Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project

FINAL REPORT

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Contents

Executive Summary

In the years of the current Title IV-E Waiver demonstration period, Indiana was able to spend dollars more flexibly to expand services and to invest in evidence-based services on a statewide level. These investments aimed to provide new and effective services to support youth and families in the child welfare system.

During the demonstration period, the landscape of the population shifted in a way that was unexpected and to the extent that surprised a nation. Since 1999, Indiana has seen drug overdose deaths increase more than 500%.[1] In a Jointpoint regression examining trends from 2010 to 2015, the CDC found that Indiana was one among 30 states to have significant increases in the rate of drug overdose deaths. And in 2013-2014, Indiana saw a statistically significant increase in the drug overdose death rate (increasing by 9.6%).[2]

Public health reporting data is usually three to five years behind what is actually happening. Today we can see that the trend was beginning to increase significantly. During this time, DCS tried to implement better service recommendations and to incorporate better, real-time solutions to addressing their changing population.

The Title IV-E Waiver evaluation identified a number of successes and strengths. Our DCS/IU collaboration also noted some areas for continuing improvement. Brief overviews of the Outcome Study, Process Study, Cost Study, and Sub-study are presented in this section.

[1] Duwve J, Hancock S, Collier C, Halverson P. Report on the toll of opioid use in Indiana and Marion County. Available at: https://www.inphilanthropy.org/sites/default/files/Richard%20M.%20Fairbanks%20Opioid%20Report%20September%202016.pdf

[2] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1

Outcome Study

Safety. Safety measurements increased in the Quality Service Review (QSR) data over the five rounds and the post-Waiver years had significantly higher safety scores than the pre-Waiver years ($p<.001$). Additionally, there was a lower percentage of subsequent substantiated abuse/neglect of cases for children while residing either in-home or in out-of-home placements according to the administrative data. However, a higher proportion of children with closed cases experienced subsequent substantiated abuse or neglect both 6 months and 1 year post case closure in the demonstration period. This finding indicates that children are safer while in care than in the pre-Waiver period, but the Department is still struggling to keep children out of care after cases are closed.

Permanency. The average number of days spent in out-of-home care for all of the closure types (adoption, reunification, guardianship) was longer in the demonstration period as compared to the baseline years. Permanency indicators in the QSR were also rated lower in the post-Waiver years as compared to the pre-Waiver years - statistically significant at $p<.001$. Stability in the QSR was rated only slightly lower, but the difference was not statistically significant. In the administrative data, the average number of placements decreased in the demonstration period suggesting that even though cases were open longer, there were fewer placement disruptions.

Well-being. Along with fewer placement disruptions in the demonstration years, there was also a 50.4% increase in the percentage of children placed with a relative as shown in the administrative data. Similar to the administrative data, the well-being measures in the QSR also improved significantly ($p<.001$). Specifically, appropriate living arrangement, physical health, emotions status, and learning and development all increased in the Waiver years.

Process Study

In the first year of the evaluation, DCS consistently used the phrase, “simply a funding mechanism” to refer to the Waiver and focused solely on making service enhancements. This philosophy changed starting in late 2013 with Casey Family Programs helping to direct better alignment of the Waiver with other established DCS goals. Through this mid-course correction of the process, DCS invested heavily in a Continuous Quality Improvement (CQI) strategy throughout the agency.

DCS invested in evidence-based programs, including Family Centered Treatment (FCT), which is the topic of the sub-study. The overall array of services available was expanded to include more programs and practices that have effectiveness data for children and youth in child welfare settings.

To better identify those who would best served by these services, DCS created a service-mapping tool for case managers that can consistently be refined as they are better able to identify populations for whom particular services work well.

As a major component of the Waiver, this process of service mapping expanded the use of concrete services. Over the past five years, the Waiver supplied more of these goods and services to families in their system. The payments for concrete services in the year leading up to the expanded Waiver (SFY 2012-2013) totaled $2,287,118. In SYF 2017, payments for concrete services increased to $16,939,397 – an increase of more than $14 million. One noted decrease in concrete service spending was in medications and medical expenses.

Regional and Executive Managers were interviewed four times during the demonstration period and provided rich, compelling findings that contextualized the implementation of the 2012 Waiver.

These interviews assisted in establishing trusting relationships with key members of the Department's executive team, which aided the evaluation overall. The evaluators observed Managers' enhanced understanding and articulation of the Waiver across rounds of data collection and ultimately observed Managers make clearer connections between the 2012 Waiver's flexibility and the Department's ability to be creative in meeting unique needs of children and families, which ultimately assisted the Department in preventing removals, expediting permanency, and providing children and youth with normative experiences related to well-being.

Five iterations of the Family Case Manager (FCM) Survey were completed as part of the Process Study. From Rounds 1 to round 5, FCM perceptions of safety, permanency, and well-being at case opening decreased and at case closure perceptions increased. At case closure, current living arrangement, health, emotional status, developmental status, learning status, and independence development increased from Rounds 1 to Round 5. A large percentage of recently closed cases received case management, home-based, mental health, and substance abuse services for both 2016 and 2017. Overall, FCMs perceived that services were more effective in 2017 than in 2016, with the exception of health care services. Relating to Child and Family Team Meetings (CFTMs), FCMs felt that members of the team demonstrated respect, but also that the team made important decisions about the child/family even when they were not present. Family engagement was ranked most often as one of the factors interfering with CFTMs. FCM rankings of service needs for families decreased or remained equal to previous rounds (excluding Round 4, in which FCMs ranked as having higher needs), apart from an increased need for dental related services, father engagement, Family Centered Treatment (FCT), and substance use and abuse.

The average availability of services remained stable except services for developmental/disability, legal assistance, and employment/training. Utilization of services remained stable with previous years except for employment/training. However, when asked about the effectiveness of these services, FCMs reported increased effectiveness for services for developmental/disability, legal assistance, father engagement, employment/training, domestic/intimate partner violence, psycho-education, child-parent psychotherapy, children's mental health initiative, and comprehensive home-based. The mean number of cases for FCMs significantly decreased from 2016 to 2017 and more FCMs found their current caseload to be completely or somewhat manageable. A fewer number and percentage of FCMs worked overtime to manage their cases in 2017 than 2016. Additionally, FCM's rated children or youth with sexually maladaptive behaviors, and large number of siblings very difficult to place rather than difficult or easy. For FCM's perception of job change and Waiver understanding, there were significant differences between years, particularly years 2015 and 2016 as compared to years 2013 and 2014 ($p<.05$).

As the last component of the Process Study, external stakeholders were surveyed in 2013 and 2015. Respondents comprised service providers, caregivers/youth, court professionals, and judges. Overall, clients were satisfied with services and felt DCS respected their family and culture. Judges rated DCS higher than other court professionals on court preparedness. Most of the tension between the court and DCS was with Court Appointed Special Advocate/Guardian ad Litem (CASA/GALs). Service providers tended to rate service effectiveness higher than DCS case managers and felt some tension with CASA/GAL and DCS in teaming settings.

Cost Study

As part of the overall Terms and Conditions for the 2012 Title IV-E Waiver, the impact of the Demonstration Program was evaluated by examining costs related to this program. Any costs saved by the improved Waiver activities were to be re-invested into the provision of services at an earlier point in the exposure of youth and families to the DCS system.

Our DCS/IU team evaluated the cost effectiveness of Waiver services and described the allocation of costs over time. Total spending by the Indiana Department of Child Services increased significantly from the beginning of this Waiver until now. This increase in spending was driven by the significant increase of cases from over 12,000 in 2012 (beginning of this Waiver) to 29,000 at present. Over this time, the proportion of case types (e.g., In-home, relative, foster home, residential, and other) remained stable. One reason for this increase in cases is the serious and ongoing opiate problem in the State.

Given the funding structure for the State of Indiana, DCS has relied on the flexible funding of the Waiver to address this overall increase in case costs. By moving Waiver funding forward, DCS has responded to these increased needs by providing appropriate services. Details about cases and funding will be provided in the main report below.

Overall, the State has reduced Waiver utilization in 2017 and 2018 so that our spending remains cost neutral. Waiver funding allowed DCS to provide more services earlier for families entering the system so that higher cost services (e.g., residential) were avoided – which saved money. Waiver funds that were saved from these higher cost services were shifted to families as early interventions – which is stated in the terms of this funding.

Sub-study

Also, as part of the original Terms and Conditions of the 2012 Waiver, our project team developed a sub-study which focused on the implementation and effectiveness of a specific treatment program. After considering options, we developed a research design that evaluated the impact and effectiveness of Family Centered Treatment (FCT) which was implemented due to Waiver funds.

The effectiveness of the Family Centered Treatment (FCT) intervention was studied from January 1, 2015-December 31, 2015. All children referred for FCT received services as indicated via the model. Fidelity was established using a manualized training and certification of home based workers, supervision, consultation with national FCT Foundation clinicians, and monthly compliance checks on dosage of the intervention. Children (and families) in the FCT treatment group were matched with children (and families) who received usual and customary care using propensity score matching. Matching characteristics were age, gender, race, region, county, number of focus children, involvement status, permanency goal, CANS score, and risk score. Overall, 20, 779 children were within DCS between January 1, 2015 and December 31, 2015 and 230 of those children not involved with the justice system received FCT. Matching characteristics were too restrictive and we were unable to obtain sufficient number of pairs to conduct and analysis. Therefore, region and permanency were removed as they were the characteristics restricting matching. The final data set then included 187 children who received FCT and 187 children who did not. The sample set demonstrated similar demographic characteristics with no significant differences.

Safety: First we analyzed the difference in remaining home throughout DCS involvement. Children who had FCT were significantly more likely to remain in the home throughout (55.61% vs. 39.04%, $p < .001$). Next, we analyzed repeat maltreatment during and 6 months post-DCS involvement. Children in FCT had higher rates of repeat maltreatment (10.61% vs. 5.98%), however, this was not statistically significant. Children in FCT did have a lower rate of repeat maltreatment 6 months after their involvement with DCS ended but again this was not statistically significant (1.68% vs. 4.35%). Finally, we assessed re-entry into DCS following involvement. Although FCT children had higher rates of re-entry than non-FCT children, this difference was not statistically significant (56.42% vs. 50%). These findings indicate that FCT was only partially effective in addressing safety concerns.

Permanency: First we analyzed total days of DCS involvement and number of days elapsed to reunification for each group. Children in FCT had fewer days on average than children who did not have FCT but this was not statistically significant (331 vs. 344). Children in FCT did have statistically significantly fewer days on average until reunification than non-FCT children (341 vs. 417, $p < .05$). These findings indicate some success using FCT to increase time to permanency.

Well-being: To analyze well-being we analyzed risk level for children in both groups. Children who participated in FCT had a lower rate of being classified as "very high risk" as compared to children who did not (50.8% vs. 51.87%) and a higher rate of being classified as "low risk" (1.6% vs. 0.53%). Neither was statistically significant. We analyzed Child Abuse and Neglect (CANS) scores for each group and found that FCT children had a slightly higher average CANS score but it was not a statistically significant difference (1.27 vs. 1.22). To clarify the well-being assessment, we assessed changes in child's safety rating. Children who had FCT had a statistically significantly higher rate of being rated as safe (35.71% vs. 28.49%, $p < .001$) and conditionally safe (39.56% vs. 27.93%, $p < .001$), and a significantly lower rate of being rated as unsafe (24.73% vs. 43.58%, $p < .001$) than children who did not participate in FCT.

Cost: We analyzed total case cost and cost per child for each group. The average total cost of the case was statistically significantly higher for children in FCT ($19,673 vs. $17,719, $p < .05$). However, the cost per child was not statistically significant ($10,277 vs. $6,481) between groups. This finding is not surprising since FCT was an additional cost to the DCS system.

Background for Current Waiver Project

Indiana has had the benefit of participating in a Child Welfare Waiver Demonstration Project (herein referred to as the 'Waiver') since 1998. Indiana's Waiver was extended in 2003, 2005, 2010, and then again in 2012. On September 14, 2012, the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), approved the Waiver Terms and Conditions for an expansion of the State's Waiver project. Indiana DCS accepted the Terms and Conditions on September 27, 2012. The Waiver period is for five years, beginning July 1, 2012. This Semi-Annual Progress Report (SAR) covers the reporting period from July 1, 2016 through December 31, 2016, and provides an overview of Waiver activities completed to date as well as project evaluation efforts, findings, and planned activities for the next reporting period.

Through the Waiver, DCS has utilized innovative methods to ensure that families are provided with services that meet their needs, and when possible, allow children to remain safely in their home. Waiver funding is integral to the agency's delivery of services as it enables DCS to offer an expanded array of concrete goods and services to help families succeed. These types of services are typically only available through other funding sources. Some of the concrete services supported by Waiver funding include: payment of utility bills, vehicle repairs, before/after school care, respite care, baby monitors, and cleaning of the home environment. These valuable services for families often prevent the need for removal of one or more children.

The Waiver also allows the State to invest in an improved and expanded array of in-home and community-based family preservation, reunification and adoption services. Examples of new programs implemented as a result of the Waiver flexibility include: a Children's Mental Health Initiative, a Family Evaluation/Multi-Disciplinary Team, Child Parent Psychotherapy, Sobriety Treatment and Recovery Teams, and comprehensive home-based services, such as Family Centered Treatment, Motivational Interviewing, and Trauma-Focused Cognitive Behavioral Therapy. Additional information regarding key projects is described below:

Sobriety Treatment and Recovery Teams: This promising practice model is currently being utilized in Kentucky and piloted in Indiana. The program is intended to alter the child welfare and service approach to serving parents with substance use disorders who have children under the age of 5. The service includes a triad approach with a specially trained Family Case Manager, a Family Mentor (someone with experience in the child welfare system and a history of addiction), and a Treatment Coordinator. This team provides quick access to assessment and services, as well as increased support and monitoring. For more information, please reference: https://www.zerotothree.org/resources/907-sobriety-treatment-and-recovery-teams-ohio

Trauma Focused Cognitive Behavioral Therapy (TF-CBT): This evidence-based practice model is being provided as a component of DCS' Comprehensive Home Based Services. Indiana is utilizing service mapping to identify appropriate families to participate in this service. Children who have experienced significant trauma and have a non-offending caregiver who is able to participate in services are included in the target population. Children are identified utilizing the Child and Adolescent Needs and Strengths (CANS) Assessment. The number of children who have been assessed for TF-CBT and the number of referrals are listed in Table 1.

Currently Indiana has 82 certified TF-CBT clinicians. They can be found at https://tfcbt.org/members/. The certification process requires the clinician be licensed and includes training, coaching and consultation which can take up to 2 years to complete. The number of therapists in the training process who will become certified is unknown. DCS has provided Trauma Focused - Cognitive Behavioral Therapy (TF-CBT) training opportunities for therapists throughout Indiana during SFYs 2014 and 2015. The Indiana Division of Mental Health and Addiction (DMHA), the Indiana Association of Resources and Child Advocacy (IARCA) and other agencies also provided training during this time period. DCS does not have data for every person taking part in the training, but estimates the number in process to be greater than 500.

Indiana's Waiver project remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array. DCS has routinely monitored the effectiveness of their practice model in order to establish goals and direction with regard to Waiver spending and service delivery. To further support these efforts, DCS has implemented a Continuous Quality Improvement (CQI) process to serve as the foundation for our continuum of service provision. This CQI framework will serve as the method for evaluating service needs, determining the quality of service being delivered and the impact of services on child and family outcomes for existing as well as new Waiver-funded services.

Numbers in the Demonstration

All children and families in Indiana receiving services from DCS after July 1, 2012 have been assigned to the Waiver demonstration and are thus considered Waiver cases. Since all children are covered under the Waiver, DCS is providing the number of cases referred for initiatives that began following the 2012 Waiver initiation. The services outlined below include those provided through the Children's Mental Health Initiative and the Comprehensive Home Based Services programs. Because of the extensive training funded by DCS and provided throughout the State, there are many more families receiving the Evidence Based Practice models outlined below. For example, DCS continues to offer trainings in TF-CBT throughout the State for residential and community based providers. Many families are receiving the service through residential programs and home-based therapy programs. At this point, those services are not easily identified and isolated in the service tracking system. DCS continues to work toward improving data collection for these services.

Table 1. Numbers in the Demonstration

Children's Mental Health Initiative*	SFY2014 (7/1/13-6/30/14)	SFY2015 (7/1/14-6/30/15)	SFY 2016 7/1/15-6/30/16	SFY 2017 7/1/16-6/30/17
Assessment for Eligibility	396	578	631	662
Services	283	553	702	878

*Children's Mental Health Initiative

- Assessment for Eligibility: The total number of children who were referred for a CMHI assessment between the dates given.
- Services: The total number of children who had at least one referral for a CMHI service, other than an assessment, between the dates given. The same children may be counted as being referred for multiple years. Please note: the methodology for counting service referrals has changed from previous reports to provide more consistent reporting across demonstration programs. As a result, some counts may have changed.

Table 2. Numbers in the Demonstration, Cont.

Service* Referrals	SFY2012 (7/1/11-6/30/12)	SFY2013 (7/1/12-6/30/13)	SFY2014 (7/1/13-6/30/14)	SFY2015 (7/1/14-6/30/15)	SFY 2016 (7/1/15-6/30/16)	SFY 2017 7/1/16-6/30/17
Alternatives for Families Cognitive Behavioral Therapy	0	0	0	11	6	2
Cognitive Behavioral Therapy	0	0	4	25	42	28
Family Centered Treatment	0	0	272	359	500	422
Intercept	116	182	201	193	232	175
Motivational Interviewing	0	0	7	82	192	219
Trauma Focused Cognitive Behavioral Therapy	0	0	18	98	133	83
START	0	0	14	**20**	19	21

* Referrals counted during SFY during which they were created. All referrals are only counted once in Table.

Evaluation Team

An Evaluation Team from the Indiana University School of Social Work and School of Medicine has conducted the evaluation of the Waiver. The Evaluation Team consists of:

- Principal Investigator: James A. Hall, Ph.D., Professor with a joint appointment in the School of Social Work and in the School of Medicine, Department of Pediatrics, Division of Adolescent Medicine.
- Co-Investigator: Barbara Pierce, Ph.D., Associate Professor in the School of Social Work; Jeremiah Jaggers, Ph.D., Assistant Professor in the School of Social Work, Michin Hong, Ph.D., Assistant Professor in the School of Social Work, and Gwendolyn Morrison, Ph.D., Associate Professor in the School of Liberal Arts (Department of Health Economics).
- William H. Barton, Ph.D. retired in May 2014 from the IU School of Social Work and is no longer Co-PI on the project as of June 2014.
- Project Manager: Teresa (Tracy) Imburgia, MPH, Certified Clinical Research Professional (CCRP).
- Data Manager: Pediatrics IT Services
- Statistician: Devon Hensel, Ph.D.
- Research Assistants: Jangmin Kim, Ph.D, Eprise Armstrong Richardson, M.S.W. (doctoral student), Eun-Hye Yi, PhD(c), Kori R. Bloomquist, Ph.D., Marie Danh, M.S.W., and Allison Muzzy, M.S. (doctoral student)

In addition to the work provided for the evaluation terms and conditions, the Evaluation Team has been productive over the demonstration period with the following contributions to science as listed below.

Peer-reviewed Publications

1. Hall, J.A.; Imburgia, T.M.; Kim, J.; Pierce, B.J.; Bloomquist, K.H.; Danh, M.; & Hensel, D.J. (2017) Mixed Methods Longitudinal Evaluation in Child Welfare Title IV-e Waiver Demonstration Project. *Child Welfare, 95(5)*
2. Pierce, B., Jaggers, J. W., Bloomquist, K., Imburgia, T. M., Danh, M., & Hall, J. (2017). Utilization of Concrete Services in Child Welfare: A Mixed Method Analysis of a Title IV-E Waiver Demonstration Program. *Journal of Public Child Welfare*, 1-17. http://dx.doi.org/10.1080/15548732.2017.1377139
3. Kim, J., Pierce, B. J., Jaggers, J. W., Imburgia, T. M., & Hall, J. A. (2016). Improving child welfare services with family team meetings: A mixed methods analysis of caseworkers' perceived challenges. *Children and Youth Services Review*, *70*, 261-268. http://dx.doi.org/10.1016/j.childyouth.2016.09.036
4. Jaggers, J. W., Richardson, E. A., Aalsma, M., & Hall, J. A. (2015). Resources, Race, & Placement Frequency: An Analysis of Child Well-Being. *Child Welfare, 94(6)*.
5. Kim, J., Park, T., Pierce, B., & Hall, J. A. (2017). Child welfare workers' perceptions of supervisory support: a curvilinear interaction of work experience and educational background. *Human Service Organizations: Management, Leadership & Governance*, (just-accepted). https://doi.org/10.1080/23303131.2017.1395775

Publications In Review, In Preparation

1. Jaggers, J.W.; Armstrong Richardson, E.; & Hall, J.A. (under review). Effect of mental health treatment, juvenile justice involvement, & child welfare effectiveness on severity of mental health problems. Community Mental Health. *Revise & Resubmit*.
2. Bloomquist, KR, Imburgia, TM, Danh, M Pierce, BJ & Hall, JA (2017) Studying Process in Title IV-E Waiver Demonstration Projects: Interviews with Regional and Executive Managers. *Journal of Public Child Welfare*. *Revise & Resubmit*.
3. Kondrat, DC, Beerbower, E, Jaggers, JW, Pierce, B, Aalsma, M & Hall, JA. The relationship of county level characteristics on length of time clients are in Child Protective Services: Exploring the context of care. *Child Maltreatment*, In review
4. Jaggers, JW, Beerbower, Kondrat, D, Aalsma, MC & Hall, JA (2017) Contextual factors influencing recommendations for Service Provision by Guardia ad litem and Court Appointed Special Advocates. *Public Child Welfare*, In review.

Oral Presentations at National Conferences

1. Yi, EH, Kim J, Jaggers JW, Pierce BJ, Hall JA. Evaluation of Service Quality in the Title IV-E Waiver Demonstration Program in Indiana. Oral presentation presented by Yi at the *63rd Annual Council on Social Work Education Annual Program Meeting*. Dallas, TX, October 2017.
2. Kim J, Park T, Pierce BJ, Hall JA. Supportive Supervision in Child Welfare: Interaction of Work Experience and Educational Background. Oral presentation presented by Kim at the *63rd Annual Council on Social Work Education Annual Program Meeting*. Dallas, TX, October 2017.
3. Armstrong-Richardson E, Kim J, Imburgia TM, Jaggers JW, Hall JA. Relationship between Systems-Related Indicators and Connectivity among Transition Aged Youth in Foster Care. Oral platform presentation presented by Armstrong-Richardson at *the Society for Adolescent Health and Medicine Annual Meeting,* New Orleans, March 2017.
4. Hall JA, Imburgia TM, Kim J, Armstrong-Richardson E, Bloomquist KR, Pierce BJ. Symposium: Multimethod Evaluation: Title IV-E Waiver Demonstration Program. Symposium presented by Hall and Pierce at the *Society for Social Work and Research*, New Orleans, January 2017.
5. Imburgia TM, Pierce BJ, Danh M, Bloomquist KR, Hall JA. Building Partnerships between Evaluators and Child Welfare Agencies through Continuous Quality Improvement and Instrument Development. Symposium presented by Kim at the *Society for Social Work and Research*, New Orleans, January 2017.
6. Kim J and Armstrong-Richardson E. Improving the Quality of Teaming from Multiple Stakeholder Perspectives. Symposium presented by Imburgia at the *Society for Social Work and Research*, New Orleans, January 2017.
7. Bloomquist KR and Imburgia TM. Exploring the Use and Impact of Concrete Services in Child Welfare Practice. Symposium presented by Bloomquist at the *Society for Social Work and Research*, New Orleans, January 2017.
8. Bloomquist KR, Danh M, Imburgia TM, Pierce BJ, Hall JA, Jaggers J, Kim J. Using Qualitative Interviews in State-level Child Welfare Evaluation Research. Oral platform presented by

Bloomquist at the *Annual meeting of the Tenth Annual Congress of Qualitative Inquiry*, *University of Illinois at Urbana-Champaign*, Urbana, IL, May 2016

9. Hall JA, Cummings T, Danh M, Bloomquist KR, Pierce BJ. Symposium: Mixed Methods Evaluation: Title IV-E Waiver Demonstration Program. Oral symposium presented by Hall at the *Society for Social Work and Research*. New Orleans, LA, January 2015.
10. Cummings T, Danh M, Bloomquist KR, Hensel D, Barton WH, Hall JA. Measuring child and adolescent well-being in the child welfare system. Oral symposium presented by Cummings at the *Society for Social Work and Research*. New Orleans, LA, January 2015.
11. Danh M, Cummings T, Bloomquist KR, Hensel D, Barton WH, Hall JA. Family Case Manager Perceptions of Client Needs and System Services. Oral symposium presented by Danh at the *Society for Social Work and Research*. New Orleans, LA, January 2015.
12. Bloomquist KR, Cummings T, Danh M, Hensel D, Barton WH, Hall JA. Regional & Executive Manager Interviews 2013 & 2014. Oral symposium presented by Bloomquist at the *Society for Social Work and Research*. New Orleans, LA, January 2015.
13. Bloomquist, K. R. (2014). "Communication, Communication, Communication": Qualitative Analysis in Title IV-E Evaluation Research. Poster presented at the *60th Annual Council on Social Work Education Annual Program Meeting*. Tampa, FL, October 2014.
14. Bloomquist KR, Danh M, Graham-Dotson Y, Cummings T, Barton WH, Hall JA, Turney, B. Case Study Analysis in Child Welfare Evaluation Research. Oral platform presented by Bloomquist Annual meeting of the *Tenth Annual Congress of Qualitative Inquiry, University of Illinois at Urbana-Champaign*, Urbana, IL, May 2014.

Poster Presentations at National Conferences

1. Imburgia TM, Hensel DJ, Pierce BJ, Armstrong-Richardson E, Hall JA. Strategies to improve adolescents' status in caregiver substance abuse cases in the child welfare system. *Society for Adolescent Health and Medicine Annual Meeting*, Seattle, WA, March 2018.
2. Armstrong-Richardson E, Imburgia TM, Hall JA. Case Characteristics Influencing Difficulty Placing Child Welfare Children and Youth in Treatment Facilities. *Society for Adolescent Health and Medicine Annual Meeting*, Seattle, WA, March 2018.
3. Bloomquist KR, Pierce BJ. Qualitative evaluation: Justifications for concrete service usage in one IV-E Waiver state. *63rd Annual Council on Social Work Education Annual Program Meeting*. Dallas, TX, October 2017
4. Armstrong-Richardson E, Imburgia TM, Pierce BJ, Jaggers JW. The Impact of Youth Engagement on Child Welfare Service Satisfaction. *20th National Conference on Child Abuse and Neglect*. Washington, DC, August 2016.
5. Cummings T, Hensel DJ, Danh M, Bloomquist KR, Pierce BJ, Kim J, Jaggers JW, Hall JA. The Difference in Age: Case Workers Perceptions of Youth in the Child Welfare System. *Society for Adolescent Health and Medicine Annual Meeting*, Washington, DC, March 2016.
6. Cummings T, Hensel DJ, Bloomquist KR, Danh M, Pierce BJ, Hall JA. Increased Use of Concrete Services for Child Welfare in Title IV-E Waiver Expansions. *Society for Adolescent Health and Medicine Annual Meeting*, Los Angeles, CA, March 2015.

7. Danh M, Cummings T, Bloomquist KR, Hensel DJ, Hall J, Barton WH. The Effects of Child Welfare Cases on Child Well-being. *Society for Adolescent Health and Medicine Annual Meeting*, Austin, TX, March 2014.

Outcome Study

Outcome Study Research Questions that were presented in the evaluation plan submitted in 2013 will be discussed throughout the outcome portion of the report. These questions are addressed through two different datasets, administrative data [comprising of the Indiana Child Welfare Information System (ICWIS) and Management Gateway for Indiana Kids (MaGIK)] and the Quality Service Reviews (QSR).

Research Questions from the 2013 Evaluation Plan:

Placement Prevention

1. Has the number of children who enter out-of-home placement for the first time decreased?

Permanency

2. Has the number of children who exit out-of-home placement to permanency through reunification, adoption, or guardianship increased?
3. Has length of time to permanency decreased?

Safety

4. Has the proportion of children who exit to each permanency outcome experiencing a subsequent substantiated report of abuse or neglect (within 6 and 12 months after services were terminated) decreased?
5. Has the proportion of children in out-of-home care with an occurrence of substantiated abuse or neglect by institutional staff or a foster parent decreased?
6. Have fewer children had subsequent out-of-home placements?

Well-Being

7. Has child well-being increased?

Outcome Indicator Tables

In collaboration with DCS, the IU Evaluation Team identified a number of outcome indicators related to child safety, permanency, and well-being. Indicators were selected based upon their relevance to findings from previous demonstrations of the Waiver, as well as their potential to illuminate changes in service outcome effectiveness and efficiency. Selected indicators include those associated with new cases, substantiation, placement (including prevention, duration, stability, and recidivism), and exits to permanency. Theoretically, improvements in service outcome effectiveness and efficiency would yield fewer new cases, fewer instances of substantiation and placement recidivism, less time, and fewer moves in out-of-home care, and a greater number of exits to permanency. It is important to note that these changes are expected to be small in magnitude since the baseline indicators are relatively favorable after the last Wavier demonstration. Baseline indicators represent measures of safety, permanency, and well-being for SFY 2010-2011 and 2011-2012. Outcome indicators for the demonstration years are provided using Federal Fiscal years, since work on the Waiver truly began in the late fall of 2012. The baseline years were pulled from the ICWIS system, which retired on June 30, 2012. Data from the outcome years were pulled from the MaGIK system. There may be slight discrepancies between the two systems that cannot be resolved.

For the following Tables, please note: CHINS (Child in Need of Services); IA (Informal Adjustment); SFY (State Fiscal Year); FFY (Federal Fiscal Year).

Table 3. Number of Children by Case Type

	Baseline SFY		Outcome Years FFY			
	2011	2012	2013	2014	2015	2016
Total number of children with an open case on 9/30 in fiscal year	*16116*	*14521*	*16344*	*18887*	*22146*	*26862*
Percentage of children designated as out-of-home CHINS on 9/30	63.0%	60.5%	59.6%	59.8%	62.4%	60.4%
Percentage of children designated as in-home CHINS on 9/30	25.5%	26.8%	25.6%	24.1%	25.8%	25.3%
Percentage of children designated as informal adjustment on 9/30	11.5%	12.7%	11.2%	12.7%	11.9%	14.3%
Percentage of children designated as collaborative care on 9/30	-	-	3.5%	3.4%	3.1%	3.0%
Total number of new cases opened in fiscal year	*21016*	*15946*	*13660*	*15934*	*19171*	*21989*
Percentage of new cases designated as out-of-home CHINS	37.5%	40.4%	51.7%	53.9%	54.8%	54.4%
Percentage of new cases designated as in-home CHINS	38.1%	41.4%	15.7%	15.5%	15.6%	13.6%

**Collaborative Car was not implemented until August 2013*

Addressing question '1. Has the number of children who enter out-of-home placement for the first time decreased?' Table 3 illustrates the percentage of out-of-home CHINS remained relatively steady with small decreases in the outcome years similar to the percentage of in-home CHINS.

Table 4. Safety

	Baseline SFY		Outcome Years FFY			
	2011	2012	2013	2014	2015	2016
Total number of children who exited to permanency in fiscal year	*8571*	*7898*	*8730*	*9403*	*11028*	*12882*
Percentage of all children who exited to permanency and experienced subsequent substantiated abuse/neglect (w/in 6 mos.)	1.8%	1.7%	3.7%	4.1%	4.6%	5.2%
Percentage of all children who exited to permanency and experienced subsequent substantiated abuse/neglect (w/in 12 mos.)	4.4%	2.1%	6.3%	7.1%	8.1%	8.5%
Total number of children who exited to permanency by reunification in fiscal year	*5649*	*5080*	*4112*	*5867*	*7296*	*8595*
Percentage of children who exited to permanency by reunification and experienced subsequent substantiated abuse/neglect (w/in 6 mos.)	2.3%	2.4%	5.0%	5.2%	6.1%	6.9%
Percentage of children who exited to permanency by reunification and experienced subsequent substantiated abuse/neglect (w/in 12 mos.)	5.8%	3.0%	8.5%	9.4%	10.6%	11.4%
Total number of children who exited to permanency by adoption in fiscal year	*1103*	*1295*	*1087*	*1094*	*1293*	*1558*
Percentage of children who exited to permanency by finalized adoption and experienced subsequent substantiated abuse/neglect (w/in 6 mos.)	0.1%	0.0%	0.4%	0.3%	0.6%	0.3%
Percentage of children who exited to permanency by finalized adoption and experienced subsequent substantiated abuse/neglect (w/in 12 mos.)	0.6%	0.0%	.05%	0.6%	0.8%	0.5%
Total number of children who exited to permanency by guardianship in fiscal year	*700*	*577*	*514*	*643*	*779*	*958*
Percentage of children who exited to permanency by guardianship and experienced subsequent substantiated abuse/neglect (w/in 6 mos.)	1.3%	1.0%	1.8%	3.7%	1.4%	1.1%
Percentage of children who exited to permanency by guardianship and experienced subsequent substantiated abuse/neglect (w/in 12 mos.)	3.0%	1.2%	3.1%	5.9%	3.9%	2.4%

Question 4 stated 'Has the proportion of children who exit to each permanency outcome experiencing a subsequent substantiated report of abuse or neglect (within 6 and 12 months after services were terminated) decreased?' These data show a rise in the percentage of children who experienced subsequent substantiated abuse/neglect in the outcome years particularly for those who exited by reunification and guardianship. For those exiting to adoption the percentage of children who had subsequent abuse/neglect did not raise at the same rate as the other permanency possibilities.

Table 5. Safety (continued)

	Baseline SFY		Outcome Years FFY			
	2011	*2012*	*2013*	*2014*	2015	2016
Total number of children with an open case on 9/30 in fiscal year	*16116*	*14521*	16344	18887	22146	26862
children residing in in-home care on 09/30 in fiscal year	*6204*	5739	5611	6320	7822	8725
--percentage of children residing in in-home care on 09/30 in fiscal year who experienced subsequent substantiated abuse/neglect since the case was opened	26.5%	23.3%	13.1%	11.4%	9.1%	6.0%
children residing in out-of-home care on 09/30 in fiscal year	10157	8780	9741	11289	13811	16213
--percentage of children residing in out-of-home care on 09/30 in fiscal year who experienced subsequent substantiated abuse/neglect since the case was opened	32.3%	31.3%	30.7%	23.2%	15.5%	8.1%

For Question 5, as the proportion of children in out-of-home care with an occurrence of substantiated abuse or neglect by institutional staff or a foster parent decreased, there was a decrease from the baseline years, with a continued decrease throughout the outcome years. This was also the case for in-home cases.

Table 6. Permanency

	Baseline SFY		Outcome Years FFY			
	2011	2012	2013	2014	2015	2016
Total number of children who exited to permanency in fiscal year	*8571*	*7898*	*8730*	*9403*	*11028*	*12882*
Percentage of children who exited to permanency by reunification	65.9%	64.3%	47.1%	62.4%	66.2%	66.7%
Percentage of children who exited to permanency by adoption	12.9%	16.4%	3.7%	4.1%	4.6%	5.2%
Percentage of children who exited to permanency by guardianship	8.2%	7.3%	5.9%	6.8%	7.1%	7.4%
Percentage of children with an open case who have a permanency plan of adoption and whose parental rights have been terminated on 9/30 in fiscal year	9.3%	7.9%	8.3%	8.0%	7.1%	5.3%

For Question 2,' has the number of children who exit out-of-home placement to permanency through reunification, adoption, or guardianship increased,' there was an increase after 2015 for those who exited to permanency through reunification. For exiting to permanency by adoption, the percentage dropped in the outcome years with the lowest year being 2013. Since then, there has been a slow increase. Guardianship has stayed relatively stable with 2011 having the largest percentage and 2013 having the lowest percentage.

Table 7. Placement Duration

	Baseline SFY		Outcome Years FFY			
	2011	2012	2013	2014	2015	2016
Average number of days spent in out-of-home care before exiting to permanency	498.8	558.4	518.1	476.1	495.0	482.6
Average number of days spent in out-of-home care before exiting to permanency by reunification	248.6	229.6	382.4	348.5	363.6	361.9
Average number of days spent in out-of-home care before exiting to permanency by adoption	908.6	958.2	1037.3	1.44.1	1113.3	1080.6
Average number of days spent in out-of-home care before exiting to permanency by guardianship	347.5	365.6	440.0	425.2	464.1	402.6

The number of days spent in out-of-home care increased for reunification, adoption, and guardianship over the outcome years.

Table 8. Placement Stability

	Baseline SFY		Outcome Years FFY			
	2011	2012	2013	2014	2015	2016
Average number of placements for children currently residing in out-of-home care	2.8	2.8	2.6	2.3	2.1	2.0

Permanency was extended, but the number of placements steadily decreased over the evaluation period.

Table 9. Well-being

	Baseline		Outcome Years			
	2011	2012	2013	2014	2015	2016
Percentage of children placed in out-of-home care with a relative on 9/30	37.0%	39.8%	42.3%	45.0%	48.3%	50.4%
Percentage of children placed in out-of-home care with a non-relative on 9/30	63.0%	60.2%	55.4%	53.3%	50.0%	47.9%
Percentage of children placed in their home county on 9/30	74.9%	73.2%	67.8%	68.1%	67.5%	67.5%

The percentage of children placed out of the home with relatives increased from the baseline to the end of the outcome years, with half being placed with relatives in 2016. Placement in the home county slightly decreased from the baseline to outcome years.

Table 10. Number of Children Entering/in/Exiting Out-of-Home Care

	Baseline		Outcome Years			
	2011	2012	2013	2014	2015	2016
Total number of children residing in out-of-home care on 9/30	10157	8780	9741	11289	13811	16213
Percentage of children residing in out-of-home care on 9/30	63.0%	60.5%	59.6%	59.8%	62.4%	60.4%
Total number of children who entered out-of-home care in fiscal year	6635	6429	10846	11593	13945	15832
Total number of children who exited out-of-home care to permanency in fiscal year	7859	7338	7583	7662	8690	10455

The number of children entering out of home care stayed relatively stable, even with the increased case count.

Quality Service Reviews (QSR) Rounds 1 through 5

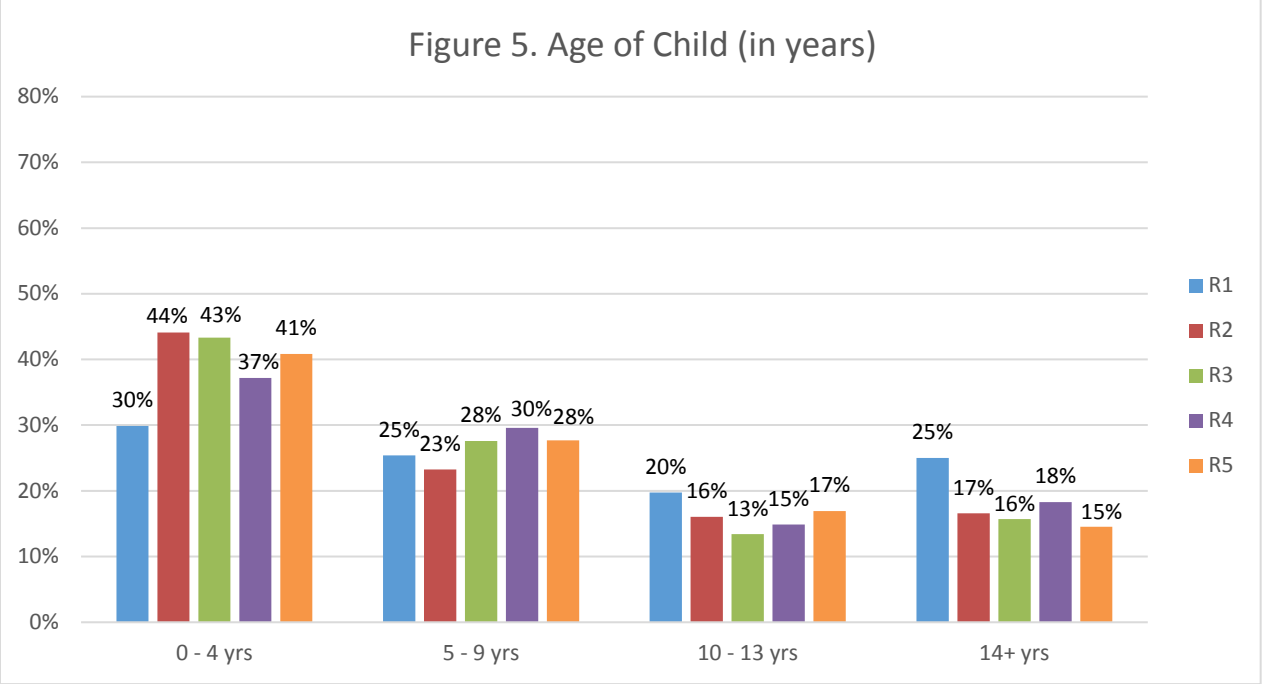
This section provides an overview of the purpose and process of DCS' Quality Service Reviews (QSRs), as well as how the IU Evaluation Team plans to use QSR data. This section presents preliminary summary data from

- Round 1 (R1 in the Figures) based on a representative state-wide sample of 512 cases reviewed between July 2007 and June 2009 and
- Round 2 (R2 in the Figures), based on a representative state-wide sample of 585 cases reviewed between July 2009 and July 2011,
- Round 3 (R3 in the Figures) based on a representative state-wide sample of 515 cases reviewed between September 2011 and July 2013,
- Round 4 (R4 in the Figures) based on a representative state-wide sample of 497 cases reviewed between September 2013 and April 2015, and
- Round 5 (R5 in the Figures) based on a representative state-wide sample of 502 cases reviewed between September 2015 and June 2017.

R1 and R2 data will serve as a baseline against which to compare potential changes during subsequent QSR rounds during the demonstration period. Round 3 is a transition period and includes pre-Waiver data as well as data collected during the demonstration period.

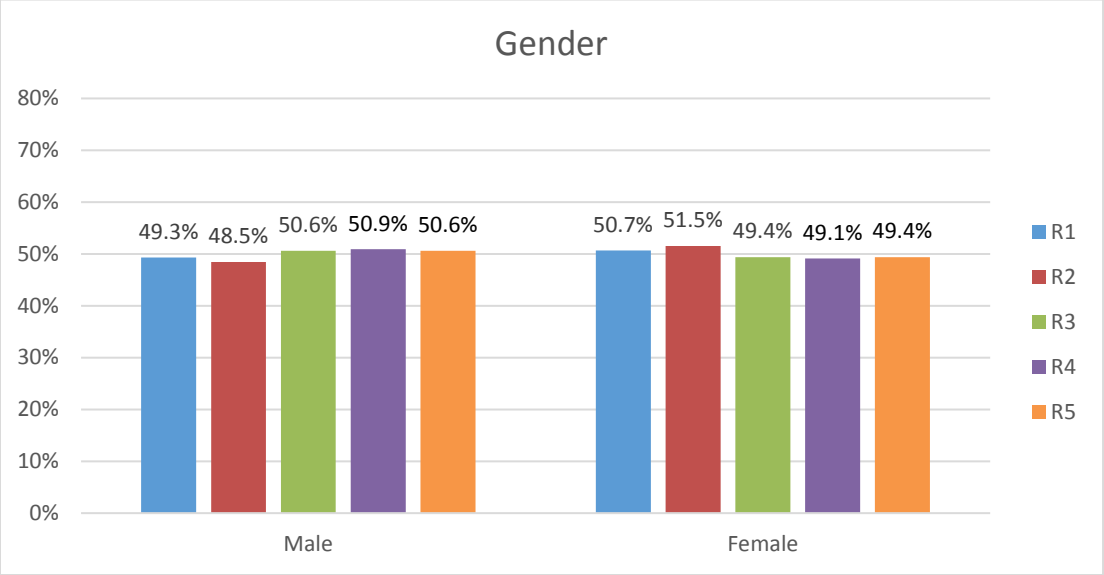
The case types reviewed in Rounds 1 through 5 included CHINS, Assessments, Informal Adjustments, and Adoption. Demographic characteristics including age, gender, race, ethnicity, and case type for Rounds 1, 2, 3, 4, and 5 are provided in Figures 1 – 7. Gender, race, and case type did not differ significantly. Then, a statistical analysis of pre- verses post- Wavier is presented.

Figure 1. Age of Child (in years)



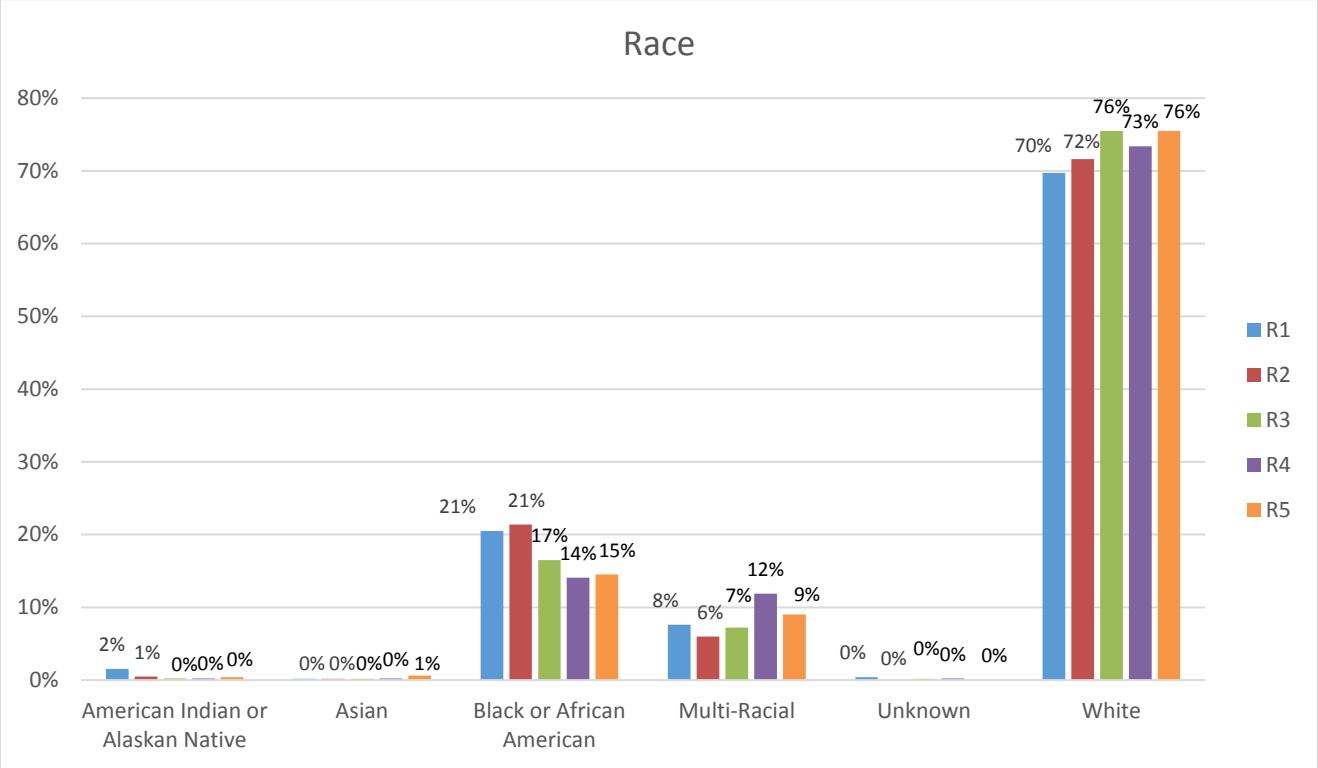
The ages of the respondents remained relatively similar over the demonstration years, with Round 1 having slightly less 0-4 year old and slightly more 14 and older youths.

Figure 2. Gender



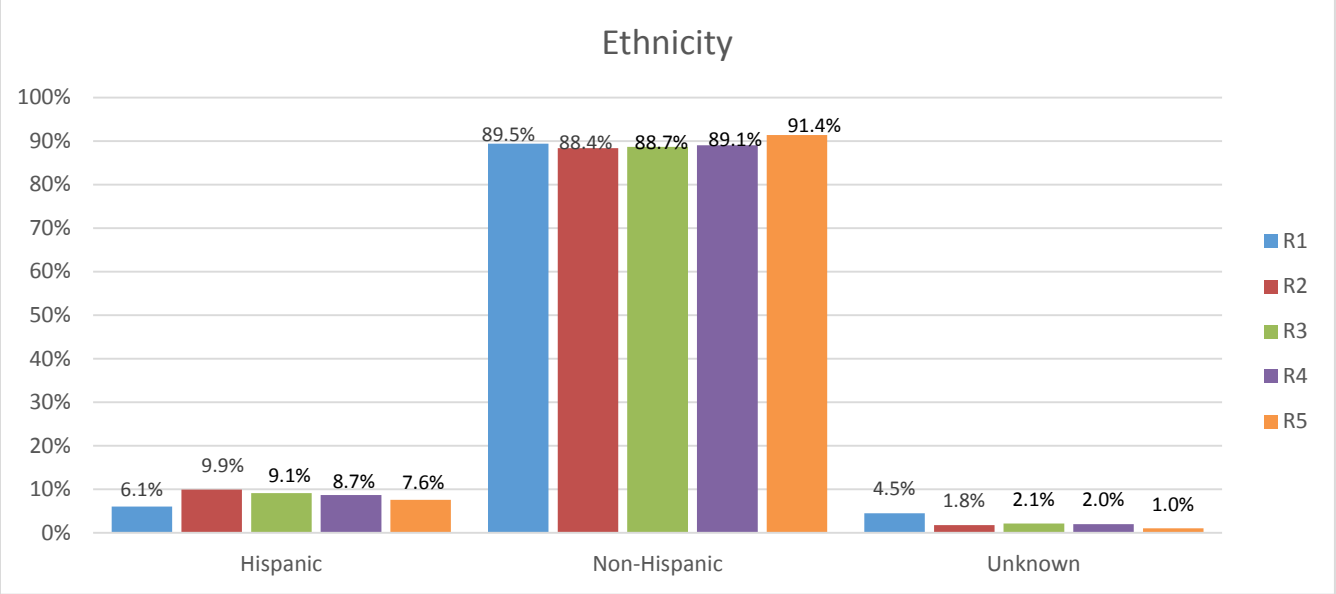
The gender breakout over the rounds stayed consistent with around half male and half female in each round.

Figure 3. Race



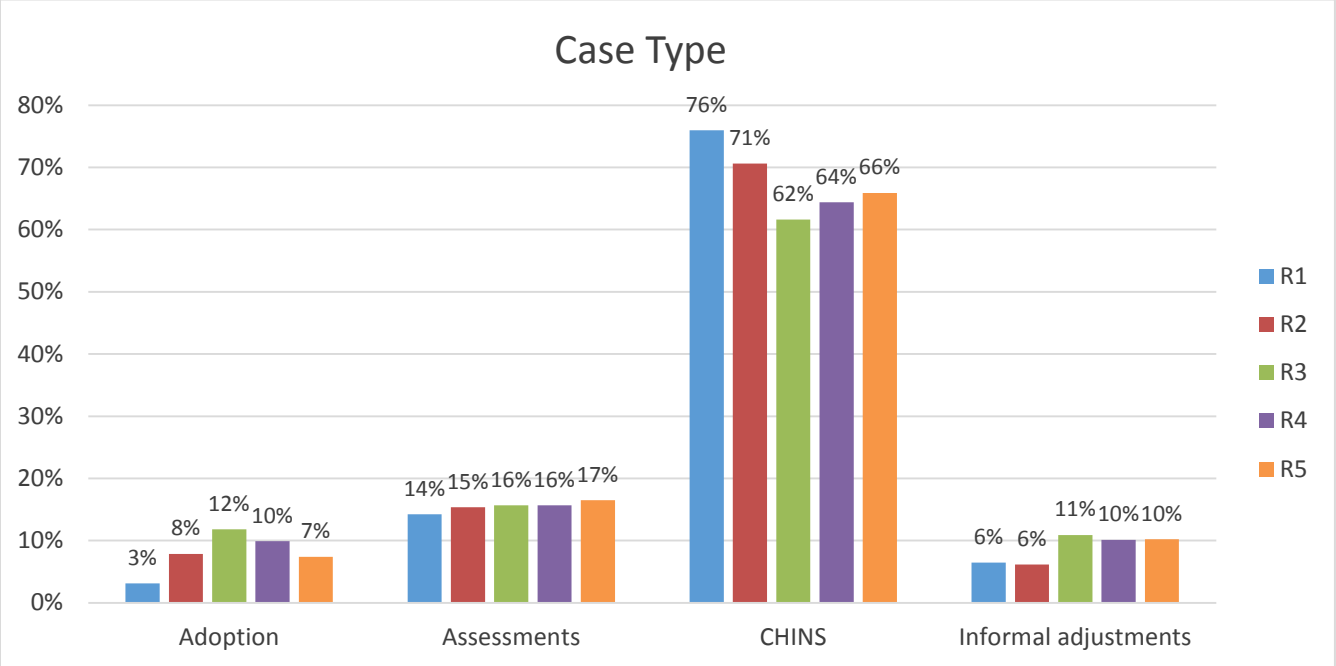
Race for all the rounds was primarily white, followed by Black or African American and multi-racial. This stayed consistent over the rounds.

Figure 4. Ethnicity



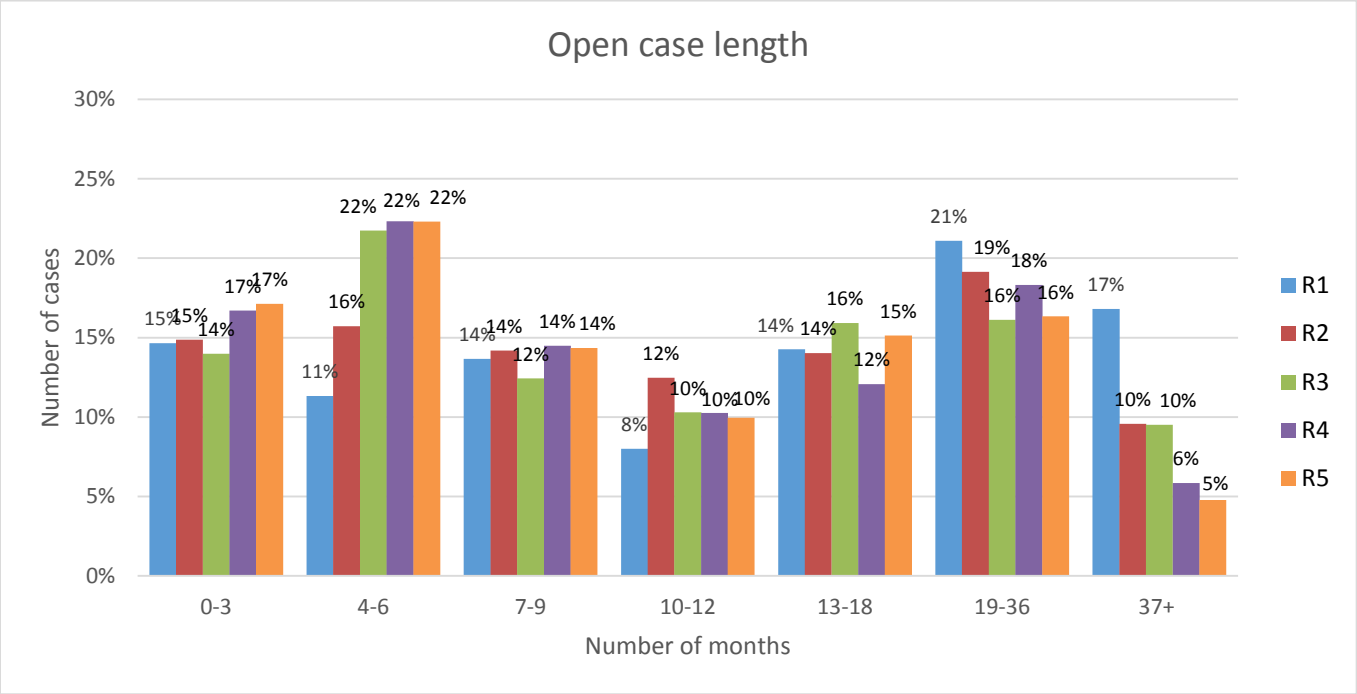
A large majority of the children in each round were non-Hispanic. The Hispanic population stayed between 6-10 percent over the rounds.

Figure 5. Case Type



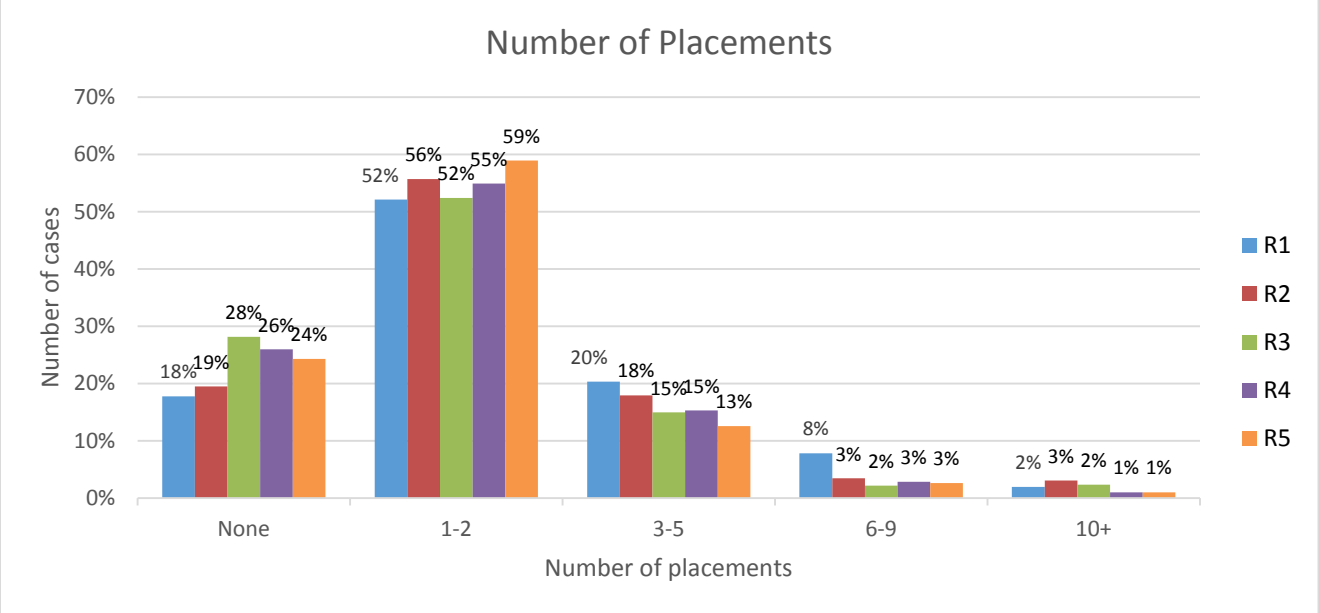
The number of CHINS cases reviewed dropped over the demonstration period, with informal adjustments increasing. Adoption topped out in R3 and began to slightly decline.

Figure 6. Open Case Length



Cases reviewed in later years seemed to be shorter than those reviewed in the earlier years. However, due of a great influx of cases starting in 2015, this could just be a reflection of more new cases in the population.

Figure 7. Number of Placements



The majority of cases in all rounds had 1-2 placements and those with no placements seemed to decline in the last two rounds (although still higher than rounds 1 and 2).

QSR Primary Outcomes Indicators

The primary outcomes of the Evaluation study include safety, permanency, and well-being. All of these indicators are included in the QSR. Tables 11 – 13 provide information on each outcome and practice indicator with a summary and definition, as defined by the QSR protocol. Each indicator is rated using a 6-point scale with higher scores reflecting better outcomes.

Table 11. QSR Outcome Indicator Scoring and Definitions

Outcome	Range	Definition
	Safety	
Safety	1 High Safety Risk – 6 Optimal	*The degree to which: The child is free of abuse, neglect, and exploitation by others in his/her place of residence and other daily settings. • The child free from injury caused by others in his/her daily home, school, and community settings. • Parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm in the home. [past 30 days]*
Behavioral Risk (Age 3 and Older)	1 Serious and Worsening – 6 Optimal & N/A	*The degree to which the child/youth consistently avoiding self-endangerment situations and refraining from using behaviors that may put him/herself or others at risk of harm. [past 30 days]*
	Permanency	
Stability	1 Adverse – 6 Optimal	*The degree to which: The child's daily living, learning, and work arrangements are stable and free from risk of disruption. • The child's daily settings, routines, and relationships consistent. • Known risks being managed to achieve stability and reduce the probability of future disruption. [Timeframe: past 12 months and next 6 months]*
Permanency	1 Adverse – 6 Optimal	*The child/youth is living with parents or out-of-home caregivers that the child, parents or out-of-home caregivers, and other stakeholders believe will sustain until the child reaches adulthood and continue onward to provide family connections and supports. • If not, the permanency efforts presently being implemented on a timely basis that will ensure that the child/youth soon will be enveloped in enduring relationships that provide a sense of family, stability, and belonging. [Consistent with requirements for sustainable, safe case closure] [past 30 days]*
	Well-Being	
Appropriate Living Arrangement	1 Adverse – 6 Optimal	*The degree to which: The child in the most appropriate/least restrictive living arrangement, consistent with needs for family relationships, social connections, age, ability, special needs, education, and positive peer group affiliation. • The child is in temporary out-of-home care, does the living arrangement meet the child's needs to be connected to his or her language and culture, community, faith, extended family, tribe, social activities, and peer group. [past 30 days]*
Physical Health	1 Worsening – 6 Optimal	*The degree to which: The child achieving and maintaining his/her optimum health status. • The child has a serious or chronic physical illness, is the child achieving his/her best attainable health status given the disease diagnosis and prognosis. [past 30 days]*

Emotional Status (Age 3 and Older)	1 Adverse – 6 Optimal	*The degree to which: The child presenting age-appropriate emotional development, adjustment, attachment, coping skills, and self-control. • The child achieving and maintaining an adequate level of behavioral functioning in daily settings and activities, consistent with age and ability. [past 30 days]*
Learning and Development (Under age 5)	1 Adverse – 6 Optimal	*The degree to which: The young child's developmental status commensurate with his/her age and developmental capacities• The child's developmental status in key domains consistent with age-appropriate expectations. [past 30 days]*
Learning and Development (Age 5 and older)	1 Adverse – 6 Optimal	*The child [according to age and ability] is: (1) regularly attending school, (2) in a grade level consistent with age, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent. [past 30 days]*
Pathway to Independence (Older youth)	1 No development – 6 Optimal	*The degree to which: The youth gaining skills, education, work experience,* *connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services, as appropriate to age and ability. • The youth developing long-term connections and informal supports that will support him/her into adulthood. [past 30 days]*
Overall Child Status	1 Adverse – 6 Optimal	*If the child's safety score is in the concerted action needed area (1, 2, 3), then the Overall Child status rating would be equal to the safety score. Give weight to stability and permanency when they score in concerted action needed and all other indicators are in the refine and maintain area.*

Table 12. QSR Practice Indicator Scoring and Definitions

Outcome	Range	Definition
	Engaging	
Role and Voice of family members (mother, father, child, other)	1 Absent or Adverse – 6 Optimal & N/A	*The degree to which family members with whom the child is living and/or will be reunited, active ongoing participants (e.g., having a significant role, voice, influence) in decisions made about child/family change strategies, services, and results. [Role and voice in recent meetings] They are active participants in the plans and services they identified. A trust-based relationship exists between all team members.*
	Teaming	
Team Formation	1 Absent or Adverse – 6 Optimal	*The degree to which: The people who provide support and services for this child and family have been identified and formed into a working team • The team has the skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background.*
Team Functioning	1 Absent or Adverse – 6 Optimal & N/A	*The degree to which: Members of the family team collectively function as a unified and coordinated team in planning services and evaluating results. • Actions of the family team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family.*
	Assessing	

Cultural Recognition	1 Adverse – 6 Optimal	*How well any significant cultural issues, family beliefs, and customs of the child and family have been identified and addressed in practice (e.g., culture of poverty, domestic violence, mental illness or incest). • The natural, cultural, or community supports are appropriate for this child and family being provided. • The degree to which the necessary supports and services are provided being made culturally appropriate in the family engagement, assessment, planning, and service delivery processes. • The degree to which family values and beliefs are recognized when developing plans for sustainable, safe case closure. Plans to address the family's maladaptive behaviors, values, and beliefs should not adversely affect the child's safety, permanency, and well-being.*
Assessing & Understanding (the child, the family)	1 Absent, Incorrect or Adverse – 6 Optimal & N/A for family	*The degree to which: The team has a shared, big picture understanding of the child and family's underlying issues, needs, strengths, protective capacities, hopes, and safety risks that must change for the child to live safely and permanently with the family of origin or adoptive family without agency supervision. •These understandings are reflected in the family change process used for helping the family achieve safety, permanency, and well-being. • Ongoing situational awareness of the child and family is being maintained throughout the child and family change process.*
Planning		
Long-term View	1 Absent or Adverse – 6 Optimal	*There is an explicit guiding view for the child and parents that should enable them to live safely and successfully without DCS supervision. • How well the LTV defines: (1) Permanency goals (primary and concurrent, if necessary) for the focus child. (2) Things that must change in the family's situation. And 3) outcomes that must be achieved for sustainable, safe case closure.*
Child and Family Planning Process	1 Absent, Ambiguous or Adverse – 6 Optimal	*The planning process is individualized and relevant to needs and* *Goals. • Change strategies, interventions, and supports are organized into a holistic and coherent service process that provides a mix of elements uniquely matched to the child/family's situation and preferences. • The combination of strategies, interventions, and supports fit the child and family's situation so as to maximize potential results and minimize conflicts and inconveniences.*
Planning Transitions and Life Adjustments	1 Adverse – 6 Optimal & N/A	*The degree to which: The current or next life change transition for the child is being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the child and family after the change occurs. • Transitional staging plans/arrangements are being made to assure a successful transition and life adjustment in daily settings • The child is returning home and to school following temporary placement in foster care, treatment, or detention, the transition and life adjustment sequence is working. • There is follow-along support for the adjustment period.*

Table 13. QSR Practice Indicator Scoring and Definitions

Intervening

Intervention Adequacy	1 Absent or Adverse – 6 Optimal	*The degree to which the change-related interventions, actions, and resources are provided to the child and family of sufficient power (precision, intensity, duration, fidelity, and consistency) to produce desired results and make timely progress necessary to meet sustainable, safe case closure requirements and to sustain family independence from the service system following closure.*
Resource Availability	1 Absent or Adverse – 6 Optimal	*The degree to which formal supports, services, and resources are necessary to implement planned change strategies available as required (i.e., timeliness, fit to the situation, and change strategy used, intensity, duration, locally accessible) for use by the: (1) focus child, (2) the parent, and (3) the caregiver in meeting family change requirements and conditions for sustainable, safe case closure (and beyond).*
Maintaining Relationships (Birth mother, Birth father, Siblings, Extended family)	1 Absent, Fragmented, Declining in Quality or Frequency, or Inappropriate – 6 Optimal & N/A	*When children and family members are living temporarily away from one another, specifically planned strategies and supports are working well to build and sustain family connections through appropriate visits and other means, unless compelling reasons exist for keeping them apart. • The degree to which strategies and efforts have been put into place to support the following between the child and his/her parents for: (1)* *Building and maintaining positive interactions. (2) Creating and using opportunities for providing emotional support. And (3) Using varied and creative opportunities for family members to nurture one another.*
Tracking and Adjusting	1 Absent, Adverse, or ineffective – 6 Optimal	*The team monitors the child and family's progress, intervention process, changes results routinely, and makes the necessary adjustments. • Strategies and services are modified to respond to the changing needs and to apply knowledge gained about planned strategies and results to create a self-correcting service process for finding what works for the child and family.*
Overall Practice Performance	1 Adverse – 6 Optimal	*Give weight to those items judged to be most important in practice at this time for this child and family.*

Reporting QSR data

Reporting of these data back to the Regions in the State becomes an important step in building action plans within each Region. DCS reports data in-state on a two-tier approach, i.e., those scores that are 1, 2, or 3 are reported as 'Action Needed' and 4, 5, or 6 are reported as 'Refine/Maintain'. The numbers in Table 15 represent the percentage of Refine/Maintain scores (4, 5, or 6) in each of the indicators for Rounds 1 through 4 of the QSRs across the regions. This method of reporting was chosen by DCS for its ability to support the strength-based training that the QSR facilitates.

The IU Evaluation Team is presenting the data in a slightly different way, as a mean score of each indicator. In this way, the IU Evaluation Team will be able to demonstrate a greater amount of variability to represent the change over the period of the demonstration. Following the "DCS Statewide Indicators at a Glance" are the data for Safety and Permanency in Figure 8, and for Well-Being and Overall Child Status in Figure 9. For more detailed descriptions of the ratings of each indicator, along with the full protocol, see http://www.in.gov/dcs/files/1QSRProtocolUpdates2009020310.pdf.

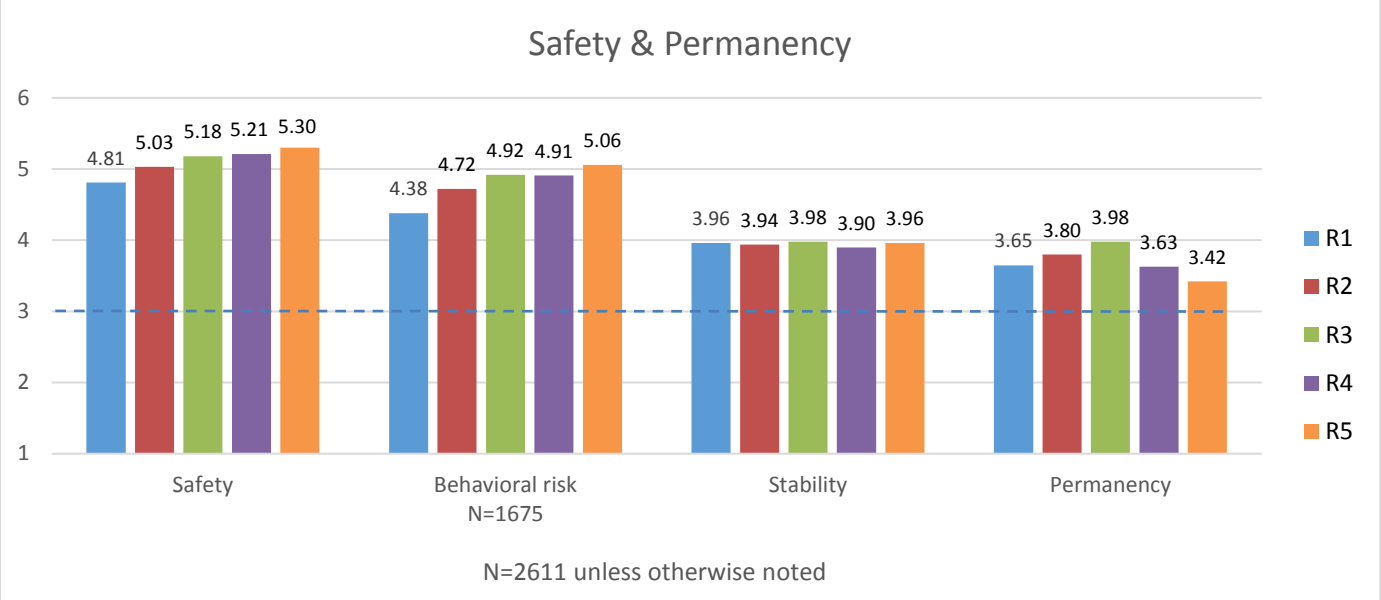
Table 15. DCS QSR Statewide Indicators at a Glance

Percentage of cases scoring at or above DCS' Refine/Maintain Threshold (4,5, or 6)

INDICATORS		Round 1	Round 2	Round 3	Round 4	Round 5
CHILD STATUS						
Safety		96	98	99	98	98
Behavioral Risk		78	86	88	88	89
Stability		63	65	65	62	65
Permanency		49	56	60	50	39
Appropriate Living Arrangement		93	96	95	97	96
Physical Health		95	97	97	99	98
Emotional Status		76	83	86	88	87
Learning and Development		82	89	88	91	90
Pathway to Independence		39	59	41	69	56
SYSTEM PERFORMANCE						
Role/Voice	Mother	44	57	63	59	52
	Father	25	29	37	31	18
	Child/Youth	50	65	68	66	73
Team Formation		33	49	44	45	34
Team Function		25	39	38	41	30
Cultural Recognition		78	83	89	90	89
Assessing & Understanding	Child	57	76	80	77	75
	Family	37	44	58	49	32
Long-Term View		36	50	54	43	35
Child & Family Planning Process		39	47	54	46	34
Planning Transitions		36	49	55	51	44
Intervention Adequacy		50	63	69	58	35
Resource Availability		75	88	93	95	90
Maintaining Relationships	Mother	61	76	69	64	65
	Father	40	36	48	42	40
	Siblings	61	70	62	64	67
	Extended Family	57	61	61	60	63
Tracking and Adjusting		48	59	63	55	42

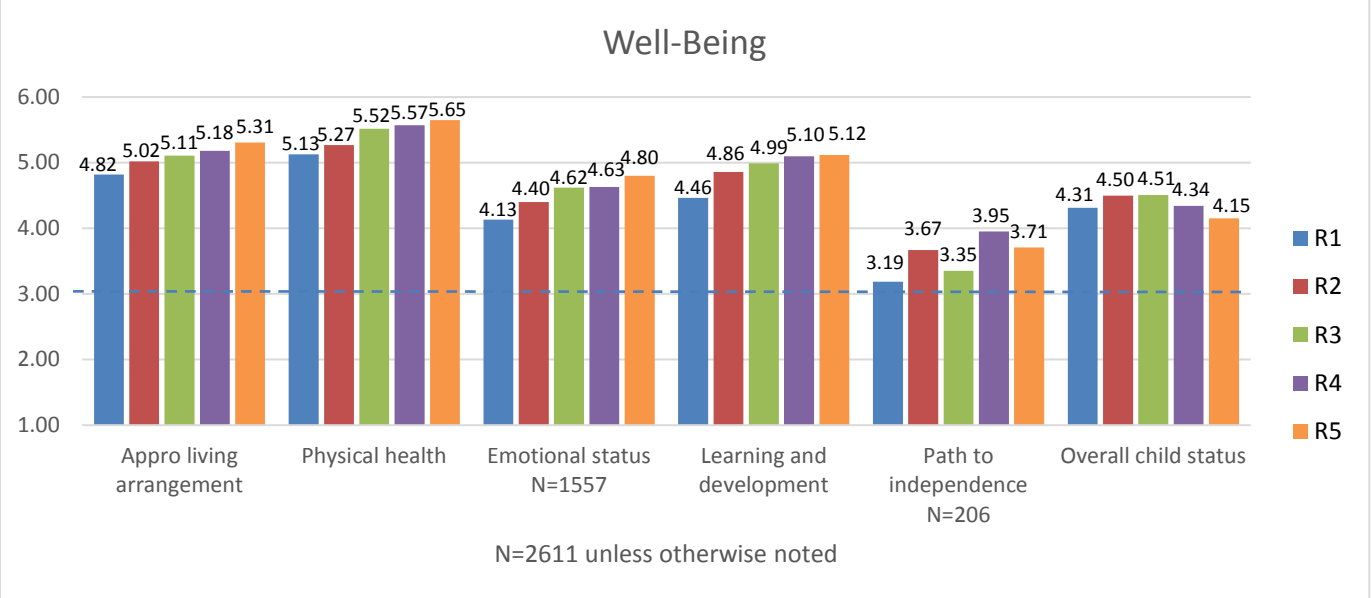
Primary Outcomes: QSR Rounds 1 through 5

Figure 8. Safety & Permanency



Safety and behavioral risk increased over the demonstration, stability stayed relatively the same, and permanency decreased.

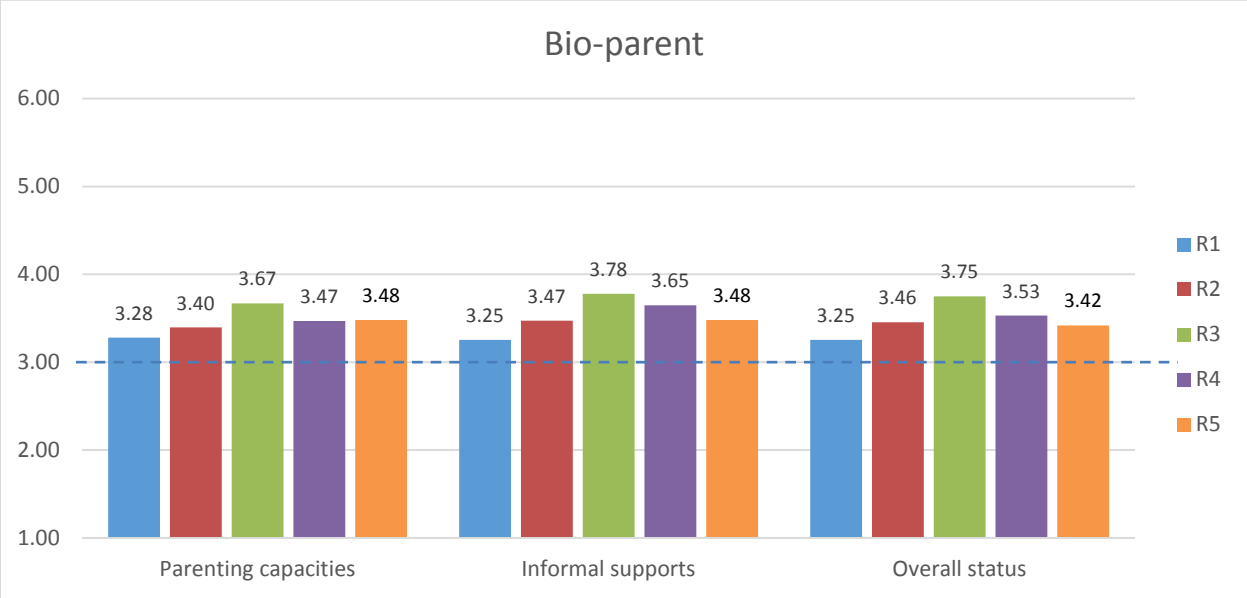
Figure 9. Well-being



Appropriate living arrangement, physical health, emotional status, and learning and development increased over time, path to independence has its highest rating in R4, and child status peaked in R3 with a decline following.

