Phase 2- Florida Title IV-E Waiver Demonstration Evaluation Semi-Annual Progress Report (10/2015-03/2016)

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Phase 2- Florida's Title IV-E Waiver Demonstration Evaluation
Semi-Annual Progress Report (10/2015-03/2016)

Executive Summary

Background

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

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

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

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

The Terms and Conditions of the Demonstration require a process, outcome, and cost analyses. Primary data was collected for this report via interviews and focus groups with the Department of Children and Families (DCF) and lead agency stakeholders. Secondary data analysis was performed with extracts from the Florida Safe Families Network (FSFN, Florida's statewide SACWIS system), FL 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/commitment, vision/values, environment, organizational capacity/infrastructure, and Demonstration impact.

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, the child welfare 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 the child welfare 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 among the various agencies and stakeholders involved with child welfare cases.

Child safety analysis. The child safety outcomes analysis tracks changes 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. The data used to produce these indicators cover the time period of SFY 11-12 through SFY 14-15, so children in all three entry and exit cohorts were followed for at least 12 months. The following indicators were examined: (1) Rate of verified maltreatment as a proportion of the State's child population; (2) 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; and (3) Proportion of children who did NOT re-enter out-of-home care within 12 months of discharge.

Overall, there is considerable variability in performance on these safety indicators among Circuits. For example, 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%.

There is a trend indicating improved performance statewide on child safety based on two out of three examined indicators. Specifically, there is a decrease in the number of verified child maltreatment cases per 1,000 child population over time, and there is an increase in the proportion of children who remained home after their dependent case was opened. 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 significantly improved.

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. 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 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 special 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 was 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; 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.

Introduction

The Florida Department of Children and Families (the Department or DCF) has contracted with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF) to develop and conduct an evaluation of Florida's IV-E Waiver Demonstration Project (Demonstration) that is effective through September 30, 2018. The contract for Florida's IV-E Demonstration evaluation was executed in January 2015 with the University of South Florida (USF). This document provides an update of evaluation components completed during the reporting period of October 2015-March 2016.

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

Other key contextual factors for the Demonstration include the role of Community-Based Care (CBC) lead agencies as key partners with shared local accountability in the delivery of child welfare services as well as the broader system partners including the judicial system. Community-Based Care (CBC) lead agencies are organized in geographic Circuits.

It is expected that the Demonstration extension will continue to result in flexibility of IV-E funds. The flexibility allows these funds to be allocated toward services to prevent or shorten the length of child placements into out-of-home care or prevent abuse and re-abuse. Consistent with the CBC model, the flexibility has been used differently by each 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.

Evaluation Plan

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

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

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

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

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

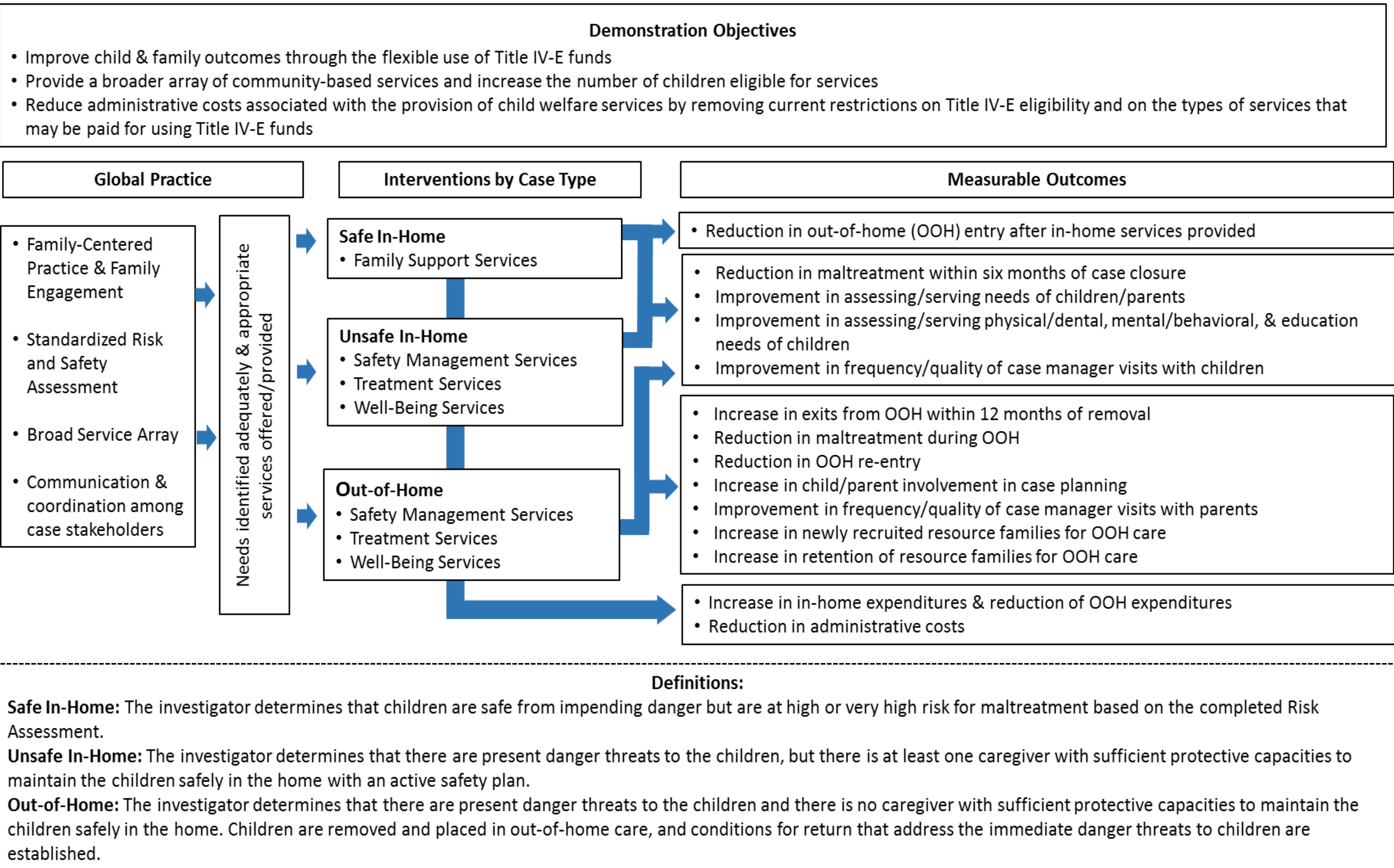
Demonstration project. The cost analysis examines the relationship between Demonstration implementation and changes in the use of child welfare funding sources

The first sub-study, reported on in the current report, 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 will be 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.

The second 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 the child welfare practice model (intervention group) and are offered voluntary Family Support Services, 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.

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

This semi-annual report includes the results from an additional round of stakeholder interviews with DCF and CBC leadership (implementation analysis), results from focus groups conducted at CBC sites (services and practice analysis), findings related to child safety and well-being indicators (outcome analysis), a cost analysis, and preliminary findings from the first sub-study on trends in service use and costs.


IV-E Waiver Demonstration Project Evaluation Logic Model
Demonstration Objectives
• Improve child & 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
• 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
Global Practice
• Family-Centered Practice & Family Engagement
• Standardized Risk and Safety Assessment
• Broad Service Array
• Communication & coordination among case stakeholders
Needs identified adequately & appropriate services offered/provided
Interventions by Case Type
Safe In-Home
• Family Support Services
Unsafe In-Home
• Safety Management Services
• Treatment Services
• Well-Being Services
Out-of-Home
• Safety Management Services
• Treatment Services
• Well-Being Services
Measurable Outcomes
• Reduction in out-of-home (OOH) entry after in-home services provided
• Reduction in maltreatment within six months of case closure
• Improvement in assessing/serving needs of children/parents
• Improvement in assessing/serving physical/dental, mental/behavioral, & education needs of children
• Improvement in frequency/quality of case manager visits with children
• Increase in exits from OOH within 12 months of removal
• Reduction in maltreatment during OOH
• Reduction in OOH re-entry
• Increase in child/parent involvement in case planning
• Improvement in frequency/quality of case manager visits with parents
• Increase in newly recruited resource families for OOH care
• Increase in retention of resource families for OOH care
• Increase in in-home expenditures & reduction of OOH expenditures
• Reduction in administrative costs
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 research components: an implementation analysis and a services and practice analysis. Descriptions of these components (goal, methods, and findings) are provided below. Each evaluation component will be ongoing and span the duration of the Demonstration.

