18).

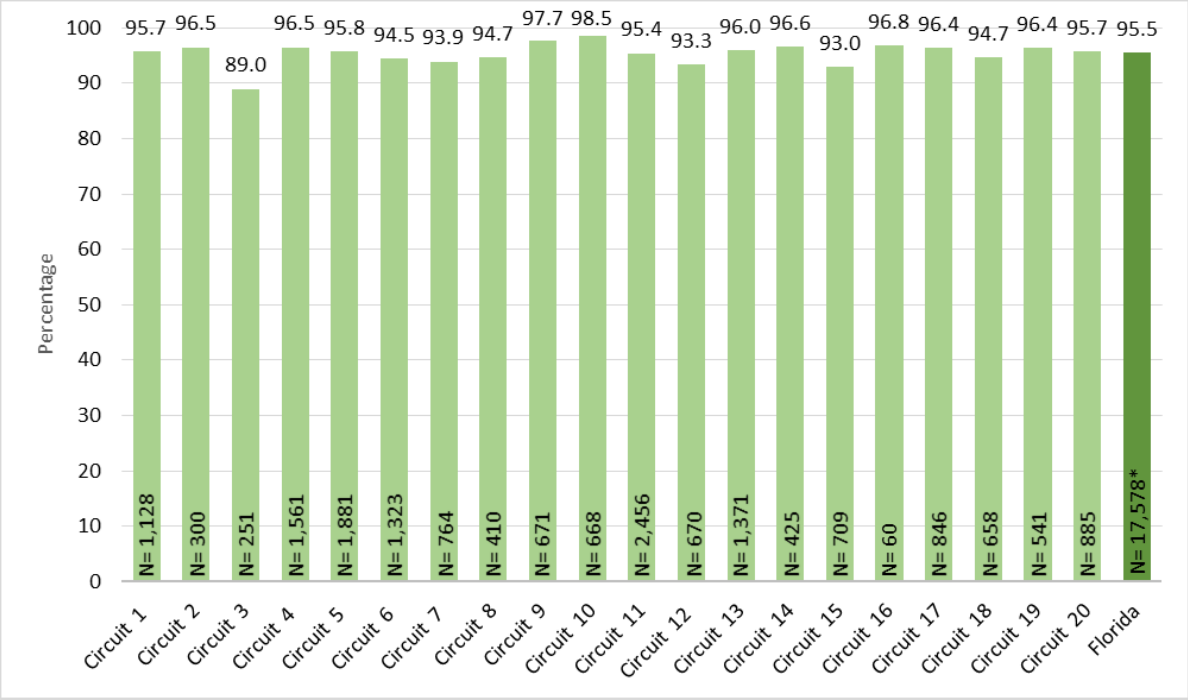
Figure 15. Proportion of Children Who Did NOT Experience Verified Maltreatment within Six Months of Service Termination in SFY 12-13



Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

When exit cohort SFY 13-14 was examined, Circuit 10 had the highest (98.5%) and Circuit 3 had the lowest proportions (89%) of children who did not experience verified maltreatment within 6 months after services were terminated (see Figure 16).

Figure 16. Proportion of Children Who Did NOT Experience Verified Maltreatment within Six Months of Service Termination in SFY 13-14



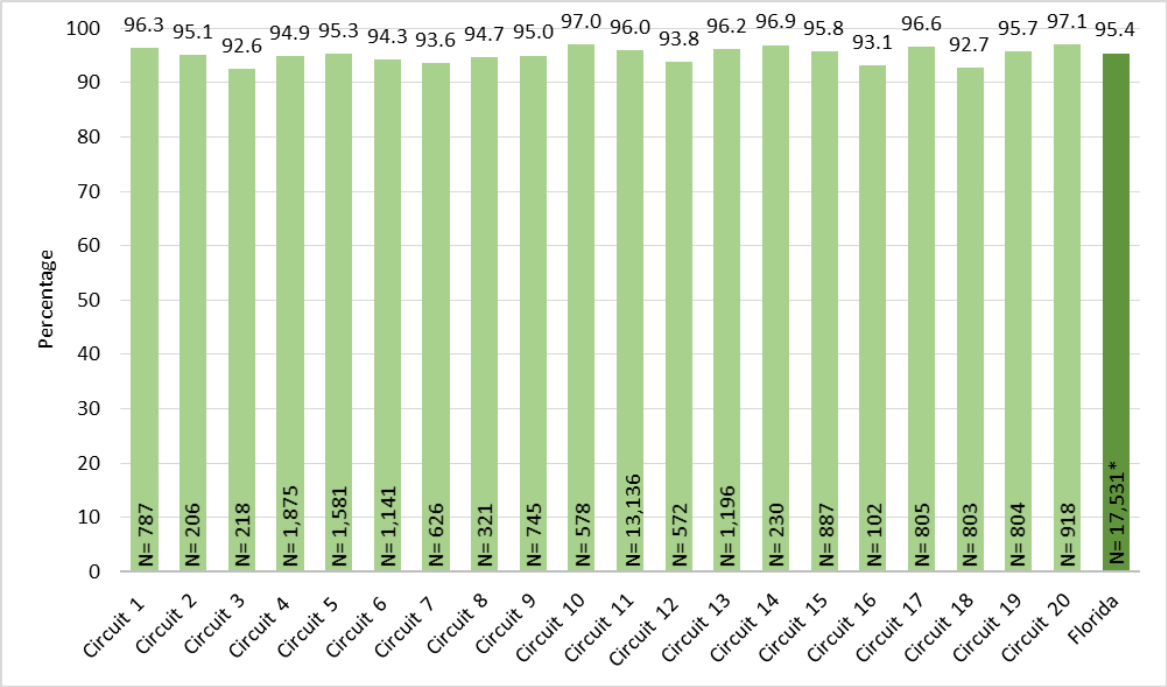
Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

The average proportion of children who did not experience verified maltreatment within 6 months after either in-home or out-of-home services were terminated for the state of Florida in SFY13-14 for the state of Florida was 95.5% (see Figure 18).

Examination of exit cohort SFY 14-15 indicated that Circuits 10 and 20 had the highest proportions of children who did not experience verified maltreatment within 6 months after services were terminated. Circuits 3 and 18 had the lowest proportions of children with no verified maltreatment after termination of services. The average proportion of children who did not experience verified maltreatment within 6 months after either in-home or out-of-home services were terminated for the state of Florida in SFY 14-15 for the state of Florida was 95.4% (see Figure 18).

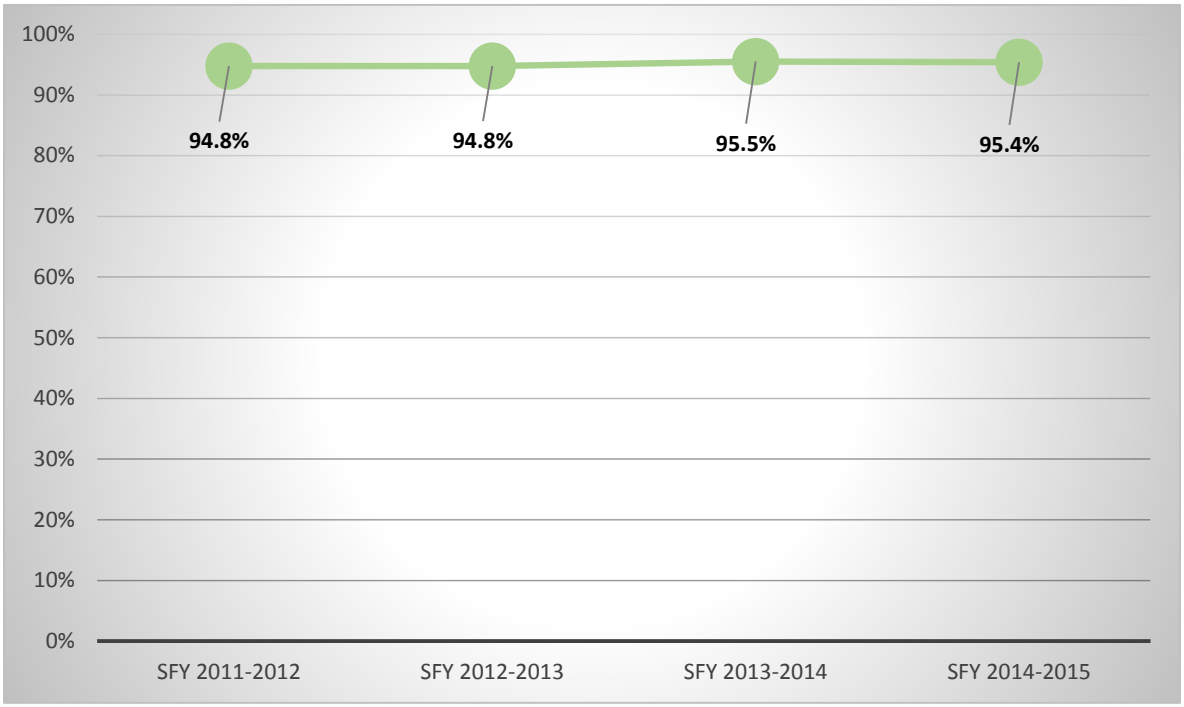
Results of Cox regression analysis indicated that for the state of Florida there was a statistically significant increase in the proportion of children with no verified maltreatment within 6 months of services termination over time (see Appendix F, Table F9).

Figure 17. Proportion of Children Who Did NOT Experience Verified Maltreatment within Six Month Service Termination in SFY 14-15



Note. *The discrepancy between the total number of cases for the state and the total cases of cases across circuits is due to missing data on county variable.
Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Figure 18. Proportion of Children Who Did NOT Experience Verified Maltreatment within Six Months of Service Termination in the State of Florida by Cohort



Note. Data Source: data abstracts taken from the Florida Safe Families Network (FSFN)
Note. Date: November 2015

Summary. Overall, there is considerable variability among Circuits across indicators. For example, Circuit 8 had the highest permanency rate throughout the three years (between 62% and 64%), one of the lowest lengths of stay (averaging 10 months), the highest proportion of children who acquired guardianship (25%), and is among the Circuits with the highest proportion of children with adoption finalized (73% for SFY 11-12 and 70% for SFY 12-13). In contrast, Circuit 7 had one of the lowest proportions of children exiting into permanency (between 39% in SFY 11-12 and 32% in SFY 13-14), one of the highest median lengths of stay (approximately 15 months across three entry cohorts), and the lowest proportion of children reunified (21% for SFY 13-14) or acquired guardianship within 12 months of the latest removal (6% for SFY 13-14).

Similarly, Circuits 10, 11, and 13 had the lowest maltreatment rates per 1,000 child population throughout the three years (between 7% and 11%). Circuit 5 had the highest proportion of children who did not enter out-of-home care after their dependent case was opened during the examined three years (approximately 95%). Circuits 4 and 8 had the highest proportion of children without re-entry during the study period ranging from 92% to 95%.

Overall, there were two observed trends. One trend indicates a decreasing proportion of children over time who experienced expedited permanency in general and who achieved permanency for reason of reunification, guardianship or adoption. The second trend indicates improved performance statewide on child safety based on three out of four examined indicators. Specifically, there is a decrease in the number of verified child maltreatment cases per 1,000 child population over time, an increase in the proportion of children who remained home after their dependent case was opened, and there is an increase in the proportion of children with no verified maltreatment within 6 months of services termination. Re-entry into out-of-home care remained stable over time.

Limitations. It is important to note a few limitations in conducting the outcome analysis. First, the study design did not include a comparison group (e.g., counties where the extension of the Demonstration project was not implemented) because the Demonstration was implemented statewide. Because a comparison group was not available, longitudinal comparison was performed using entry or exit cohorts and no time by group interaction was examined. Second, this study was limited to measures of lead agency performance that relate to selected child permanency and safety outcomes. Finally, the findings do not account for the effects of child or family socio-demographic characteristics or any of the lead agency characteristics or characteristics of the Circuits.

Child and Family Well-Being

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews and adopted use of the Child and Family Services Reviews (CFSR)— federally-established guidelines to conduct ongoing case reviews (U.S. Department of Health and Human Services, 2014). Through these CFSRs, CBCs review cases to ascertain the quality of child welfare practices relevant to the safety, permanency, and well-being of children.

Key questions. Table 13 below presents the key questions relevant to child and family well-being and their alignment with CFSR performance items. Specifically, these questions focus on an agency's assessment of needs and provision of appropriate services to children and families, involvement of children and families in case planning, case managers' visitation with children and parents, and addressing the physical/dental health, mental/behavioral health, and educational needs of children.

Table 13

Child & Family Well-Being Outcomes: Hypothesis and Evaluation Questions

Well-Being Hypothesis
There will be improvement in the physical, mental health, developmental and educational well-being outcomes for children and their families.
Well-Being Outcome Evaluation Questions
1. Did the agency make concerted efforts to assess the needs of and provide services to children, parents, and foster parents to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family? 2. Did the agency make concerted efforts to involve the parents and children (if developmentally appropriate) in the case planning process on an ongoing basis? 3. Were the frequency and quality of visits between caseworkers and children sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals? 4. Were the frequency and quality of visits between caseworkers and the mothers and fathers of the children sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals? 5. Did the agency make concerted efforts to assess children's educational needs, and appropriately address identified needs in case planning and case management activities? 6. Did the agency address the physical health needs of children, including dental health needs? 7. Did the agency address the mental/behavioral health needs of children?

Data sources and data collection. The constructs of child and family well-being are examined according to the applicable CFSR outcomes and performance items shown in Table 14. These focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, mental health needs. CFSR Child and Family Well-Being Outcomes 1, 2, and 3 are rated as Substantially Achieved (SA), Partially Achieved (PA), or Not Achieved (NA); accompanying performance items are rated as either a strength or an area needing improvement. Performance item ratings are used to calculate a summated rating of the performance items addressing each outcome. The CFSR Onsite Review Instrument and Instructions (USDHHS, 2014) includes details regarding the review process.

Table 14

CFSR Well-Being Outcomes and Performance Items

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

Data Source: CFSR Onsite Review Instrument and Instructions (USDHHS, 2014)

Data analysis. The results below disaggregate outcome and performance item ratings by Circuit. However, these data are derived from a live dataset in that cases are reviewed on an ongoing basis. For this reason, the number of applicable cases and accompanying ratings shown below are not final. Results reported below represent finalized CFSR data submitted on or before April 21, 2016. Further, as Quality Assurance staff continue to familiarize themselves with use of the CFSR tool for case reviews, inter-rater reliability will be improved and the reported findings will be based on their consistent understanding on what the tool is measuring. In addition, the period under review (PUR) for SFY 15-16, is 12 months prior to review of the case. For instance, the PUR for the first quarter of SFY 15-16, is the first quarter of the previous fiscal year. Data for the PUR for quarters 1, 2, and 3 of SFY 15-16 are aggregated and detailed in this report.

Results.

CFSR well-being outcome 1. The first well-being outcome pertains to enhancement of the family's capacity to provide for the needs of their children. Four performance items (12-15) encompass the first well-being outcome.