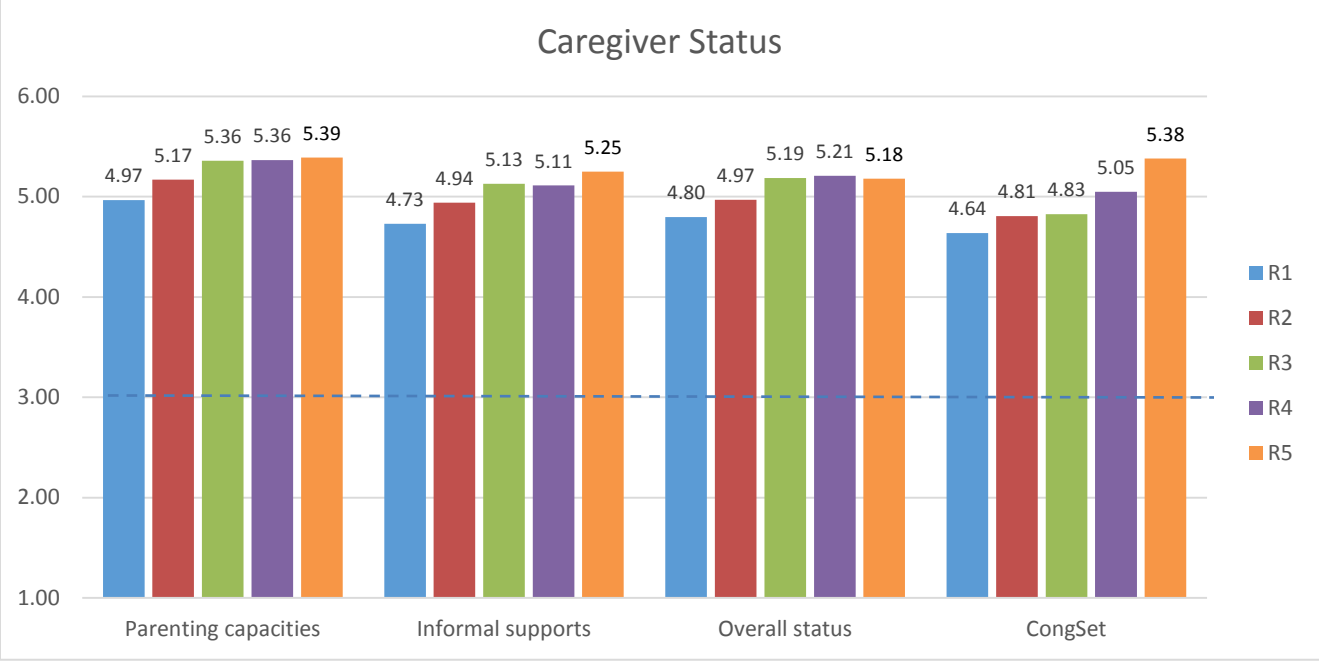
Parent/Caregiver Status

Figure 10. Bio-parent



Bio-parent's capacity, informal support, and overall status peaked in R3, but R4&5 were still higher than the first two rounds.

Figure 11. Caregiver

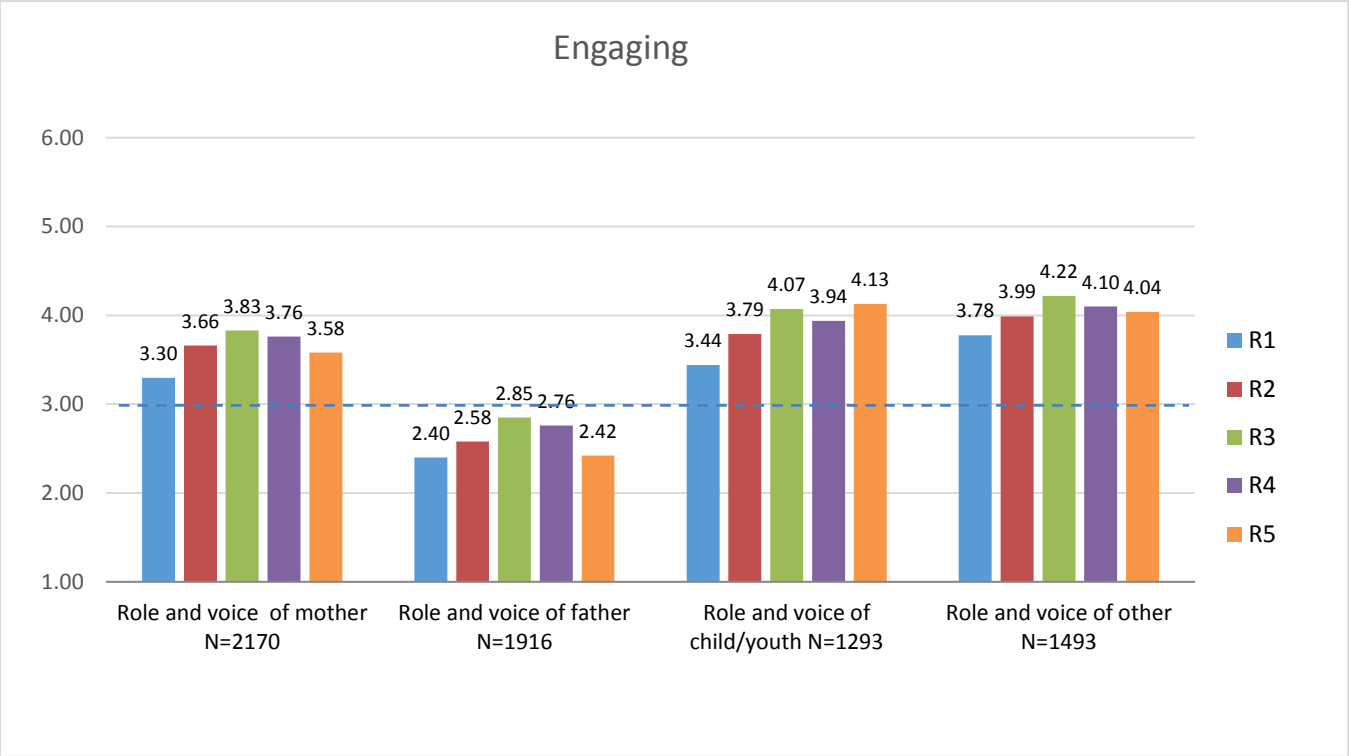


The caregiver's parenting capacities, informal support, overall status and congregate care had a slight increase over time.

QSR Practice Indicators Rounds 1 through 5

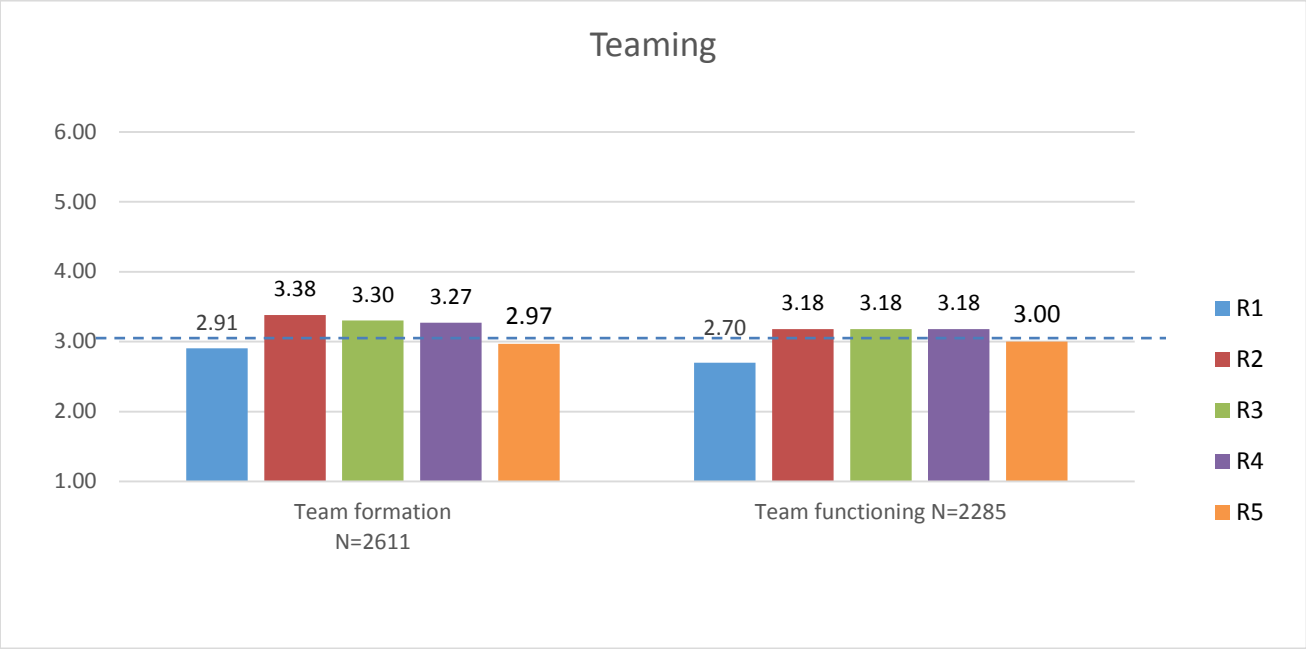
The QSR additionally takes into account System/Practice Performance indicators to guide the next steps of practice development and to lead to better results for local children and families. Table 7 lists the definition of each of these indicators, with results in Figures 12-17. Again, higher ratings indicate better system or practice performance.

Figure 12. Engaging



While the role and voice of the parents and others peaked in 2013 and started a slight decline in R4&5, the role and voice of the child increased to its highest point in R5.

Figure 13. Teaming



Teaming remianed one of the lowest rated practice indicators over all of the rounds. Team formation continues to decline, but team functioning is stayed flat in R2,3,&4, with a slight decrease in R5.

Figure 14. Assessing

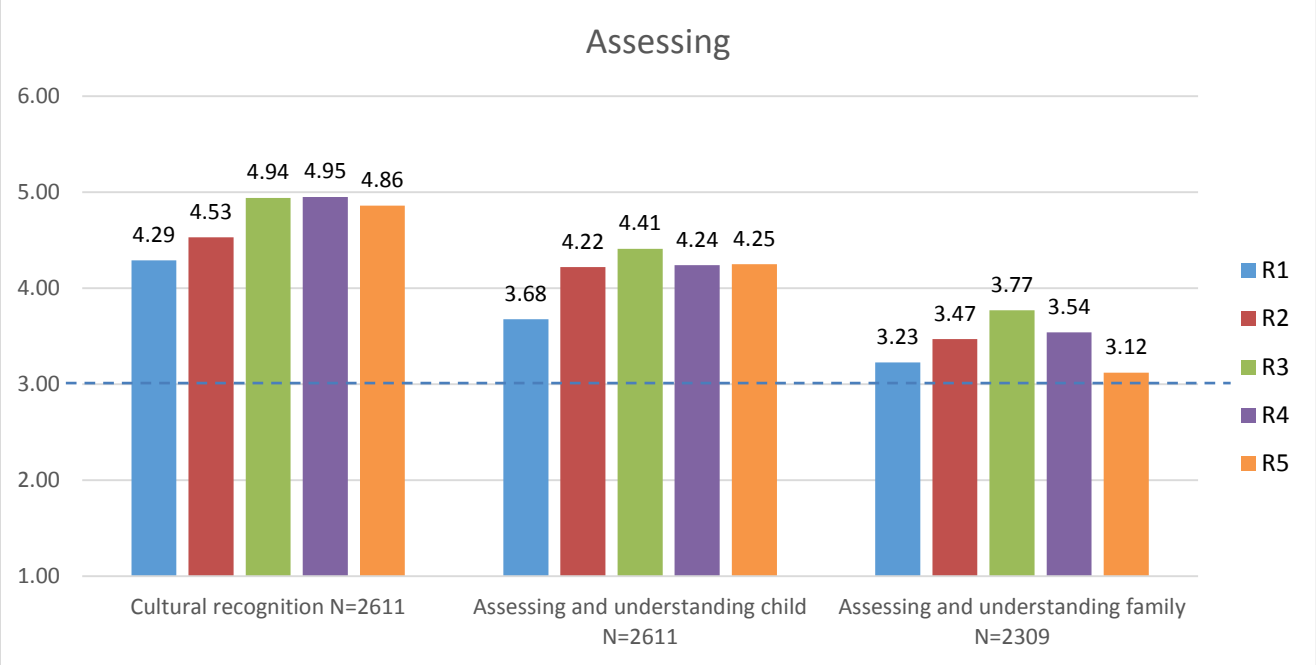


Figure 15. Planning

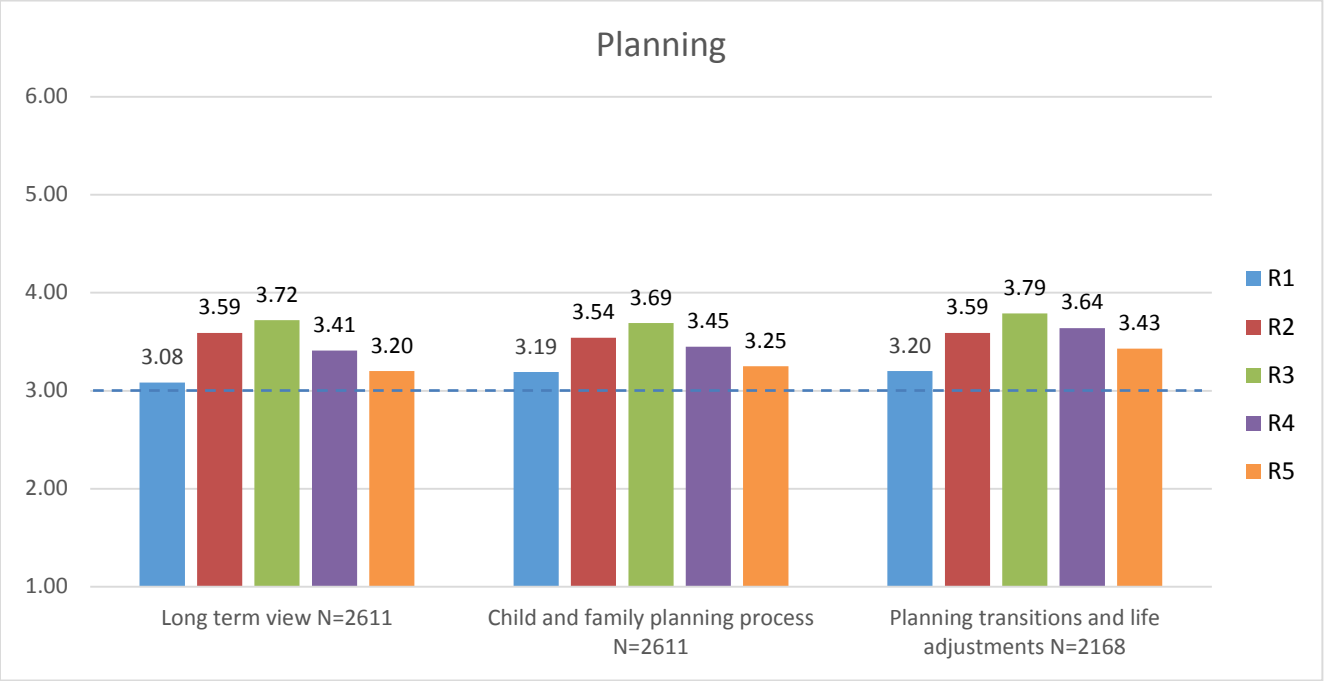


Figure 16. Maintaining Relationships

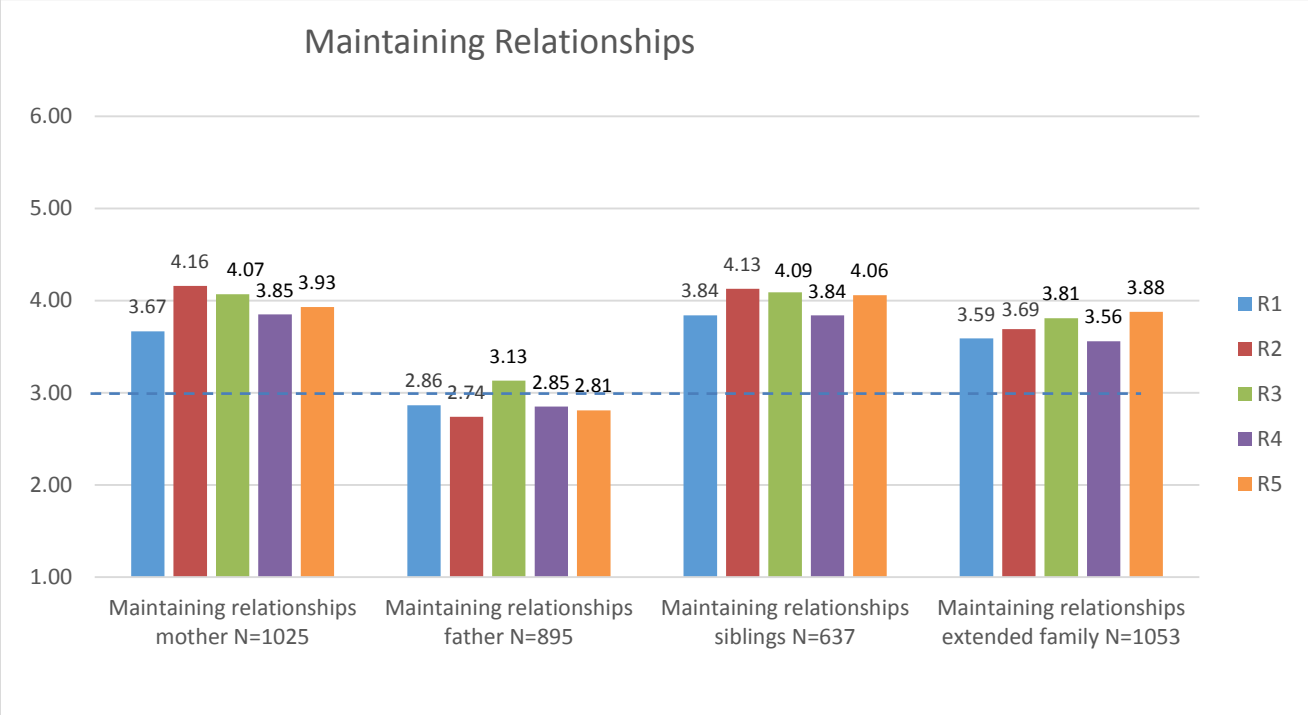
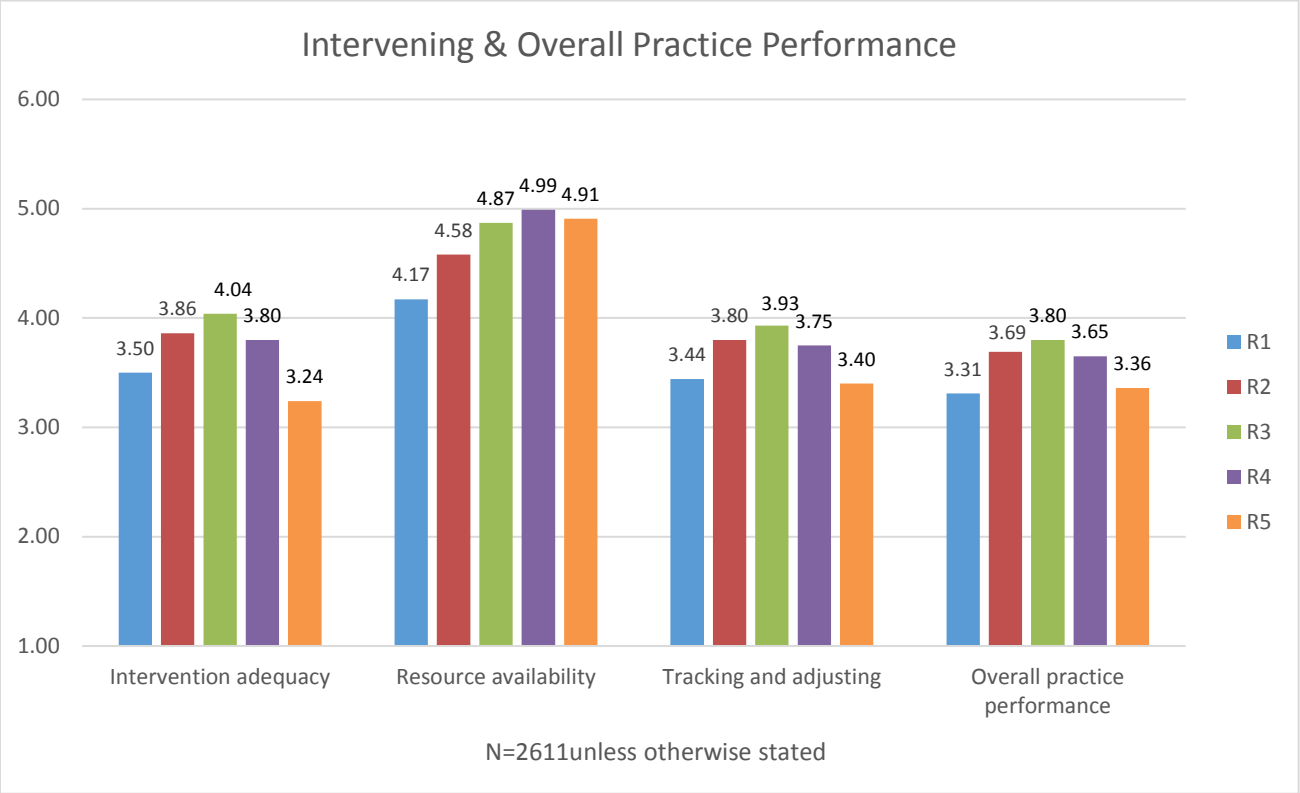


Figure 17. Intervening & Overall Practice Performance



QSR Comparison Pre- and Post- Waiver

This section provides an overview of the purpose and process of DCS' Quality Service Reviews (QSRs), as well as a comparison of indicators pre- and post- Waiver. Post-wavier is the term used for the demonstration period that is dates after July 1, 2012 ending on June 30, 2017. This section presents preliminary summary data from Rounds 1 to 5, based on a representative state-wide sample of around 500 cases each round. Rounds 1 and 2 were pre- Waiver years, Round 3 was during the wavier expansion, and Rounds 4 and 5 were post- wavier years. For the analyses of pre-Waiver (n=1317) vs. post-Waiver (1294), all cases reviewed before July 1, 2012 were included in the pre-Waiver group and any case on or after July 1, 2012 were included in the post-Waiver group. Differences between the pre- and post- wavier years are analyzed using t-tests and chi-squared tests. The summary of each round is listed below in Table 16:

Table 16. QSR Round Summaries

Round	Number of Cases Reviewed	Time Period of the Review	Language for this report
1	512	July 2007 – June 2009	**Pre-Wavier July 2007-June 2012**
2	585	July 2009 – July 2011	
3	515	September 2011 – July 2013	**Post-Waiver July 2012-June 2017**
4	497	September 2013 – April 2015	
5	502	September 2015 – July 2017	

The demographics of pre- and post- Waiver cases stayed relatively similar. The only significant difference was an increase in people who identified as multi-racial in the post-Waiver group. For each of the following demographic characteristics Tables, p-values are: NS (Not significant),*p<.05, **p<.01, ***p<.0001.

Table 17. Average Age (SD)

Pre 2012 Waiver	Post 2012 Waiver	p-value
7.57 (6.23)	7.15 (5.25)	NS

Table 18. Gender

		Pre 2012 Waiver	Post 2012 Waiver	p-value
Female	Count	676	639	NS
	%	51.3%	49.4%	
Male	Count	641	655	
	%	48.7%	50.6%	

Table 19. Race

		Pre 2012 Waiver	Post 2012 Waiver	p-value
White	Count	969	940	
	%	73.9%	72.8%	
Black or African American	Count	245	213	
	%	18.7%	16.5%	
Multi-racial	Count	83	132	
	%	6.3%	10.2%	**
American Indian or Alaskan Native	Count	11	3	
	%	0.8%	0.2%	
Native Hawaiian or Pacific Islander	Count	1	0	
	%	0.1%	0.0%	
Asian	Count	3	3	
	%	0.2%	0.2%	

Table 20. Ethnicity

		Pre 2012 Waiver	Post 2012 Waiver	p-value
Not Hispanic/Latino/a	Count	1181	1153	NS
	%	92.1%	90.9%	
Hispanic/Latino/a	Count	101	116	
	%	7.9%	9.1%	

QSR Outcome and Practice Indicators Comparison Pre- and Post- Wavier

In Table 21, we present provides the Outcome and Practice Indicators' average score pre- and post- wavier, the change between the two, and whether that difference is significant. The total number of cases was 2611, with 1317 in the Pre 2012 Waiver group and 1294 in the Post 2012 Waiver group. Safety and well-being indicators significantly increased from pre- to post- wavier, but permanency significantly declined. Other significant declines in the post Waiver years were the overall child status (which can be due to the permanency decline) and intervention adequacy. Significant increases in the post Waiver years were seen in parenting capacities and informal supports for bio-parents and caregivers, overall caregiver status, role and voice of the mother and child, cultural recognition, assessing and understanding the child, and resource availability.

Table 21. Differences in Pre- and Post- 2012 Waiver for Outcome and Practice Indicators

Child Status	Pre-Waiver	Post-Waiver	Change	p-value
Safety	4.97	5.24	0.27	***
Behavioral Risk	4.62	4.96	0.34	***
Stability	3.96	3.94	-0.02	
Permanency	3.79	3.60	-0.19	***
Appropriate Living Arrangement	4.97	5.20	0.23	***
Physical Health	5.25	5.60	0.35	***
Emotional Status	4.32	4.69	0.37	***
Learning and Development	4.74	5.07	0.33	***
Pathway to Independence	3.45	3.65	0.20	
Child Status	4.45	4.28	-0.17	***
Bio-parent				
Parenting capacities	3.41	3.51	0.10	*
Informal supports	3.47	3.59	0.12	*
Overall Bio-parent	3.45	3.52	0.07	
Caregiver				
Parenting capacities	5.13	5.36	0.23	***
Informal supports	4.87	5.18	0.31	***
Overall Caregiver	4.93	5.19	0.26	***
Congregate care settings	4.75	5.04	0.29	
System Performance				
Role & Voice of the Mother	3.56	3.69	0.13	*
Role & Voice of the Father	2.58	2.62	0.04	
Role & Voice of the Child/Youth	3.71	4.01	0.30	***
Team Formation	3.15	3.19	0.04	
Team Function	2.99	3.10	0.11	
Cultural Recognition	4.51	4.91	0.40	***
Assessing & Understanding Child	4.06	4.26	0.20	***
Assessing & Understanding Family	3.42	3.42	0.00	
Long-Term View	3.44	3.38	-0.06	
Child & Family Planning Process	3.44	3.42	-0.02	
Planning Transitions	3.50	3.57	0.07	
Intervention Adequacy	3.76	3.65	-0.11	*
Resource Availability	4.46	4.94	0.48	***
Maintaining Relationships with Mother	3.96	3.91	-0.05	
Maintaining Relationships with Father	2.88	2.86	-0.02	
Maintaining Relationships with Siblings	4.00	3.92	-0.08	
Maintaining Relationships with Extended Family	3.71	3.69	-0.02	
Tracking and Adjusting	3.70	3.64	-0.06	
Overall System Performance	3.57	3.56	-0.01	

*p<.05, **p<.01, ***p<.0001

Case Demographic Characteristics Comparison Pre- and Post- Waiver

Current placements Pre- and Post- wavier were significantly different (p<.0001), where there was an increase in the percentage of those who remained in the custodial/non-custodial home and those who went to relative's home opposed to a decrease in the percentage of those who went into congregate care, foster homes, independent living, pre-adoptive homes, and therapeutic foster care. The number and percent of placement types pre- and post- wavier are listed below in Table 22.

Table 22. Changes in Current Placements Pre- and Post- 2012 Waiver

		Pre 2012 Waiver	Post 2012 Waiver	Change
Congregate Care	Count	86	48	
	%	6.5%	3.7%	-2.8%
Custodial/Non-Custodial Home	Count	515	585	
	%	39.2%	45.2%	6.0%
Foster Home	Count	285	246	
	%	21.7%	19.0%	-2.7%
Independent Living	Count	7	0	
	%	0.5%	0.0%	-0.5%
Pre-Adoptive Home	Count	120	99	
	%	9.1%	7.7%	-1.5%
Relative Home	Count	236	293	
	%	17.9%	22.6%	4.7%
Therapeutic Foster Care	Count	66	23	
	%	5.0%	1.8%	-3.2%

The type of the cases shifted to less CHINS and more adoptions, assessments, and informal adjustments (p<.01) shown in Table 23. It is important to note, however, that the overall system had an increase in the number of all case types during the demonstration period.

Table 23. Case Types Pre- and Post- 2012 Waiver

		Pre 2012 Waiver	Post 2012 Waiver	Change
Adoption	Count	85	124	
	%	6.5%	9.6%	3.1%
Assessment	Count	199	206	
	%	15.1%	15.9%	0.8%
CHINS	Count	935	835	
	%	71.0%	64.5%	-6.5%
Informal Adjustment	Count	97	129	
	%	7.4%	10.0%	2.6%

Case lengths tended to be shorter in the post wavier years (Table 24). For pre wavier cases, the highest percentage of cases was 19.8% falling into the category of 19-36 months for the number of months the

case was opened. For post Waiver cases, the highest percentage was 21.6% in the 4-6 month category. The differences in the distributions of pre- and post- wavier cases were significant (p<.0001).

Table 24. Case Length in Pre- and Post- 2012 Waiver

		Pre 2012 Waiver	Post 2012 Waiver	Change
0-3 months	Count	192	211	
	%	14.6%	16.3%	1.7%
4-6 months	Count	205	280	
	%	15.6%	21.6%	6.1%
7-9 months	Count	176	185	
	%	13.4%	14.3%	0.9%
10-12 months	Count	137	131	
	%	10.4%	10.1%	-0.3%
13-18 months	Count	188	185	
	%	14.3%	14.3%	0.0%
19-36 months	Count	260	216	
	%	19.8%	16.7%	-3.1%
37+ months	Count	158	86	
	%	12.0%	6.6%	-5.4%

Agency Involvement Comparison Pre- and Post- Waiver

Agencies Involved with the cases increased between pre- and post- wavier years. Below we present the differences in utilization pre- and post- (Table 25) wavier along with each Round (R1-R5) over time (Figure 18). The use of substance abuse services and mental health services increased significantly from pre- to post- Wavier years. Cases that were not involved with any agencies were less frequent in post Wavier years (p<.0001). Finally, there was a small, yet significant decrease in the use of developmental disability services from pre- to post- Waiver.

Table 25. Agencies Involved Pre- and Post- 2012 Waiver

Agencies Involved	Pre 2012 Waiver	Post 2012 Waiver	Change	p-value
None	27.0%	11.0%	-16.0%	***
Developmental Disabilities	5.1%	2.2%	-2.9%	***
Juvenile Justice	4.9%	5.1%	0.2%	
Mental Health	53.3%	59.4%	6.1%	**
Older Youth Services	2.1%	2.1%	0.0%	
Substance Abuse/support	23.5%	37.9%	14.4%	***
Vocational Rehabilitation	1.2%	0.6%	-0.6%	

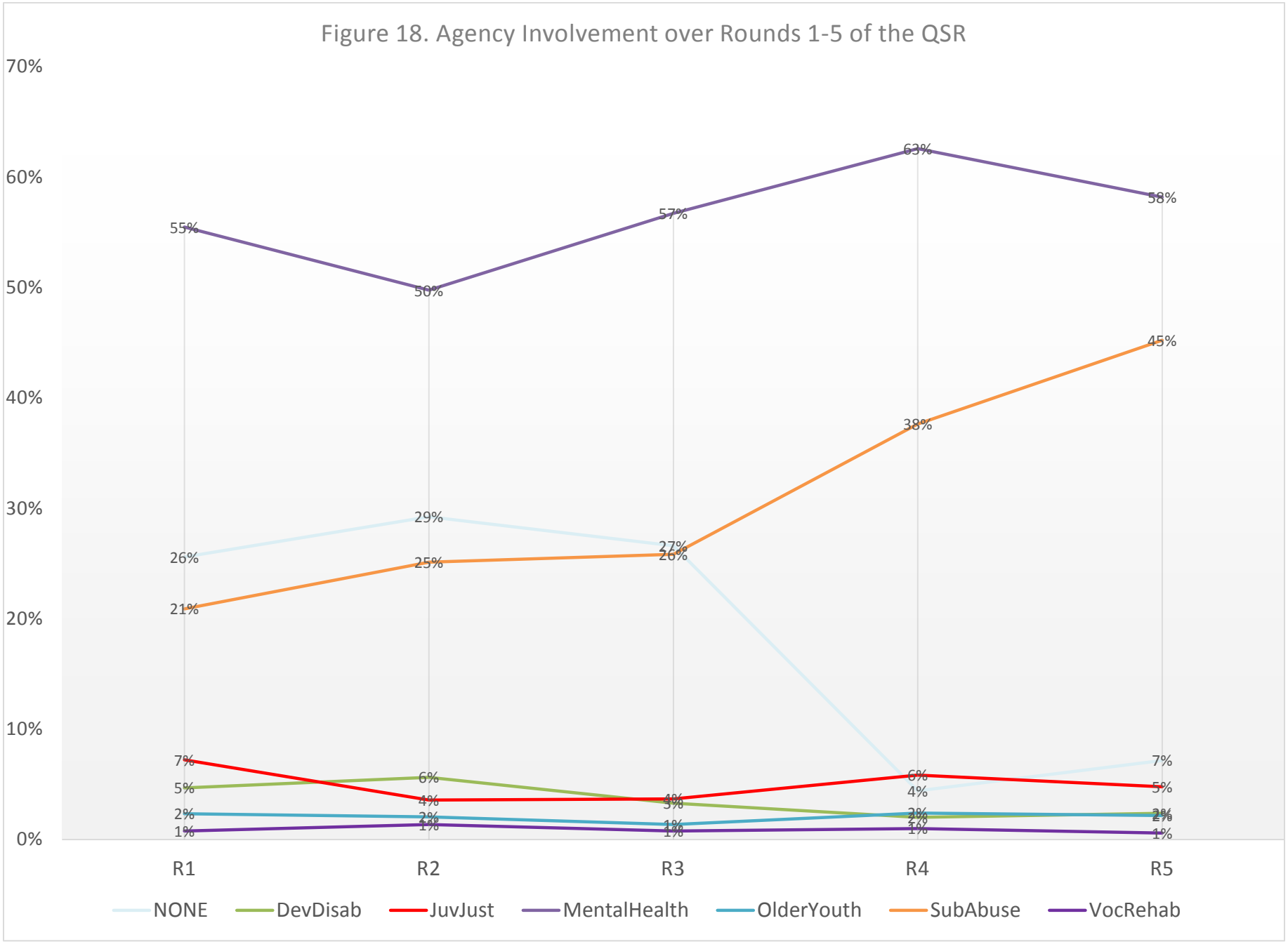


Figure 18. Agency Involvement over Rounds 1-5 of the QSR
70%
60%
50%
40%
30%
20%
10%
0%
R1
R2
R3
R4
R5
NONE
DevDisab
JuvJust
MentalHealth
OlderYouth
SubAbuse
VocRehab

Special Characteristics of the Child Comparison Pre- and Post- Waiver

When cases are rated, reviewers identify any special characteristics of the child that may need special considerations when making decisions about the case. The percentage of children having no special characteristics decreased significantly from pre- to post- wavier years (p<.01) along with behavioral problems, school problems, identified history of sexual abuse, chronic illness, physical disabilities, pregnancy, and fetal alcohol syndrome (Table 26). Methamphetamine related cases were seen significantly more often in the post years when compared to the pre wavier years (p<.01). Below the Tables are two Figures 19 and 20 that show the change in the prevalence of the child's characteristics over the five rounds (R1-R5). They are organized by those that are most often cited in Figure 19 and those that have the lowest prevalence in Figure 20. This was done only for the purpose of easier readability of the data.

Table 26. Special Characteristics of the Child Pre- and Post- 2012 Waiver

Special Characteristics of the Child	Pre 2012 Waiver	Post 2012 Waiver	Change	p-value
None	43.3%	37.0%	-6.3%	**
Behaviral Problems	26.9%	21.6%	-5.3%	**
ADD/ADHD	17.9%	18.1%	0.2%	
Emotional Disturbance	16.0%	15.5%	-0.5%	
School Problems	15.3%	11.4%	-3.9%	**
History of Sexual Abuse	12.4%	8.1%	-4.3%	***
Drug Addiction/SubAbuse	3.9%	4.3%	0.4%	
Intellectual Disability	4.1%	3.8%	-0.3%	
Meth Amphetamine Related	1.3%	3.0%	1.7%	**
Premature Birth	4.6%	4.3%	-0.3%	
Involved in Juvenile Court	3.6%	3.2%	-0.4%	
Chronic Illness	5.4%	2.9%	-2.5%	**
Failure To Thrive	1.7%	1.5%	-0.2%	
Multiple Birth	1.2%	0.9%	-0.3%	
Physical Disability	2.7%	1.2%	-1.5%	**
Pregnancy	0.8%	0.2%	-0.6%	*
Fetal Alcohol Syndrome	1.4%	0.2%	-1.2%	***
Battered Child Syndrome	0.8%	0.5%	-0.3%	

Figure 19. Prevalence of Special Characteristics of the Child in Rounds 1-5 of the QSR

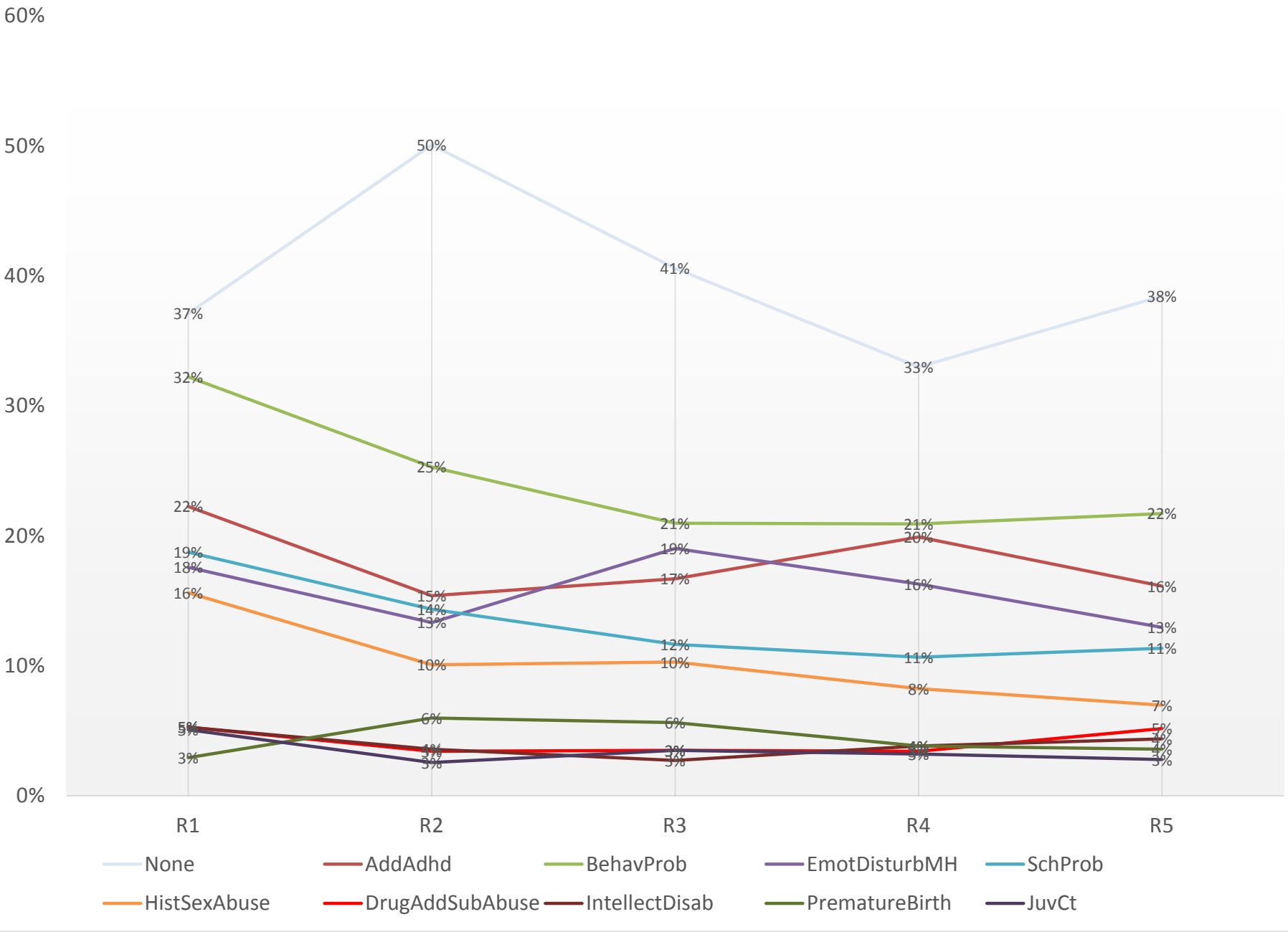
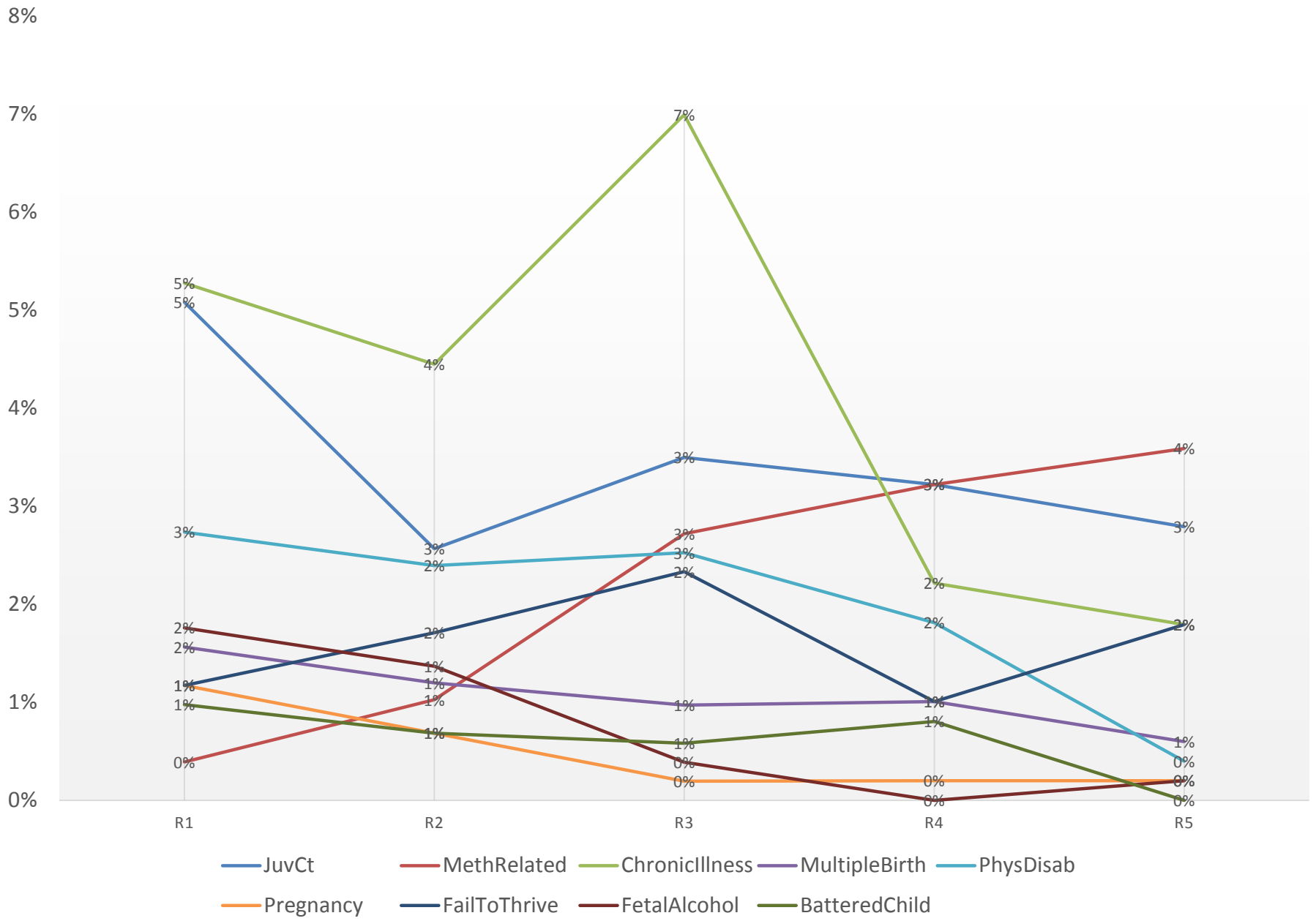


Figure 20. Prevalence of Special Characteristics of the Child in Rounds 1-5 of the QSR



Caregiver Stress Factors Comparison Pre- and Post- Waiver

Similar to the special characteristics of the child, raters in the QSR also identify any caregiver stress factors that should be considered when making decisions about a case. Below is the Table of caregiver stress factors (Table 27). Prevalence of domestic violence, drug abuse, spousal/family violence, emotional distress, legal problems, unstable living conditions, and inadequate housing for caregivers increased from the pre- to post- Waiver years. Prevalence of having no stress factors and a lack of parenting skills decreased significantly between the pre- and post- wavier years. Most notably, the highest prevalence of all stress factors in the post Waiver years was drug abuse.

Below the Tables are two Figures 21 and 22 that show the change in the prevalence of the caregivers' stress factors over the five rounds (R1-R5). They are organized by those that are most often cited in Figure 21 and those that have the lowest prevalence in Figure 22. This was done only for the purpose of easier readability of the data.

Table 27. Caregiver Stress Factors

Caregiver Stress Factor	Pre 2012 Waiver	Post 2012 Waiver	Change	p-value
None	7.3%	2.6%	-4.7%	***
Income	40.0%	37.4%	-2.6%	
Physical Health	11.3%	10.4%	-0.9%	
Alcohol	13.3%	13.6%	0.3%	
Domestic Violence	26.7%	39.7%	13.0%	***
Drug Abuse	46.7%	60.7%	14.0%	***
Spousal/Family Violence	10.3%	18.2%	7.9%	***
Emotional Distress	4.2%	8.3%	4.1%	***
Family Discord	30.7%	27.9%	-2.8%	
Legal Problems	26.6%	32.1%	5.5%	**
Mental Health Issues	38.7%	40.2%	1.5%	
Abused/Neglected as a Child	26.4%	26.6%	0.2%	
Unstable Living Conditions	28.2%	32.4%	4.2%	*
Inadequate Housing	24.1%	31.5%	7.4%	***
Physically Disabled	4.0%	3.4%	-0.6%	
Authoritarian Disipline	5.5%	4.6%	-0.9%	
Lack of Parenting Skills	50.6%	45.4%	-5.2%	*

Figure 21. Prevalence of Caregiver Stress Factors in Rounds 1-5 of the QSR

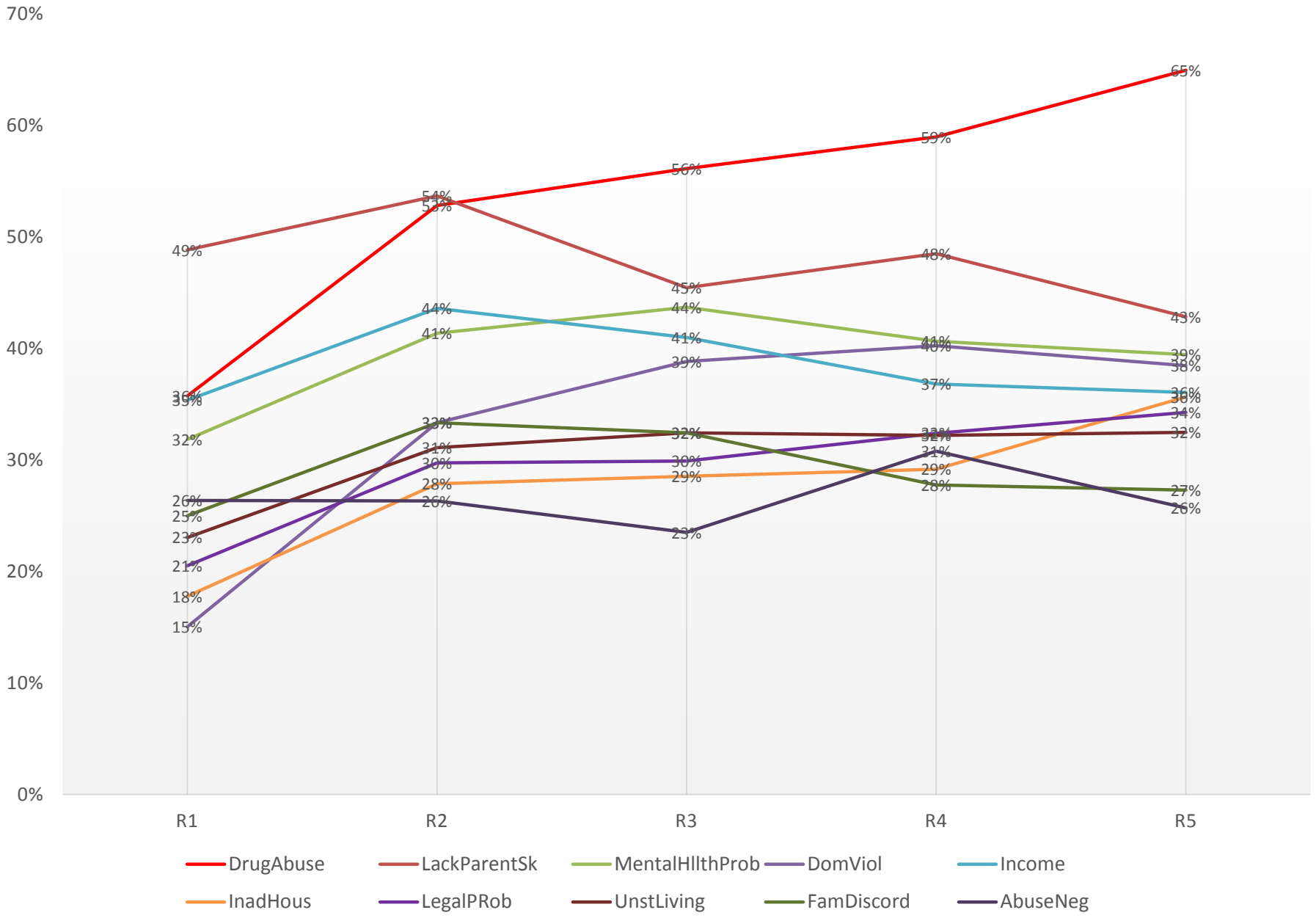
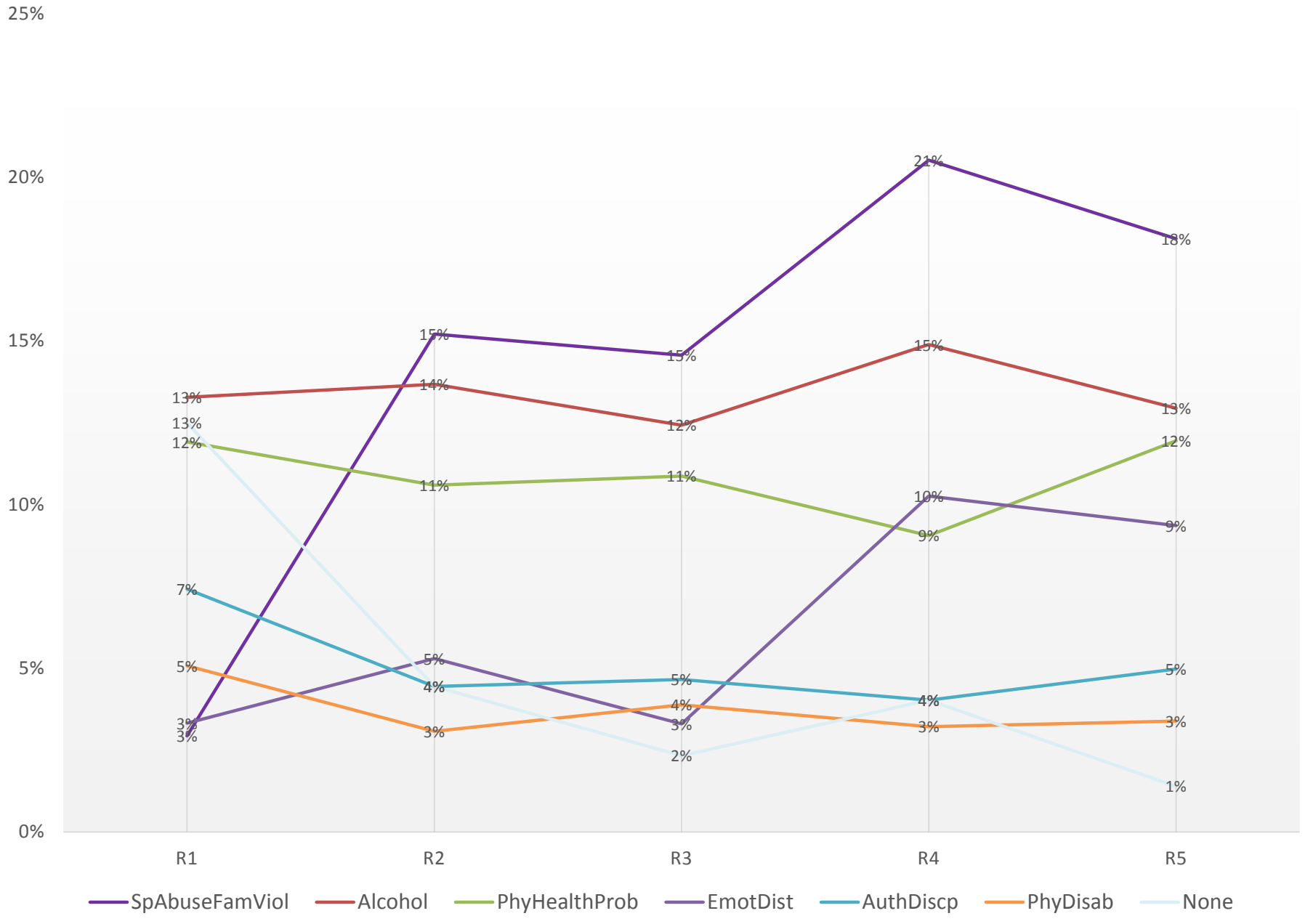


Figure 22. Prevalence of Caregiver Stress Factors in Rounds 1-5 of the QSR



QSR Rounds 1 through 5 Summary

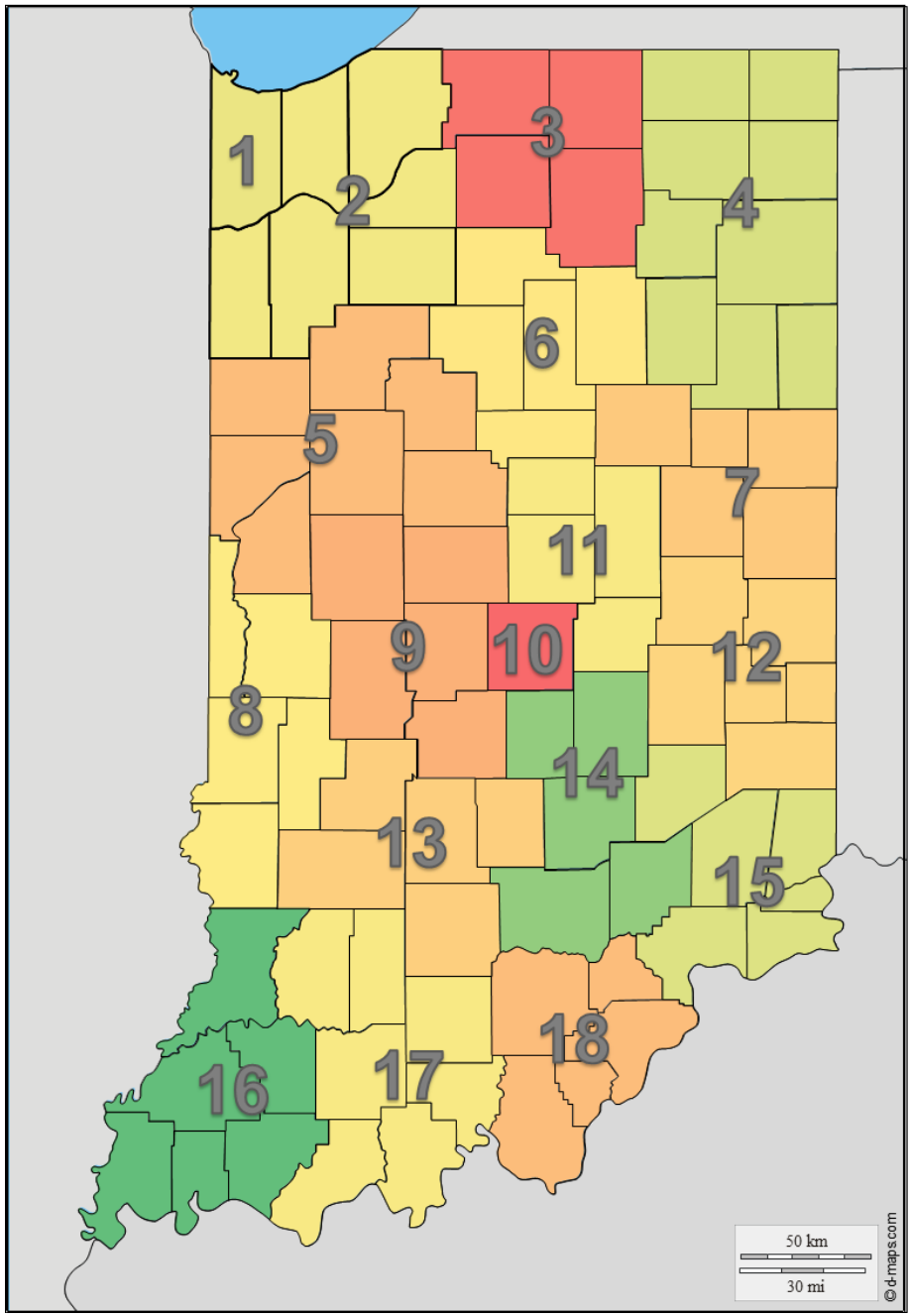
In summary, significant differences between rounds were found using chi-square and independent sample t-tests. The data indicated improvements in many practice performance and outcome indicators from Round 1 to Round 3. While most indicators demonstrated a decrease in Round 4, the declines were minimal and were still improvements from the earlier Rounds of 1 and 2. It should be emphasized that these Round 1 (2007-2009) and Round 2 (2007-2009) data periods occurred before the initiation of the 2012 Waiver. Therefore, these data represent baseline levels. Round 3 will serve as a transition round and will be eliminated from future analyses comparing before and after Waiver implementation. Round 4 is the period in which changes to the Waiver are being stabilized and may serve as the first point of a consistent trend with more Rounds to come. An intended effect of the 2012 Waiver is to improve practice performance, by enhancing the array of available services and the flexibility of their use, and thereby improving outcomes for children and families. Results from future QSR rounds, subsequent to the initiation of the 2012 Waiver, that show further improvement in Practice Indicators and Outcome Indicators would be consistent with the intended effects of the 2012 Waiver.

QSR Visual Change Pre vs Post Waiver by Region

The following Indiana Maps aim to better understand which Regions gained or lost the most on particular items in the QSR from Pre 2012 Wavier to Post 2012 Waiver. Again, data were divided into all cases before July 1, 2012 and those on or after July 1, 2012. In other words, regions will be identified with the highest mean or percent change to those with the lowest mean or percent change.

The practice outcomes will be displayed first for all of the regions. Then, resource availability and intervention adequacy will be presented from the practice indicators since the Waiver aimed to directly impact those indicators.

After the practice indicators are presented, selected caregiver stress factors are presented. Those selected were those with the largest percent gains from pre- to post- Waiver. They include caregiver drug use, domestic violence, spousal abuse/family violence, inadequate housing, and legal problems. The aim is to locate the regions that have had the highest change between pre- and post-Waiver years.



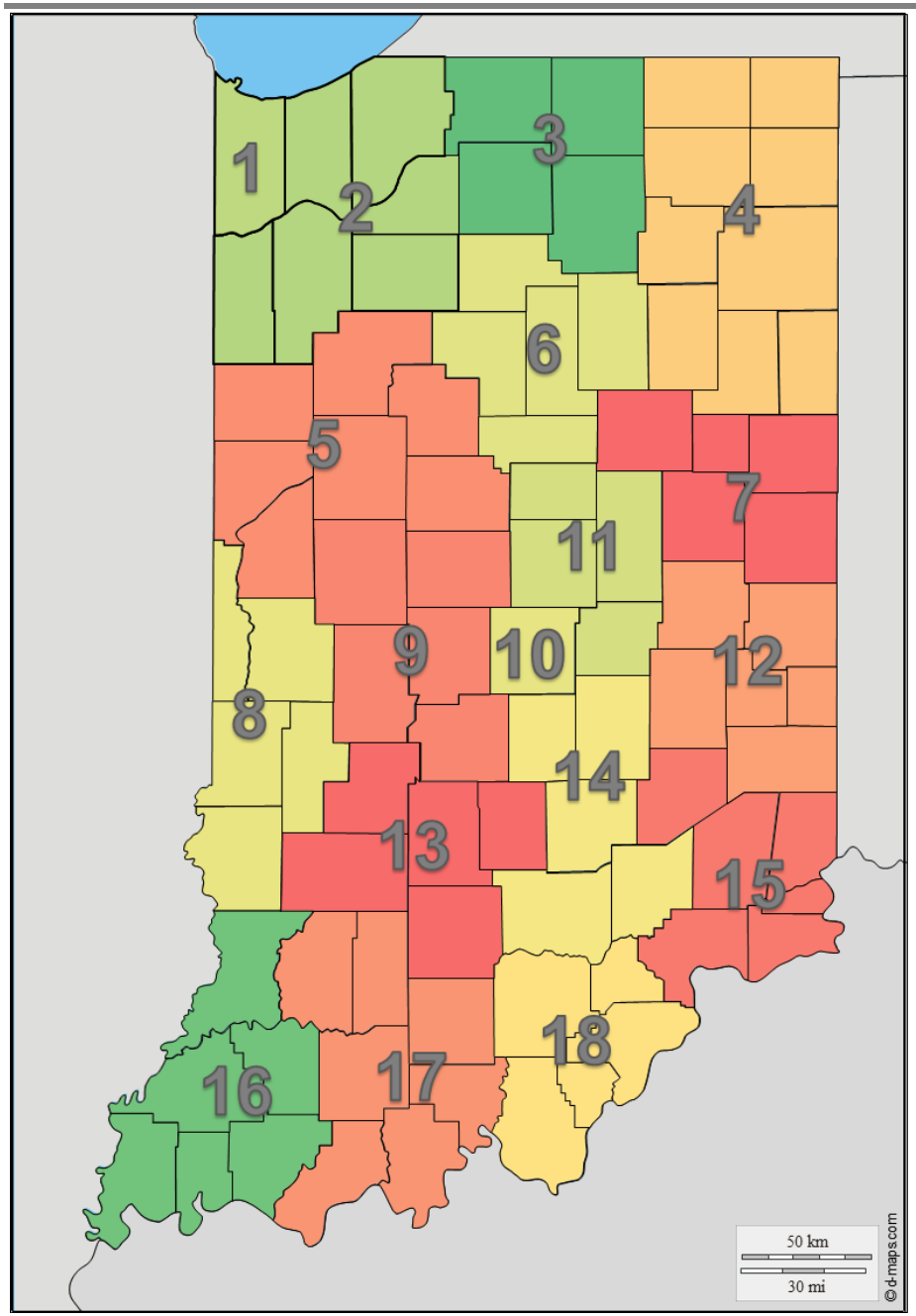
Safety

Mean Increases in Safety ratings pre vs. post Waiver from the QSR by Region

Region	n	Pre Waiver	Post Wavier	Mean Change
16	116	4.66	5.25	0.59***
14	112	4.97	5.47	0.50**
4	175	4.86	5.23	0.37**
15	112	4.97	5.33	0.36*
1	325	5.04	5.37	0.33***
2	113	4.96	5.28	0.32*
11	111	4.87	5.18	0.31
17	117	4.9	5.21	0.31*
8	117	4.88	5.18	0.30
6	112	5.14	5.43	0.29*
12	116	4.91	5.17	0.26
13	108	4.93	5.18	0.25
7	117	4.94	5.18	0.24
18	110	4.97	5.19	0.22
5	116	4.91	5.13	0.22
9	117	5.14	5.34	0.20
3	117	5.04	5.14	0.10
10	400	5.05	5.13	0.08

*p<.05, p<.01, p<.001

All regions increased their safety ratings from pre to post waiver. Region 16 made the most gains from pre to post waiver, as it had the lowest safety rating pre-waiver. In the post waiver years, Region 14 had the highest average safety scores, followed by region 6. Regions 3 and 10 gained the least in safety scores. However, NO region declined in safety from pre to post wavier.



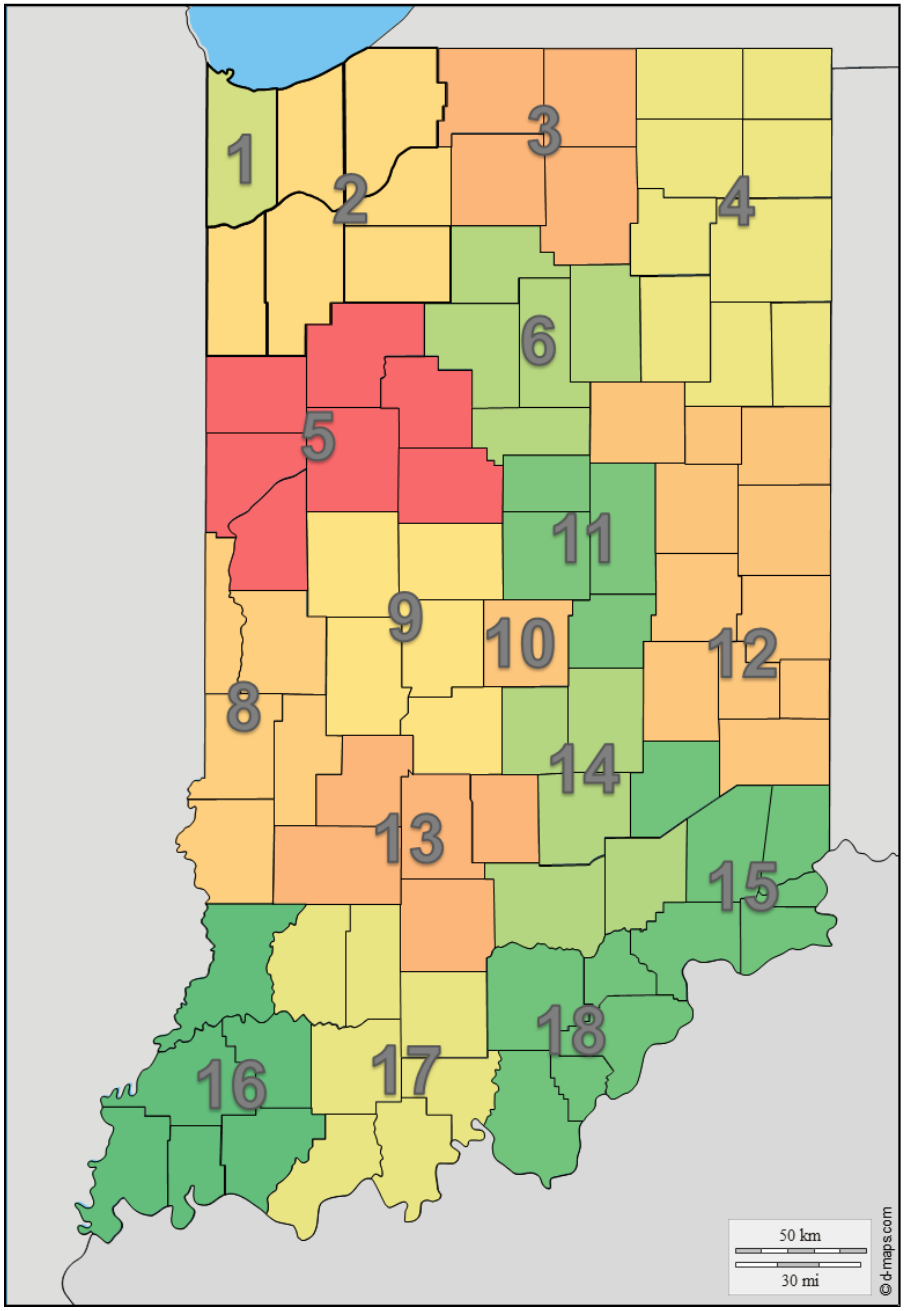
Permanency

Mean change in Permanency ratings pre vs. post Waiver from the QSR by Region

Region	n	Pre Waiver	Post Wavier	Mean Change
3	117	3.46	3.73	0.27
16	116	3.45	3.68	0.23
2	113	3.93	3.97	0.04
1	325	3.66	3.68	0.01
11	111	3.64	3.59	-0.05
6	112	3.52	3.43	-0.09
10	400	3.75	3.65	-0.10
8	117	3.78	3.67	-0.11
14	112	3.67	3.53	-0.14
18	110	3.63	3.43	-0.20
4	175	3.82	3.55	-0.27
12	116	4.00	3.58	-0.42
17	117	3.84	3.38	-0.46*
5	116	3.99	3.51	-0.48*
9	117	4.00	3.49	-0.51*
15	112	4.04	3.49	-0.55*
13	108	4.20	3.60	-0.60**
7	117	3.99	3.38	-0.61**

*p<.05, p<.01, p<.001

Region 3 and 16 made the most gains from pre to post waiver, however they were relatively small and not significant. Those regions did go from being the lowest rated regions pre waiver to being in the middle of the pack. Regions 13 and 7 declined the most between pre and post-wavier, with 7 and 17 having the lowest average permanency score post waiver.



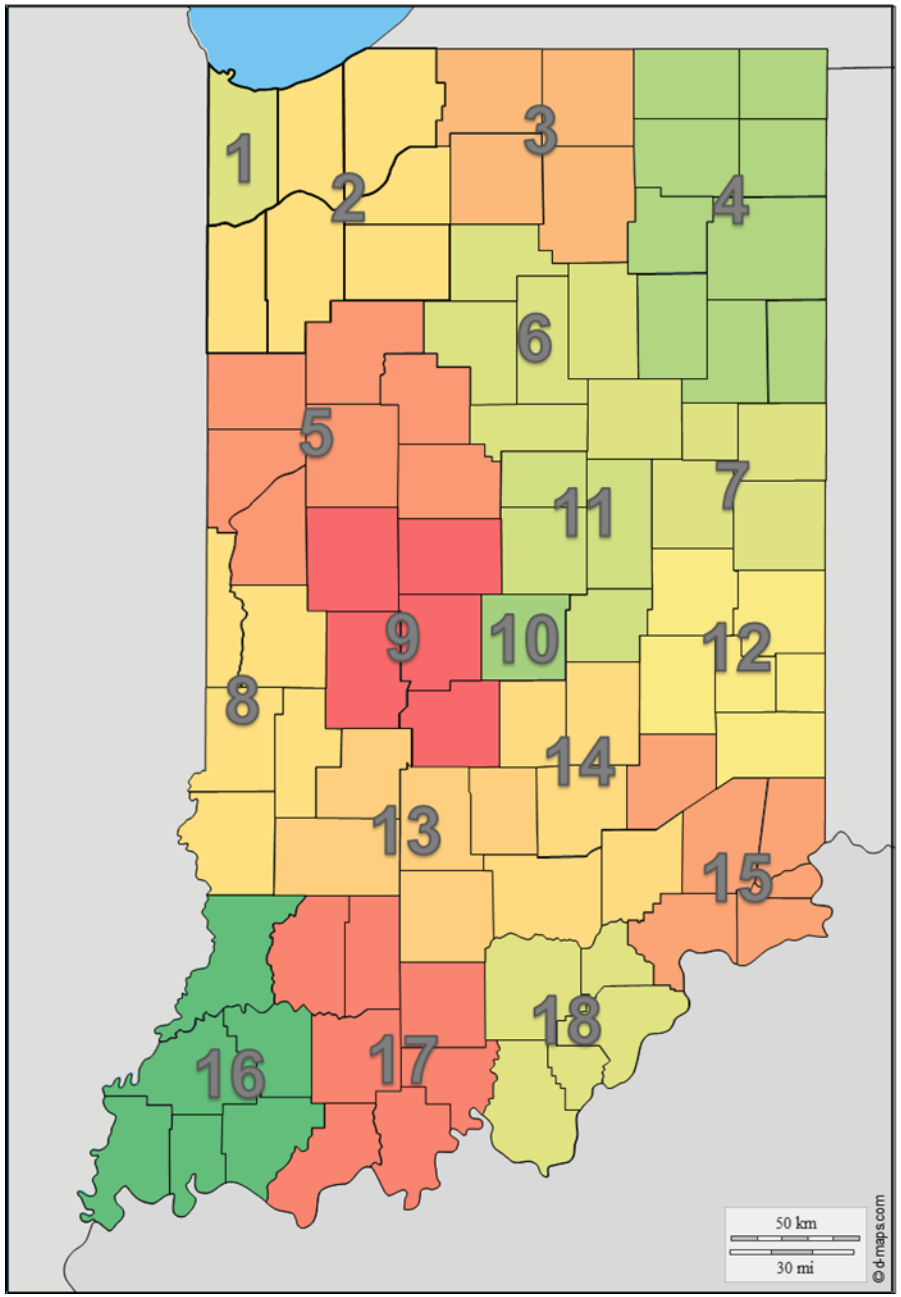
Well-being

Mean change in average well-being ratings pre vs. post Waiver from the QSR by Region

Region	n	Pre Waiver	Post Wavier	Mean Change
16	116	4.73	5.23	0.50***
18	110	4.76	5.24	0.49***
15	112	4.83	5.31	0.49***
11	111	4.72	5.20	0.48***
14	112	4.87	5.29	0.42
6	112	4.70	5.11	0.42**
1	325	4.81	5.19	0.39***
17	117	4.91	5.27	0.36**
4	175	4.79	5.15	0.36**
9	117	4.94	5.27	0.32**
2	113	4.89	5.19	0.30*
8	117	4.95	5.23	0.27*
12	116	4.83	5.08	0.25
10	400	4.86	5.11	0.25***
7	117	4.97	5.22	0.25*
3	117	4.73	4.97	0.23
13	108	4.96	5.17	0.21
5	116	4.92	4.94	0.02

*p<.05, p<.01, p<.001

All of the regions improved their well-being ratings from pre to post wavier. Regions 16,18,15, and 11 had the highest gains that were all significant (p<.001). The lowest ranking improved post waiver at 4.94, when the lowest ranking pre waiver was 4.70.



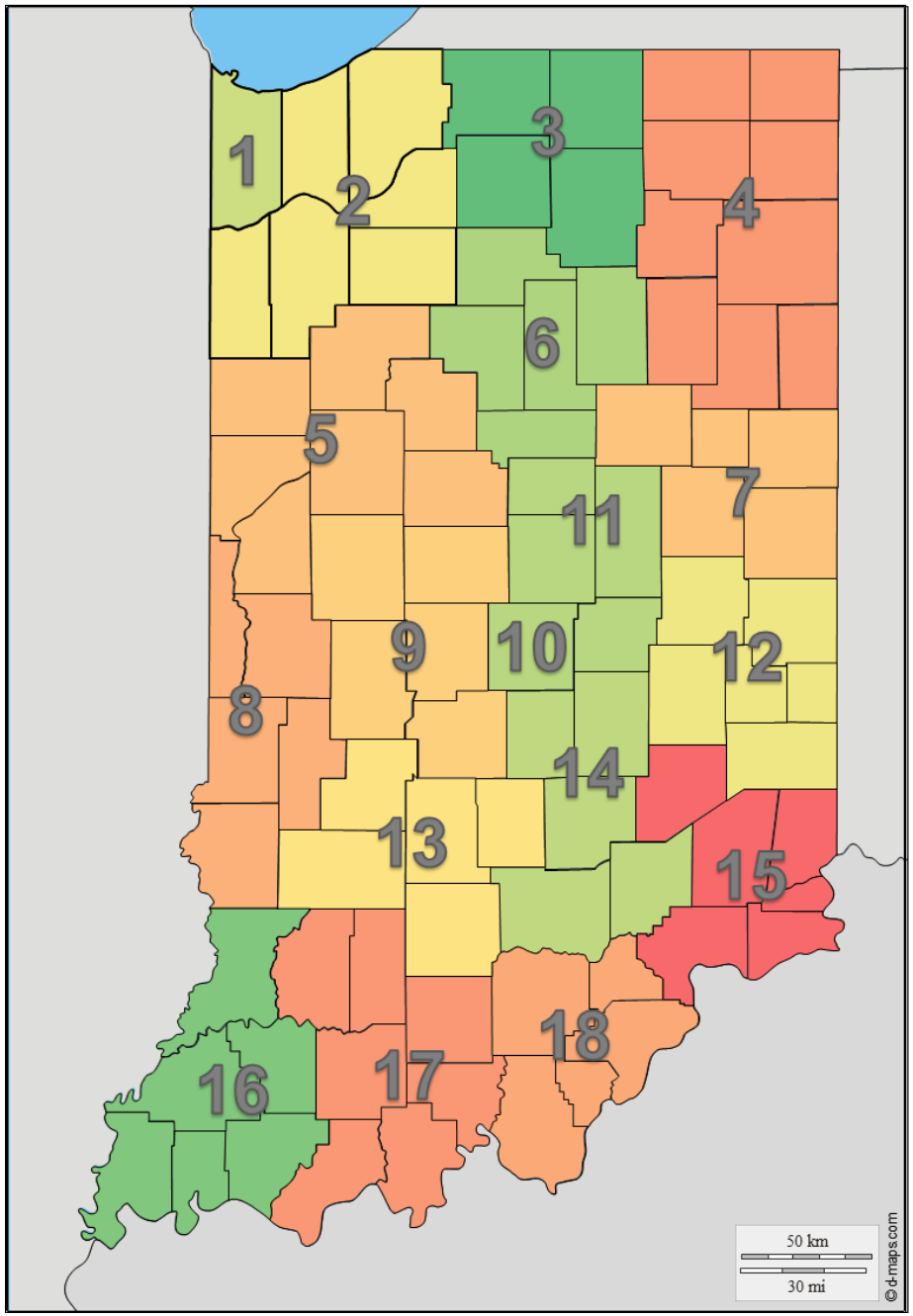
Resource Availability

Mean change in average resource availability ratings pre vs. post Waiver from the QSR by Region

Region	n	Pre Waiver	Post Wavier	Mean Change
16	116	4.11	5.09	0.98***
10	400	4.52	5.24	0.72***
4	175	4.57	5.24	0.67***
11	111	4.29	4.83	0.54*
6	112	4.41	4.91	0.50**
1	325	4.66	5.16	0.49***
7	117	4.29	4.78	0.49*
18	110	4.40	4.88	0.48*
12	116	4.49	4.87	0.38
2	113	4.31	4.65	0.34
8	117	4.46	4.80	0.34
14	112	4.63	4.96	0.33
13	108	4.54	4.85	0.31
3	117	4.63	4.90	0.27
15	112	4.49	4.72	0.23
5	116	4.43	4.64	0.21
17	117	4.19	4.36	0.17
9	117	4.39	4.51	0.12

*p<.05, p<.01, p<.001

All of the regions improved their resource availability ratings from pre to post wavier. Regions 16, 10, 4, and 11 had the highest gains that were all significant (p<.05). Regions 10, 4, and 1 had the highest ratings post waiver. The lowest ranking improved post waiver at 4.36, up from the lowest ranking region pre waiver (4.11).