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. The domain of vision and values, described in previous reports, was conceptually integrated into the domain of leadership, as there was too much overlap between the two and not enough data to report out on solely specific to vision and values. This semi-annual 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 October 2015 through March 2016. The stakeholder interview data in this report is a continuation of the interviews reported in Florida's Title IV-E Waiver Demonstration Project Semi-Annual Report 2. The findings from Semi-Annual Report 2 and this report will be collated in the Interim Evaluation Report.

Methods. Fifteen 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. In the next phase of the Demonstration implementation analysis, interviews will be conducted with judges, child protection investigators and their supervisors.

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).

Data analysis. 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 conclusions. 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.

Findings.

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. 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 our previous report, 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.

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 has 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."

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 1, the number of children that entered out-of-home care statewide has decreased (with minor increases recently) since the implementation of the Demonstration. However, the recent increases in out-of-home care cases are not at the level they were prior to implementation of the Demonstration.

Table 1: *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

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 the child welfare 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 the child welfare 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.

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 the child welfare 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." 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. Related to this issue, one recommendation was to change the allocation formula so that CBCs can access additional funds as needed during a fiscal year when there is an increase in children coming into the system.

Stakeholders also spoke to how some CBCs have renegotiated contracts in order to align with the child welfare 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.

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.

Many of the responses related to organizational capacity discussed the impact of the implementation of the child welfare 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 the child welfare practice model and the Demonstration. Several respondents believe that the implementation of the child welfare 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.

Several interviewees noted that the high turnover rate amongst investigators and case managers led to an inexperienced workforce that is unfamiliar with the child welfare 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 the child welfare 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 the child welfare 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 waiver 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 the prevention and intervention. And I would say that they utilize that and use that sometimes and order that to help families.

The final theme related to organizational capacity was related to tracking and documentation of Title IV-E eligibility. As noted in our previous report (Armstrong, et al., 2015), interviewees continued to discuss the time and staff demands related to the Department's requirement to continue eligibility determination. There also was recognition that the new IV-E eligibility module n FSFN will reduce administrative burden for the CBCs.

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. 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.

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.

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.”

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."

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."

Summary. The goal of the implementation analysis component is to identify and describe implementation of the Demonstration in terms of leadership, vision and values, environment, stakeholder involvement, and organizational capacity and infrastructure. 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, the child welfare 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. One strength that identified was the funding flexibility offered by the Demonstration and its relationship to successful implementation of the child welfare practice model. For example, funding is available to develop an array of safety management services to use during safety planning with a family. 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.

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.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This component also assesses changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification. For the current report, preliminary findings are presented from a set of case management focus groups conducted in various areas of the state. This analysis is currently still in process, but an overview of some prominent themes emerging from the focus groups is provided here. The intent is to follow up with a corresponding set of focus groups with child protective investigators. A complete analysis of all the focus groups will be prepared for the next progress report.

Methods. 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. Focus groups were conducted from January to March of 2016. Two focus groups were held in 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 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 version 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, so the results presented in the current report should be considered preliminary and not conclusive.

Findings. Although analysis of the focus groups is not complete at this point, a few of the most prominent themes emerging from the data to date are highlighted. Four overarching themes have begun to emerge from the analysis 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. Findings related to each theme are discussed in brief. The next progress report will include a more detailed analysis of the results from the focus groups conducted with case managers.

Family preservation. Overall, case managers value 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 associated with removing children, and saw preventing that trauma as the greatest benefit to in-home services. A number of case managers also expressed a belief that unnecessary removals do occur and that there is a need to prevent this from happening. On the other hand, some case managers perceived that there are cases in which children remain in the home when it is not safe, and this was a considerable concern. Child safety was the primary concern expressed by case managers regarding the use of in-home services. These concerns were 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 their concerns about a child's safety are sometimes ignored, 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.

Expressions of skepticism towards families were frequently related to concerns about child safety. In nearly every focus group, case managers expressed doubts about the sincerity or motivations of some 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 have 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 assessment 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 not all the various players are on the same page; thus, these discussions 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 as 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 sometimes 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 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 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. As noted earlier, 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 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 various system stakeholders treat them with disrespect, 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. Furthermore, the lack of cohesion creates confusion for families trying to navigate the system, and this exacerbates the hostility and resentment frequently exhibited by system-involved families.

Summary. The findings 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.

Outcome Analysis

Safety Indicators

Child safety, permanency, and well-being represent important areas for continued improvement and are of the goals of the Demonstration project and its extension. To achieve these objectives, Florida has Demonstration authority to use funds for various services and the development of innovative strategies that would reduce the risk for child re-abuse as well as improve child safety and well-being. Although the current Demonstration requirements place greater emphasis on child well-being (James Bell Associates, 2013), child safety remains a critical goal for the child welfare system because failed safety suggests that child well-being is in jeopardy. In addition, research has shown that failed child safety including child maltreatment, 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).

Repeat maltreatment and, in the most severe cases, re-entry into out-of-home care pose particular concerns for child welfare agencies due to their detrimental consequences for both children and their families (Kimberlin, Anthony, & Austin, 2009). To better understand the extent to which child safety is ensured, this section focuses on three outcomes related to child safety. To examine child safety outcomes, specific indicators were developed and calculated. The indicators were selected and developed in collaboration with the Florida Department of Children and Families.

Methods. The outcome analysis tracks changes 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. The data used to produce these indicators cover the time period of SFY 11-12 through SFY 14-15, so children in all three entry and exit cohorts were followed for at least 12 months. The following indicators were examined:

- Rate of verified maltreatment as a proportion of the State's child population;
- 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;
- Proportion of children who did NOT re-enter out-of-home care within 12 months of discharge.

Sources of data. The data sources for the quantitative child protection indicators used in this report were data abstracts taken from the Florida Safe Families Network (FSFN).

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

Findings: rate of verified maltreatment.

This report provides an unduplicated count of children who were alleged victims of maltreatment in investigative reports received during the 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. The Department calculated this measure. Because this measure consists of cross-sectional data, rates of verified maltreatment are presented for four state fiscal years (the description of the indicator is in Appendix E Measure 1).

As shown in Table 2 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%.

[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).