Performance item 12. This item pertains to the assessment of needs and the provision of appropriate services for children, parents, and foster parents. Three sub-items are

aggregated for this item: needs assessment and services to children, needs assessment and services to parents, and needs assessment and services to foster parents. As shown in Table 15, statewide, 63% of cases reviewed were rated as a strength, and the remaining 37% of cases scored this item as an area in need of improvement. There are no national standards pertaining to well-being performance items; however, a substantial number of cases were rated as a strength for Circuits 2, 14, and 17. For some Circuits, a greater percentage of cases were rated as needing improvement than as a strength for this item.

Table 15

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

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	40	12.5% (n=5)	87.5% (n=35)
2	14	93% (n=13)	7% (n=1)
3	11	9% (n=1)	91% (n=10)
4	82	62% (n=51)	38% (n=31)
5	38	63% (n=24)	37% (n=14)
6	40	75% (n=30)	25% (n=10)
7	46	78% (n=36)	22% (n=10)
8	15	0% (n=0)	100% (n=15)
9	37	54% (n=20)	46% (n=17)
10	36	56% (n=20)	44% (n=16)
11	49	55% (n=27)	45% (n=22)
12	26	85% (n=22)	15% (n=4)
13	36	69% (n=25)	31% (n=11)
14	14	100% (n=14)	0% (n=0)
15	42	76% (n=32)	24% (n=10)
16	1	100% (n=1)	0% (n=0)
17	40	87.5% (n=35)	12.5% (n=5)
18	20	50% (n=10)	50% (n=10)

19	40	60% (n=24)	40% (n=16)
20	51	71% (n=36)	29% (n=15)
State	678	63% (n=426)	37% (n=252)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Performance item 13. This item pertains to efforts made to involve the parents and children (if developmentally appropriate) in case planning processes. Statewide, 64% of cases reviewed were rated as a strength, and the remaining 36% of cases reviewed scored this item as an area in need of improvement (Table 16). At least 90% of cases reviewed were rated as a strength for Circuits 14 and 15.

Table 16

Performance Item 13: Child and Family Involvement in Case Planning

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	38	11% (n=4)	89% (n=34)
2	13	69% (n=9)	31% (n=4)
3	9	22% (n=2)	78% (n=7)
4	82	69% (n=56)	31% (n=25)
5	27	67% (n=18)	33% (n=9)
6	35	80% (n=28)	20% (n=7)
7	45	73% (n=33)	27% (n=12)
8	14	0% (n=0)	100% (n=14)
9	36	61% (n=22)	39% (n=14)
10	34	65% (n=22)	35% (n=12)
11	47	38% (n=18)	62% (n=29)
12	24	83% (n=20)	17% (n=4)
13	32	84% (n=27)	16% (n=5)
14	11	91% (n=10)	9% (n=1)
15	41	90% (n=37)	10% (n=4)

16	1	100% (n=1)	0% (n=0)
17	35	83% (n=29)	17% (n=6)
18	20	50% (n=10)	50% (n=10)
19	40	65% (n=26)	35% (n=14)
20	48	69% (n=33)	31% (n=15)
State	631	64% (n=405)	36% (n=226)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Performance item 14. This performance item considers the sufficient frequency and quality of visits between caseworkers and children to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. As shown in Table 17, statewide, 65% of cases reviewed were rated as a strength. Accordingly, 35% of cases reviewed scored this item as an area in need of improvement. Circuits 6, 10, 13, 14, and 17 achieved greater than 90% of cases reviewed as a strength. For Circuits 1, 3, and 8, greater than 90% of cases reviewed were rated as an area in need of improvement.

Table 17

Performance Item 14: Case Worker Visits with Child

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	40	5% (n=2)	95% (n=38)
2	14	36% (n=5)	64% (n=9)
3	11	9% (n=1)	91% (n=10)
4	82	62% (n=51)	38% (n=31)
5	38	71% (n=27)	29% (n=11)
6	40	92.5% (n=37)	7.5% (n=3)
7	46	57% (n=26)	43% (n=20)
8	15	0% (n=0)	100% (n=15)
9	37	46% (n=17)	54% (n=20)
10	36	94% (n=34)	6% (n=2)

11	49	71% (n=35)	29% (n=14)
12	26	88% (n=23)	12% (n=3)
13	36	94% (n=34)	6% (n=2)
14	14	100% (n=14)	0% (n=0)
15	42	86% (n=36)	14% (n=6)
16	1	100% (n=1)	0% (n=0)
17	40	95% (n=38)	5% (n=2)
18	20	45% (n=9)	55% (n=11)
19	40	32.5% (n=13)	67.5% (n=27)
20	51	76% (n=39)	24% (n=12)
State	678	65% (n=442)	35% (n=236)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Performance item 15. This performance item considers the sufficient frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring child safety, permanency, and well-being. As shown in Table 18, 36% of cases scored as a strength. A greater portion of reviewed cases were rated as an area in need of improvement (64%), statewide. This provides evidence that the quantity and quality of visits between caseworkers and the mothers and fathers were insufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals. In the case of most Circuits, a greater proportion of cases were rated as an area in need of improvement as opposed to a strength.

Table 18

Performance Item 15: Case Worker Visits with Parents

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	37	11% (n=4)	89% (n=33)
2	12	58% (n=7)	42% (n=5)
3	8	0% (n=0)	100% (n=8)
4	75	47% (n=35)	53% (n=40)

5	23	35% (n=8)	65% (n=15)
6	34	53% (n=18)	47% (n=16)
7	44	32% (n=14)	68% (n=30)
8	12	0% (n=0)	100% (n=12)
9	35	29% (n=10)	71% (n=25)
10	33	42% (n=14)	58% (n=19)
11	46	28% (n=13)	72% (n=33)
12	21	71% (n=15)	29% (n=6)
13	29	45% (n=13)	55% (n=16)
14	8	87.5% (n=7)	12.5% (n=1)
15	35	37% (n=13)	63% (n=22)
16	1	100% (n=1)	0% (n=0)
17	31	42% (n=13)	58% (n=18)
18	17	29% (n=5)	71% (n=12)
19	37	11% (n=4)	89% (n=33)
20	48	35% (n=17)	65% (n=31)
State	586	36% (n=211)	64% (n=375)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Well-being outcome 1 ratings. Table 19 details ratings for this outcome pertaining to families having the enhanced capacity to provide for their children's needs. The ratings shown in Table 19 are a compilation of the ratings for performance items 12 through 15. Of the cases reviewed statewide, 49% met the standards of substantial achievement and 35% were partially achieved. The standard for this outcome was not achieved or addressed for 16% of cases reviewed. In order to achieve substantial conformity with well-being outcome 1, the percentage of cases reviewed that were rated as substantially achieved would need to be 95% or greater. In this baseline assessment, neither Florida statewide nor any individual Circuit achieved substantial conformity for this outcome measure.

Table 19

Well-Being Outcome 1 Ratings

SFY 15-16				
Circuit	**Applicable Cases**	**Substantially Achieved**	**Partially Achieved**	**Not Achieved**
1	40	5% (n=2)	20% (n=8)	75% (n=30)
2	14	50% (n=7)	50% (n=7)	0% (n=0)
3	11	9% (n=1)	9% (n=1)	82% (n=9)
4	82	45% (n=37)	45% (n=37)	10% (n=8)
5	38	55% (n=21)	32% (n=12)	13% (n=5)
6	40	65% (n=26)	32.5% (n=13)	2.5% (n=1)
7	46	48% (n=22)	48% (n=22)	4% (n=2)
8	15	0% (n=0)	100% (n=15)	0% (n=0)
9	37	38% (n=14)	46% (n=17)	16% (n=6)
10	36	47% (n=17)	53% (n=19)	0% (n=0)
11	49	35% (n=17)	49% (n=24)	16% (n=8)
12	26	77% (n=20)	23% (n=6)	0% (n=0)
13	36	67% (n=24)	31% (n=11)	3% (n=1)
14	14	93% (n=13)	7% (n=1)	0% (n=0)
15	42	67% (n=28)	29% (n=12)	5% (n=2)
16	1	100% (n=1)	0% (n=0)	0% (n=0)
17	40	75% (n=30)	25% (n=10)	0% (n=0)
18	20	40% (n=8)	25% (n=5)	35% (n=7)
19	40	37.5% (n=15)	37.5% (n=15)	25% (n=10)
20	51	57% (n=29)	35% (n=18)	8% (n=4)
State	678	49% (n=332)	35% (n=238)	16% (n=108)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

CFSR well-being outcome 2. The second well-being outcome pertains to receipt of appropriate services to meet the educational needs of children. One performance item encompasses this outcome.

Performance item 16. This performance item evaluates efforts made to assess children's educational needs and appropriately address those needs. The majority of cases met criteria indicative of a strength (76%); 24% of cases reviewed indicated that educational needs were an area in need of improvement (see Table 20). Again, there are no national standards pertaining to well-being performance items. For most Circuits, greater than 75% of cases were rated as a strength. Cases reviewed in Circuits 2 and 14, in particular, were rated as a strength in greater than 90% of cases.

Table 20

Performance Item 16: Educational Needs of the Child

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	22	55% (n=12)	45% (n=10)
2	11	100% (n=11)	0% (n=0)
3	4	75% (n=3)	25% (n=1)
4	45	84% (n=38)	16% (n=7)
5	20	80% (n=16)	20% (n=4)
6	29	76% (n=22)	24% (n=7)
7	23	78% (n=18)	22% (n=5)
8	7	0% (n=0)	100% (n=7)
9	22	86% (n=19)	14% (n=3)
10	19	89% (n=17)	11% (n=2)
11	41	76% (n=31)	24% (n=10)
12	19	79% (n=15)	21% (n=4)
13	29	86% (n=25)	14% (n=4)
14	9	100% (n=9)	0% (n=0)
15	25	80% (n=20)	20% (n=5)
16	1	100% (n=1)	0% (n=0)
17	22	77% (n=17)	23% (n=5)
18	9	67% (n=6)	33% (n=3)

19	24	62.5% (n=15)	37.5% (n=9)
20	26	54% (n=14)	46% (n=12)
State	407	76% (n=309)	24% (n=98)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Well-being outcome 2 ratings. CFSR Well-Being Outcome 2 pertains to receipt of adequate services to meet the educational needs of children. As shown in Table 21, of the cases reviewed statewide, 84% met the standards of substantial or partial achievement. The standard for this outcome was not achieved or addressed for 16% of cases reviewed. All cases reviewed in Circuits 2 and 14 did meet the standard for substantial achievement.

Table 21

Well-Being Outcome 2 Ratings

SFY15-16				
Circuit	**Applicable Cases**	**Substantially Achieved**	**Partially Achieved**	**Not Achieved**
1	22	55% (n=12)	5% (n=1)	41% (n=9)
2	11	100% (n=11)	0% (n=0)	0% (n=0)
3	4	75% (n=3)	0% (n=0)	25% (n=1)
4	45	84% (n=38)	4% (n=2)	11% (n=5)
5	20	80% (n=16)	10% (n=2)	10% (n=2)
6	29	76% (n=22)	10% (n=3)	14% (n=4)
7	23	78% (n=18)	9% (n=2)	13% (n=3)
8	7	0% (n=0)	14% (n=1)	86% (n=6)
9	22	86% (n=19)	0% (n=0)	14% (n=3)
10	19	89% (n=17)	5% (n=1)	5% (n=1)
11	41	76% (n=31)	15% (n=6)	10% (n=4)
12	19	79% (n=15)	5% (n=1)	16% (n=3)
13	29	86% (n=25)	7% (n=2)	7% (n=2)
14	9	100% (n=9)	0% (n=0)	0% (n=0)
15	25	80% (n=20)	4% (n=1)	16% (n=4)

16	1	100% (n=1)	0% (n=0)	0% (n=0)
17	22	77% (n=17)	5% (n=1)	18% (n=14)
18	9	67% (n=6)	11% (n=1)	22% (n=2)
19	24	62.5% (n=15)	4% (n=1)	33% (n=8)
20	26	54% (n=14)	23% (n=6)	23% (n=6)
State	407	76% (n=309)	8% (n=31)	16% (n=67)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

***CFSR well-being outcome 3*.** The third well-being outcome pertains to receipt of adequate services to meet the physical and mental health needs of children. Results of the performance items for this outcome are shown in Tables 22 and 23.

Performance item 17. This performance item addresses accurate assessment and receipt of appropriate services of the physical health needs of children. This item also addresses children's dental health needs. As indicated in Table 22, the majority of cases reviewed were rated as a strength (75%). The proportion of cases indicative of an area in need of improvement was 25%. Circuits 2, 4, 9, and 10, achieved greater than 90% of cases rated as a strength.

Table 22

Performance Item 17: Physical Health of the Child

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	28	39% (n=11)	61% (n=17)
2	9	100% (n=9)	0% (n=0)
3	7	43% (n=3)	57% (n=4)
4	55	95% (n=52)	5% (n=3)
5	29	83% (n=24)	17% (n=5)
6	38	87% (n=33)	13% (n=5)
7	33	55% (n=18)	45% (n=15)
8	11	27% (n=3)	73% (n=8)

9	29	97% (n=28)	3% (n=1)
10	26	96% (n=25)	4% (n=1)
11	49	78% (n=38)	22% (n=11)
12	24	79% (n=19)	21% (n=5)
13	35	83% (n=29)	17% (n=6)
14	9	78% (n=7)	22% (n=2)
15	27	63% (n=17)	37% (n=10)
16	1	100% (n=1)	0% (n=0)
17	23	70% (n=16)	30% (n=7)
18	14	50% (n=7)	50% (n=7)
19	24	54% (n=13)	46% (n=11)
20	33	82% (n=27)	18% (n=6)
State	504	75% (n=380)	25% (n=124)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Performance item 18. This performance item addresses accurate assessment and receipt of appropriate services of the mental and behavioral health needs of children. As shown in Table 23, similar to the results of the other performance item within this outcome measure, the majority of cases reviewed were rated as a strength (73%). Although a substantial number of cases were rated as a strength for many Circuits, in four Circuits, a greater percentage of cases were rated as needing improvement than as a strength for this item.

Table 23

Performance Item 18: Mental/ Behavioral Health of the Child

SFY15-16			
Circuit	**Applicable Cases**	**Strength**	**Needing Improvement**
1	21	38% (n=8)	62% (n=13)
2	8	87.5% (n=7)	12.5% (n=1)
3	6	33% (n=2)	67% (n=4)
4	45	82% (n=37)	18% (n=8)

5	9	100% (n=9)	0% (n=0)
6	20	90% (n=18)	10% (n=2)
7	21	67% (n=14)	33% (n=7)
8	6	17% (n=1)	83% (n=5)
9	22	77% (n=17)	23% (n=5)
10	14	64% (n=9)	36% (n=5)
11	33	88% (n=29)	12% (n=4)
12	17	82% (n=14)	18% (n=3)
13	21	76% (n=16)	24% (n=5)
14	9	89% (n=8)	11% (n=1)
15	25	76% (n=19)	24% (n=6)
16	0	0% (n=0)	0% (n=0)
17	16	81% (n=13)	19% (n=3)
18	10	80% (n=8)	20% (n=2)
19	19	42% (n=8)	58% (n=11)
20	19	58% (n=11)	42% (n=8)
State	341	73% (n=248)	27% (n=93)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Well-being outcome 3 ratings. CFSR Well-Being Outcome 3 pertains to receipt of adequate services to meet the physical and mental health needs of children. Table 24 shows the summated ratings of the two performance items addressing this outcome. Of the cases reviewed statewide, 68% met the standards of substantial achievement and 13% were partially achieved. The standard for this outcome was not achieved or addressed for 19% of cases reviewed.