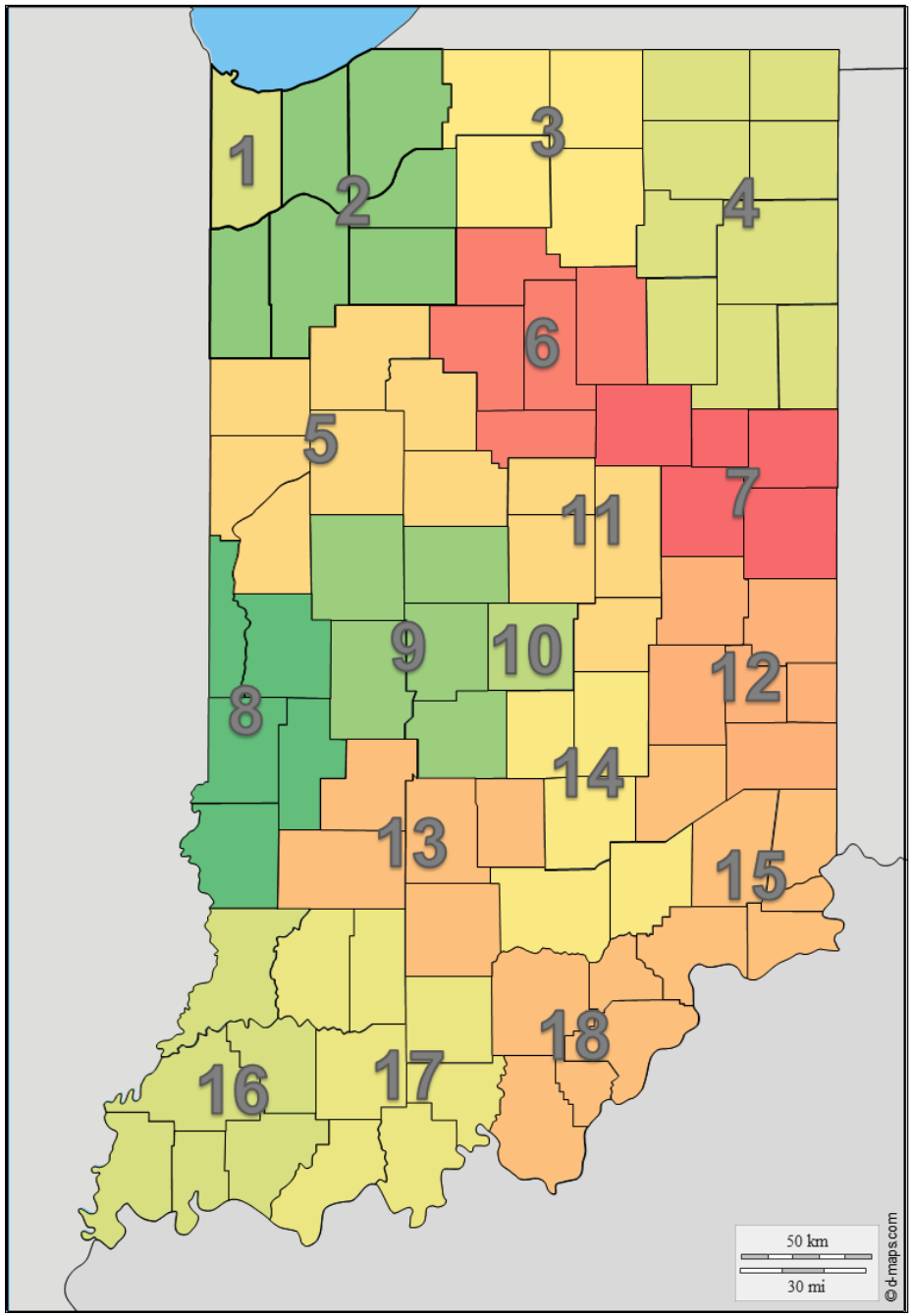
Intervention Adequacy

Mean change in Intervention Adequacy ratings pre vs. post Waiver from the QSR by Region

Region	n	Pre Waiver	Post Wavier	Mean Change
3	117	3.54	3.79	0.25
16	116	3.47	3.65	0.18
6	112	3.77	3.84	0.07
10	400	3.76	3.81	0.05
11	111	3.64	3.69	0.05
14	112	3.72	3.75	0.03
1	325	3.73	3.73	0.00
12	116	3.74	3.66	-0.08
2	113	3.87	3.78	-0.09
13	108	3.59	3.44	-0.15
9	117	3.97	3.75	-0.22
7	117	3.78	3.51	-0.27
5	116	3.96	3.68	-0.28
8	117	3.76	3.42	-0.34
18	110	3.65	3.28	-0.37
4	175	3.79	3.36	-0.43
17	117	3.79	3.35	-0.44*
15	112	3.90	3.28	-0.62**

*p<.05, p<.01, p<.001

6 regions had small, but non significant increases in intervention adequacy ratings from pre to post waiver. Regions 17 and 15 had the highest losses (p<.05). Regions 6, 10, and 3 had the highest post waiver ratings. Regions 9, 5, and 15 used to have the highest ratings in the pre-waiver years.



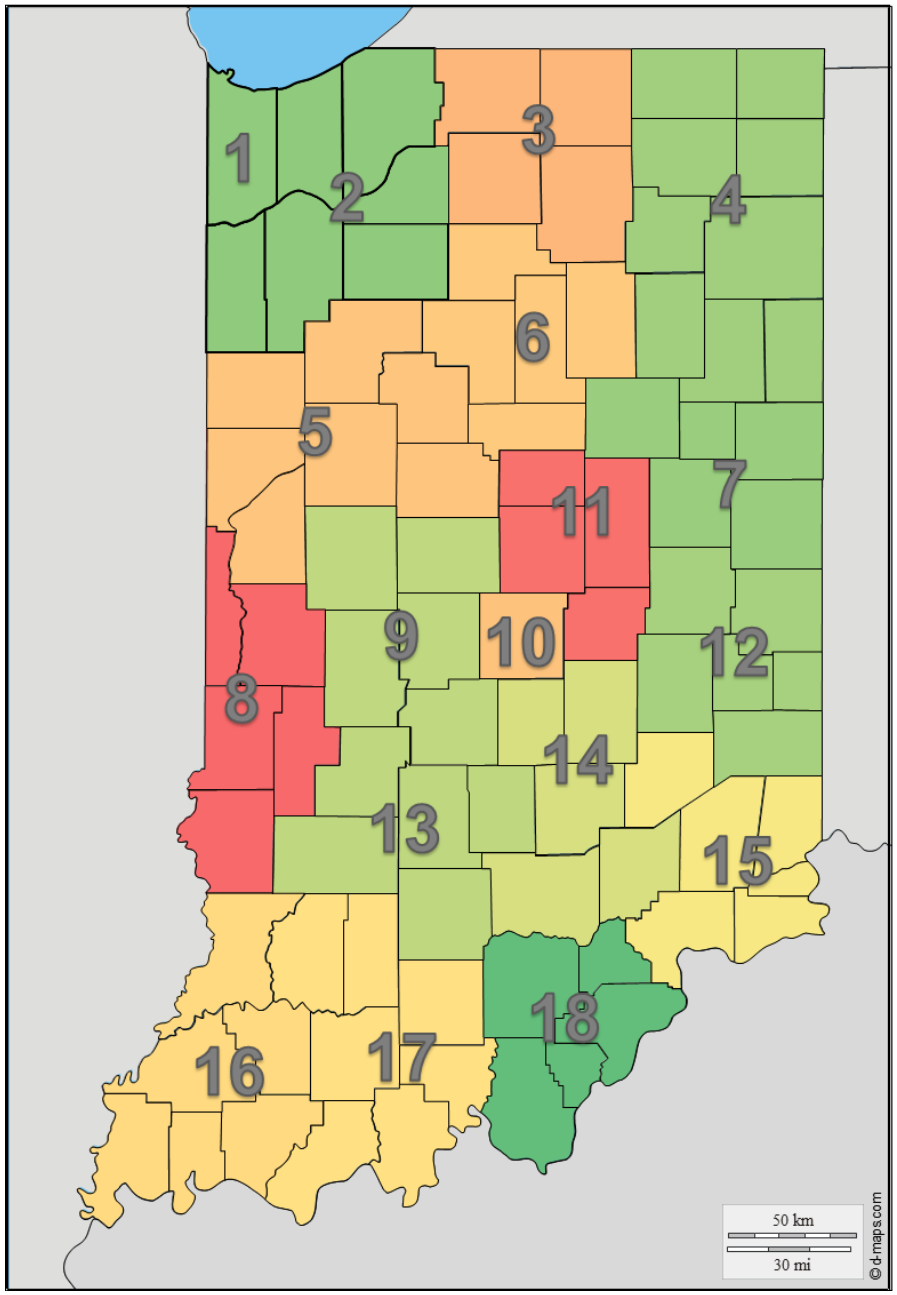
Caregiver Drug Abuse

Percent change in Caregiver Drug Abuse pre vs. post Waiver from the QSR by Region

Region	n	Pre Wavier (%)	Post wavier (%)	Percent Change
8	117	66.7	66.7	0.0
2	113	53.3	57.4	4.1
9	117	62.9	68.1	5.2
10	400	44.0	52.3	8.3
16	116	53.2	63.8	10.6
1	325	38.1	49.2	11.1
4	175	42.3	53.5	11.2
17	117	60.0	72.3	12.3
14	112	55.2	68.9	13.7
3	117	34.8	49.3	14.5
5	116	33.3	51.1	17.8
11	111	53.3	71.2	17.9
15	112	40.6	62.8	22.2
18	110	51.5	73.8	22.3*
13	108	46.3	68.7	22.4*
12	116	48.9	73.9	25.0*
6	112	36.4	70.6	34.2***
7	117	34.7	73.3	38.6***

*p<.05, p<.01, p<.001

All but 1 region had an increase in the percentage of caregivers with drug abuse issues. Regions 6 and 7 had the highest gains (p<.001) from pre to post waiver years. Regions 18, 13, and 12 also had significant increases. Regions 12, 18, and 7 had the highest percentages all above 70% in the post waiver years. Those regions with the lowest percentage in post waiver years were still close to 50% of the population.



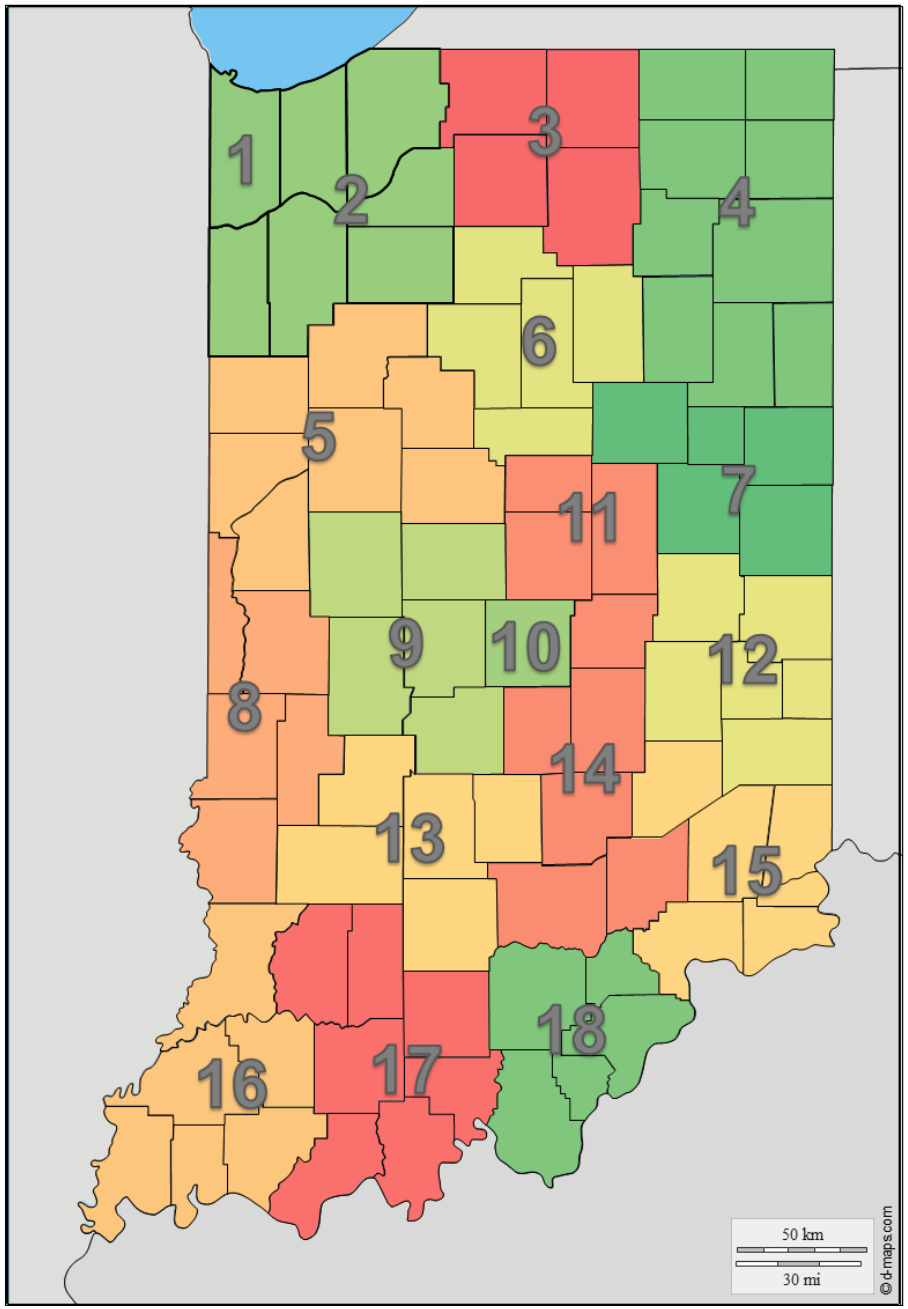
Caregiver Domestic Violence

Percent change in Caregiver Domestic Violence pre vs. post Waiver from the QSR by Region

Region	n	Pre Wavier (%)	Post wavier (%)	Percent Change
18	110	30.9	26.2	-4.7
1	325	23.9	25.7	1.8
7	117	34.7	37.8	3.1
4	175	29.8	33.8	4.0
12	116	25.5	30.4	4.9
13	108	43.9	52.2	8.3
9	117	21.4	29.8	8.4
14	112	37.3	48.9	11.6
15	112	18.8	34.9	16.1
17	117	37.1	55.3	18.2
16	116	31.9	50.7	18.8
6	112	13.6	33.8	20.2*
5	116	26.1	46.8	20.7*
10	400	23.7	44.6	20.9***
3	117	21.7	43.7	22.0
2	113	15.6	38.2	22.6**
11	111	20	48.5	28.5**
8	117	26.4	55.6	29.2**

*p<.05, p<.01, p<.001

While region 18 had a decrease in percentage of caregivers with domestic violence issues, all other regions saw an increase from pre to post wavier years. Regions 8, 11, and 2 had the highest gains (p<.001) from pre to post waiver years. Regions 6, 5, and 10 also had significant increases. Regions 8, 17, and 13 had the highest percentages just above 50% in the post waiver years. Those regions with the lowest percentage in post waiver years were 1 and 18 on opposite ends of the state.



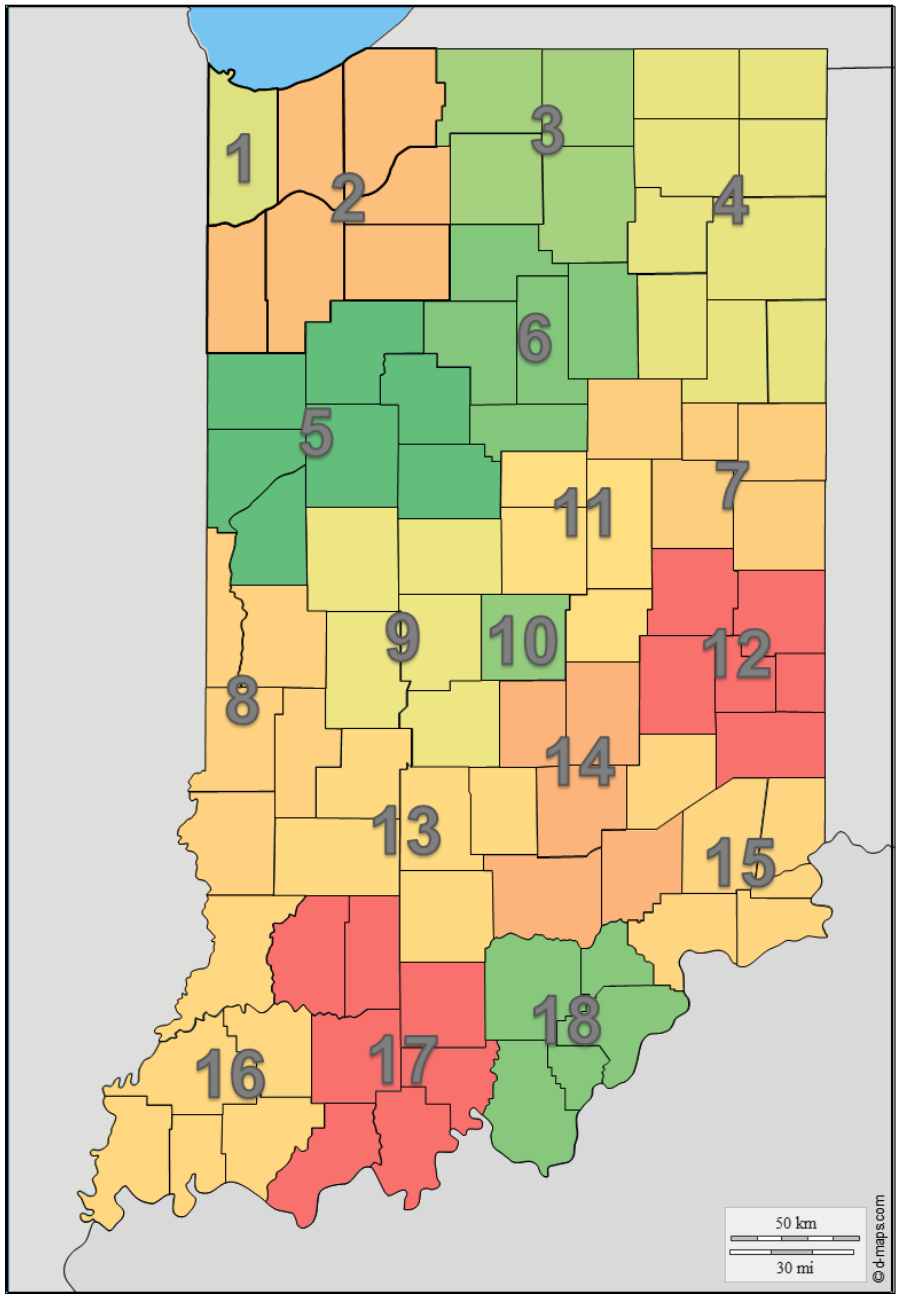
Caregiver Spousal Abuse/Family Violence

Percent change in Caregiver Spousal Abuse/Family Violence pre vs. post Waiver from the QSR by Region

Region	n	Pre Waiver (%)	Post Waiver (%)	Percent Change
7	117	11.1	11.1	0.0
4	175	13.5	15.5	2.0
18	110	14.7	16.7	2.0
1	325	10.4	13.6	3.2
2	113	6.7	10.3	3.6
10	400	9.7	14	4.3
9	117	10.0	14.9	4.9
6	112	4.5	13.2	8.7
12	116	8.5	17.4	8.9
13	108	7.3	19.4	12.1
15	112	8.7	20.9	12.2
5	116	13.0	25.5	12.5
16	116	12.8	26.1	13.3
8	117	18.1	33.3	15.2
11	111	2.2	19.7	17.5*
14	112	13.4	31.1	17.7*
17	117	5.7	25.5	19.8**
3	117	6.5	26.8	20.3**

*p<.05, p<.01, p<.001

While region 7 remained the same, all other regions saw an increase in the percent of caregiver spousal abuse/family violence from pre to post wavier years. Regions 3, 17, 14, and 11 had the highest gains (p<.05) from pre to post waiver years. Regions 8 and 14 had the highest percentages just above 30% in the post waiver years. Those regions with the lowest percentage in post waiver years were 2 and 7.



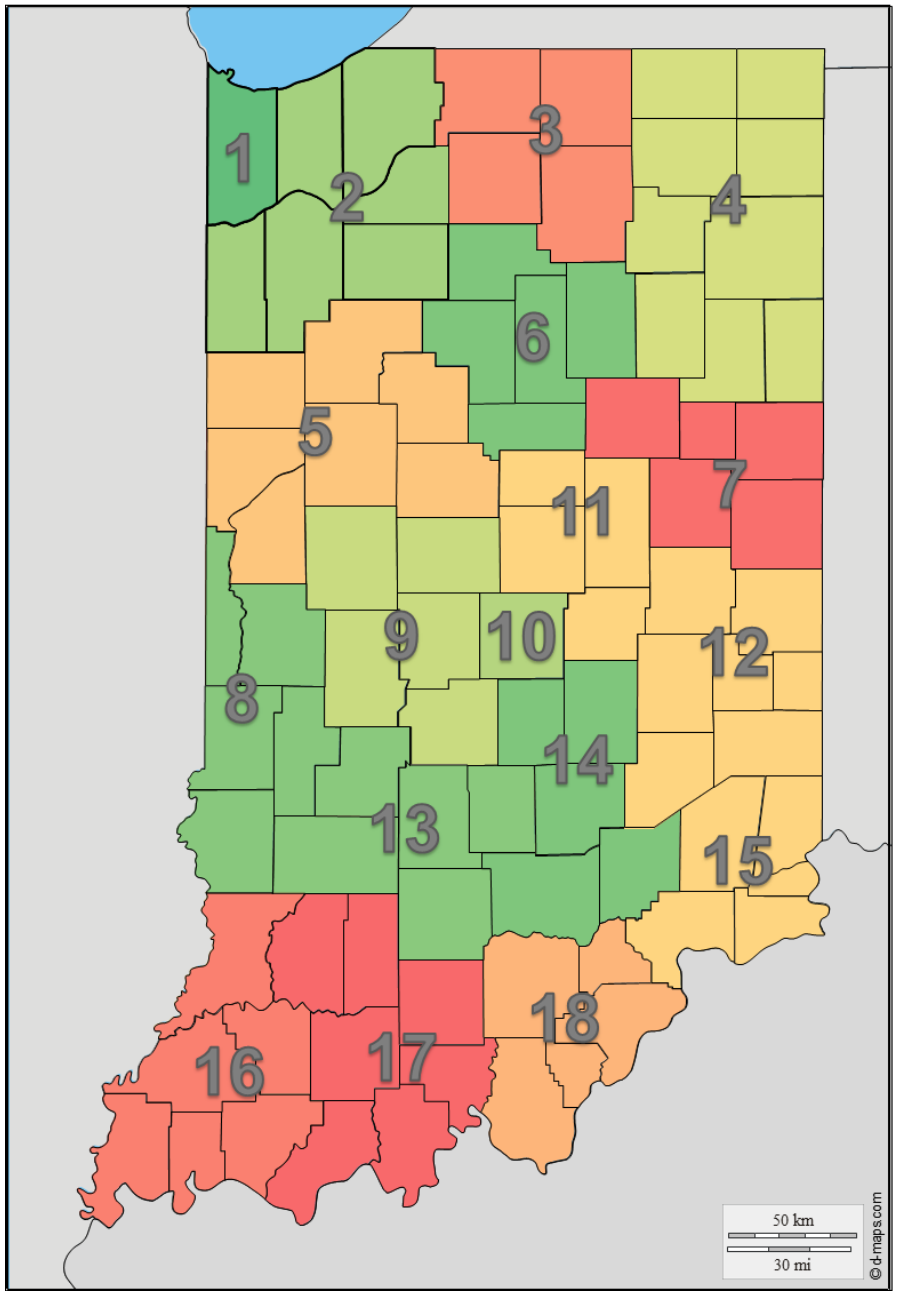
Inadequate Housing

Percent change in those Caregivers with Inadequate Housing pre vs. post Waiver from the QSR by Region

Region	n	Pre Wavier (%)	Post wavier (%)	Percent Change
5	116	33.3	27.7	-5.6
12	116	34.0	30.4	-3.6
6	112	27.3	25.0	-2.3
18	110	27.9	26.2	-1.7
10	400	29.5	29.0	-0.5
3	117	23.9	25.4	1.5
1	325	19.4	26.7	7.3
4	175	24.0	32.4	8.4
9	117	22.9	31.9	9.0
11	111	17.8	30.3	12.5
13	108	12.2	25.4	13.2
16	116	25.5	39.1	13.6
8	117	23.6	37.8	14.2
7	117	20.8	35.6	14.8
2	113	15.6	32.4	16.8
14	112	32.8	51.1	18.3
17	117	12.9	40.4	27.5**
15	112	20.3	48.8	28.5**

*p<.05, p<.01, p<.001

Some regions (5, 12, 6, 18, and 10) had a decrease in caregivers with inadequate housing, the majority of regions saw an increase from pre to post wavier years. Regions 15 and 17 had the highest gains (p<.01) from pre to post waiver years. Regions 14 and 15 had the highest percentages around 50% in the post waiver years. Those regions with the lowest percentage in post waiver years were 6, 3, and 13.



Legal Problems

Percent change in those Caregivers with Legal Problems pre vs. post Waiver from the QSR by Region

Region	n	Pre Wavier (%)	Post wavier (%)	Percent Change
1	325	12.7	9.9	-2.8
6	112	36.4	35.3	-1.1
14	112	43.3	42.2	-1.1
8	117	36.1	35.6	-0.5
13	108	31.7	31.3	-0.4
2	113	35.6	36.8	1.2
10	400	23.2	25.4	2.2
9	117	32.9	36.3	3.4
4	175	21.2	25.4	4.2
11	111	33.3	42.4	9.1
12	116	29.8	39.1	9.3
5	116	27.5	38.3	10.8
18	110	20.6	33.3	12.7
3	117	23.9	40.8	16.9
16	116	23.4	42.0	18.6*
15	112	23.2	41.9	18.7
7	117	30.6	51.1	20.5*
17	117	25.7	46.8	21.1*

*p<.05, p<.01, p<.001

Some regions (1, 6, 4, 8, and 13) had a slight decrease in caregivers with legal problems, the majority of regions saw an increase from pre to post wavier years. Regions 17 and 7 had the highest gains (p<.05) from pre to post waiver years and the highest percentages in the post waiver years. Those regions with the lowest percentage in post waiver years were 1, 9, and 10.

Process Study

The process study comprises the 2012 Waiver story and changing perceptions of key stakeholders within DCS over the demonstration period. The Waiver story consists of the mid-course correction and establishment and expansion of CQI, including use of a new service-mapping tool within DCS as well as the increase in use of concrete services. Regional managers, Family Case managers, caregivers, court professionals, and service providers all provided input on key questions surrounding the Waiver. Specifically, they were able to rate DCS services and staff as well as provide feedback on the need, availability, utilization, and effectiveness of services. This section will provide executive summaries of the regional manager interviews over four years of the demonstration, FCM surveys distributed in all five years of the demonstration, service provider, court professional, and caregiver/youth surveys distributed in 2013 and 2015.

CQI in Child Welfare Practice

From Summative to Formative

In the first year of the evaluation, DCS consistently used the phrase, "simply a funding mechanism" to refer to the Waiver and focused solely on making service enhancements. The original idea was that the role of the evaluator in the 2012 Waiver would be similar to the previous demonstration. The prior Waiver demonstration was evaluated in a summative manner without in-depth work with DCS on a day-to-day level.

Judge Mary Beth Bonaventura was named as the new director of DCS on January 30, 2013. When Judge Bonaventura was appointed, it was clear that the 2012 Waiver demonstration and its evaluation would take a new direction. DCS executives solicited assistance from Casey Family Programs to get the ball rolling on this "mid-course correction." Through meetings with Casey Family Programs, DCS began to better articulate what the Waiver was intended to do and what practice would look like without the flexibility of the 2012 Waiver. This new articulation and understanding led DCS, along with Casey and the IU Evaluation Team, to begin to align the Waiver with the DCS Practice Model, five-year strategic plan, and family services plan goals, objectives, and interventions. The Waiver can now be articulated as a funding mechanism with practice implications. In this way, the Waiver aligns with the agency's efforts for CQI.

The Five Year Strategic Plan has four major goals:

1. **Ensure the safety of Hoosier children through informed decision-making beginning at the initial assessment.**
2. **Promote safe, timely, and stable permanency options for children.**
3. **Ensure the well-being of Hoosier children by integrating a trauma-informed care approach to child welfare practice.**
4. **Promote a culture of learning whereby staff persons at all levels of the agency consider ways to improve practice, programs and policy.**

Goal four supports a culture of CQI within the agency. CQI can be thought of as the philosophy, policy, programs, and practices that drive and monitor continued efforts to support and maintain quality practice on behalf of children and families in Indiana. At the core of the CQI approach is the development of an organizational culture that supports continuous learning. DCS recognizes the need and value of integrating qualitative and quantitative data to provide a more comprehensive view of the agency's strengths and areas for improvement. Data gathered, analyzed, and shared for the Wavier evaluation support CQI efforts and permits DCS to make necessary changes to policy, programs, and practice through data-informed decision-making. The Waiver serves as a tool for targeted system improvements. The flexibility of the Waiver allows DCS to stay anchored in a general theory of change on behalf of children and families in Indiana and drives this general theory of change toward more specific initiatives that support the DCS Practice Model.

The DCS practice model was founded in 2005 on five core competency areas: Teaming, Engaging, Assessing, Planning and Intervening (TEAPI). The practice model incorporates an approach which includes engaging families, teaming and planning with families, and supporting families when possible, while still holding parents accountable for their children. This model operates through Child

and Family Team (CFT) Meetings, in which a DCS FCM facilitates an individualized team, including the family members, informal supports, and relevant service providers that reviews strengths, risks, and needs and develops and monitors the implementation of a collaborative service plan.

Organizing CQI in Practice

DCS and the IU Evaluation Team have conceptualized how CQI will be organized and executed within the agency. This takes a great deal of commitment from all parts of the Executive Team. The Central CQI Team is comprised of key Executive staff representing all areas of the Department from field to fiscal staff. This Central CQI Team meets bi-weekly for at least two hours per meeting. Up to this point, the primary goal of these meetings has been to document CQI initiatives and opportunities for each of the objectives listed in the DCS Child and Family Services Plan. All work completed or initiated for each objective and intervention, as well as responsible staff for that objective or intervention has been documented. For objectives and interventions that have not yet been initiated, the Central CQI Team is responsible for creating a priority level and timetable so that the objective or intervention is completed within the five-year period. The Central CQI Team desires a two-way exchange, whereby CQI needs and efforts are brought from the field to the Central CQI Team, and decisions and efforts at the Central CQI level are funneled down to the field. The Central CQI Team is committed to continuing these working meetings and formally disseminating findings and information to mid-level and field staff in an effort to be more transparent within the Department and to support data-driven decisions in practice.

CQI Readiness Survey

As part of the CQI selection of pioneer regions to begin CQI projects, the CQI team developed a survey to assess how ready each Region is for a CQI process. The survey was programmed and analyzed by the IU Evaluation Team. DCS sent an email to roughly 430 Regional Managers, Local Office Directors, and Supervisors in each region with one reminder follow-up email two week after the launch. The survey was launched on May 31st with the last respondents completing on June 21st.

Respondents

378 surveys were completed and usable for analysis purposes. Respondents consisted of supervisors, local office directors, division managers, and regional managers across 18 regions. Approximately, 40% (n = 148) of the respondents reported that they have worked with DCS for 6-10 years, followed by more than 20 years (19.7%) and 3-5 years (18.6%). A complete listing of the frequencies can be found in Table 28.

Table 28. Respondents' years of working experience

Years of work experience	*Frequency*	*Percent*
0-2 years	2	.5
3-5 years	70	18.6
6-10 years	148	39.4
11-15 years	51	13.6
16-20 years	31	8.2
More than 20 years	74	19.7
Total	**376**	**100**

Measures of CQI Readiness

The CQI Readiness survey includes a total of 29 items that ask respondents to evaluate various aspects of the CQI readiness for management on the four-point Likert scale (1= strongly disagree to 4 = strongly agree). One item was reverse coded because it reflects poor readiness: "Decisions made by people tend to be the reason something goes wrong in a case." Figure 3 displays the average ratings of the CQI readiness. The average ratings ranged from 2.39 to 3.22 across the items, with the total average score of all the items of 2.86 (SD = .33). This suggests that respondents, on average, agreed with the most questions.

- The top five highest ranked items were:
  1. *I am encouraged to use MaGIK reports to improve the way we do our work* (M = 3.22, SD = .54);
  2. *Overall, I am motivated to find ways to improve the way I do my work* (M = 3.16, SD = .58),
  3. *I know how to analyze (review) the quality of my staff's work to see if changes are needed* (M = 3.12, SD = .44),
  4. *I know how to measure the quality of my staff's work* (M = 3.09, SD = .48), and
  5. *Our staff members cooperate and work as a team to solve problems* (M = 3.06, SD = .62).
- In contrast, the five lowest ranked items were:
  1. *When creating statewide changes in our current policies, I know how I can provide input* (M = 2.39, SD = .76);
  2. *Decisions made by people tend to be the reason something goes wrong in a case* [Reversed coded] (M = 2.49, SD = .61);
  3. *Overall, the leaders in DCS care about me and my development* (M = 2.50, SD = .75);
  4. *In recent memory, I have received recognition and/or praise for doing good work* (M = 2.51, SD = .75); and
  5. *When something goes wrong, we look at what may have gone wrong in the process first* (M = 2.63, SD = .68).

Figure 23. Average State Rating of the CQI Readiness

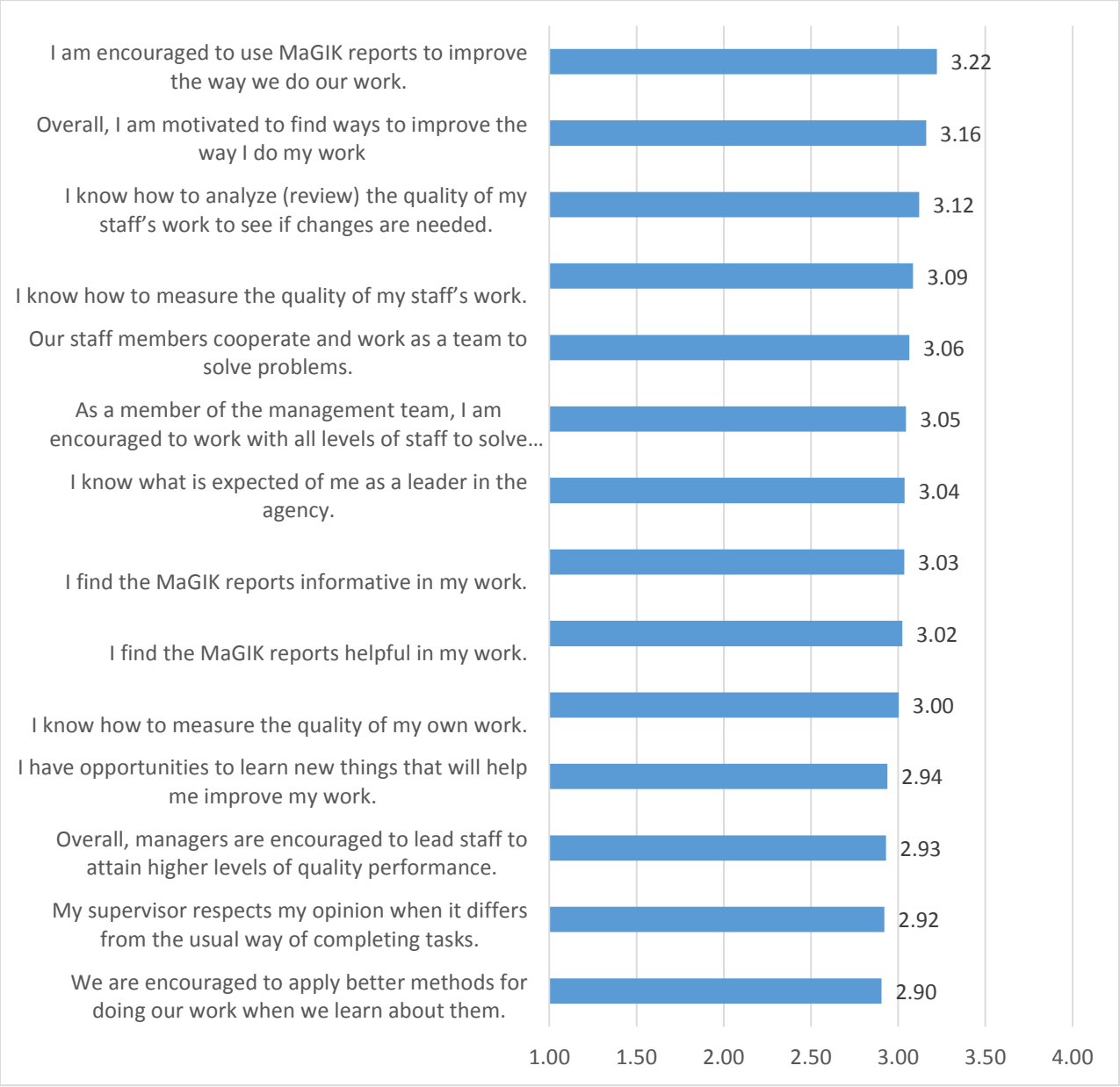


Figure 23 (continued). Average State Rating of the CQI Readiness

Table 24. Readiness by Region

Region	Number	Overall CQI Mean (1-4 Range)	Std. Deviation
Region 17	13	3.08	0.39
Region 8	8	3.01	0.34
Region 15	17	2.99	0.34
Region 2	12	2.98	0.21
Region 5	14	2.96	0.20
Region 7	11	2.96	0.51
Region 16	29	2.96	0.31
Region 12	9	2.93	0.20
Region 18	16	2.92	0.26
Region 14	17	2.91	0.35
Region 4	42	2.89	0.24
Region 9	11	2.88	0.20
Region 11	16	2.86	0.29
Region 13	15	2.86	0.24
Region 6	10	2.80	0.41
Region 3	19	2.77	0.19
Region 1	28	2.73	0.45
Region 10	45	2.73	0.39
Total	332	2.88	0.33

CQI Readiness Summary

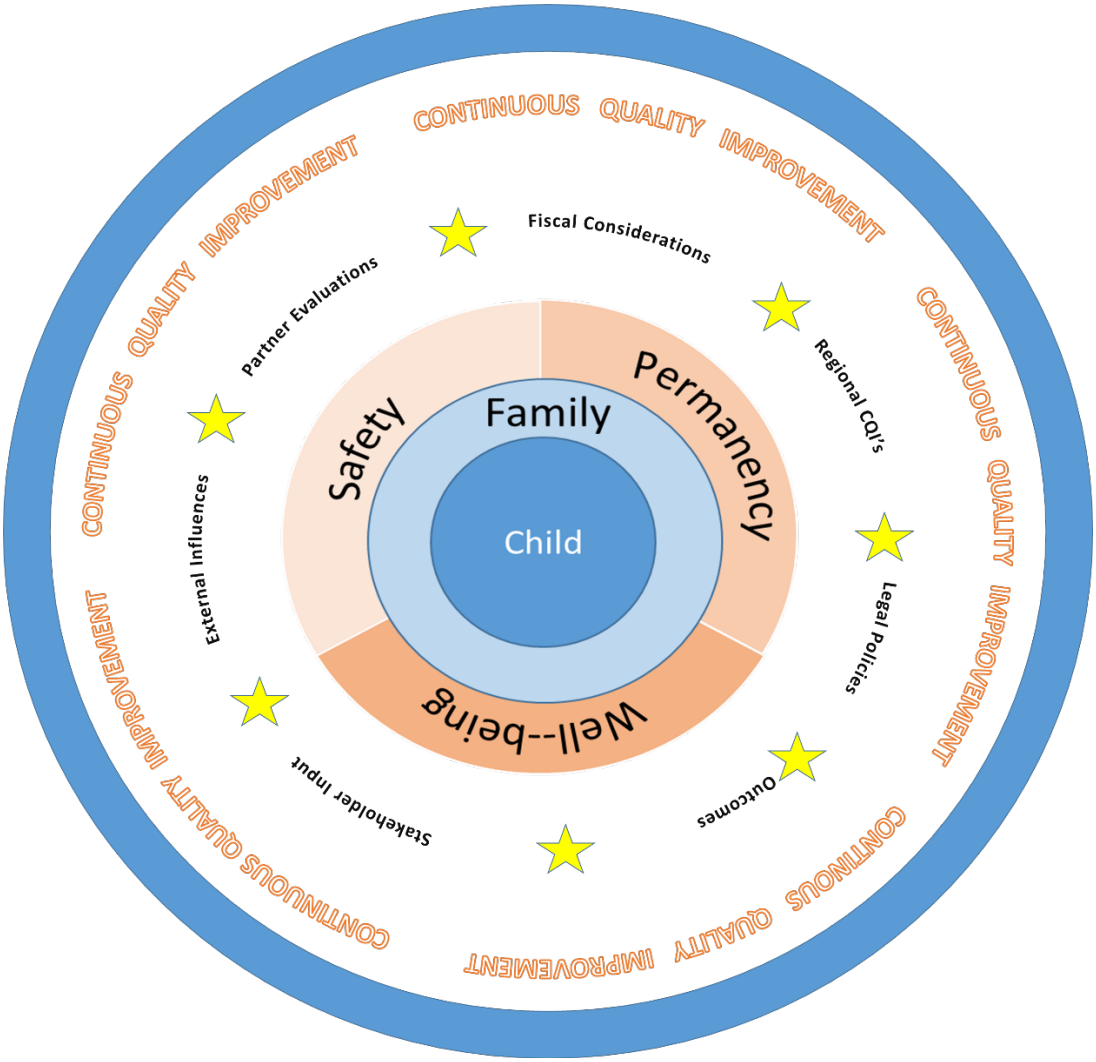
These data assisted in the selection of CQI pilot projects in pioneer regions. During the demonstration period, the Continuous Quality Improvement Division, with support from the Innovation Strategy Group, continued development of a three-stage training and mentorship initiative to deliver CQI experience to all levels of the organization. The first stage was learning about the agency's CQI structure, purpose, tools used in decision-making, and where the participant fits into the overall need to continuously examine and improve the work that DCS does. The second stage consisted of classroom delivery of tools and overall CQI methodology complete with robust field examples and experiential learning which then prepares the learner to take an active role in leading projects and initiatives with expert guidance and mentorship from staff in the CQI Division. The third stage had the staff member actively lead an actual CQI project with Six Sigma certified staff aiding in the learner's development and shepherding the project from start to completion.

The CQI Division discussed how CQI would operate, provide support, and monitor CQI in the large agency with many projects with many people and parts moving forward to improve processes and outcomes. There have been focused discussions around how to best articulate CQI throughout the entire agency. In quarter 4 of Indiana SFY 2017, DCS established the Innovation Strategy Group. This

group has the mission to oversee, coordinate, and measure outcomes of agency-wide strategic, improvement, and large change initiatives as well as aiding in the replication of positive change from smaller initiatives like those which might be regionally-based projects.

Staff from the Continuous Quality Improvement Division have been assigned to the larger, agency-wide initiatives as well as aiding the efforts of Field Operations based upon their already-existing regional assignments. They will be tasked with aiding process owners in exploration of potential improvements and delivery of recommendations for positive change. All activities will be tracked in a cloud-based project management and operational excellence platform called EON. EON allows real-time updates of all things process improvements at any level of the organization.

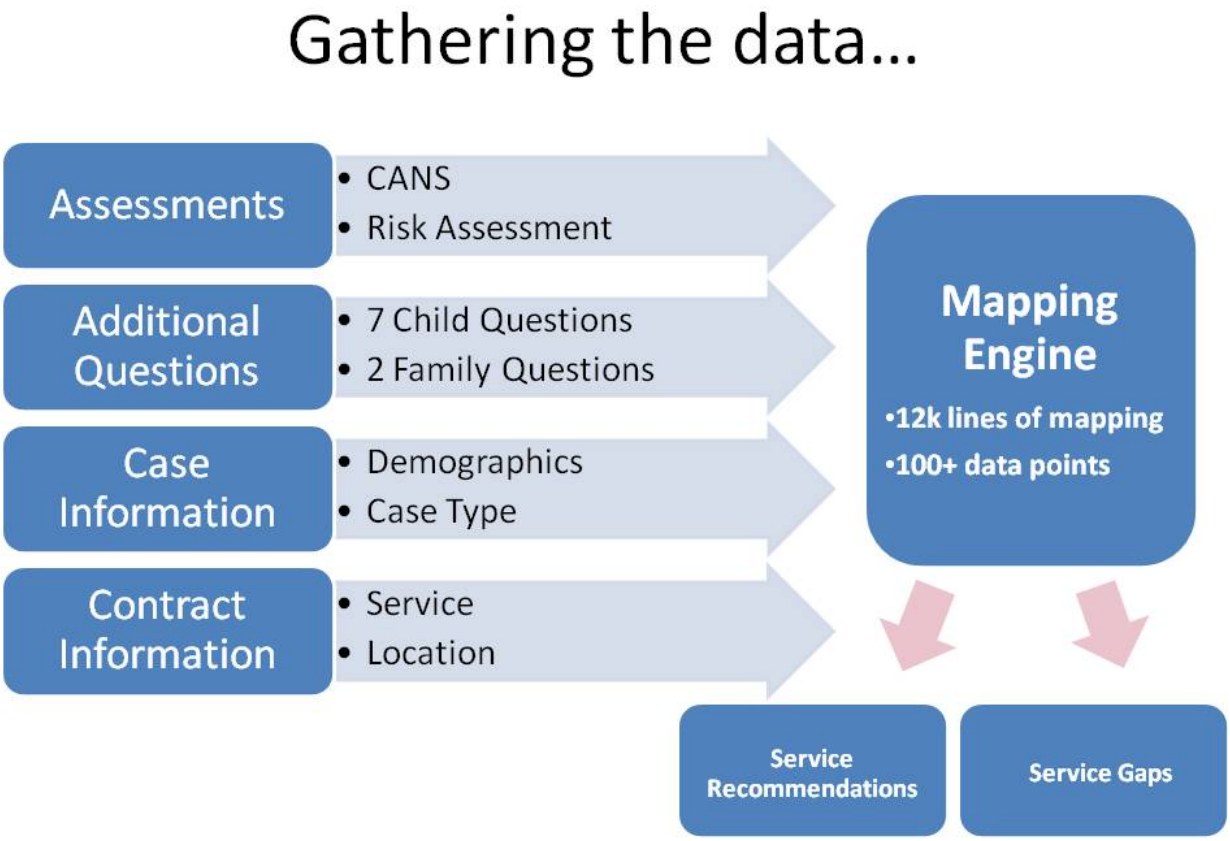
Figure 25. CQI drivers and outputs



Service Mapping

One of the most important products developed as a result of the Waiver was service mapping. Indiana is in the fortunate position, as a result of the Waiver, of being able to greatly enhance its community based service array. Indiana has chosen to do this by enhancing the service array with multiple evidence-based practice models. With this expansion, and each evidence-based practice having a specific target population, the service array has become too complex to utilize traditional service referral methods, thus necessitating a more complex system of making referrals. Service mapping provides an electronic service consultant, allowing even inexperienced FCMs to make quality service decisions. The system reduces the use of cookie cutter services, by utilizing assessment and other information to recommend services for families based on their individual circumstances, improving the chances for positive outcomes.

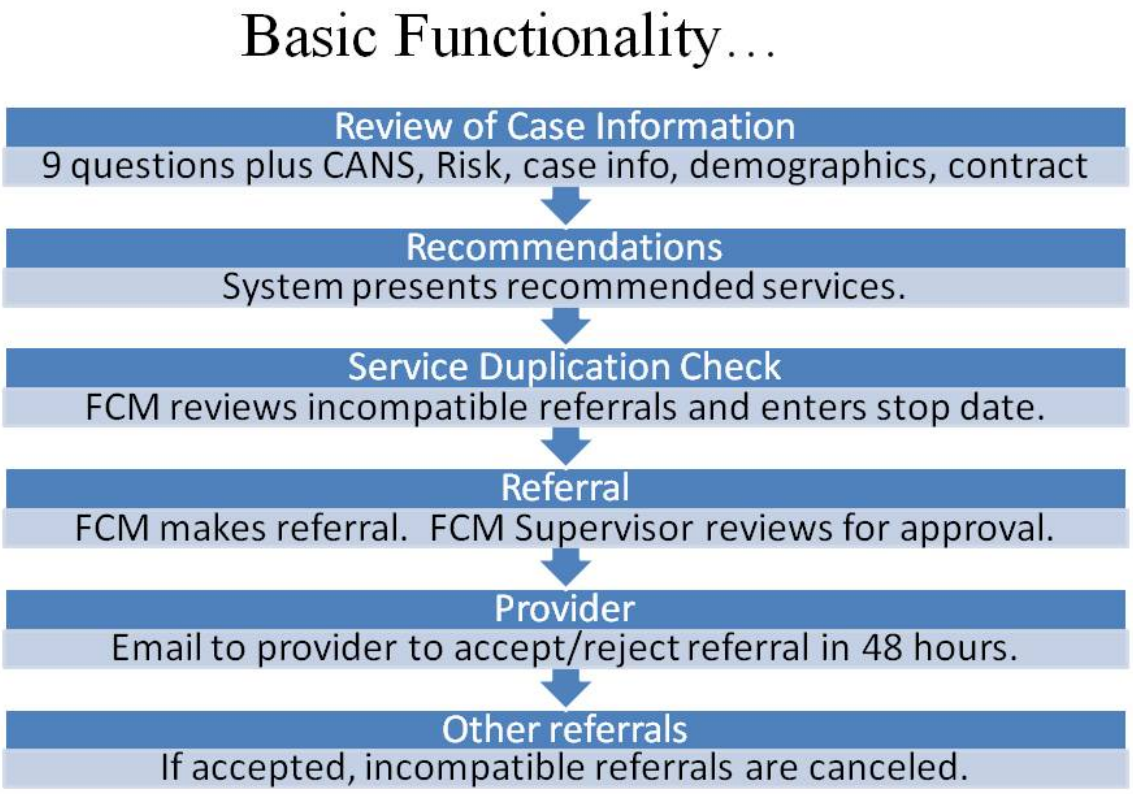
Figure 26. Gathering the Data



The system utilizes information from the Child and Adolescent Needs and Strengths (CANS) assessment as well as the Structured Decision Making tool for Risk Assessment. In addition the FCM is asked seven questions about each child and two questions about the family. This information is then paired with the

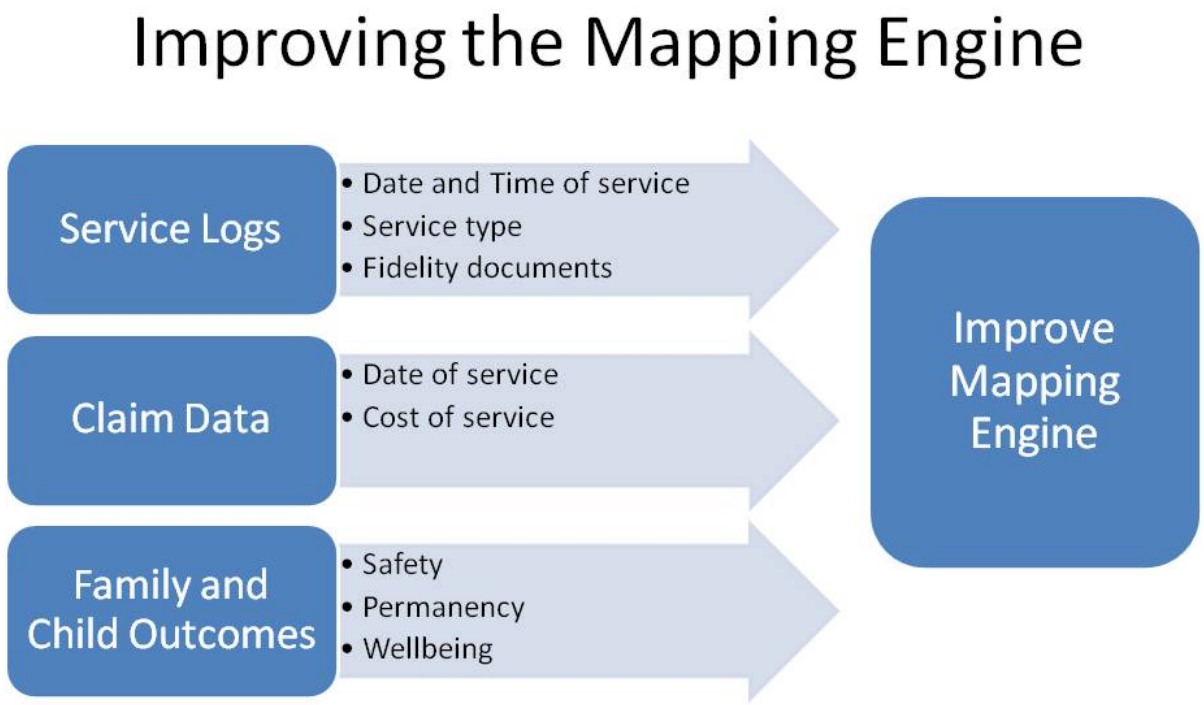
case information (demographic characteristics, case type, & other information) and contract information to produce service recommendations for the family. The Mapping Engine utilizes more than 100 data points in order to determine individualized services for families. There are more than 12,000 different ways for a family to map to a service. In addition to Service Recommendations, the Mapping Engine provides information about service gaps; essentially summarizing what services would have been mapped had they been available in the community.

Figure 27. Basic Functionality



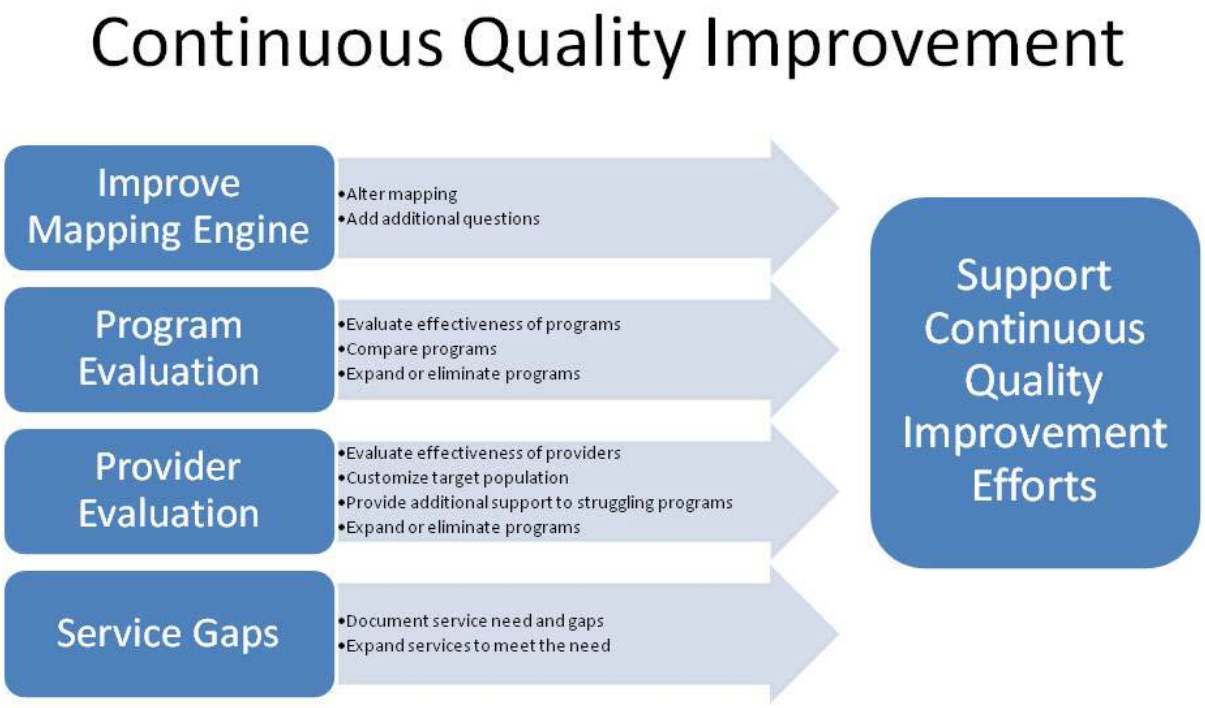
The basic functionality includes gathering information and providing a recommendation. Also, to ensure service duplication is minimized, the system checks to see what other services are being provided at the time a new referral is initiated. These duplicative referrals are canceled in the system if the provider accepts the referral in the system within 48 hours. Providers, FCMs, and Supervisors are notified via email of the referral progress as it moves through the system (e.g., when the referral is sent to the provider via email, when the provider accepts or rejects the referral, when the duplicative referrals are canceled).

Figure 28. Improving the Mapping Engine



Several other systems work in conjunction with the Mapping Engine. Service Logs were developed to provide detailed data on the actual service provision, including the date and time of service, the type or category of service being provided, as well as any fidelity documents or milestones that pertain to the model. Claim data will also be utilized to show the cost of the service provision. Family and child outcomes in the areas of safety, permanency, and well-being will be utilized as well to improve the Mapping Engine and ensure the families are matched to the most appropriate services.

Figure 29. CQI and Service Mapping



Service Mapping is a critical part of the Continuous Quality Improvement of services. As DCS makes improvements, the focus will be on the outcomes of children, youth, and families. The Mapping Engine will be altered as more information becomes available as to the success of the families involved in the various services. The mapping may be altered to provide alternative recommendations for families who are not successful in the recommended services. Additional questions may be added to determine more information about families to improve service recommendations.

Programs will be evaluated to determine the effectiveness of programs with specific target populations. The FCT Sub-study is one example of how program evaluation is tied to service mapping. Results from this study may expand or eliminate programs or alter the target population served by specific evidence based practices. In addition to evaluating at the program level, DCS will evaluate at the provider level. This information will allow for comparison between providers. This could lead to further refinement of the target population by service provider, further support and training of the provider, or elimination or expansion of some service provider services.

Service gaps will be identified and closely monitored. This information will assist DCS as regional needs assessments are completed to develop the Biennial Regional Services Strategic Plans. The plan could lead to an expansion or elimination of services in a particular county or region.

Concrete services

The utilization of concrete services may have changed since the beginning of the 2012 Waiver demonstration period. Given the expanded flexibility of the Waiver, the hypothesis was that the availability and use of concrete services would better support safety, permanency, and well-being in new and creative ways. This CQI initiative was the first requested by the Executive Team to the IU Evaluation Team (although a clear central CQI approach had not yet been articulated). As part of the Process Study component of the evaluation, the IU Evaluation Team examined concrete services through a State data management system, KidTraks. These data are provided in this section of the report.

Methods

Concrete services disbursement data were collected from DCS' KidTraks system from SFY 2011 through SFY 2017. Using the end date of the service, disbursements were analyzed by state fiscal year rounding to the nearest dollar.

Description of Services

General Products:

Birth certificates, car seats, children's bed and bedding, death certificates, initial and ongoing clothing, medications, school supplies, and other products

General Services:

Burial of wards, dental, GED/skills based programs, summer school, tutoring, emergency support systems, medical expenses, non- contracted services, transportation of parent, transportation of child, respite, placement transition visits, and recreation activities

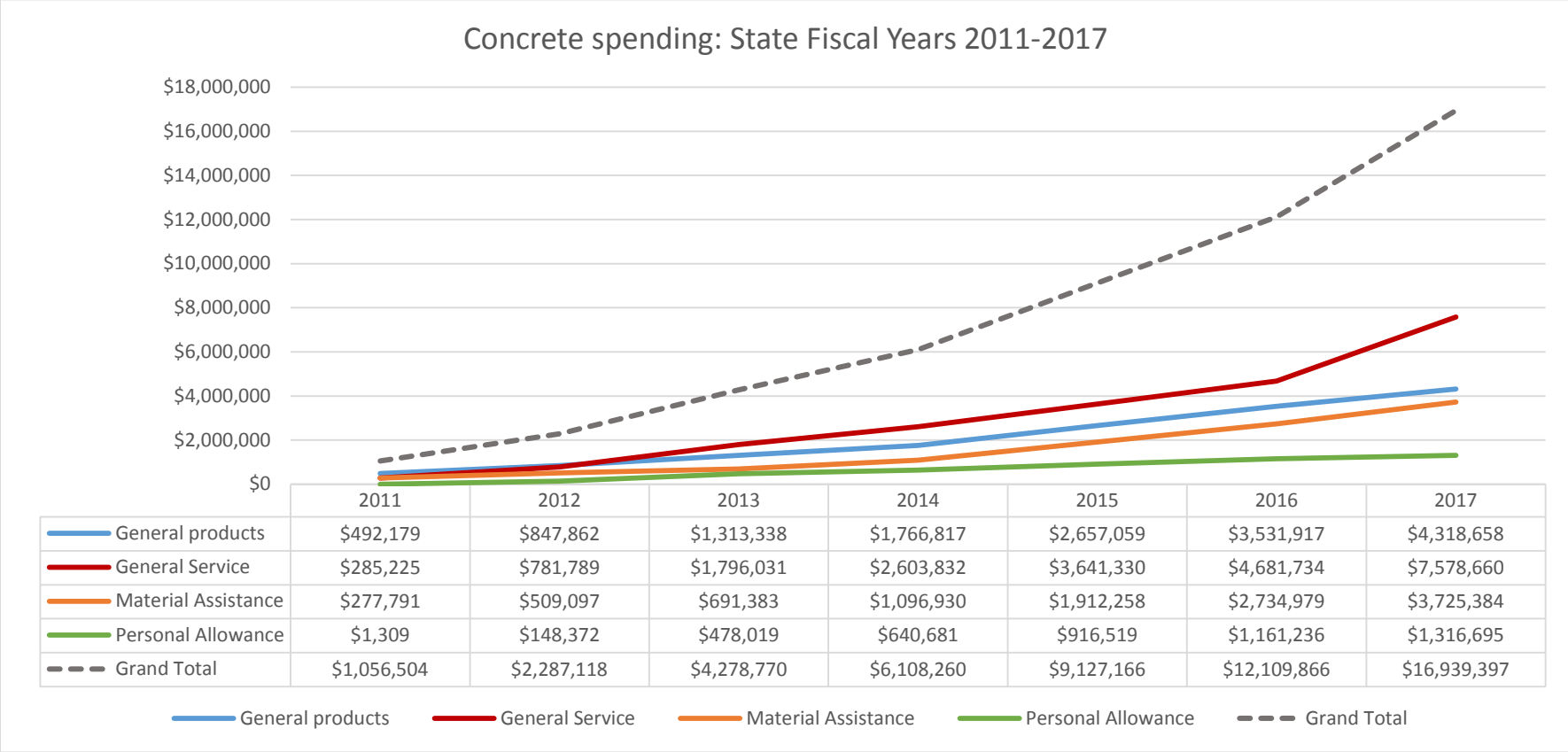
Material Assistance:

Day care services, rent, utilities, and pest control

Personal Allowance:

All other extracurricular activities, application fees, birthday allowance, computer/electronic devices, driver's education, dues, class pictures, field trips, internet classes, preschool, community center dues, lessons, parking/tolls/bus passes, musical instruments, summer camp, team sport league fees, uniforms, sporting equipment, graduation items, high chair/baby equipment, holiday allowance, prom items, special circumstance, special event, special occasion clothing, special programs, and sport team costs

Figure 30. Concrete Service Pre- and Post- Waiver



	2011	2012	2013	2014	2015	2016	2017
General products	$492,179	$847,862	$1,313,338	$1,766,817	$2,657,059	$3,531,917	$4,318,658
General Service	$285,225	$781,789	$1,796,031	$2,603,832	$3,641,330	$4,681,734	$7,578,660
Material Assistance	$277,791	$509,097	$691,383	$1,096,930	$1,912,258	$2,734,979	$3,725,384
Personal Allowance	$1,309	$148,372	$478,019	$640,681	$916,519	$1,161,236	$1,316,695
Grand Total	$1,056,504	$2,287,118	$4,278,770	$6,108,260	$9,127,166	$12,109,866	$16,939,397

	2011	2012	2013	2014	2015	2016
Total number of children with an open case on 9/30 in fiscal year	*16116*	*14521*	16344	18887	22146	26862
Total concrete service dollars divided by the number of children on 9/30	*65.56*	*157.50*	267.79	323.41	412.14	450.82

Concrete service spending in all categories increased over the demonstration period. SFY 2017 spending was 16,939,397 which was over 13.5 million more than the baseline years combined in 2011 (1,054,504) and 2012 (2,287,118). The largest spending increase occurred in general services, which surpassed general products spending starting in 2013. The details of each category are provided below in the following Tables.

Table 29. General Product Spending SFYs 2011-2017

GENERAL PRODUCTS	2011	2012	2013	2014	2015	2016	2017
Birth certificate	$387	$975	$611	$2,189	$3,668	$5,999	$4,942
Car Seat, upgrade or emergency	-	-	$5,854	$14,853	$32,215	$38,951	$47,046
Children's bed and bedding	$69,159	$251,351	$440,417	$653,241	$1,091,378	$1,593,493	$2,055,412
Initial clothing	$33,695	$276,701	$564,580	$760,044	$1,027,785	$1,188,001	$1,239,869
Clothing	-	-	$66,729	$114,619	$186,608	$208,502	$221,739
Ongoing clothing	$258,963	$211,447	$63,206	$127,958	$205,510	$304,478	$486,975
Death certificate	$6	$72	$40	$240	$138	$615	$191
Medications	$61,774	$30,066	$25,681	$13,450	$23,082	$4,849	$3,753
Other	$67,998	$77,212	$146,134	$80,223	$86,674	$187,029	$258,713
School Supplies	$197	$38	$85	-	-	-	$17
Grand Total	**$492,179**	**$847,862**	**$1,313,338**	**$1,766,817**	**$2,657,059**	**$3,531,917**	**$4,318,658**

Table 29 shows the changes in spending for general products pre- and post- Waiver. There were large increases in children's bedding and initial clothing. Spending for concrete service medications decreased over the demonstration period.

Table 30. General Service Spending SFYs 2011-2017

GENERAL SERVICE	2011	2012	2013	2014	2015	2016	2017
Burial of wards	$1,600	$4,802	$17,184	$12,559	$14,225	$13,728	$20,271
Dental	$25,531	$29,099	$41,725	$43,351	$52,002	$32,160	$29,718
Emergency shelter	$130	$291,982	-	-	-	$731	-
Education	-	-	-	-	-	-	-
GED/Skills based program	-	-	$503	$3,154	$533	$9,902	$860
Summer school/programs	$270	$300	$3,390	$4,071	$7,056	-	$16,018
Tutoring	$150	$1,975	$4,028	-	-	-	-
Emergency support services	$64,972	-	$651,904	$769,629	$810,539	$583	-
Medical expenses	$147,636	$127,777	$343,324	$147,567	$184,099	$157,999	$128,788

Non-contracted community based services (court ordered or appeal required)	-	-	$182,406	$50	$999	$610	$1,300
Non-contracted services	-	$245	$8,182	$922,167	$1,621,050	$3,472,846	$6,440,229
Parental travel for:							
Other	$1,941	-	-	$32,772	$52,664	$53,254	$54,495
Visitation	-	$30,100	$53,536	$65,558	$83,450	$62,475	$58,835
Placement transition visits	-	-	$3,132	$5,535	$14,532	$7,342	$5,949
Recreation activities	$2,154	$465	$2,753	$15,686	$3,195	$840	$341
Respite	-	$5,754	$2,730	$1,384	$1,700	$919	$1,425
Respite - Unlicensed relative	-	-	$3,875	$6,534	$15,358	$20,074	$19,761
Transportation of the child	$40,840	$289,289	$477,359	$573,280	$770,264	$844,431	$796,212
Tutoring Non-contracted provider	-	-	-	$536	$9,665	$3,838	$4,457
Grand Total	**$285,225**	**$781,789**	**$1,796,031**	**$2,603,832**	**$3,641,330**	**$4,681,734**	**$7,578,660**

Table 31. Material Assistance Spending SFYs 2011-2017

MATERIAL ASSISTANCE	2011	2012	2013	2014	2015	2016	2017
Day care services	$168,669	$209,510	$371,908	$664,797	$1,167,295	$1,851,689	$2,552,075
Pest control	$1,470	$6,806	$18,809	$15,806	$64,761	$100,176	$193,557
Rent assistance	$80,385	$185,442	$188,269	$255,841	$405,947	$512,676	$658,081
Utilities	$27,267	$107,338	$112,397	$160,486	$274,256	$270,439	$321,671
Grand Total	**$277,791**	**$509,097**	**$691,383**	**$1,096,930**	**$1,912,258**	**$2,734,979**	**$3,725,384**

Table 31 demonstrates increases in Material Assistance spending from pre-Waiver to the current year. This spending represents assistance to families who need pest control or rent assistance to maintain a child in the home or to provide for upgrades in the current home to accommodate reunification efforts.

Table 32. Material Assistance Spending SFYs 2011-2017

PERSONAL ALLOWANCE	2011	2012	2013	2014	2015	2016	2017
All other extra-curricular activities/fees	$254	$10,792	$22,773	$40,353	$60,535	$83,494	$100,370
Application fees	$100	$437	$1,094	$1,408	$825	$1,431	$1,746
Birthday allowance	$100	$37,104	$88,037	$99,255	$114,290	$133,220	$138,759
Car seat upgrade or additional need	-	-	$8,809	$25,733	$19,155	$16,994	$5,288
Computer hardware/software/device	-	-	$14,259	$72,520	$163,939	$196,710	$214,594
Driver's education	-	$820	$3,060	$4,616	$4,124	$8,078	$7,156
Dues	-	$2,245	$811	-	-	-	$35
Education							
Class Pictures	-	-	$1,353	$4,567	$5,923	$6,227	$6,960
Field trips	-	-	$1,974	$5,193	$4,733	$8,747	$12,034
Internet classes	-	-	$112	-	-	$50	-
Preschool	-	-	$2,877	$5,329	$8,029	$10,429	$7,879
Extra-Curricular Activities							
Community center and dues	$200	$942	$3,789	-	$24	$46	$136
Lessons	-	$5,251	$15,951	$21,025	$27,428	$31,350	$36,692
Parking/tolls/bus passes	-	-	$590	$540	$2,123	-	$764
Musical instrument	-	$953	$1,698	-	$98	$1,572	$67
Summer camp	$200	$17,703	$36,878	$48,062	$61,596	$56,411	$59,463
Team sport league fees	-	-	$14,574	$31,146	$35,669	$59,121	$62,058
Uniforms	-	$1,668	$3,058	$48	$40	$90	$60
Sporting equipment	$42	$5,205	$4,481	$24	$206	$697	$589
Graduation items	-	$4,122	$6,602	$5,229	$4,590	$4,306	$5,440
High chair/baby equipment	-	$120	$6,568	$27,013	$38,350	$41,554	$50,444
Holiday allowance	-	$121	$116,391	$132,118	$157,190	$179,317	$189,809
Prom items	$100	$8,063	$6,899	$6,041	$8,775	$8,722	$8,369

PERSONAL ALLOWANCE (continued)	2011	2012	2013	2014	2015	2016	2017
Special circumstance (other)	$213	$36,734	$91,268	$91,088	$176,912	$284,998	$363,700
Special event	-	$3,144	$7,825	$12,995	$16,759	$21,527	$36,854
Special occasion clothing	-	$7,149	$6,795	$87	-	$138	$97
Special programs	$100	$1,354	$6,222	$6,162	$5,095	$6,005	$7,208
Sports team costs	-	$4,444	$3,270	$130	$110	-	$125
Grand Total	**$1,309**	**$148,372**	**$478,019**	**$640,681**	**$916,519**	**$1,161,236**	**$1,316,695**

Table 32 represents increases in personal allowance spending from pre to current Waiver year. Many of these allowances are used to improved well-being of children who are in care such as camp or extracurricular activity expenses. In some instances, it pays for driver education, prom, or school pictures for older youth.

Regional and Executive Manager Interviews

Method

The IU Evaluation Team conducted interviews with the Indiana DCS Regional and Executive Managers from 2013-2016. Details of each round of analyses and their findings are presented along with comparison in the final year to describe the change in perceptions over the years.

The purpose of this analysis was to analyze data from semi-structured, qualitative interviews with DCS Regional and Executive Mangers regarding their histories with DCS, the regions and areas they manage, and their perceptions and experiences related to the 2012 Waiver in each year of the Waiver demonstration period.

The framework for the analysis is case study. Case study methods are not as explicit as some other forms of qualitative research and the subject matter can vary greatly. A case can be a village, a neighborhood, a community, a program, etc. and is often made up of many smaller cases, including the stories of multiple, specific individuals. Case study research involves the study of an issue explored through one or more cases within a bounded system (such as a setting or context) over time through detailed, in-depth data collection, involving multiple data sources. The product of case study research involves a report of a case description and case-based themes. This analysis is considered a collective case study, making use of multiple cases (Regional and Executive Managers) to illustrate an issue (the 2012 Waiver) within the bounded context of the Indiana DCS from 2013-2016.

While in qualitative research, face-to-face interviews are preferable to other forms of communication; telephone interviews for this study became necessary due to time and distance constraints.

Research Questions

Evaluators used a semi-structured interview schedule that changed each year based on progression of knowledge about the Waiver. Interviews ranged in length from 30 to 90 minutes in general. General interview topics included Managers' background information, region-specific qualities and services, and the 2012 Waiver. Interview questions were designed to elicit information regarding Managers' tenure and roles with DCS, regional strengths and needs, and knowledge, effects, and potential benefits of the 2012 Waiver. See table 33.

Ongoing yearly primary questions are:

- What are Regional/Executive Managers' perceptions of their roles & responsibilities?
- What are Regional/Executive Managers' perceptions of various components of regional/state child welfare practice?
- What are Regional/Executive Managers' perceptions of the 2012 Waiver?

Table 33. Research Questions by Data Collection Round

2013	2014	2015	2016
• What do RM/EM know about the 2012 Waiver? • How was information about the 2012 Waiver communicated to RM/EM? • What are RM/EM perceptions of the 2012 Waiver? • What gaps in knowledge exist regarding the 2012 Waiver?	• What challenges & positives do RM/EM experience in their roles? • What are the needs/strengths of each region? The state? • How do RM/EM perceive key relationships? • What are RM/EM perceptions about concrete services? • What do RM/EM know about the 2012 Waiver? • What are RM/EM perceptions of the 2012 Waiver?	• What challenges and positives do Managers experience in their positions? • What are the needs and strengths of each region? The state? • How do Managers perceive key relationships? • What are Managers' perceptions of concrete services? • What do Managers know about the 2012 Waiver? • What are Managers' perceptions of the 2012 Waiver? • What can Managers tell us about the role of experience in performing their duties? • How do Managers approach staff development?	• What challenges and positives do Managers experience in their positions? • What are the needs and strengths of each region? The state? • How do Managers perceive key relationships? • What are Managers' perceptions of concrete services? • What do Managers know about the 2012 Waiver? • What are Managers' perceptions of the 2012 Waiver? • How do Managers describe being mentored in their roles? • What are Managers' reactions to qualitative themes from the 2016 FCM survey? • How do Managers' describe plans to prepare for leadership change and what will Managers to do maintain stability?

In Round 4 evaluators also asked about Managers' perceptions of and experiences with being mentored, Managers' reactions to "It would be great if _____" data from the 2016 Family Case Manager (FCM) Survey, and how Mangers' planned to respond to impending State leadership changes, in an effort to maintain stability on behalf of children, families, and Department staff.

Analysis

Following the completion of all interviews, three IU Evaluation Team members collaborated for data analysis. The analysis procedure included each evaluator reviewing and developing a detailed summary of each case (interview), reviewing case descriptions, identifying common themes within each case, and identifying common themes across cases (all interviews). Next, IU Evaluation Team members cooperated to categorize grand, sub-themes, and tertiary themes from the combined cases and to select exemplar quotes to represent these themes. The final step in the analysis was to develop assertions from the cases. The additional IU Evaluation Team members were informed and consulted throughout the data analysis process.

Results

Demographics. Regional managers on average 4-5 years of tenure in their role, have held an average of 3 positions at the agency, all have a Bachelor's degree, and most have a master's degree. Over the 4 years between 9 and 11 of the RMs had at least one social work degree. RMs are generally more female than male and have been with DCS for between 19 and 23 years.

Table 34. Participant Background Information for all Rounds

Characteristic	2013 N = 20	2014 N = 20	2015 N = 18	2016 N = 20
Gender	11 female 9 male	10 female 10 male	11 female 7 male	11 female 7 male
Average Department Tenure	23 years	22 years	21 years	19 years
Average Role Tenure	5 years	5 years	4 years	4.5 years
Average Prior Department Positions	3 positions	3 positions	3 positions	3 positions
Bachelor's Degree	N = 20	N = 20	N = 18	N = 20
Master's Degree	N = 12	N = 13	N = 12	N = 14
Social Work Degree	N = 11	N = 9	N = 10	N = 11

Round 1 Results-2013.

Region-specific services. Managers were asked to describe their region/area, identify service strengths and service needs, and to describe the relationship between DCS and the courts in their region/area. Regional descriptions were unique; however, in general, RMs described quality staff and positive relationships with the courts. Additionally, findings revealed consistency in unmet service needs across regions and throughout the State. The following is a list of the most predominant unmet service needs; numbers to the right indicate the number of Managers who identified the need as unmet in their region/area:

1. Effective Drug Treatment (17);
2. Basic Needs/Housing/Transportation (13);
3. Domestic Violence Services (6);
4. Mental Health Treatment (5); and
5. Foster Homes (3)

Waiver perceptions. Regional and Executive Managers were asked to describe their knowledge of the 2012 Waiver, communication about the Wavier, Waiver training, effects of the Waiver, and the Waiver's potential to make a difference. Findings regarding Waiver knowledge, communication, and effects are described below and in Table 26. Responses regarding 2012 Waiver training were significantly varied. The following list represents common responses related to Managers' Waiver training:

1. Regional Manager Meeting (7);
2. None (6);
3. Not much/very little (3);
4. I Don't Know (2); and
5. Other (2)

Themes. Results of the 20 semi-structured interviews produced seven grand themes. Grand themes are the themes that were the most prominent across the 20 cases. In addition, findings revealed 14 sub-themes, or secondary themes under the grand themes, and five tertiary themes under the sub-themes. Table 26 displays identified themes and exemplar quotes.

Managers indicated administrative challenges to be significant in their roles. Commonly cited administrative challenges included staffing (including training and preparation), turnover, and high caseloads. Another theme among cases was that of unique rural challenges. Managers highlighted differences in service needs and availability in rural versus urban areas. In particular, Managers expressed that meeting the basic needs of children and families in rural areas of the state is particularly difficult. Managers often expressed concern for substance abuse in their respective areas. Specifically, Managers spoke of the prevalence of substance abuse and the perceived effectiveness and availability of substance abuse treatment for clients with addiction challenges. Managers also discussed service quality in their respective areas, including the variability in service quality and in communication with providers. Another theme that emerged from the interviews was that of a perceived gap between central administrative staff and field staff. Managers cited disconnections, as well as communication needs between staff at the central state office and staff in the field. The final themes that emerged from the interviews were related to Waiver knowledge, that is, what was known unknown about the 2012 Waiver and what knowledge was missing or lacking about the 2012 Waiver. Managers often referenced the Waiver as a funding stream and mechanism that resulted in fewer Waiver-related responsibilities for Managers and field staff. Managers often expressed a limited or lack of understanding of what the Waiver could do for DCS and for children and families. They also highlighted a pervasive lack of 2012 Waiver knowledge by FCMs.

Summary and Conclusions 2013

These findings suggest that while Managers generally praise their local staff and report positive relationships with the courts, they experience a number of challenges in their roles and within the regions/areas they manage. Regions, as well as the counties they comprise, are unique; however, certain needs consistently go unmet—particularly those associated with substance abuse and basic

needs. Additionally, the rurality of some areas presents particular challenges with regard to service availability and effectiveness.