Rate of Verified Maltreatment as a Proportion of the State's Child Population

Table 2: *Proportion of Children with Verified Child Abuse in the State of Florida by Cohort: Per capita rate/1000.*

Circuit	Counties in Circuit	SFY 2011-2012 Child Abuse Rate (%)	SFY 2012-2013 Child Abuse Rate (%)	SFY 2013-2014 Child Abuse Rate (%)	SFY 2014-2015 Child Abuse Rate (%)
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	21.49	19.7	16.91	16.98
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	14.01	9.92	10.89	8.94
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	22.13	18.35	20.84	17.98
Circuit 4	Clay, Duval, Nassau	14.14	14.68	14.35	11.21
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	18.30	18.80	13.95	9.94
Circuit 6	Pasco, Pinellas	21.15	20.19	17.59	16.75
Circuit 7	St. Johns, Flagler, Putnam, Volusia	16.78	15.06	11.95	12.74
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	22.43	21.91	19.56	13.90

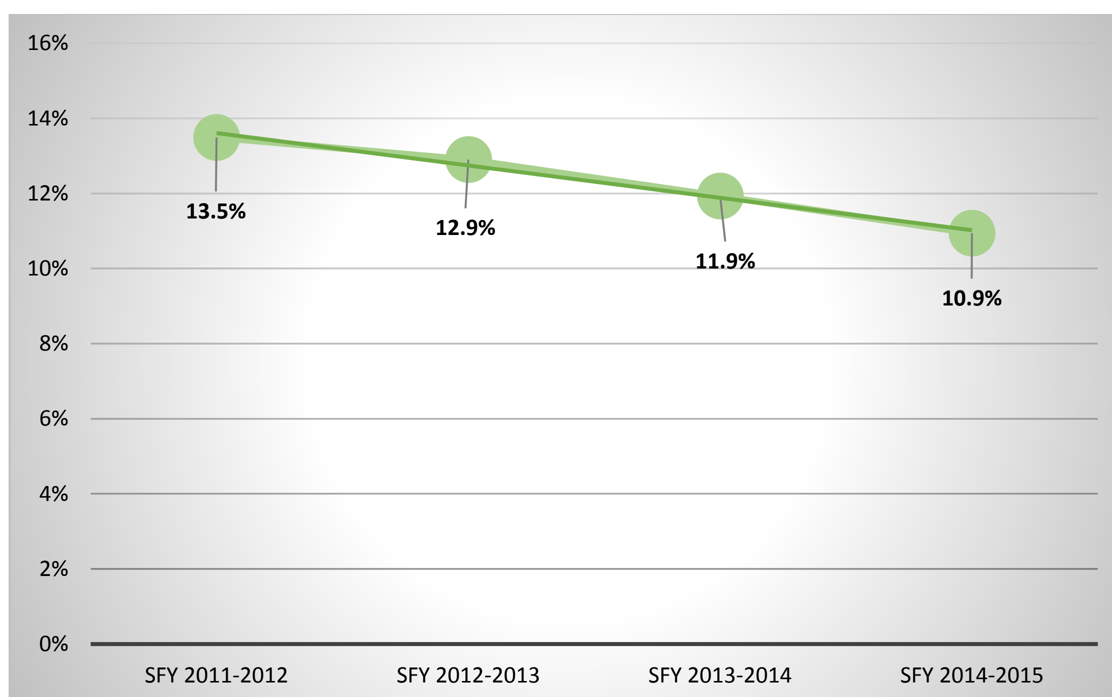
Circuit	Counties in Circuit	SFY 2011-2012	SFY 2012-2013	SFY 2013-2014	SFY 2014-2015
		Child Abuse Rate (%)	Child Abuse Rate (%)	Child Abuse Rate (%)	Child Abuse Rate (%)
Circuit 9	Orange, Osceola	13.71	12.88	10.14	8.24
Circuit 10	Hardee, Highlands, Polk	11.32	11.54	10.18	8.74
Circuit 11	Miami-Dade	6.88	6.65	7.88	8.02
Circuit 12	DeSoto, Manatee, Sarasota	18.19	15.69	13.30	15.75
Circuit 13	Hillsborough	10.75	10.77	10.35	9.91
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	12.51	14.32	13.78	11.39
Circuit 15	Palm Beach	9.97	9.86	13.14	7.24
Circuit 16	Monroe	15.36	18.00	20.82	27.74
Circuit 17	Broward	13.23	12.92	12.54	13.11
Circuit 18	Seminole, Brevard	12.67	10.93	7.66	10.35
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	14.73	11.70	10.11	12.60
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	10.71	10.90	10.35	8.75
State of Florida		13.5	12.90	11.93	10.94

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 1). 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 F1, Appendix F).

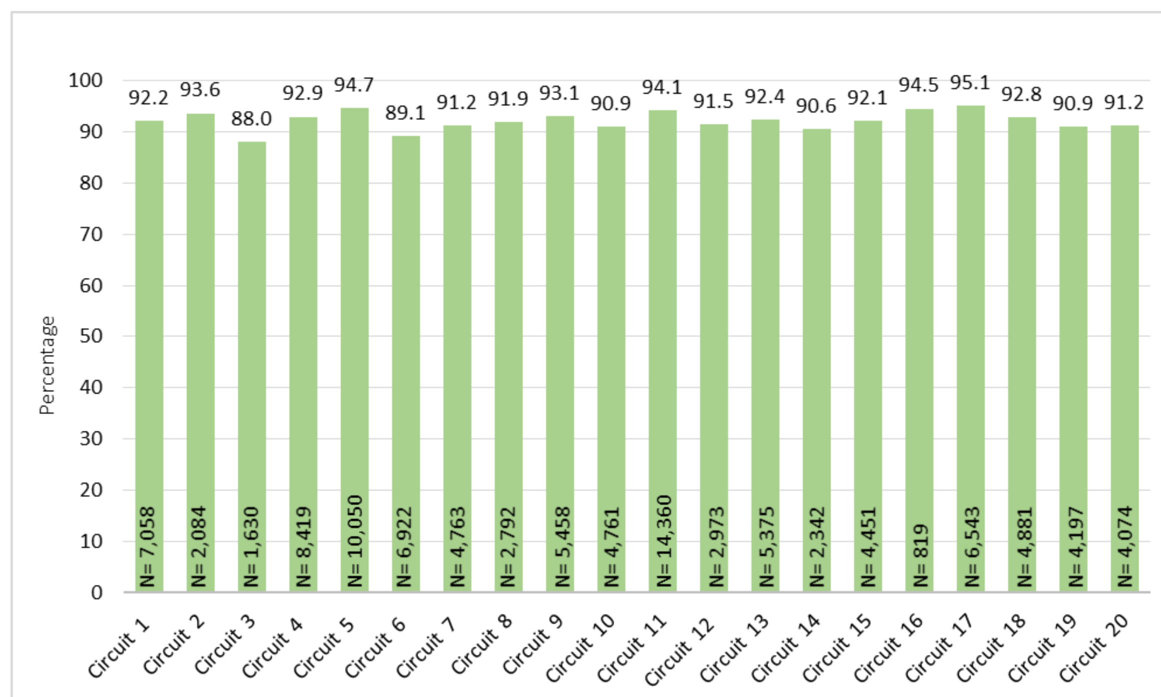
Figure 1*: Proportion of Children with Verified Child Abuse in the State of Florida by Cohort: Per capita rate/1000.*



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 2). As shown in Figure 2, 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 5).

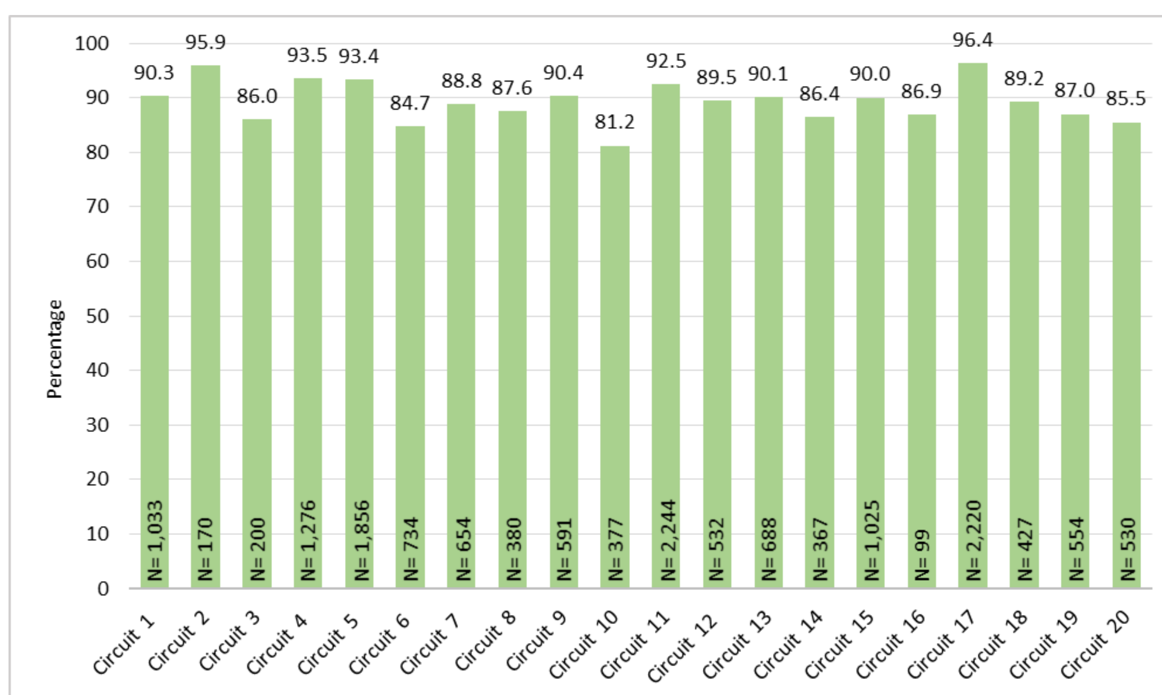
Figure 2: *Proportion of Children Whose Case Was Open in SFY 2011-2012 and Who Did NOT Enter Out-of-Home Care within 12 Months*