Table 24

Well-Being Outcome 3 Ratings

SFY 15-16				
Circuit	**Applicable Cases**	**Substantially Achieved**	**Partially Achieved**	**Not Achieved**
1	34	29% (n=10)	24% (n=8)	47% (n=16)
2	9	89% (n=8)	11% (n=1)	0% (n=0)
3	8	25% (n=2)	25% (n=2)	50% (n=4)
4	67	84% (n=56)	10% (n=7)	6% (n=4)
5	29	83% (n=24)	3% (n=1)	14% (n=4)
6	39	85% (n=33)	5% (n=2)	10% (n=4)
7	37	57% (n=21)	11% (n=4)	32% (n=12)
8	12	25% (n=3)	8% (n=1)	67% (n=8)
9	34	85% (n=29)	9% (n=3)	6% (n=2)
10	29	83% (n=24)	10% (n=3)	7% (n=2)
11	49	71% (n=35)	16% (n=8)	12% (n=6)
12	25	76% (n=19)	16% (n=4)	8% (n=2)
13	35	74% (n=26)	11% (n=4)	14% (n=5)
14	10	80% (n=8)	10% (n=1)	10% (n=1)
15	35	63% (n=22)	14% (n=5)	23% (n=8)
16	1	100% (n=1)	0% (n=0)	0% (n=0)
17	24	62.5% (n=15)	17% (n=4)	21% (n=5)
18	16	50% (n=8)	19% (n=3)	31% (n=5)
19	27	41% (n=11)	26% (n=7)	33% (n=9)
20	38	68% (n=26)	13% (n=5)	18% (n=7)
State	558	68% (n=381)	13% (n=73)	19% (n=104)

Note. Figures may not total to 100% due to rounding.
Note. Data Source: CFSR Online Monitoring System
Note. Date retrieved: April 21, 2016

Summary. In summary, for this baseline assessment there was substantial variation across Circuits in achieving substantial conformity for the three well-being indicators. A few

Circuits, such as Circuits 2, 10, and 14 most notably, stand out as consistently obtaining strength ratings for the relevant performance items. Across well-being outcomes and performance indicators according to these reviews, Circuits 1, 3, and 8 appear to be less effective in the quality of child welfare practices relevant to the safety, permanency, and well-being of children. The performance item related to enhancement of a family's capacity to provide for the needs of their children is an area of concern**.** This performance item rates the frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. This item was rated as a strength in only about one-third of the cases that were reviewed statewide. Subsequent reports for the upcoming state fiscal years will allow for the assessment of trends in CFSRs and progress towards achieving national standards for these outcomes at both the Circuit-level and the State-level.

Cost Analysis

Key Questions

The cost analysis examines the relationship between the Demonstration implementation and changes in the use of child welfare funding sources. Similar to the outcome analysis the cost analysis also has specific hypothesis that align with the Terms and Conditions. The key questions are:

1. Was the Demonstration implementation associated with a substitution from out-of-home expenditures to in-home prevention/early intervention/diversion expenditures using IV-E funding?
2. How has the Demonstration implementation impacted the use of other child welfare funding such as TANF and State funds?
3. Is the increased flexibility of the Demonstration associated with a reduction in administrative costs?
4. Was the Demonstration implementation cost-effective? What services were most cost-effective?

States have taken a number of approaches to examining the cost impact of the Demonstrations. The majority have focused on the required aspects of costs; e.g., cost neutrality and administrative costs. In general IV-E Demonstrations have had little to no impact on overall costs as States have reinvested any savings in additional services for children and families. Title IV-E funding reimburses States for a portion of expenditures for a restricted set of child welfare services. Allowable services are primarily focused on out-of-home services

including foster care maintenance and administration and training services related to foster care. In addition, payments to adoptive parents are reimbursable. One of the primary purposes of IV-E Demonstrations is to provide States with greater flexibility in the services that can be paid using IV-E funding. Such flexibility can allow States to provide in-home preventive services that would otherwise require IV-B funding. While the combination of IV-E and IV-B funding would suggest that both in-home and out-of-home services can be provided using Federal funding, IV-E funding is far greater than IV-B funding leading to a greater emphasis on out-of-home services.

Data Sources and Data Collection

Data for the cost analysis will be derived from Florida Accounting Information Record (FLAIR), Florida DCF Office of Revenue Management, stakeholder interviews, and FSFN.

Demonstrations with Capped IV-E Allocations

We reviewed the results from six states that have implemented and completed Demonstrations under a capped IV-E Waiver allocation. Under this program, IV-E payments from the Federal government are capped at a certain level and states are given greater flexibility in how those dollars are spent. The six states are California, Florida, Ohio, North Carolina, Indiana, and Oregon. Major findings from the evaluations of costs are summarized below.

As anticipated Demonstrations have resulted in a shift of funds away from out-of-home services to focus more on prevention. The Demonstrations were required to be cost neutral. In others words, achieving a cost savings was not a desired goal. Rather the requirement was that the Demonstration did not cost the federal government additional money. States were able to achieve this requirement based on the use of capped funding. Any savings were reinvested into providing additional services.

Current Trends in Florida and Implications for Costs

Florida's Demonstration provides a pre-determined amount of federal funding for foster care. The Demonstration Terms and Conditions requires that savings resulting from the Demonstration be used for the further provision of child welfare services; this clause is also referred to as "maintenance of effort." Using data from the DCF Office of Revenue Management, we compared planned expenditures for SFY 14-15 to actual FFY 04-05 expenditures (see Table 25). The FFY 04-05 expenditures are prior to the implementation of the original Demonstration. Thus, the differences represent a cumulative effect of the original Florida IV-E Waiver Demonstration and the Demonstration extension.

In calculating FFY 04-05 and SFY 14-15 planned expenditures, two sets of adjustments were made. The base year requirement has been reduced for reductions in federal funds (and

associated state matching funds) that are unrelated to the Demonstration. In addition, the amount of planned SFY 14-15 federal funds includes an adjustment for the annual increase that is part of the pre-determined federal funding. This adjustment prevents a reduction in state commitment due to increased federal funds. In other words, the State's funding level for child welfare services cannot be reduced because of the annual federal funding increase. When adjusted for reductions in federal funds (and associated state match) unrelated to the Demonstration, the base year funding requirement was $704,135,682. Planned expenditures for SFY 14-15, after adjustment for Demonstration related increases, are $780,544,921. This difference of $76,409,239 indicates that the State of Florida will exceed the level of effort (as measured by expenditures) that existed prior to the original Demonstration, assuming all planned expenditures are actually incurred.

Results. There are several noteworthy changes in specific categories. For example, State Independent Living expenditures (beyond match requirement; row 8) increased from $514,660 in FFY 04-05 to $19,250,167 in SFY 14-15. Expenditures for adoption services increased dramatically from both Federal and State funding sources (rows 21 and 22). Finally, State funding for Prevention, Intervention, and In-Home Supports (row 10) increased from $27,540,388 in FFY 04-05 to $68,926,694 in SFY 14-15.

Table 25

Title IV-E Base Year Level of Effort Worksheet

		Federal	State	Federal	State
Row	**Fund Source**	**Expenditures - October 1, 2004 through September 30, 2005**	**Expenditures - October 1, 2004 through September 30, 2005**	**Planned Expenditures SFY2014-15 for IVE-IVB Services**	**Planned Expenditures SFY2014-15 for IVE-IVB Services**
1	IV-E Foster Care Maintenance	50,754,233	33,163,382	0	13,879,389
2	IV-E Foster Care Administration w/o SACWIS	83,178,110	83,178,099	167,983,114	92,147,138
4	Title IV-B, Part 1	15,655,725	11,347,611	13,160,237	4,324,739
5	Title IV-B, Part 2	14,228,992	1,315,263	14,869,367	370,812
6	Chafee IL Match	7,889,242	3,547,100	5,979,489	1,494,873
7	Education and Training Voucher	3,521,171	603,723	2,396,966	599,242

8	State Independent Living Beyond Match Requirement	0	514,660	0	19,250,167
9	State Funded Maintenance Payments - Non IV-E	0	36,136,640	0	18,496,569
10	Prevention, Intervention, In-Home Supports State Funded - Non TANF	0	27,640,388	0	65,199,151
11	Medicaid Administration - Child Welfare	1,265,398	1,265,398	1,240,988	1,240,988
12	State Access and Visitation - Child Welfare	404,817	0	498,271	0
13	Promoting Safe and Stable Families - Marriage Grants	534,747	0	0	0
14	Child Abuse Prevention and Treatment	769,651	0	1,101,921	0
15	Community Based Child Abuse Prevention - Family Resource and Support	1,454,155	363,538	1,409,513	352,378
16	TANF MOE - Child Welfare	0	42,394,833	0	88,403,998
17	TANF Federal - Child Welfare	96,501,978	0	56,642,709	0
18	SSBG Funded Child Welfare Federal	15,859,779	0	9,003,108	0
19	SSBG II Funded Child Welfare Federal	41,216,118	0	41,305,125	0
20	Other State Funded Title IV-B-or IV-E Equivalents	0	55,069,533	0	35,560,129
21	TANF/State Funded Adoption Assistance Non-Title IV-E	7,662,366	9,761,620	16,037,534	30,581,895
22	Title IV-E Adoption Assistance Subsidy Payments	37,056,174	24,959,079	67,734,753	49,882,503
23	Total	377,952,656	331,260,867	399,363,095	421,783,971
24	Adjustment arising from factors other than waiver** beyond control of the State (1)	(4,136,818)	(941,023)	(40,602,145)	0
25	Adjusted Requirement	373,815,838	330,319,844	358,760,950	421,783,971

			704,135,682	**76,409,239**	780,544,921

Note. Represents Federal Award adjustments since the base year that are out of the control of the Department. For the SFY 14-15 Federal column, the $40 million adjustment represents the annual Federal increases to the Title IV-E Waiver since its implementation through SFY 13-14. These increases cannot be used to meet the State's "Savings" requirement pursuant to Section 2.2(l) of the Title IV-E Waiver Terms and Conditions contract.
Note. Training costs will be reimbursable separately in addition to the amount of the capped allocation, therefore, training costs are not included in SFY 14-15 and have been removed from the base year.
Note. The effect of CS/SB 1036-Extended Foster Care to State funds in SFY 14-15 have been applied to Foster Care Room and Board and Maintenance Adoption Subsidies based on the fiscal analysis. The estimated effect was also adjusted in the base year for the same amount.
Note. Data Source: DCF Office of Financial Management
Note. Date: September 2015
(1) The federal award adjustments since the base year that are out of the control of the Department has not been updated to reflect FFY 2014 grant awards since they are not known at this time.

During the reporting period of 10/15-03/16 we examined lead agency appropriations by type of service. In particular, it was examined whether there were changes between the original Demonstration period and the Demonstration extension. The evaluation of the Demonstration extension has used SFY 11-12 and SFY 12-13 as the base years. Data for SFY 07-08 through SFY 10-11 was reported for completeness. The DCF Office of Financial Management provided all data.

Table 26 examines whether the emphasis on prevention services during FFY 06-07 through 10-11 has remained the same, changed even more, or moved back towards dependency services. Our goal was not to examine the impact of the original Demonstration; thus, we did not include the base years used in the evaluation of the original Demonstration. As reported in Table 26, dependency case management and licensed care declined during the original Demonstration. Dependency case management expenditures continued to decline in SFY 13-14 from $310.1 million to $307.5 million. However, dependency case management increased in SFY 14-15 to $311.1 million. Licensed care expenditures reached its lowest level in SFY 12-13 before increasing slightly in SFY 13-14 (from $132 to $133.9 million), and increasing to $151.8 million in SFY 14-15 (a 13.4% increase).

Prevention services increased in the first year of the Demonstration extension from $49.1 million to $55.7 million before declining in SFY 14-15 to $45.2 million. Client services have increased during the Demonstration extension, from $27.4 million in SFY 12-13 to $33.5 million in SFY 13-14 and 43.6 million in SFY 14-15. Adoption services increased from SFY 07-08 to SFY 11-12. There was a one-year decline in adoption services expenditures in SFY 12-13 from $18.0 million to $15.9 million before rebounding to $18 million in SFY 13-14 and SFY 14-15.

Table 26

Community Based Care Lead Agency Expenditures for Specific Services

Fiscal Year	Dependency Case Management	Licensed Care	Prevention Svcs	Client Svcs	Adoption Svcs	Training	Other	Total
07/08	327,167,484	172,532,743	24,284,050	16,736,217	13,626,914	8,925,635	11,971,122	575,244,165
08/09	310,889,908	149,413,648	30,092,056	16,116,453	13,725,918	8,148,096	13,324,959	541,711,038
09/10	316,902,133	136,720,060	40,687,830	23,682,923	16,148,191	9,843,760	16,657,455	560,642,352
10/11	314,122,572	134,091,184	44,974,708	27,573,766	17,091,970	9,386,252	16,816,677	564,057,129
11/12	315,125,367	137,055,940	47,060,719	31,319,238	18,022,569	9,681,853	16,043,997	574,309,683
12/13	310,123,200	132,078,629	49,100,929	27,478,313	15,900,119	9,208,624	17,843,704	561,733,518
13/14	307,578,753	133,910,062	55,737,746	33,498,932	18,077,557	9,040,471	18,364,623	576,208,144
14/15	311,143,326	151,873,569	45,271,501	43,589,980	18,300,765	8,718,304	25,122,925	604,020,370

Note. Data Source: DCF Office of Financial Management
Note. Date: March 2016
Note. Client services include services provided to Out-of-Home dependency clients which are not allowable as foster care maintenance payments, services to In-Home dependency clients, and services provided to Pre-Adoption and Post Adoption clients. Specific services that might be included in this category include: Assessment and Evaluation, Child Care, Counseling, Home Maintenance, Housekeeping, In-Home Family Support, Information and Referral, Legal Services, Respite, Temporary Housing, Transportation.

Maintenance adoption subsidies (MAS) are presented in Table 27 from SFY 07-08 through SFY 14-15. The number of adoptions declined from SFY 07-08 (n=3,674) to SFY 10-11 (n=3,009). Adoptions increased in 3,252 in SFY 11-12 and have been fairly stable since then.

Despite the decline in adoptions from SFY 07-08, the total MAS budget increased steadily from $100.5 million to $149.6 million in SFY 12-13. The budget has continued to increase under the Demonstration extension reaching $168.0 million in SFY 14-15.