Overall, Managers appear to have a very limited understanding of the 2012 Waiver, which in many cases has led to diminished levels of interest and investment in the Waiver. Limited communication and training about the Waiver may have been the genesis of this limited understanding. Despite a lack of knowledge about the 2012 Waiver, many RMs express they are pleased to be relieved of some responsibilities associated with previous demonstrations of the Waiver. Reactions to how much FCMs should or need to know about the 2012 Waiver are mixed. In some cases, Managers feel staff have no need to know about the 2012 Waiver and perhaps their lack of knowledge about the inner workings of the Waiver will permit FCMs to focus more fully on their daily responsibilities, including the safety and well-being of children. In other cases, Managers highlighted FCM's lack of knowledge as an additional example of the perceived disconnect between central office and field staff. While many Regional Managers were pleased to be relieved of some duties previously associated with the Waiver, many also desired to be more knowledgeable about the Waiver and how they could use the Waiver to benefit children and families.

Finally, in general, Managers appeared to have a limited understanding of the Title IV-E Waiver IU Evaluation Team—including the team's purpose, role, and potential to benefit DCS. Despite this lack of knowledge, multiple Managers expressed their desire to learn about the IU Evaluation Team's findings regarding Waiver and related research.

Table 35. 2013 Themes and Evidence of Regional and Executive Manager Perceptions

2013 Themes	2013 Evidence
Administrative Challenges • Staffing • Turnover • Caseloads	*"Some of the serious challenges are staff retention and managing staff vacancies. An additional challenge involves rising caseloads, which may be due in part to staff turnover, but there has also been an increase in assessments in the past year."*
Rural Challenges • Poverty o *Meeting Basic Needs*	*"The needs and capacities of rural vs. urban regions are not the same and should not be compared as if they are. The needs of the rural counties do not match the service capacity."*
Substance Abuse • Prevalence • Effectiveness of Treatment • Availability of Treatment	*"There is a gap between the need and availability of substance abuse treatment in the region."* *"Effective change is not possible without substance abuse treatment."*
Service Quality • Variability • Provider Communication	*"They are effective in dealing with the issues they are trained to deal with, some may not have the capability to meet a client's specific need, for example addiction issues, but they do they best they can with what they have."*
Gaps between Central Administration and Field • Disconnection o *Communication Needs*	*"Cluelessness & silos at central office, really throughout the central level. Realities are lost… central office comes up with a great idea, but it has unintended consequences."*
Waiver Knowledge • Funding Stream • Off My Plate o Invisibility o FCM Concerns	*"We have it, every child is covered. All that money stuff, we don't have to manage that."* *"The Waiver does not have high relevance for me, it is now simply a funding stream and there is not local control of Waiver funds. I do not have a tremendous amount of interest in the Waiver."*
Waiver Unknown • What is the 2012 Waiver? o *Investment* • Training • What Can We Do?	*"I don't know anything about the Waiver."* *"Once eligibility was pulled, we really have no clue about what's paying for what, and we really don't worry about it."* *"We need more information about the Waiver, to know if it is valuable for serving children and families."*

Region-specific services. RMs were asked to describe their region, identify service strengths and needs, and describe the relationships with key stakeholders, including the courts and service providers. Regional descriptions were unique; nevertheless, overall, RMs described positive relationships with the courts and providers in their region. At times, RMs described minor challenges with individual judges, including philosophical differences related to practice, and room for improvement in communication between DCS and providers. RMs reported at times not referring to agencies that did not meet clients' service needs or standards, at times resulting in a gap in services. However, in most cases in which a challenge existed with a provider or the court, RMs reported collectively working through differences on behalf of children and families. Findings revealed Managers' perceptions of the greatest needs in their region, as well as service needs perceived to go unmet.

Table 36 presents the needs Regional Managers perceive are among the greatest in their region, as well as the needs that go unmet. The number to the right of the identified need indicates the number of Regional Managers who reported that particular need. Some Regional Managers named more than one need for each category.

Table 36. Regional Needs 2014

Greatest Regional Needs	Unmet Regional Needs
Substance Abuse (13)	Effective Substance Abuse Treatment (13)
Transportation (9)	Mental Health Services (4)
Mental Health (5)	Domestic Violence (4)
Foster Homes (3)	Available Foster Homes (3)
Domestic Violence (2)	Transportation (1)

Of note, multiple Managers indicated domestic violence services as an unmet need in their region, despite only two RMs identifying domestic violence as among the greatest needs in the region. Categories of particular needs remained the same in Round 2 when compared to Round 1. Nevertheless, particular attention to transportation challenges, which may compromise access to treatment and resources, was more pronounced in the Round 2 interviews. When discussing transportation needs, multiple RMs also expressed challenges with provider transportation – citing contractual issues with not paying providers for transportation and the challenges this can create, particularly in rural areas of the state. Executive Managers echoed RMs' perceptions regarding greatest needs in the State, citing substance abuse and transportation.

Relationship with Central office. In addition to relationships with courts and service providers, Regional and Executive Managers were asked about their perception of the relationship between central office and field staff. The evaluators believe this question is important to the Process Study component of the evaluation since the 2012 Waiver is a fiscal mechanism with practice (field) implications. Thus, knowledge about the relationship between fiscal and field may provide valuable process-related data. In Round 1, Managers indicated, overall, a fractured relationship between central office and field, one of silos, disconnect, and poor communication. In Round 2, Managers expressed some improvements and some on-going challenges. Over half of the Managers indicated a relationship that ranged from at least mediocre to good. Multiple Managers cited changes in executive field leadership as a catalyst for positive change. Among challenges in the relationship between central office and field, Managers expressed some confusion regarding roles and responsibilities and the continued need for clear and

continuous communication. Also, at times, field staff members perceive a lack of transparency, as well as a lack of true understanding of fieldwork and responsibilities by central office staff. Despite these challenges, multiple Managers reported that central office staff members are hardworking and committed and that, in general, central office staff are accessible and willing to assist when they are asked for support by Regional Managers. Findings from Round 2 indicate a shift toward a more positive and supportive relationship between central office and field, although room for improvement and positive growth exist, especially with regard to transparency and communication.

Concrete Services

Questions related to the use of concrete services, funds used to purchase non-contractual goods and services on behalf of children and families with DCS involvement, were added to the Round 2 interviews. The evaluators asked concrete services-related questions in an effort to explore perceptions of effectiveness, barriers to use, and unique or creative examples of concrete service usage among Regional Managers. Because the 2012 Waiver permits for the flexible use of Title IV-E funds, including purchasing goods and services for families with children who remain in the home, exploring the use of these services represents a valuable effort in the Waiver process and outcome components of the evaluation. Overall, Regional Managers reported that concrete services are extremely useful, especially when they can prevent removal or expedite permanency. Nevertheless, there seems to be considerable variability with regard to the use of concrete services. Regional Managers ranged from reporting that they rarely deny an appeal, to using concrete services very conservatively in an effort to prevent unnecessary spending. Regional Managers, in general, reported a general lack of understanding in terms of what can be purchased using concrete service funding and what is off limits. A lack of policy clarity was among the noted barriers to using concrete services. Other barriers to use included a cumbersome process overall, Procurement card spending limitations, lack of willing vendors, and challenges with regional fiscal officers (i.e. concerns about spending). Regional Managers noted that when local office directors had a good understanding of the value and availability of concrete services, they are used more frequently. FCMs are reported to have a lack of understanding about concrete services and may potentially feel intimidated with regard to requesting an appeal from their Regional Manager. The use of concrete services are generally perceived to be useful and necessary by Regional Managers and perhaps even more available since the 2012 Waiver, although multiple Regional Managers were not sure they could attribute increased availability or use of concrete services to the Waiver directly. However, lack of communication and clarity about how and when to use concrete services on behalf of children and families may be compromising the use of these services in the State.

Despite variability among concrete service knowledge and use, many Regional Managers were able to identify unique or creative uses to ensure or promote safety, permanency, and well-being. Examples of each are shared in this section. A greater number of well-being examples are shared. In particular, many of these examples demonstrate the flexibility in concrete services funding to meet the unique needs of children and families.

Safety:

There was an instance where a newborn, [we had] concerns about its development, [the] local office purchased these mats that are monitors that can sense when a child is not breathing or moving or whatever because of the fragile condition of the child, maybe a premature birth. [The] local office identified that this mat should be in the baby's crib – kind of like a baby monitor. Idea was to try to assist with safety of the child.

We have a family where there was some septic back-up into the house, creating some health issues. It was the only real reason these children could not remain in the home. That was the primary piece. We used concrete services to do some repairs to the septic system. That created the safety piece for the children so they could return quicker to home.

Been able to help with past due rent that would cause a family to be homeless if it was not paid. It is much cheaper to assist a family with a poverty issue than it is to place their children in care – financially and emotionally. You can lessen trauma if you can keep a family [together].

A family with bed bugs. The professional said it was one of the three worst cases in the State and the only way to treat it was to destroy everything. The family owned the home. If they left, they would abandon their mortgage. We used concrete services to destroy materials outside of the home, dumpster and trash removal, and used donations to replace their belongings.

Permanency:

Severely infested cockroach home. [We] worked with [a] provider to irradiate the cockroaches, seal the home, and fumigate it. We were at the point where we were going to have to remove the children, [but] by temporarily relocating the family and fumigating the home; we were able to close their case.

Yes – we had a special needs adoption, we built ramps to the home, we built ramps to the swimming pool, I believe we paid for minor remodeling.

We've helped with additions to a house for a family who needed adjustments to adopt a child with special needs.

Well-being:

We had a child in residential, [the] case worker and CASA really wanted to get an iPad for a child who is legally blind, he does have some vision. Through [the] iPad, there are certain apps he can do, [the apps are] centered on people with visual impairment.

[We] have a two year old in a relative placement who we really needed to do some well-being things. Relatives were taking care of her, but they wanted a museum pass – very fun, but it also increases some of your developmental learning, but because [they] needed to purchase a family membership, there was some debate. It really seemed to be a well-being piece for her. Good example of how we look at things that way.

We had a girl who was in a relative placement, who really wanted to go to a church camp and she got into her faith and it's was comforting to her. We were able to pay for [the camp].

[A] girl was graduating from HS, DCS let her use her 300 dollars to buy a car. We approved it. Group decision. She is 18, she's graduating after Christmas – a semester early, going to [community college], working full time, starting collaborative care, the foster home was in the middle of the county, rural county. Why wouldn't we allow her to use her money to buy a car? That was 20% of her car. Well-being, safety, permanency – parents couldn't do the transportation. It makes more sense than to say just no.

We have a 13 year old child, who due to her young years, her mouth was let go so badly, she had some deformities….she needed extensive ortho work, we settled for price less than ortho was asking. Do

we really need to do this? The FCM sent me pictures. [I said] we need to Figure out a way to help this young lady. Medicaid wouldn't pay for it. The cost exceeded Pcard limit. [But,] we approved higher limit. [It] took a lot, but it was a good feeling when the bill was paid. We were able to get that young lady's mouth restructured. She has greater functionality and greater well-being – she doesn't look in the mirror and see deformity.

We have a little guy who was born with lung issues and we ended up removing him and he got his initial clothing allowance and then a month or so later, he needed a chest compressor that he had to wear all the time. Because of that vest, none of the clothes would fit, so we bought additional clothing because of that vest.

Waiver perceptions. Regional and Executive Managers were asked to describe their knowledge of the 2012 Waiver, changes in their knowledge over the past year, effects of the Waiver, and ways the Waiver connects to DCS' Strategic Plan. Overall, Regional Managers find it difficult to articulate their understanding of the Waiver and the majority of Regional Managers reported no new Waiver-related knowledge. Regional Managers struggled to communicate specific examples of how the Waiver connects to the Strategic Plan. Nevertheless, Regional Managers appear to have a general understanding of the Waiver's flexibility and the potential of the Waiver to aid children and families in creative ways, such as through the use of concrete services. It is possible that Regional Managers were influenced to discuss the potential of the Waiver to benefit children and families in terms of flexibility and concrete service funding based upon the questions asked by the interviewers. However, it is also possible that the philosophy of the Waiver as a mechanism to continue the DCS Practice Model, Safely Home Families First, is beginning to trickle down to Managers. Additional findings regarding the Waiver are described in this section and in Table 37. Table 37 presents the responses Regional Managers provided regarding new Waiver knowledge gained over the past year.

Table 37. New Waiver Knowledge 2014

Response	Number of Regional Managers
No New Knowledge	13
New Flexibility/Concrete Service Knowledge	4
New Prevention Knowledge	1

Of note, Executive Managers did report enhanced knowledge and understanding of the 2012 Waiver, including recognition that not all states are afforded a Title IV-E Waiver, the State is fortunate to have a Waiver, and a need to document Waiver-related efforts, as Waiver funding in its current form ends in 2019.

Themes. Results of the 20 semi-structured interviews produced eight grand themes. In addition, findings revealed 16 sub-themes, or secondary themes under the grand themes, and 7 tertiary themes under the sub-themes. Table 38 displays the identified themes and exemplar quotes for each.

Regional Managers indicated turnover and staffing to be significant administrative challenges in their role. Turnover was discussed in terms of positive turnover, including turnover to retirement or a new position (usually managerial in nature), negative turnover, including merit/disciplinary-based or lack of fit, and turnover effects including the challenge of identifying, hiring, and training new, qualified, competent staff. Overall, Regional Managers reported capable and committed management staff. Differences between rural and urban areas emerged as an additional theme. In general, Managers

highlighted differences in service availability and service accessibility in rural and urban areas. Lack of transportation to access services and lack of payment for provider transportation to client homes were identified as particular rural challenges. Managers discussed generalized poverty less in Round 2 than in Round 1; however, discussion of meeting families' basic needs still presented as an issue and reason for DCS involvement in both rural and urban settings. Managers routinely identified substance abuse among their region's greatest needs. Specifically, Managers discussed the pervasive nature of substance abuse and the overall lack of effective substance abuse treatment. Other needs identified to be great among Managers included transportation, mental health services, available foster homes, and domestic violence services. Another theme that emerged from the interviews was that of key relationships. Although Managers reported variability in service quality, depending on provider agencies and individual practitioners, Managers perceived relationships with service providers to be largely positive. Relationships with the courts in their regions were also perceived to be positive, despite occasional differences with individual judges. Although most Managers perceive the relationship between central office and field to be acceptable or favorable, concerns related to transparency, communication, and a true understanding of fieldwork by central office staff continue to exist. Despite these challenges, multiple Managers believe central office staff are hardworking and committed and are accessible and willing to assist when needed. Overall, Managers perceive concrete services to be necessary and very useful in meeting particular client and family needs. Managers were able to identify unique and creative uses of concrete services to meet particular safety, permanency, and well-being needs. As reported in the previous section, although some Regional Managers reported using concrete service often and rarely denying an appeal, others reported a much more conservation approach, desiring to explore alternative resources and prevent over/unnecessary use of concrete service spending. In general, there appears to be a lack of policy clarity regarding the use of concrete services. In addition to some confusion regarding appropriate uses, Managers identified multiple barriers to using concrete services include cumbersome processes and discrepancies with finance officers. Regarding 2012 Waiver knowledge, in general, Managers had difficulty articulating their understanding of the Waiver and connections between the Waiver and DCS' Strategic Plan. Nevertheless, it appears Managers are aware of the Waiver's increased flexibility and potential to meet families' unique needs through the use of concrete service spending. Yet, Regional Managers often reported gaining no new knowledge of the Waiver in the past year. Many Regional Managers continued to express a general lack of understanding and a sense of disconnection with the Waiver. In addition to needing further Waiver insight, Managers cited interest in Waiver evaluation data and requested routine updates on Waiver-related projects and assessments. Managers believed the IU Evaluation Team could be helpful in providing this information. A greater level of rapport was observed between Managers and interviewers in Round 2 as compared to Round 1. All interviews were scheduled and completed in a timely fashion and Managers appeared open and willing to share with interviewers in a more comfortable and comprehensive way in Round 2.

Summary and Conclusions 2014

Findings suggest that although Regional Managers experience challenges with staffing and turnover, they feel confident in the leadership of their management staff. Regional Managers also look favorably upon their relationships with key regional stakeholders, including the courts and service providers. Challenges that emerge with individual judges or agencies are addressed appropriately and do not appear to compromise service delivery or meeting the needs of children and families, except in cases in which DCS ceases to refer to specific agencies with service detriments. Regions and the counties that comprise them are unique and Regional Managers are well-versed in describing the characteristics, needs, and strengths of each. Region and county-specific insights demonstrate Regional

Managers' investment in the areas they manage. While regions and counties do appear to have unique identities, particular needs, especially effective substance abuse treatment, continue to go unmet. The availability of foster homes emerged as a great and unmet need in Round 2. The need for more foster homes was discussed much less in Round 1. Changes in executive leadership appear to be a catalyst for improvements in the relationship between central office and field; however, communication and transparency challenges continue to exist. Although Managers believe concrete services are helpful and are effective in meeting safety, permanency, and well-being needs of children and families, lack of policy clarity and burdensome processes at times make it difficult to use concrete service as successfully and efficiently as possible to meet unique needs. Overall, Regional Managers continue to communicate a limited understanding of the 2012 Waiver. Executive Managers, on the contrary, report enhanced knowledge and appreciation of the Waiver. A lack of new knowledge disseminated to Regional Managers has likely led a continued gap in Waiver understanding and the ability to connect the Waiver to DCS' Strategic Plan. This being said, Regional Managers do appear to have a general sense of the Waiver's flexibility and the potential for this flexibility to support the Practice Model. Similar to Round 1 findings, Managers expressed the desire for greater information related to the Wavier and the Waiver evaluation. Interest in data, assessments, and updates appeared to be enhanced in Round 2 when compared to Round 1. Managers appear to share a greater rapport with the IU Evaluation Team interviewers and see the IU Evaluation Team as a potential resource to provide them with data and Waiver-specific information. Executive Managers recognize the necessity of being purposeful about Waiver communication and documentation as DCS' practice overall is reliant upon the Waiver's flexibility to serve all children and families with child welfare needs ranging from prevention through permanency.

Table 38. 2014 Themes and Evidence of Regional and Executive Manager Perceptions

2014 Themes	2014 Evidence
Staffing • Management • Turnover	*The staff is very inexperienced, many under one or two years. The turnover leads to the need for staff sharing (between counties) which leads to marginalized knowledge of resources in unfamiliar areas. The supervisors, however, are skilled, experienced, steady, strong managers.* *We are nowhere close to managing what [cases] we have. We have a very, very new staff and many more experienced [staff] get promoted quickly.*
Key Relationships • Central Office/Field o Improvements o Continued Challenges • Courts • Service Providers	*Good relationship with them. And I think this past year, diff parts of central office have made better efforts to be out in the field. Still kind of that under tone that they are separate, it's gotten better.* *At some point, the ability to communicate as professionals should be fostered more. Feelings get hurt. Communicate honestly, not emotional or politically. You need that communication before you can effectively work together.* *Relationship is excellent, very good relationship with the judge. Sometimes the magistrates go overboard, but good for the most part. Pilot to go paperless, so we've had a lot of contact with them. We*

	communicate. If the judge has an issue, he knows he can get in contact with me, simple as that.
Substance Abuse & Treatment	*As probably every other region in the state – the reason we get involved in abuse and neglect cases is where substance abuse is very strong. One FCM said 90% of cases are drug related, I would say at least 75% or 80%. We have noticed in [one county] some heroin – straight shot from Chicago. People will travel down from Chicago, get into trouble, we wind up with their kids. Starting to see more heroin and cocaine.* *If people can get past substance abuse treatment, then they do better. High turnover rate at the treatment centers, [turnover] impedes progress when staff changes.*
Unmet/Under-met Service Needs • Transportation • Mental Health Services • Foster Homes • Domestic Violence Services • Contractual Concerns o Provider Transportation o Mom & Pop Shops	*[Our greatest needs are] foster homes and substance abuse. We still struggle – aren't where we need to be yet with providing good services with domestic violence.* *For the families, good substance abuse treatment. Better ways to provide transportation to families. How can we think outside the box? [We] use a lot of in-home services…want to connect them with mental health [services], but it's hard to get them to services.* *Need more foster homes. Occasionally it takes a long time to find a FH for a child. If it was up to me, we would pay relative placements a per diem. Sometimes they aren't financially in the best shape.* *Service standards. If anyone needs to travel, it's going to take some time. It challenges our service providers. Cannot charge directly for travel time or no shows. It's a challenge when they have to drive. Makes it difficult to actually apply services.* *We've had local rural providers in the small agencies, [they] have gone by the way side. Too difficult in this contract age. We used to have mom and pops – [they] had a better understanding of the counties and weren't there to provide a generic service – [they were] there to provide very specific service. You could go out and build a provider to do what you needed them to do. Those days are gone.*
Rural & Urban Differences • Availability • Accessibility	*For a lot of our rural kids……we need rural specific services – like a group home in a rural area….the rural kids go to a group home with urban kids in an urban area and its cultural shock, too much. Transportation challenge in rural counties.* *There is no subsidized housing in some rural areas. Transportation is a huge issue. Rural areas struggle with therapists trained in child welfare and trauma. Some small, community mental health center models are inflexible at times.*

Concrete Services • Meeting Unique Needs • Barriers to Use	*[Concrete services are] usually very effective. If it's really why we've gotten involved, it's one of the most welcomed services – meeting basic needs.* *I think we have expanded … I would say yes… I think it's because we have expanded our outlook of what types of CS are helpful and how that relates to the stability of the child. Yes, we have expanded.* *I've heard the process is a little more cumbersome now, as far as entering the information in, creating the referral, entering the info into the system, more steps now and the turnaround time is sometimes slower than what it helpful. A lot of times if they have identified a need, if we can't get this addressed quickly, we are looking to have to remove the children. My goal would be to work on quicker response time.*
Waiver Knowledge	*I do think one of the challenges…good thing but creates challenges, eligibility is centralized, we magically have people who do that for FCMs, they haven't done a great job in the past because they've had to wear so many hats…but it's a challenge too… when you don't have to do it, you don't understand it.* *I don't know much. We don't have as much active control; I still think there is a need to know more about it.* *I think I would just go back to the fact that this pot of money allows us to make kids feel as normal as possible and the money affords us the opportunity to do that. "Normal" as in a home with no abuse or neglect.*
Other Manager Desires • Data • Updates	*Well it probably wouldn't hurt for us to keep up on what you are finding in terms of the evaluation. For example – concrete services by region – are we under-utilizing? The start of the conversation is our expenditures and how do we compare to other regions. Those conversations may be helpful so we are using the Waiver to meet the needs, the way it was intended to meet needs.* *Generally, the progress of the evaluation. For example, preliminary reports. We aren't seeing those, that may be intentional, but progress information could be helpful.*

Round 3 Results 2015

The findings for Round 3 of data collection produced six grand themes, 19 sub-themes under those grand themes, and eight tertiary themes under those sub-themes. Table lists grand themes that emerged from this iteration of the study as well as the grand themes that emerged from previous iterations. Grand themes from the 2015 data are discussed and evidence of these themes are shared below. A complete Table of 2015 grand, sub, and tertiary themes along with evidence of these themes can be found in Table 39. An overview of findings from this study can be found in the summary and conclusions section of this document.

Table 39. Grand Themes

2013 Grand Themes	*2014 Grand Themes*	*2015 Grand Themes*
Administrative Challenges	Staffing	Role of Experience
Rural Challenges	Key Relationships	People as Foundation of Practice
Substance Abuse	Substance Abuse & Treatment	Child Welfare Practice
Service Quality	Unmet Service Needs	Relationship between CO & Field
Gaps between Fiscal & Field	Rural & Urban Differences	Concrete Services
Waiver Knowledge	Concrete Services	Connecting the Dots
Waiver Unknown	Waiver Knowledge	
	Interests & Requests	

Role of experience. At the request of the Direct of Field, the evaluators explored managers' perceptions of the role experience plays in performing one's duties as a Regional Manager. Managers overwhelmingly expressed that experience is a valued and necessary component of being an effective Regional Manager. Managers acknowledged the need to routinely respond to crises and felt experience permitted them to act effectively. Additionally, managers expressed a keen need to understand field in order to be effective in their work. Overall, managers agreed that serving in roles such as an FCM and LOD gave them field experience and a deeper understanding of what it is like to work in the field – critical components to their roles as Regional Managers. The following is a quote that represents these sentiments. Additional evidence related to the role of experience can be found in Table 12.

> *I am a very firm believer that you need to come up through the ranks to be successful in this job. Had I never removed a child before, I don't think I would be able to understand what that's like. Same for directing a local office. I may be blind to decisions that would be good for a LOD. It also helps me better support them. I think experience…I have a hard time believing that someone could be very effective in this position without having gone through some of that.*

People as the foundation of practice. In previous rounds of data collection, staffing and turnover were consistently noted as challenges that Regional Managers faced in their positions. In Round 3, there was less discussion of staffing and turnover challenges, however, a theme of the significance that people, staff members and provider employees, play in the very foundation of child welfare practice emerged. In this round, managers more often discussed challenges related to new and inexperienced staff than openings and turnover. Managers were pleased to have fewer openings, but the newness and

inexperience of a majority of FCMs in some cases proved to be real challenges for some regions. Managers routinely identified experienced, reliable, committed regional management staff as a strength of their regions. Managers expressed the need to recruit and effectively train highly qualified staff. Managers, especially in more rural regions, expressed the challenge of competing with contractual providers for the same well-qualified workers. The idea that the practice is only as good as the people who fill the positions and do the work emerged from the data. High caseloads continues to be a challenge in some regions.

Relationship between field and central office. In addition to relationships with courts and service providers, which have consistently been reported to be positive throughout the state, Managers have been asked about their perception of the relationship between central office and field staff. The evaluators believe this question is important to the process study component of the evaluation since the 2012 Waiver is a fiscal mechanism with practice (field) implications. In Round 1, managers indicated, overall, a fractured relationship between central office and field, one of silos, disconnect, and poor communication. In Round 2, managers expressed some improvements and some on-going challenges. Over half of the managers indicated a relationship that ranged from mediocre to good. Multiple managers cited changes in executive field leadership as a catalyst for positive change. A new Field Director was appointed, the title of Executive Manager shifted to that of Associate Deputy Director of Field, and a new Associate Deputy Director of Field was hired to manage the south regions. As in previous rounds, managers continue to see themselves as a bridge, a mediator, a conduit between central administration and field staff. The data revealed that while a gap continues to exit and is problematic, members of the executive team are aware of the divide and are working to address and repair these critical relationships. The following is a quote that represents this awareness and a sense of solidarity. Additional evidence related to the relationship between central administration and field can be found in Table 12.

> *I think that bridges are being built everyday…I really think communication is crucial…sometimes we do a good job, other times we fail miserably. I am always a person in my leadership to ask 'why'…I think we are making headways in the disconnect…everyone is working hard to address it. Anyone in a leadership role has to avoid that 'us versus them' mentality…we are all in this together.*

Child welfare practice. Compared to previous rounds, in Round 3, managers spoke more of general child welfare practice. Perhaps new questions related to Regional Service Councils (periodically held regional meetings attended by Regional Managers and other members of the Department as well as providers, judges, and other regional stakeholders to discuss regional-related issues such as community partners, services, finances, and future plans) and staff development resulted in this finding. Managers spoke about the importance of qualified staff, quality supervision, and the challenges that accompany frontline child welfare workers. When discussing needs related to placements for children in out-of-home care, managers consistently cited the need for specialized and therapeutic placements – available foster homes for children with emotional and behavioral challenges, older children, and large sibling groups. Additionally, managers spoke of how persistent service needs (i.e., lack of effective substance abuse treatment and domestic violence services), contractual barriers (i.e., providers not being paid for their travel – a particular issue in rural communities), and high caseloads compromise basic practice principles and meeting the needs of children and families.

Table 40 presents the needs Regional Managers perceive are among the greatest in their region as well as the needs that go unmet or are considered to be under-met. The number to the right of the identified need indicates the number of Regional Managers who reported that particular need. Some Regional Managers named more than one need for each category. Although some variation in number of responses exists, the top five reported greatest needs as well as needs that go un/under-met have remained consistent across the three years of data collection. Substance abuse and the need for effective substance abuse treatment has overwhelmingly been reported to be the greatest and most under-met need across the state in all three rounds of interviews.

Table 40. Regional Needs

Greatest Regional Needs	*Unmet Regional Needs*
Substance Abuse (13)	Effective Substance Abuse Treatment (10)
Domestic Violence (4)	Domestic Violence Services/Batterer Interventions (3)
Mental Health (4)	Mental Health Services (1)
Foster Homes (3)	Available (Specialized) Foster Homes (3)
Transportation (2)	Transportation/Access to Services (5)

Concrete services. Recall that concrete services are used to purchase non-contractual goods and services on behalf of children and families with child welfare needs. Concrete services allow the Department to meet unique service needs in order to promote safety, permanency, and well-being. Provided the flexibility that the 2012 Title IV-E Waiver permits, the evaluators executed the decision to explore the use and perceived value of concrete services at the regional-level in the 2014 Manager interviews. Managers were asked about the use of concrete services in their region, any perceived enhanced use of concrete services since the 2012 Waiver, barriers to use, and examples of how concrete services had met a permanency, safety, and well-being need for a child or family. In 2014, managers generally reported that concrete services were very useful, especially when use of funds could prevent removal or expedite permanency. However, variability in use and a general lack of understanding in terms of what could be purchased emerged from the interviews. A lack of clarity regarding policy was a noted barrier to using concrete services. In addition to the questions asked in Round 2 of data collection, in Round 3, the evaluators also asked managers how they went about developing staff with regard to concrete services.

In Round 3 of data collection overall, managers reported a more normalized and ingrained use of concrete services to meet safety, permanency, and well-being needs. As was the case in Round 2 of data collection, the evaluators asked managers to identify examples of how concrete service had met a particular safety, permanency, and/or well-being need. Managers spoke to an enhanced use of concrete services and perceived the use of concrete services to be a tool for achieving positive outcomes. However, managers struggled to identify specific examples in Round 3. This finding may suggest a more business-as-usual perspective of concrete service use in 2015 than in previous years when examples of unique usage stood out more in the minds of managers. Managers also talked less about barriers and lack of clarity related to concrete services policy in 2015 than in Round 2. Perhaps one of the more enlightening findings revealed that managers perceived a clear link between the use of concrete services and the 2012 Waiver. This finding will be discussed further in next section.

Connecting the dots. Approximately six months prior to Round 3 data collection, members of the evaluation team gave a presentation regarding concrete service use, among other evaluation topics, to members of the Executive Team, including Regional and Executive managers. At this time, managers shared unique ways their regions had used concrete services, providing others in the room with specific examples of ways they had creatively met safety, permanency, and well-being needs. The discussion was lively and attendees were engaged. In each of the three rounds of data collections, managers have been asked to describe their knowledge of the 2012 Waiver, changes in their knowledge over the past year, effects of the Waiver, and ways the Waiver connects to the Department's strategic plan. In Round 1 of data collection, knowledge of the 2012 Waiver was extremely limited. Many managers expressed no real understanding of the Waiver, i.e., "I don't know anything about the Waiver", others referred to the Waiver as "simply a funding stream". In Round 2, although managers, in general, continued to struggle to articulate their understanding of the Waiver, general understanding of the Waiver's flexibility and the potential of the Waiver to aid children and families in creative ways, such as through the use of concrete services emerged from the data. In Round 3, overall, managers perceived a clear link between the 2012 Waiver and concrete services. Managers perceive the Waiver as a catalyst for expanded use of concrete services, flexibility in spending, and creative use of funds to meet safety, permanency, and well-being needs on behalf of children and families in the state. The following quote captures this ideology.

> *I feel like Waiver is there to cover some of those things that we normally wouldn't be able to do…I still can't define it, but those things that can prevent removal, more of a way to be creative with a family to meet their needs…*

The evaluation team believes the presentation in the spring of 2015, prior to the 2015 interviews, is a significant factor in shaping the perceptions of managers to observe a connection between the Waiver and concrete services. As noted in a previous section, discussion of the use and value of concrete services in this round of data collection seemed to be more normalized and a part of every practice for many of the Regional Managers. In addition to recognizing a connection between the Waiver and concrete services, managers seemed to perceive that without Waiver funds, the Department would not have the ability to practice and meet the safety, permanency, and well-being needs of children and families in the ways they currently do. The following quote exemplifies this idea.

> *Child welfare as we know it truly exists because of Waiver funds…*

For the first time since these qualitative data have been collected, managers seemed to be able to anchor the 2012 Waiver to child welfare practice in the state.

Summary and Conclusions 2015

Observed rapport with Regional and Executive Managers as well as collected data have become richer with each iteration of this study. The following represents summary findings of Round 3 data collection which explored the perceptions of 16 Regional Managers and two Executive Managers with regard to their backgrounds, areas and staff they manage, concrete services, and the 2012 Waiver. Regional Managers continue to perceive their role as a bridge between central administration and field staff. Regional Managers are members of the Department's central administration. Nevertheless, they walk in both worlds – administration and field. Regional Managers described a gap that exists between field

staff and central office as well as a sense of "fear" that some field staff have with regard to central administration. This fear is unhealthy and at times Regional Managers struggle to identify the root of this fear. Nevertheless, they understand that, at times, field staff do not feel understood by central administration and feel that decisions made by central administration have unintended negative consequences. Regional Managers experience both positives and negatives in their roles. Positives frequently involve working with dedicated and passionate staff members while negatives often involve staffing challenges and high caseloads. Managers perceive experience, including coming up through the ranks, and holding other field and management positions prior to becoming a Manager, as critical to being able to manage crises, make sound decisions, understand their staff, and be effective in their roles. Regional Managers revealed that people—staff—are the foundation of practice and to practice well and provide sound services, staff must be of a high quality and must be trained well. While some strides have been made to address staffing shortages and turnover, working with an inexperienced staff is a challenge. This challenge makes having an experienced and dedicated management team in each region especially valuable. Committed management teams and generally positive relationships with courts and providers were routinely acknowledged as regional strengths.

Across the state, there are consistent dire needs- these include substance abuse, domestic violence, mental health needs, available foster homes, and lack of transportation. Service needs in these areas are often unmet or under-met. Transportation and access to services is a particular challenge in rural areas. Service contracts that do not permit service providers to be paid for their travel time make it difficult to provide home-based and other services in more remote areas. The creative and unique use of concrete services becomes particularly important when challenges exist among traditional, contractual services. Managers recognize the use of concrete services as a necessary tool in meeting the needs of children and families and achieving positive outcomes. In general, managers use concrete services frequently and find them invaluable in preventing removal and expediting permanency. Multiple managers mentioned wishing more could be done with concrete services to achieve permanency through guardianship. They expressed that there is a true lack of affordable legal representation for those seeking legal guardianship of youth in need.

Managers perceive a connection between the 2012 Waiver and concrete services. Many managers perceive the Waiver to be a catalyst for enhancing regions' use of concrete services and a basis for the way the Department functions and practices today. Although some managers continue to struggle with articulating the 2012 Waiver, in general, managers associate the Waiver with being able to use funds in unique and creative ways to meet the safety, permanency, and well-being needs of children and families in the state. Many managers recalled the evaluators' presentation of concrete service and past interview data, a likely factor in managers' perceived connections between concrete services and the Waiver. Managers routinely expressed a desire to know more about how and in what ways the Waiver is working or not working. They desire data that is easily digestible, data that can make a difference for them in their region. Managers see the evaluation team as a resource to better understanding the Waiver and what it is and can do for children and families in the state. Additionally, Regional Managers see their peers as resources – they found the opportunity to share and learn from other Regional Managers, with specific regard to concrete service use, as valuable. Additional opportunities for Regional Managers to collectively learn about evaluation data and share with one another is recommended.

These Round 3 interview data were shared with the executive team, including Regional and Executive Managers. The evaluation team collaborated with the Director of Field, Associate Deputy

Directors of Field, and other executive-level staff members to develop an interview schedule for Round 4 of data collection, planned to commence in the fall of 2016. The development of questions for the next iteration of this study will take into consideration the assertions from previous years of Manager Interviews. Assertions can be thought of as interpretations of cases or lessons learned from the data in a study. Table 41 presents the broad take-away messages or lessons learned from each of the three rounds of data collection to date for this process-study component of the evaluation.

Table 41. Study Assertions

2013 Assertions	*2014 Assertions*	*2015 Assertions*
Generally praise local staff & report positive relationships with courts	Turnover is particularly challenging; management is capable & committed	Inexperience of new staff; strong management teams; dedication
Experience many administrative & role-related challenges	Courts & provider relationships generally positive	Positive relationships with courts & service providers
Regions are unique, but particular needs consistently go unmet	Relationship between central administration & field has improved, room for progress	Regions are diverse, substance abuse is a pervasive challenge; treatment needs
Rural areas experience unique challenges	Particular needs consistently go unmet	Contracting & service standards challenges
Significant gaps exist between central administration & field staff	Rural & urban areas differ	Concrete services have expanded & are necessary for positive outcomes
Very limited understanding of Waiver	Articulating Waiver is a challenge & there is no new knowledge in general	Concrete services & creativity linked to Waiver
Limited Waiver training & communication	Concrete services are helpful, but confusion exists	Evaluation data is source of Waiver knowledge & understanding

Table 42. Regional and Executive Manager Perceptions

Themes	*Evidence*
Concrete Services **Enhanced Use** **Concrete Services as a Tool** **Linked to the Waiver**	*I love doing it (using concrete services). I like not being handcuffed by limited options. When you can get creative, you can come up with all kinds of neat options and it helps families get out of the system more quickly.* *Oh, I think it's (using concrete services) is real helpful – in some cases it really does make or break a case…we used to be able to do it under our old system…and then it kind of went by the wayside and it kind of came back with the ability of the Waiver.*
Relationships between Field and Central Administration **Gaps** **Building Bridges** **Field Fears** **The "Why"** **Regional Managers as Conduits** **Support from other RMs**	*I think that bridges are being built everyday…I really think communication is crucial…sometimes we do a good job, other times we fail miserably. I am always a person in my leadership to ask 'why'…I think we are making headways in with disconnect…everyone is working hard to address it. Anyone in a leadership role has to avoid that 'us versus them' mentality…we are all in this together.* *Okay, well, I think there is an unhealthy fear that exists (between field and central administration) and I am not really sure where that comes from or why…*
Child Welfare Practice **Regional Challenges** **Service Needs** **Contractual Issues** **Increasing Caseloads** **Regional Service Councils** **Key Relationships**	*We don't benefit from services in [capital city] and service providers out of [city] aren't going to come out of [city] to service us here. That is very challenging for us. Probably our biggest need surrounds substance abuse treatment and domestic violence treatment. Some of that has to do with our own guidelines for contracts.* *We've increased our caseloads so much, if feels like we are losing ground…it's hard to keep up morale…*
The Role of Experience **Critical to Crises** **Understanding the Field**	*Experience is invaluable…experience helps us to be able to apply what we've learned and share what we've learned One of the greatest things is to be able to share what we learn.*

	…I think it is difficult to go into that level of leadership (central administration) and be child welfare if you don't know child welfare…
People as the Foundation **Staffing** **Fewer Openings** **Inexperienced Staff** **Provider Staffing Issues** **Walk-around Management** **Strong Management Teams** **Passionate, Dedicated Staff**	*…just a lot of new people…95% have a year or less…* *Lots of times we are competing with other service providers for the same good staff.* *The staff is very passionate about their jobs, they are dedicated to their work. I think all of the management has built and continues to build support…very strong relationships in their communities.*
Connecting the (Waiver) Dots **Waiver Knowledge** **Desire for More Information** **Value of Evaluators**	*I guess, to put it in Layman's terms, I feel like the Waiver is there to cover some of these things that we normally won't be able to do…I still can't define it…but those things that can prevent removal, more of a way to be creative with a family to meet their needs.* *I will be honest, I have a very limited understanding of it, I wasn't in my position prior to 2012. I know we don't have the slots any more, all of the matching up behind the scenes happens at central office. I know we are encouraged to use concrete services to meet families where [they] are at.* *The info [the Waiver evaluation team] puts out – that's where I get my information [about the Waiver].*

Round 4 Results 2016 and Four Year Summary.

Themes. The evaluators identified six grand themes, eleven subthemes, and nine tertiary themes in Round 4 (See Table 43). Although some grand themes remained consistent in the fourth round of data collection, other novel themes emerged. The six grand themes included Managers' perceptions of significant staffing challenges including those associated with inexperienced caseworkers and problematic ratios of supervisors to caseworkers; policy changes that affect practice and thus widen a perceived gap between direct line workers and central administrative staff; limited, yet developing formalized mentoring opportunities for Regional Managers; a commitment to the Department's mission to keep children safe as a stabilizer in times of change; the expanded and integrated use of concrete services to meet needs and carry out child welfare practice across the state; and a clear connection between the Waiver's flexibility and specific desired outcomes related to safety, permanency, well-being, and prevention. See Table 44 for a list of grand themes for all rounds of data collection. Table 43 identifies grand, subthemes, and tertiary themes for Round 4 as well as evidence to support these themes

Table 43. Round 4 Themes and Evidence

Themes	Evidence
Significant Staffing Challenges **Filling openings** **Inexperienced, stretched supervisors** ***The perfect storm***	*We are adding staff hand over fist…the hotline is sending just buckets of new reports…the number of reports we are getting is exceeding our ability to add staff, which is going to be a challenge on the permanency side…if you are spending all of your time on the intake side, you aren't attending to the permanency side very well…* *We have a boatload of brand new staff that aren't experienced…[the] number of supervisors has not increased with the increased staff… supervisors are really stretched thin….*
Gaps between Field & Central Office **Policy changes affect practice** ***Need for improved communication about nature & consequences of change*** **Workers' voices underrepresented** ***Lack of understanding on both sides***	*I think [workers] are pretty frustrated…policy & practice changes are based on emergencies…run into situations where practice doesn't make sense…I don't know that [workers] feel represented…* *I think there is a historical albatross, they can't shake that us vs. them & that's frustrating, we are all one team, we just wear different hats to make things work…I think at every level, we need to be inclusive instead of exclusive, we need to have better communication, not in siolos, better communication…*
Developing, Limited RM Mentorship **Informal mentors** ***Learning from others*** ***Variations in perceived support***	*Typically, a lot of what I get mentored on is from peers, RM who have been around a little bit longer…I rely on them pretty frequently when I have questions that come up. I have two or three different mentors I would go to, depending on the question.*

	Well, that's a new question, a truly interesting question. I think that, um, I do have a supervisor, and if I have questions, I can reach out to that person and ask for assistance and guidance. I have peers that I can reach out to and I've had one [RM], specifically, that's tried to help me as much as they are possibly able to – to learn the ropes, my go-to person…
Rooted in Mission during Change **Child safety priority** **Change is not new** ***Be clear, be calm***	*…. there come times in [the agency] when change happens swiftly, this could be one of those times… [we are] talking about how the bottom line is - we are here to ensure child safety and that's not something that changes…* *…we are going to continue to protect children and do what we do right now…if we've got the basics down, we are going to be okay…* *I think maintaining calm in the storm is a good thing. I am going to continue doing my job and try to minimize impact to staff…if there are changes that have to be implemented that affect staff, having good information and disseminating it with the proper tone and needs, that's what I will be doing…*
Expanded Concrete Services **Expanded use** ***Integrated into practice*** ***Policies clarified***	*Having the ability to adjust or flex… [concrete services] give us the ability to be creative to make sure the needs of families are met…I believe concrete services are improving our practice…having the ability to just go forth and do it when it is in the best interest [of the child] has helped us tremendously.* *I think [caseworkers] use concrete services a lot, I sign a lot of [approvals]. I think [caseworkers] understand the use of them and they utilize them as need be…to meet the needs…and the Waiver give us the flexibility to do that where otherwise we couldn't.*
Waiver Flexibility as Practice & Prevention **Clear link between Waiver & concrete services** **Waiver as practice model** ***Life without Waiver*** **Data & evaluation team valued**	*Child welfare as we know it truly exists because of Waiver funds…* *One, that we've increased our use of it, two, that I hope it continues…what I know is that it's huge in the life of children in [the state]…I believe we'd have children we have to remove, that we'd have disruptions, and that we'd have children we would not be able to place back home if it was not for the 2012 Waiver program…and, I like when you guys come & give us all the data about it!*

Table 44. Grand Themes for all Rounds

2013 Grand Themes	2014 Grand Themes	2015 Grand Themes	2016 Grand Themes
Administrative Challenges	Staffing	Role of Experience	Significant Staffing Challenges
Rural Challenges	Key Relationships	People as Foundation of Practice	Gap between Field & Central Office
Substance Abuse	Substance Abuse & Treatment	Child Welfare Practice	Limited, Developing RM Mentorship
Service Quality	Unmet Service Needs	Relationship between Central Office & Field	Rooted in Mission during Change
Gaps between Fiscal & Field	Rural & Urban Differences	Concrete Services	Expanded Concrete Services
Waiver Knowledge	Concrete Services	Connecting the Dots	Waiver Flexibility as Practice & Prevention
Waiver Unknown	Waiver Knowledge		
	Interests & Requests		

Summary & Conclusions

In past rounds, managers reported administrative challenges such as turnover and staffing. The orientation of discussion related to staffing approached that of crisis proportions in Round 4, however. Managers often spoke of staffing challenges as primary in their regions, placing staffing-related challenges above service-related challenges. Managers indicated that recent agency policy changes resulted in a significant influx in the number of children in out-of-home care. Additionally, although caseworkers were being hired to fill open case manager positions, the inexperience of caseworkers coupled with recently promoted supervisors with limited leadership experience created problematic greenness among field staff closest direct field work. Additionally, while more caseworkers are being hired, the number of supervisors is not increasing, adding to supervisors' caseloads. Managers expressed how new staff were being hired to meet the immediate needs of children coming into care and some feared that resources necessary to meet permanency needs were suffering.

Managers again spoke of perceived distance in the relationship between field staff and central administration. Despite many managers reiterating that field and the agency's central office personnel being on the same "team", managers reported that direct line workers often felt as if policy changes resulted from crises and practice changes that ensued did not make sense in the field. These workers often felt they did not have a voice in driving changes that affected practice. Managers spoke of a greater need for inclusivity, improved communication, and eradicating silos that perpetuate the perceived divide between these two types of child welfare professionals.

Similar to previous years, Round 4 data indicated substance abuse, basic needs, including transportation, and foster homes to be among the most significant in regions and across the state. The need for foster homes appeared to be greater in Round 4, provided the increase in the number of children coming into foster care.

As noted above, the interview schedule changed in each round of data collection, due to changing contexts and prior findings. In Round 4, participants were asked specifically about the role and availability of mentoring to support their professional development. Most managers described limited, informal mentoring supports. Those who felt well-supported often reported creating connections with more experienced managers on their own. Executive Managers described the availability of support by their supervisor and discussed the need and forthcoming development of more formalized mentoring opportunities for RM.

Another new area of inquiry in Round 4 was related to impending leadership change in state government, which could affect agency leadership as the governor appoints the director. Perhaps some of the most encouraging data about child welfare practice in the state emerged from a new question designed to explore how managers would maintain stability for children, families, and staff in the face of change. Managers consistently shared that the work of the agency, as a whole, was rooted in their number one charge – to keep children safe. Managers overwhelmingly indicated that a commitment to safety & strengthening families grounded leadership and practice, despite change and instability.

Waiver-specific findings from Round 4 also proved to be somewhat unique. In Round 3, managers began to articulate a connection between the use and value of concrete services for children and families with the 2012 Waiver. In Round 4, this sentiment was solidified. Expansion and integration of using concrete services to meet needs and goals was well represented in participant responses. Managers indicated that the state's current practice model existed because of the Waiver and that many found it difficult to conceptualize child welfare practice in the state without the ability to spend dollars flexibility and in unique ways to meet the safety, permanency, and especially well-being needs of children. An even greater level of rapport between the participants and researcher was observed in Round 4 and managers indicated they really enjoyed both sharing and receiving Waiver-related data.

The final step in data analysis involves developing assertions or lessons learned from the analyzed cases. Table 4 outlines the assertions or take-away messages for all rounds of data collection.

Table 45. Assertions Table for all Rounds

2013	2014	2015	2016
Generally praise local staff & report positive relationships with courts	Turnover is particularly challenging; management is capable & committed	Inexperience of new staff; strong management teams; dedication	Staffing challenges stem from the "perfect storm" of host of policy, practice, & personnel changes
Experience many administrative & role-related challenges	Courts & provider relationships generally positive	Positive relationships with courts & service providers	Managers are attuned to staff discontent/desires for change; Providing data in interviews produces ideas for new data
Regions are unique, but particular needs consistently go unmet	Relationship between central administration & field has improved, room for progress	Regions are diverse, substance abuse is a pervasive challenge; treatment needs	Policy changes with practice implications are perceived to take place without appropriate consideration
Rural areas experience unique challenges	Particular needs consistently go unmet	Contracting & service standards challenges	Substance abuse treatment & foster homes are significant needs
Significant gaps exist between central administration & field staff	Rural & urban areas differ	Concrete services have expanded & are necessary for positive outcomes	Commitment to safety & strengthening families grounds leadership & practice, despite change/instability
Very limited understanding of Waiver	Articulating Waiver is a challenge & there is no new knowledge in general	Concrete services & creativity linked to Waiver	Waiver is inextricably connected to

			enhanced use of concrete services
Limited Waiver training & communication	Concrete services are helpful, but confusion exists	Evaluation data is source of Waiver knowledge & understanding	Conceptualizing practice without Waiver flexibility & creativity is difficult

The four rounds of interview data provided rich, compelling findings that contextualized the implementation of the 2012 Waiver. These interviews assisted in establishing trusting relationships with key members of the Department's executive team, which aided the evaluation overall. To assess the Managers' enhanced understanding and articulation of the Waiver, the evaluators examined data across rounds of data collection. Ultimately the evaluation team observed that Managers made clear connections between the 2012 Waiver's flexibility and the Department's ability to be creative in meeting unique needs of children and families. This improvement in perceptions ultimately assisted the Department in preventing removals, expediting permanency, and providing children and youth with normative experiences related to well-being.

Should the Evaluation Team have the opportunity to collect additional data, interviews designed to elicit Managers' perceptions of the Waiver's overall impact, plans for post-Waiver creativity, and the role of relationships with external evaluators in supporting data-driven practice could prove to be valuable to the Department and further evaluation efforts.

Family Case Manager (FCM) Survey

Methods

As part of the Process Study component of the evaluation, FCMs were surveyed to explore the types of services available to achieve the goals of the Waiver. Beginning in 2012, plans were made to administer this survey (with amendments as appropriate) annually throughout the demonstration period to determine if perceptions of the array of services change following the Waiver's implementation as well as whether or not new services are created, existing services are expanded, or a combination of both.

A pilot of the survey was conducted with 20 FCMs who were enrolled in a child welfare scholars program at the IU School of Social Work, as well as several DCS executives. Input and recommendations were incorporated into the questionnaire where applicable. To capture baseline information within a year of implementing the Waiver, the first FCM survey was distributed via email to all FCMs in April 2013. The electronic survey used the Qualtrics web-based survey tool.

After Round 1 in 2013, additional sections were added to the survey based upon how the Waiver was being utilized by DCS. Round 2 was administered in April 2014 and also aimed at capturing FCMs' views on various practices and services for children and families.

With a more directed effort, the Round 3 FCM survey in 2015 went through significant edits and additions with the joint work of the Evaluation Team and DCS and was administered in May 2015. DCS included staff from the field, evaluation, services, and fiscal areas to formulate new questions. Sections were added to investigate teaming, older youth, crisis services, supervision, and placement challenges.

In Round 4, the Evaluation team again worked with DCS Executive staff to amend questions and create additions that provided more information about the most recently closed cases as well as questions to better investigate placement and workload challenges. Data collection occurred in June 2016.

Data for Round 5 of the FCM survey began in July 2017.

Respondents

Demographic characteristics of those who completed the questionnaire are provided in Table 46.

Round 1

In 2013, 1287 surveys were distributed. Of the 968 survey questionnaires received, 889 were completed and usable for analysis purposes. The FCMs ranged in age from 22 to 69 years, with a mean of 34.9 years. The majority of respondents identified as being White, and the remainder identified themselves as either Black or Other. Also, FCMs had a mean of nearly eight years of experience working in social services and a mean of about 4.5 years working for DCS, or as an FCM.

Round 2

In 2014, 58% of the nearly 1500 surveys distributed were completed. After omitting surveys of FCMs who did not carry an active caseload, 54% of all distributed surveys were used for analysis. FCMs were similar to the previous year ranging in age from 22 to 69 years, with a mean of 35.1 years. The majority identified as White and the remaining FCMs identified themselves as either Black or Other. The

mean length of FCM experience was 4.3 years, slightly lower than the mean for the prior iteration of the survey.

Round 3

In 2015, 1300 (85%) of the 1535 surveys distributed were completed. Surveys completed by FCMs without an active caseload were omitted and the remaining 1238 (95%) of the surveys were used for analysis. Similar to the demographics in previous Rounds, FCMs ranged in age from 22 to 70 years, with a mean age of 34.39 years. Respondents' reported races were similar to previous Rounds, in that the majority identified as White, followed by Black and Other. In this Round, FCMs had the lowest average of years worked in the position 4 years, while the previous two years were 4.4 and 4.3 years, respectively.

Round 4

In 2016, 1909 surveys were distributed, 1511 people started the survey (79%), and 1461 people finished the survey (76.5%). Of the 1461 people who completed the survey, 1351 (92%) were FCMs with active caseloads and used for analysis. Similar to previous years, respondents were primarily White (78%) and Female (83%), with a mean age of 34.9 years. In Round 4, respondents worked an average of 3 years in the position, which was lower than all other rounds.

Round 5

In 2017, 2,176 surveys were distributed, 1643 people started the survey (76%), and 1,570 people (with two hearing about the survey through anonymous link) finished the survey (74%). Of the 1,570 people who completed the survey, 1499 (95.5%) were FCMs with active caseloads and used for analysis. Similar to previous years, respondents were primarily White (77%) and Female (85%), with a mean age of 34.9 years. In Round 5, respondents worked an average of 3 years in the position, which was lower than all other rounds, and slightly lower than round 4. FCMs had less than 3 years in their position, for the first time in all the years since surveying began. This could be a consequence of the increased numbers of new case managers; there are more this year than ever before. This is a result of DCS increasing hiring to offset the gaps created by implementng a lower case to case worker ratio. Tables 46 and 47 show the case manager demographics across all five rounds.

Table 46. Family Case Manager Demographic Characteristics

	2013 Mean(SD) or %	2014 Mean(SD) or %	2015 Mean(SD) or %	2016 Mean(SD) or %	2017 Mean (SD) or %
Age (years)	34.9 (10.0)	35.1 (10.0)	34.4 (9.4)	34.6 (9.3)	34.7 (9.8)
Gender: Female	83.4%	85.9%	84.9%	83.3%	84.5%
Male	16.1%	14.1%		16.2%	15%
Other	N/A	N/A	N/A	N/A	0.5%
Race: White	76.9%	75.2%	78.4%	77.6%	76.8%
Black	18.4%	19.9%	17.7%	17.2%	17.9%
Other	4.7%	4.9%	3.9%	5.2%	5.3%
No. of yrs worked in social services	7.8 (7.2)	7.8 (7.3)	7.5 (7.2)	7.1 (6.8)	6.2 (6.8)
No. of yrs worked for DCS	4.6 (5.0)	4.4 (5.5)	4.2 (4.7)	3.6 (4.5)	3.4 (4.5)
No. of yrs worked as an FCM	4.4 (4.7)	4.3 (5.2)	4.0 (4.5)	3.4 (4.2)	2.91 (4.2)

Table 47. Family Case Manager Demographic Characteristics

	2013 Range	2014 Range	2015 Range	2015 Range	2017 Range
Age (years)	22-69	22-69	22-70	21-66	21-71
No. of yrs worked in social services	.17-44	.25-46	.08-44	.08-40	0-39
No. of yrs worked for DCS	.34-44	.38-46	.08-36	.08-38	0-31
No. of yrs worked as an FCM	.08-44	.25-46	.08-35	.08-38	0-31

Changes over time for Most Recently Opened and Closed Cases

Starting in 2013, FCMs have been asked to rate their most recently opened case and most recently closed case in the domains of safety, permanency, and well-being. The hypotheses were that since Waiver implementation, 1. FCMs most recently closed cases will improve in the domains of safety, permanency, and well-being over time and 2. FCMs most recently opened cases will remain the same or decline in the domains of safety, permanency, and well-being. Below is the Figure that presents mean scores for the FCMs' most recently opened and most recently closed cases (Range 1-5).

Table 48. Demographic Information about the Most Recently Opened Cases

	Percent or Mean (SD)				
	2013	2014	2015	2016	2017
Gender					
Female	52.4	50.9	50.0	48.7	50.9
Male	47.5	48.8	49.3	51.0	48.9
Other	0.1	0.2	0.7	0.3	0.2
Age	5.9 (5.4)	5.9 (5.4)	3.8 (4.9)	5.7 (5.5)	6.5 (5.4)
Race					
White	73.8	72.9	70.5	72.1	73.9
Black or African American	17.5	18.5	18.6	16.7	14.9
American Indian/Alaska Native/Native Hawaiian or Other Pacific Islander	0.4	0.1	0.2	0.5	0.4
More than One Race	6.9	6.6	8.8	8.8	8.9
Other	1.4	1.8	2.0	1.9	1.9
Ethnicity					
Hispanic	8.5	6.9	5.7	6.3	6.4
International Cultural Affairs Referral (yes)	-	-	-	11.1	42.9

Table 49. Demographic Information about the Most Recently Closed Cases

	Percent or Mean (SD)				
	2013	2014	2015	2016	2017

Gender					
Female	49.8	53.2	51.5	49.3	50.8
Male	49.0	46.8	48.3	50.4	49.0
Other	0.0	0.0	0.0	0.2	0.2
Age	7.5 (6.3)	9.7 (5.9)	6.4 (5.6)	7.3 (6.7)	8.4 (5.5)
Race					
White	74.2	73.9	71.7	73.7	72.7
Black or African American	16.6	18.4	17.0	16.5	17.8
American Indian/Alaska Native/Native Hawaiian or Other Pacific Islander	0.3	0.1	0.1	0.6	0.6
More than One Race	7.1	6.0	8.9	8.2	7.6
Other	1.8	1.6	1.8	1.0	1.3
Ethnicity					
Hispanic	6.8	5.4	9.4	6.2	7.0
US Citizen					
Yes	N/A	N/A	N/A	99.2	99.8
Number of FCMs that served the case	0.8 (1.1)	0.9 (1.1)	1.1 (0.3)	1.2 (4.0)	1.1 (0.2)
Number of months case was open	-	-	-	12.8 (16.1)	14.4 (21.5)
Number of CFTMs held through case	-	-	-	4.1 (3.9)	4.5 (5.3)

Figure 31. Safety, Permanency, and Well-being (Range 1-6)

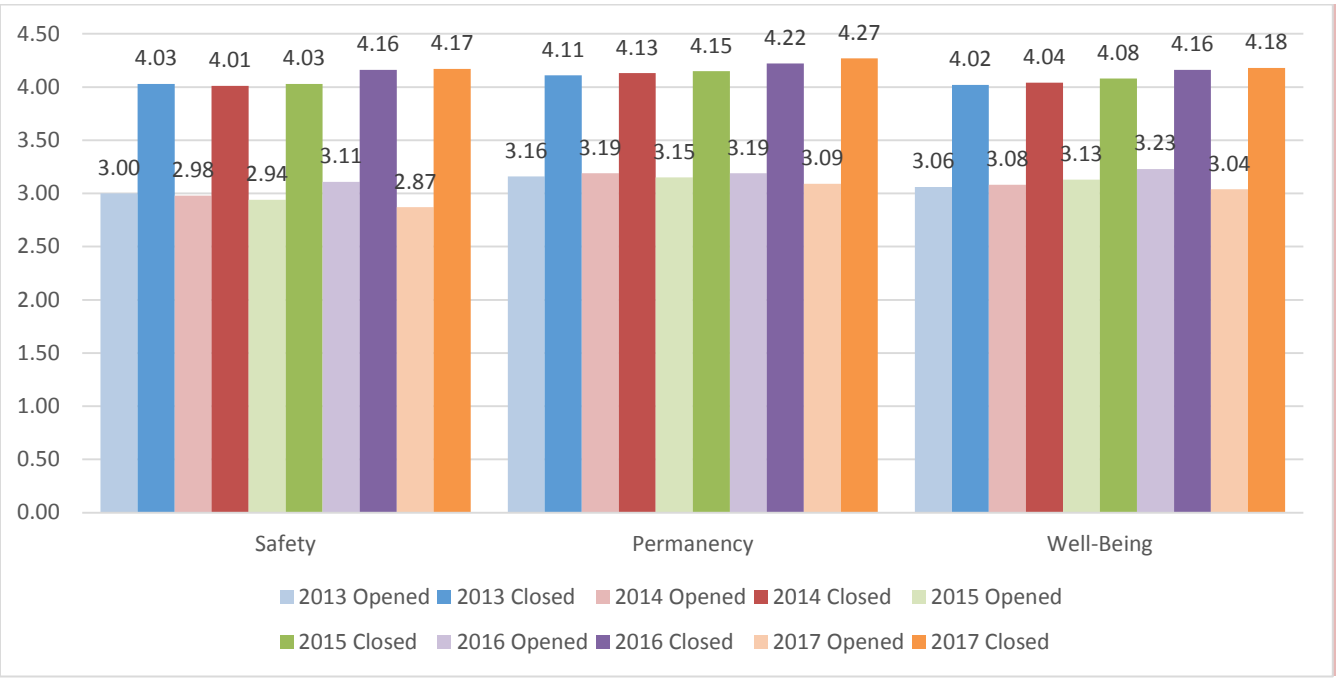


Figure 32. Well-being domains (Range 1-6)

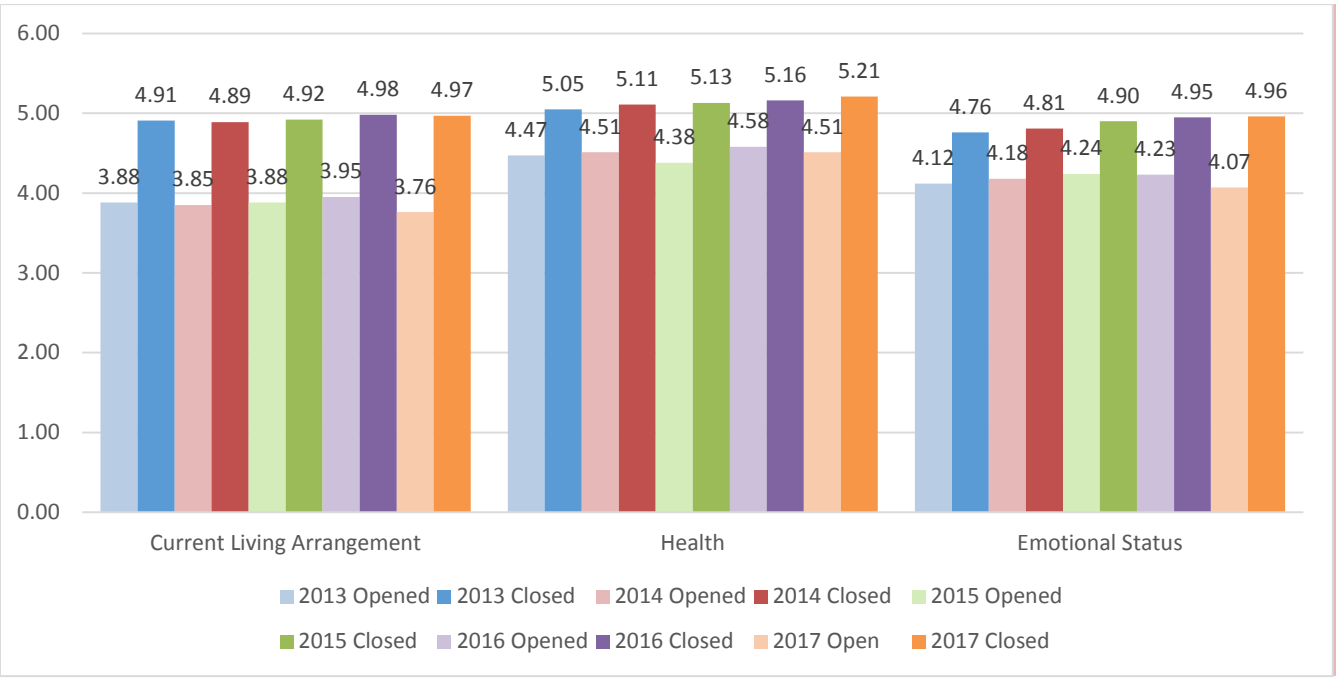
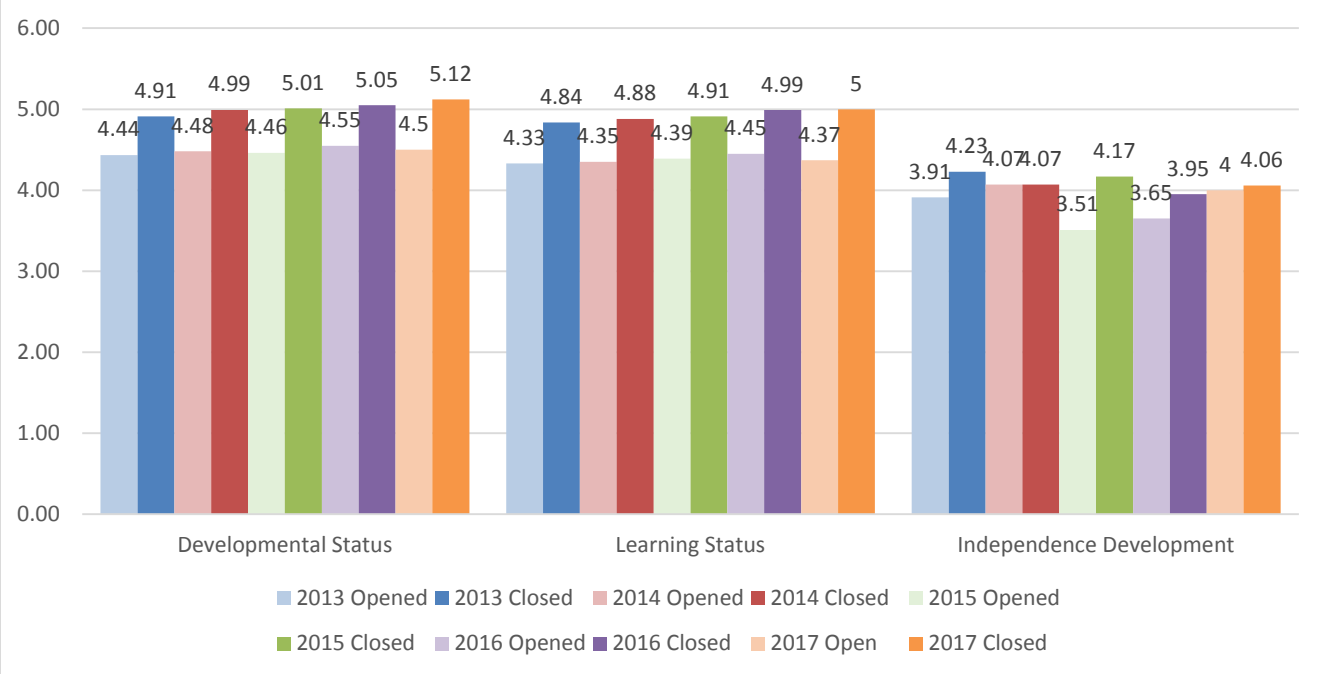


Figure 33. Well-being domains continued (Range 1-6)



Similar to the overall well-being indicator, FCMs' perceptions of their last closed cases emotional status, developmental status, and learning status all had significant changes over time for both opened and closed cases, but the magnitude of the change was slightly greater at closed cases than at opened cases.

For health, the most recently opened cases remained similar at case open over time, while the most recently close cases saw improvement over time. For the current living arrangement and independence development, change in FCMs' perception over time was not a significant factor for either the most recently opened or closed cases.

Most Recently Closed Cases

In Round 5, nearly 70% of FCMs reported a recently closed case (n=1005). Table 7 displays demographic information about the most recently closed cases FCM selected. There were slightly more females than males included in the cases FCMs chose. The majority of closed cases were children and youth aged 3 years or older (84.1%), white (72.7%), non-Hispanic (93.0%), and US citizens (99.8%).

As can be seen in Figure 6, 67% of the closed cases were Child in Need of Services (CHINS) cases (n = 661), 5% (n = 51) were Assessment, and 24% (n = 241) were Informal Adjustment cases. Of CHINS cases, the majority were out of home (n=567; 74%) with the rest being in home. Among children who were removed from their home (n = 586), the most prevalent out of home placement was relative's home (58%), followed by foster home (23%) and therapeutic foster home (2.7%). Across all five rounds, the percentage of CHINS cases decreased, while the percentage of assessment cases increased. The percentage of informal adjustment cases decreased from Round 1-4, and slightly increased from rounds 4 to 5. The percentages of 3CM/CHINS and collaborative care cases remained relatively steady over the rounds.

Figure 34. Most Recently Closed Case Types by Percentage

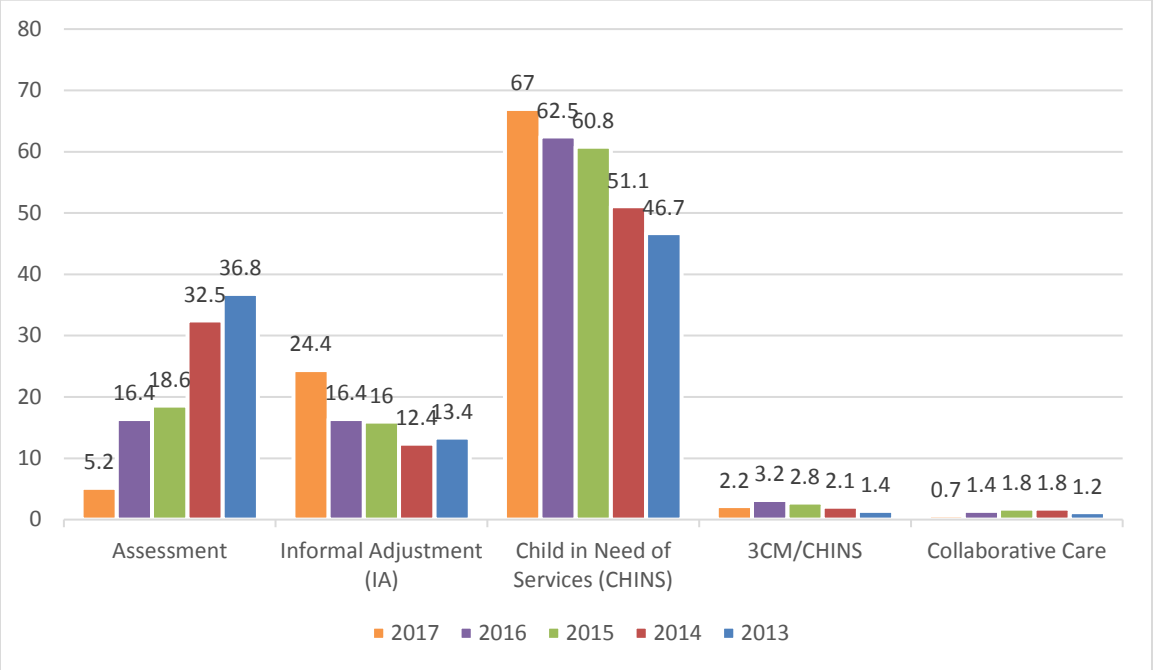


Figure 35. Out of Home Care Placements for Most Recently Closed Cases

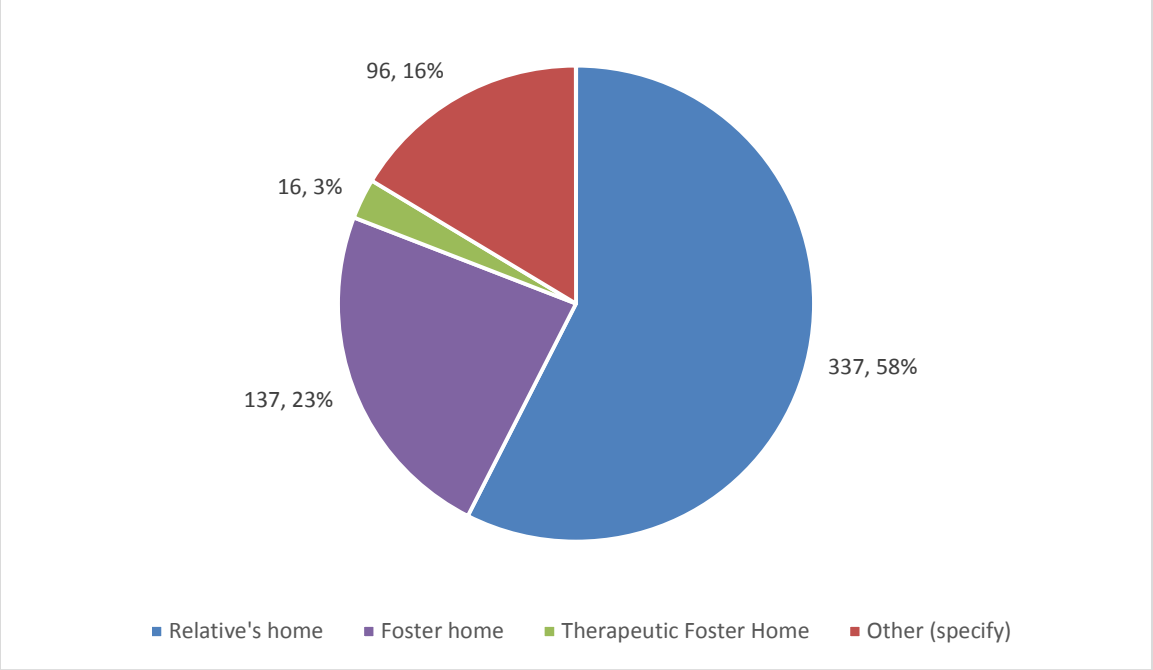


Figure 35 displays the services that children and/or their parents had received for both 2017 and 2016; *n* values are represented in Table 50. FCMs reported that the five top services utilized include: (1) case management, (2) home-based services, (3) substances abuse services, (4) mental health services for both parent and child, and (5) concrete items/services. While the majority of services remained the same as Round 4, concrete items was an addition to the top five list in Round 5.

Table 50. Status of the Most Recently Closed Case

	Percent				
	2013	2014	2015	2016	2017
Reunification	70.6	55.9	70.1	64.5	67.1
Adoption	10.4	8.2	8.4	6.0	7.8
Guardianship	4.6	3.6	4.9	7.3	6.2
APPLA	3.9	3.1	2.9	2.8	2.5
Fit and Willing Relative	2.4	1.9	2.5	2.1	1.2
Runaway	0.8	0.7	0.7	0.9	0.4
Aging Out w/o Permanency	0.3	0.2	0.5	0.8	0.8
Closure by Court	6.8	5.4	8.4	-	-
Closed Assessment	-	-	-	-	5.3
Other	-	20.8	10.0	15.6	8.7

Figure 36. Percentage of Services provided for Closed Cases

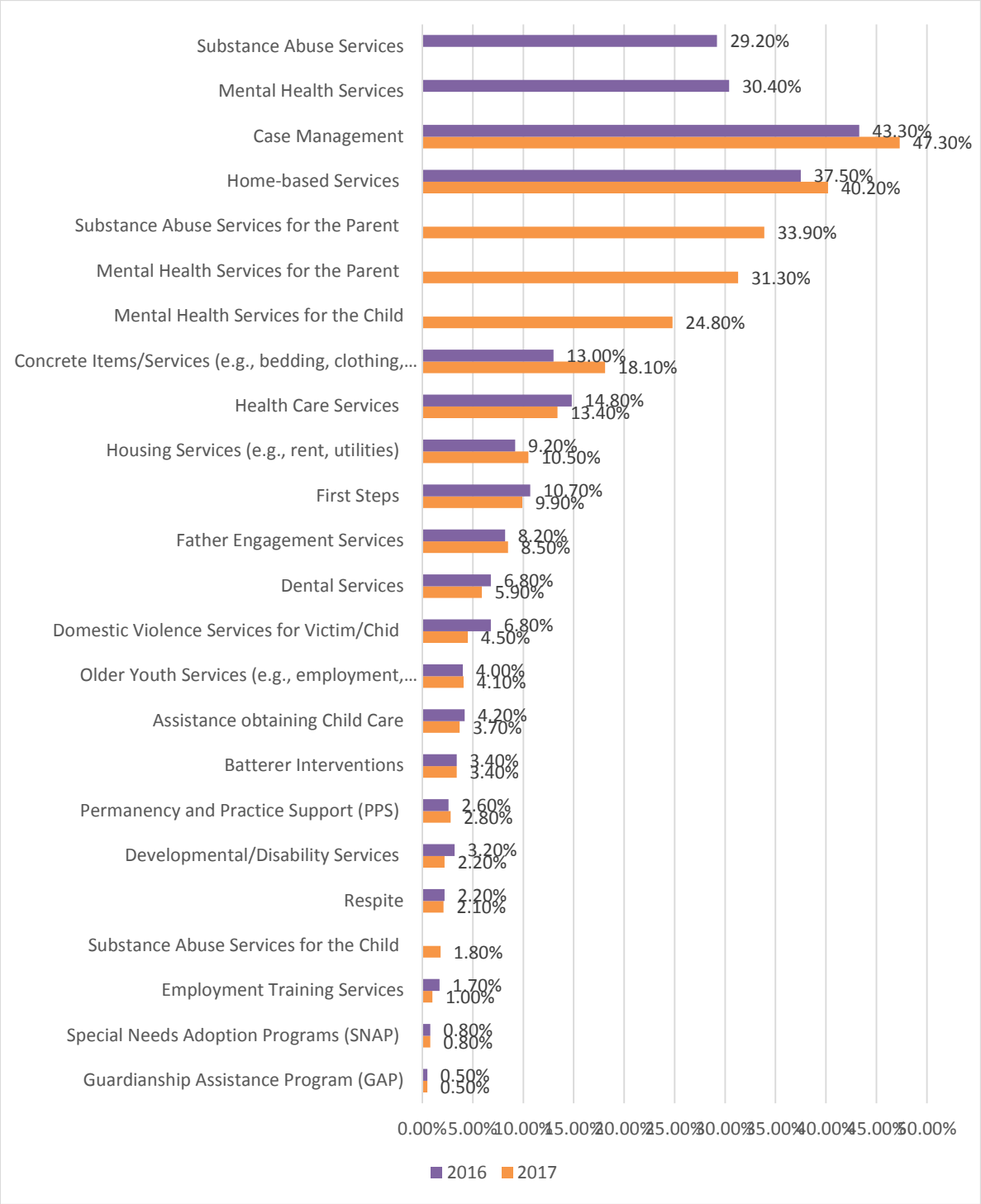


Table 51. Services Provided for Closed Cases.

	2017	2016		2017	2016
Guardianship Assistance Program (GAP)	8	7	**Father Engagement Services**	134	120
Special Needs Adoption Programs (SNAP)	12	11	**First Steps**	156	157
Employment Training Services	15	25	**Housing Services (e.g., rent, utilities)**	165	134
Substance Abuse Services for the Child	29		**Health Care Services**	211	216
Respite	33	32	**Concrete Items/Services (e.g., bedding, clothing, pest control)**	284	190
Developmental/Disability Services	35	47	**Mental Health Services**		444
Permanency and Practice Support (PPS)	44	38	**Mental Health Services for the Child**	389	
Batterer Interventions	53	49	**Mental Health Services for the Parent**	492	
Substance Abuse Services for the Parent	532		**Case Management**	742	633
Home-based Services	631	548	**Substance Abuse Services**		426

In 2016 and 2017, FCMs were also asked to rate the effectiveness of utilized services to meet child/family needs; responses ranged from Not at all (=1) to Completely (=3). In general, most services appeared to be at least "somewhat" effective (see Figure 8). More specifically, 100% of respondents (n=8) who reported found that the Guardianship Assistantship Program (GAP) was completely effective. Additionally, 93.9% of Respite (n=33), 91.4% of Dental services (n=93), 91.7% of Special Needs Adoption Program (SNAP) (n=12), 87.9% percent of Concrete Services (n=282), and 83.3% of health care services (n=210) were rated as "completely" effective. However, the services that had the highest percentage of "not at all effective" as indicated by FCMs were father engagement services (17.9%), substance abuse services for the parent (15.4%), and employment training services (13.3%).