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

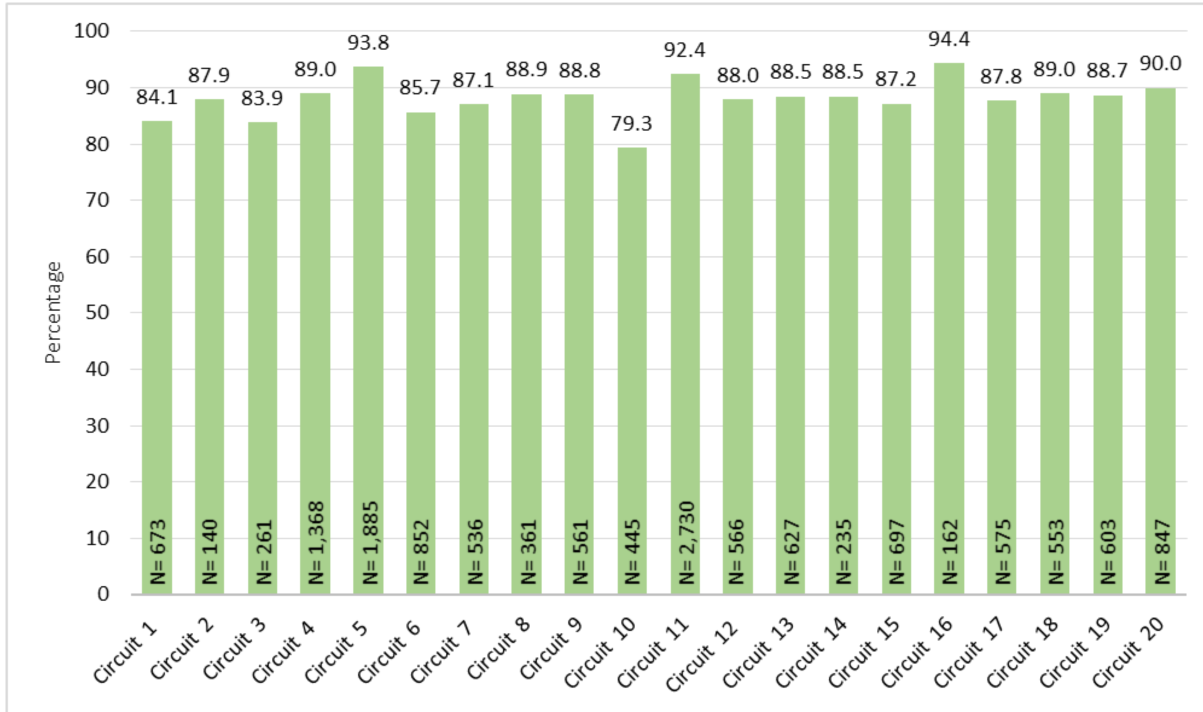
receiving in-home services for the state of Florida was 90.8%. Figure 3 displays the proportion of children that had a case opened in SFY 12-13 and did not enter out-of-home care within 12 months.

Figure 3: *Proportion of Children Whose Case Was Open in SFY 2012-2013 and Who Did NOT Enter Out-of-Home Care within 12 Months*



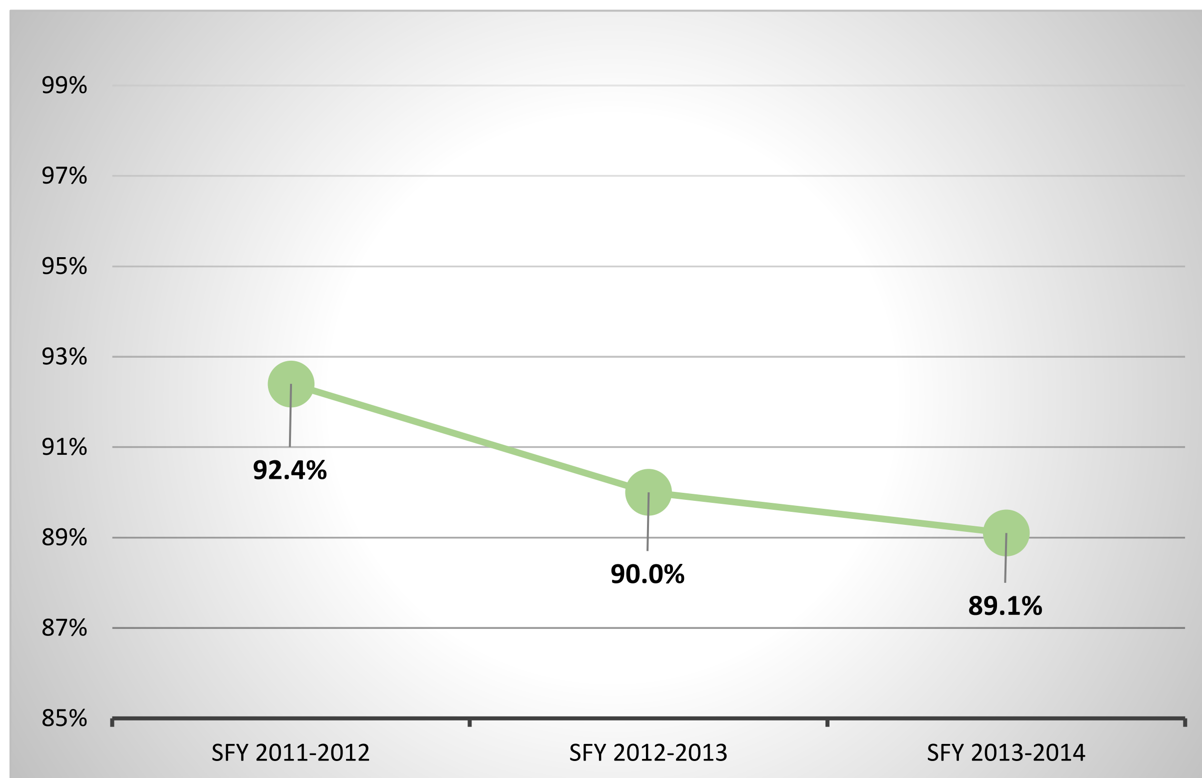
When the entry cohort SFY 13-14 was examined, Circuit 16 had the highest (94%) and Circuit 10 had the lowest proportion (79%) of children who did not enter out-of-home care after initially receiving in-home services (see Figure 4). The average proportion of children who did not enter out-of-home care 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 5).

Figure 4: *Proportion of Children Whose Case Was Open in SFY 2013-2014 and Who Did NOT Enter Out-of-Home Care within 12 Months*



As shown in Figure 5 below, 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 SFY11-12 to 89.1% in SFY13-14, a statistically significant difference (see Table F2, Appendix F).

Figure 5: *Proportion of Children in the State of Florida Who Did Not Enter Out-of-Home Care within 12 Months*



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

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 3).