Table 27

History of Maintenance Adoption Subsidies (MAS) - Budget and Expenditures

Fiscal Year	Initial Budget for MAS	Additional MAS Budget from LBC Actions	Total MAS Budget Available	Total MAS Expenditures	Total # of Adoptions Finalized
07/08	97,183,122	3,367,134	100,550,256	100,960,832	3,674
08/09	111,338,851	1,908,500	113,247,351	111,490,435	3,776
09/10	124,603,030	-	124,603,030	122,982,298	3,367
10/11	130,642,608	2,203,562	132,846,170	131,448,871	3,009
11/12	141,675,422	-	141,675,422	140,696,458	3,252
12/13	148,261,828	1,400,000	149,661,828	150,405,112	3,353
13/14	156,842,838	5,383,639	162,226,477	161,176,455	3,245
14/15	168,001,927	-	168,001,927	170,962,310	3,229

Note. Data Source: DCF Office of Financial Management
Note. Date: March 2016
Note. During 2015 Legislative Session, The FY 15-16 GAA (in Section 45) contained $4,288,722 in Back of the Bill Funding for FY 14-15 MAS deficits. During 2014 Legislative Session, HB5001 (FY 14-15 GAA) provided an additional $5,383,639 for MAS in the back of the the bill for FY1 3-14. During 2013 Legislative Session, SB1500 (FY 13-14 GAA) provided an additional $1.4M for MAS in the back of the bill for FY 12-13. During FY 10-11, DCF received an increase in MAS due to ARRA funding. In FY 08-09, DCF received $1,908,500 in additional MAS budget authority based upon ARRA after GAA was approved. In June 2008 (FY 07-08) per LBC action, DCF received $3,367,134 in additional MAS budget authority from the appropriated Risk Pool category.
Note. Client services include services provided to Out-of-Home dependency clients which are not allowable as foster care maintenance payments, services to In-Home dependency clients, and services provided to Pre-Adoption and Post Adoption clients. Specific services that might be included in this category include: Assessment and Evaluation, Child Care, Counseling, Home Maintenance, Housekeeping, In-Home Family Support, Information and Referral, Legal Services, Respite, Temporary Housing, Transportation.

Table 28 contains annual expenditures for Independent Living services. Total independent living expenditures increased from $29.8 million in SFY 07-08 to $52.3 million in SFY 10-11. Total expenditures fell to $46.3 million in SFY 12-13, and declined further during the Demonstration extension reaching $39.6 million in SFY 14-15.

Expenditures for specific programs within Independent Living have changed considerably since SFY 12-13. Expenditures for case coordination and life skills training have declined $2.4 million (from $12.9 to $10.5 million) while expenditures for the Road to Independence program declined $20 million (from $26.8 to $6.8 million) and transitional

expenditures declined $5.5 million (from $5.5 million to 0). At the same time two new programs, Extended Foster Care and Postsecondary Education Services started with expenditures reaching $6.4 and $15.3 million in SFY 14-15.

Table 28

Independent Living Expenditures by Program by Fiscal Year

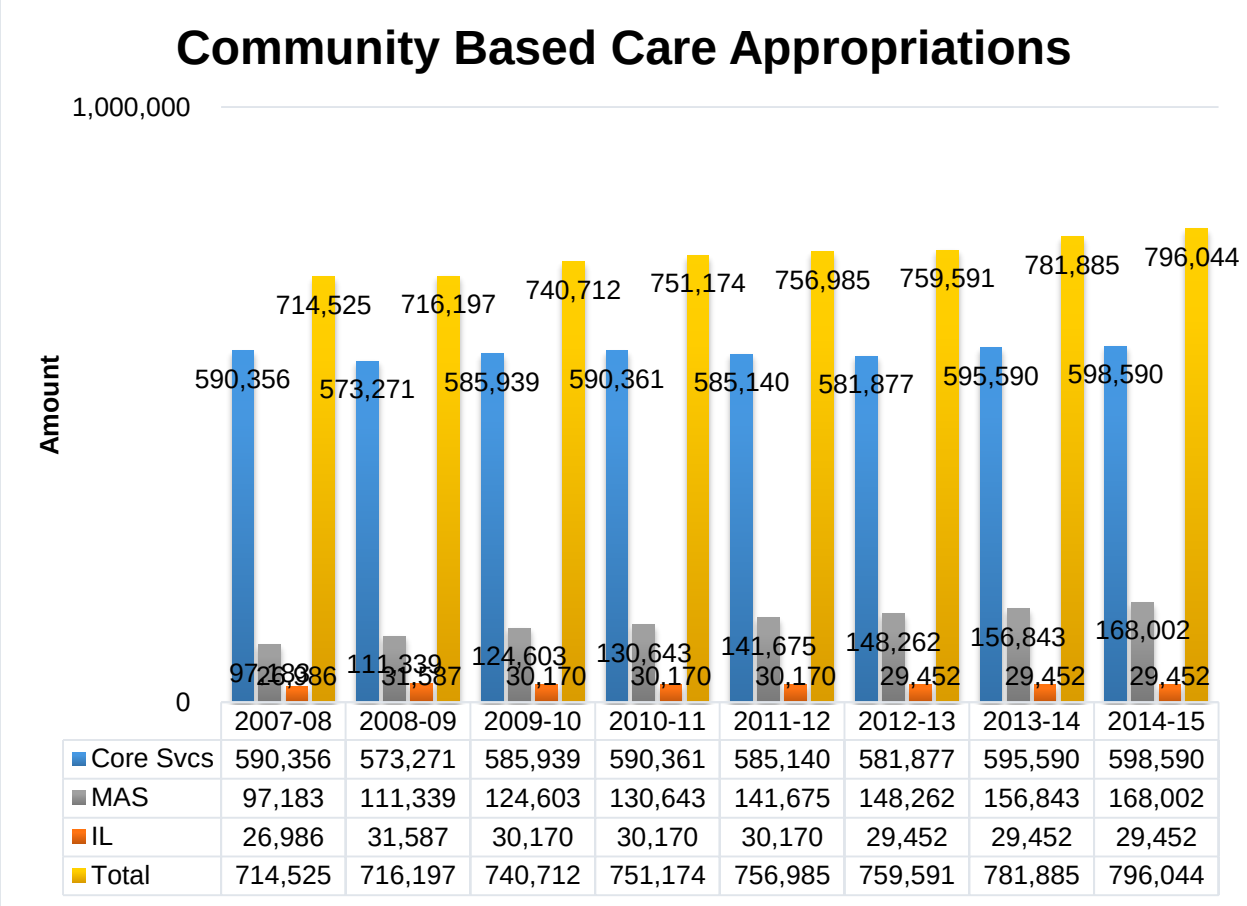
	1	2	3	4	5	6	7	1 thru 7
State Fiscal Year	**Case Coordi-nation & Life Skills Traini-ng**	**Subsid-ized IL (SIL Ages 16-17)**	**Road to Indepe-ndence (RTI)**	**Transit-ional**	**After care**	**Exte-nded Foste r Care (EFC)**	**Posts-econdary Educati-on Services & Supports (PESS)**	**Total IL Expend -itures**
07/08	7,823,445	472,801	16,942,761	3,487,197	1,045,986	-	-	29,772,190
08/09	8,834,560	833,921	23,458,611	4,349,971	1,056,032	-	-	38,533,096
09/10	10,738,650	737,457	35,260,681	4,265,864	877,447	-	-	51,880,099
10/11	11,626,648	408,919	35,204,423	4,591,816	448,780	-	-	52,280,586
11/12	13,066,982	276,761	29,858,300	5,208,321	628,794	-	-	49,039,158
12/13	12,929,557	164,621	26,854,501	5,474,269	847,282	-	-	46,270,229
13/14	12,441,197	108,705	20,764,502	2,368,999	667,920	1,431,030	5,073,086	42,855,440
14/15	10,515,962	1,651	6,848,109	-	625,356	6,381,856	15,263,802	39,636,735

Note. Data Source: DCF Office of Financial Management

Note. Date: March 2016
Note. Client services include services provided to Out-of-Home dependency clients which are not allowable as foster care maintenance payments, services to In-Home dependency clients, and services provided to Pre-Adoption and Post Adoption clients. Specific services that might be included in this category include: Assessment and Evaluation, Child Care, Counseling, Home Maintenance, Housekeeping, In-Home Family Support, Information and Referral, Legal Services, Respite, Temporary Housing, Transportation.

Figure 19 contains on overall summary of Community-Based Care appropriations from SFY 07-08 through SFY 14-15. Overall, appropriations have increased over time with much of the increase due to Maintenance Adoption Subsidies. Appropriations for core services and independent living services also increased, but to a much smaller degree. Total appropriations were $782 million in SFY 12-13 and increased to $796 million in SFY 13-14 and $830 million in 14-15.

Figure 19. Community Based Care Appropriations



	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Core Svcs	590,356	573,271	585,939	590,361	585,140	581,877	595,590	598,590
MAS	97,183	111,339	124,603	130,643	141,675	148,262	156,843	168,002
IL	26,986	31,587	30,170	30,170	30,170	29,452	29,452	29,452
Total	714,525	716,197	740,712	751,174	756,985	759,591	781,885	796,044

Note. Data Source DCF Office of Financial Management.
Note. Dollars are reported in thousands.
Note. Date: March 2016

Thus, the Demonstration extension has seen a number of changes in lead agency expenditures by type of service. The trend away from dependency services and towards prevention services continued into SFY 13-14 but then reversed in SFY 14-15. Maintenance adoption subsidies have continued to increase while expenditures for independent living services have declined. Overall, appropriations for Community-Based Care have continued to increase. It is challenging to attribute any causal relationship between the Demonstration extension and changes in appropriations or expenditures.

Summary

The Demonstration extension has seen a change in costs compared to the original Demonstration. While the trend towards using more prevention services continued into SFY 13-14, the trend reversed in SFY 14-15. Similarly, there were costs were lower for dependency and licensed foster care services in SFY 13-14 than SFY 12-13, but increased in SFY 14-15. It will be important to continue to follow these service costs to see how service costs change during the Demonstration extension.

Limitations

The primary limitation to the analysis is the relatively straightforward research design. Because the Demonstration is statewide, we cannot use a randomized or quasi-experimental research design to assess the impact of the Demonstration on costs. Instead, the primary methods utilize analysis of trends over time to determine whether the Demonstration is associated with expected changes. Clearly, no causal relationships can be determined using such an approach.

Sub-Study: Cross-System Services and Costs

This section reports on a sub-study using cost and service data. A second sub-study combining the process analysis, outcome analysis and cost analysis will be conducted in future years of the evaluation. Youth (e.g., children ages 0 to 18 years) involved in the child welfare system often receive services that are funded through state Medicaid programs and other funding sources, and are at-risk for juvenile justice involvement. Appropriate and effective services provided through the child welfare system have the ability to effect services and expenditures with other public sector systems. It is important to examine how changes in the child welfare services provided to youth also affect service use and costs for other public sector systems. Specific public sector systems that will be examined over time in this sub-study are Medicaid, Juvenile Justice, and Baker Act (involuntary examinations). The analysis examines trends in service use and costs for youth served by the child welfare system and other state systems. As such, there is no explicit comparison group. Evaluation team members have considerable experience using these alternative data sources and matching FSFN data with these data sources.

Data Sources and Data Collection

A cohort analysis will be conducted following youth who were removed from the home at different points in time to examine how services, costs, and outcomes in other public-sector systems vary depending on whether the youth entered the child welfare system before or after implementation of the Demonstration extension.

The sub-study will be completed in stages based on the availability of data. In this report, Medicaid enrollment and claims/encounter data for youth that received out-of-home services was analyzed. This report only examines youth that were removed from the home. Youth that only received in-home services and other funding sources will be examined in a future report.

Data analysis

Enrollment and service use data was examined for three cohorts. The cohorts contain youth removed from the home during SFY 11-12, SFY 12-13, and SFY 13-14. Identifiers for youth were from FSFN. For youth in each cohort we extracted all Medicaid enrollment and claims/encounter data for the 12 months before and after removal. Enrollment data are maintained by the Agency for Health Care Administration (AHCA). Claims and encounter data include all fee-for-service claims, Prepaid Mental Health Plan encounters, HMO encounters, and encounters from the Statewide Medicaid Managed Care (SMMC) program.

Prior to 2014, Medicaid enrollees had two primary options. First, there was the traditional fee-for-service program for physical health care services. Behavioral health services were carved-out and provided through the Prepaid Mental Health Plan (PMHP). In particular, youth in the child welfare system were included in the Child Welfare PMHP. Alternatively, Medicaid beneficiaries could also enroll in a Health Maintenance Organization (HMO) that would be responsible for both physical and behavioral health care. In 2014, that choice was removed, and the Statewide Medicaid Managed Care (SMMC) program transitioned most enrollees in the fee-for-service program into managed care plans responsible for both physical and behavioral health. In addition, there is a specialty plan (Sunshine Health Child Welfare Specialty Plan) that is responsible for services to youth in the child welfare system. The PMHP program was discontinued.

Results

First, Medicaid enrollment patterns for youth in the child welfare system were examined. Enrollment in the year prior to removal from the home and the year after removal from the home was also examined. There were 45,879 removals during SFY 11-12 through SFY 13-14, with 42,851 (93.4%) having Medicaid enrollment in the 12 months after removal.

Youth are generally Medicaid eligible after removal from the home. There were several potential reasons why evidence of Medicaid enrollment could not be found. First, administrative data, while an important source of data, is imperfect. Thus, some youth are likely to have Medicaid enrollment, but incorrect or missing Social Security Numbers would cause a non-match. Second, it is possible some youth have coverage through private insurance and thus despite being eligible, were not enrolled in Medicaid. Third, some youth will not be eligible for Medicaid due to not having the appropriate non-citizen status.

Table 29

Proportion of youth with Medicaid coverage after removal from home, SFY 11-13

		Medicaid Enrolled				
Circuit	**Youth**	**After removal**	**Before removal**	**OR**	**95% CI**	
1	2636	95.7%	94.8%	1.81	1.42	2.31
2	983	95.4%	93.3%	1.71	1.22	2.39
3	803	94.6%	94.3%	1.45	1.03	2.04
4	2530	95.0%	94.4%	1.56	1.24	1.98
5	2963	93.1%	92.4%	1.10	0.90	1.36
6	5103	93.5%	92.9%	1.17	0.97	1.41

7	2546	92.6%	91.9%	1.03	0.83	1.27
8	929	93.1%	93.1%	1.11	0.82	1.49
9	2404	92.4%	91.8%	--		
10	2763	94.4%	93.9%	1.38	1.10	1.72
11	4269	92.6%	91.9%	1.03	0.85	1.24
12	1792	93.5%	93.1%	1.18	0.93	1.51
13	3574	93.8%	93.4%	1.24	1.01	1.52
14	922	95.7%	95.4%	1.81	1.27	2.57
15	2647	93.7%	92.9%	1.21	0.97	1.50
16	208	94.7%	92.3%	1.47	0.79	2.74
17	2877	92.2%	91.8%	0.98	0.80	1.20
18	2193	92.5%	91.3%	1.01	0.81	1.25
19	1486	92.9%	92.5%	1.08	0.84	1.38
20	2251	91.5%	90.7%	0.88	0.72	1.09
Overall	45879	93.4%	92.8%			

Note. Data Sources: SFY 11-12 through 13-14 Florida Safe Families Network (FSFN), Medicaid enrollment and claims/encounter data, and Florida Substance Abuse and Mental Health Information System (SAMHIS).
Note. Data were accessed January 25, 2016.