Figure 37. Effectiveness of Services Provided for Closed Cases (Mean)

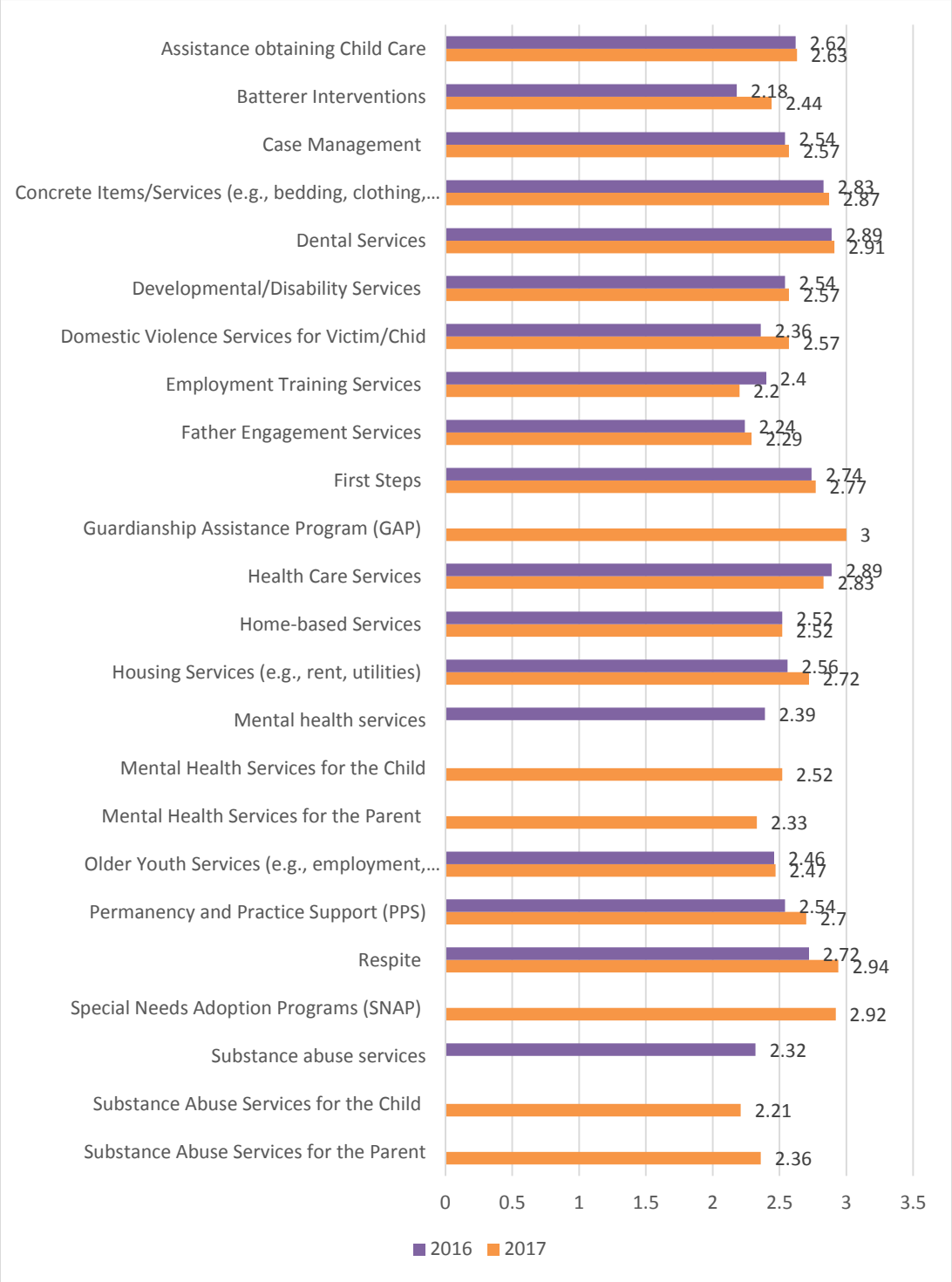
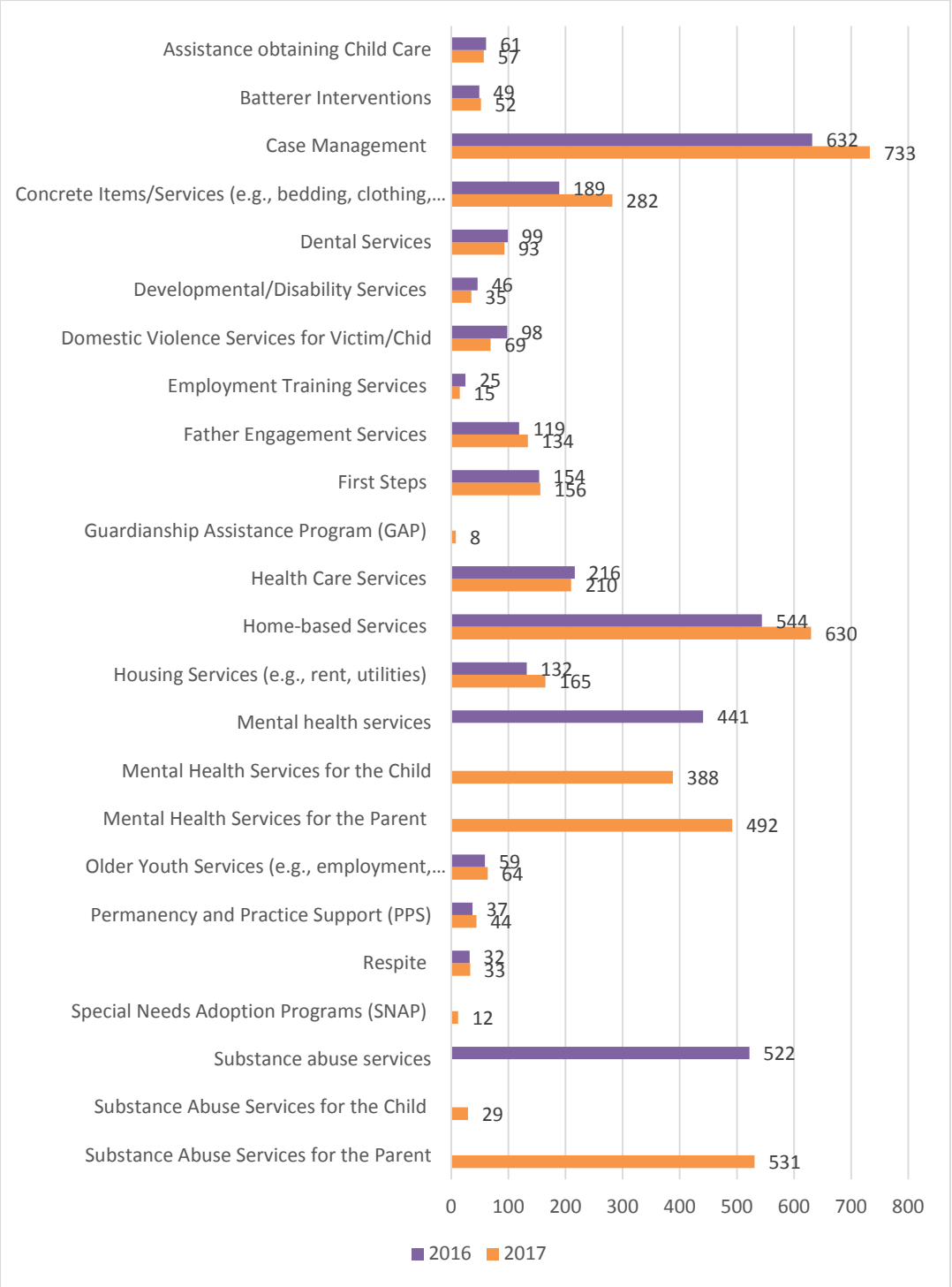
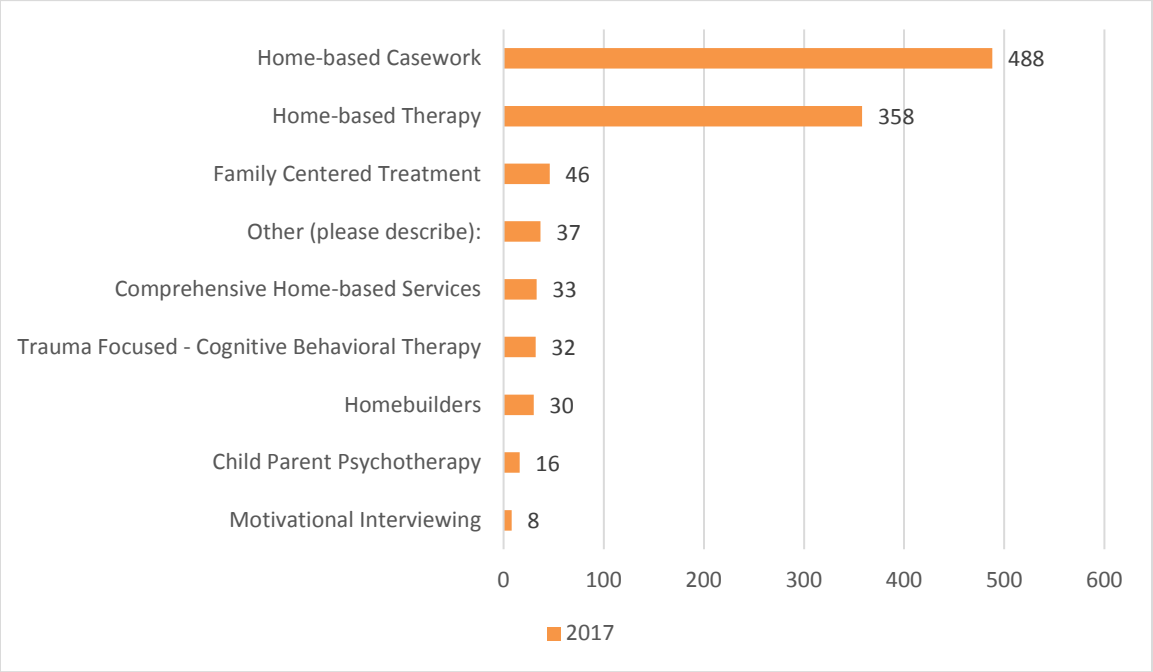


Figure 38. Effectiveness of services (N)



In 2017, FCMs were asked to indicate which home based service the families of their most recently closed case used. Home-based casework (n=488) and therapy were the most likely services to be used. Motivational interviewing (n=8) and child-parent psychotherapy (n=16) were the least reported used.

Figure 39. Home based services of most recently closed case

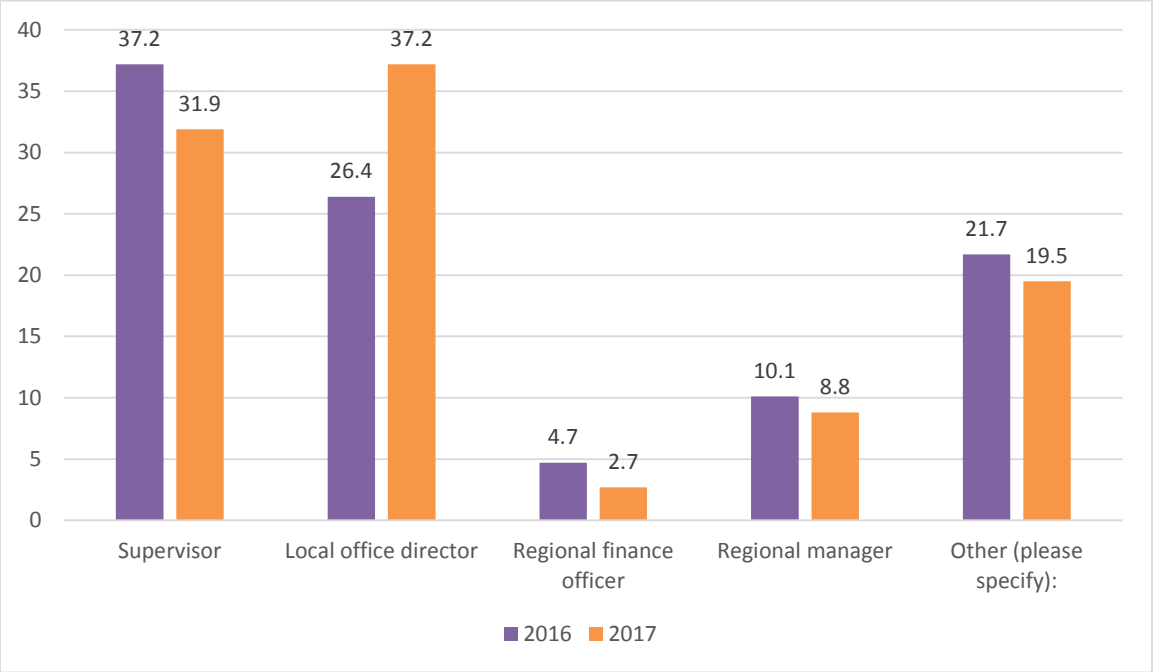


Concrete Services

In 2015, FCMs were asked if there were any items or services that could have moved a child to permanency quicker. Of those who answered, about 5% (n=47; 5.7%) and (n=46; 5.6%) respectively reported that there were items and services that could have helped move a family to permanency. In 2016, FCMs were asked whether there were any items or services that were essential to keeping the child/youth safely in the home that they were not able to access either through DCS funding or other community resources. In 2016, nearly 10% (n=129, 9.9%) reported that there were items or services unattainable. In 2016 and 2017, FCMs were then asked whether they had a concrete service or item denied. In 2016, n=129 (9.9%) and in 2017 n=117 (8.2%) reported being denied a concreate item or

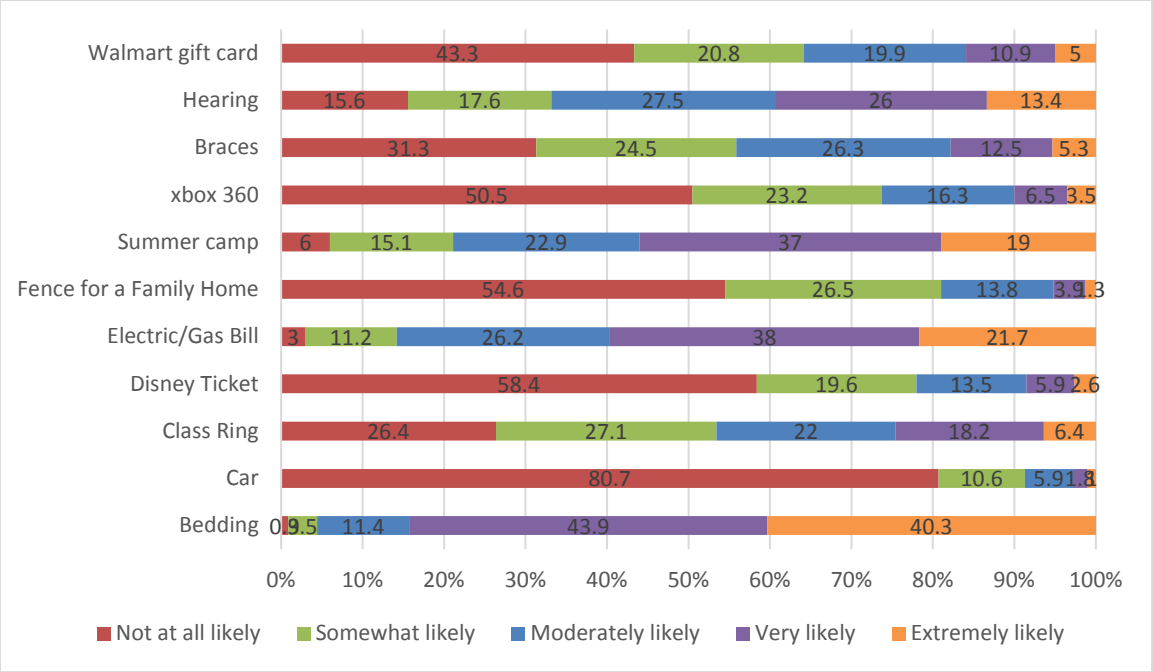
service. When FCMs were asked to report the level of denial, supervisors (37.2%) were found to be the primary deniers in 2016, this was shifted to the local office director in 2017 (37.2%).

Figure 40. Level of Service/Item Denial by Percentage.



In 2016, FCMs rated the likelihood of approval of certain concrete items/services. As illustrated in Figure 41, bedding, electric/gas bill, and summer camp were the three items/services most likely to be approved, while a car, Disney ticket and fence were rated as not at all likely to be chosen.

Figure 11. Items/Services most likely to be approved.

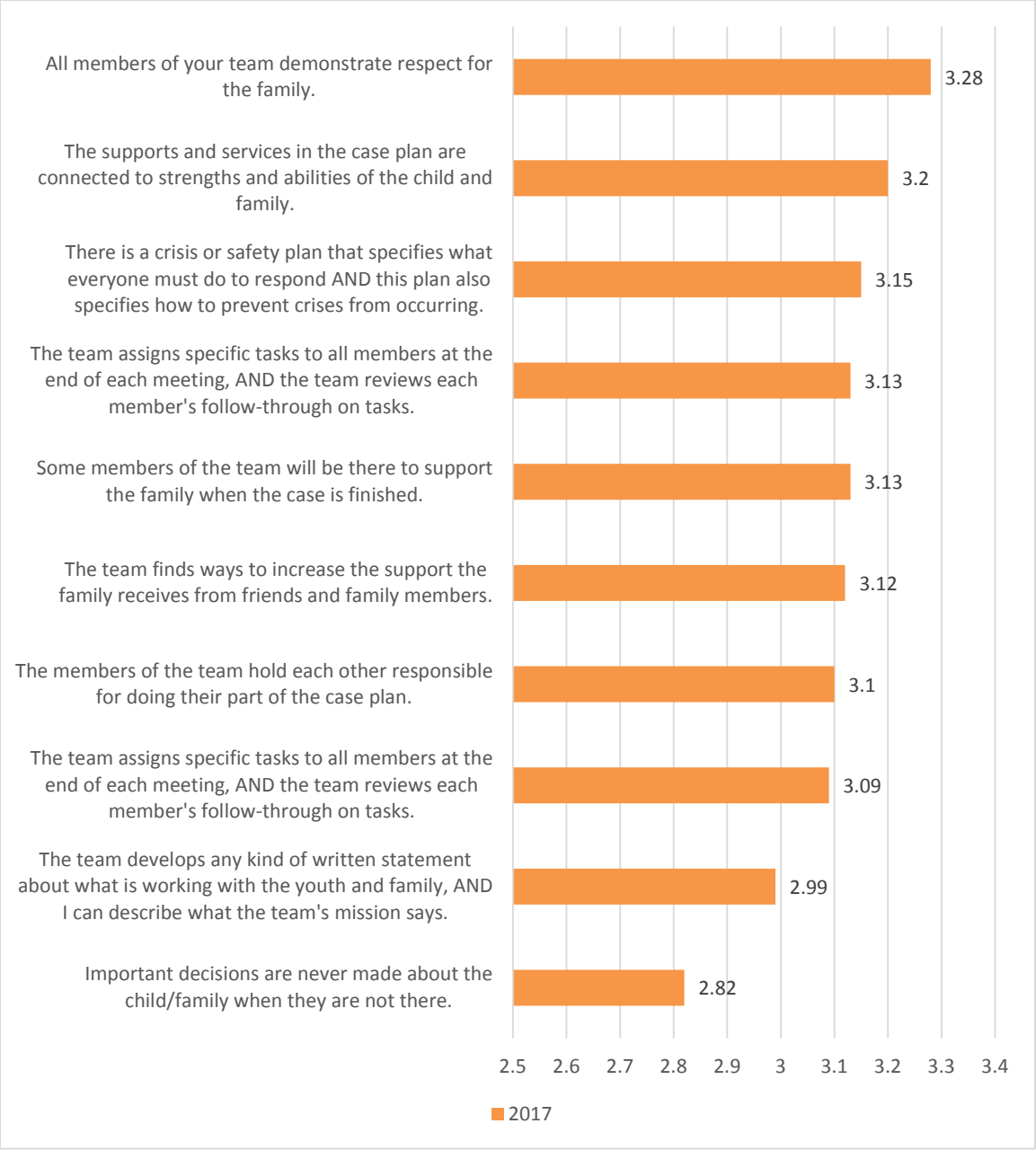


FCMs were also asked to list what some of the unmet needs were. Of those listed more than once: additional clothing, bed/bedding, races, transportation (bus fare, gas money, vehicle repair), child care, housing (rent, Section 8), utilities, rehab, and supervised visitation.

Child and Family Team Meetings (CFTMs)

In Round 5, FCMs were asked to rate the fidelity of implementing a Child and Family Team Meeting (CFTM) (Figure 9) using the reduced and modified version of the Wraparound Fidelity Index (Pullmann, Bruns, & Sather, 2013). The average score of 10 items that represent the core principles of CFTM, respectively, was 3.1 (range 1-4), suggesting that FCMs agreed or strongly agreed with most statements. In particular, FCMs were more likely to perceive that "all members of the team demonstrate respect for the family" (M = 3.28), whereas they were less likely to perceive that "important decisions are never made about the child/family when they are not there" (M = 2.82). In other words, they reported a relatively lower level of family voice and choice in CFTMs.

Figure 42. The Average Ratings of the Fidelity of CFTM

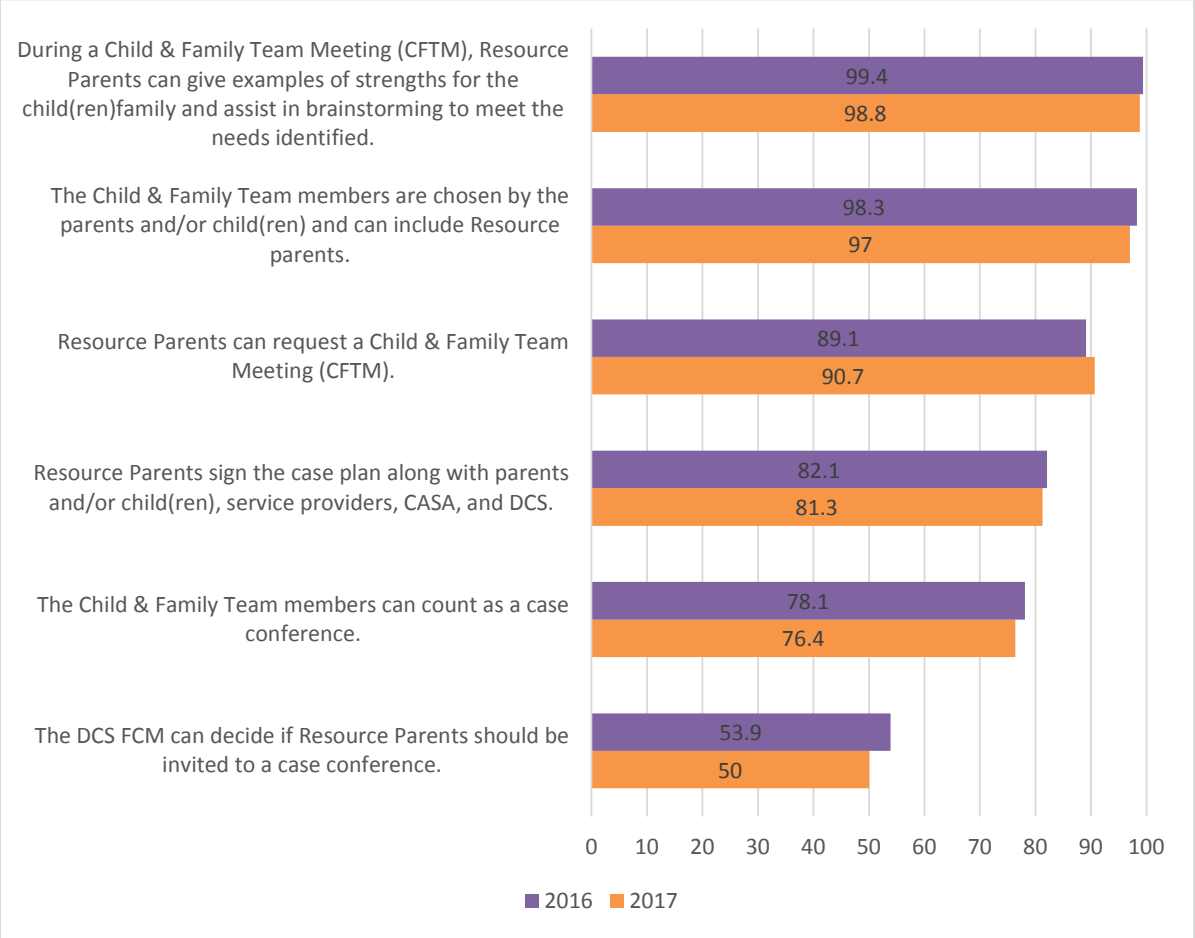


FCMs were also asked to respond to true/false statements on child and family team meetings. Figure 43 represents the number of FCMs who answered correctly the questions on CFTMs. The questions and correct percentages are illustrated in Figure 43, and listed with justification below.

- During a Child and Family Team Meeting, Resource Parents can give examples of strengths for the child(ren)/family and assist in brainstorming to meet the needs identified. **This is true, all team members contribute during the CFTM.**

- The Child and Family Team members are chosen by the parents, and/or child(ren), and can include Resource Parents. It was true that **the CFTM is a family driven process and parents and/or child decide who should they would like on their team.**
- Resource Parents can request a Child and Family Team Meeting. **Yes, Resource Parents can request a CFTM. An example would be if Resource Parents need assistance in supporting the child(ren).**
- Resource Parents sign the Case Plan along with Parents and/or child, Service Providers, CASA and DCS. Yes, **resource Parents are a required party to sign the Case Plan.**
- The Child and Family Team Meeting does not count as a Case Conference. **A CFTM can count as a Case Conference if certain parties attend. In 2016, this was marked as false, but in 2017 the answer was changed to true.**
- The FCM can decide if Resource Parents should be invited to a case conference. **Answer: Foster Parents are automatically invited to a Case Conference and are to receive a copy of the case Plan.**

Figure 43. FCM Knowledge of CFTMs – Percent of FCMs who answered question correctly



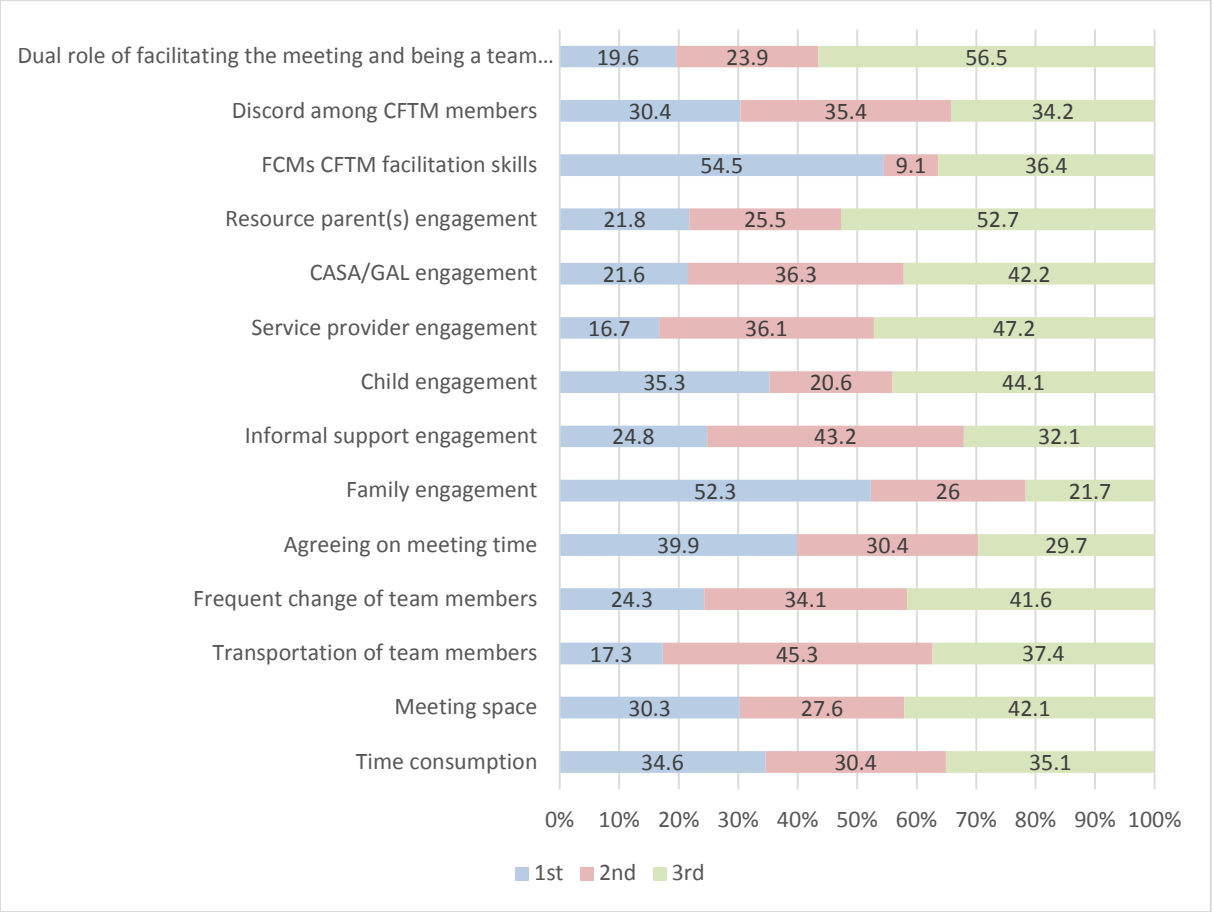
In round 5, FCMs were asked to select and rank the top three items that most often interferes with holding CFTMs from a list. Family engagement was the most often ranked as number 1, and agreeing on

meeting time was the second most ranked as number 1. The dual role of facilitating the meeting and being a team member was one of the lowest ranked items interfering with CFTMs.

Table 52. Items interfering with CFTMs Ranked (N)

	1	2	3
Time consumption	132	116	134
Meeting space	23	21	32
Transportation of team members	57	149	123
Frequent change of team members	62	87	106
Agreeing on meeting time	240	183	179
Family engagement	352	175	146
Informal support engagement	105	183	136
Child engagement	12	7	15
Service provider engagement	24	52	68
CASA/GAL engagement	22	37	43
Resource parent(s) engagement	12	14	29
FCMs CFTM facilitation skills	6	1	4
Discord among CFTM members	123	143	138
Dual role of facilitating the meeting and being a team member	9	11	26

Figure 44. Items interfering with CFTMs Ranked (%)



Perceptions of the Service Array

The questionnaire also listed a comprehensive array of services and, for each, FCMs were asked to rate: a) the need for that service; b) availability of that service when needed; c) utilization of that service when available; and d) effectiveness of that service when utilized. Questions focusing on services used by families were developed using components of the health services utilization model.[3] Service need, availability, utilization, and effectiveness were each rated on five-point scales with high scores indicating greater need, availability, and so on.

In 2015, Waiver supported services were added to the list of services for FCMs to rate. These included comprehensive home-based services, trauma focused cognitive behavioral therapy, family centered treatment, child parent psychotherapy, children's mental health initiative, and motivational interviewing.

Mean responses of questions relating to service arrays are displayed in Figures 45-52. Overall, FCMs reported that most services were "sometimes" or "usually" needed, available, and utilized. Additionally, FCMs reported that most services were moderately effective when utilized by families.

More specifically, services perceived as most frequently needed (Figures 45 and 46) included miscellaneous "Other" services (e.g., camps, after-school programming), Substance Abuse services, Mental Health services, Health Care services, and Public Assistance. On the other hand, Psycho-education, Developmental Disability services, Dental services, and services related to Father Engagement and Domestic Violence were perceived as needed relatively less frequently. Among the most needed services, FCMs perceived that most were usually available (Figures 47 and 48. Similar to their perception of need, FCMs perceived greater availability of services as compared to previous years. It seems that there was a larger increase in perceived availability for Wavier supported services.

FCMs reported that most services were usually utilized when available (Figures 49 and 50). And similar to availability and need, services were perceived as more utilized less in past years. In terms of perceived effectiveness (Figures 51 and 52), FCMs rated miscellaneous "Other" services (e.g., camps, after-school programming), Dental services, Motivational Interviewing, and Trauma Focused-Cognitive Behavioral Therapy as the most effective, with the rest perceived as moderately effective. The services perceived as least effective were Substance Abuse services, Domestic Violence, Mental Health services, and Father Engagement. Compared to previous years, perceived effectiveness increased in 2016.

[3] Davidson, P. L., Andersen, R. M., Wyn, R., & Brown, E. R. (2004). A framework for evaluating safety-net and other community-level factors on access for low-income populations. *Inquiry, 41*(1), 21-38.

Figure 45. 2013 – 2017 Average Rating of Need for Services

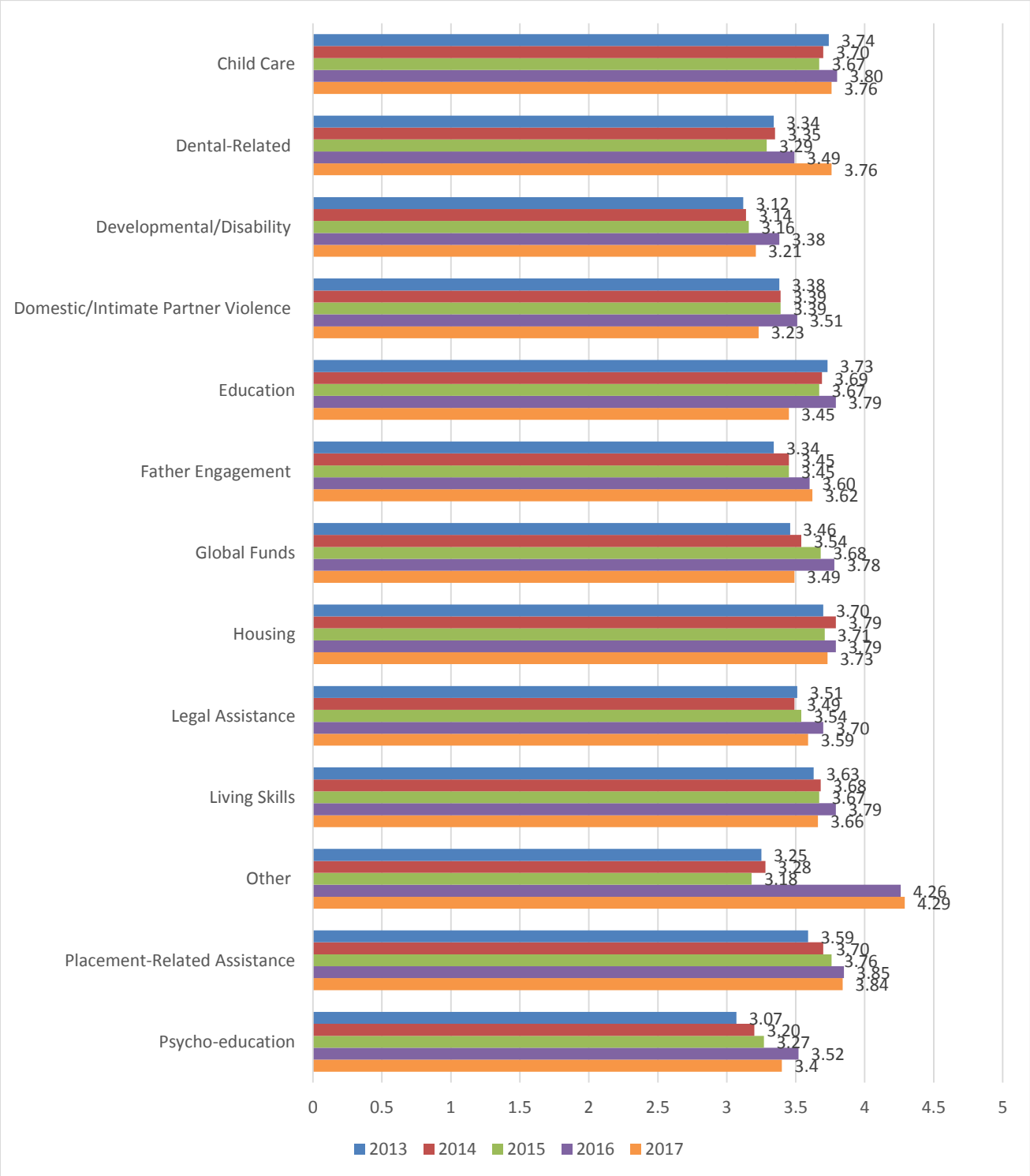


Figure 46. 2013 – 2017 Average Rating of Need for Services (Continued)

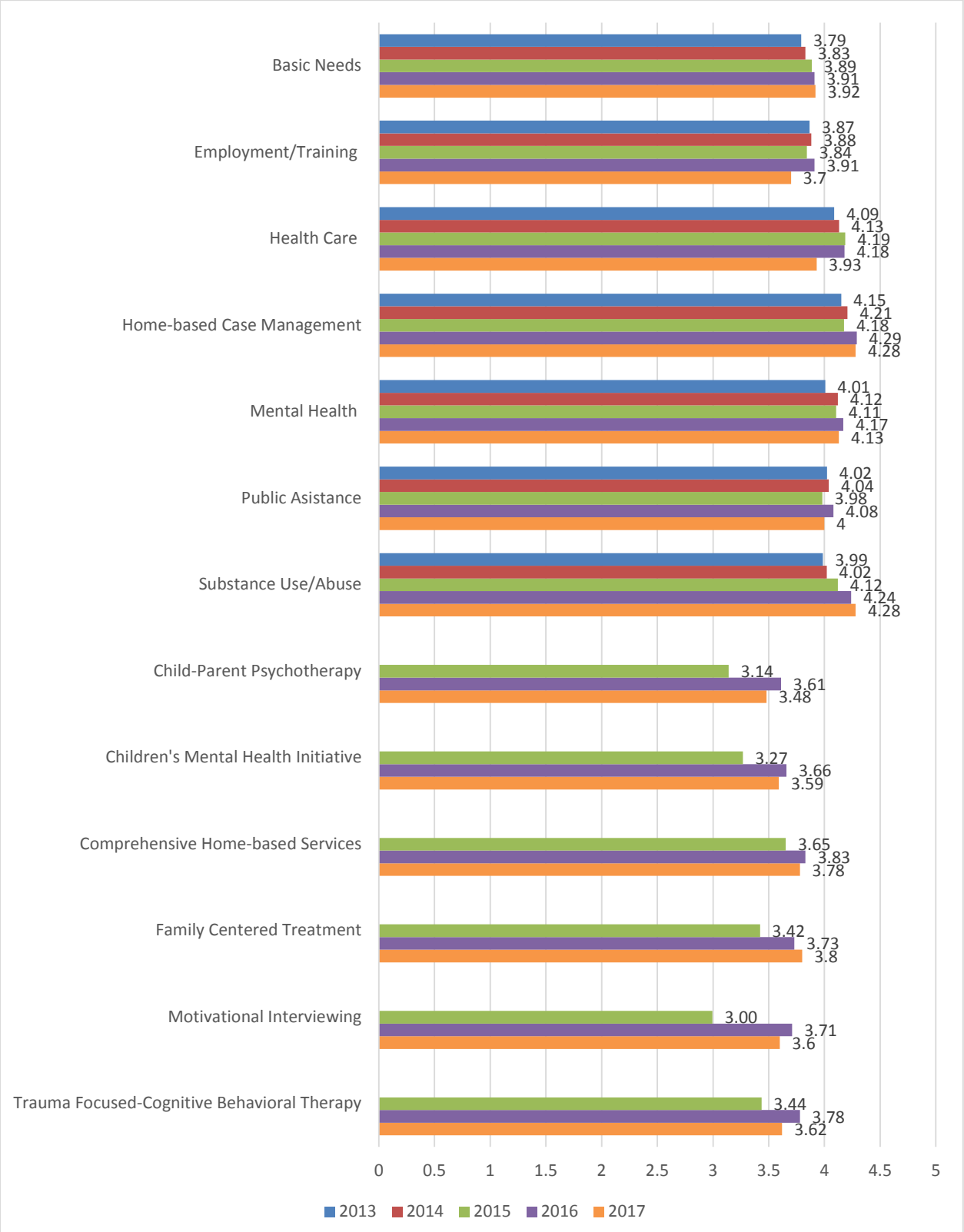


Figure 47. 2013 – 2017 Average Rating of Availability for Services

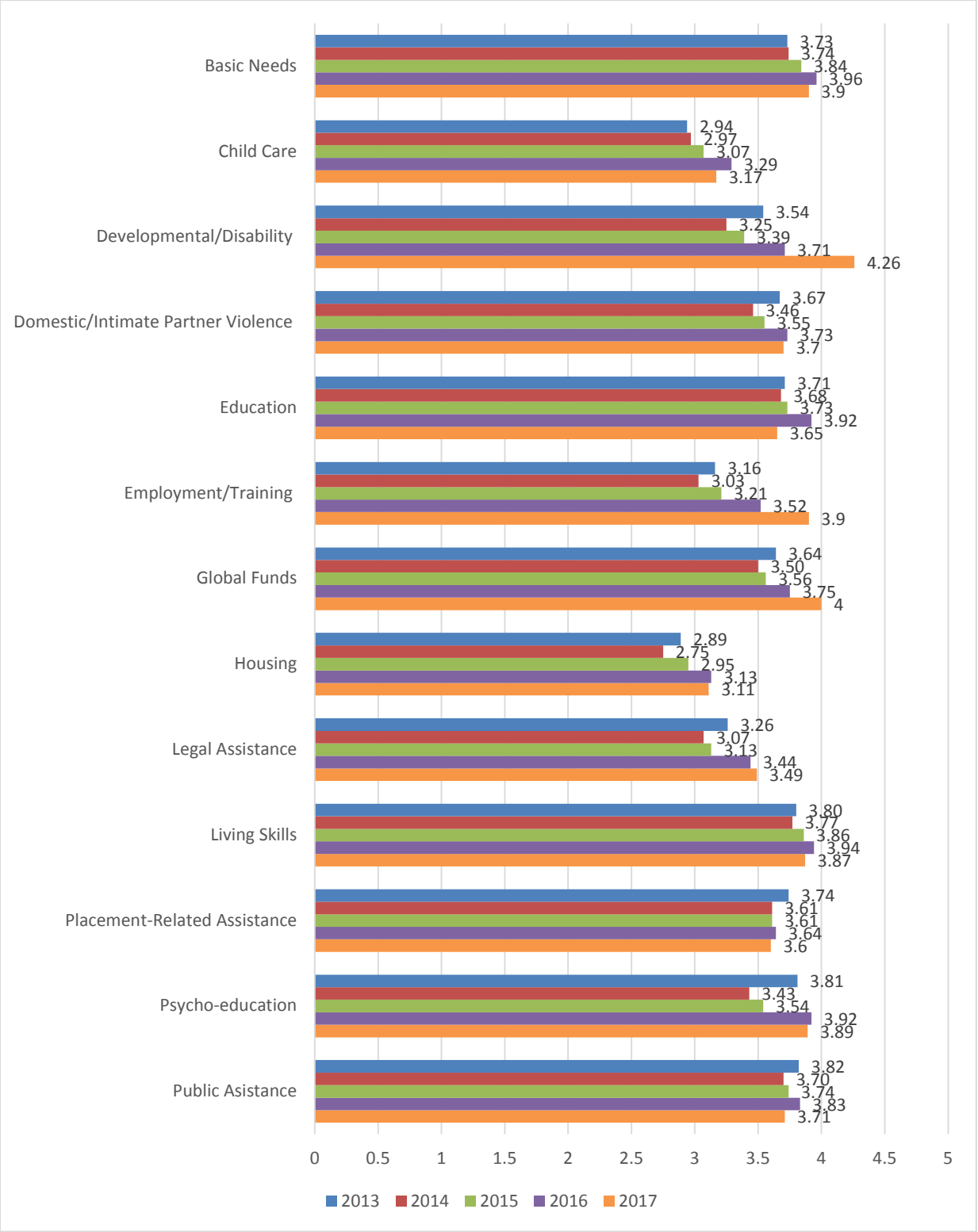


Figure 48. 2013 – 2017 Average Rating of Availability for Services (Continued)

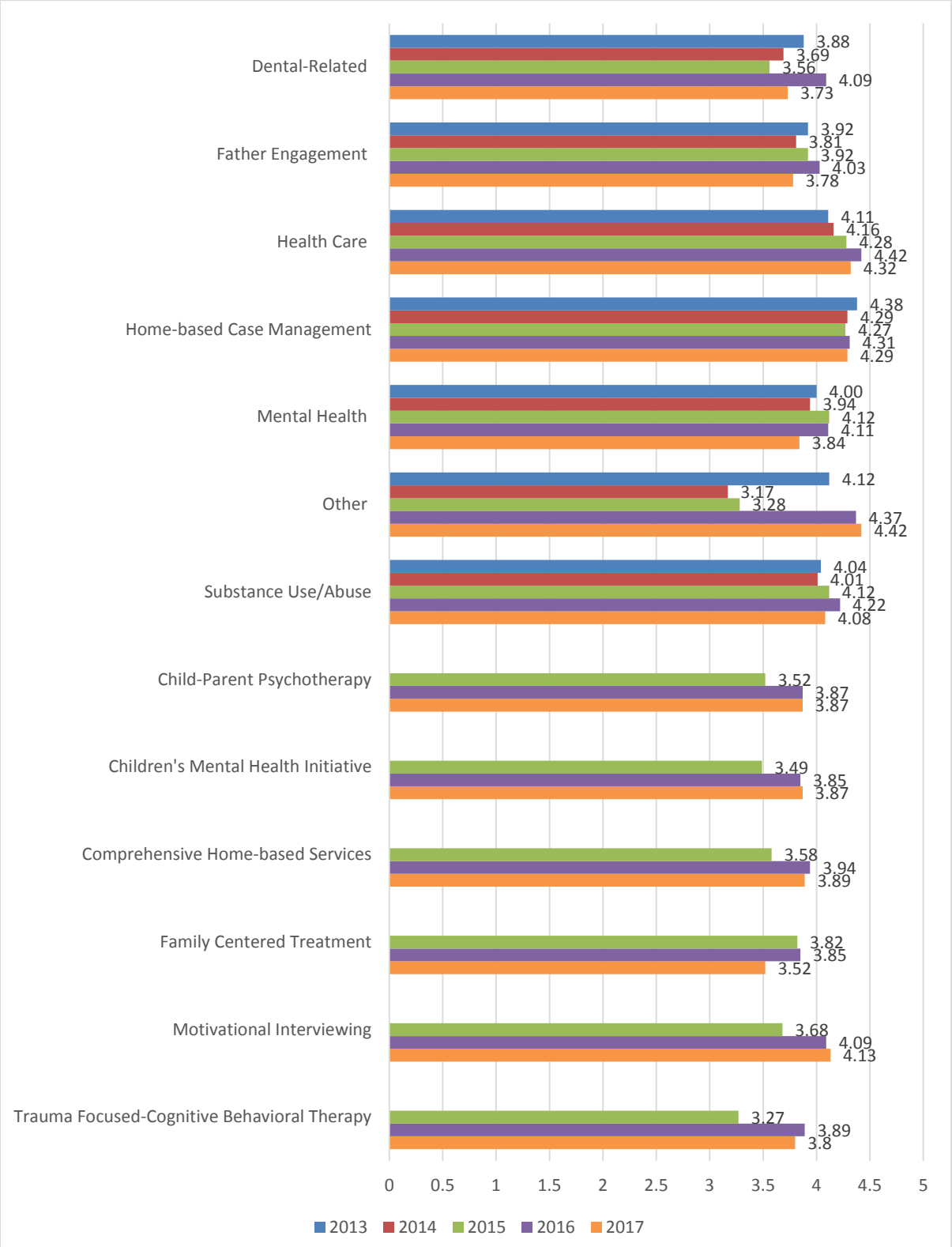


Figure 49. 2013 – 2017 Average Utilization of Services When Needed

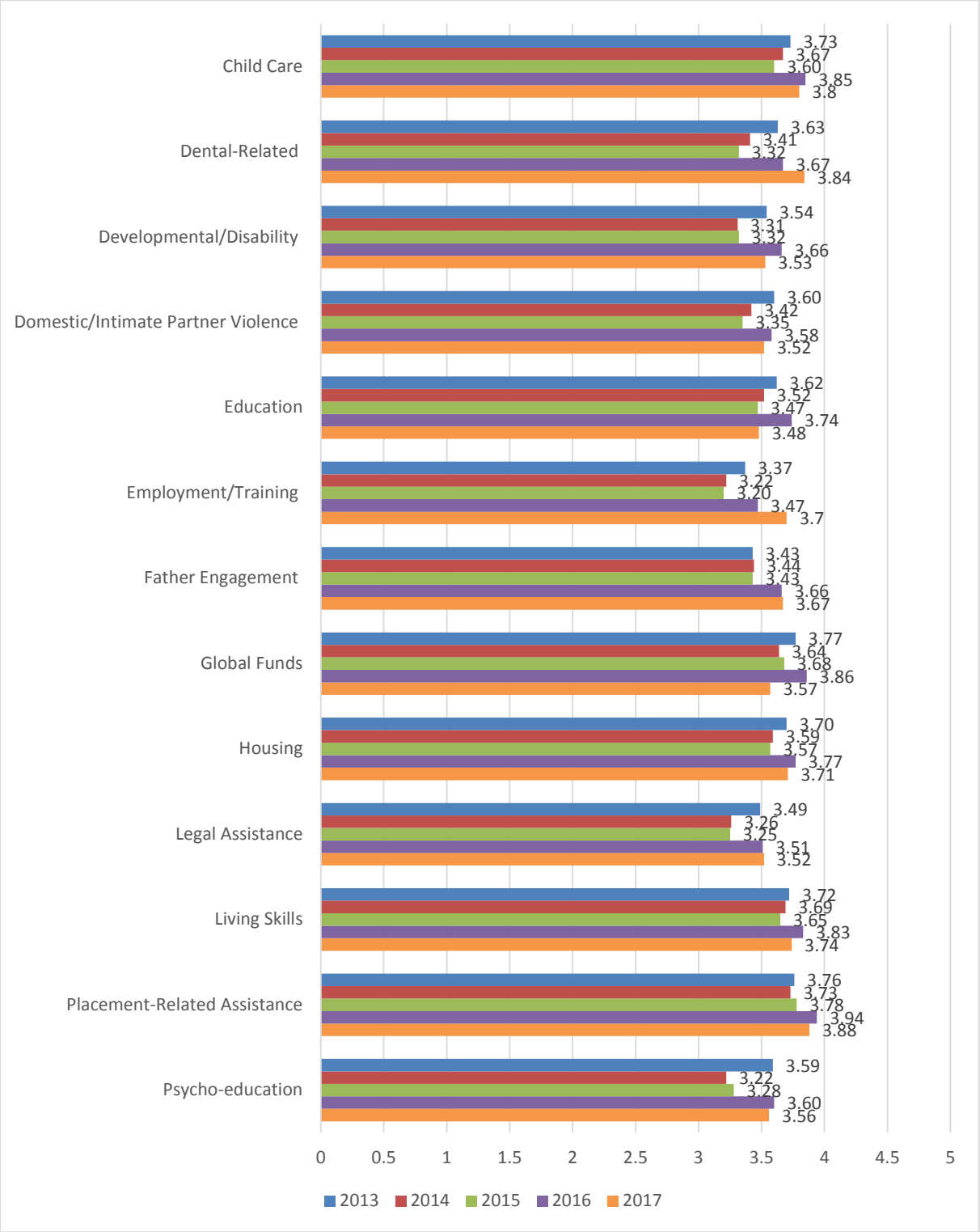


Figure 50. 2013 – 2017 Average Utilization of Services When Needed (Continued)

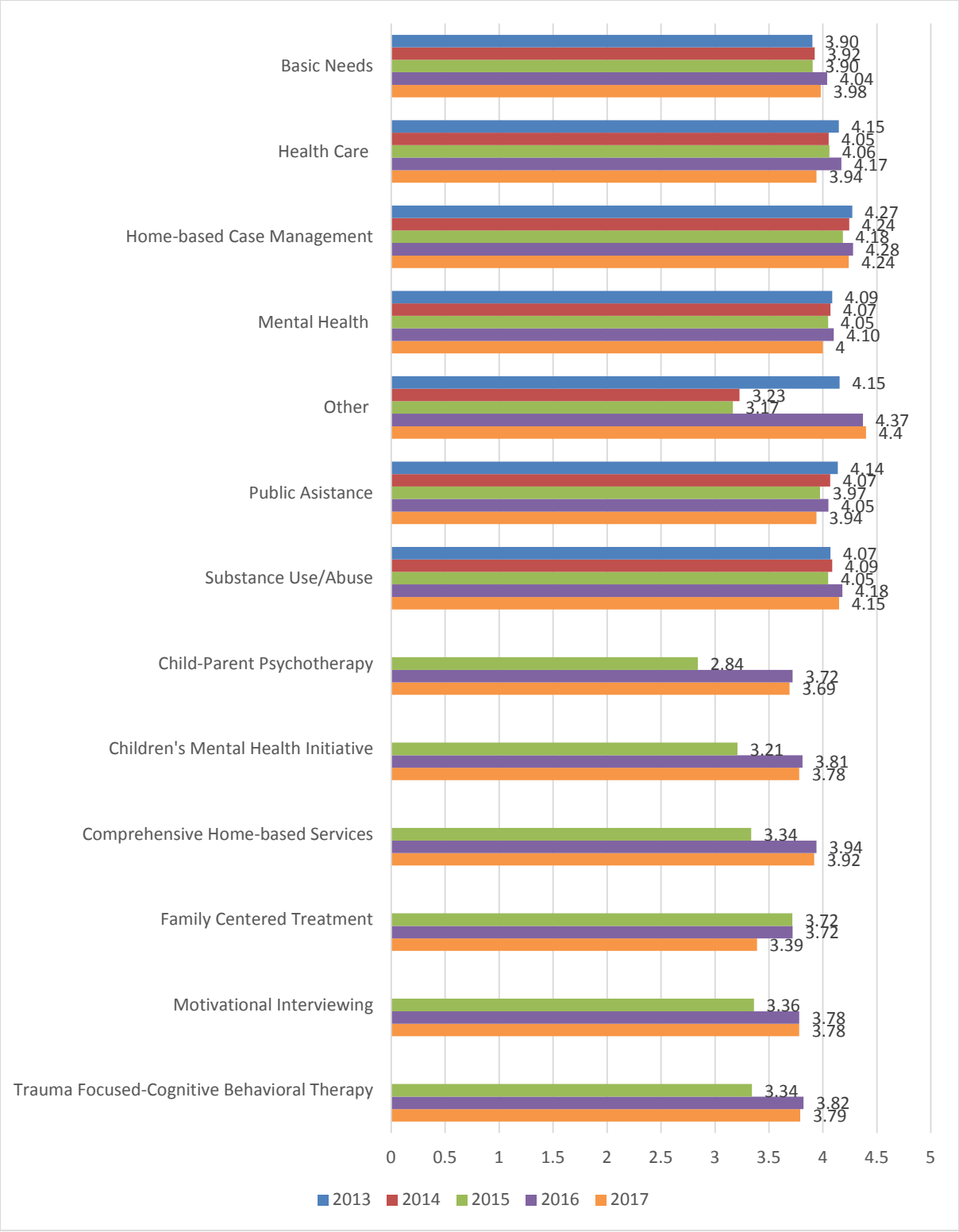


Figure 51. 2013 - 2017 Average Effectiveness of Services when Available

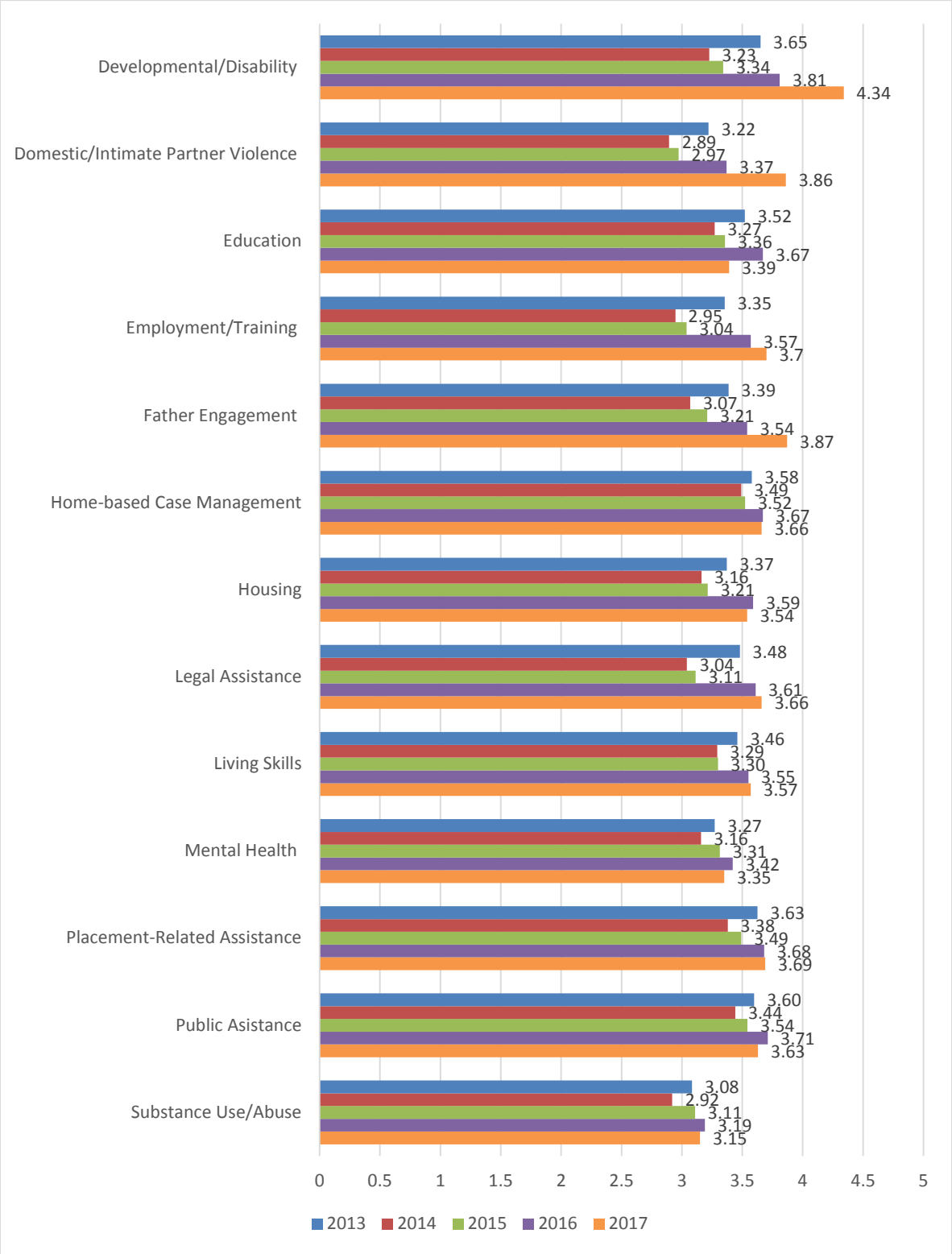
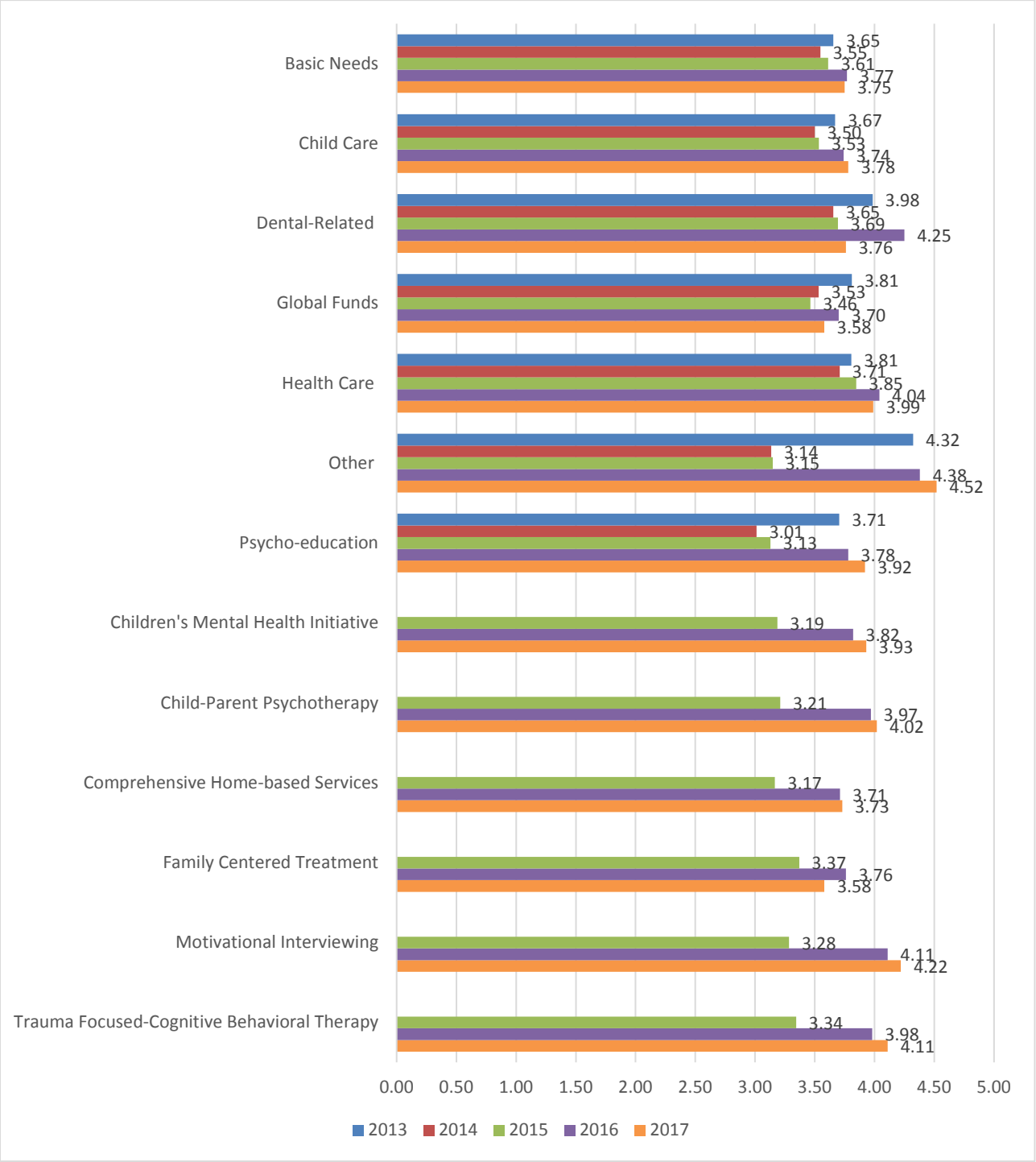


Figure 52. 2013 - 2017 Average Effectiveness of Services when Available (Continued)

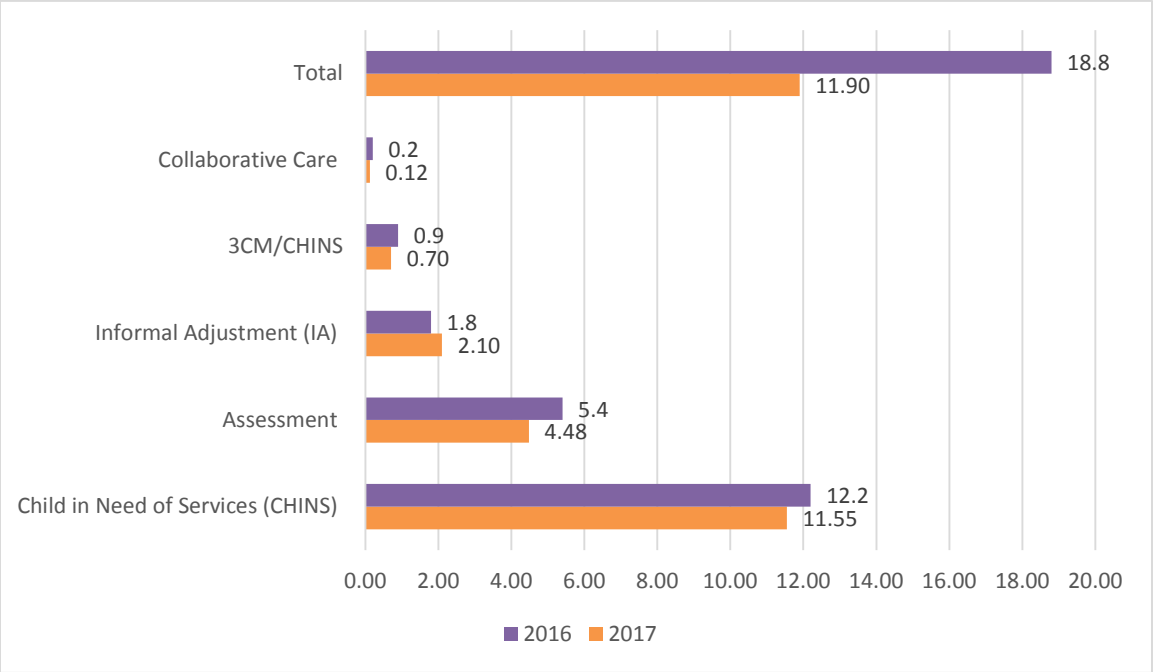


Workload

FCMs were asked to answer questionnaires that assessed the type and level of their assigned cases and workload. As can be seen in Figure 18, the average number of assigned cases per FCM was

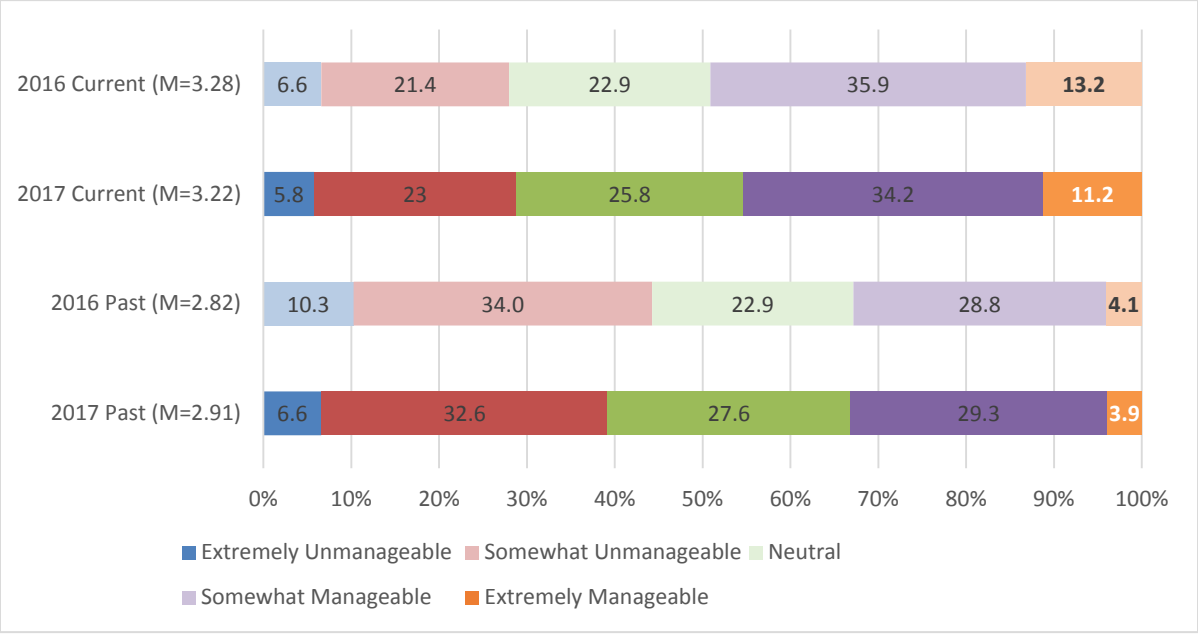
about 11.90 (SD = 5.6), which is lower than in Round 4. Of the five types of cases, the average number of CHINS cases was 11.6 (SD = 9.5) and the number of assessments was 4.5 (SD = 6.5). State mandate requires FCMs to maintain caseload of no more than 12 initial assessments and 17 ongoing cases.

Figure 53. Mean Number of the Assigned Case (By Type)



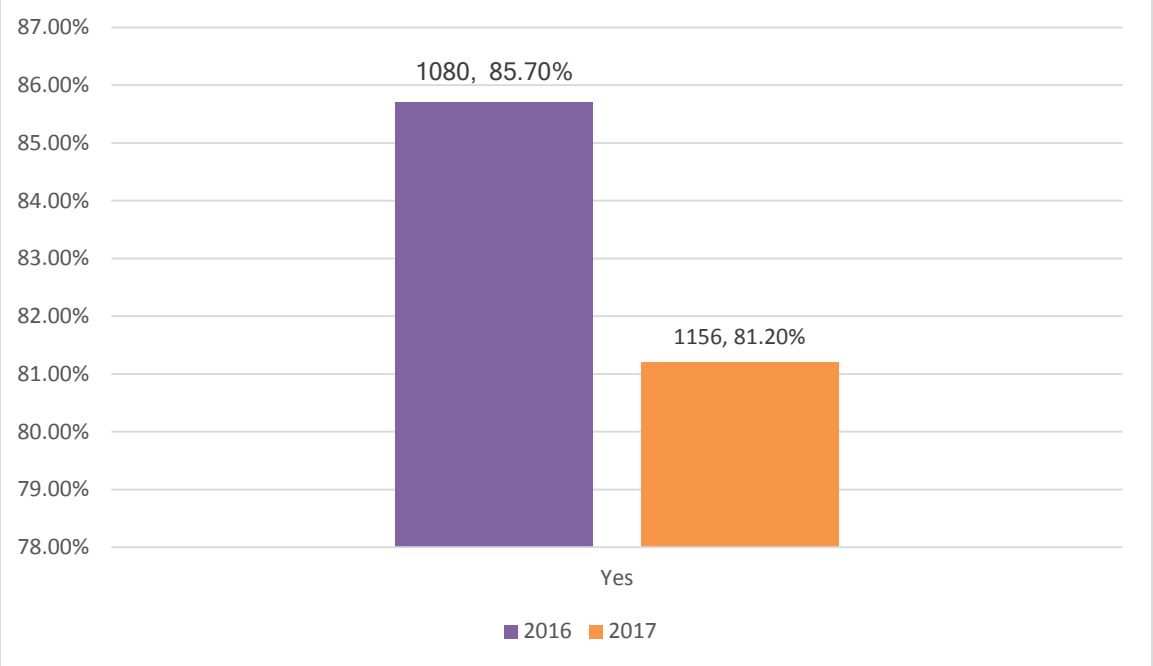
In addition to the FCMs' caseload, FCMs were asked to rate perceptions of their past and current workload on a five-point scale (1 = extremely unmanageable to 5 = extremely manageable). Figure 21 shows that FCMs on average, perceived that their current workload was somewhat manageable (M = 3.22, SD = 1.10), which was higher than perceptions of their past workload (M = 2.91, SD = 1.02). More specifically, around 45% of respondents indicated that their current workload was somewhat or extremely manageable, while 33% reported that their workload over the last year was somewhat or extremely manageable.

Figure 54. FCMs' Perceptions of Past and Current Workload (2017)



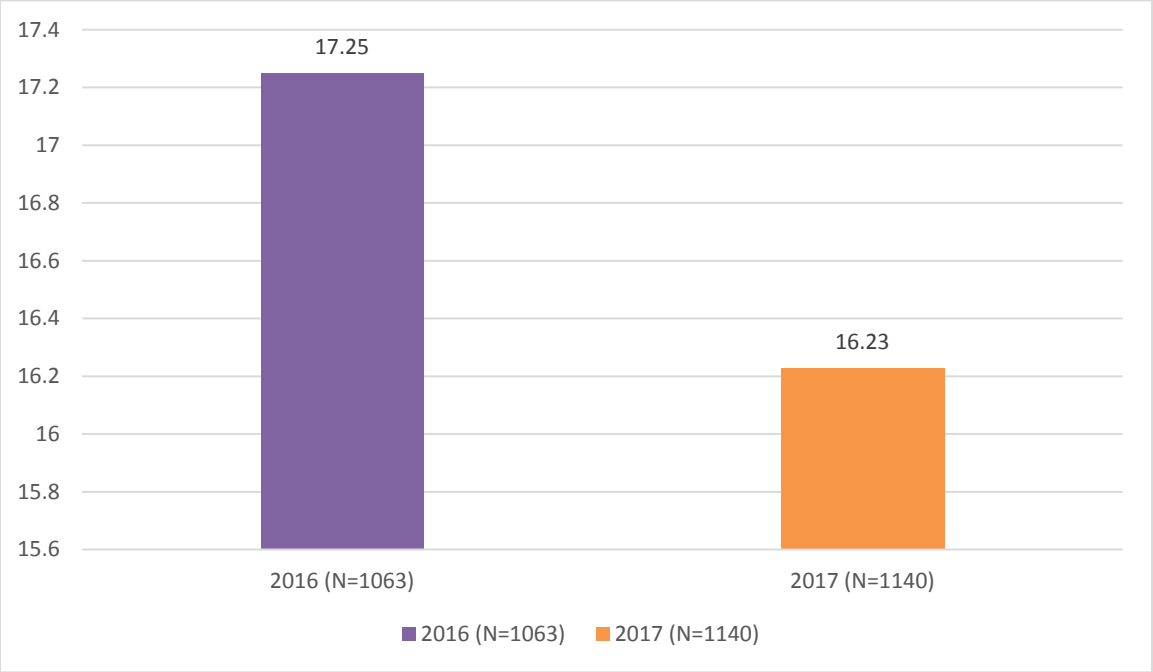
In Rounds 4 and 5, FCMs were asked if they needed to use overtime hours to manage their workload. Fewer FCMs reported needing to work overtime in 2017 (81.2%) than in 2016 (85.7%) which could be a symptom of increased case managers overall to address decreased case sizes.

Figure 55. Overtime Worked



As a follow up, FCMs were asked to list the number of hours of overtime they worked in the past month. In 2016, the numbers ranged from 0-156, and in 2017 they ranged from 0-123. The mean number of hours was lower in 2017 (M=16.23, SD=12.91) than in 2016 (M=17.25, SD=14.82).

Figure 56. Mean number of hours overtime worked (past month)



Placement

Several questions related to placements were added the Family Case Manager survey for the 2016 survey.

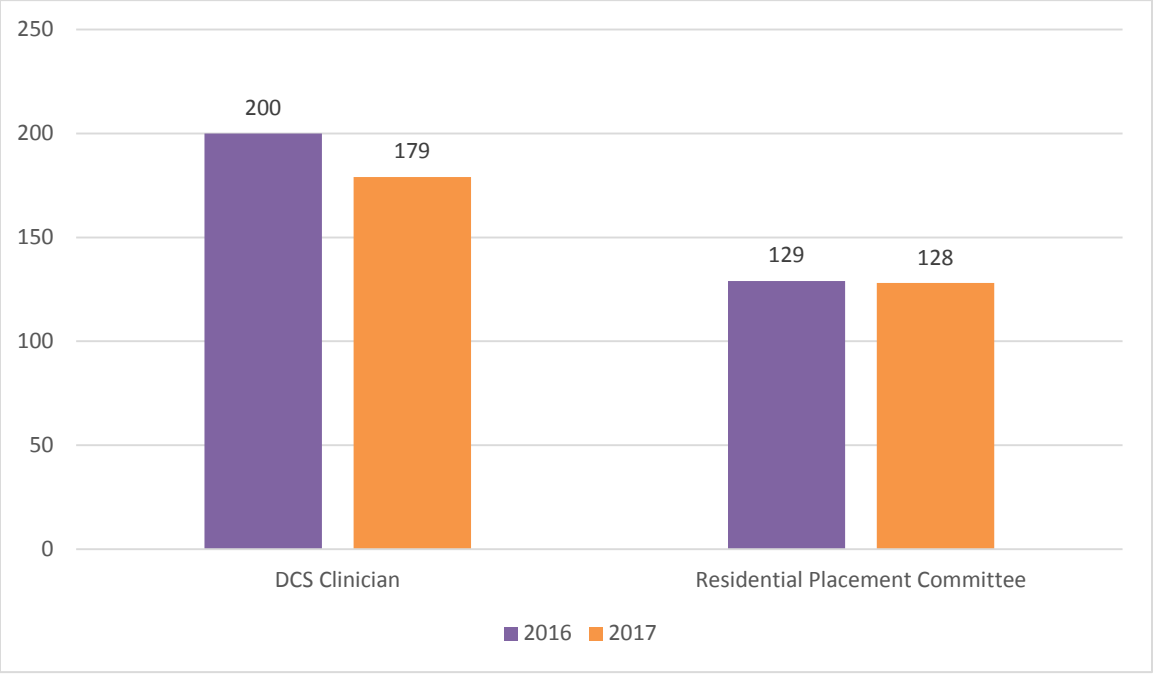
Round 4

Of those who responded in 2016, 73% (*n* = 842) reported having difficulty placing a child. Two hundred FCMs (13.7%) reported that they consulted with a DCS clinician to help place the child/youth; 129 (8.8%) of FCMs used the Residential Placement Committee to help with placement.

Round 5

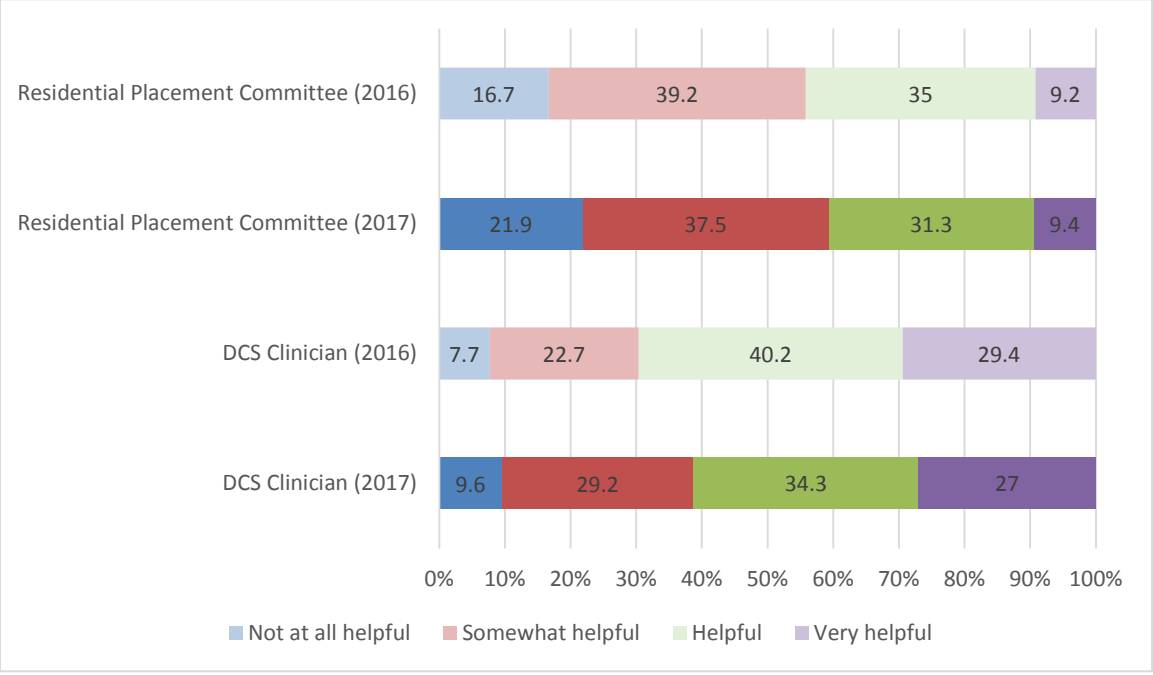
Of those who responded (n=1294), 72.3% (n=935) reported having difficulty placing a child. Of those who responded, slightly fewer FCMs reported consulting with a DCS clinician in 2017 than 2016. Approximately equal numbers of FCMs reported consulting a residential placement committee in 2017 as 2016.