As shown in Figure 6, the proportion of children who did not re-enter out-of-home care in SFY 11-12 ranged from 87.4% (Circuit 18) to 95.6% (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 Circuits 8 and 9 (see Figure 7). 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 8). As shown in Figure 9, 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 6: *Proportion of Children Exited Out-of-Home Care in SFY 2011-2012 and Did Not Reenter within 12 Months*

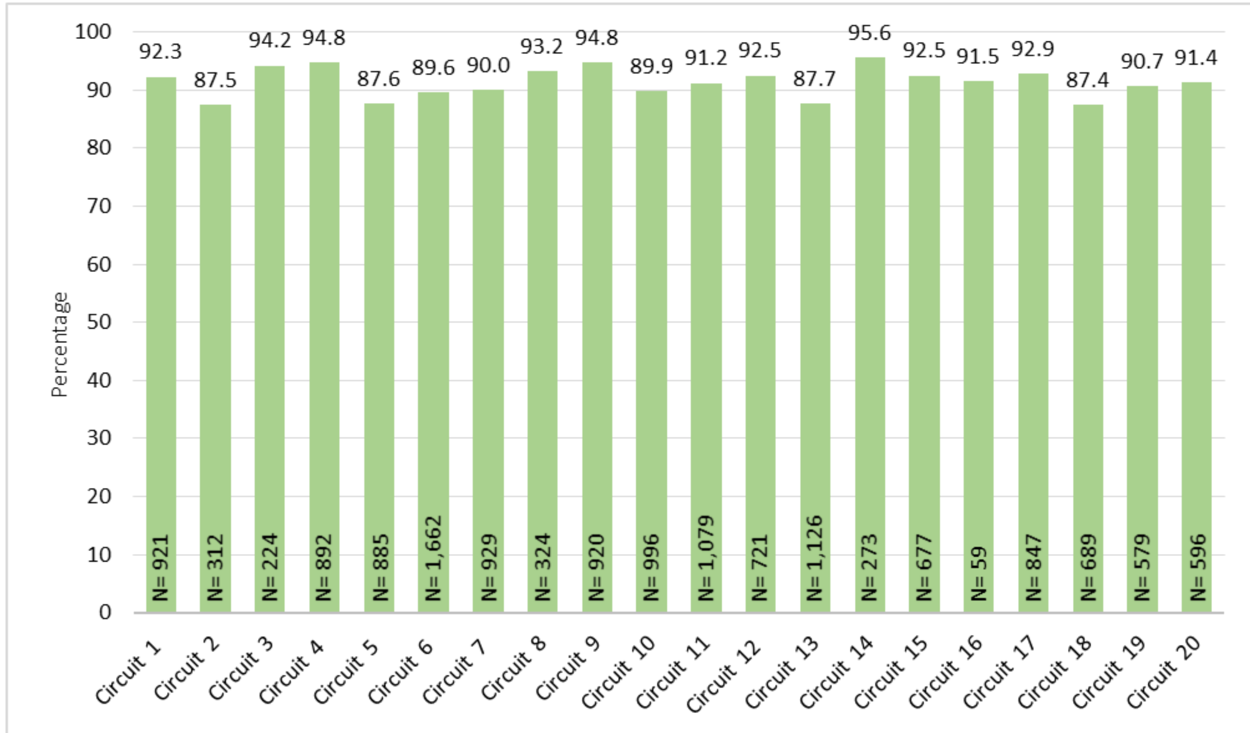


Figure 7: *Proportion of Children Exited Out-of-Home Care in SFY 2012-2013 and Who Did Not Reenter within 12 Months*

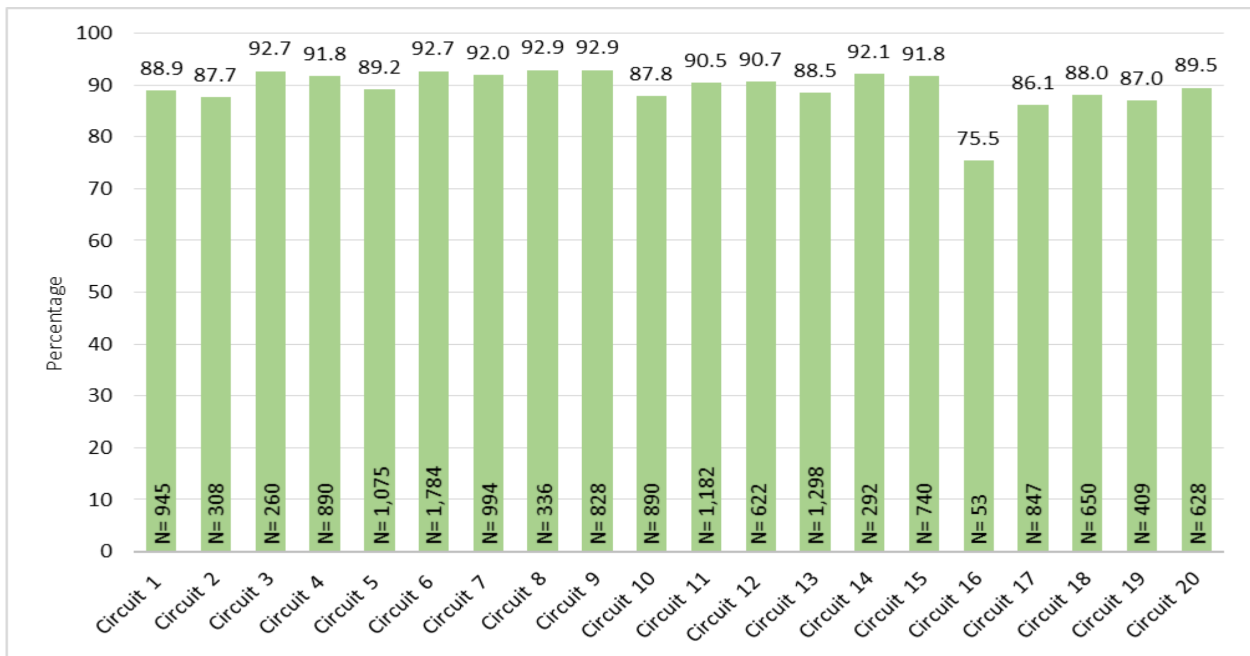


Figure 8: *Proportion of Children Exited Out-of-Home Care in SFY 2013-2014 and Who Did Not Reenter within 12 Months*