There is limited ability to examine reasons for non-enrollment with administrative data. Medicaid enrollment across Circuits was examined to determine whether non-enrollment post-removal was more prevalent in certain Circuits. Table 29 contains the proportion of removals where the youth had Medicaid enrollment in the year following removal. Medicaid enrollment was most common in Circuits in the Northern part of the State. Among the Circuits with the highest rates of enrollment were Circuits 1, 2, 3, 4, and 14. Medicaid enrollment was less common in the Southern part of the State (Circuits 11, 17, and 20) and the Central region of the State (Circuits 7, 9, 18, and 19)[2]. The statewide proportion of out-of-home care youth enrolled in Medicaid post-removal was 93%.

We also estimated a simple logistic regression to compare enrollment rates across Circuits. Odds ratios from the regression are reported in Table 29. Once again, enrollment was significantly higher among Circuits in the northern part of the State (Circuits 1, 2, 3, 4, and 14) with all exhibiting higher Medicaid enrollment rates than the comparison Circuit (9). Circuits with significantly higher enrollment rates were Circuits 10 and 13.

[2]These findings could be due to non-citizen status, or a variety of other factors.

Given that this report focuses on Medicaid enrollment and claims data, it cannot be determined whether youth without any Medicaid enrollment were receiving services paid by other means. Thus, the remainder of the analysis focuses on youth that were Medicaid enrolled in the year after removal. It is also worth noting that we did not discontinue following the youth if they were no longer out-of-home. Once removed from the home, the focus is on the Medicaid-funded services that the youth received. Finally, this analysis is very descriptive in nature. Future reports will provide a more detailed statistical analysis and more rigorously test hypotheses regarding the effects of the Demonstration extension.

Interestingly the vast majority of youth (93%) were also Medicaid enrolled in the year prior to removal. Youth averaged 288 days of Medicaid enrollment in the year prior to removal (data not shown). This finding suggests that most youth were Medicaid eligible due to other factors (e.g., family income below poverty level). Thus, we should have a good picture of services received by youth in the year before and after removal from the home. For the purpose of this report, it was assumed that youth did not receive services when they were not Medicaid enrolled. We expect few youth would have private coverage and then transition to Medicaid after removal. Of course, youth may receive some services funded through other public sector mechanisms. We will explore this possibility using SAMHIS data in future reports. For the purpose of this report, youth were assumed to be receiving no services when they were not Medicaid enrolled.

Service utilization. Table 30 examines service use and expenditures from several perspectives. The first set of statistics examine average utilization across all youth in the sample. The middle section examines average use among users of services. The final section examines average utilization among youth that used a specific service. The discussion below focuses on expenditures with patterns for units and days also reported. Units reflect the definition for CPT procedure codes. Thus, a single behavioral health office visit might include 3 or 4 units of service (with each unit denoting a 15-minute office visit). Days of service are also somewhat challenging for outpatient claims that span several days; it is unclear whether services are provided on each day or not. Thus, both units and days of service are useful for examining patterns over time, but care should be taken when looking across services or looking at absolute numbers of units or days.

A number of results are noteworthy. First, conclusions regarding total expenditures depend on the perspective of the comparison. Youth averaged $3,805 in total Medicaid expenditures in the year prior to removal compared to $4,881 in the year after removal. Thus, it would appear that expenditures increased after removal. However, this simply reflects the

much lower penetration rates in the year prior to removal. Only 63.7% (n=27,319) of youth used any Medicaid services in the year prior to removal compared to 96.7% of youth in the year after removal. When looking only at youth that received services, the average expenditures were $5,971 in the year prior to removal and $5,049 in the year after removal. It can be concluded that more youth received services in the year after removal, and that among users, average expenditures declined in the year after removal.

We also examined utilization of specific services. For this report, we classified services as physical health inpatient, physical health outpatient, behavioral health inpatient, and behavioral health outpatient. Services were classified based on the primary diagnosis for the claim/encounter and the service type listed on the claim/encounter. Two patterns were clear. Physical health inpatient utilization declined in the year after removal. This might reflect a need for physical health inpatient services due to maltreatment. Alternatively, youth with complex medical needs may receive better case management after entering out-of-home care and thus have fewer acute care episodes. The average physical health inpatient expenditures declined from $2,382 to $984 among all youth, and from $3,738 to $1,108 among all users of Medicaid services. The $3,738 average for physical health inpatient services among users of Medicaid services comprised nearly 63% of the $5,971 total expenditures on the youth. The use of outpatient services increased in the year after removal. In particular, the use of behavioral health outpatient services increased in the year after removal, although utilization of physical health outpatient services also increased. Behavioral health outpatient expenditures increased from $353 to $1,768 among all youth and from $555 to $1,829 among all users of Medicaid services. Thus, despite overall expenditures declining among users of services in the year after removal, the focus of treatment shifted considerably; presumably towards a more therapeutic emphasis.

The final section of Table 30 examines utilization of specific services. For example, average expenditures for youth with a physical health inpatient stay declined from $22,098 among 4,621 users of the service prior to removal, to $16,533 among 2,553 users after removal. Thus, there were fewer youth using physical health inpatient services in the year after removal, and expenditures were lower for the youth that used services. Average expenditures for behavioral health outpatient services increased from $1,721 among 8,810 users of the services prior to removal, to $2,558 among 29,641 users of the services after removal. Thus, there were many more youth receiving behavioral health outpatient services, and the youth that received services were receiving more services.

Table 30

Medicaid Expenditures by Service Category

			Year prior to removal		Year after removal	
				Mean		Mean
All youth with Medicaid enrollment (n=42,876)						
Total expenditures				$ 3,805.04		$ 4,881.70
Physical health inpatient						
	Units			2.18		0.91
	Days			2.03		0.97
	Expenditures			$ 2,382.02		$ 984.60
Physical health outpatient						
	Units			36.42		71.28
	Days			14.00		26.77
	Expenditures			$ 875.06		$ 1,868.93
Behavioral health inpatient						
	Units			0.34		0.52
	Days			0.35		0.91
	Expenditures			$ 194.18		$ 259.71
Behavioral health outpatient						
	Units			17.80		71.08
	Days			10.83		43.18
	Expenditures			$ 353.78		$ 1,768.46
Used any Medicaid services			n=27,319	63.7%	n=41,449	96.7%
Total expenditures				$ 5,971.85		$ 5,049.76
Physical health inpatient						
	Units			3.42		0.94
	Days			3.19		1.00
	Expenditures			$ 3,738.48		$ 1,018.49
Physical health outpatient						
	Units			57.17		73.74

	Days			21.98		27.70
	Expenditures			$ 1,373.38		$ 1,933.27
Behavioral health inpatient						
	Units			0.54		0.53
	Days			0.56		0.94
	Expenditures			$ 304.75		$ 268.65
Behavioral health outpatient						
	Units			27.94		73.53
	Days			17.00		44.67
	Expenditures			$ 555.24		$ 1,829.35
Users of specific service category						
Physical health inpatient			n=4,621		n=2,553	
	Units			20.22		15.29
	Days			18.81		16.25
	Expenditures			$ 22,098.06		$ 16,533.75
Physical health outpatient			n=25,558		n=38,575	
	Units			61.11		79.24
	Days			23.49		29.76
	Expenditures			$ 1,467.45		$ 2,076.62
Behavioral health inpatient			n=691		n=1,004	
	Units			21.30		22.07
	Days			22.02		38.89
	Expenditures			$ 12,048.47		$ 11,089.81
Behavioral health outpatient			n=8,810		n=29,641	
	Units			86.64		102.82
	Days			52.73		62.46
	Expenditures			$ 1,721.13		$ 2,558.10

Note. Data Sources: SFY 11-12 through 13-14 Florida Safe Families Network (FSFN), Medicaid enrollment and claims/encounter data, and Florida Substance Abuse and Mental Health Information System (SAMHIS).
Note. Data were accessed January 25, 2016.

Table 31 examines service use across the three years (SFY 11-12, SFY 12-13, and SFY 13-14). Averages were reported for youth that used any Medicaid service in the pre-period, and in the post-period. This is the same as the *Used Any Medicaid Service* group in Table 30. Total Medicaid expenditures vary somewhat across the three years, increasing between SFY 11-12 and SFY 12-13 before declining in SFY 13-14. As noted above, the Medicaid program was undergoing considerable changes in 2014 with many enrollees transitioning into the SMMC program. The changes can make cross-year comparisons challenging. In particular, data quality for PMHP's was not the best, with many encounters missing important data. SMMC data appear to be an improvement, but there can often be issues with incomplete data when new programs are starting. Thus, any comparisons across the three years should be done cautiously.

The evaluation has focused on SFY 13-14 as the first year of the extension, with SFY 11-12 and SFY 12-13 seen as the base years. Thus, under the Demonstration extension, youth removed from the home received fewer Medicaid funded services before and after removal. Indeed, physical health inpatient expenditures were particularly lower among youth removed from the home in the Demonstration extension year (SFY 13-14) compared to the pre-extension years. At the same time, an increase in the number of youth removed from the home in SFY 13-14 occurred. It is challenging to draw specific conclusions regarding this change in enrollment and expenditures. For example, changes in enrollment patterns may reflect the impact of the Demonstration extension on removal decisions. Changes in Medicaid service and expenditure patterns also may reflect changes in the characteristics of youth entering out-of-home care (e.g., less medical and behavioral health care needs), or may reflect the implementation of the SMMC program.

This analysis highlights the fact that policy changes made by one State agency can have important implications for other State agencies. Differences in enrollment and service utilization patterns that result from policy changes can have important implications for the appropriate funding of the SMMC Child Welfare Specialty plan by AHCA. For example, an increase in the number of removals could lead to increased enrollment in the Specialty plan. While a possibility, we did not examine SMMC enrollment patterns and did not explicitly determine if youth transitioned to the Specialty Plan after removal (versus continuing with the same plan as prior to removal). In addition to changes in enrollment, there could also be changes in the characteristics of youth enrolled in the plan that could lead to changes in expected service use. Risk adjustment models are not likely to capture such changes, and could result in considerable over- or under- funding of the Specialty Plan.

Expenditure changes for specific services between the pre- and post- removal periods reflect the same patterns in each year. Expenditures are lower after removal for physical health inpatient services, and increase for physical and behavioral health outpatient services.

Table 31

Expenditures by Year

Service		Year prior to removal		Year after removal	
SFY 11/12	Tot expend	# Users	Mean per user	# Users	Mean per user
n=15,035		9210	$ 6,036.21	14417	$ 5,105.15
Physical inpatient	Units		2.46		1.04
	Days		2.75		1.12
	Expend		$ 3,818.02		$ 1,116.11
Physical outpatient	Units		61.61		72.67
	Days		20.49		27.38
	Expend		$ 1,238.35		$ 1,782.07
Behavioral inpatient	Units		0.52		0.50
	Days		0.54		0.51
	Expend		$ 317.26		$ 255.82
Behavioral Outpatient	Units		31.78		76.35
	Days		20.77		58.08
	Expend		$ 662.59		$ 1,951.15
SFY 12/13	Tot expend	8243	$ 6,487.77	12681	$ 5,520.18
n=13,149					
Physical inpatient	Units		2.88		1.14
	Days		3.16		1.22
	Expend		$ 4,306.76		$ 1,207.32
Physical outpatient	Units		62.28		84.73
	Days		23.50		29.63
	Expend		$ 1,407.51		$ 2,113.15

Behavioral inpatient	Units		0.43		0.62
	Days		0.44		0.63
	Expend		$ 246.47		$ 292.36
Behavioral Outpatient	Units		28.26		76.81
	Days		17.11		51.84
	Expend		$ 527.03		$ 1,907.35
SFY=2013/14	Tot expend	9866	$ 5,480.74	14351	$ 4,578.46
n=14,692					
Physical inpatient	Units		4.77		0.67
	Days		3.62		0.69
	Expend		$ 3,189.45		$ 753.58
Physical outpatient	Units		48.76		65.10
	Days		22.10		26.30
	Expend		$ 1,470.91		$ 1,926.23
Behavioral inpatient	Units		0.65		0.50
	Days		0.67		1.65
	Expend		$ 341.77		$ 260.60
Behavioral Outpatient	Units		24.09		67.78
	Days		13.40		24.85
	Expend		$ 478.61		$ 1,638.05

Note. Data Sources: SFY 11-12 through 13-14 Florida Safe Families Network (FSFN), Medicaid enrollment and claims/encounter data, and Florida Substance Abuse and Mental Health Information System (SAMHIS).
Note. Data were accessed January 25, 2016.

Table 32 contains average expenditures by Circuit. The vast majority of youth who were Medicaid enrolled used Medicaid funded services in the year after removal. Penetration ranged from 94.7% in Circuit 18 (1921/2028) to 98.4% in Circuit 1 (2483/2522). Penetration rates across Circuits varied to a greater degree prior to removal. For example, only 55% of youth used Medicaid funded services in Circuit 13 (1832/3353) in the year prior to removal, compared to 82.2% in Circuit 8 (711/865).

While average total expenditures declined after removal (see Table 30), not all Circuits had such a decline in expenditures. Indeed, average Medicaid expenditures increased in the year after removal in five Circuits including Circuits 1, 2, 11, 14, and 19. Three of these Circuits (1, 2, and 14) are located in the Northwest region. The increase in average expenditures can be explained by lower physical health inpatient expenditures in the year prior to removal. Indeed, Circuits 1, 2, and 14 were all among the bottom five Circuits in average inpatient expenditures prior to removal.

Average physical health inpatient expenditures in the year prior to removal were highest in Circuits 3, 6, 9, 12, and 20, three of which are located in the Suncoast region. Future research should examine the reasons for inpatient care (e.g., diagnosis), whether those reasons were related to maltreatment (e.g., illness versus injury), whether the youth were known to the child welfare system prior to needing inpatient care (prior involvement), and ultimately whether the need for inpatient care might have been avoidable.

Average behavioral health outpatient expenditures increased in all 20 Circuits. There was not a clear geographic pattern in behavioral health outpatient expenditures. Circuits with the lowest average prior to removal were located in the Northwest (Circuit 1), Northeast (3, 8), Central (10), and Suncoast (20) regions. Thus, no Circuits in the southern part were among those with the lowest expenditures. Circuits with the highest average behavioral health outpatient expenditures prior to removal were located in the Northwest (2), Northeast (7), Southeast (15), and Southern (11, 16) regions. The ranking of Circuits based on the change in behavioral health expenditures also was spread throughout the State. Circuits with the largest change in expenditures were located in the Northeast (7), Central (19), Southeast (15, 17) and Southern (11) regions.