Figure 57. Placement Consultations



As illustrated in Figure 58, the DCS clinician was considered more helpful than the Residential Placement Committee. Helpfulness of both the DCS clinician and the RPC declined in Round 5, when compared to Round 4.

Figure 58. Helpfulness of DCS Clinician and RPC



As shown in Figures 59 and 60, foster homes and residential treatment facilities were the most desired placement for difficult to place children and youth in both 2016 and 2017—these are also where FCMs were most likely to place for both years.

Figure 59. Frequency of where FCMs want to place

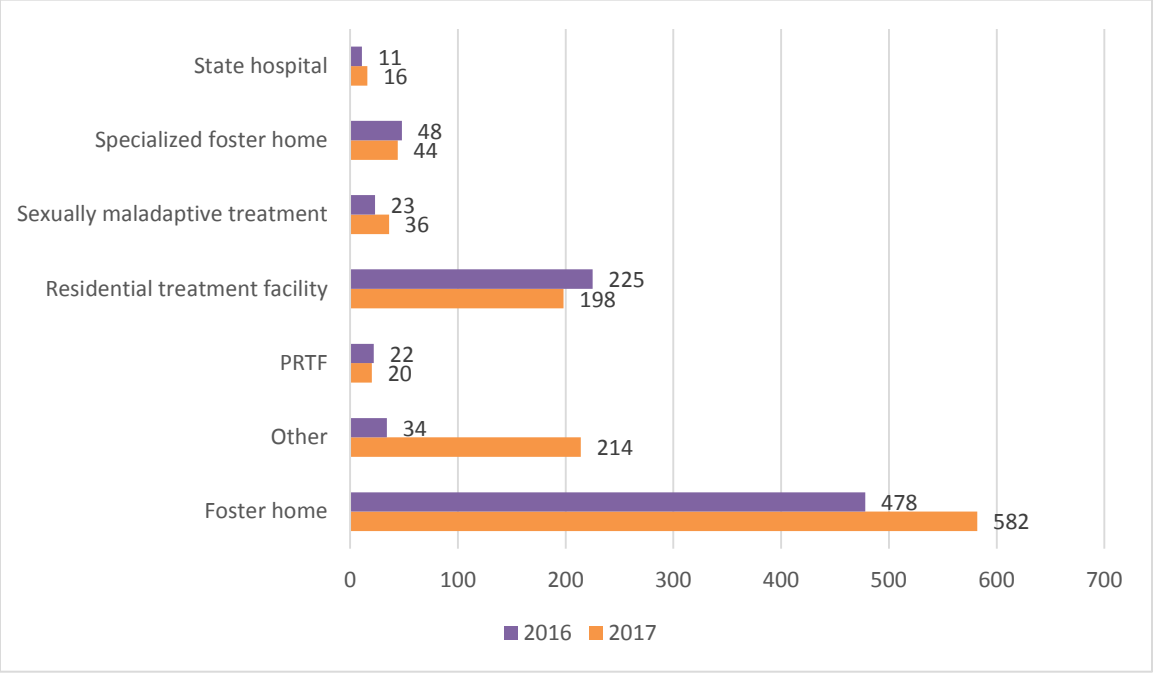
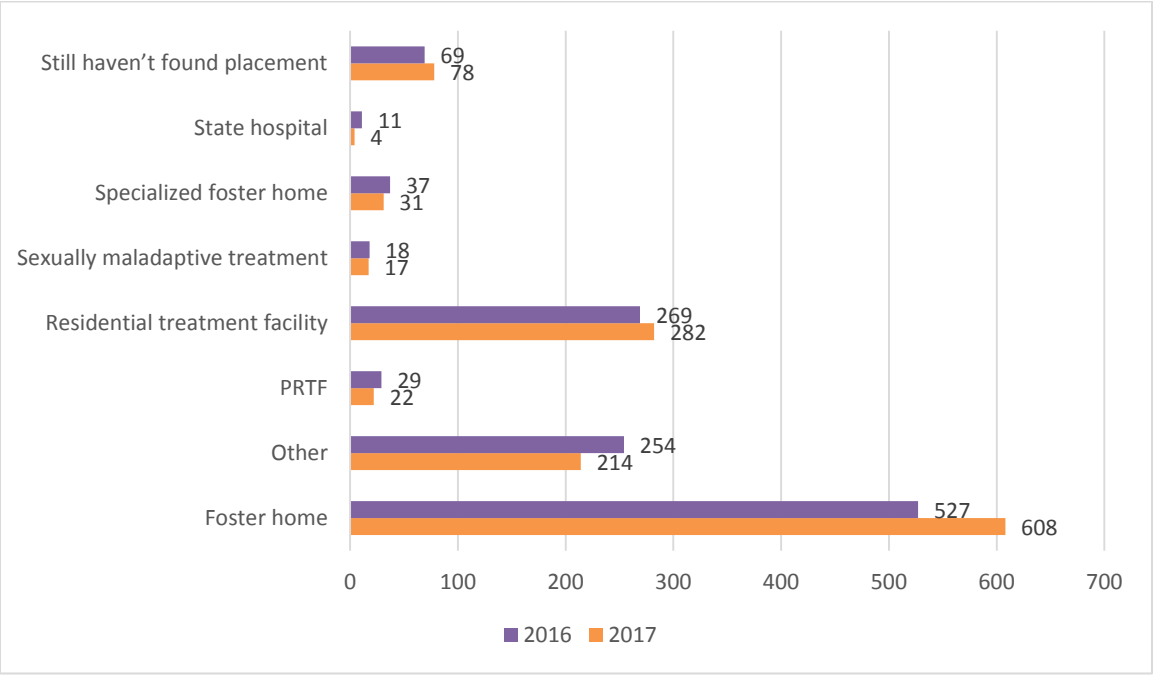
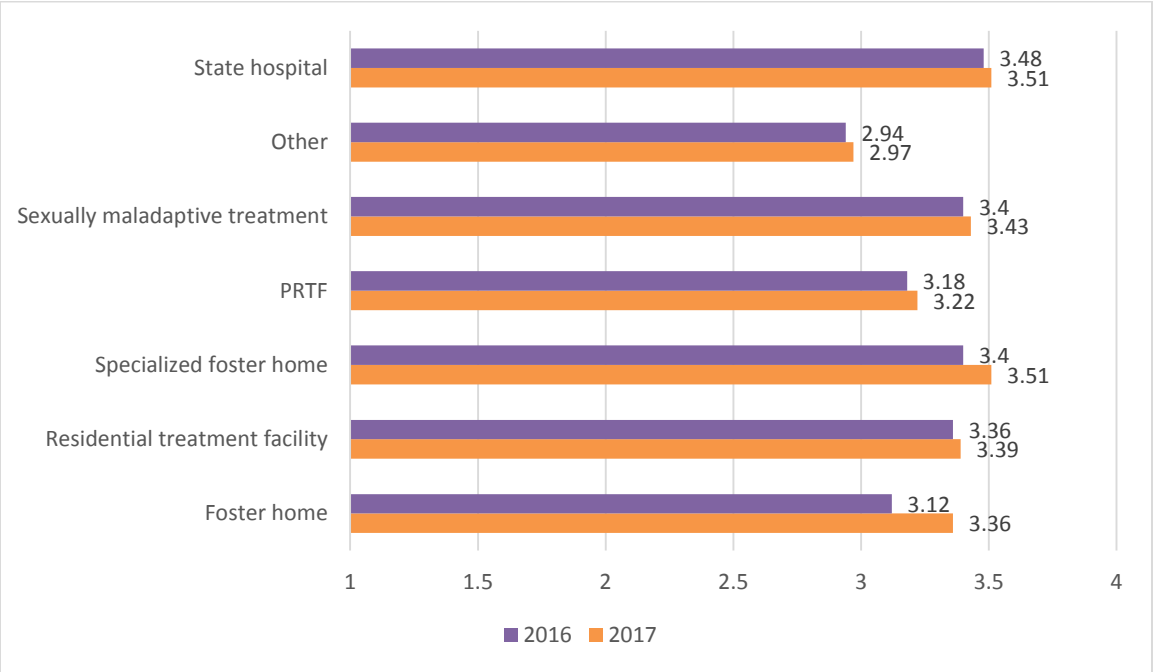


Figure 60. Frequency of where FCM placed



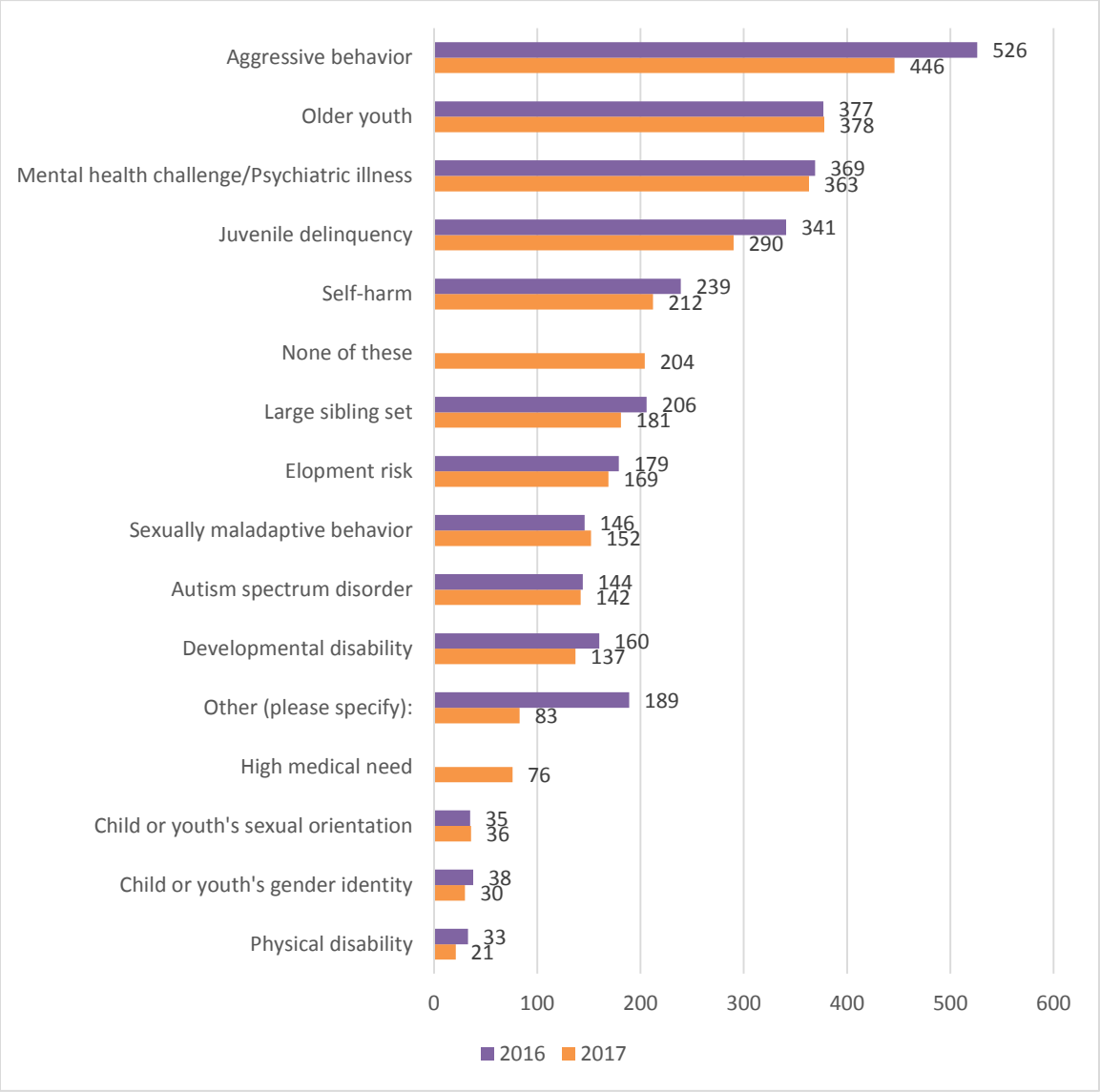
FCMs were asked to rate the difficulty with listed placements ranging from very easy (=1) to very difficult (=4). Figure 24 shows the mean score. FCMs report that state hospitals are one of the most difficult placements, and PRTFs are one of the least. FCMs report increased difficulty placing in foster homes in 2017 when compared to 2016.

Figure 61. FCMs report of placement ease.



As shown in Figure 62, in terms of frequency, a child or youth with aggressive behaviors was one of the most influential factors related to placement challenges in both 2016 and 2017, followed by being an older youth (mental health challenges/psychiatric illness. A child's physical disability, gender identity or sexual orientation were the least reported contributing factors to difficulty placing children and youth.

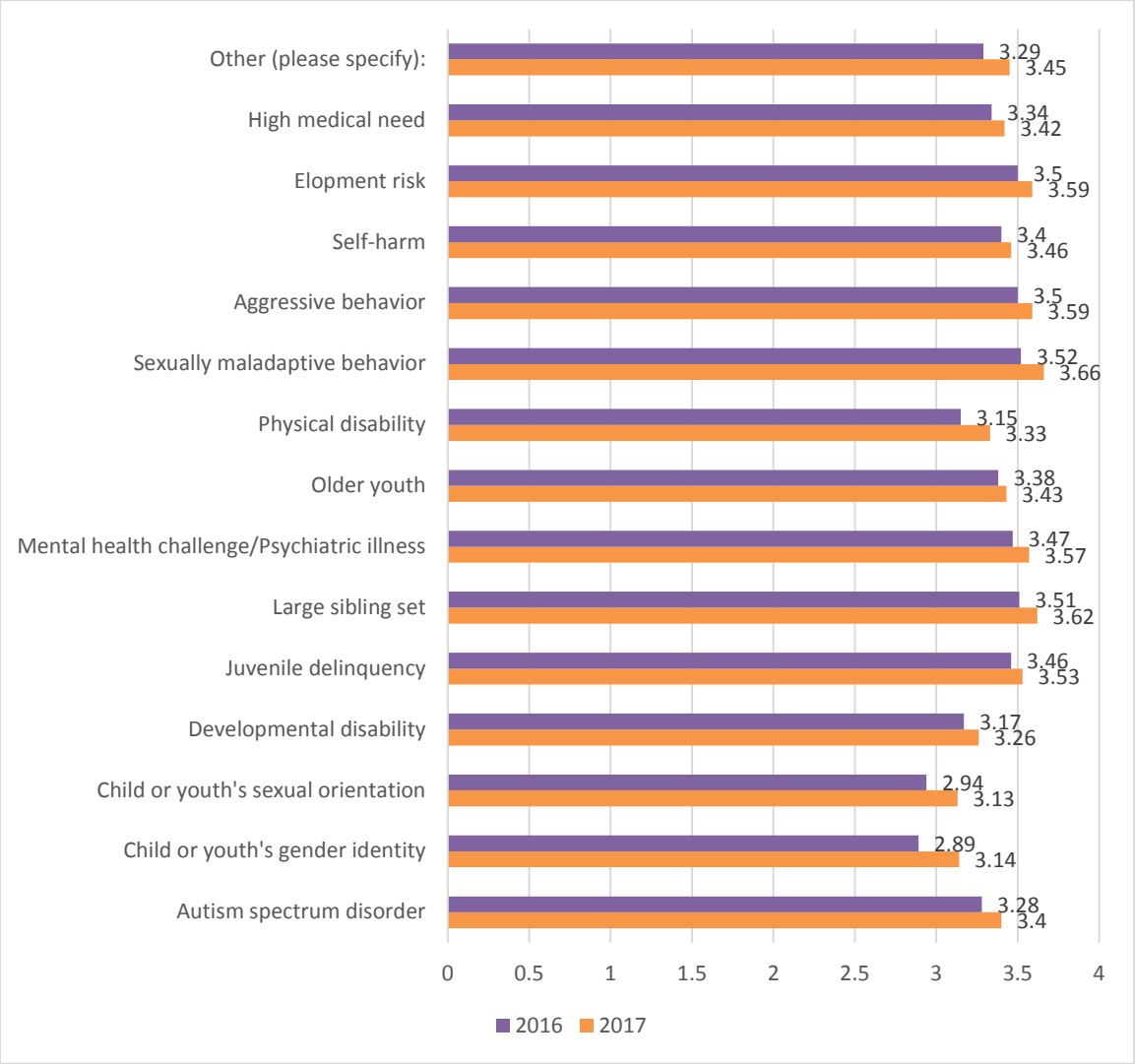
Figure 62. Placement challenges by characteristic



Case managers were also asked to identify the how difficult they found placing children and youth with certain characteristics. Results ranged from Very Easy (=1) to Very Difficult (=4).

See Figure 63 for results. Children or youth with sexually maladaptive behaviors and large sibling groups were all rated closer to very difficult than difficult or easy. While still being rated as difficult, a child or youth's gender identity and/or sexual orientation were rated as less difficult than other characteristics.

Figure 63. Mean scores for difficulty placing by characteristics



FCM perception of Wavier understanding over time and shifting cases

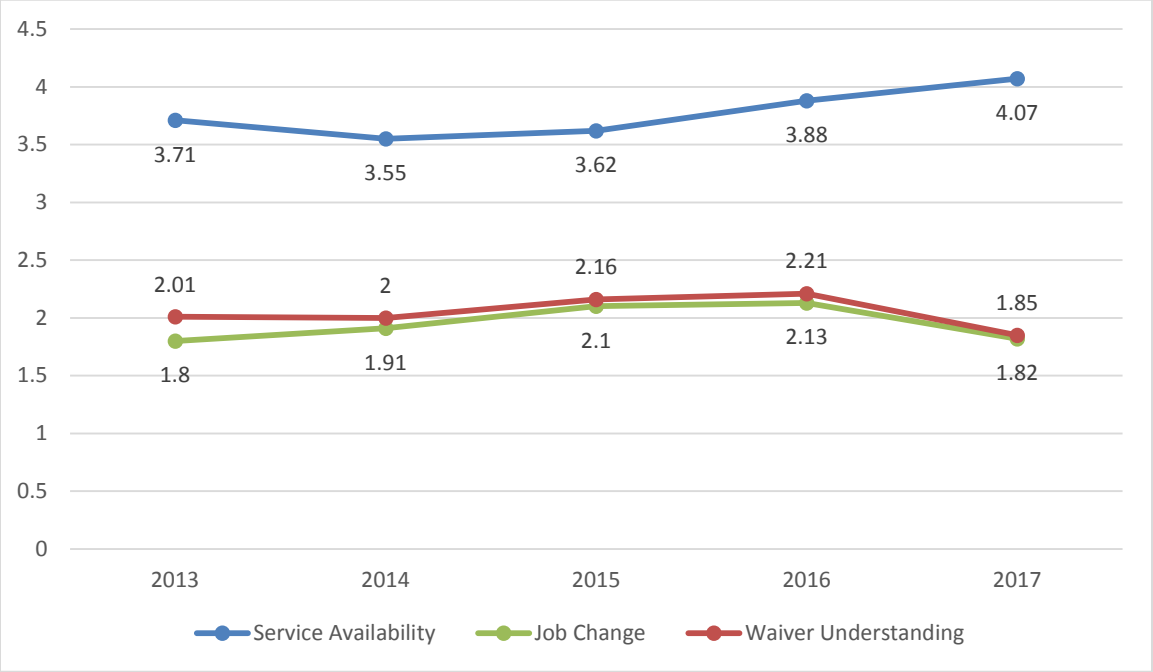
During the last five iterations of the FCM survey, FCMs who have been with the organization since July 2012 or longer have been asked to rate their understanding of the Waiver and their perceptions of shifting caseload goals since 2012. In 2013, 852 FCMs rated Waiver knowledge, followed by 801 in 2014, 415 in 2015, 284 in 2016, and 556 in 2017. This number decreased overall as an FCM would have to have been an FCM for 6 years in 2017 to complete this section; it is unclear why the numbers sharply increased from 2016 to 2017. The hypothesis was that there would be an increase in knowledge about the Waiver, which should trend similarly to their perception of how much their job had changed since the 2012 Waiver (Figure XX). Additionally, one of the key points of the Waiver was to expand the service array. Here, FCM's perception of the service array is an important factor in what they actually offer clients who they serve. An increase in service options would have an impact on how

they perceive their job functions. With the addition of new services along with service mapping implemented at the state level, a small, yet significant change should be expected in Waiver knowledge and perceived job change as communication to the FCMs about the Waiver has never included any shift in the practice model that FCMs deliver.

Waiver knowledge was a single item that asked 'How well do you understand the current 2012 Waiver?' Ratings were on a 5 point scale from 1 (not at all) to 5 (extremely well). Job change was also assessed with one item that asked 'How much has your job changed due to the 2012 Waiver?' Ratings for this item were on a 5 point scale from 1 (not at all) to 5 (a great deal). Also, in Figure 64, we included all FCMs perception of service availability. This item was the mean score of their ratings of each service over the five years on a 5 point scale from not at all available when needed to extremely available when needed.

The Waiver understanding was similar to the perception of change to their job. In addition, with more knowledge and more perceived job change, they did recognize an increase in the services that were available. The trend line for service availability was very similar to their Waiver knowledge and job change.

Figure 64. FCM perception of Waiver.



For FCM's perception of job change and Waiver understanding, there were significant differences between years, particularly years 2015 and 2016 as compared to years 2013 and 2014 ($p<.05$). These increases in Waiver knowledge and job change are similar to how Regional Managers changed their understanding of the Waiver over the demonstration years. Between years 2016 and 2017, there was a decrease in Waiver understanding for the first time. This could be due to the large number of new FCMs hired prior to 2017's survey launch.

FCM Survey Summary

In this report, the Evaluation team provided a time analysis of the most recently opened and closed cases, data on the service array over time, and workload perception. From the FCMs perspective, it seems like there have been improvements over the past year on managing workloads, and with a heightened perception of need, the availability, utilization, and effectiveness of services have also increased. Over time, FCMs perception of the safety, permanency, and some well-being indicators of the most recently closed cases have consistently improved since 2012.

Community Surveys

Methods

As part of the Process and Outcome Study components of the evaluation, the Executive Team and the IU Evaluation Team wanted to collect information on services, satisfaction with DCS workers and services, and teaming. The teams referred to the Community Survey that was done in 2013. These surveys had three distinct and different groups: Foster parents, service providers, and people representing the court system. To better understand these different perspectives, the CQI team developed three different surveys. All three surveys were distributed on Monday, August 3rd.

The CQI team wanted to expand on the group of foster parents to all people in parenting capacities and older youth. This survey consisted of foster parents, bio-parents, relative caregivers, and youth (Caregiver and Youth Survey). A letter was sent to all FCMs with language stating: "DCS is dedicated to the principles of Continuous Quality Improvement (CQI), a cycle of problem solving activities that require the deliberate use of evidence. Given that shared responsibility, as our CQI efforts continue to expand, DCS wants to give a voice to those who receive our services. In order to complete this, we need your help over the next two weeks." To complete this survey, FCMs, at a monthly visit, asked the caregiver and youth who were either in 3CM/CHINS or Collaborative Care if he/she would like to fill out a survey on the delivery of services to children and families in Indiana and that they were selected as a possible participant because they are an individual that receives services from the Department of Child Services (DCS) in Indiana. The FCM filled out the name of the focus child whose first name was first in alphabetical order. This was done as the questions focused on a particular child, and with the possibility of multiple children in the home, the CQI team wanted to randomize who was selected in the house. The caregiver/youth then filled out the survey. The Caregiver and Youth Survey stopped collection on Friday August 14th at 11:59pm.

The Community Service Provider survey mirrored the previously administered FCM survey asking them to rate the need, availability, utilization and effectiveness of services as well as some questions on teaming and specific questions about their facility. The CQI group was able to categorize people by frontline workers, program managers, CEO, and Central office/Administration. This survey was distributed to a listserv of service providers, asking them to answer the survey and forward it on to anyone in their agency or other agencies that are DCS service providers. This snowball sampling method took longer than the other methodologies, so the survey was in data collection until Saturday, August 22nd.

The Court Survey was sent out to Judges, prosecutors, probation, and CASA/GAL. Judge Bonaventura sent out the survey to Judges. Probation, prosecutors, and CASA/GAL were sent out on a listserv put together by the Executive Team. Similar to the Service Provider Survey, the Court used a form of snowball sampling and left the survey open until Saturday, August 22nd. Again, this population was asked about service effectiveness and teaming. They were also asked to rate DCS employees in regard to court processes.

Presented in this section are the results of the three surveys along with a comparison at the end between those from different surveys, including the differences in perceived need, availability, utilization and effectiveness of services between service providers and FCMs similar to the comparison done in 2013.

Caregiver and Youth Survey

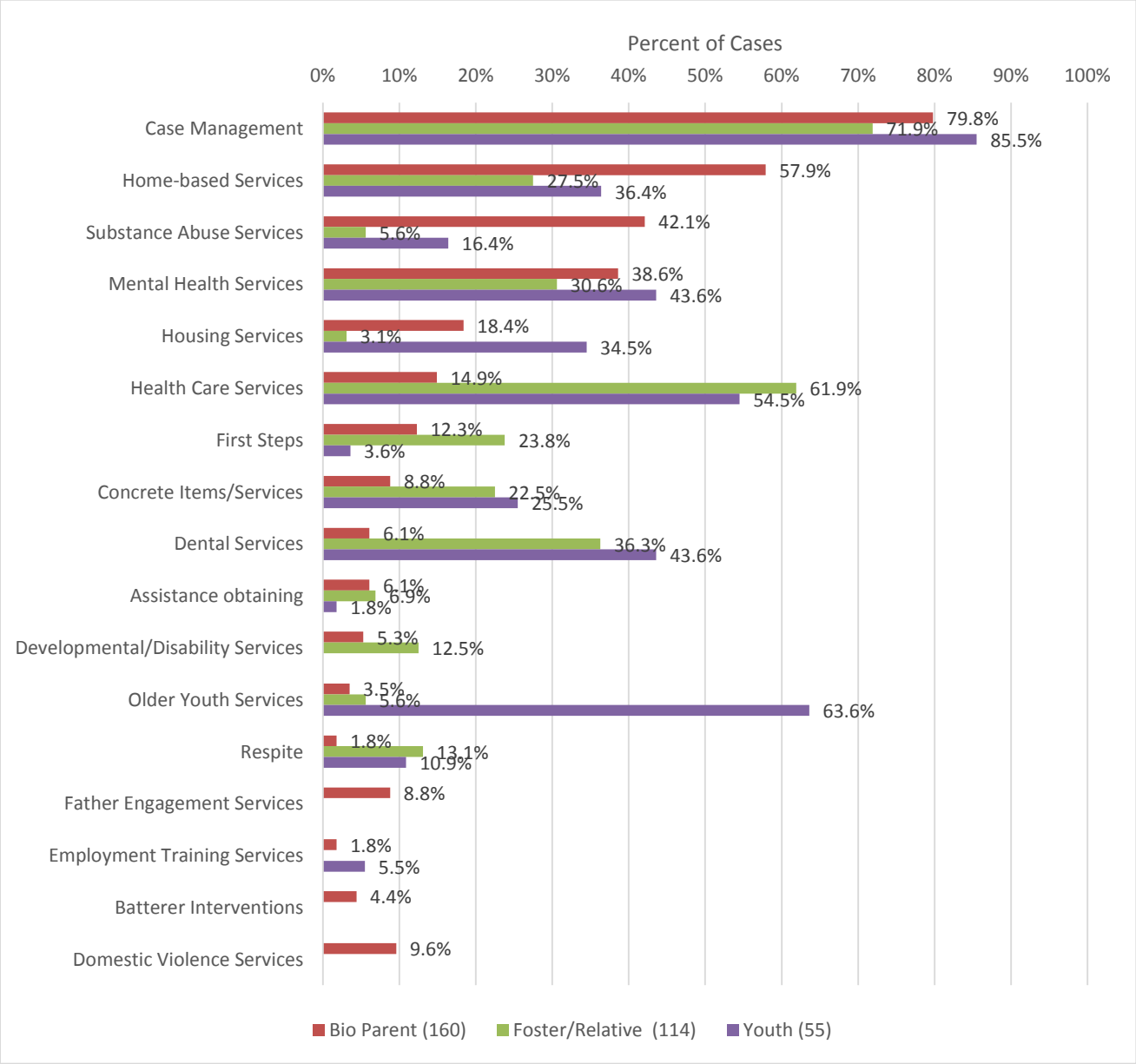
The demographic characteristics of those who completed the questionnaire are provided in Table 53. Respondents consisted of bio parents (n = 121), foster parents (n = 123), relatives (n = 56), and youth (n = 56). For all respondents, the majority of respondents were females (82.3%). They also identified as white (78.7%), black or African American (12.9%), or other racial groups (e.g., Asian, more than one race, other). The same pattern was found for all subgroups: bio parent, foster parent, relative, and youth. Overall, respondents had nearly 35 years of average age, each group had a slightly different mean of age: 30.67 years for bio parents, 41.75 years for foster parents, 47.82 years for relatives, and 18.75 years for youth. As the numbers of respondents are relatively low, these results are not representative of the entire population.

Table 53. Demographic Characteristics of Caregivers and Youth

	Overall		Bio parent		Foster parent		Relative		Youth	
	N	%	N	%	N	%	N	%	N	%
Gender										
Female	274	82.3	95	84.1	95	85.6	47	88.7	37	66.1
Male	55	16.5	18	15.9	13	11.7	6	11.3	18	32.1
I choose not to answer	4	1.2	0	0.0	3	2.7	0	0.0	1	1.8
Race										
White	263	78.7	94	83.2	90	81.1	43	79.6	36	64.3
Black or African American	43	12.9	12	10.6	14	12.6	8	14.8	9	16.1
American Indian/Alaska Native	3	0.9	2	1.8	1	.9	0	0.0	0	0.0
Asian	2	0.6	0	0.0	0	0.0	0	0.0	2	3.6
More than One Race	9	2.7	2	1.8	3	2.7	0	0.0	4	7.1
Other	10	3.0	3	2.70	1	.9	3	5.6	3	5.4
I choose not to answer	4	1.2	0	0.0	2	1.8	0	0.0	2	3.6
Ethnicity										
Non-Hispanic	286	91.4	103	94.5	95	93.1	46	93.9	42	79.2
Hispanic	11	3.5	3	2.8	4	3.9	1	2.0	3	5.7
I choose not to answer	16	5.1	3	2.8	3	2.9	2	4.1	8	15.1
Age	M	SD	M	SD	M	SD	M	SD	M	SD
	34.66	13.28	30.67	8.46	41.78	9.44	47.82	13.11	18.75	4.59

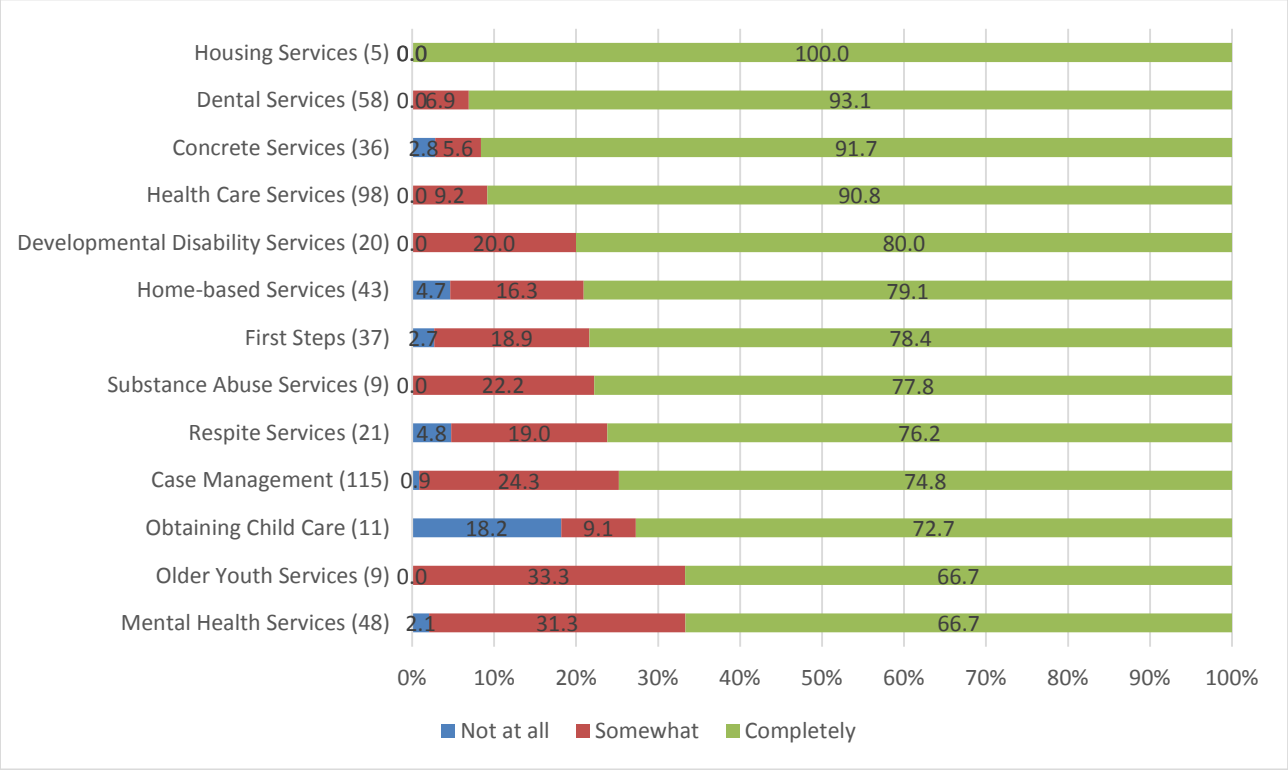
Figure 66 presents the percentage of the services used by families. Overall, case management was most frequently used for all subgroups (bio parent = 79.8%, foster parent/relative = 71.9%, and youth = 85.5%). Further examination of responses indicated that there were substantial differences in the use of services between the types of respondent. In addition to case management, bio parents more frequently utilized home-based services (57.9%), substance abuse services (42.1%), and mental health services (38.6%), while foster parents/relatives more frequently utilized health care services (61.9%), dental services (36.3%), and mental health services (30.6%). In contrast, youths were more likely to use older youth services (63.6%), health care services (54.5%), and mental health services (43.6%).

Figure 66. Percentage of Services that Families Received



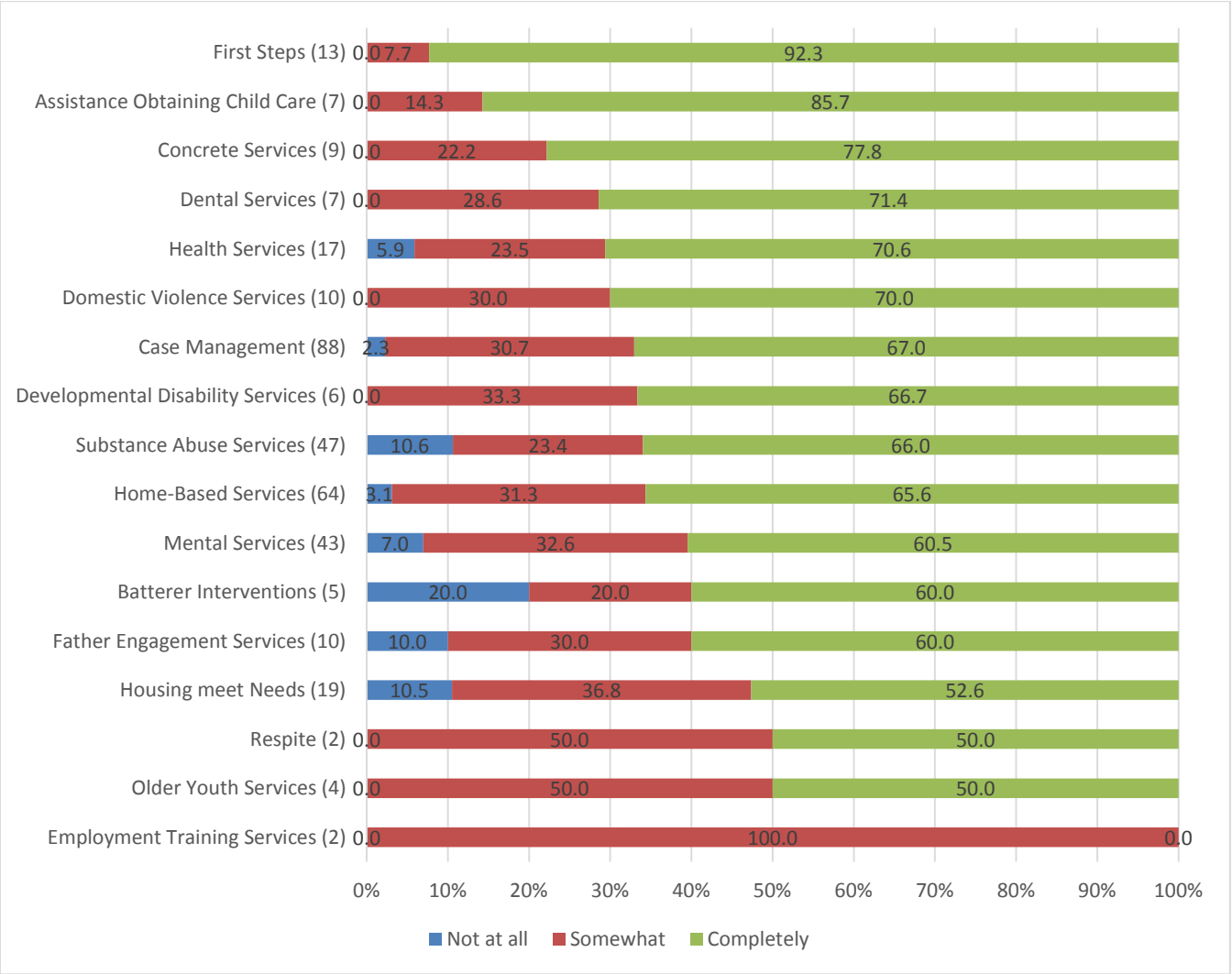
Furthermore, foster parents and relatives were asked to rate the extent to which services that they used met their needs. In Figure 67, many respondents indicated that the services used for families "completely" met their needs, ranging from 66.7% to 100% across the services. More specifically, the highest rated were housing services (100%), dental services (93.1%), concrete services (91.7%), and health care services (90.8%). However, over eighteen percent of the respondents, who used the services to obtain child care (n =11), reported that the services did not meet their needs at all. This percentage was relatively higher than those of other services.

Figure 67. Effectiveness of Services to Meet Family's Needs Rated by Foster Parents/Relatives



Bio parents were also asked to rate the extent to which services that they used met their needs (see Figure 68). Many respondents indicated that the services used for families "completely" met their needs, ranging from 50% to 92.3% across the services. More specifically, the highest rated were first steps (92.3%), assistance obtaining child care (85.7%), concrete services (77.8%), and dental services (71.4%).

Figure 68. Effectiveness of Services to Meet Family's Needs Rated by Bio Parents



Similar to other adult respondents, at least 50% of youth reported that all the services used "completely" met their needs (see Figure 41). Youth rated highest on employment training services, first steps, and child care; but it should be noted that only a small number of youth (≤3) rated these services.

Figure 69. Effectiveness of Services to Meet Family's Needs Rated by Youth

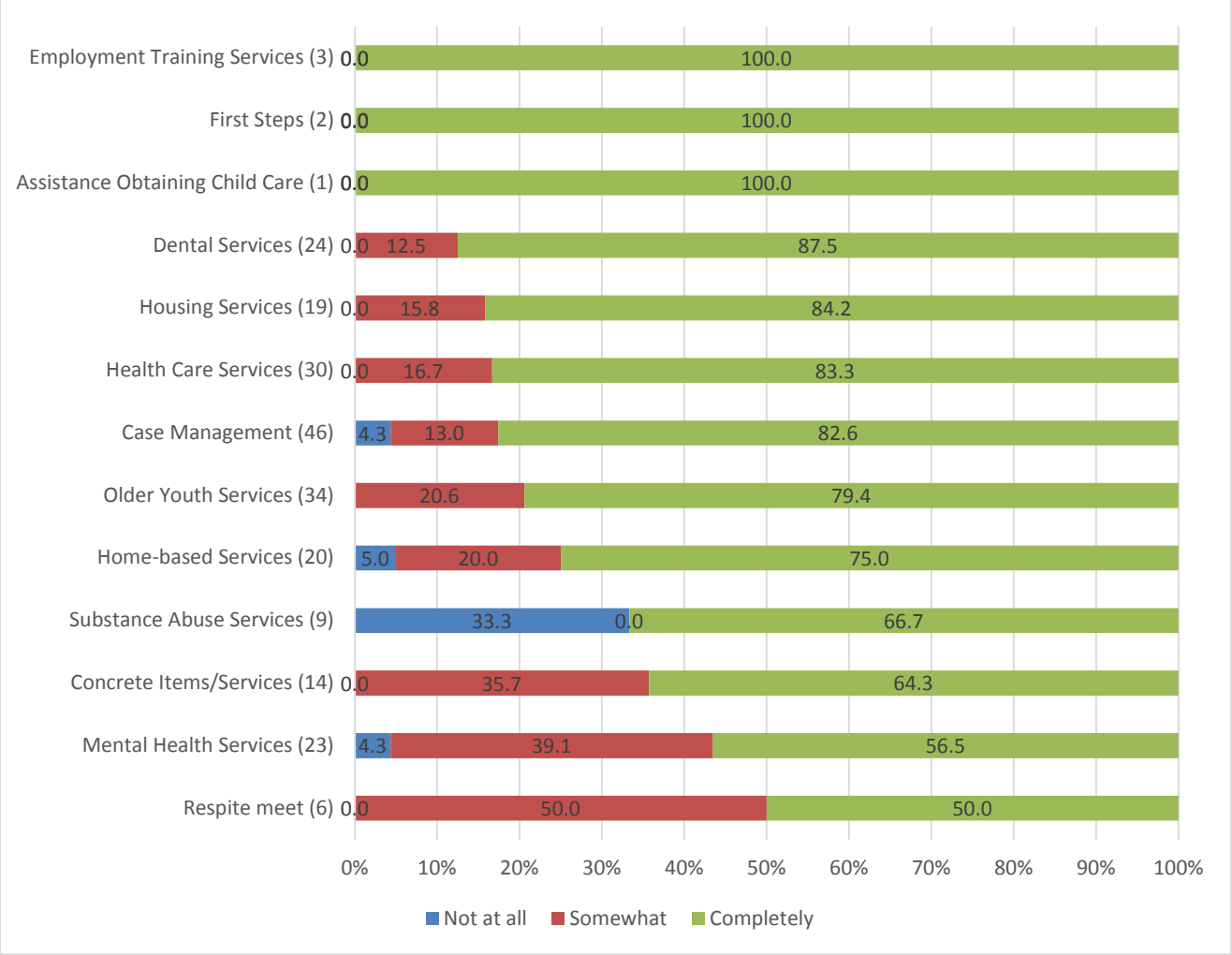
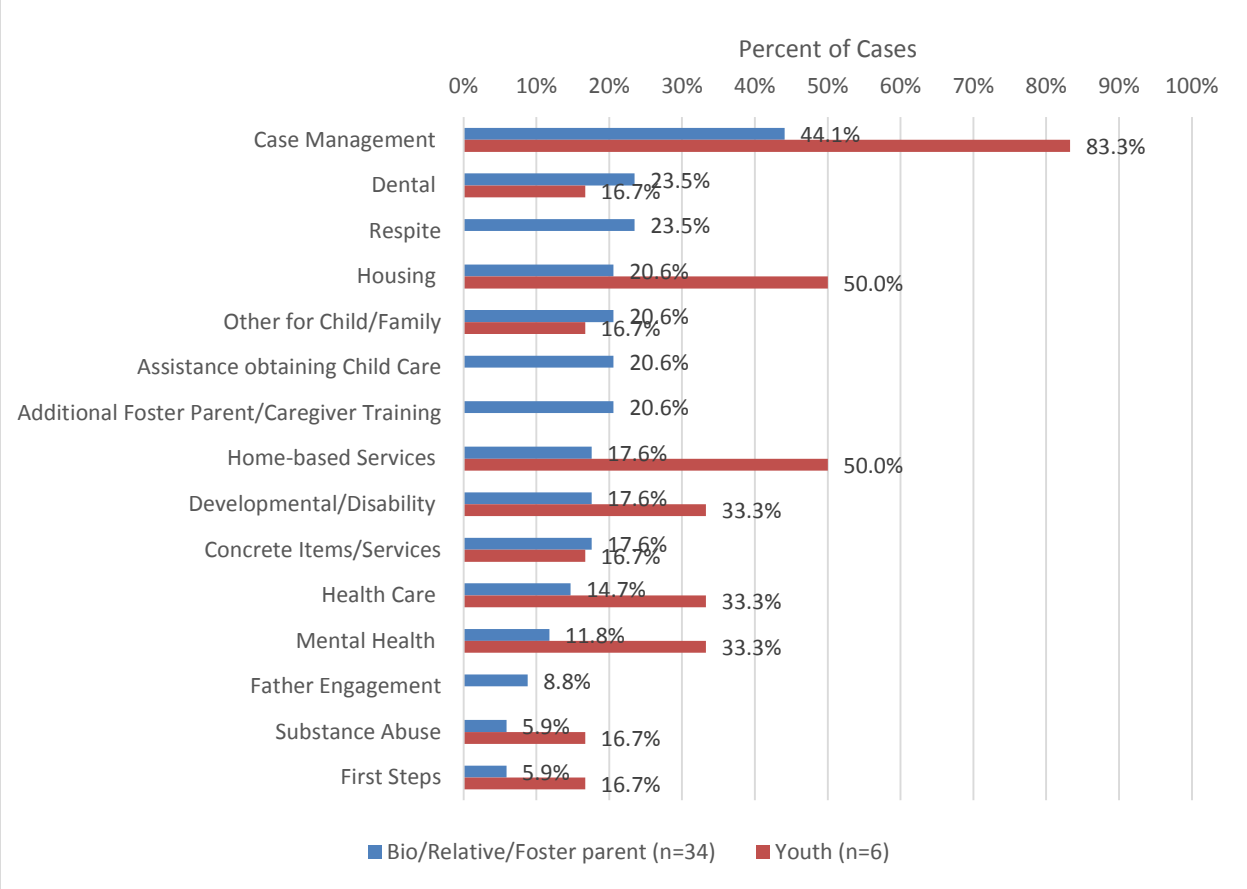


Figure 70 displays the percentage of services that were not available to child/families despite the potential benefits of the services. Adult caregivers (n = 34) indicated that the least available service was case management (44.1%), followed by dental services (23.55), respite (23.5%), and other services. youth (n = 6) also reported that the least available service was case management (83.3%), followed by housing (50%), home-based services (50.0%), and other services.

Figure 70. Percentage of the Lack of Services



Mean responses of questions relating to satisfaction of adult caregivers and youth in DCS services and case managers are presented in Figures 71-74. In general, both adult caregivers and youth agreed or strongly agreed with most questions of satisfaction about DCS services and case managers (see Figure 71 and 72). For adult caregivers, the questions with relatively higher average scores include: "I know what my DCS Family Case Manager (FCM) expects me to do" (M = 3.52), "the services DCS provides to my family respects our culture" (M = 3.45), and "my DCS FCM helps me get the services my family needs" (M = 3.45). There was one question that showed a significant difference between types of adult caregivers. Relatives were more likely than bio parents to perceive that "my family is better off after receiving DCS services (3.52 vs. 3.22, $p < .05$). Similarly, youth rated relatively higher average scores on some questions: "I know what my DCS Collaborative Care Case Manager expects me to do" (M = 3.77), "my DCS Collaborative Care Case Managers helps me get the services my family needs" (M = 3.76), and "my DCS Collaborative Care Managers uses my ideas to help me" (3.73). Figure 73 depicts the results of comparing the levels of satisfaction in three questions that were commonly answered by three groups. Youths perceived significantly higher satisfaction in the statement, "working with DCS has improved/is improving the situation of my family" than did bio parent (3.62 vs. 3.24, $p < .01$). They also

had a significantly higher average score on the statement, "I know how to get services through DCS" as compared to both foster parent/relative and bio parent groups" (3.59 vs. 3.35 and 3.33, $p < .05$).

Figure 71. Adult Caregivers' Average Rating of Satisfaction in DCS Services and Case Managers

Figure 72. Youth's Average Rating of Satisfaction in DCS Services and Case Managers

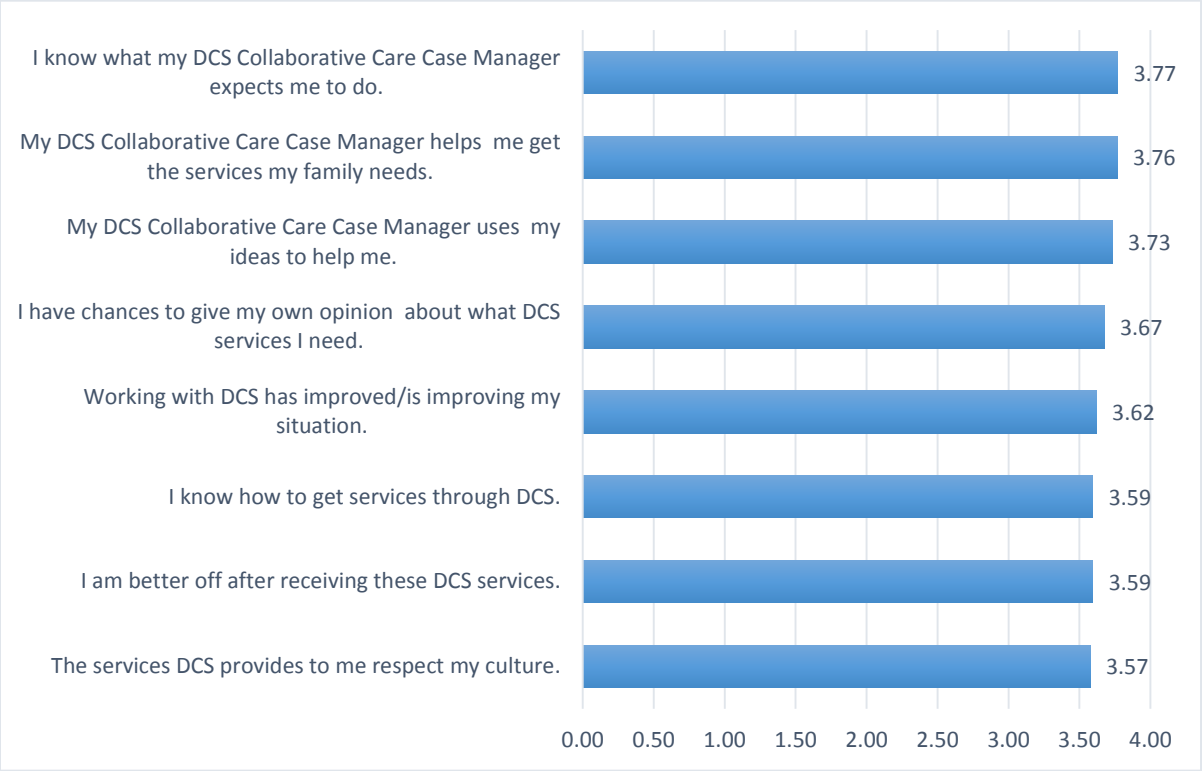


Figure 73. Comparing Average Rating of the Satisfaction between the Types of Respondent

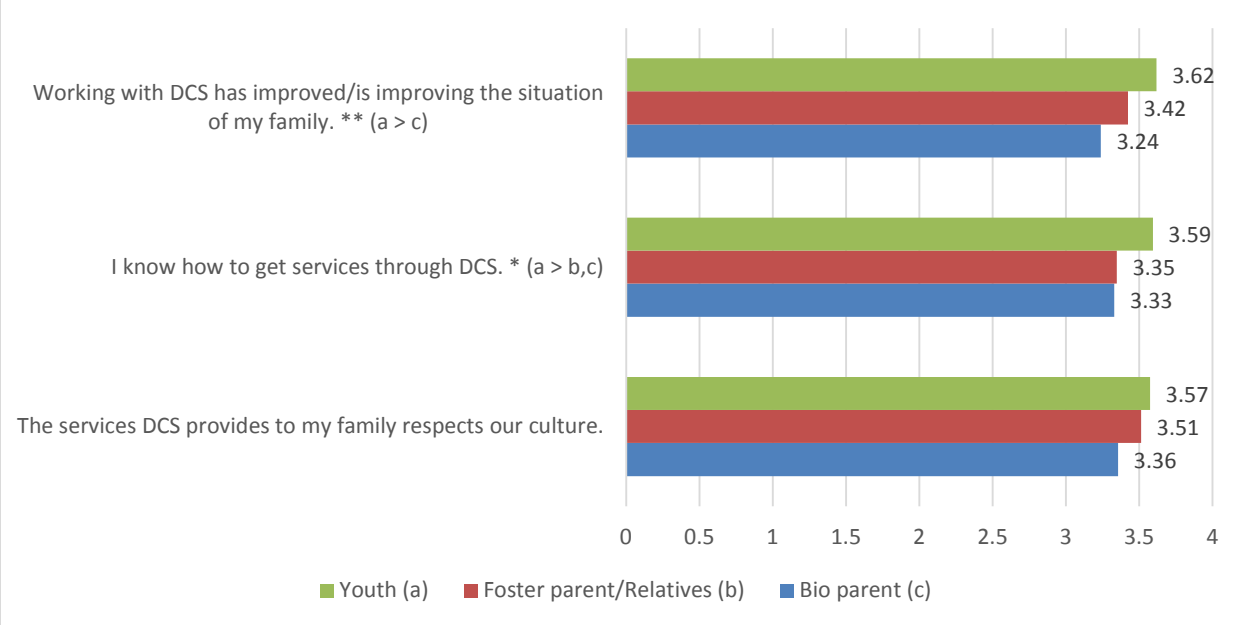
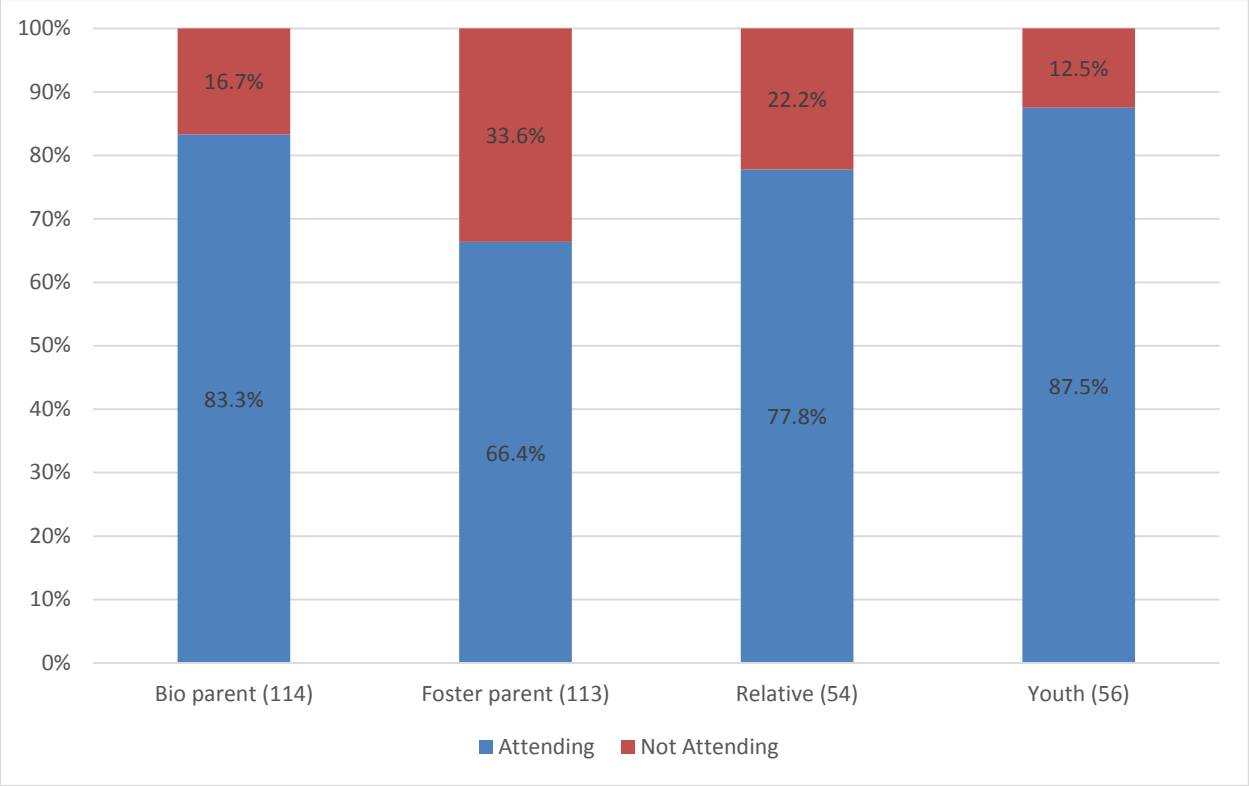


Figure 74 shows the percentage of the attendance of Child and Family Team Meeting (CFTM) by the types of respondent. More than sixty-five percent of all subgroups had attended in a CFTM in the past 12 months. More specifically, Youth had the most experience in attending CFTM (87.5%). The second ranked group was bio parents (83.3%), followed by relatives (77.8%), and foster parents (66.4%). Such differences were statistically significant (Chi-square = 13.44, $p < .01$).

Figure 74. Percentage of the Attendance of a CFTM



Community Service Provider Survey

In the community service provider survey, the majority of respondents were frontline workers (n = 181), followed by program managers (n = 161), agency CEO (n = 114), and central/administrative operations (n = 95). Table 54 depicts the demographic characteristics of respondents who completed the questionnaire. Overall, the majority of respondents were females (73.8%) and identified themselves as white (75.7%). The same pattern was found for all subgroups. Each subgroup's average age ranged from 40.8 to 50.8, with an overall mean of 44 years old. Frontline workers (M = 40.8) was slightly younger than other groups.

Table 54. Demographic Characteristics of Community service providers

	Overall		Frontline worker		Program manager		Agency CEO		Central/Adm. Operation	
	N	%	N	%	N	%	N	%	N	%
Gender										
Female	267	73.8	93	79.5	86	74.8	42	64.6	46	70.8
Male	63	17.4	12	10.3	20	17.4	17	26.2	14	21.5
I choose not to answer	32	8.8	12	10.3	9	7.8	6	9.2	5	7.7
Race										
White	271	75.7	85	74.6	92	80.7	47	72.3	47	72.3
Black or African American	30	8.4	8	7.0	9	7.9	6	9.2	7	10.8
American Indian/Alaska Native	1	.3	0	0.0	0	0.0	1	1.5	0	0.0
Asian	1	.3	0	0.0	1	.9	0	0.0	0	0.0
More than One Race	4	1.1	1	.9	2	1.8	0	0.0	1	1.5
Other (please describe):	7	2.0	4	3.5	1	.9	2	3.1	0	0.0
I choose not to answer	44	12.3	16	14.0	9	7.9	9	13.8	10	15.4
Ethnicity										
Non-Hispanic	290	82.9	89	79.5	100	88.5	48	78.7	53	82.8
Hispanic	8	2.3	2	1.8	3	2.7	2	3.3	1	1.6
I choose not to answer	52	14.9	21	18.8	10	8.8	11	18.0	10	15.6
Age	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
	44.0	12.2	40.8	12.6	42.2	11.9	50.8	12.0	45.6	9.2

Figure 75 presents the percentage of the types of agency at which respondents are employed. Nearly 40 percent (37%) of respondents were employed at residential agencies, and 25% were working at Licensed Child Placing Agencies (LCPA).

Figure 75. Respondents' Types of Agency

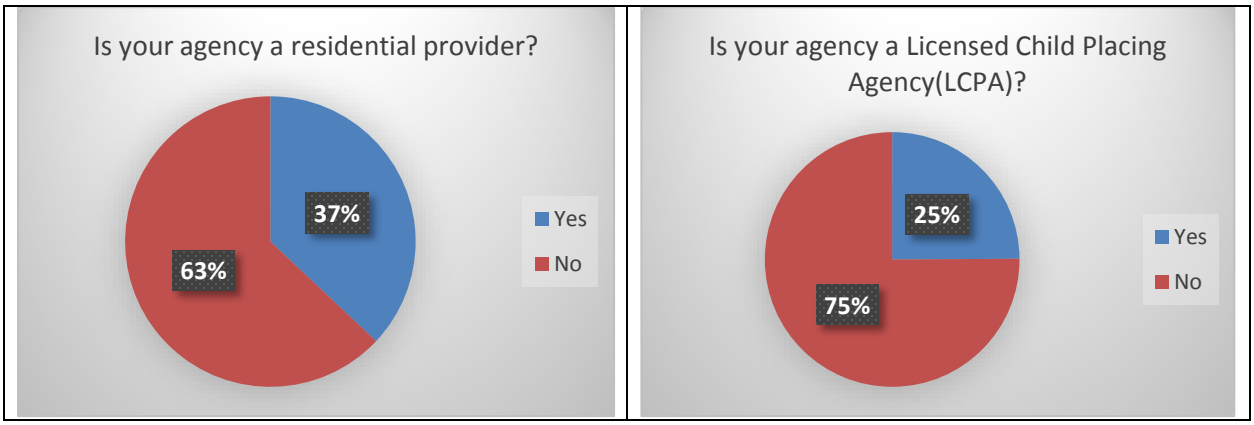
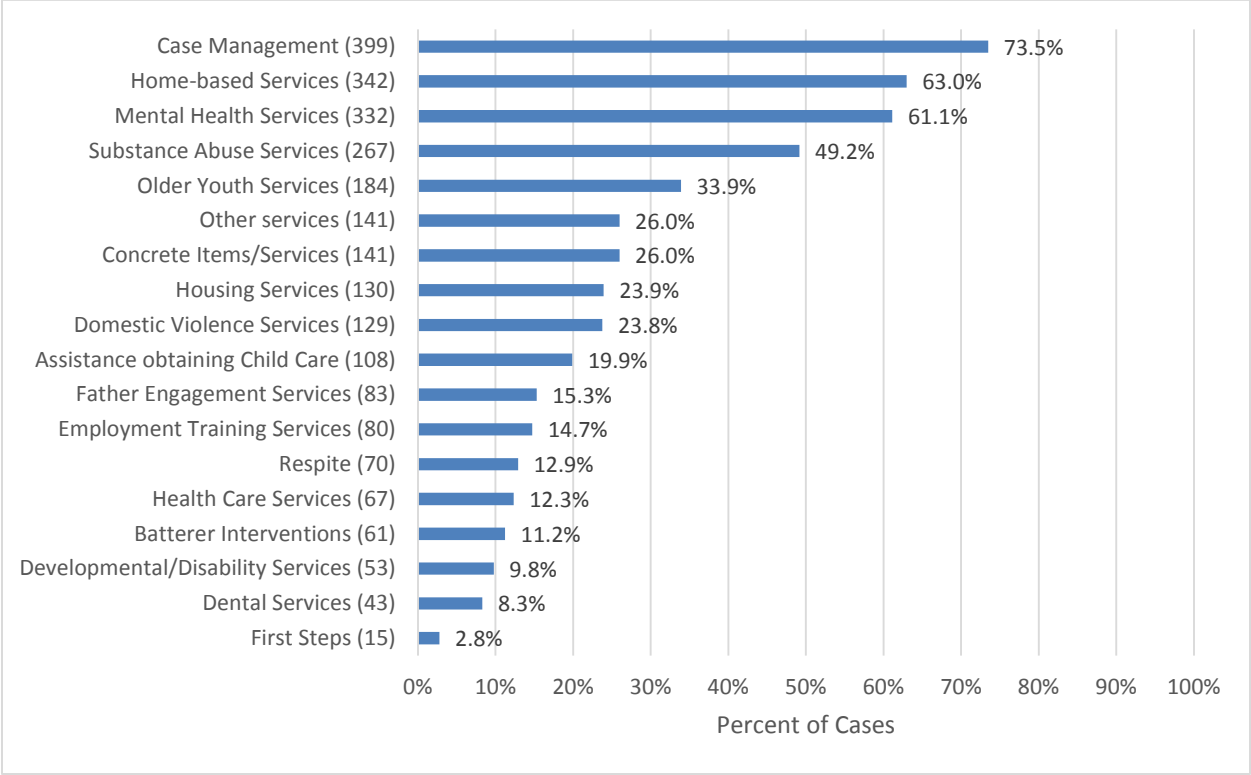


Figure 76 displays the percentage of services provided by the respondent' agencies. Respondents ranked case management (73.5%), home-based services (63%), and mental health services (61.1%) as the top three services that they frequently provided. In contrast, the services that they less likely provided include First Step (2.8%), dental services (8.3%), and developmental/disability services (9.8%).

Figure 76. Percentage of Services provided by The Respondent's Agencies



Community service providers were asked to rate: a) the need for each service; b) availability of a service when needed; c) utilization of a service when available; and d) effectiveness of a service when utilized. Mean responses of questions relating to service arrays by different types of service providers are displayed in Figures 77-80. Overall, respondents indicated that most services were "sometimes" or "usually" needed (see Figure 77). The highest ranked services with a greater need include: case management (M = 4.41), mental health services (M = 4.25), home-based services (M = 4.06), and home-based casework (M = 4.04). Further examination of responses indicated that there were some significant differences between the perceptions of need for services between the types of respondent. Frontline workers perceived a significantly greater need than agency CEOs for home-based casework (4.2 vs. 3.8, $p < .05$), and also a significantly greater need than program managers for older youth services (3.77 vs. 3.40, $p < .05$).

Figure 77. Average Rating of Need for Services

Figure 77 (continued). Average Rating of Need for Services

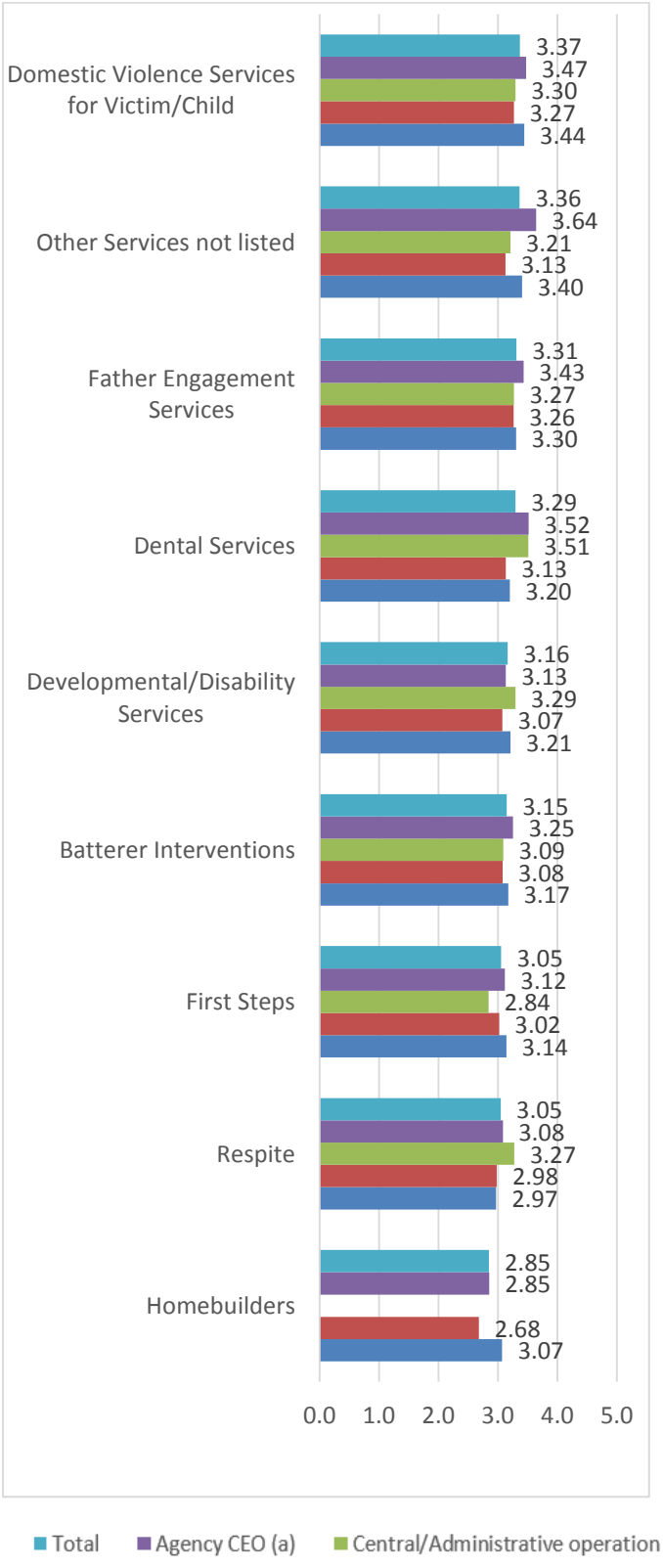


Figure 78 depicts the average rating of the availability of services when needed between the four respondent types. Similar to the findings from the service need, the highest ranked services with respect to the service availability include: case management (M = 4.14), home-based casework (M = 3.98), home-based services (M = 3.93), mental health services (M = 3.83). Further investigation revealed significant differences in the perception of service availability between the subgroups. Agency CEOs gave a significantly lower availability than either a particular group or all other groups across 7 of the 26 service types. Additionally, frontline workers perceived a significantly higher availability than did program managers for developmental/disability services (3.37 vs. 3.01, $p < .05$).

Figure 78. Average Rating of the Availability of Services when Needed

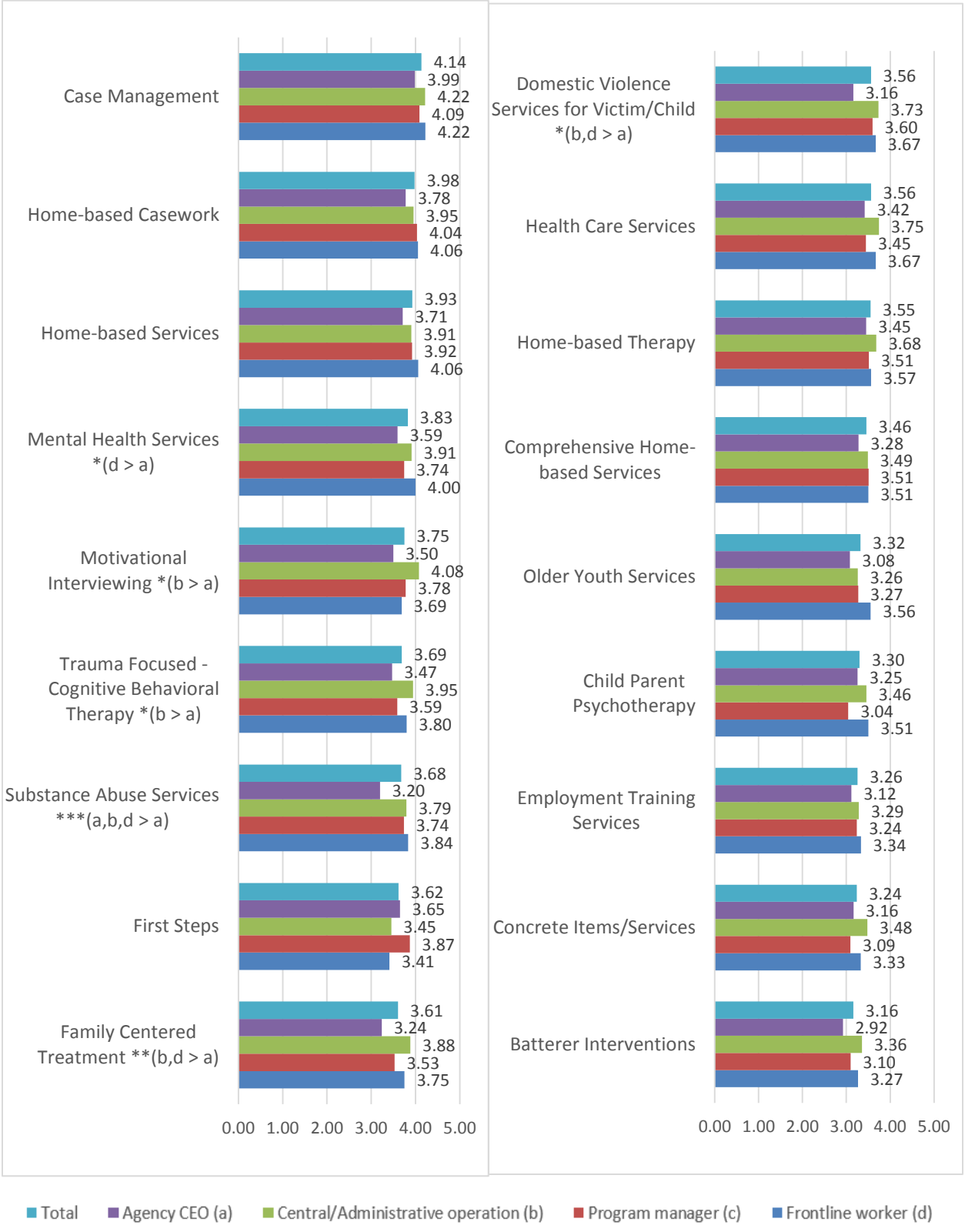
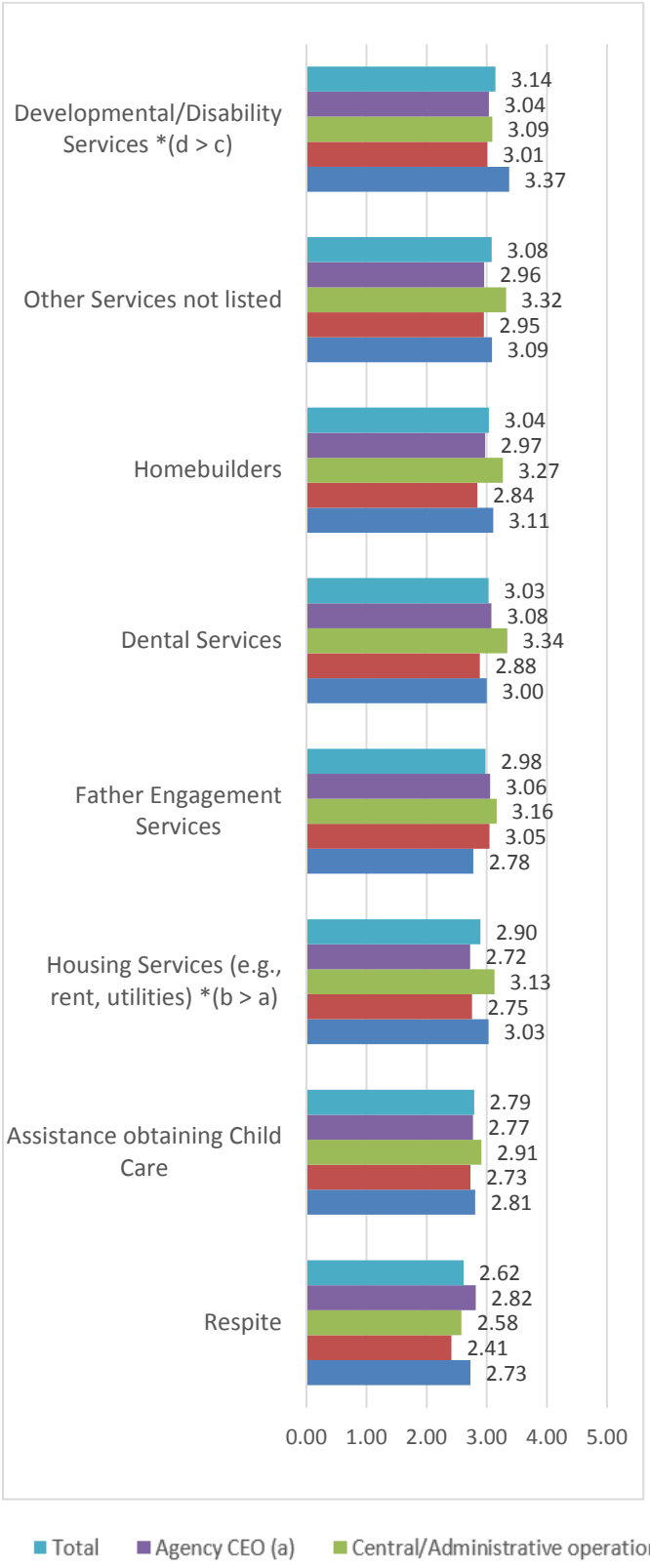


Figure 78 (continued). Average Rating of the Availability of Services when Needed



In Figure 79, the four top ranked services were the same for utilization as they were for availability. However, there were only significant differences in two services between the respondent types. Agency CEOs (M = 3.68) had a significantly lower utilization than did both central/administrative operations (M = 4.13) and frontline workers (M = 4.15) for case management ($p < .01$). They also indicated a significantly lower utilization than did frontline workers for housing services (3.22 vs. 3.75, $p < .05$).