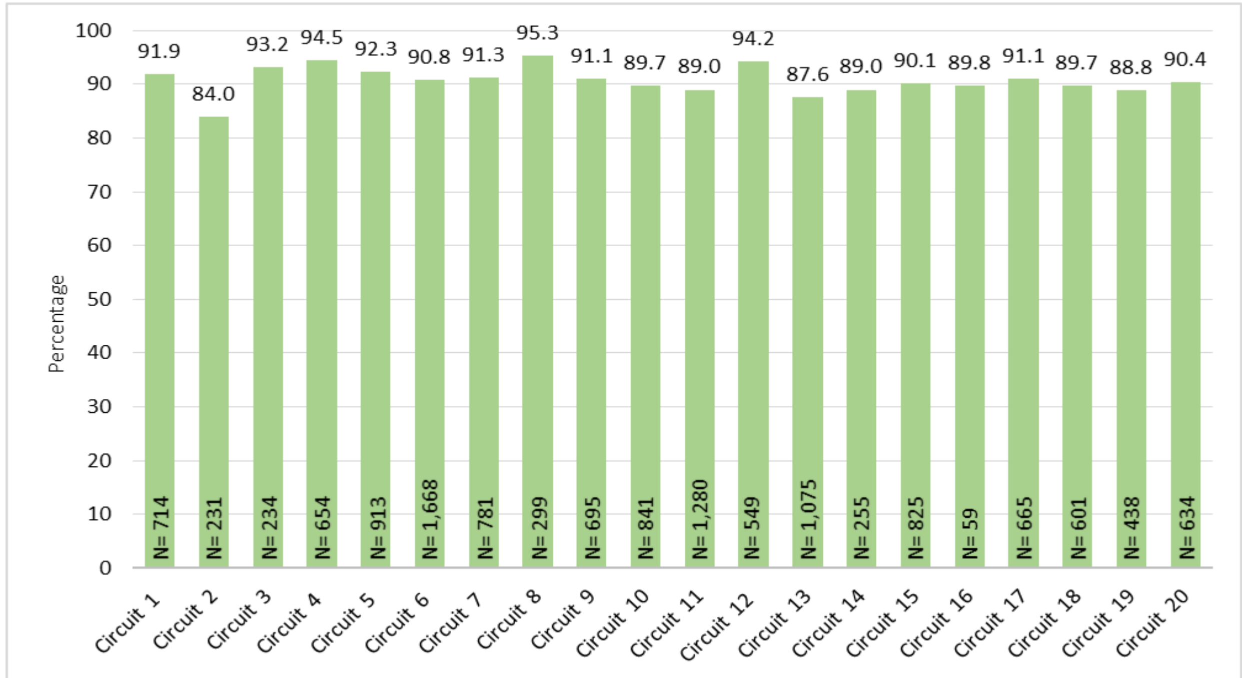
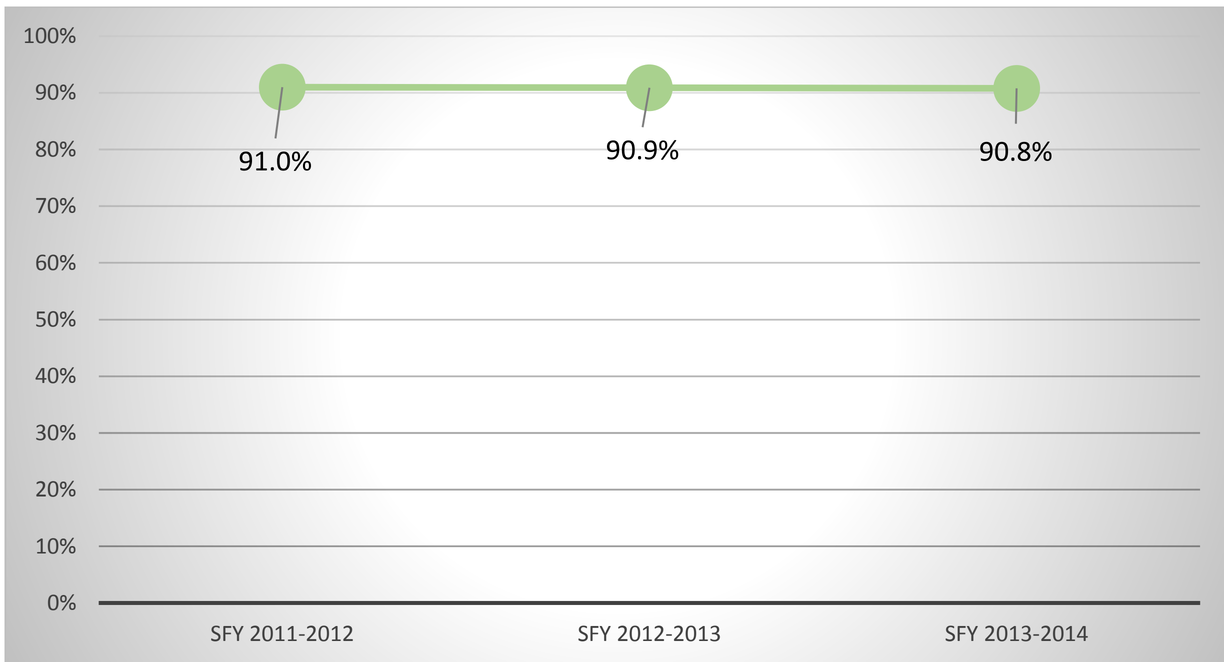


Figure 9: *Proportion of Children Exited Out-of-Home Care and Who Did Not Reenter within 12 Months*



Summary. Overall, there is considerable variability among Circuits on measured indicators. For example, 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%.

There is a trend indicating improved performance statewide on child safety based on two out of three examined indicators. Specifically, there is a decrease in the number of verified child maltreatment cases per 1,000 child population over time, and there is an increase in the proportion of children who remained home after their dependent case was opened. 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 IV-E 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. No time by group interaction was examined. Second, this study was limited to measures of lead agency performance that relate to child safety outcomes. Finally, the findings do not account for the effects of child or family socio-demographic characteristics, 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. The constructs of child and family well-being are examined according to the applicable CFSR outcomes and performance items shown in Table 3. 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.

Table 3: *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

Table 4 below presents the evaluation 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. 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.

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. 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. As QA team members continue to utilize the CFSR tool,

inner-rater reliability will improve and the findings will be based on a consistent understanding of what is being measured.

Table 4: *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?

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. Most cases are applicable to the first sub-item. As shown in Table 5, statewide, 61% of cases reviewed were

rated as a strength, and the remaining 38% 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 5: *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	74	61% (n=45)	39% (n=29)
5	38	63% (n=24)	37% (n=14)
6	--	--	--
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	43	53% (n=23)	47% (n=20)
12	26	85% (n=22)	15% (n=4)
13	--	--	--
14	14	100% (n=14)	0% (n=0)
15	41	76% (n=31)	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	49	69% (n=34)	31% (n=14)
State	585	61% (n=358)	39% (n=227)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

Performance item 13. This item pertains to efforts made to involve the parents and children (if developmentally appropriate) in case planning processes. Cases deemed not applicable for review of this item were those in which 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, and cases in which it was documented in case files that involvement of the parents were not in the child's best interest. Statewide, 62% of cases reviewed were rated as a strength, and the remaining 38% of cases reviewed scored this item as an area in need of improvement (Table 6). At least 90% of cases reviewed were rated as a strength for Circuits 14 and 15.

Table 6: *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	73	70% (n=51)	30% (n=22)
5	27	67% (n=18)	33% (n=9)
6	--	--	--
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	41	39% (n=16)	61% (n=25)
12	24	83% (n=20)	17% (n=4)
13	--	--	--
14	11	91% (n=10)	9% (n=1)
15	40	90% (n=36)	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	46	67% (n=31)	33% (n=15)
State	547	62% (n=340)	38% (n=207)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

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. All cases are applicable for review of this item. As shown in Table 7, statewide, 62% of cases reviewed were rated as a strength. Accordingly, 38% of cases reviewed scored this item as an area in need of improvement. Circuits 10, 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 7: *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	74	65% (n=48)	35% (n=26)
5	38	71% (n=27)	29% (n=11)
6	--	--	--
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	43	70% (n=30)	30% (n=13)

12	26	88% (n=23)	12% (n=3)
13	--	--	--
14	14	100% (n=14)	0% (n=0)
15	41	85% (n=35)	15% (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	49	78% (n=38)	22% (n=11)
State	585	62% (n=361)	38% (n=224)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

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. Cases not applicable for review of this item were those in which 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, cases in which it was documented in case files that involvement of the parents were not in the child's best interest, or cases in which it was documented in case files that the parent indicated he or she did not want to be involved in the child's life. As shown in Table 8, 35% of cases scored as a strength. A greater portion of reviewed cases were rated as an area in need of improvement (65%), 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 8: *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	68	49% (n=33)	51% (n=35)
5	23	35% (n=8)	65% (n=15)
6	--	--	--
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	40	27.5% (n=11)	72.5% (n=29)
12	21	71% (n=15)	29% (n=6)
13	--	--	--
14	8	87.5% (n=7)	12.5% (n=1)
15	34	35% (n=12)	65% (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	46	37% (n=17)	63% (n=29)
State	507	35% (n=175)	65% (n=332)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