Table 32

Expenditures by Circuit

Medicaid SFY 11/12-13/14					
		Year prior to removal		Year after removal	
	Enrolled	# Users	Mean per enrolled	# Users	Mean per enrolled
Circuit 1	2522				
Total expenditures		1895	$ 3,428.16	2483	$ 4,116.37
Physical inpatient			$ 1,663.91		$ 444.46

Physical outpatient			$ 1,142.20		$ 2,054.44
Behavioral inpatient			$ 254.50		$ 308.39
Behavioral outpatient			$ 367.55		$ 1,309.09
Circuit 2	938				
Total expenditures		662	$ 4,660.93	899	$ 5,149.31
Physical inpatient			$ 1,774.89		$ 540.76
Physical outpatient			$ 1,352.88		$ 1,893.85
Behavioral inpatient			$ 595.78		$ 371.36
Behavioral Outpatient			$ 937.38		$ 2,343.34
Circuit 3	760				
Total expenditures		618	$ 6,255.59	739	$ 4,645.05
Physical inpatient			$ 4,505.14		$ 1,639.71
Physical outpatient			$ 1,313.40		$ 1,917.52
Behavioral inpatient			$ 123.82		$ 23.18
Behavioral Outpatient			$ 313.23		$ 1,064.64
Circuit 4	2404				
Total expenditures		1548	$ 5,254.75	2322	$ 4,473.67
Physical inpatient			$ 3,451.37		$ 757.54
Physical outpatient			$ 1,303.44		$ 2,033.03
Behavioral inpatient			$ 71.85		$ 237.24
Behavioral Outpatient			$ 28.09		$ 1,445.86
Circuit 5	2758				
total expenditures		1681	$ 5,162.33	2631	$ 3,219.01
Physical inpatient			$ 3,398.30		$ 557.74
Physical outpatient			$ 1,167.74		$ 1,562.23
Behavioral inpatient			$ 130.18		$ 87.16
Behavioral Outpatient			$ 466.10		$ 1,011.89

Circuit 6	4769				
Total expenditures		2834	$ 8,104.03	4551	$ 5,740.50
Physical inpatient			$ 5,417.89		$ 1,415.13
Physical outpatient			$ 1,411.96		$ 2,098.80
Behavioral inpatient			$ 598.07		$ 294.54
Behavioral Outpatient			$ 676.11		$ 1,932.03
Circuit 7	2358				
Total expenditures		1548	$ 5,769.39	2278	$ 5,455.19
Physical inpatient			$ 3,367.37		$ 806.92
Physical outpatient			$ 1,253.81		$ 1,639.71
Behavioral inpatient			$ 316.29		$ 223.51
Behavioral Outpatient			$ 831.91		$ 2,785.05
Circuit 8	865				
Total expenditures		711	$ 5,560.13	846	$ 3,976.38
Physical inpatient			$ 4,041.10		$ 821.38
Physical outpatient			$ 1,187.56		$ 2,192.78
Behavioral inpatient			$ 100.65		$ 46.55
Behavioral Outpatient			$ 230.83		$ 915.68
Circuit 9	2222				
Total expenditures		1330	$ 6,719.93	2149	$ 5,306.73
Physical inpatient			$ 4,394.87		$ 1,101.87
Physical outpatient			$ 1,492.37		$ 2,061.46
Behavioral inpatient			$ 305.58		$ 308.54
Behavioral Outpatient			$ 527.11		$ 1,834.86
Circuit 10	2608				
Total expenditures		1479	$ 4,825.20	2491	$ 3,838.22
Physical inpatient			$ 2,746.64		$ 626.03
Physical outpatient			$ 1,421.75		$ 1,832.44

Behavioral inpatient			$ 353.67		$ 144.92
Behavioral Outpatient			$ 303.14		$ 1,234.84
Circuit 11	3954				
Total expenditures		2429	$ 6,178.51	3827	$ 6,678.66
Physical inpatient			$ 3,502.20		$ 480.95
Physical outpatient			$ 1,566.29		$ 2,095.22
Behavioral inpatient			$ 328.23		$ 421.31
Behavioral Outpatient			$ 781.80		$ 2,681.18
Circuit 12	1676				
Total expenditures		1029	$ 8,970.24	1643	$ 5,694.85
Physical inpatient			$ 6,602.02		$ 1,136.13
Physical outpatient			$ 1,659.19		$ 2,631.66
Behavioral inpatient			$ 294.67		$ 552.62
Behavioral Outpatient			$ 414.36		$ 1,374.44
Circuit 13	3353				
Total expenditures		1832	$ 5,861.70	3228	$ 4,221.18
Physical inpatient			$ 4,188.82		$ 958.12
Physical outpatient			$ 1,073.64		$ 1,723.90
Behavioral inpatient			$ 183.06		$ 125.37
Behavioral Outpatient			$ 416.18		$ 1,413.79
Circuit 14	882				
Total expenditures		722	$ 3,993.80	864	$ 4,344.59
Physical inpatient			$ 2,263.73		$ 321.43
Physical outpatient			$ 1,197.60		$ 1,763.70
Behavioral inpatient			$ 37.39		$ 63.63
Behavioral Outpatient			$ 495.08		$ 2,195.83
Circuit 15	2479				

Total expenditures		1584	$ 7,091.13	2413	$ 6,952.04
Physical inpatient			$ 4,347.85		$ 1,972.77
Physical outpatient			$ 1,641.63		$ 1,728.11
Behavioral inpatient			$ 313.18		$ 550.27
Behavioral Outpatient			$ 788.47		$ 2,700.89
Circuit 16	197				
Total expenditures		151	$ 5,109.55	192	$ 5,079.21
Physical inpatient			$ 2,537.42		$ 1,335.01
Physical outpatient			$ 1,315.55		$ 1,884.52
Behavioral inpatient			$ 486.29		$ 117.76
Behavioral Outpatient			$ 770.29		$ 1,741.92
Circuit 17	2654				
Total expenditures		1662	$ 6,343.67	2596	$ 5,505.28
Physical inpatient			$ 4,035.32		$ 780.56
Physical outpatient			$ 1,466.67		$ 1,972.29
Behavioral inpatient			$ 279.92		$ 371.52
Behavioral Outpatient			$ 561.76		$ 2,380.91
Circuit 18	2028				
Total expenditures		1217	$ 5,687.08	1921	$ 5,015.13
Physical inpatient			$ 2,963.03		$ 847.89
Physical outpatient			$ 1,491.93		$ 1,922.02
Behavioral inpatient			$ 535.85		$ 287.16
Behavioral Outpatient			$ 696.26		$ 1,958.05
Circuit 19	1381				
Total expenditures		979	$ 4,051.91	1346	$ 5,230.66
Physical inpatient			$ 1,967.01		$ 1,018.12
Physical outpatient			$ 1,109.69		$ 1,556.55
Behavioral inpatient			$ 329.34		$ 271.97

Behavioral Outpatient			$ 645.87		$ 2,384.02
Circuit 20	2060				
Total expenditures		1404	$ 6,877.63	2022	$ 4,080.41
Physical inpatient			$ 4,627.27		$ 1,155.62
Physical outpatient			$ 1,644.61		$ 2,008.44
Behavioral inpatient			$ 273.84		$ 55.82
Behavioral Outpatient			$ 331.90		$ 860.53

Note. Data Sources: SFY 11-12 through 13-14 Florida Safe Families Network (FSFN), Medicaid enrollment and claims/encounter data, and Florida Substance Abuse and Mental Health Information System (SAMHIS).
Note. Data were accessed January 25, 2016.

Conclusion and Upcoming Analysis

There are a number of interesting results that emerged from this sub-study. The vast majority of youth that were enrolled in the Medicaid program after removal from the home were also enrolled prior to removal. However, service penetration was much higher after removal from the home. The pattern of service use also differed before and after removal. Physical health inpatient services were more common before removal, and were likely related to the reasons for removal. Behavioral health outpatient services were much more common after removal from the home. Behavioral health services are likely crucial to future youth outcomes due to the trauma associated with maltreatment.

Several differences across time were found with more youth removed from the home after extension of the Demonstration; although this change may be due to other changes in the child welfare system and not the Demonstration. The service mix also changed after the extension of the Demonstration with inpatient physical health services prior to removal becoming less common.

Finally, there were a number of differences in service utilization patterns across Circuits. Service utilization declined after removal from the home, particularly for physical health inpatient services. However, this trend was not apparent in all Circuits, and service penetration and changes in service use varied considerably across Circuits.

Limitations

This analysis only examined Medicaid funded services. Consequently, it does not include all services received by youth. Youth may also receive services funded by DCF and/or lead agencies. In addition, the analysis is very descriptive. Given the Demonstration was

implemented statewide, the development and testing of specific hypotheses if challenging. As always, the use of administrative data enables us to examine a wide variety of questions that could not easily be answered using primary data, but also has some shortcomings. Like any administrative data source, Medicaid claims and encounter data are likely to have a certain degree of error.

Summary and Discussion

This is the interim evaluation report for Florida's IV-E Waiver Demonstration. The evaluation includes four related components: (a) a process analysis comprised of an implementation analysis and a services and practice analysis, (b) an outcome analysis, (c) a cost analysis, and (d) two sub-studies. This report includes findings from both components of the process analysis (implementation analysis and services and practice analysis), outcome analysis (permanency, child safety, and child and family well-being indicators), cost analysis, and the sub-study on cross-system services and costs.

Implementation Analysis

The goal of the implementation analysis is to identify and describe implementation of the Demonstration in terms of leadership, environment, organizational capacity and infrastructure, Demonstration impact, and lessons learned. In regards to leadership, there was agreement among stakeholders that since the initiation of Florida's Demonstration in October 2006 there has been consistency over time in Florida's vision and goal for the Demonstration: to safely reduce the number of children in out-of-home care. One related observation was that many individuals in leadership roles at both DCF and CBCs understand and have fully supported the Demonstration's goals over time. There were also comments about how changes in leadership and policy direction at federal, state, and local levels create new priorities and affect ongoing reforms such as IV-E Demonstrations.

Two primary themes emerged regarding the environmental factors that support Demonstration implementation. The first theme is the importance of interagency collaboration especially with the judiciary system as a facilitator of Demonstration implementation. The second theme is the relationship between the Demonstration and Florida's practice model. Respondents discussed how the flexible use of Demonstration funds can support the practice model through the development of a more diverse set of services and supports for families. Two potential barriers were identified: lack of understanding about engagement of families in services before the initial assessment process is completed and the learning curve related to learning and effectively implementing Florida's practice model. Other environmental factors

mentioned that influence the Demonstration were spikes in out-of-home care and contextual variables, such as domestic violence, substance abuse, mental health, and human trafficking.

Organizational capacity includes infrastructure characteristics that directly support the implementation and sustainability of the Demonstration, such as funding and service array. One funding challenge is the fiscal impact related to the increase of children removed from their families; often this means recruiting and certifying new foster families and increasing case management staff. However, stakeholders reported diversification and growth of services such as safety management, family support, prevention, diversion, and in-home services.

The primary theme regarding Demonstration impact was that it has become an integral part and necessity in the way CBCs and case managers operate. Another major theme is that without the flexibility in funding provided by the Demonstration, CBCs would be very limited in what they could do for families and that the flexibility in funding has facilitated a variety of beneficial objectives including diversification and expansion of the service array.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs, and practice improvements including and enhanced use of in-home services. For this report, findings from the service array survey are presented and preliminary findings from 10 case management focus groups conducted in various areas of the state.

Findings from the service array survey administered by DCF indicate that at the time the survey was administered, there was not a clear shared understanding across CBC lead agencies of the new service categories introduced by the state, nor did lead agencies appear to have a strong understanding of how to assess the level of evidence associated with a particular practice or program. DCF did provide further clarification to lead agencies regarding the service categories during follow-up site visits. It is difficult to ascertain the extent to which evidence-based programs have been implemented statewide based on the survey results, since few respondents identified specific program models that are being used in their responses. Only five recognizable program models with an evidence-base, reported across seven lead agencies, could be identified from the survey responses.

The findings from the focus groups identify several factors that affect child welfare practice and particularly the effectiveness of family preservation efforts. While case managers overall value family preservation and perceive the use of an in-home service approach as potentially improving the ability to address family issues, they are concerned about the ability of

the system to ensure child safety. The availability of adequate services and resources to support families is one of the greatest barriers experienced by case managers. The other major barrier experienced is a lack of system cohesion among the various agencies and stakeholders involved with child welfare cases, which can serve to undermine the efforts of case managers in working with families to resolve child safety concerns. The results from the focus groups are preliminary, and represent the perspectives of case managers only.

Outcome Analysis: Permanency and Safety Indicators

The outcome analysis on permanency and child safety tracks changes in three baseline years (SFY 11-12, SFY 12-13 and SFY 13-14) for successive entry and exit cohorts of children who were followed from the time they either entered the child protection system or exited out-of-home care. Overall, there is a considerable variability among Circuits on measured indicators. For example, Circuit 8 had the highest permanency rate throughout the three years (between 62% and 64%), one of the lowest lengths of stay averaging 10 months, the highest proportion of children who acquired guardianship (25%), and is among the Circuits with the highest proportion of children with adoption finalized (73% for SFY 11-12 and 70% for SFY12-13). In contrast, Circuit 7 had one of the lowest proportions of children exiting into permanency (between 39% in SFY11-12 and 32% in SFY13-14), one of the highest median lengths of stay (approximately 15 months across three entry cohorts), and the lowest proportion of children reunified (21% for SFY 13-14) or acquired guardianship within 12 months of the latest removal (6% for SFY13-14).

Similarly, Circuits 10, 11, and 13 had the lowest maltreatment rates per 1,000 child population throughout the three years (between 7% and 11%). Circuit 5 had the highest proportion of children who did not enter out-of-home care after their dependent case was opened during the examined three years (approximately 95%). Circuits 4 and 8 had the highest proportion of children without re-entry during the study period ranging from 92% to 95%.

Two overarching trends were observed. One trend indicates a decreasing proportion of children over time who experienced expedited permanency in general and who achieved permanency for reason of reunification, guardianship or adoption. The second trend indicates improved performance statewide on child safety based on three out of four examined indicators. Specifically, there is a decrease in the number of verified child maltreatment cases per 1,000 child population over time, an increase in the proportion of children who remained home after their dependent case was opened, and there is an increase in the proportion of children with no verified maltreatment within 6 months of services termination. Re-entry into out-of-home care remained stable over time.

Outcome Analysis: Child and Family Well-Being

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

Consistent with the findings for permanency and child safety, there was substantial variation across Circuits in their performance for the well-being indicators. A few Circuits, such as Circuits 2, 10, and 14 most notably, stand out as consistently obtaining strength ratings for the relevant performance items. Across well-being outcomes and performance indicators according to these reviews, Circuits 1, 3, and 8 appear to be less effective in the quality of child welfare practices relevant to the safety, permanency, and well-being of children. The performance item related to enhancement of a family's capacity to provide for the needs of their children is an area of concern. This performance item rates the frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. This item was rated as a strength in only about one-third of the cases that were reviewed statewide. Subsequent reports for the upcoming state fiscal years will allow for the assessment of trends in CFSRs and progress towards achieving national standards for these outcomes at both the Circuit-level and the State-level.

Cost Analysis

The goal of the cost analysis in this evaluation is to examine whether there were changes in CBC lead agency appropriations by type of service between the original Demonstration period and the Demonstration extension. The trend in the original Demonstration period away from dependency services and towards prevention services continued into SFY 13-14 but then reversed in SFY 14-15. Maintenance adoption subsidies have continued to increase while expenditures for independent living services have declined. Overall, appropriations for Community-Based Care have continued to increase. It is challenging to attribute any causal relationship between the Demonstration extension and changes in appropriations or expenditures. For example, the implementation of Florida's practice model may also result in changes in the services being emphasized by lead agencies.