Figure 79. Average Rating of the Utilization of Services when Available

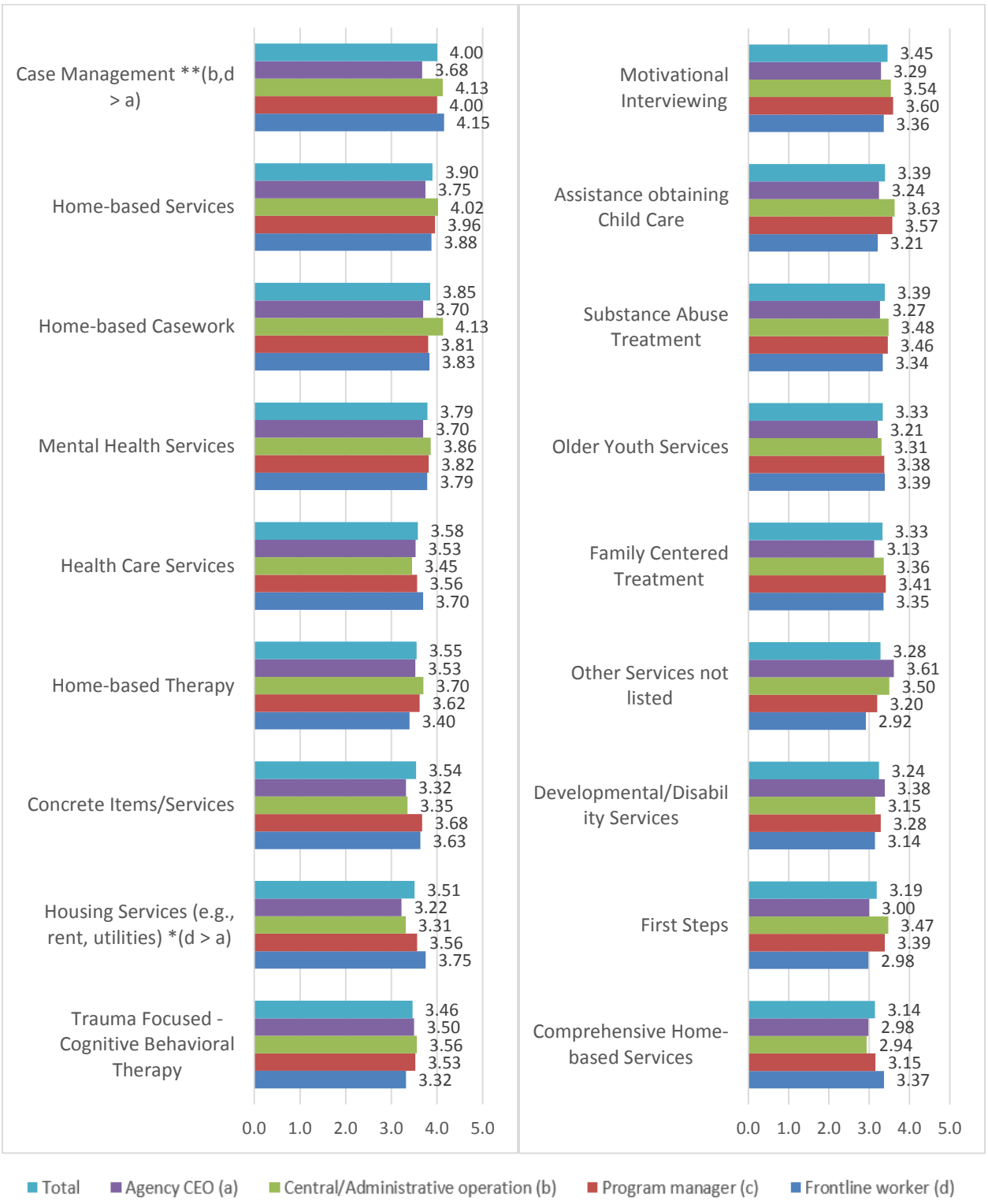
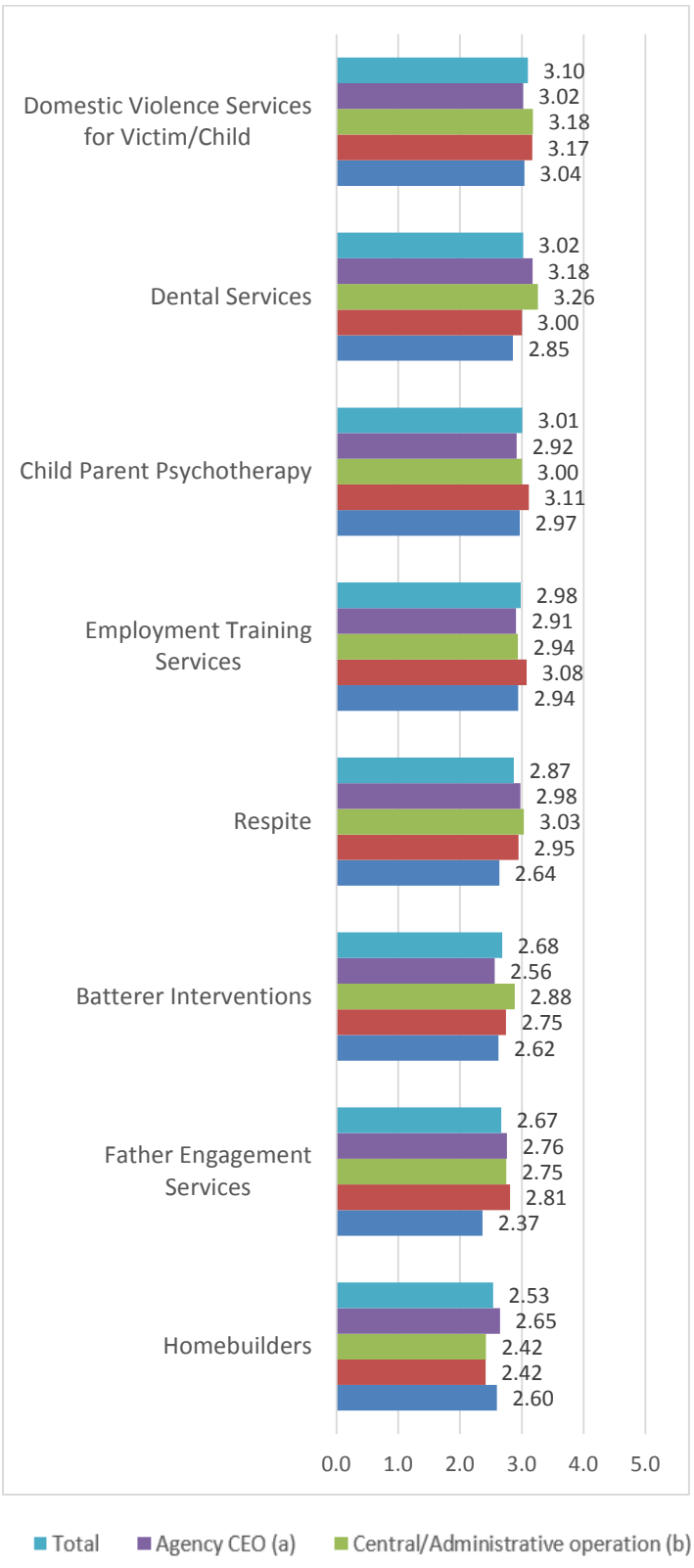


Figure 79 (continued). Average Rating of the Utilization of Services when Available



As can be seen in Figure 80, respondents generally perceived that the most effective service was trauma focused-cognitive behavioral therapy (M = 3.8), followed by case management (M = 3.76), home-based services (M = 3.74), and home-based casework (M = 3.73). The interesting findings is that the effectiveness of mental health services was relatively ranked lower although it was consistently ranked higher in all other components of services. Furthermore, agency CEOs reported a significantly lower effectiveness than did central/administrative operations for home-based services and home-based therapy, and also a significantly lower effectiveness than did frontline workers for older youth services. There was also significant difference in the effectiveness of dental services between central/administrative operations (M = 4.11) and frontline workers (M = 3.47) at the .05 level.

Figure 80. Average Rating of the Effectiveness of Services when Utilized

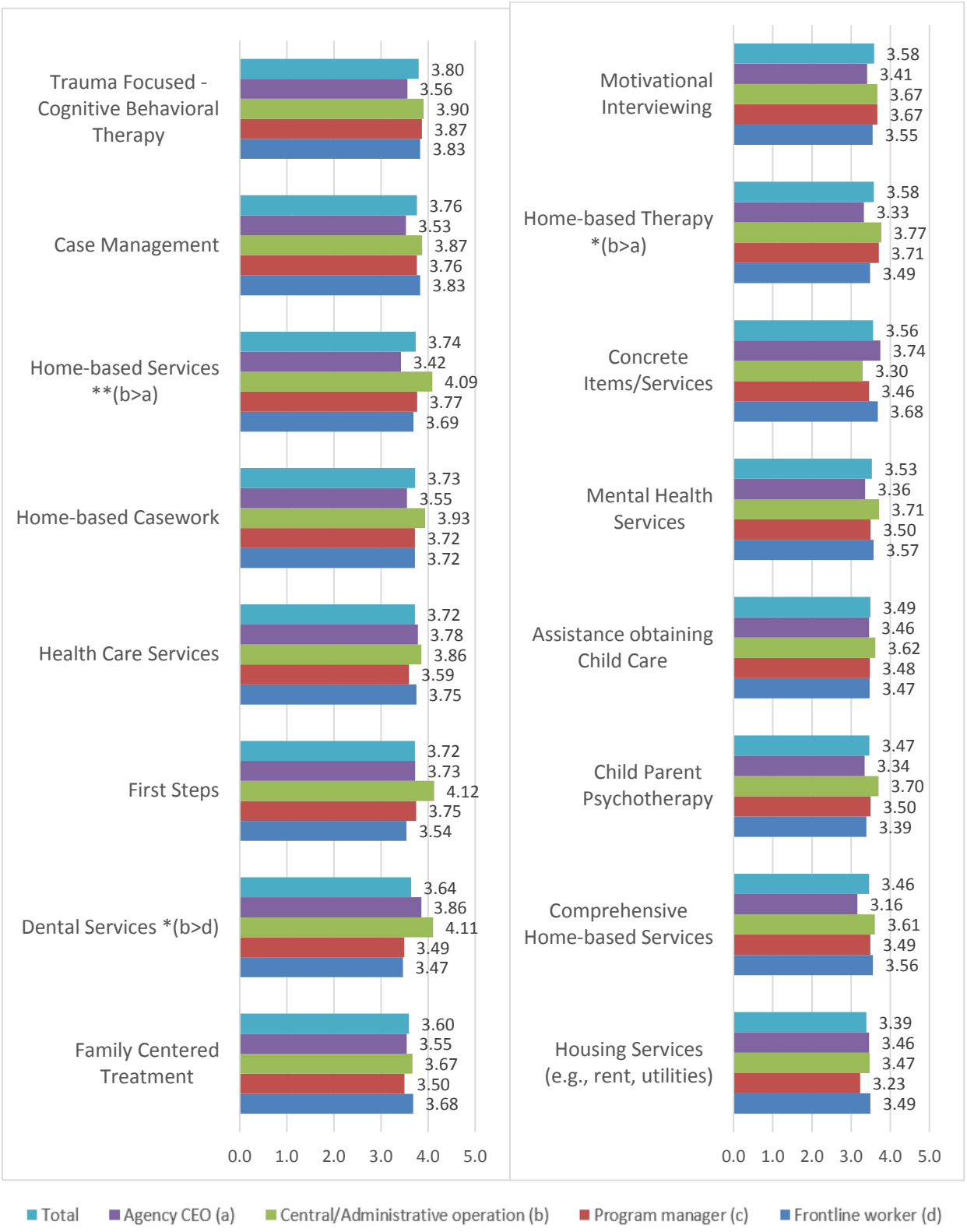


Figure 80 (continued). Average Rating of the Effectiveness of Services when Utilized

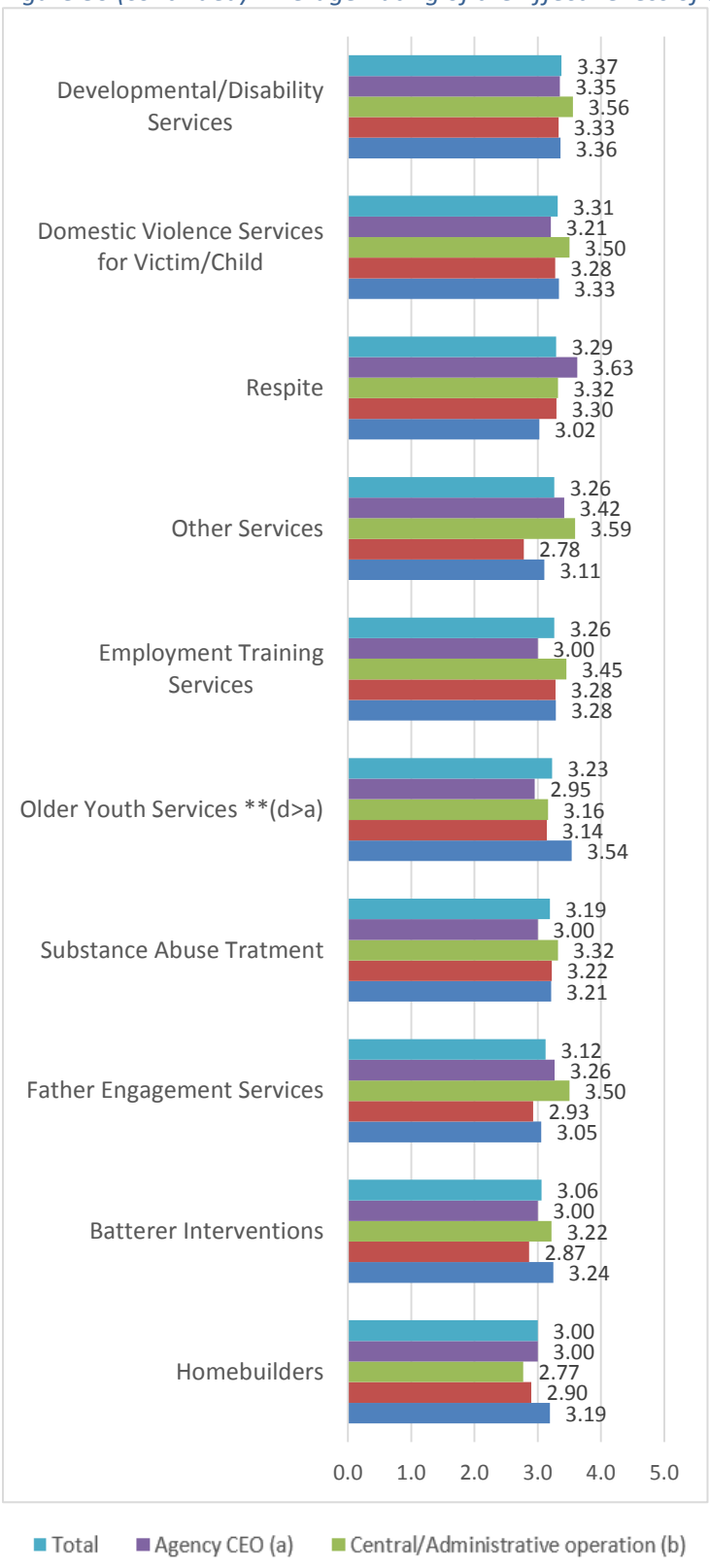
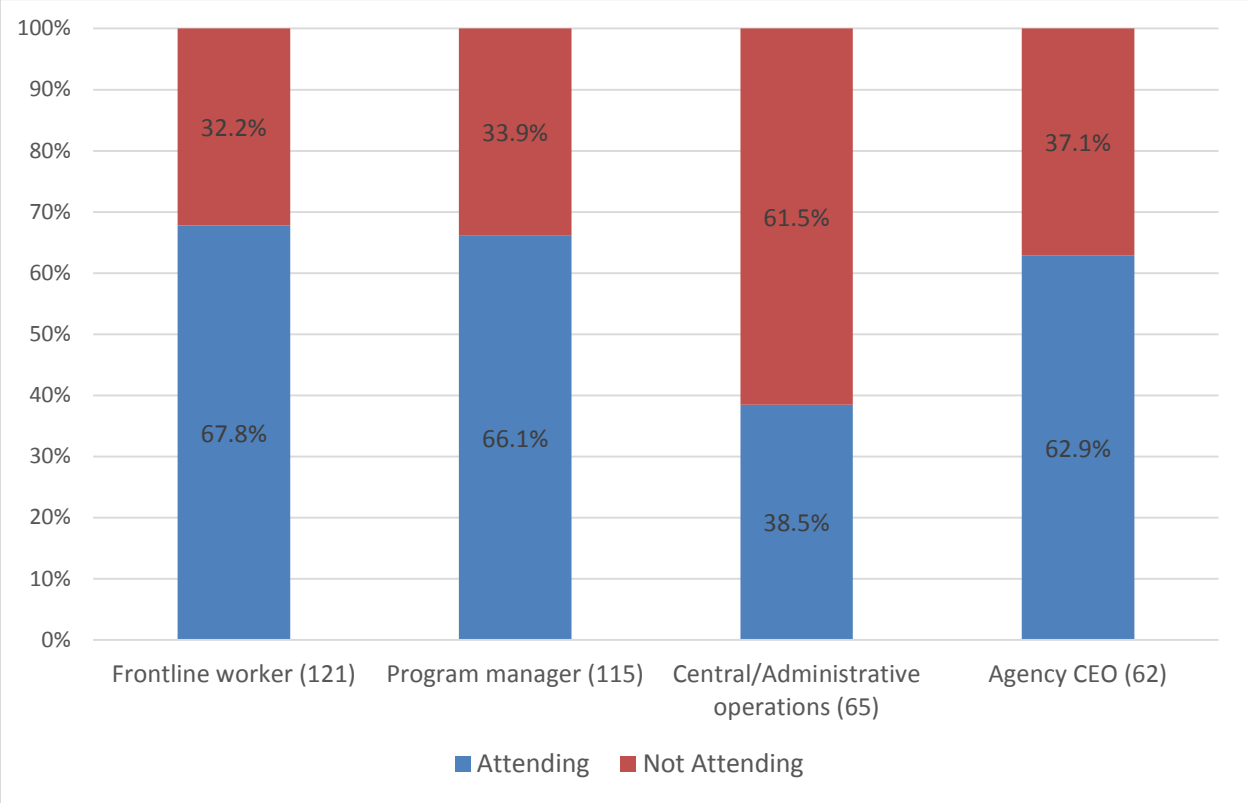


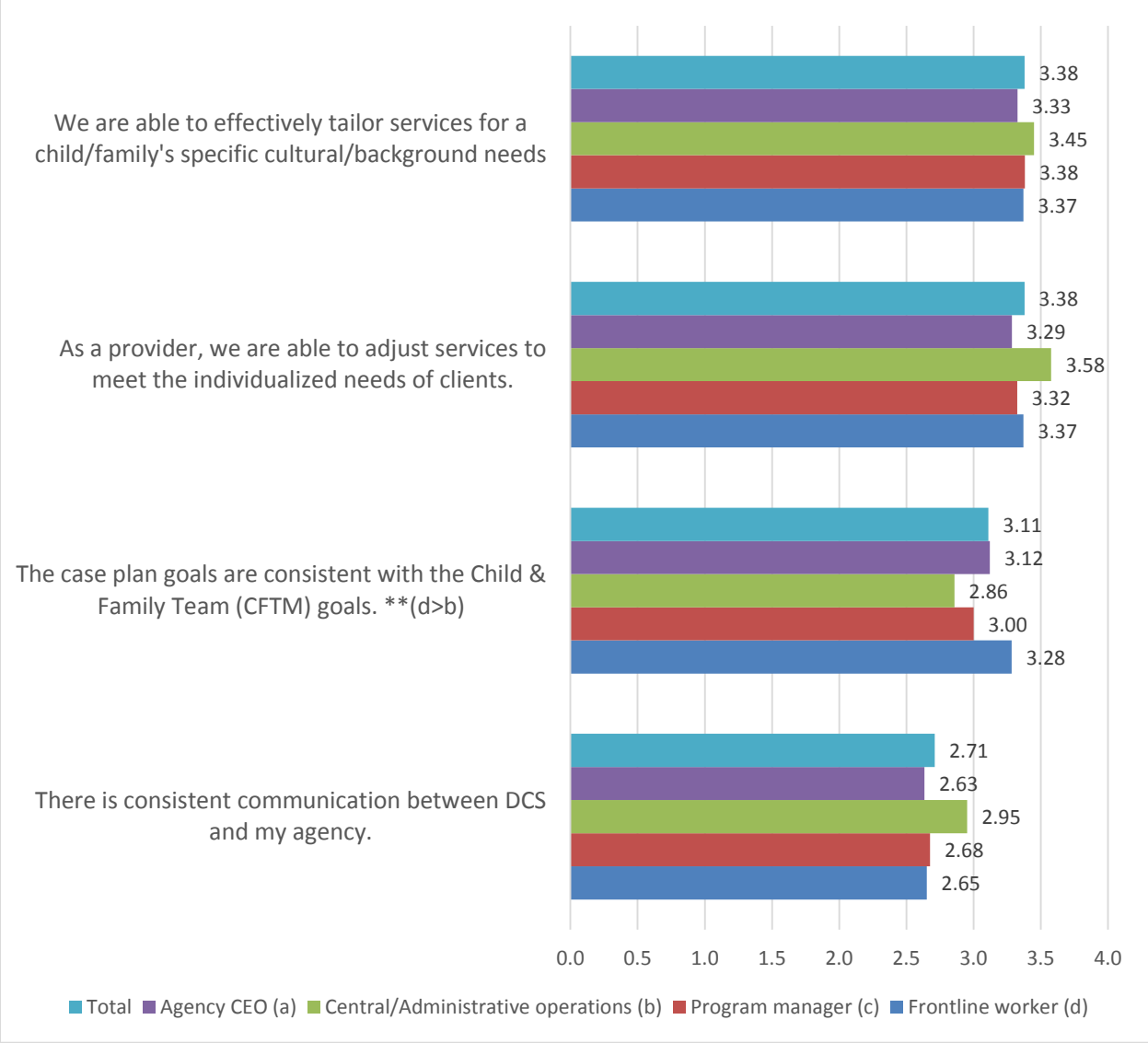
Figure 81 depicts the percentage of the attendance of Child and Family Team Meeting (CFTM) by the types of respondent. Although frontline workers had most experience in attending a CFTM in the past 12 months, many program managers (66.1%) and agency CEOs (62.9%) also frequently attended a CFTM. However, central/administration operations (38.5%) were less likely to attend a CFTM in comparison to other groups. Such differences were statistically significant (Chi-square = 17.56, $p < .01$).

Figure 81. Percentage of the Attendance of a CFTM



Respondents were asked to answer questions to investigate their experiences in attending a CFTM. Overall, respondents agreed or strongly agreed with all statements (See Figure 82). More specifically, the highest average rating statement was "we are able to effectively tailor services for a child/family's specific cultural/background needs" (M = 3.38), whereas the lowest average rating statement was "there is consistent communication between DCS and my agency" (M = 2.71). There were not significant differences in the perceptions of the CFTM experience between the respondent types, with the exception of one statement, "the case plan goals are consistent with the Child & Family Team (CFTM) goals" (frontline workers 3.28 > central/administrative operations 2.86, $p < .01$).

Figure 82. Average Rating of the Experience in a CFTM



Court Survey

In the court survey, the majority of respondents were GAL/CASA (n = 478), followed by probation (n = 87), prosecutor (n = 39), and judge (n = 31). Table 55 depicts the demographic characteristics of respondents who completed the questionnaire. Overall, seventy-two percent of respondents were female, but subgroups had a slightly different gender proportion. Many GAL/CASA (80.7%) and probation officers (59%) were females, while many prosecutors (58.6%) and judges (64.5%) were males. The majority of all respondents identified themselves as white (87%) and this pattern were found for all subgroups. The subgroup's average age ranged from 43.23 (probation) to 54.52 (GAL/CASA), with an overall mean of 52.95 years old.

Table 55. Demographic Characteristics of Court Respondents

	Overall		**GAL/CASA**		**Probation**		**Prosecutor**		**Judge**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Gender										
Female	408	72.0	346	80.7	46	59.0	9	31.0	7	22.6
Male	119	21.0	64	14.9	18	23.1	17	58.6	20	64.5
I choose not to answer	40	7.1	19	4.4	14	17.9	3	10.3	4	12.9
Race										
White	490	87.0	377	88.7	60	76.9	25	86.2	28	90.3
Black or African American	16	2.8	14	3.3	2	2.6	0	0.0	0	0.0
American Indian/Alaska Native	2	.4	1	.2	1	1.3	0	0.0	0	0.0
More than One Race	7	1.2	7	1.6	0	0.0	0	0.0	0	0.0
Other (please describe):	2	.4	1	.2	1	1.3	0	0.0	0	0.0
I choose not to answer	46	8.2	25	5.9	14	17.9	4	13.8	3	9.7%
Ethnicity										
Non-Hispanic	466	87.4	358	89.5	61	78.2	22	84.6	25	86.2
Hispanic	7	1.3	5	1.3	2	2.6	0	0.0	0	0.0
I choose not to answer	60	11.3	37	9.3	15	19.2	4	15.4	4	13.8
Age	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
	52.95	13.74	54.52	14.10	43.23	10.32	48.30	7.69	52.58	9.57

Figure 83 indicates the quality of legal services/advocacy provided by DCS attorneys and the preparedness of DCS staff for court. In general, respondents reported that the DCS attorneys' legal services were "somewhat" effective (M = 3.68), and FCMs (M = 3.84) and DCS attorneys (M = 3.88) were "somewhat" prepared. There were significant differences in these perceptions between the types of the respondent in the court survey (see Figure 55 for detailed information). The common finding is that Judges rated higher scores in all three domains than other particular groups. For example, Judges had significantly higher average scores than did prosecutors for the preparedness of DCS attorneys for court (4.27 vs. 3.49, $p < .01$) and for the quality of legal services /advocacy provided by DCS attorneys (3.80 vs. 3.22, $p < .01$). Similarly, they reported a significantly higher perception of the preparedness of FCMs for court than did GAL/CASA (4.00 vs. 3.43, $p < .01$).

Figure 83. Average Rating of the Quality of DCS Legal Services and the Preparedness of DCS staff

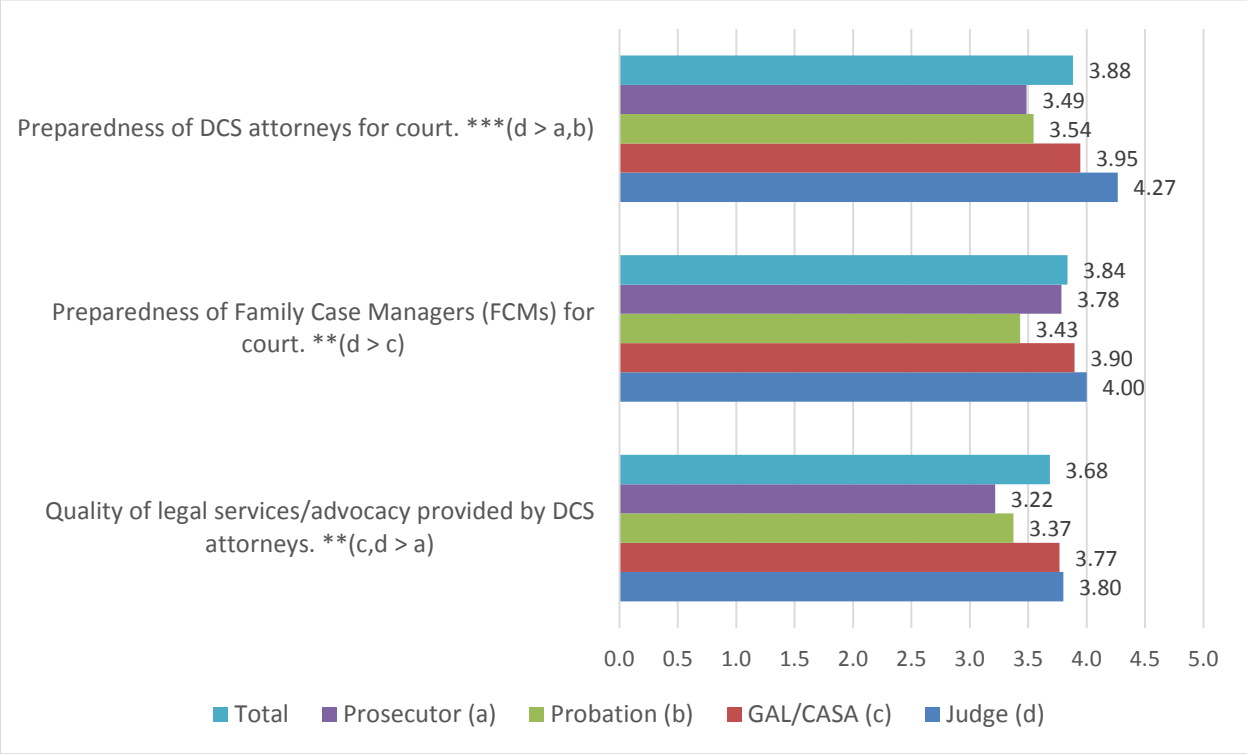
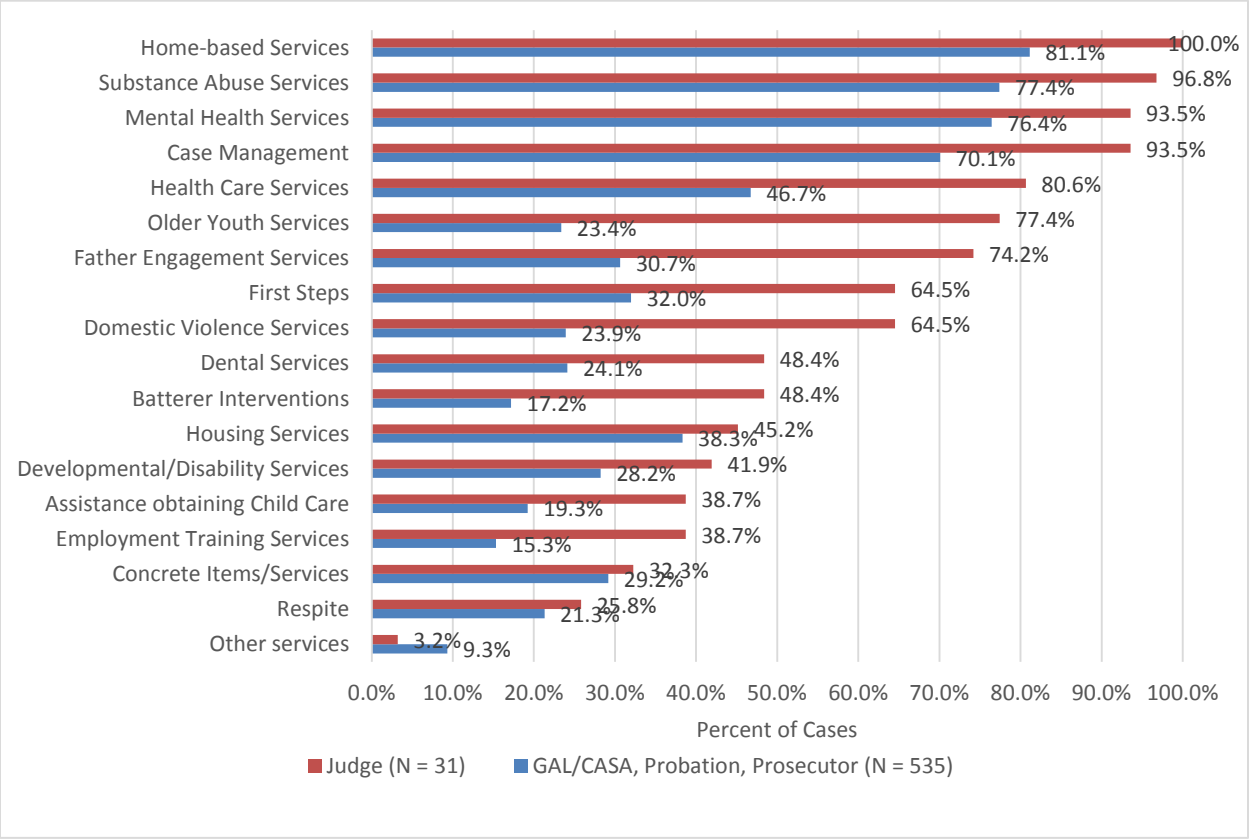


Figure 84 displays the services that children and/or their parents had been recommended or ordered to use. Both judges and other court respondents, including GAL/CASA, probation officers, and prosecutor, equally reported that the five top services that were more frequently recommended and ordered for children and their families included: (a) home-based services, (b) substance abuse services, (c) mental health services, (d) case management, and (e) health care services.

Figure 84. Percentage of the Services Recommended or Ordered for Children and their Families



A subsequent analysis was conducted to evaluate the effectiveness of the recommended or ordered services rated by judges (Figure 85) and other court respondents (Figure 58). In general, both groups indicated that most services were at least "somewhat" effective. More specifically, more than ninety percent of both groups commonly reported that dental services, first steps, health care services, and respite were "somewhat" and "completely" effective. On the other hand, judges showed that housing services (21.4%), mental health services (17.2%), and substance abuse services (16.7%) were "not effective at all". Other court respondents also indicated that employment training services (27%), substance abuse services (25.5%), and father engagement services (24.8%) were "not effective at all".

Figure 85. Effectiveness of the Recommended Services Rated by Judges

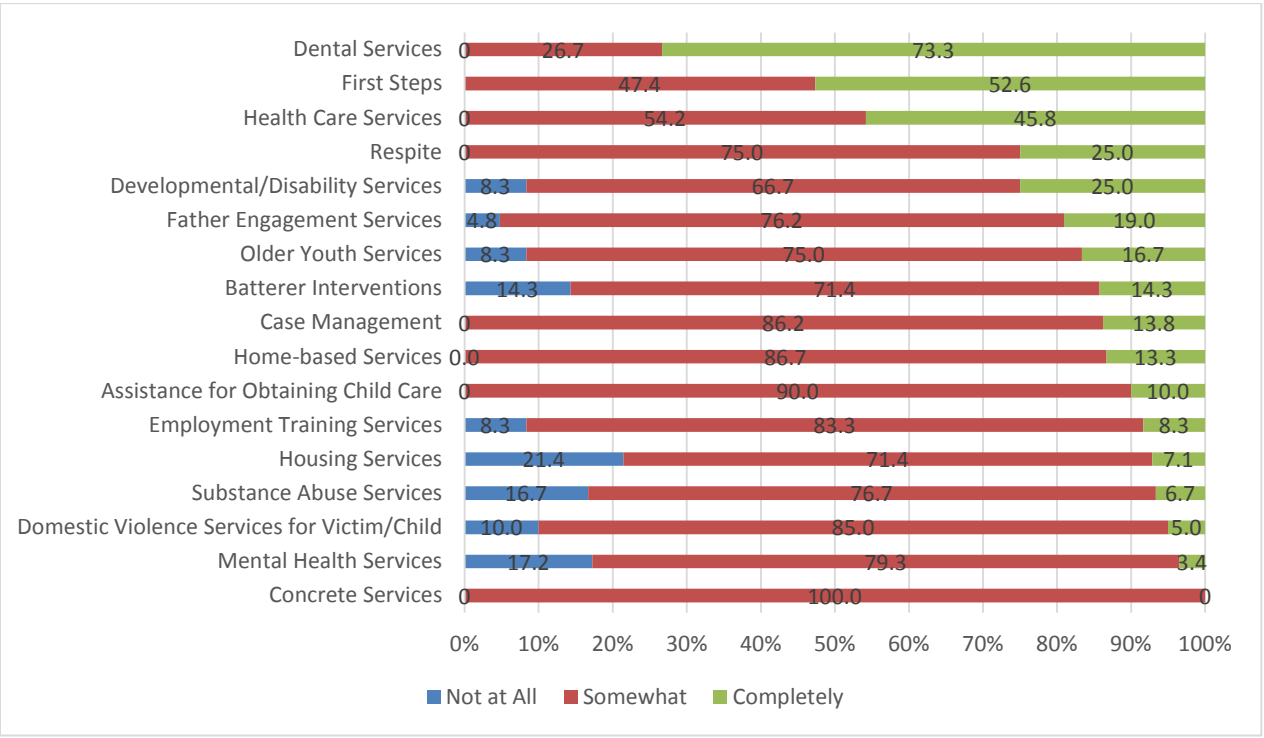


Figure 86. Effectiveness of the Recommended Services Rated by Non-judge Respondents

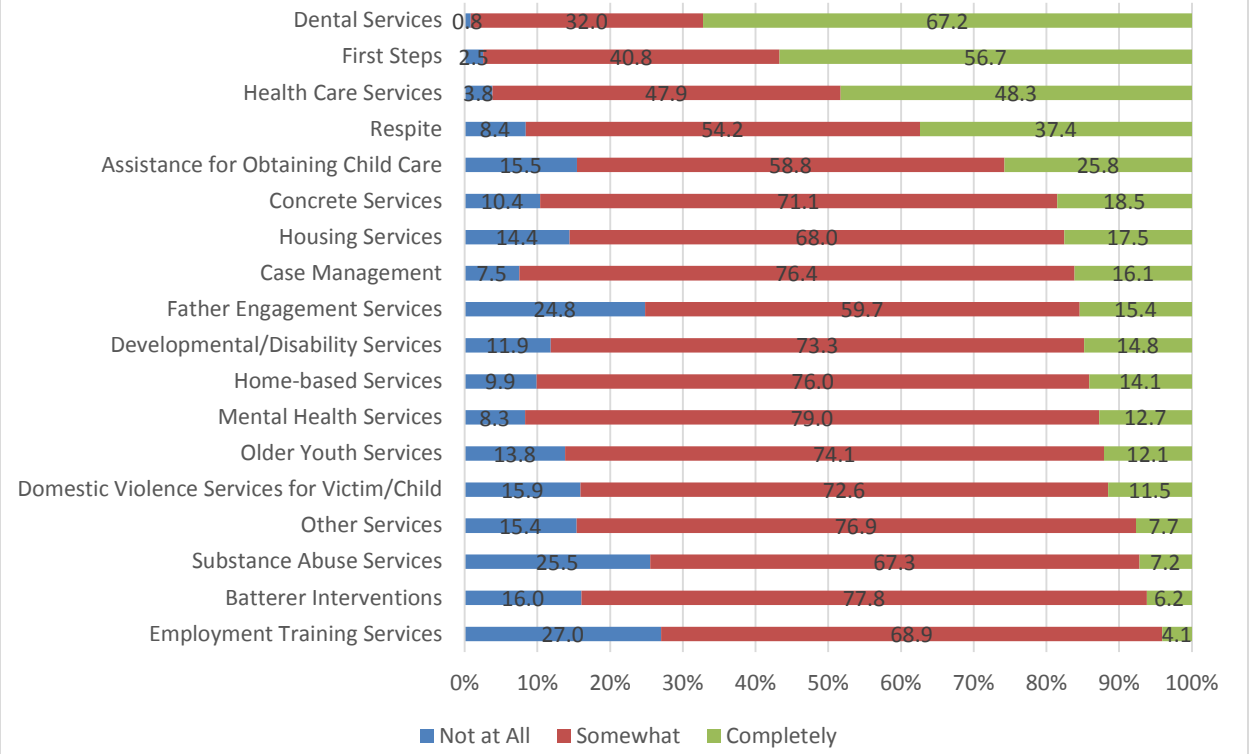


Figure 87 exhibits the percentage of services that were not available to the child/family despite the potential benefits of the services. As compared to the caregiver and youth groups, respondents in the court survey generally perceived lower levels of the lack of services.

Figure 87. Percentage of the Lack of Services

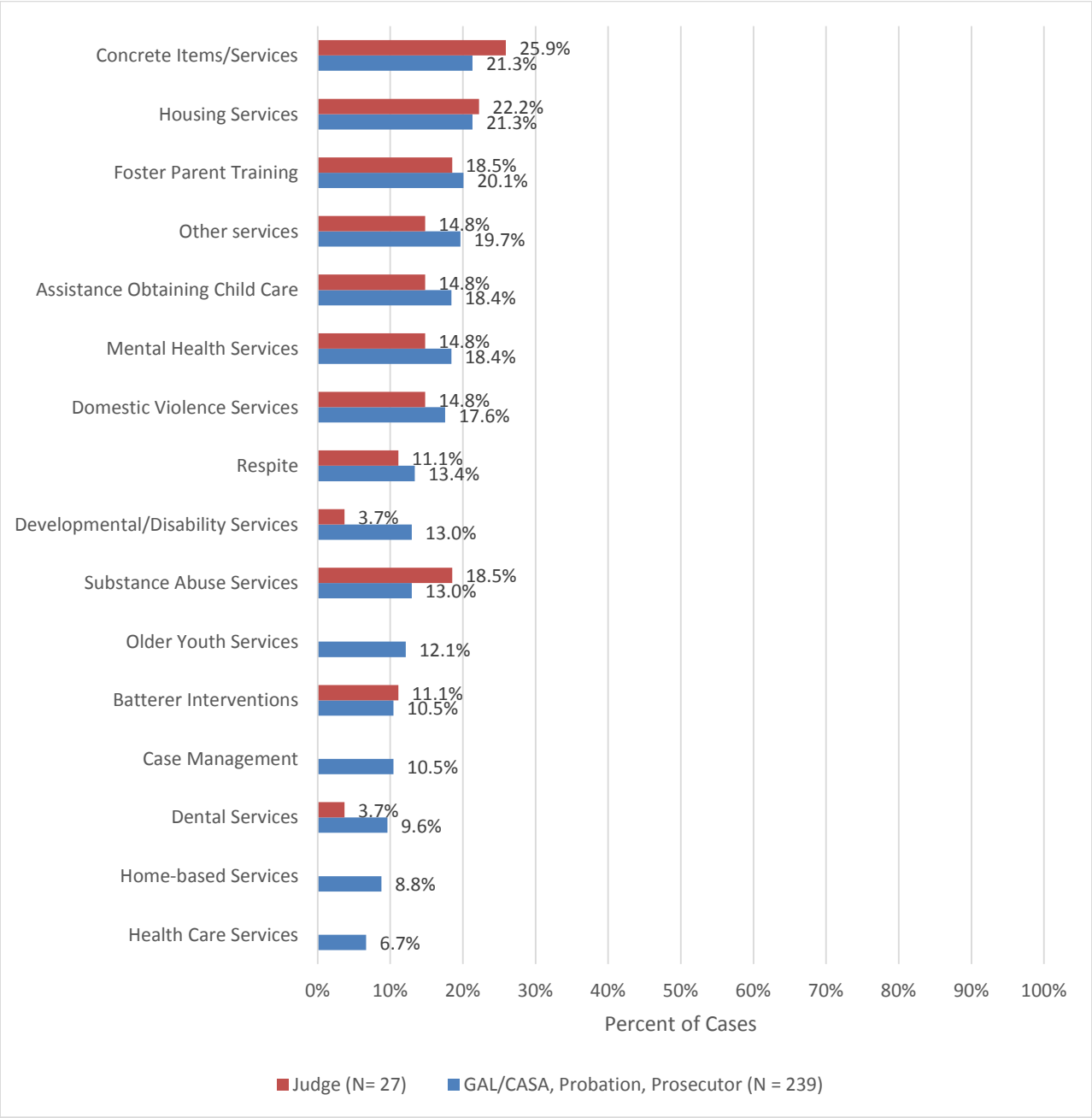
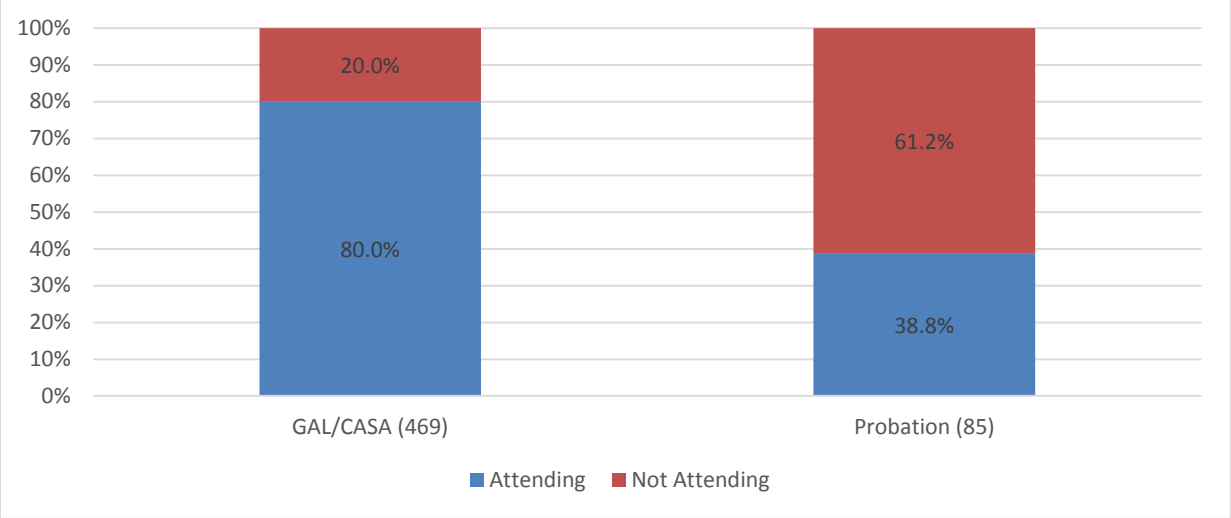


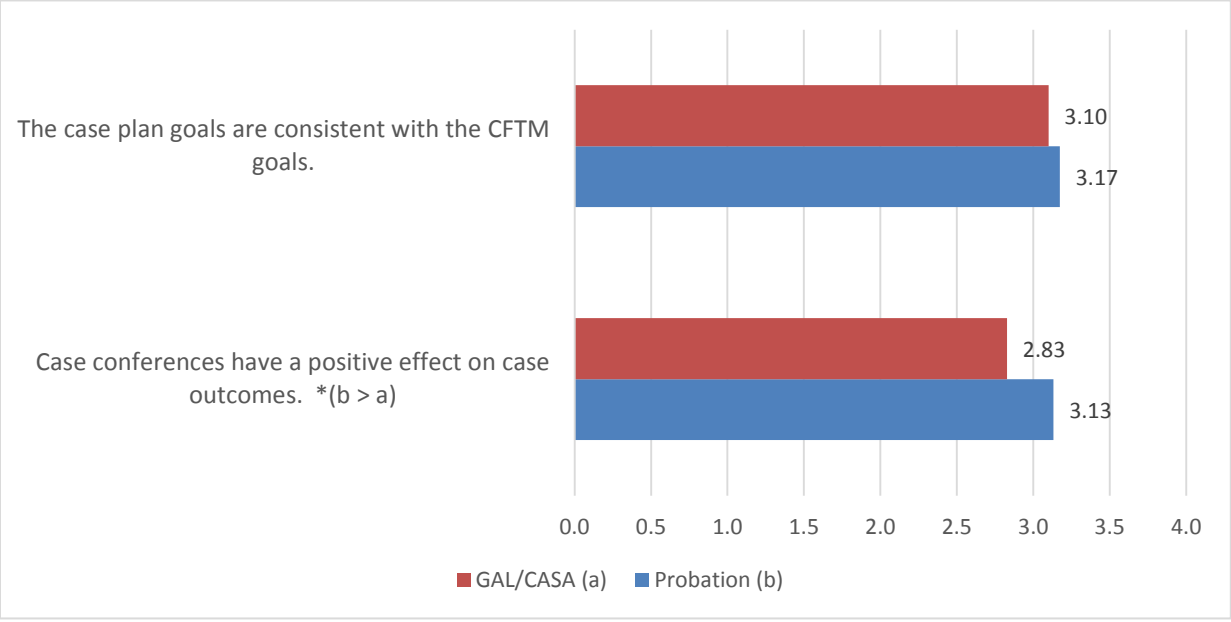
Figure 88 displays the percentage of the attendance of a case conference for the groups of GAL/CASA and probation. Eighty percent of GAL/CASA attended a case conference in the last 12 months. Conversely, nearly 39% of probation officers participated in a case conference.

Figure 88. Percentage of the Attendance of a Case Conference



GAL/CASA and probation were also asked to rate two questions to investigate their experiences in a case conference (see Figure 89). Overall, all respondents agreed or strongly agreed with all statements. More specifically, probation officers perceived a significantly higher perception of the positive effect of the case conference on case outcomes (3.13 vs. 2.83, $p < .05$).

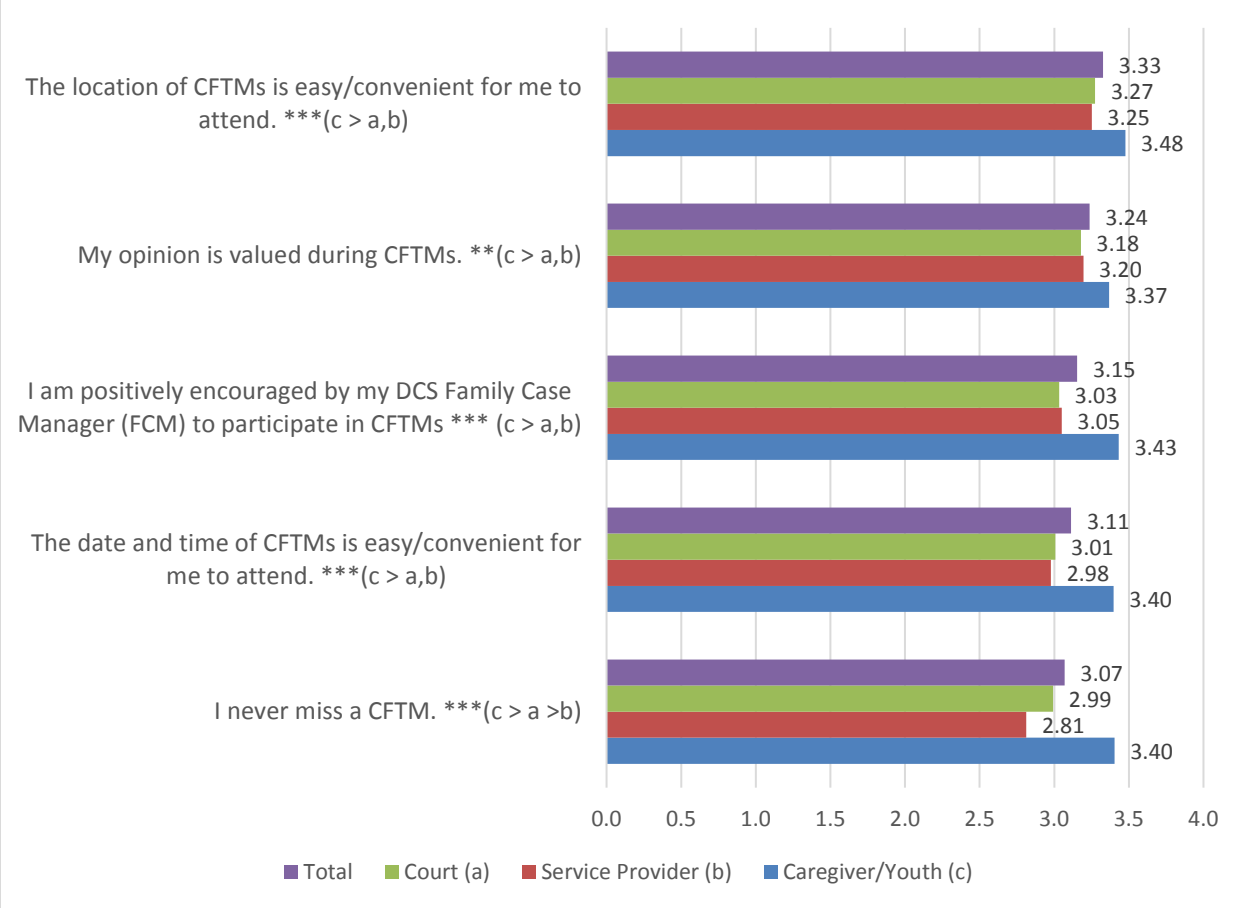
Figure 89. Average Rating of the Experience in a Case Conference



Comparison Analysis of Child and Family Team Meeting (CFTM) Among Different Stakeholder Groups

A further analysis examined significant differences in several domains of a Child and Family Team Meeting (CFTM) between three different stakeholder groups: caregiver and youth, service provider, and court. Figure 90 depicts the mean responses of questions relating to the quality of a CFTM by three stakeholder groups. A caregiver and youth group had significantly higher average scores in all the questions ($p < .01$ to $.001$).

Figure 90. Comparing the Quality of a CFTM among Three Stakeholder Groups



Both service providers and GAL/CASAs were asked to answer in binary questions (yes/no) to investigate the level of their knowledge of a CFTM. As can be seen Figure 91, There was a significant difference in the average number of the correct answers between service providers ($M = 3.47$) and GAL/CASAs ($M = 3.12$) ($t= 3.44$, $p < .01$). The examination of each question's correct answer shows somewhat mixed results (see Figure 64). Overall, over 95 percent of all respondents reported the correct answer to Question 1, whereas about 33% reported the correct answer to the Question 5. Moreover, service providers had significantly more correct answers to Question 3 (100% vs. 60.4%, $p < .001$ by Fisher's exact test) and Question 4 (78.3% vs. 64.9%, $p < .001$ by Fisher's exact test).

Figure 91. Comparing Overall Knowledge of a CFTM between Service Providers and GAL/CASAs

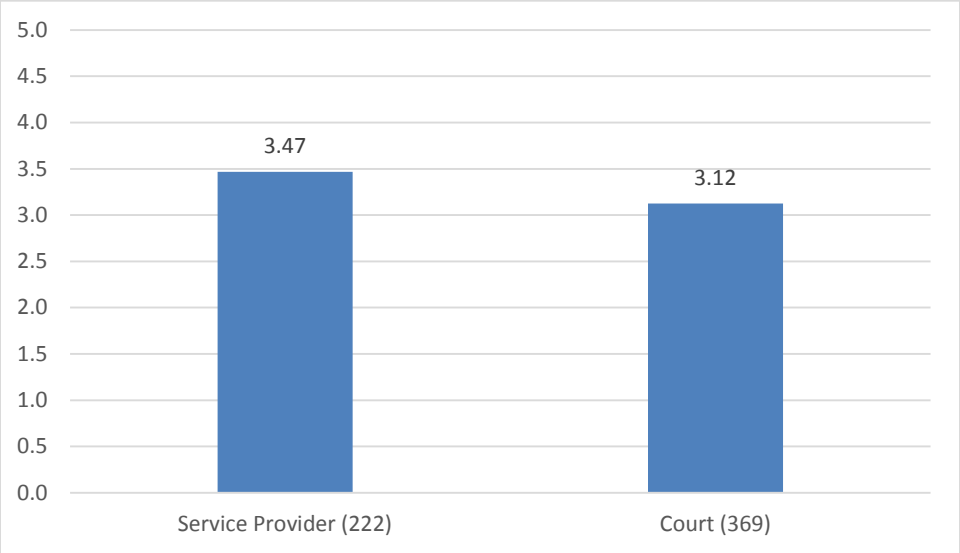
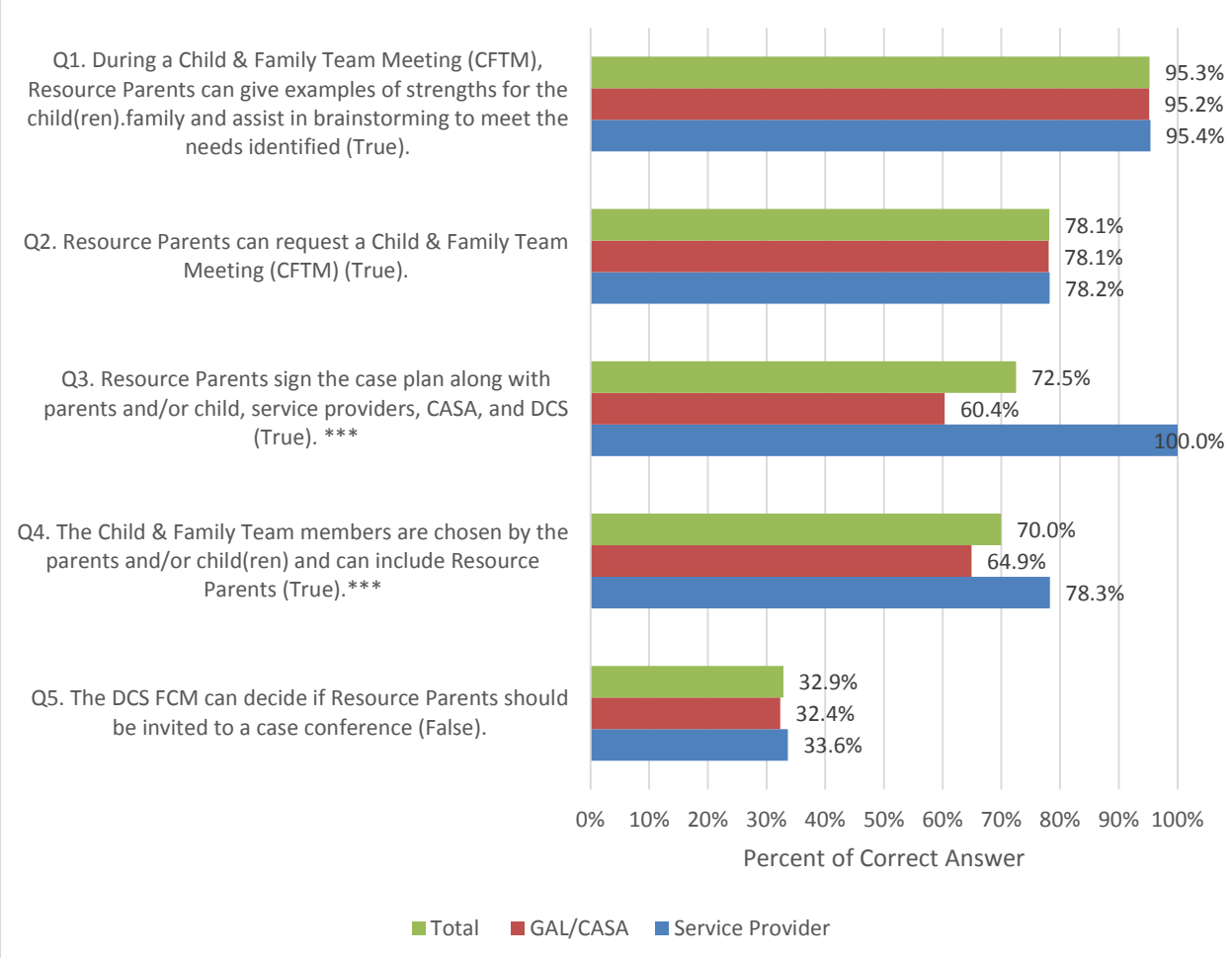
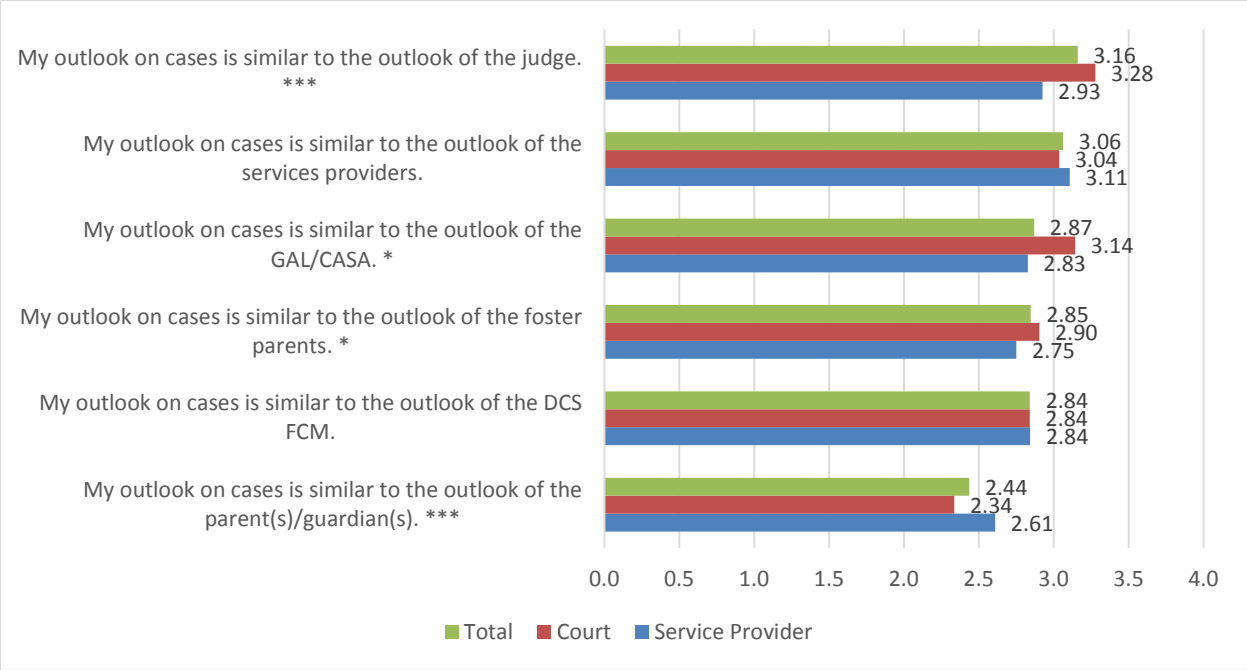


Figure 92. Percentage of the Correct Answer to Individual Questions about a CFTM



The respondents in the service provider and court surveys were also asked to rate the similarity in their outlook on cases to other team members in a CFTM (e.g., parent/guardian, foster parent, DCS FCM, service provider, judge, GAL/CASA). Figure 65 shows that all respondents generally perceived a more similar outlook on cases with the judge (M = 3.16), while they perceived a less similar outlook with the parent/guardian (M = 2.44). There were also significant differences in the outlook between different stakeholder groups. The court respondents were more likely than service provider groups to perceive that their outlook was similar to the outlook of the judge (3.28 vs. 2.93, $p < .001$), the GAL/CASA (3.14 vs. 2.83, $p < .05$), and the foster parent (2.90 vs. 2.75, $p < .05$). On the other hand, service providers were more likely than court respondents to perceive that their outlook was similar to the outlook of parent/guardian (2.61 vs. 2.34, $p < .001$).

Figure 93. Comparing the Similarity in the Outlook on Cases between Service Provider and Court Groups



FCM and Service Provider Comparisons

Methods

As part of the Process and component of the evaluation, the Executive Team and the IU Evaluation Team wanted to collect information on services, satisfaction with DCS workers and services, and teaming from major stakeholders. The community survey was designed to better capture the outcomes of child welfare services as perceived by key stakeholders in child welfare. Potential participants were identified via DCS. The online community survey was distributed to various stakeholders ranging from service providers to foster parents in 2013 and 2015. The first round of the survey was gathered in September 2013 while the second round of the survey was collected in August 2015.

Presented in this section are the results of comparing the four outcomes of child welfare services perceived by service providers between 2013 and 2015: a) the need for that service, b) availability of that service when needed, c) utilization of that service when available, and d) effectiveness of that service when utilized. The section also includes the results of comparing the perceived service outcomes between service providers and FCMs across the years. Eleven specific services were selected and used for the compassion analyses, which were commonly evaluated in both rounds of the community surveys and were available to compare with the FCM surveys. The selected services include dental, health care, mental health, substance abuse, employment, housing, developmental/disability, domestic violence, father engagement, home-based casework, and child care services.

Respondents

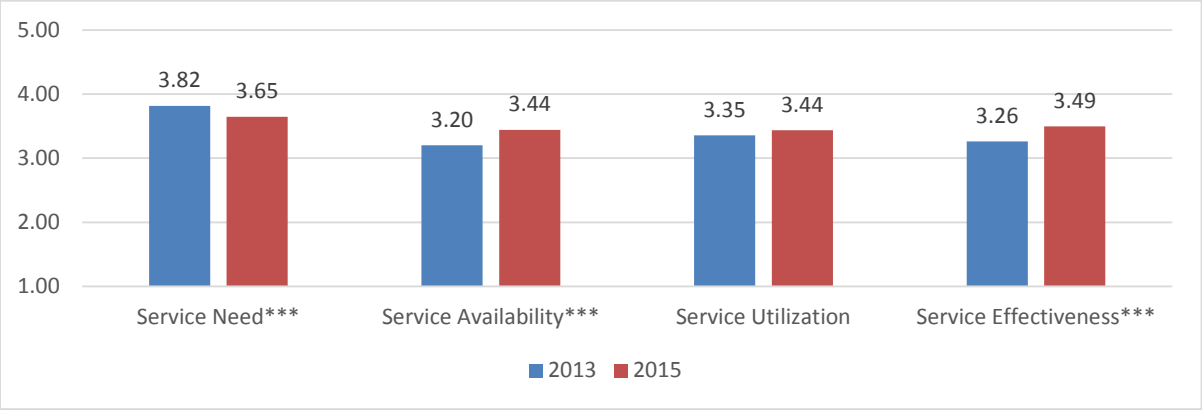
For the community survey in 2013, 518 responses of service providers were complete and usable for analysis purposes. Specific groups include community service providers (n = 231), educational staff (n = 171), healthcare provider (n = 46), residential provider staff (n = 37), and licensed child placing agency (n = 33). The demographic characteristics of the respondents are not available in this first round of the survey.

For the community survey in 2015, 557 responses of service providers were usable for analysis purposes. Specific groups include frontline workers (n = 181), program managers (n = 161), agency CEO (n = 114), and central/administrative operations (n = 95). The majority of respondents were females (73.8%) and identified themselves as white (75.7%). The average age was 44 years old.

Trend in Service Outcomes Perceived by Service Providers

Figure 94 displays the trend in overall service need, availability, utilization, and effectiveness perceived by service providers from 2013 to 2015. Service providers reported a significantly lower score on service needs in 2015 ($M = 3.65$) as compared to 2013 ($M = 3.82$, $p < .001$). The three other outcomes perceived by service providers—availability, utilization, and effectiveness—were consistently improved in 2015 although the increase in service utilization was not statistically significant.

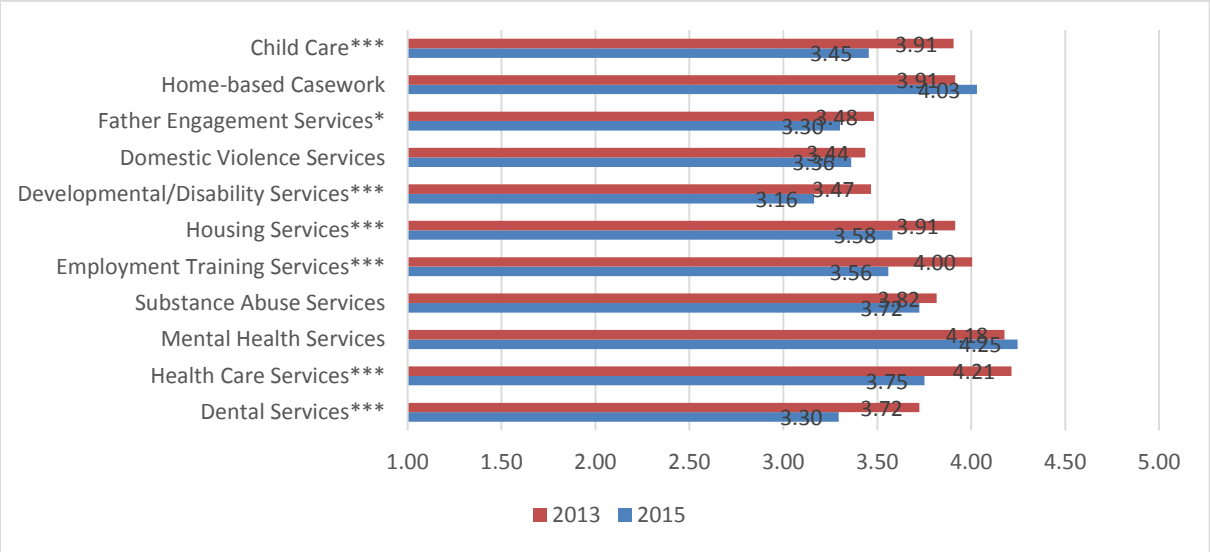
Figure 94. Trend in the Perceived Overall Service Outcomes



***p <.001

Figure 95-98 provide more detailed information about the mean changes in specific services' perceived outcomes between 2013 and 2015. Similar to the overall trend, many services showed a significantly reduced need from 2013 to 2015, including child care, father engagement, developmental/disability, housing, employment, healthcare, and dental services (Figure 95). Service providers showed a relatively increased need for mental health services and home-based casework in 2015, but these differences were not statistically significant.

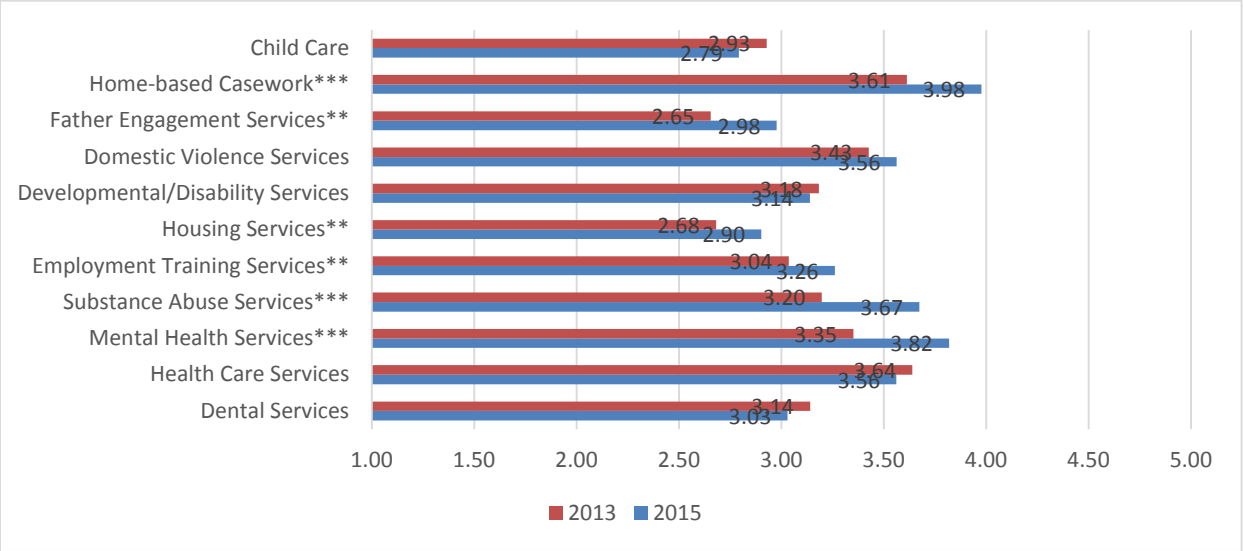
Figure 95. Trend in the Perceived Needs for Specific Services



***p <.001, **p < .01, *p < .05

Consistent with the overall trend in service availability, service providers perceived that many services had been increasingly available to children and families from 2013 to 2015 (Figure 96). Specific services showing significantly increased availability include home-based casework, father engagement, housing, employment, substance abuse, mental health services.

Figure 96. Trend in the Perceived Availability for Specific Services



***p <.001, **p < .01, *p < .05

In Figure 97, service providers reported significantly increased utilization for some services from 2013 to 2015: home-based casework, substance abuse, and mental health services. However, they perceived that some services were less utilized in 2015 as compared to 2013. Specific services with the significantly decreased utilization include child care, health care, and dental services. The decreased utilization of these services was understandable in that their need and availability also tended to show the decreased patterns in Figure 95 and 96.

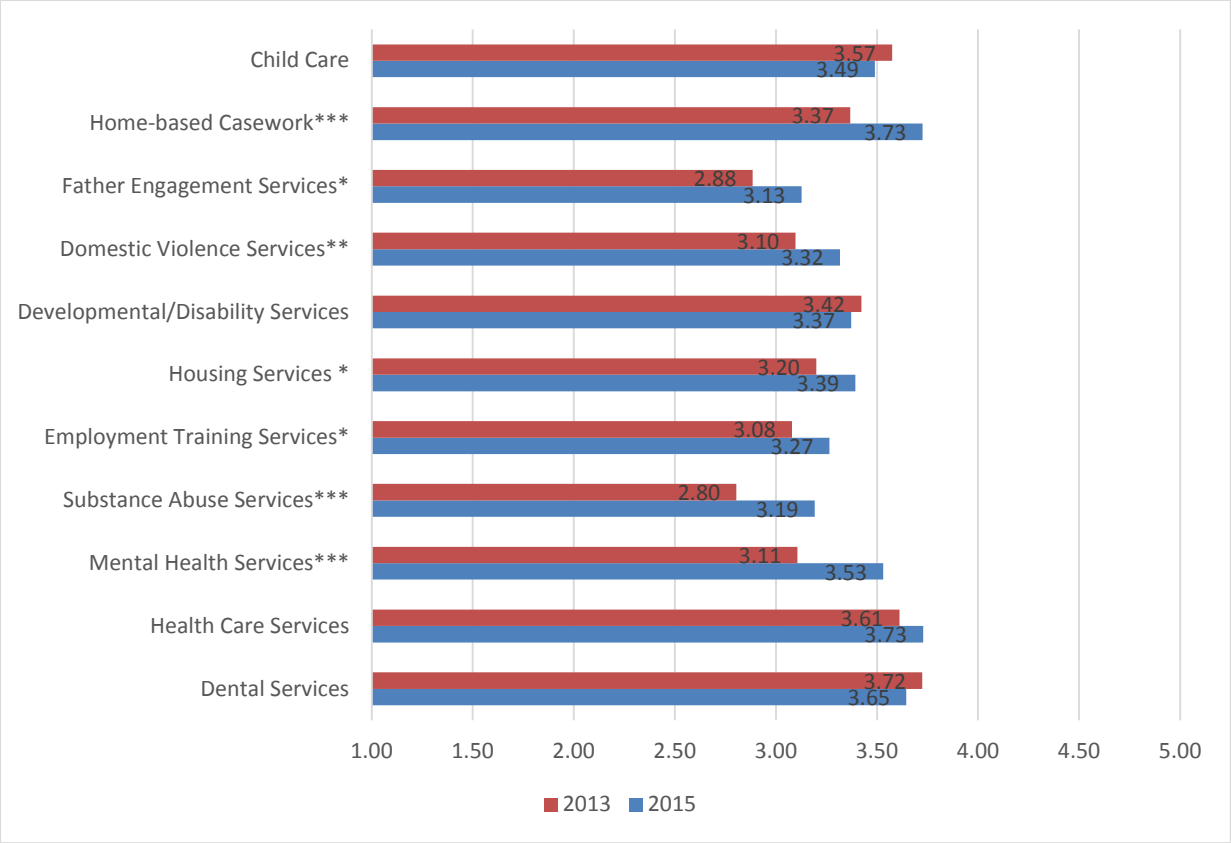
Figure 97. Trend in the Perceived Utilization for Specific Services

***p <.001, **p < .01, *p < .05

Finally, Figure 98 shows the mean changes in service effectiveness perceived by service providers from 2013 to 2015. The changing pattern of the most services' effectiveness is similar to the overall increased

effectiveness shown in Figure 94. A significantly improved effectiveness was identified in seven services: home-based casework, father engagement, domestic violence, housing, employment, substance abuse, and mental health services. However, service providers indicated relatively lower effectiveness for child care and dental services in 2015, but the differences were not statistically significant.

Figure 98. Trend in the Perceived Effectiveness for Specific Services



Comparing the Trend in Perceived Service Outcomes between Service providers and Family Case Managers (FCMs)

An additional analysis was conducted to examine how the mean changes in service providers' perceptions of service outcomes can differ from the FCMs' perceptions. Figure 99 reveals the results of the changing trends in the overall service outcomes between service providers and FCMs across the years. Service providers showed decreased service needs whereas FCMs indicated increased service needs from 2013 to 2015. Both groups perceived increased service availability and utilization although the FCMs' perceptions were relatively higher than the service providers' perceptions. Finally, both groups reported increased service effectiveness. But, FCMs had the relatively lower perceptions of the effectiveness than did service providers in both years and this difference became slightly greater in 2015.

Figure 100. Comparing the Trend in Overall Service Outcomes between Service Providers and FCMs

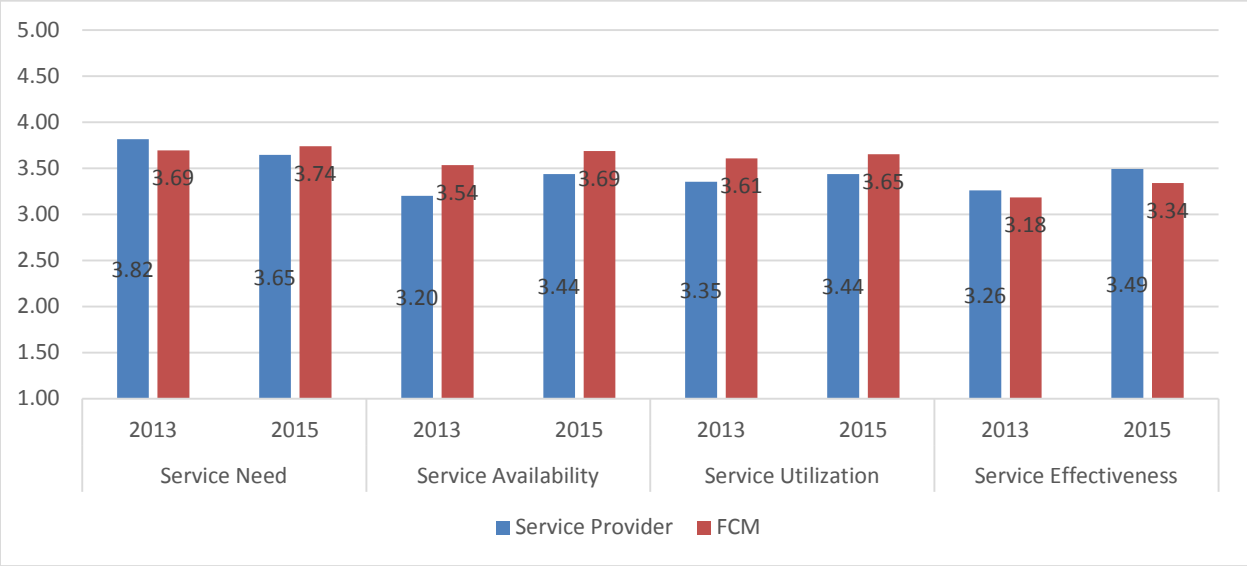
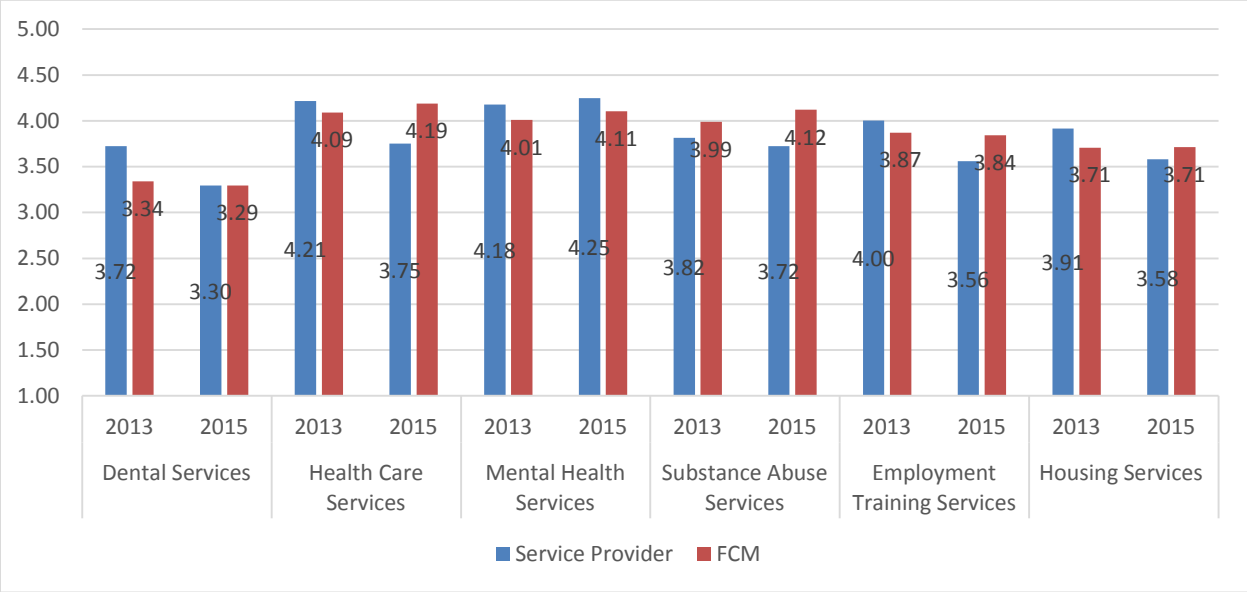
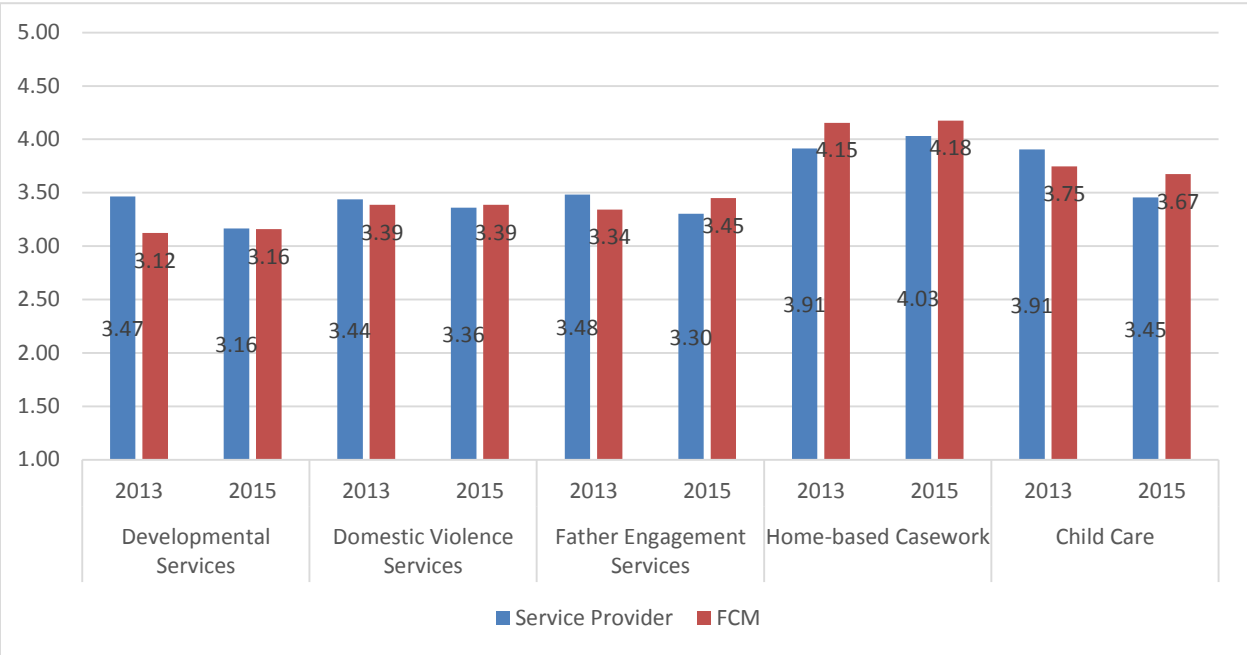


Figure 102-105 provide more detailed information about comparing the mean changes in specific services' outcomes between service providers and FCMs. As shown in the overall service need, some services, such as health care services and employment training services, had the similar patterns of the service need—a decreased need from service providers and an increased need from FCMs (Figure 101). However, some services showed different patterns. For example, FCMs rated a relatively higher score on the needs for substance abuse and home-based casework in both years. In contrast, service providers rated a relatively higher score on the need for mental health services in both years.