Well-being outcome 1 ratings. Table 9 details ratings for this outcome pertaining to families having the enhanced capacity to provide for their children's needs. The ratings shown in Table 9 are a compilation of the ratings for performance items 12 through 15. Of the cases reviewed statewide, 47% met the standards of substantial achievement and 36% were partially

achieved. The standard for this outcome was not achieved or addressed for 18% 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 9: *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	74	43% (n=32)	47% (n=35)	9% (n=7)
5	38	55% (n=21)	32% (n=12)	13% (n=5)
6	--	--	--	--
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	43	35% (n=15)	49% (n=21)	16% (n=7)
12	26	77% (n=20)	23% (n=6)	0% (n=0)
13	--	--	--	--
14	14	93% (n=13)	7% (n=1)	0% (n=0)
15	41	66% (n=27)	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	49	57% (n=28)	35% (n=17)	8% (n=4)
State	585	47% (n=273)	36% (n=208)	18% (n=104)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

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. Cases not applicable for review are foster care cases in which the child is age two or younger, there is no apparent developmental delay, and 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. The majority of cases met criteria indicative of a strength (75%); 25% of cases reviewed indicated that educational needs were an area in need of improvement (see Table 10). 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 10: *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	42	86% (n=36)	14% (n=6)
5	20	80% (n=16)	20% (n=4)
6	--	--	--
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	36	75% (n=27)	25% (n=9)
12	19	79% (n=15)	21% (n=4)
13	--	--	--

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	25	52% (n=13)	48% (n=12)
State	340	75% (n=255)	25% (n=85)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

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 11, of the cases reviewed statewide, 82% met the standards of substantial or partial achievement. The standard for this outcome was not achieved or addressed for 18% of cases reviewed. All cases reviewed in Circuits 2 and 14 did meet the standard for substantial achievement.

Table 11: *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	42	86% (n=36)	5% (n=2)	10% (n=4)
5	20	80% (n=16)	10% (n=2)	10% (n=2)
6	--	--	--	--
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	36	75% (n=27)	14% (n=5)	11% (n=4)

12	19	79% (n=15)	5% (n=1)	16% (n=3)
13	--	--	--	--
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	25	52% (n=13)	24% (n=6)	24% (n=6)
State	340	75% (n=255)	7% (n=25)	18% (n=60)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

CFSR well-being outcome 3. The third well-being outcome pertains to receipt of adequate services to meet the physical and mental health needs of children. Results of the performance items for this outcome are shown in Tables 12 and 13.

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. Cases not applicable for review are 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. As indicated in Table 12, the majority of cases reviewed were rated as a strength (73%). The proportion of cases indicative of an area in need of improvement was 27%. Circuits 2, 4, 9, and 10, achieved greater than 90% of cases rated as a strength.

Table 12: *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	51	94% (n=48)	6% (n=3)
5	29	83% (n=24)	17% (n=5)
6	--	--	--
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	43	77% (n=33)	23% (n=10)
12	24	79% (n=19)	21% (n=5)
13	--	--	--
14	9	78% (n=7)	22% (n=2)
15	26	62% (n=16)	38% (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	32	81% (n=26)	19% (n=6)
State	419	73% (n=307)	27% (n=112)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

Performance item 18. This performance item addresses accurate assessment and receipt of appropriate services of the mental and behavioral health needs of children. Cases not applicable for review are 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 are also not applicable for review if 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. As shown in Table 13, similar to the results of the other performance item within this outcome measure, the majority of cases reviewed were rated as a strength (70%). 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 13: 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	41	80% (n=33)	20% (n=8)
5	9	100% (n=9)	0% (n=0)
6	--	--	--
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	28	86% (n=24)	14% (n=4)
12	17	82% (n=14)	18% (n=3)
13	--	--	--
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	18	56% (n=10)	44% (n=8)
State	290	70% (n=204)	30% (n=86)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

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 14 shows the summated ratings of the two performance items addressing this outcome. Of the cases reviewed statewide, 66% met the standards of substantial achievement and 14% were partially

achieved. The standard for this outcome was not achieved or addressed for 20% of cases reviewed.

Table 14: *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	62	82% (n=51)	11% (n=7)	6% (n=4)
5	29	83% (n=24)	3% (n=1)	14% (n=4)
6	--	--	--	--
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	43	70% (n=30)	16% (n=7)	14% (n=6)
12	25	76% (n=19)	16% (n=4)	8% (n=2)
13	--	--	--	--
14	10	80% (n=8)	10% (n=1)	10% (n=1)
15	34	62% (n=21)	15% (n=5)	24% (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	37	68% (n=25)	14% (n=5)	19% (n=7)
State	471	66% (n=310)	14% (n=66)	20% (n=95)

Note. Figures may not total to 100% due to rounding.
Note. Data not available as the reviews were not finalized for Circuits 6 and 13

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

The Demonstration provides greater flexibility in the use of Federal funds. One goal of the Demonstration is to shift funds from dependency to prevention services in an effort to prevent the future removal of children from the home. Indeed, as reported in the evaluation of the original IV-E Demonstration (Vargo, Armstrong, Jordan, Sharrock, Sowell, & Yampolskaya, 2012) there was a notable shift between the years prior to the Demonstration (FFY 04/05-05/06) and after the Demonstration (FFY 06/07-10/11) from dependency to prevention services. The goal of the cost analysis in this semi-annual report is to examine lead agency appropriations by type of service. In particular, this report examines 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 15 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 15, 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 13-13 from $18.0 million to $15.9 million before rebounding to $18 million in SFY 13-14 and SFY 14-15.

Table 15: *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. Source: DCF Office of Financial Management
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 16 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) with the decline likely due to the emphasis on reducing removals from the home. 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 16: *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
2007/08	97,183,122	3,367,134	100,550,256	100,960,832	3,674
2008/09	111,338,851	1,908,500	113,247,351	111,490,435	3,776
2009/10	124,603,030	-	124,603,030	122,982,298	3,367
2010/11	130,642,608	2,203,562	132,846,170	131,448,871	3,009
2011/12	141,675,422	-	141,675,422	140,696,458	3,252
2012/13	148,261,828	1,400,000	149,661,828	150,405,112	3,353
2013/14	156,842,838	5,383,639	162,226,477	161,176,455	3,245
2014/15	168,001,927	-	168,001,927	170,962,310	3,229

Note. Source: DCF Office of Financial Management
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 17 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.