Sub-Study on Cross-System Services and Costs

Finally, the interim report includes initial findings on the sub-study related to cross-system services and costs. Medicaid enrollment and claims/encounter data for youth that received out-of-home services was analyzed for youth that were removed from the home. The vast majority of youth that were enrolled in the Medicaid program after removal from the home were also enrolled prior to removal. However, service penetration was much higher after removal from the home. The pattern of service use also differed before and after removal. Physical health inpatient services were more common before removal, and were likely related to the reasons for removal. Behavioral health outpatient services were much more common after removal from the home. Finally, there were a number of differences in service utilization patterns across Circuits. Service utilization declined after removal from the home, particularly for physical health inpatient services. However, this trend was not apparent in all Circuits, and service penetration and changes in service use varied considerably across Circuits.

Lessons Learned and Next Steps

The goal of the Demonstration is to increase the number of children who can safely remain at home. A common theme across several components of this report are Circuit-level variations, including performance on child safety indicators as well as child and family well-being indicators, differences in the use of CBC appropriations by service type, and differences in cross-system service utilization patterns. The evaluation will continue to examine and track these cross-Circuit variations and make related recommendations.

For the implementation analysis, additional stakeholder telephone interviews will be conducted with judges, court personnel, Child Protective Investigators and their supervisors during the next year of the Demonstration extension evaluation. These interviews will address issues such as the role of the courts in the Demonstration extension and the relationship between the child welfare agency and the court system, including any efforts to jointly plan and implement the extended Demonstration project (e.g., communication with or education for judges regarding the IV-E Waiver).

Next steps for the services and practice analysis include the completion of a set of focus groups with CPIs, full analysis of the case manager and CPI focus groups, and development and administration of the service array survey with CBC lead agencies. CPI focus groups will be convened in the same five circuits that were selected for the case manager focus groups. This will provide a more balanced analysis that incorporates both perspectives. Analysis of the focus groups will examine similarities and differences across sites

and between case managers and CPIs. The anticipated completion for this task is September 2016. Once this analysis is compete, development of the service array survey will begin, and is expected to be completed and ready to begin administration in October 2016. The survey will be administered to the CEOs of each CBC lead agency using a web-based survey program. Anticipated completion of the survey administration is January 2017, with analysis of results expected to be complete by March 2017. This is a tentative timeline and is subject to change if unanticipated delays occur in the data collection process.

For the programmatic outcomes related to child safety and permanency, future data analysis will track progress over time on the child safety and permanency indicators that we examined for the baseline years. In addition, we will examine the effects of multiple child characteristics, such as demographics, health problems, and others that have been linked to child safety (Shaw, 2006; Yampolskaya, Armstrong, & King-Miller, 2011) and permanency (Choi & Ryan, 2007; Grella et al., 2009; McDonald et al., 2007). Finally, research has shown the value of having information about subgroups of children with different combinations of characteristics (Yampolskaya et al., 2014). Therefore, the profiles of children served in the child protection system will be examined, and the association between sub-groups of children with similar characteristics and child safety and permanency outcomes will be examined.

Regarding the child and family well-being outcomes, results from the ongoing Child and Family Service Reviews will be updated in each semi-annual progress report at the circuit level and statewide. Further, subsequent reports for the upcoming state fiscal years will allow for the assessment of trends in CFSRs and progress towards achieving national standards for these outcomes at both the Circuit-level and the State-level.

Future reports for the cost analysis will examine costs at the lead agency level. We will examine how the relative breakdown of the cost groups differs across lead agencies. In addition, we will assess whether such differences can be explained by differences in youth characteristics, and whether differences in costs across lead agencies for specific service groups are associated with differences in performance measures. There is no known obstacles to completion of these components at this time.

Future analysis for the cross-systems services and cost sub-study will examine the differences across time and across Circuits in more detail. In particular, we will examine the relationship between youth characteristics and service use to determine how much of the differences across Circuits can be explained by differences in youth characteristics. In addition, we will examine State Substance Abuse and Mental Health Information System (SAMHIS) data to include services paid by funding sources other than Medicaid. Youth that only received DCF

in-home services will also be included and compared to youth that received out-of-home services. Finally, we will examine whether service use patterns are associated with outcomes.

Recommendations

The following policy and practice recommendations are offered to the Department of Children and Families and Florida's lead agencies:

- Review and adapt Florida's IV-E Waiver logic model and theory of change with input from lead agencies and the Department. Consider issues of sustainability of long term goals for system change and child and family outcomes.
- Work with lead agencies and the Coalition to establish an authorized list of services Title IV-E funding can now be used for, allowing for a list of creative services lead agencies have put into place and out of the box thinking other agencies might learn from and be able to apply IV-E funds to in the future.
- During training and technical assistance activities related to Florida's practice model, facilitate discussion and identification of how the flexible use of IV-E funds can support the development of a more comprehensive service array.
- As new leaders emerge in Florida's child welfare system at state and community levels, provide educational opportunities regarding the vision and goals of Florida's IV-E Demonstration.
- The Department and CBCs should continue to jointly develop and implement strategies to address the high turnover rates among case managers and child protective investigators.
- The Department and CBCs should continue to work toward long term sustainability of child welfare funding mechanisms and additional ways to leverage state and federal fiscal resources.
- Review current outreach strategies and educational opportunities for key stakeholders external to DCF including the judicial system, Guardians ad Litem, and providers. Discuss ways to increase engagement around training events.
- Continue public relations and media campaigns with legal partners, external partners, and the community that includes examples of success with individual families. Discuss the impact of negative media attention and strategies to maintain a positive organizational environment while still being responsive to individual events.
- Continue to provide ongoing training, coaching, and mentoring for both CPIs and case managers on the implementation of Florida's practice model, including ongoing

assessment and monitoring of fidelity to identify areas of focus for continuous quality improvement efforts.

- Ensure that standardized processes and expectations for collaborative casework between CPIs and case managers are in place and adhered to, such as joint home visits and family assessments during the transition from investigation to case management.
- Encourage among CBCs the expansion of approaches such as family team conferencing, family group decision making, or family group conferencing at the front-end of system involvement. These family-centered approaches contribute to greater system collaboration and cohesion since all concerned parties are brought to the table, facilitates greater clarity for families about the system and expectations, and engages families in the identification of their needs and supports. For CBCs that are implementing such practices, this should include the incorporation of fidelity assessment processes.
- CBCs should ensure that service providers comply with contract language relating to the evaluation and demonstration of service effectiveness and requirements for assessing and reporting client outcomes to the child welfare agency/case manager
- Continue to identify strategies to fill current service gaps at the community-level.
- Develop funding strategies to fill current service gaps at the community-level and expand the availability of providers who offer in-home services.
- To further prevent re-entry into out-of-home care, more intensive services, such as frequent visitations by a case manager, in-home parent education, and various supports (e.g., providing information about specific resources, connecting families with necessary services) should be provided to families immediately after reunification or adoption
- The Department has recently learned that there was some inconsistency among CBCs in the period under review (PUR) dates used for CFSR case reviews. Specifically, some CBCs were using the previous 9 months as the PUR and others were using the previous 12 months. In order to rectify this, it is recommended that the Department make consistent the PUR for CFSR reviews.

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Appendix A

IV-E Waiver Stakeholder Questions

1. What are your views regarding how the IV-E Waiver extension has impacted the Department and/or lead agencies (e.g., changes to the service array, changes in cost allocations and spending, etc.)
2. One of the expectations with the IV-E Waiver was that fewer children would need to enter out-of-home care. Have you seen this trend in your local system? What impact has it had on your organization and staff (e.g., providers, case managers, supervisors)?
3. Are there any ways in which your lead agency has uniquely adapted the flexibility that came with the IV-E Waiver to your local system's and community's needs? Please explain.
4. Please discuss any relevant asset mapping or needs assessments that were done in conjunction with the Waiver extension, or to facilitate service system changes desired as the result of Waiver extension.
5. Please discuss how the implementation process for the IV-E Waiver extension is proceeding thus far regarding:
    (a) staff structure,
    (b) changes in policy or procedure,
    (c) administrative oversight,
    (d) problem resolution, and
    (e) funding committed.

6. What adaptations have your agency, providers, CPIs and staff made to increase attention to Family Support and Safety Management Services in relation to what the iv-e Waiver allows? Have you been able to shift resources for this purpose since Waiver implementation?
7. Please discuss any salient issues regarding staffing and training to carry out the IV-E Waiver extension (e.g., experience, education and characteristics of staff). How many and which staff are focused on IV-E Waiver implementation?
8. Another expectation of the IV-E Waiver is that changes in practice (e.g., implementation of the state service delivery model) would lead to improved outcomes for children. Have you been able to change practice as the result of the IV-E Waiver? And if so, has it had an impact on child safety, permanency or well being? How so?

9. What has been the role of the courts in the IV-E Waiver extension period? Has it changed since the Waiver was renewed? What about child welfare legal services? Please describe, including any examples of efforts to jointly plan and communicate between the Court and DCF, or the Court and lead agencies, or lead agencies and child welfare legal services.
10. What are some of the other reform efforts (besides the IV-E Waiver) that your agency is a part of or you are aware of that impact the work that you do for children and families?
11. Whether your work is done at the policy or practice level, what are some of the current social, economic and political issues that most often impact the work that you do for children and families?

Appendix B
Verbal Informed Consent

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

Pro # 5830146300

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

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

The person who is in charge of this research study is Mary I. Armstrong, Ph.D**.** This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. Other research team members include Amy Vargo, Patty Sharrock, Svetlana Yampolskaya, Melissa Johnson, John Robst, and Monica Landers.
The research will be conducted at Child welfare agencies and stakeholder offices in Florida.
This research is being sponsored by The Department of Children and Families.

Purpose of the study

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

Why are you being asked to take part?

We are asking you to take part in this research study because you work in or are affiliated with a child welfare agency, or have been identified as having knowledge about certain aspects of Florida's Title IV-E Waiver and Community-Based Care.

Study Procedures:

If you take part in this study, you will be asked to give us your opinions through an interview that will take about 30-90 minutes to complete. The interview will be tape-recorded (with your permission) to make sure our notes are correct.

Total Number of Participants

A total of 200 individuals will participate in the study at all sites over the next five years.

Alternatives / Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Your decision to participate or not participate will not affect your job status in any way.

Benefits

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

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

Risks or Discomfort

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

Compensation

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

Costs

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

Privacy and Confidentiality

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

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

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

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an unanticipated problem, call Mary Armstrong at 813-974-4601.

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

Consent to Take Part in this Research Study

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

Appendix C
Florida Code List

(revised 091115; updated 022316; updated 030316; updated 031016; updated 031116)

Leadership: Leadership is crucial in establishing and promoting the vision for change, creating a sense of urgency around this vision, and creating buy-in for the change effort at all levels of the system.

Leadership Involvement – discussion of ways leaders at various levels of DCF have been included in the waiver planning and implementation process

Consistency in leadership – either consistency or changes in leadership of DCF or lead agencies

Vision/Values – discussion of the extent to which there is a vision for change among leadership, staff and stakeholders

Environment: In the context of systems change, the environment refers not so much to the physical environment (which typically cannot be changed, but must be worked within) but rather the political, social, and cultural environment in which services are provided. Building environmental capacity entails ensuring that there is political will and community readiness and acceptance for the identified changes, and fostering an organizational and system culture that promotes open communication and creative problem solving to identify and address barriers, resistance, and conflict that may hinder successful implementation of the change effort. It includes development of system-wide structures to support implementation and shared accountability across system partners.

Contextual Variables

- Poverty
- Housing
- Employment – regarding clients seeking jobs or the current job market that may influence turnover rates for case workers or CPIs
- Domestic Violence
- Substance abuse
- Mental health
- Juvenile justice system
- Unaccompanied minors
- Human trafficking

- Other reform efforts – Coinciding reform efforts to the IV-E Waiver other than the Florida Practice Model

Staff Support – the extent to which there is support and buy-in for the Waiver among DCF front-line staff (e.g. CPS workers, caseworkers, and supervisors), including issues pertaining to personal beliefs and values; and, the process to change laws to better support child welfare practice goals/goals of the IV-E Waiver

Political Support – discussion of the political environment and extent to which political support and buy-in for the Waiver exists, including issues pertaining to personal beliefs and values as well as support for funding

Community Support – discussion of the broader social environment and extent to which there is support and buy-in among the general community (e.g. community providers/organizations, advocacy groups, and families), including issues pertaining to personal beliefs and values

DCF Climate – discussion of aspects of the organizational climate at DCF, e.g. issues such as trust and respect between leadership and front-line staff, the extent to which there is an environment that supports teamwork and problem solving, etc. either within DCF or between DCF and lead agencies

Internal Communication – discussion of communication processes within DCF

External Communication – discussion of communication processes with system partners outside DCF; discussion of the extent to which system partners (e.g. judges, GALs, providers, etc.) work together as a system, including joint planning with system partners; discussion of issues in working/interacting with external stakeholders (e.g. judges, GALs, etc.) that impact child welfare practice

Service Array/Resources – discussion of community resources currently in place, and/or service/resource needs

Media – influence of either news media or social media on child welfare activities

Spikes in Out-of-Home Care Population – influxes in children coming into foster care

Organizational Capacity/Infrastructure: examines the development and implementation of policies and procedures that support effective practice, provision of training, skill-building, coaching, supervision, and technical assistance to support effective implementation of practice changes, and the availability and use of data and oversight processes to monitor implementation and support continuous quality improvement.

Policies & Procedures – discussion of the extent to which policies and procedures are aligned with the Waiver goals, changes/revisions that have been made to align policies and procedures, or changes that are still needed in order to align them

Training – discussion of training that has been provided to prepare staff/stakeholders to implement the waiver, and additional/on-going training needs
Technical Assistance – discussion of technical assistance that has been provided to help with waiver implementation, and additional/on-going technical assistance needs
Caseworker Skills – discussion of the extent to which caseworkers have the necessary knowledge and skills, and skill-building that is still needed; turnover issues
Family engagement – discussion of issues pertaining to how or what extent or what problems exist in the current system regarding family engagement
CPS Practice – changes in CPS practice; turnover issues
Florida Practice Model – discussion of the Model, including strengths and challenges related to its use
Assessment – discussion of child or family/parents assessment process
Supervision – discussion of supervision processes, including coaching, mentoring, etc. and what supervision is needed to support successful implementation
Quality Improvement Processes – discussion of the use of data to inform decision-making and identify areas for practice improvement, and processes for the development of improvement plans based on the data
Oversight & Monitoring – discussion of processes for the collection and review of data, but without a clear connection to implementation of practice improvement processes
Funding – discussion of how services are funded, strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.
FSFN – discussion of Florida's SACWIS system, including strengths and challenges related to its use.
Removal Decisions – changes in how the decision is made to place a child out of home
Judiciary – ways in which the waiver has impacted/affected/changed practice of judges
GALs – ways in which the waiver has impacted/affected/changed practice of GALs
Child Welfare Legal Services – ways in which the Waiver has impacted/affected/changed practice of CWLS

Waiver Impact

Family engagement – how the Waiver has impacted the extent to which and what methods are used to engage families
Caseworker Practice – ways in which the waiver has impacted/affected/changed practice of caseworkers

Supervisory Practice – ways in which the waiver has impacted/affected/changed practice of supervisors

Family Well-being – ways in which the waiver has impacted family outcomes (e.g. strengthening families, increasing access to resources, increasing self-sufficiency, etc.)

Child Safety/Well-being – ways in which the waiver has impacted child safety and well-being outcomes

Services – changes in the availability/accessibility of services since implementation

Organizational – ways in which the waiver has impacted the organizational environment/processes

Client Characteristics – ways in which the waiver has impacted the characteristics of families served by the child welfare/foster care system

Morale – ways in which the waiver has impacted morale among DCF staff/leadership

Removal Decisions – how the IV-E Waiver has impacted changes in how the decision is made to place a child out of home

Funding – how the Waiver has impacted funding and funding flexibility such as strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.

Conclusion

Recommendations – any specific recommendations that are made about how to improve waiver implementation

Lessons – any discussion of lessons learned about implementation

Decision Rules for Coding

1. Don't double code, except for policy recommendations OR in cases where there are coinciding events where in there is a precursor and antecedent (e.g., funding cuts and reductions in services, OR media and removals)
2. If things come up that are directly stated as lessons learned and recommendations, please directly code as such. If an important issue comes up that lends itself to our making a recommendation or summarizing a lesson learned, please double code to the relevant topic and lessons learned or recommendations.
3. Don't code the actual protocol question in isolation or with the data, unless the data does not actually answer that question
4. Don't code things as Impact unless they have actually happened (e.g., hopes for impact might go under vision or goals)

5. Don’t make a new global code for strengths/facilitators and barriers/challenges; please insert these two codes as needed at a third level underneath each topic

Appendix D
Focus Group Interview Guide

This focus group is being conducted as part of the evaluation for the Florida Title IV-E Waiver. The Waiver allows states the flexibility to use federal funds normally allocated to foster care services for other child welfare services, such as in-home and diversion services to prevent out-of-home placement, or post-reunification services to reduce the likelihood of recidivism. The intent of these questions is to better understand your practice and your perceptions of the services available to child welfare involved families in your community, including both the strengths and the challenges or barriers present in the current child welfare system. Your participation in this discussion is completely voluntary. We value your opinions and experiences, and we want to know what you think could be done to improve the system in your community and throughout the state of Florida.

1. In your opinion, what is the primary purpose of the child welfare system?
    - What is your role?
2. What things support you in doing your job well? What things make it difficult for you to do your job?
3. What do you think are the greatest challenges or barriers for families involved in the child welfare system? (e.g. in caring for their children, in completing their case plan, in making sustainable changes to improve their personal and family functioning)
    - How do you support and encourage the families on your caseload?
4. How do you identify and assess family needs?
    - How are families engaged in this process? (Probe: parents, children, others)
    - What are the processes for connecting clients to appropriate services based on their identified needs?
5. How do you assess a family's progress and changes over time (e.g. behavior change)?
    - How is the family engaged in this process?
6. How does practice differ between in-home and out-of-home cases?
7. How are decisions made about whether a child can remain safely in the home or needs to be removed?
    - What factors, indicators and/or evidence inform these decisions?
    - Under what circumstances can an in-home safety plan be implemented?
    - What circumstances warrant the removal of the child?

- What strategies are used to avoid unnecessary out-of-home placement?

8. What are your primary concerns about keeping children in the home when there is a substantiated report of abuse or neglect?
    - What could be done to alleviate these concerns?
9. What do you think are the benefits of keeping children in the home while working with families?
    - What services are available to support family preservation?
10. For out-of-home cases, how are decisions made about reunification and when a child can be returned home?
    - What factors, indicators or evidence inform these decisions?
    - What services are available to support successful reunifications?
11. To the best of your knowledge, how would you describe the availability of services for families involved with the child welfare system in your community?
    - To what extent are adequate services available to meet the various needs of clients? What EBPs are used? What are the current barriers/gaps in the service array?
12. What do you like most about your job? What do you like least or find most challenging?
13. What would you like to see change about the current child welfare system?

Appendix E: Permanency and Safety Outcomes

Measure 1

The number and proportion of all children exiting out-of-home care for permanency reasons within 12 months of the latest removal.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Only children who were in out-of-home care for at least eight (8) days were included in the calculation of this measure. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved permanency. Permanency is defined as discharge from out-of-home care to a permanent home for the following reasons as indicated in FSFN: (a) reunification, that is the return of a child who has been removed to the removal parent or other primary caretaker, (b) permanent guardianship (i.e., long-term custody or guardianship) with a relative or non-relative, (c) adoption finalized, that is when the Court enters the verbal order finalizing the adoption, and (d) case dismissed by the court.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[3] Because every child was followed for 12 months, this measure is identical to a percent where the numerator is the number of children who exited out-of-home care for permanency reasons within 12 months after entry. The denominator is all children who entered and stayed for at least 8 days in out-of-home care at any time during a specific fiscal year.

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

Measure 2

The median length of stay for children in out-of-home care (i.e., point in time measured in number of months at which half of the children are estimated to have exited out-of-home care)

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Only children who were in out-of-home care for at least eight (8) days were included in the calculation of this measure. This measure is presented in number of months between the date of removal from home as indicated by the *Removal Date* in FSFN and the date the child is discharged from out-of-home care as indicated by the *Discharge Date*. Children were followed for at least 12 months to assess the number of months passed before 50% of these children exited out-of-home care. An estimate of the median number of months spent in out-of-home care was generated by Life Tables, which is a type of Event History Analysis. [1] This measure reports the number of months at which half of the children are estimated to have exited out-of-home care into permanency.

Measure 3

The number and proportion of children who were reunified (i.e., returned to their parent or primary caregiver) within 12 months of the latest removal.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Only children who were in out-of-home care for at least eight (8) days were included in the calculation of this measure. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker. Reunification is identified based on one of the reasons for discharge as indicated in FSFN.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. [1] Because every child was followed for 12 months, this measure is identical to

a percent where the numerator is the number of children who exited out-of-home care for reunification reason within 12 months after entry. The denominator is all children who entered and stayed for at least 8 days in out-of-home care at any time during a specific fiscal year.

Measure 4

The number and proportion of children who exited out-of-home care into permanent guardianship (i.e., long-term custody or guardianship by relatives or non-relatives) within 12 months of the latest removal.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Only children who were in out-of-home care for at least eight (8) days were included in the calculation of this measure. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved permanent guardianship. Permanent guardianship is defined as discharge from out-of-home care for the following reasons as indicated in FSFN: (a) guardianship to non-relative, (b) guardianship to relative, (c) long-term custody to relative, (d) living with other relatives, and (e) other guardianship.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. [1] Because every child was followed for 12 months, this measure is identical to a percent where the numerator is the number of children who exited out-of-home care for the reason of permanent guardianship within 12 months after entry. The denominator is all children who entered and stayed for at least 8 days in out-of-home care at any time during a specific fiscal year.

Measure 5

The number and proportion of children with finalized adoptions (i.e., the date of the Court's verbal order finalizing the adoption) within 24 months of the latest removal.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and had 'adoption' in their case plans as their primary goal. Placement in out-of-home care is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Children were followed for 24 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and were adopted. Adoption finalized is defined as discharge from out-of-home care for adoption reason as indicated in FSFN and is the date of the Court's verbal order finalizing the adoption.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[1] Because every child was followed for 24 months, this measure is identical to a percent where the numerator is the number of children who exited out-of-home care for the reason of adoption within 24 months after entry. The denominator is all children who entered out-of-home care at any time during a specific fiscal year and whose primary treatment goal was adoption.

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

Safety Outcomes

Measure 6: Proportion of Children with Verified Child Abuse in the State of Florida by Cohort: Per capita rate/1000.

This measure is a percent. The numerator is all children in Florida children who were alleged victims of maltreatment in investigative reports received during a specific time period. The denominator includes all children up to 18 years of age in the state of Florida.

Measure 7: The number and proportion of children who were NOT removed from their primary caregiver(s) and were placed into out-of-home care within 12 months of the date their in-home case was opened

This measure is based on entry cohort. An entry cohort is defined as all children whose case was opened for lead agency services as indicated by the *Begin Date* in FSFN and who were receiving in-home child welfare services for more than 7 days. Children will be followed for 12 months from the date of the dependency case was open to determine whether they were subsequently placed in out-of-home care.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[4] Because every child will have 12 months follow-up data, this measure is identical to a percent. The numerator is the subset of the number of children in the denominator who were placed into out-of-home care during the 12 month period following the date when the case was opened. The denominator is the number of children whose cases were opened during a given fiscal year.

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

Measure 8: The number and proportion of children who did NOT reenter out-of-home care within 12 months of their most recent discharge from out-of-home care for permanency reasons.

This measure is based on exit cohort. An exit cohort is as the children who "left" out-of-home care during a certain time period. Specifically, an exit cohort is defined as all children who exited out-of-home care for permanency reasons during a given fiscal year and it is based on the date the child was discharged from out-of-home care as indicated by a *Discharge Date* in FSFN. Children will be followed for 12 months from the date of discharge from out-of-home care for permanency reasons to determine whether they are subsequently placed in out-of-home care as indicated by a new *Removal Date* in FSFN.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. Because every child will have 12 months follow-up data, this measure is identical to a percent where the numerator is the number of children who did NOT enter out-of-home care within 12 months after exit for permanency reasons only. Only children who exited out-of-home care for reasons of permanency will be included in the calculation of the measure. The denominator is all children who had a Discharge Date in FSFN during a specified fiscal year (i.e., exit cohorts) and who were discharged for permanency reasons. The measure is based on children who exited their first episode of out-of-home care.

Measure 9: The number and proportion of children who did NOT experience verified maltreatment within six months of case closure (i.e. termination of out-of-home services or in-home supervision).

This measure is based on exit cohort. Exit cohort are the children who "left" child protection system during a certain time period. An exit cohort for this measure is defined as all children for whom supervision was terminated as indicated by the date when the dependency case closed - "*End Date*" in FSFN. *Termination of Supervision* is defined as closure of services including out-of-home care and in-home services. These children will be followed up for 6 months to determine whether a subsequent child maltreatment report was received as indicated by the *report received date* in FSFN and the investigation resulted in disposition of verified maltreatment, that is, evidence sustained a finding that the child was a victim of maltreatment as defined by state law.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[1] Because every child will have 6 months follow-up data, this measure is identical to a percent where the numerator is all children for whom supervision was terminated and who were not reported as victims of maltreatment within 6 months after services terminated. The denominator is the number of children whose cases were closed (i.e., discharged from a removal episode or exited from in-home services) during a specific fiscal year.

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

Appendix F: Results of Statistical Analyses

Permanency Indicators

Table F1

Results of Cox Regression. Children Exited Out-of-Home Care for Permanency Reasons within 12 Months of the Latest Removal in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

	Children Entering Out-of-Home Care (*N* = 61,588)		
	β	$\chi^2_{(1)}$	OR
Cohort	- 0.06	106.10*	0.95

Note. *$p < .05$.

Table F2

Results of ANOVA. Length of Stay for Children in Out-of-Home Care in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

Cohort	Average number of months in out-of-home care	*N* = 45,025	
		F	*df*
SFY 11-12	15.7	641.8*	2
SFY 12-13	14.6		
SFY 13-14	11.1		

Note. *$p < .001$.

Table F3

Results of Cox Regression. Children Reunified within 12 Months of the Latest Removal in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

	Children Entering Out-of-Home Care (*N* = 61,588)		
	β	$\chi^2_{(1)}$	OR
Cohort	- 0.05	49.32*	0.95

Note. *$p < .05$.

Table F4

Results of Cox Regression. Children Exited Out-of-Home Care into Permanent Guardianship within 12 Months of the Latest Removal in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

	Children Entering Out-of-Home Care (*N* = 61,588)		
	β	$\chi^2_{(1)}$	OR
Cohort	- 0.07	32.86*	0.94

Note. *$p < .001$.

Table F5

Results of Cox Regression. Children with Finalized Adoptions within 24 Months of the Latest Removal in the State of Florida by Cohort (State Fiscal Years 2011 and 2012)

	Children With Adoption as a Primary Goal (*N* = 7,843)		
	β	$\chi^2_{(1)}$	OR
Cohort	0.01	0.01	1.00

Note. *$p < .05$.

Safety Indicators

Table F6

Results of ANOVA Test. Children with Verified Child Abuse in the State of Florida by Cohort: Per capita rate/1000 in the State of Florida by Cohort (State Fiscal Years 2011 through 2014-2015)

Cohort	Average number of months in out-of-home care	*N* = 45,025	
		F	*df*
SFY 11-12	13.5	5.97*	3
SFY 12-13	12.9		
SFY 13-14	11.9		
SFY14-15	10.9		

Note. *$p < .001$.

Table F7

Results of Cox Regression. Children Who were NOT Removed From Their Primary Caregiver(s) and Were Placed into Out-of-Home Care Within 12 Months of the Date Their In-Home Case was Opened in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

	Children Entering Out-of-Home Care (*N* = 61,404)		
	β	$\chi^2_{(1)}$	OR
Cohort	- 0.09	47.97*	0.92

Note. *$p < .05$.

Table F8

Results of Cox Regression. Children Who Did Not Reenter Out-of-Home Care within 12 Months of the Discharge in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

	Children Entering Out-of-Home Care (*N* = 56,626)		
	β	$\chi^2_{(1)}$	OR
Cohort	0.01	0.47	1.00

Note. *$p < .05$.

Table F9

Results of Cox Regression. Children Who Were NOT Maltreated within 6 Months of the Service Termination in the State of Florida by Cohort (State Fiscal Years 2011 through 2013-2014)

	Children Entering Out-of-Home Care (*N* = 56,626)		
	β	$\chi^2_{(1)}$	OR
Cohort	0.07	7.96*	1.07

Note. *$p < .05$.

Appendix G: Non-Applicable Cases

The table below details circumstances under which cases were not applicable for review.

Table G1

Cases not applicable for CFRS Review by Performance Item

Performance Item 12	• All cases applicable
Performance Item 13	• Involvement of children was not developmentally appropriate • Parental rights of both parents were terminated during the PUR • Parents were deceased during the PUR • Concerted efforts to find applicable parents were rated as an area needing improvement • Documentation in case files indicated that involvement of the parents were not in the child's best interest
Performance Item 14	• All cases applicable
Performance Item 15	• Parental rights of both parents were terminated during the PUR • Parents were deceased or their whereabouts were unknown during the PUR • Concerted efforts to find applicable parents were rated as an area needing improvement • Documentation in case files indicated that involvement of the parents were not in the child's best interest • Documentation in case files indicated that the parent expressed he or she did not want to be involved in the child's life
Performance Item 16	• Child is age two or younger • There is no apparent developmental delay • In-home services cases in which there is no reason to expect that educational needs of the children involved would be addressed by the agency due to circumstances of the case or reasons for agency involvement

Performance Item 17	• In-home services cases in which there is no reason to expect that physical and dental health issues of the children involved would be addressed by the agency due to circumstances of the case or reasons for agency involvement
Performance Item 18	• Foster care cases in which existing mental/behavioral health needs were adequately addressed prior to the PUR and no remaining needs were identified during the PUR • In-home services cases in which there is no reason to expect that mental/behavioral health issues of the children involved would be addressed by the agency due to circumstances of the case or reasons for agency involvement