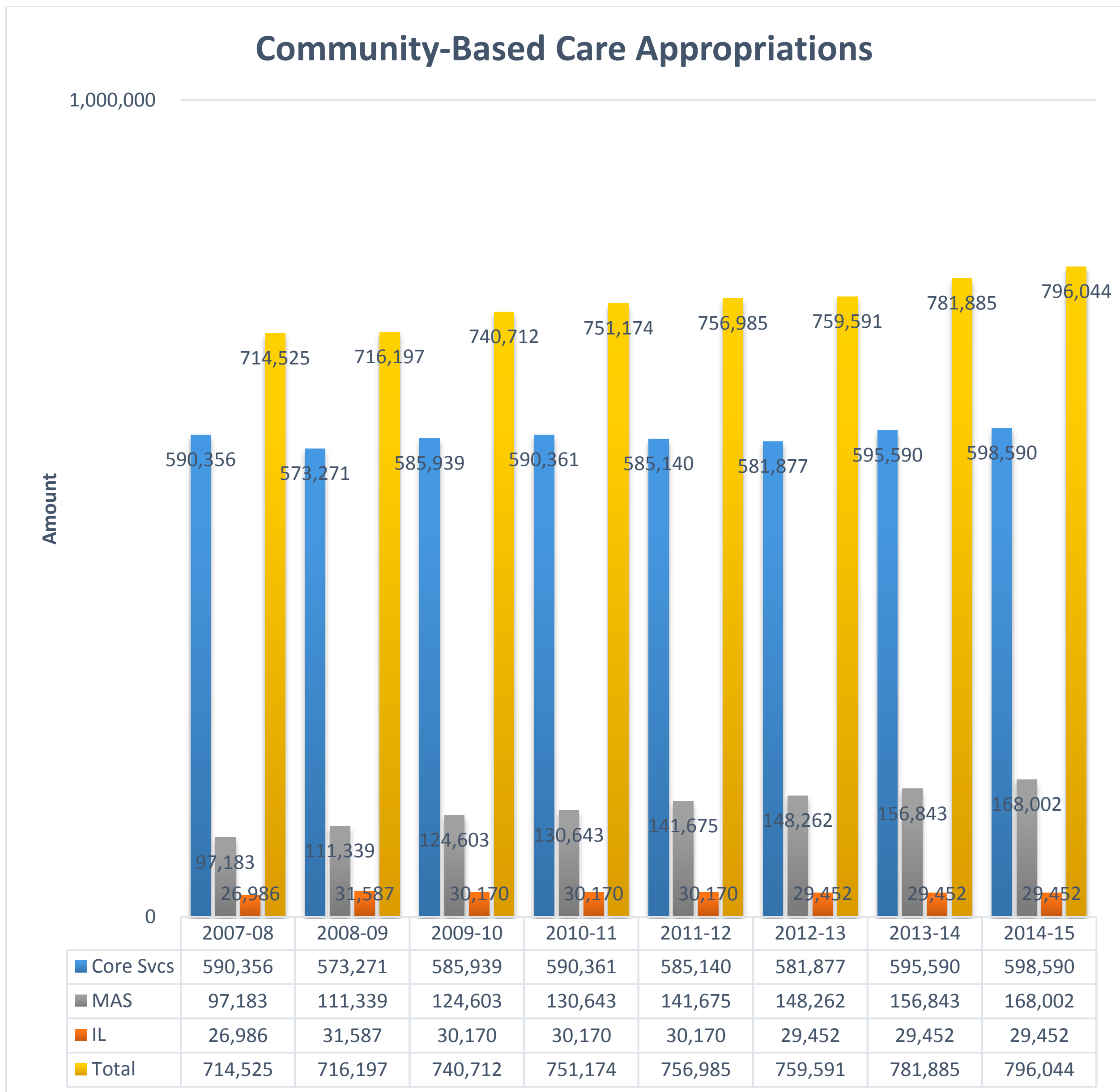
Table 17: *Independent Living Expenditures by Program by Fiscal Year*

	1	2	3	4	5	5	5	1 thru 5
State Fiscal Year	**Case Coordination & Life Skills Training**	**Subsidized IL (SIL Ages 16-17)**	**Road to Independence (RTI)**	**Transitional**	**Aftercare**	**Extended Foster Care (EFC)**	**Postsecondary Education Services & Supports (PESS)**	**Total IL Expenditures**
2007/08	7,823,445	472,801	16,942,761	3,487,197	1,045,986	-	-	29,772,190
2008/09	8,834,560	833,921	23,458,611	4,349,971	1,056,032	-	-	38,533,096
2009/10	10,738,650	737,457	35,260,681	4,265,864	877,447	-	-	51,880,099
2010/11	11,626,648	408,919	35,204,423	4,591,816	448,780	-	-	52,280,586
2011/12	13,066,982	276,761	29,858,300	5,208,321	628,794	-	-	49,039,158
2012/13	12,929,557	164,621	26,854,501	5,474,269	847,282	-	-	46,270,229
2013/14	12,441,197	108,705	20,764,502	2,368,999	667,920	1,431,030	5,073,086	42,855,440
2014/15	10,515,962	1,651	6,848,109	-	625,356	6,381,856	15,263,802	39,636,735

Note. Source: DCF Office of Financial Management
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 10 contains on overall summary of Community-Based Care appropriations from SFY 07-08 through SFY 14-15. Core services include dependency case management, licensed care, prevention services, client services, adoption, training, and other. 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 $759 million in SFY 12-13 and increased to $782 million in SFY 13-14 and $796 million in 14-15.

Figure 10: *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. Source DCF Office of Financial Management.
Note. Dollars are reported in thousands.

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.

Sub-Study: Cross-System Services and Costs

This section reports on a special 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.

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.

Medicaid

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.

Medicaid enrollment. 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, are 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 18: *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%			

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 18 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, using PROC GENMOD in SAS to account to multiple observations within each Circuit. Odds ratios from the regression are reported in Table 18. 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.

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.

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

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 State Substance Abuse and Mental Health Information System 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 19 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 19 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 19: *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

Table 20 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 19.

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 12-14) 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 20: *Expenditures by Year*

Service		Year prior to removal			Year after removal		
		# Users		Mean per user	# Users		Mean per user
SFY=2011/12 n=15,035	Tot expend	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=2012/13 n=13,149	Tot expend	8243	$ 6,487.77	12681	$ 5,520.18
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 n=14,692	Tot expend	9866	$ 5,480.74	14351	$ 4,578.46
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

Table 21 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 19), 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 21: *Expenditures by Circuit*

Medicaid SFY 2011/12 - 2013/14

		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			$	428.09		$	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		$	1,480.95
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

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.

Future analysis for this 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.

Summary and Discussion

This is the third in a series of semi-annual evaluation reports for the 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 (child safety and child and family well-being indicators), cost analysis, and the sub-study on cross-system services and costs.

The goal of the implementation analysis is to identify and describe implementation of the Demonstration in terms of leadership, vision and values, environment, and organizational capacity and infrastructure. 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.

Regarding environmental factors that affect the Demonstration, spikes in out-of-home care and contextual variables such as domestic violence, substance abuse, mental health, and human trafficking were voiced as challenges. The perceptions of interviewees were that the increases in out-of-home care were related to the role of the media in child deaths, the child welfare practice model, turnover in CPIs and case managers, and changes in how CPIs conduct investigations. As noted in the Analysis of Increases in Out of Home Care: 2013-2015 (2016) report, it is helpful to differentiate between stakeholder perceptions that are directly associated with the implementation of the child welfare practice model and perceptions that are related to factors that are external to the practice model, but may affect its implementation such as judicial

issues, case load sizes, turnover rates for CPIs and case managers, and negative attention from the media.

Organizational capacity includes infrastructure characteristics that directly support the implementation and sustainability of the Demonstration. One strength that was identified is the funding flexibility offered by the Demonstration and its relationship to successful implementation of the child welfare practice model through the development of an array of safety management services. 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. Some stakeholders also spoke to having the ability to transition to services that were evidence-based and/or specialized for target populations.

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, preliminary findings are presented from 10 case management focus groups conducted in various areas of the state.

The focus group findings describe 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 effective 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.

The outcome analysis on 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 considerable variability among Circuits on the measured indicators. There is a trend indicating improved performance statewide on two out of three examined indicators. Specifically, there is a decrease in the number of verified child maltreatment cases per 1,000 child population over time, and there is an increase in the proportion of children who

remained home after their dependent case was opened. Re-entry into out-of-home care remained stable over time.

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. This report 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.

There was substantial variation across Circuits in achieving conformity for the well-being indicators. A few Circuits stand out as consistently obtaining strength ratings for the relevant performance items. Other Circuits appear to be less effective in the quality of child welfare practices relevant to improving the capacity of families to care for their children and in service provision. A statewide area of concern is the status of one performance item related to the enhancement of a family's capacity to provide for the needs of their children. 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.

The goal of the cost analysis in this report 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 the child welfare practice model may also result in changes in the services being emphasized by lead agencies.

Finally, this 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.

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.

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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

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

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

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

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

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

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

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

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

<u>Funding</u> – 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.

<u>Conclusion</u>

<u>Recommendations</u> – any specific recommendations that are made about how to improve waiver implementation

<u>Lessons</u> – 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
Safety Outcomes

Measure 1: 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 2: 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.[3] 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.

Measure 3: 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.

[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.

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.

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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

Table F1: *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 F2: *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 F3: *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.