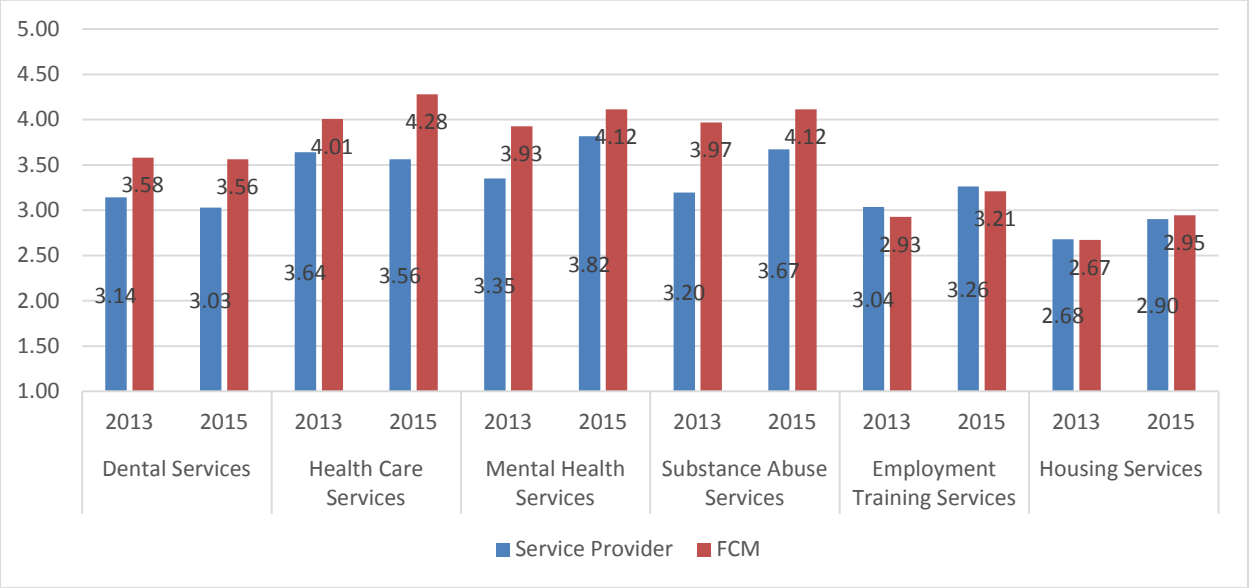
Figure 101. Comparing the Trend in the Perceived Need for Specific Services between Service Providers and FCMs

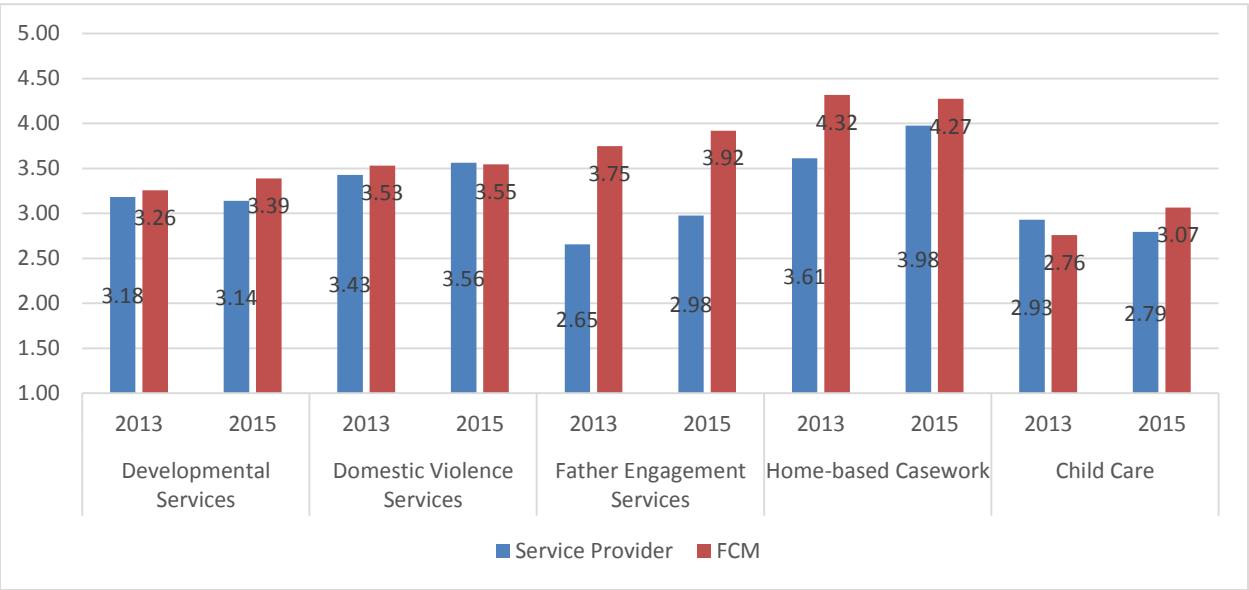




Both service providers and FCMs indicated that the availability of many services had increased from 2013 to 2015 although the degree of the changes varied across different services: the availability of father engagement services was greatly improved (Figure 102). They also reported the different patterns in certain services' availability. For example, service providers tended to have the decreasing perceptions of available child care services, whereas FCMs tended to have the increasing perceptions of the service's availability.

Figure 102. Comparing the Trend in the Perceived Availability for Specific Services between Service Providers and FCMs





Similarly, both groups reported the constantly increased utilization of many services, such as mental health, substance abuse, and domestic violence services (Figure 103). However, service providers perceived a subsequent decrease in utilizing developmental/disability and child care services, whereas FCMs perceived a subsequent increase in utilizing these services.

Figure 104. Comparing the Trend in the Perceived Utilization for Specific Services between Service Providers and FCMs

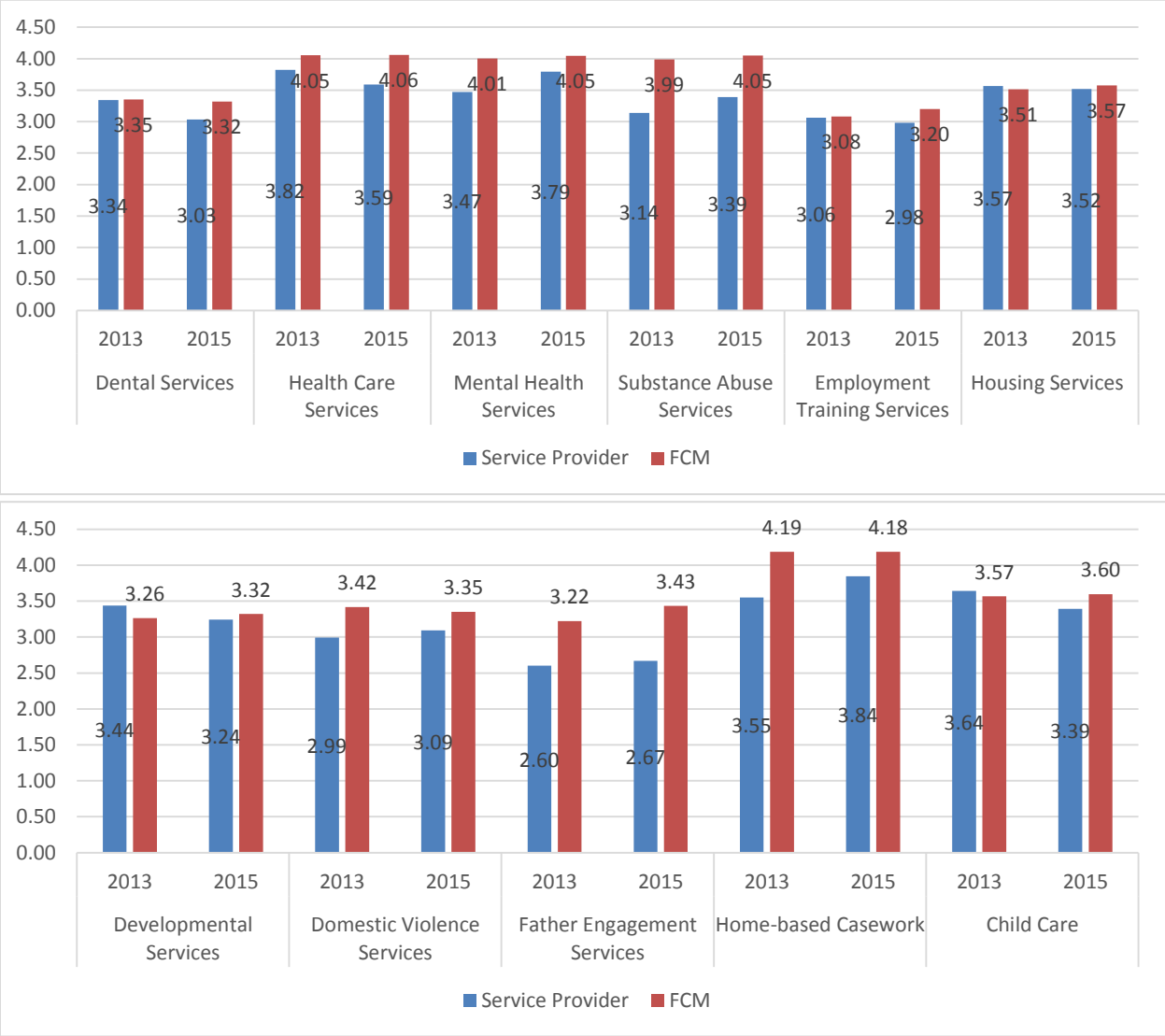
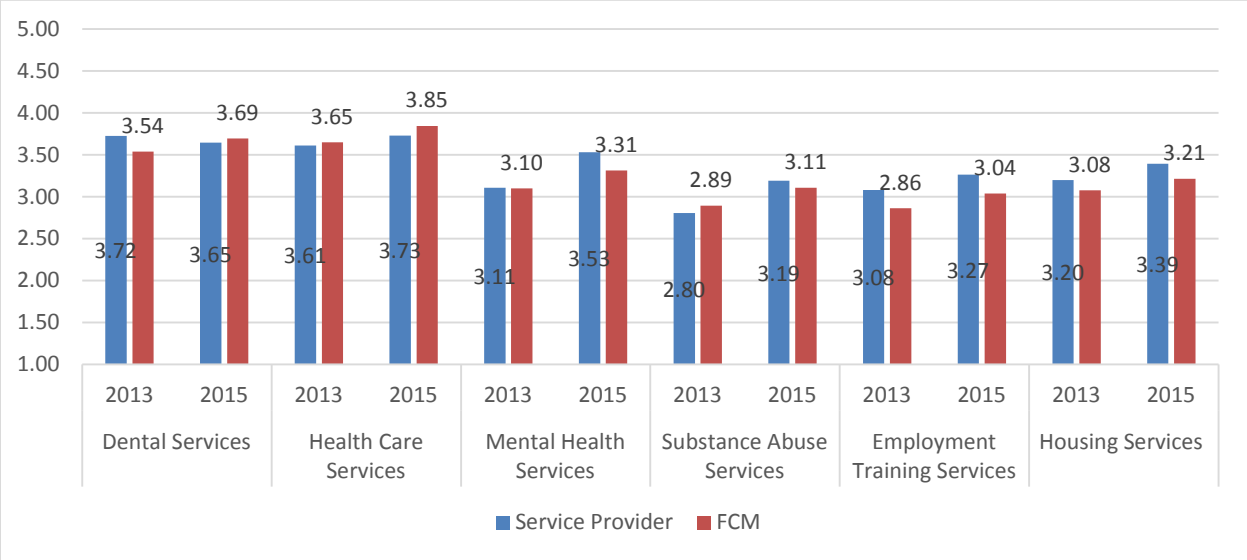
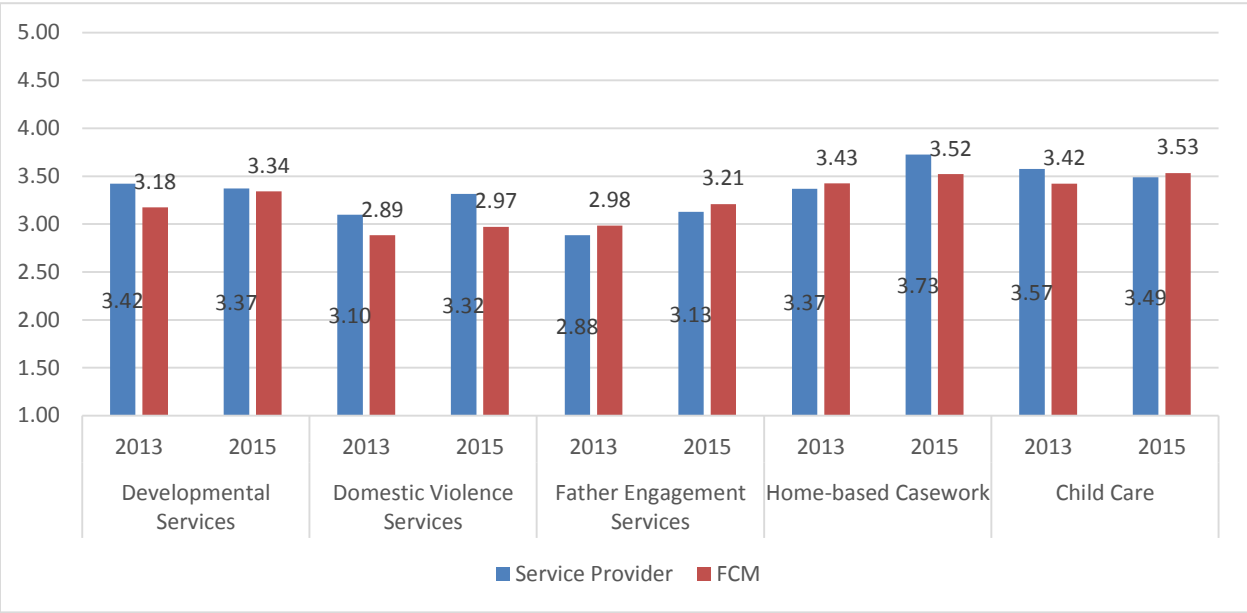


Figure 105 presents that both groups reported the constantly increased effectiveness of many services, including health care, substance abuse, employment, housing, domestic violence, and home-based casework. More specifically, as compared to service providers, FCMs reported a relatively higher score on the effectiveness of health care and father engagement services in both years. Another interesting finding was that service providers reported the decreased effectiveness of child care and dental services, whereas FCMs reported its increased effectiveness.

Figure 105. Comparing the Trend in the Perceived Effectiveness for Specific Services between Service Providers and FCMs

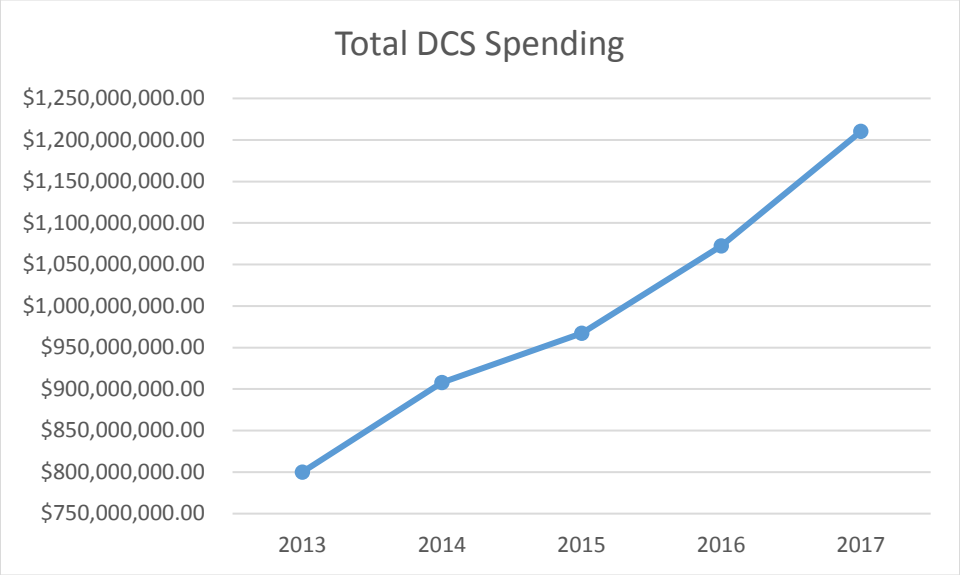




Cost Study

The Title IV-E Capped Allocation Waiver that the State of Indiana has being participating in over the last several years has had many benefits that have been well discussed throughout this report. One of the major benefits realized by the state has been the flexibility of the funding. The state has been able to utilize this funding for more cost than were traditionally eligible and to use the allocation amount during different periods of time. All of this has been done while keeping under the state's overall allocation amount for the time period.

Figure 106. Total DCS Spending



As the graph above shows, total spending by the Indiana Department of Child Services has been increasing in an almost dramatic fashion over the course of the Waiver. This has made the review of this the cost very difficult as so many other variables have been a factor during this time period. One of the main issues that have been seen as a cause would be the drastic increase in total case load over that time period.

Figure 107. Total Cases

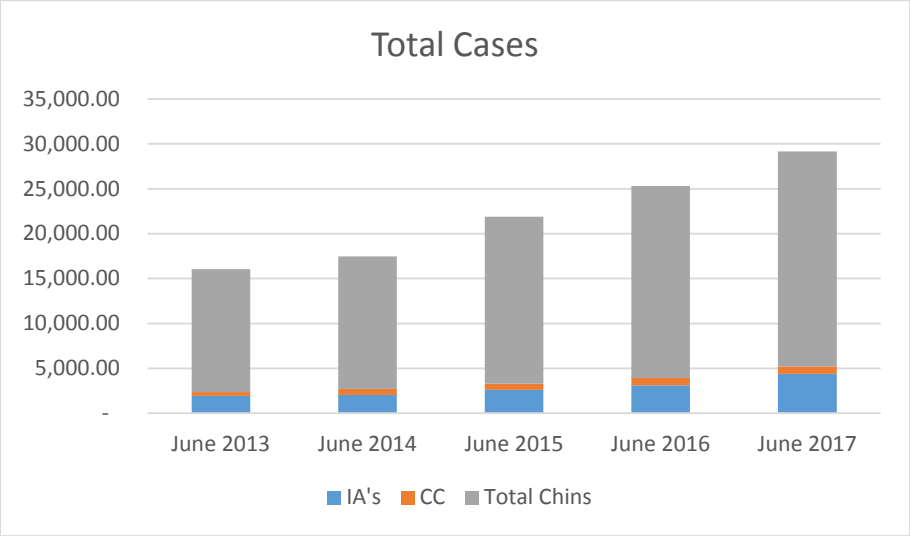
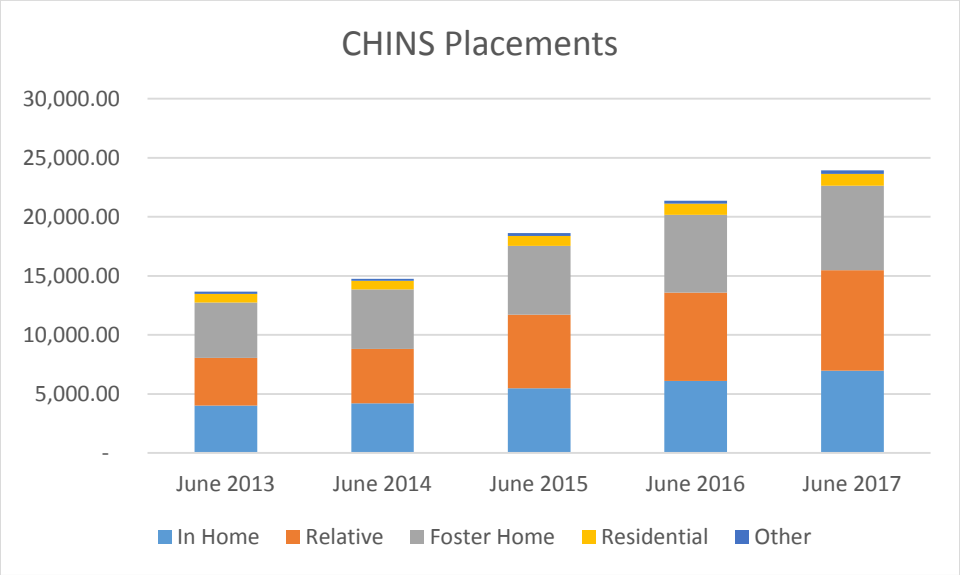


Figure 108. CHINS Placements



Since the beginning of the current iteration of the Waiver, there has been a near doubling of the number of cases in the system. Although this increase has seen substantial rise in the amount of children in the system, it has not seen a lot of variation in the breakdown of the placement types. We see that our system continues to operate within the same percentage of placement type during the Waiver period.

Figure 109. Breakdown of total cases

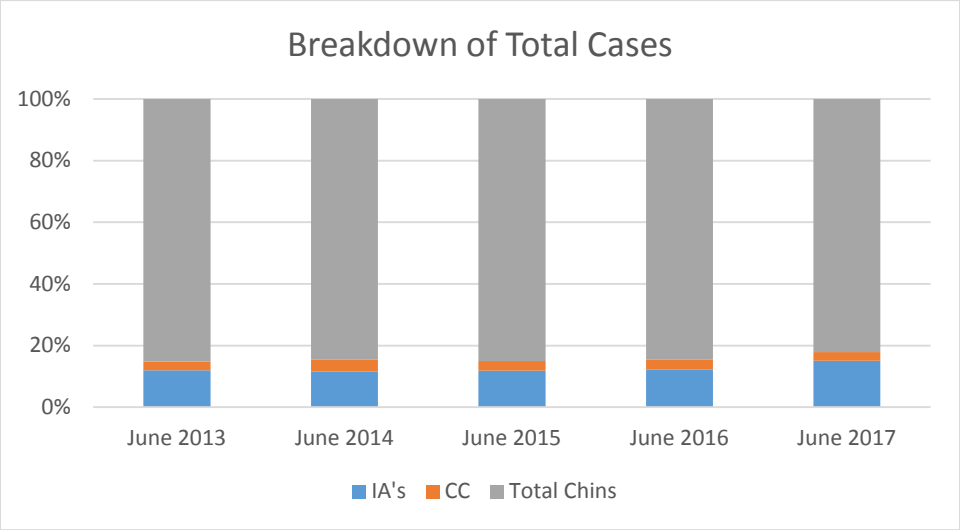
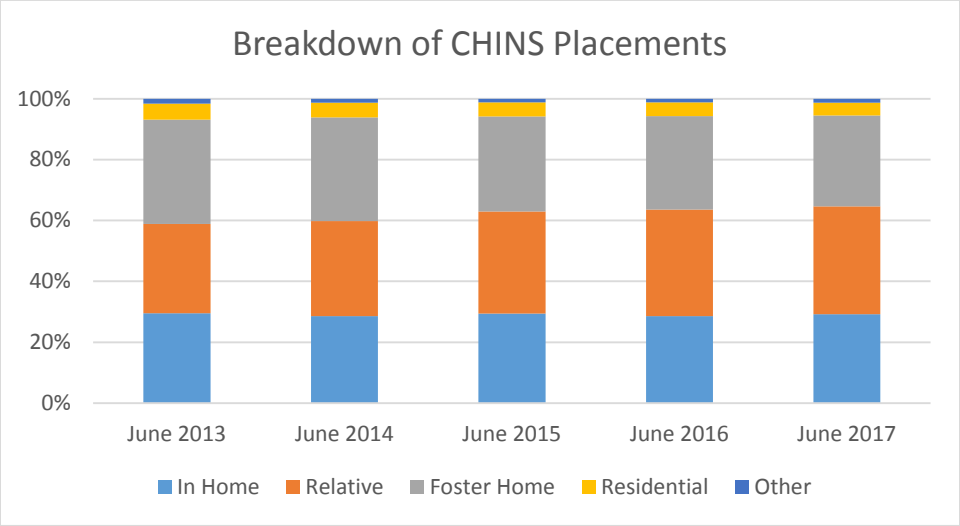


Figure 110. Breakdown of CHINS placements

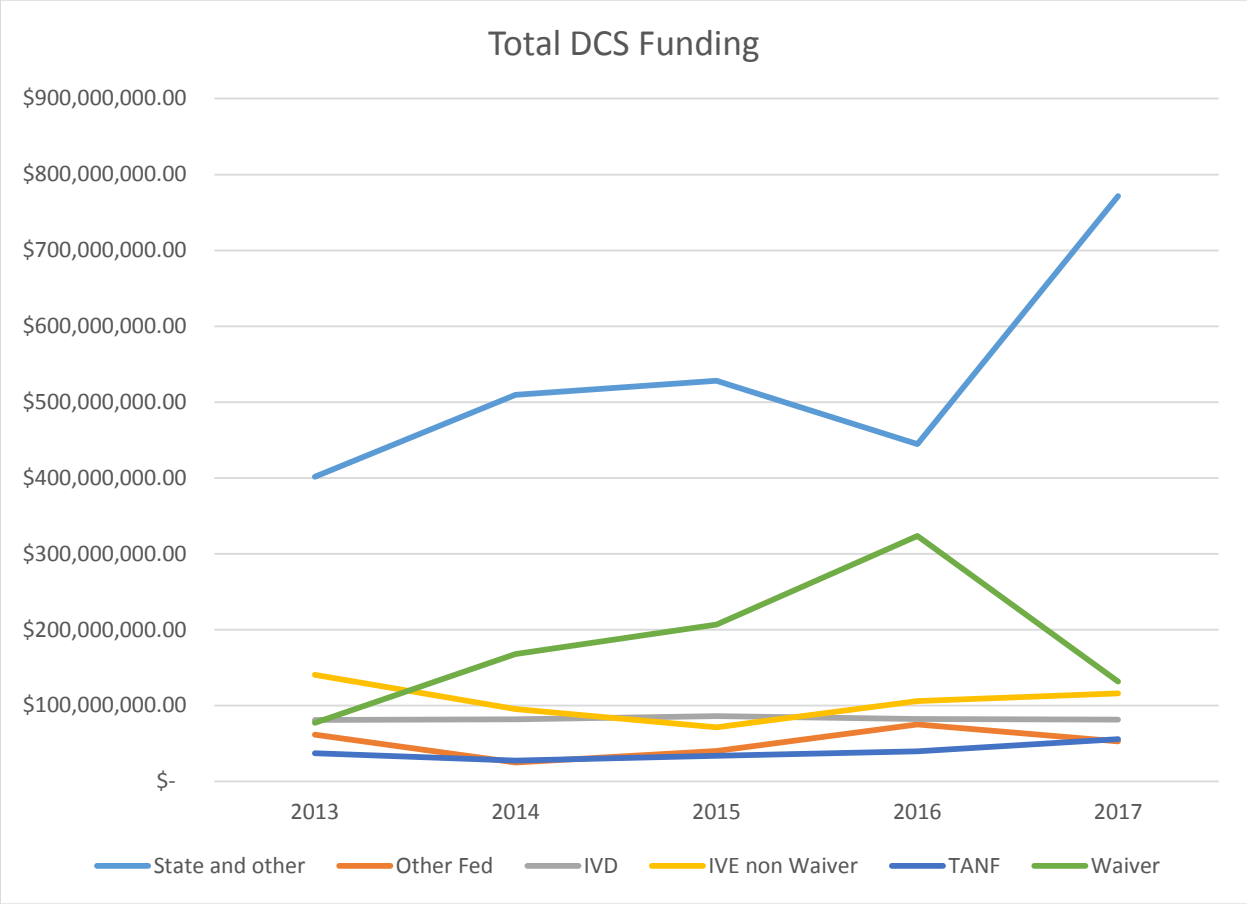


Other factors have come into play with the rising total cost of the agency. Indiana's cases where parent drug abuse is indicated as a removal reason have increased by 153% between 2013 and 2017. Agency spend on substance abuse related services jumped by 45% between 2016 and 2017.

As the spending has increased during this time period funding from non-Waiver grants has remained substantial steady. This means that as the spending has increased funding of those expenses has to come from one of two sources, state funding or utilizing the Capped Allocation Waiver. The state of Indiana works on a two year budget cycle which makes funding flexibility very difficult. The increase in the amount of children and the Opioid epidemic has pushed cost up so quickly that without the ability to move Waiver funding forward, the state would have been unable to cover cost. This can be seen in the 2016 funding chart. Additionally, the state reduced its utilization of the Waiver in 2017 and 2018

that allows it to remain cost neutral. By the end of the current Waiver Extension to March 31st 2018 Indiana will only claim the amount of the allocation tables and no more.

Figure 111. Total DCS Funding



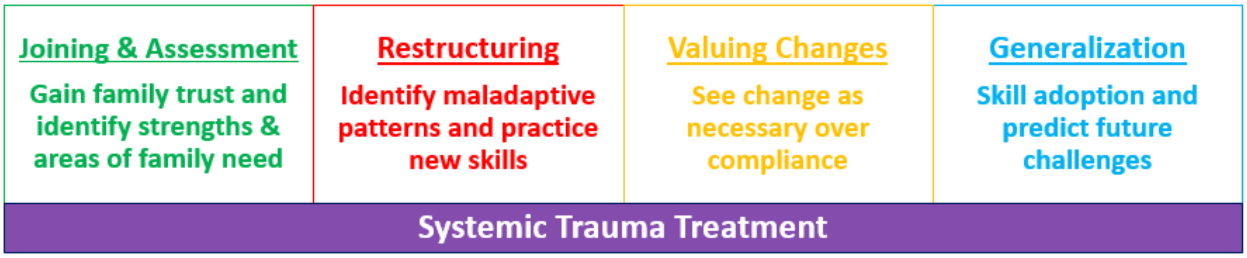
Additionally, the state reduced its utilization of the Waiver in 2017 and 2018 that allows it to remain cost neutral. By the end of the current Waiver Extension to March 31st 2018 Indiana will only claim the amount of the allocation tables and no more. Indiana was able to increase utilization during the middle of the period but then reduce in the following years to be able to remain neutral.

During the period of the current Capped allocation Waiver, Indiana and ACF renegotiated the amounts of the capped allocations because Indiana showed an increase in IV-E eligible cost. Indiana has shown that an increase in the amount of children and the Opioid epidemic has contributed to rising IV-E Foster Care cost. These factors have gone to negative the impact of the Waiver shifting funding to services whose goal is to prevent entry into the foster care system. Indiana continues to review the traditional IV-E eligible Foster Care cost and sees that they outpace the Capped allocations by year. This shows that the Waiver has a lower cost than traditional.

Sub-Study: Family Centered Treatment (FCT)

FCT background

Family Centered Treatment (FCT) is a home-based, family centered approach for family preservation. It is an intensive intervention with demonstrated positive outcomes for children in residential treatment as well as providing a way to divert children from residential treatment. It is an evidence-based practice with proven outcomes for the probation population as well as those children involved in the child welfare system. There are four phases in FCT:



*Retrieved from: http://www.familycenteredtreatment.com/home/#family-centered-treatment

In addition, FCT is often effective for families with very complex needs that have not responded to previous home-based services.

FCT in Indiana is available statewide. There are five providers in Indiana: Centerpointe Community Based Services, Family Solutions, Ireland Home Based Services, Lifeline Youth and Family Services, and SCAN (Stop Child Abuse & Neglect). Each county aims to have one designated provider for FCT with the exception of Marion County (Indianapolis) which has three. Estimated team sizes were calculated by considering the number of youth currently in residential treatment, those youth entering residential treatment, and families for which more than $16,000 of home based services have been provided.

Implementation of FCT began with trainings in September of 2013.

The sub-study includes all of the newly opened cases for families enrolled in Family Centered Treatment FCT from January 1, 2015 until December 31, 2015. Each focus child in the home will be matched to a child within DCS not receiving FCT. Each focus child in the home will assessed individually and as a member of the family group. This will allow the evaluation to look within and between families in FCT.

Data on those who have entered FCT since Jan 1, 2015 was provided by DCS to the Evaluation Team in June 2016. Data included CANS, risk/safety assessments, the case plan goals, placements, CFTMs, demographic characteristics, maltreatment type, removal reason and risk factor, Permanency and Practice Support Team (PPS) referrals, permanency round table, other services, and the fidelity tracker. This report will provide key demographic information about the families in FCT during 2015.

The research questions were:

Safety

1. Do children who are placed in-home when treatment is initiated remain in-home throughout the treatment period and after treatment for FCT and non-FCT families?
2. Are families who participate in FCT less likely to have an incident of repeat maltreatment (substantiated abuse or neglect) than non-FCT families?
3. Are families who participate in FCT less likely to have an incident of re-entry into the DCS system than non-FCT families?

Permanency

1. Do families who participate in FCT achieve permanency more timely than non-FCT families?
2. Are families who participate in FCT more likely to have their children reunified than non-FCT families?
3. How much time elapses to case closure after treatment concludes for FCT and non-FCT families?

Well-being (related to family functioning)

1. Does family functioning improve for families who participate in FCT?
2. Do families who participate in FCT have greater improvement in family functioning than non-FCT families?

Cost

1. What are the costs associated with FCT and non-FCT families?

Perception of Family Centered Therapy (FCT)

Beginning in 2015, FCMs were asked questions relating to their experience with FCT. Approximately 400 (N = 415; 32.4%) reported referring a family to Family Centered Treatment and having the family participate in FCT. The number of FCMs referring families who received FCT services increased each year.

Figure 112. Number of FCMs with FCT experience

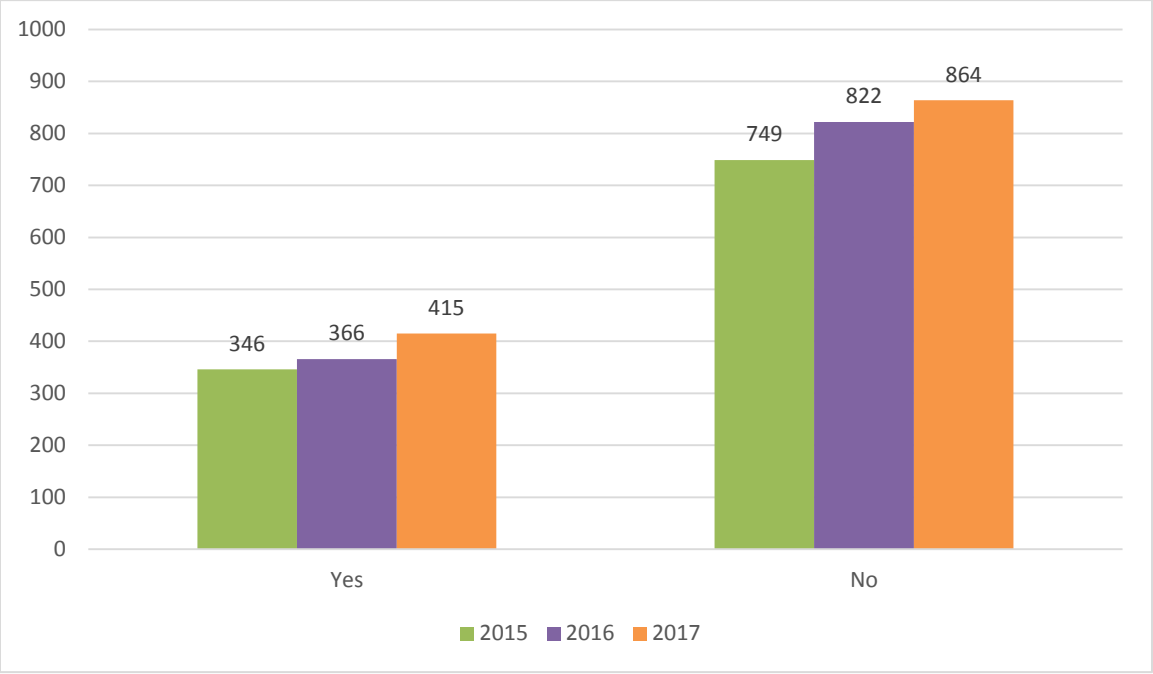
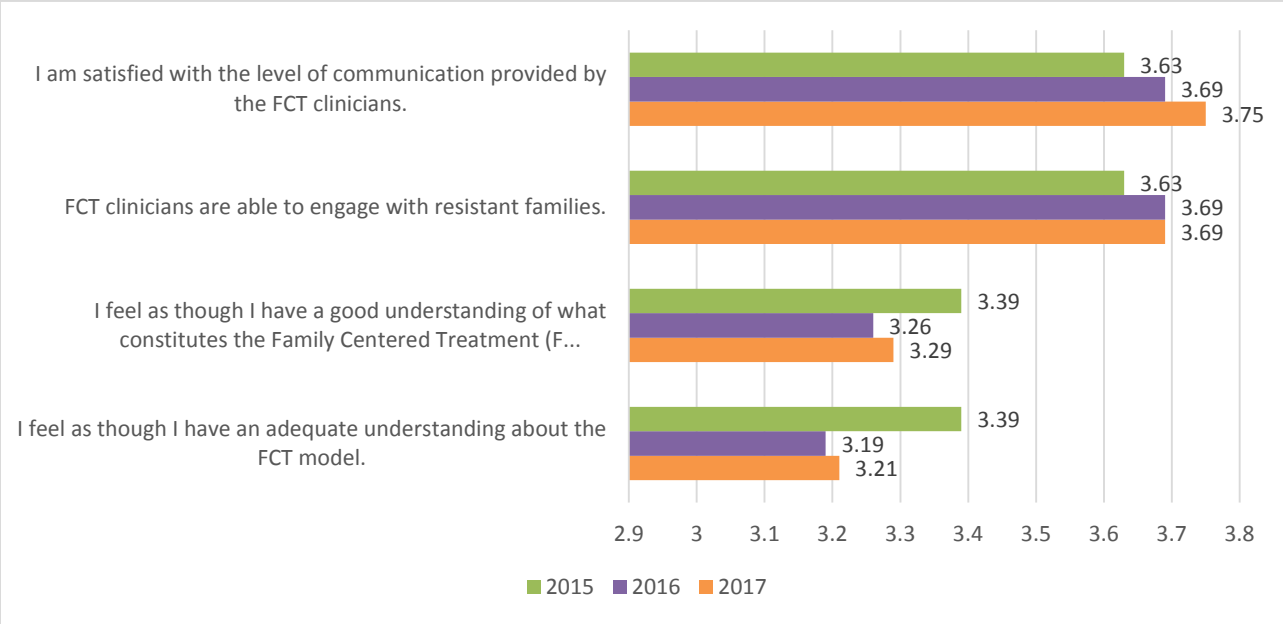


Figure 113. FCM Mean agreement regarding FCT model

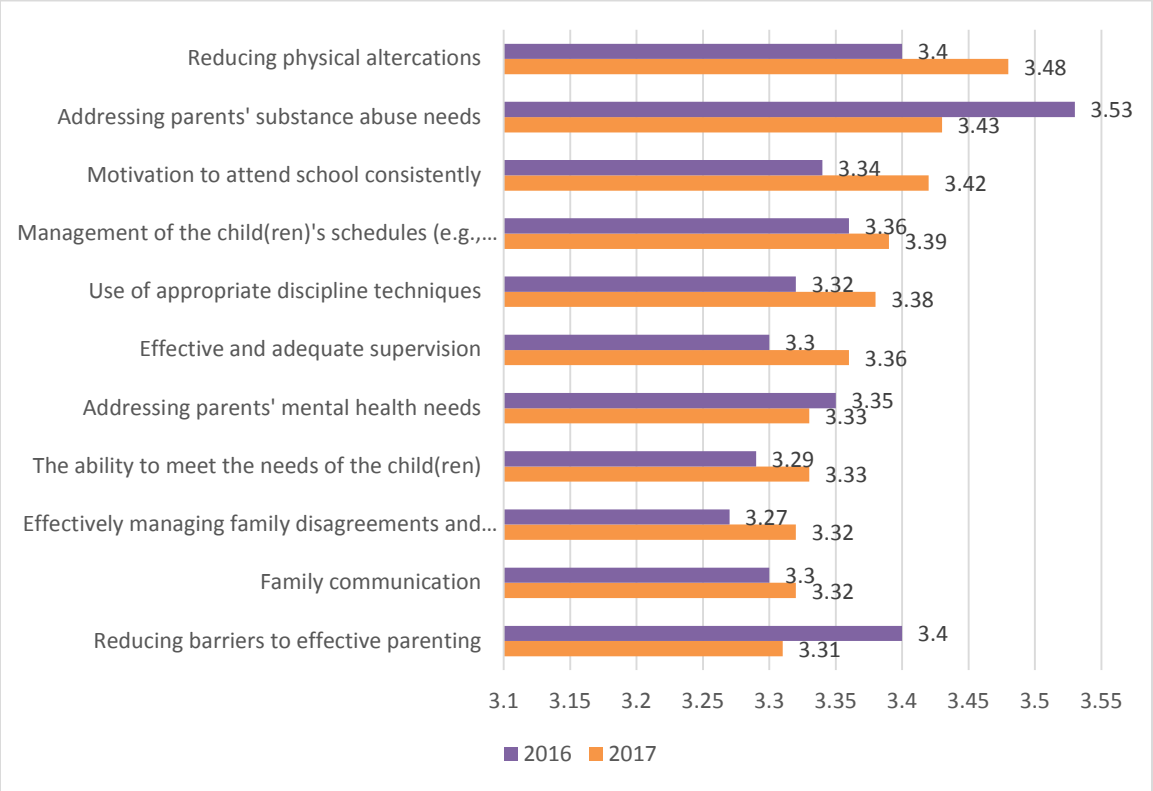


FCMs were asked to rate their level of agreement with four statements relating to satisfaction with the FCT model/clinicians. Answers ranged from strongly disagree (=1) to strongly agree (=5). FCMs mean answers centered around agree. The mean scores indicate that FCMs do not have a clear understanding of the FCT model, but have some satisfaction with the level of communication provided by FCT clinicians. FCM satisfaction and belief that clinicians could engage with families increased from 2015 to 2017. Feelings about engagement remained consistent from 2016 to 2017. Additionally,

satisfaction increased from 2015 to 2017. Understanding about the FCT model decreased from 2015 to 2017, but increased from 2016 to 2017. The decreased understanding is can be understood through the lens of intense training which likely occurred in 2015 with the introduction of the FCT model.

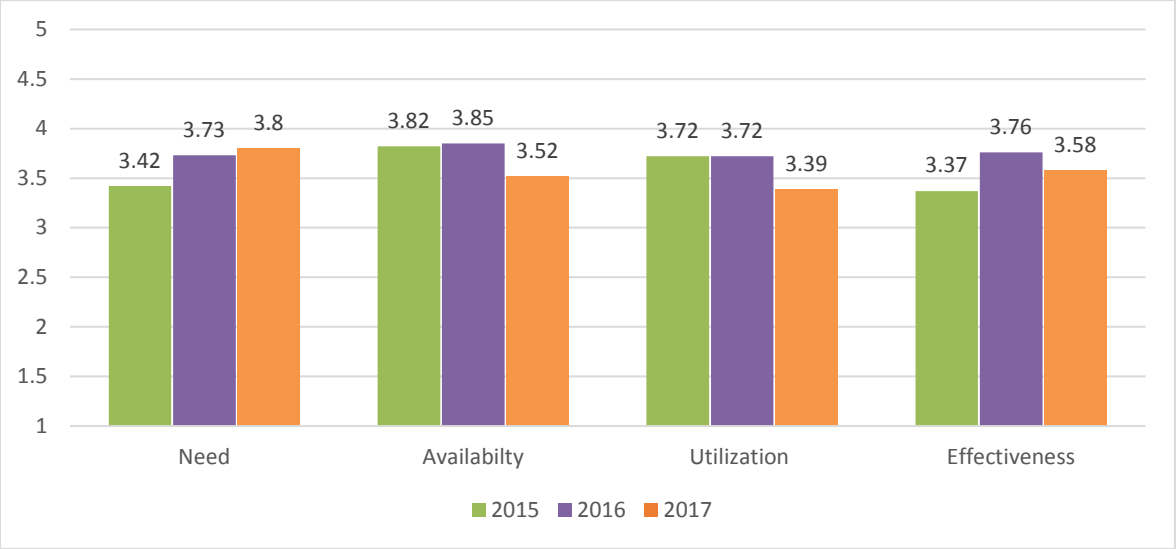
In 2016 and 2017, FCMs were asked to rate how satisfied they were with the FCT services that families received after an FCM referral help to accomplish a list of items including reducing physical altercations, addressing substance abuse needs, and reducing barriers to effective parenting. Responses ranged from 1 (Not Effective) to 5 (Extremely Effective). IN 217, FCMs reported that the mean effectiveness of FCT service in reducing physical altercations had increased since 2016, but the mean effectiveness of addressing parents' substance abuse needs had decreased. Additionally, aside from addressing parent's mental health needs, and reducing barriers to effective parenting, which both decreased from 2016 to 2017, FCMs believed that the effectiveness of services increased from 2016 to 2017.

Figure 114. Mean effectiveness scores of FCT services.



Finally, FCMs also rated the need, availability, utilization, and effectiveness of FCT from 2015-2017. Rated on a 5 point scale from not at all to extremely, FCMs perceived an increasing need for FCT. Availability increased and then decreased in 2017. Utilization dropped in 2107, and the effectiveness grew in 2016 and went down slightly in 2017 (yet still higher than 2015's perceived effectiveness).

Figure 115. FCMs Perception of FCT Service 2015-2017



FCT comparison

Propensity-score matching (PSM) was used to match children within DCS receiving FCT with children within DCS who did not receive FCT. Matching characteristics were age, gender, race, region, county, number of focus children, involvement status, permanency goal, cans score, and risk score. PSM uses the matching characteristics identified to determine the probability of receiving FCT. PSM then finds the child who did not receive FCT that has the exact same probability, using the same matching characteristics, as the child who received FCT. Once the probabilities are matched, a dataset of probability-matched children who received FCT and those that did not is created.

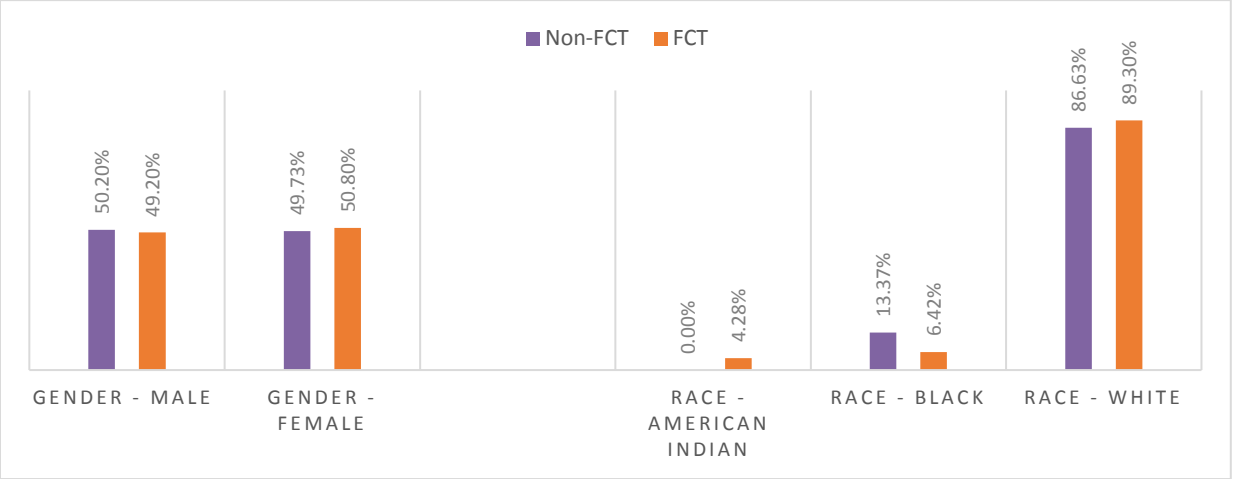
Overall, 20,779 children were within DCS during January 1, 2015 and December 31, 2015. There were 230 children within DCS that received FCT and were not involved with juvenile detention. Matching characteristics (age, gender, race, region, county, number of focus children, involvement status, permanency goal, cans score, and risk score) were too restrictive and we were unable to obtain a sufficient amount of pairs to conduct analysis. Region and permanency goal were removed as they were the two characteristics restricting the matching. The final dataset included 187 children who received FCT and 187 children who did not receive FCT.

PSM matches children on the probability of their chances of having FCT based on a collective score of their characteristics. Therefore, the children receiving FCT and those that did not receive FCT may not match exactly on characteristics, rather they match exactly on their probability of receiving FCT.

Overall Demographic Comparison

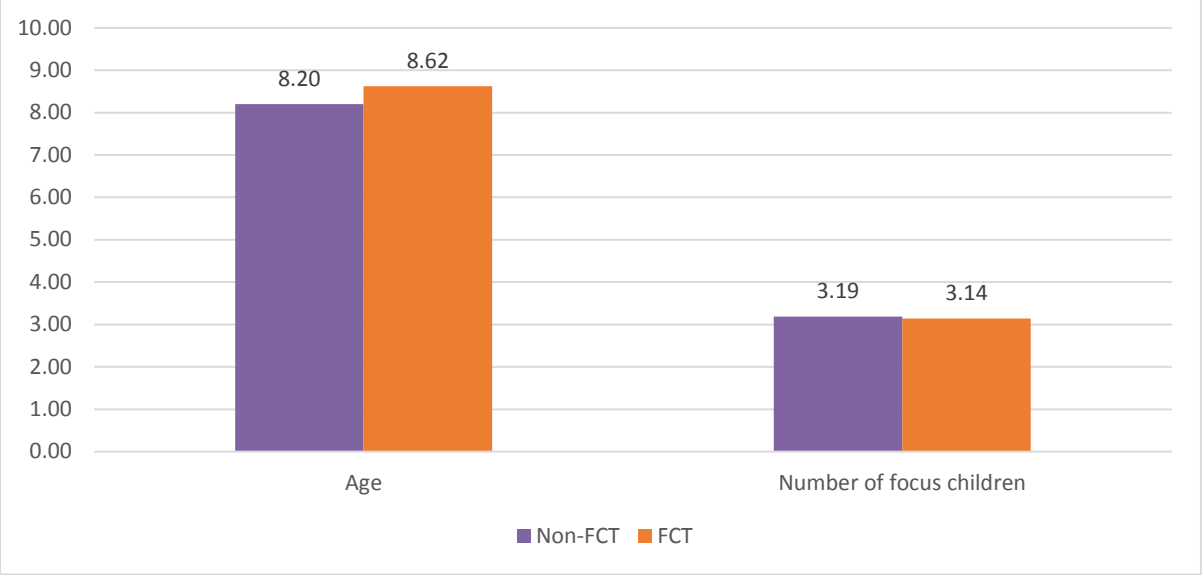
Children who did and did not receive FCT were similar across all demographic variables, with no significant differences between them on gender, race, age, and number of focus children in the family. Children who did and did not receive FCT were evenly male (49.2% and 50.2%, respectively) and female (49.73% and 49.2%, respectively) and predominantly white (89.3% and 86.63%, respectively).

Figure 116. Percentages of gender and racial categories of Non-FCT and FCT families



In addition, children who did and did not receive FCT had a mean age of 8.2 and 8.62 years and 3.19 and 3.14 number of focus children in the family, respectively.

Figure 117. Mean age and number of focus children of Non-FCT and FCT families

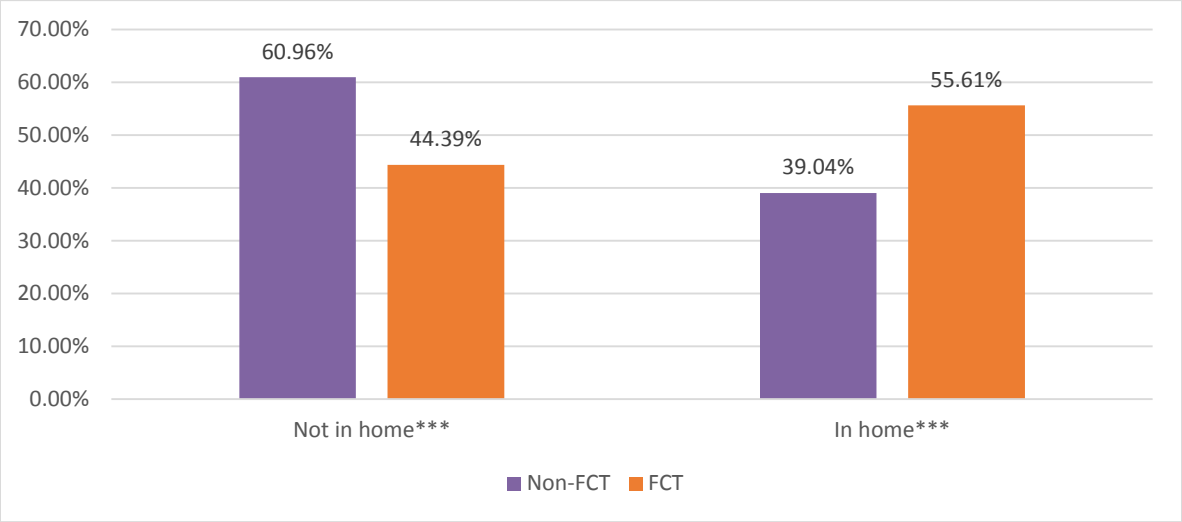


Safety, Well-being, Permanency, and Cost Comparison

Safety

To answer the research questions associated with safety, we first analyzed the difference in remaining in home throughout the children's involvement with DCS period. Children who participated in FCT were significantly more likely to remain in home throughout their involvement with DCS than children who did not participate in FCT (55.61% vs. 39.04%, $p < .001$).

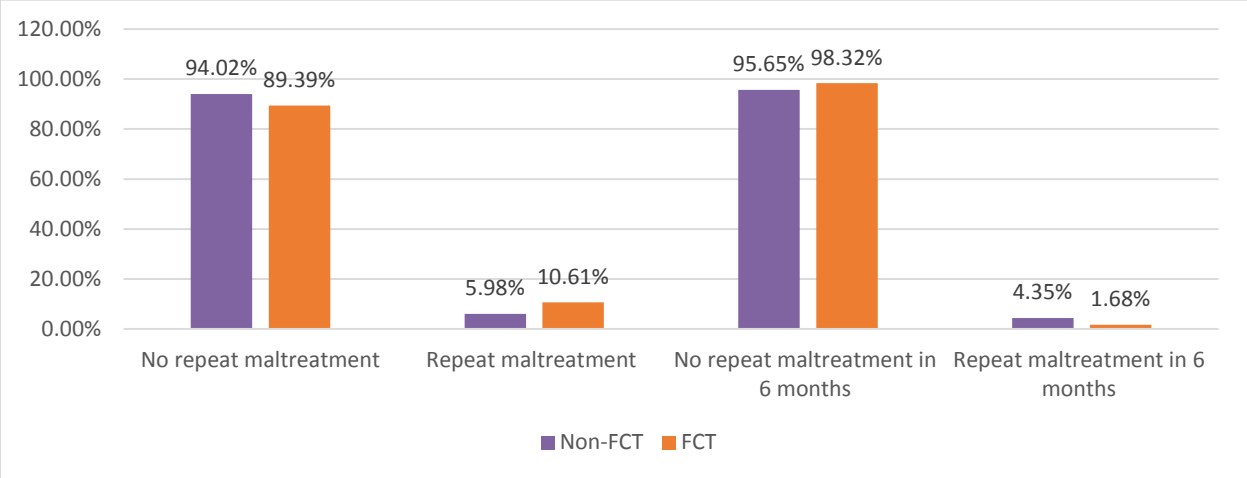
Figure 118. Percentages of Non-FCT and FCT families remaining in home



***p < .001

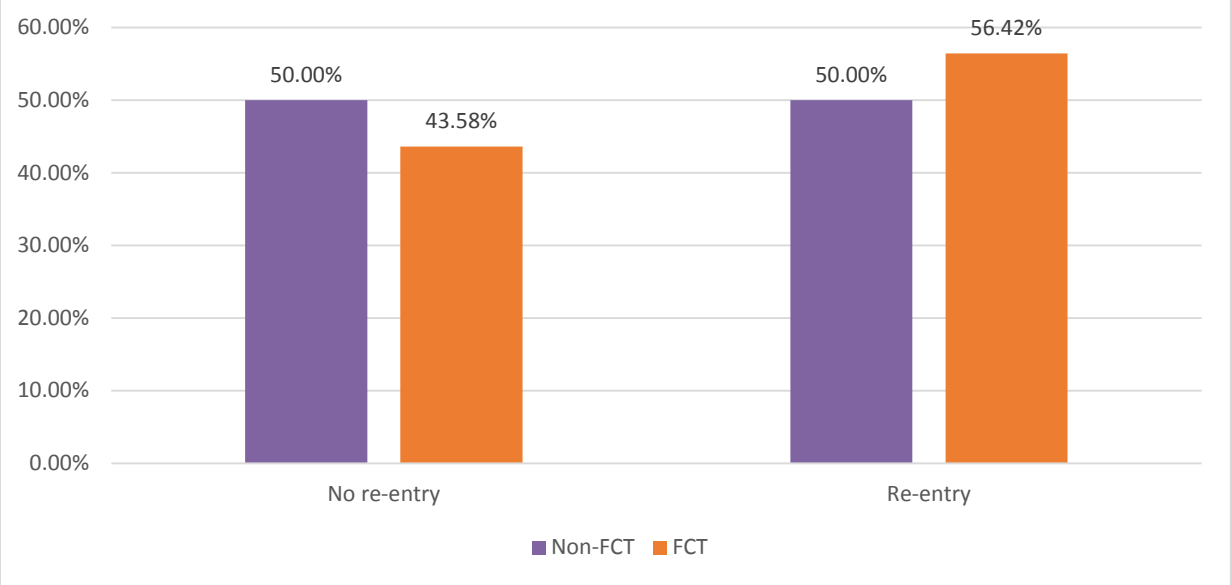
We next analyzed incidents of repeat experiences of maltreatment during their involvement as well as 6 months after their involvement with DCS. Children in FCT had a higher rate of repeat maltreatment during their involvement with DCS (10.61% vs. 5.98%), but this difference was not statistically significant. Children in FCT had a lower rate of repeat maltreatment 6 months after their involvement with DCS (1.68% vs. 4.35%), but again, this difference was not statistically significant.

Figure 119. Repeat maltreatment during and 6 months after involvement of Non-FCT and FCT families



Finally, we assessed if there were a significant difference of re-entry into DCS following their involvement among children who participated in FCT and those that did not. While FCT children had a higher rate of re-entry than children not participating in FCT (56.42% vs. 50%), this too was also not a statistically significantly different rate.

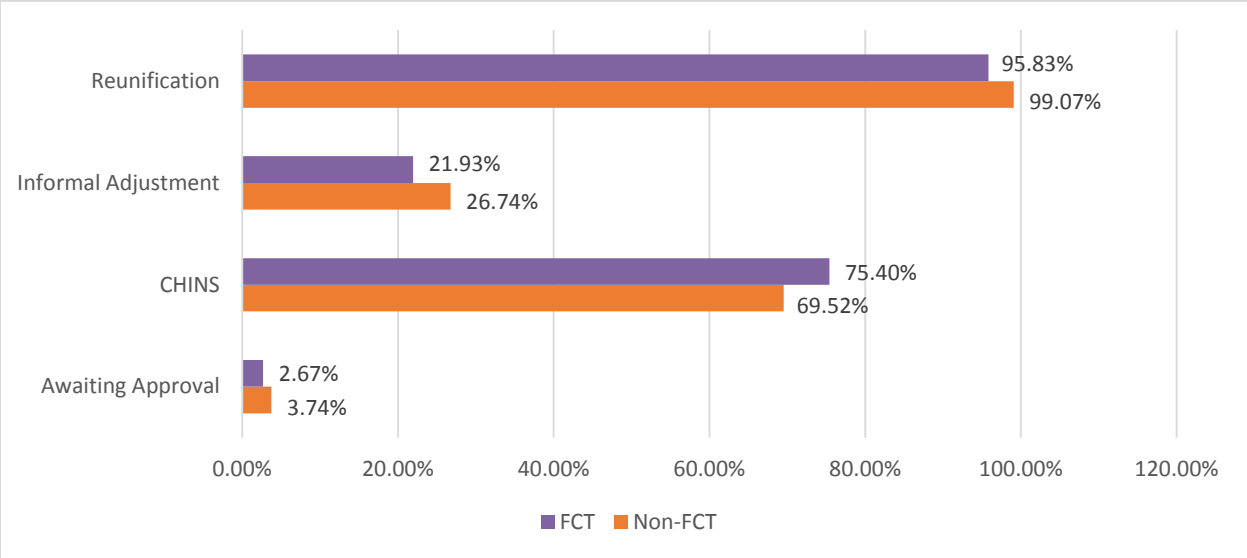
Figure 120. Percentages of re-entry of Non-FCT and FCT families



Permanency

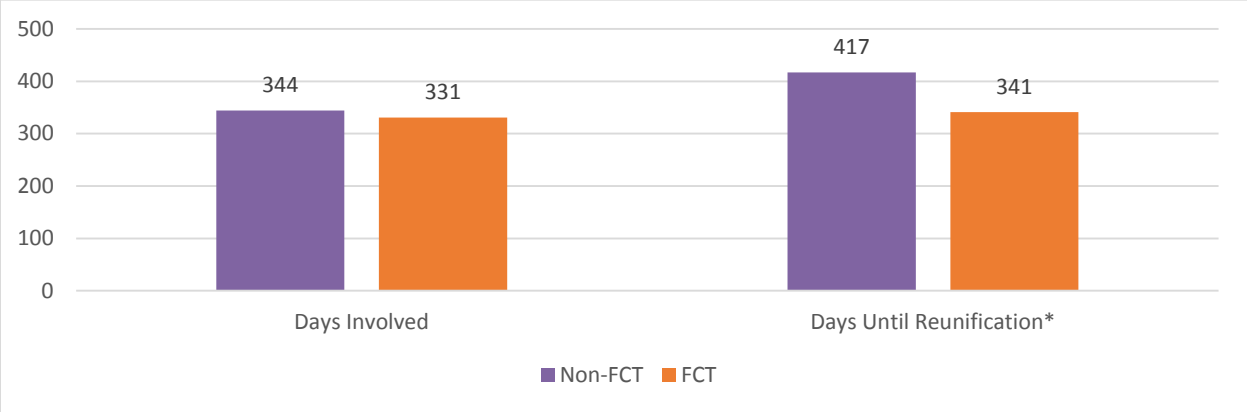
To answer the research questions associated with achieving permanency, we first analyzed if there were changes in a goal of reunification with the family among children that did and did not participate in FCT. Children who participated in FCT were more likely to have reunification as a goal than children who did not participate in FCT (99.07% vs. 95.83%), while children who did not participate in FCT had a higher rate of being a child in need of services (CHINS) than children who were in FCT (75.40% vs. 69.52%). However, neither of these differences were statistically significant.

Figure 121. Percentages of involvement status of Non-FCT and FCT families



Finally, to assess permanency, we analyzed how many total days of involvement in DCS and how many days elapsed until reunification occurred among children who participated in FCT and those that did not. Children in FCT were involved in DCS for fewer days on average than children that did not participate in FCT (331 vs. 344), but this was not statistically significant. Children in FCT had a significantly fewer amount of days on average until reunification than those did not participate in FCT (341 vs. 417, $p < .05$).

Figure 122. Mean number of days involved and until reunification of Non-FCT and FCT families

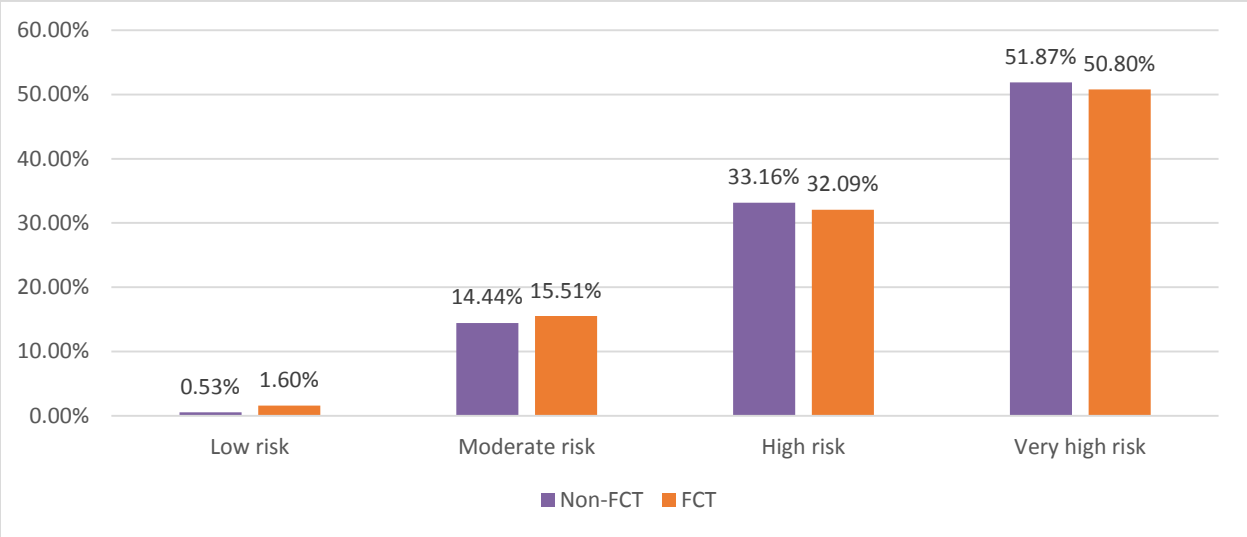


*p < .05

Well-being

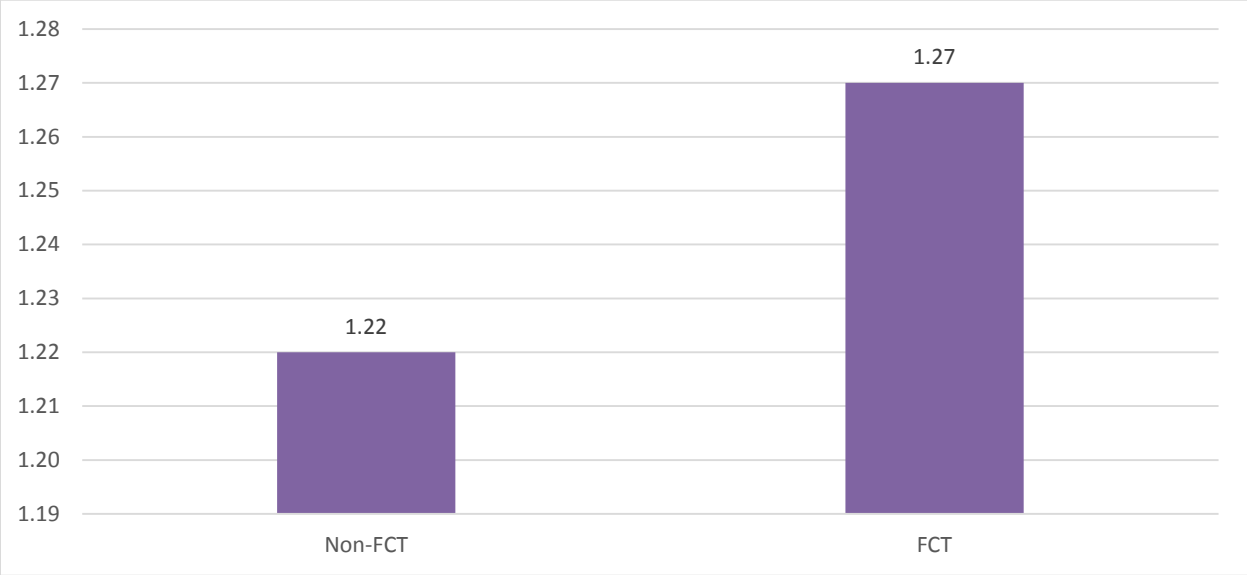
To answer the research questions associated with well-being, we first analyzed the risk level associated with children who participated in FCT and those that did not. Children who participated in FCT had a lower rate of being classified as "very high risk" as compared to children who did not (50.8% vs. 51.87%), and higher rate of being classified as "low risk" (1.6% vs. 0.53%). However, neither of these differences were statistically significant.

Figure 123. Percentages of risk levels of Non-FCT and FCT families



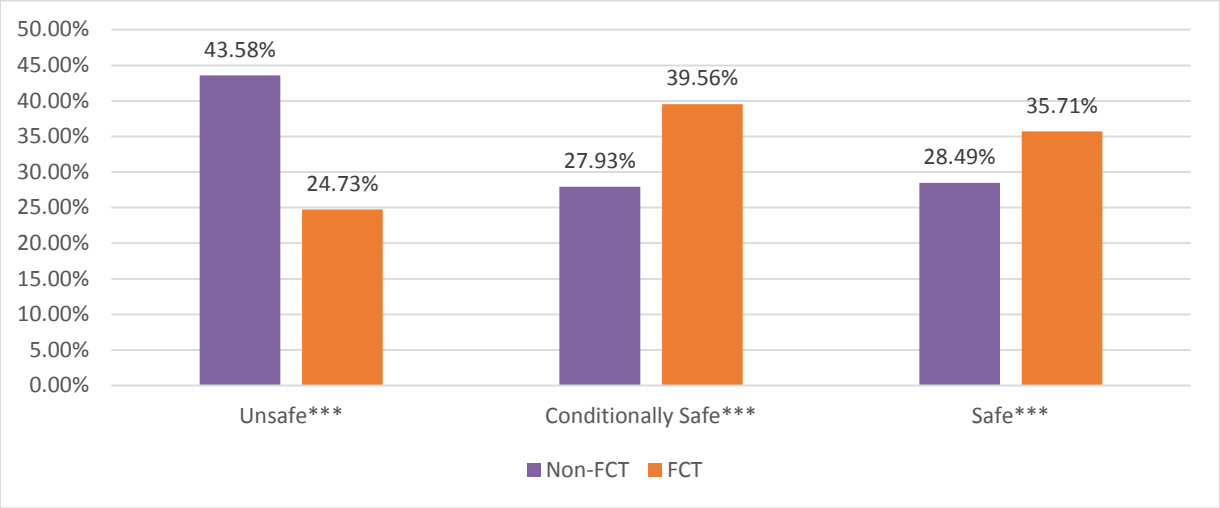
Next, children who participated in FCT has a slightly higher average CANS score than children who did not (1.27 vs. 1.22), but again, this difference was not statistically significant.

Figure 124. Mean CANS score for Non-FCT and FCT families



Finally, to further clarify the assessment of the child's well-being we assess changes in the child's safety rating. Children who participated in FCT had a significantly higher rate of being rated as safe (35.71% vs. 28.49%, $p < .001$) and conditionally safe (39.56% vs. 27.93%, $p < .001$), and a significantly lower rate of being rated as unsafe (24.73% vs. 43.58%, $p < .001$) than children who did not participate in FCT.

Figure 125. Percentage of Non-FCT and FCT families ranked as safe

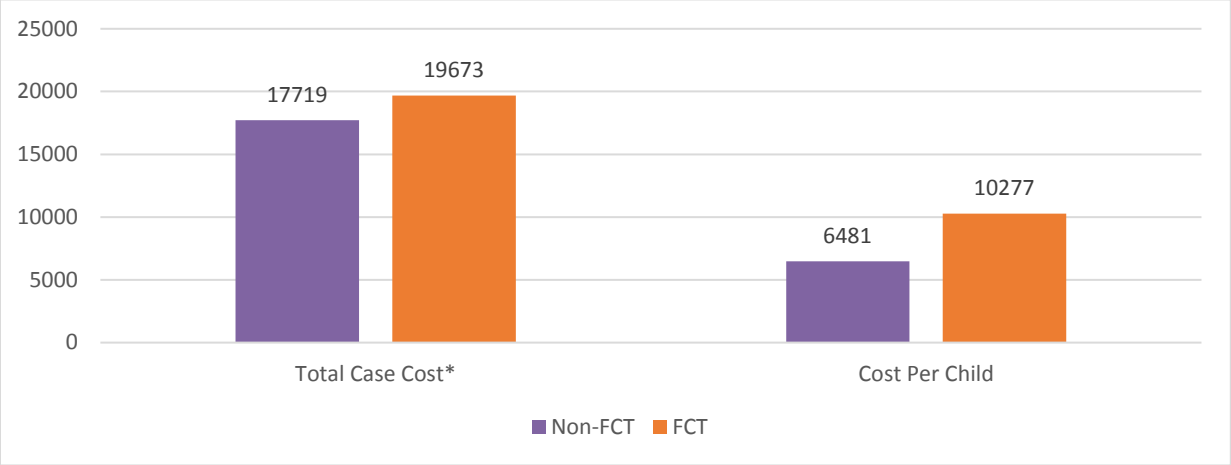


***p < .001

Cost

Finally, to assess the costs associated with FCT, we analyzed the total case cost and cost per child for children who participated in FCT and those that did not. While the average total cost of the case was statistically significantly higher for children in FCT than children not in FCT ($19,673 vs. $17,719, $p < .05$), the cost per child was not statistically significant ($10,277 vs. $6,481).

Figure 126. Mean total cost and cost per child of Non-FCT and FCT families



*p < .05

Summary of FCT Comparison Findings

Overall, children, and families, who participated in FCT appear to fare better than children who do not participate in FCT. While the cost of administering the program is higher for children who participate in FCT than those that do not, children who participated in FCT have better outcomes associated with their safety, permanency goals, and well-being. Children who participated in FCT were more likely to remain in-home during their involvement with DCS, as well as be reunited with their family in shorter timeframe and more likely to be ranked as conditionally safe and safe.

Summary and Conclusions

This report serves as the final report for the Indiana Title IV-E Waiver project. The Indiana Title IV-E Waiver project was implemented statewide in order to spend federal dollars more flexibly to expand services and invest in evidence-based services for Hoosier children and families. This evaluation involved four studies: outcome; process; cost; and a sub-study, which evaluated Family Centered Treatment. Overall, there were some successes and some areas for improvement. One clear limitation during this demonstration project timeframe was the nationwide opioid crisis from which Indiana was not immune. In fact, Indiana was among 30 states with the most significant increases in the rate of drug overdose and death.

Outcome Study

This study measured safety, permanency, and well-being using Quality Service Review data (QSR) over the 5 rounds of data collection during the Waiver period. There were statistically significantly higher ratings of safety from pre-Waiver to post-Waiver years ($p<001$). Overall there was a lower percentage of subsequent substantiated abuse/neglect for children residing either in-home or in out-of-home placements according to state administrative data. In the Waiver demonstration period however, there was a higher proportion of children with closed cases who experienced subsequent substantiated abuse/neglect at 6 months and 1 year post case closure. The state struggles to keep children in out of care after case closure. In evaluating permanency we found that children in out of home care for all types of case closure (adoption, guardianship, reunification) spent more days out of the home during the demonstration period as compared to baseline. QSR permanency indicators were also rated lower during the Waiver period as compared to baseline ($p<.001$.) Average number of placements, however decreased in the Waiver period suggesting fewer placement disruptions. Fewer disruptions in the demonstration period is a positive step for the state as was an increase in the percentage of children placed with a relative. This percentage increase to 50.4% of all children placed as demonstrated in administrative data. Further, QSR well-being measures improved significantly ($p<.001$). Appropriate living arrangement, physical health, emotions and learning and development all increase in the Waiver years.

Process Study

In year one of the current Waiver, DCS personnel referred to the Waiver as “a funding mechanism” and focused on service enhancements. In 2013 Casey Family Programs helped the agency to better align with the full goals of the Waiver and DCS began to invest in a continuous quality improvement strategy. To determine who would best be served by evidence-based services, which the agency invested in, a service mapping tool for case managers was developed and is continuously refined. A major component of the implementation of the Waiver was the expanded use in payment for concrete services. These payments were used to supply more goods and services to families in their own systems. Payments increased in most categories while payment for medications and medical expenses decreased possibly due to expanded use of Medicaid in the State.

To identify context and perceptions of implementation, a qualitative study of interviews of regional and executive managers occurred. In the beginning managers discussed that the Waiver was used as a fiscal mechanism however, over time they developed an appreciation of the use of this

funding mechanism to influence practice to prevent removals, expedite permanency, and provide children and youth with normative experiences to enhance well-being.

External stakeholders were surveyed in 2013 and 2015. This survey was sent to service providers, caregivers, youth, court professionals, and judges. Overall, stakeholders were satisfied with services and believed that DCS respected their families and culture. Judges rated DCS higher than other court professionals. Tension was identified between DCS and CASA/GALs. Service providers rated service effectiveness higher than DCS case managers did and also identified tension between CASA/GALs and DCS caseworkers during team meetings.

Cost Study

During the period of the current Capped allocation Waiver, Indiana and ACF renegotiated the amounts of the capped allocations because Indiana showed an increase in IV-E eligible cost. Indiana has shown that an increase in the amount of children and the Opioid epidemic has contributed to rising IV-E Foster Care cost. These factors have gone to negative the impact of the Waiver shifting funding to services whose goal is to prevent entry into the foster care system. Indiana continues to review the traditional IV-E eligible Foster Care cost and sees that they outpace the Capped allocations by year. This shows that the Waiver has a lower cost than traditional. Overall, Waiver funding has remained cost neutral and funds saved by reducing more expensive services utilization were shifted to early intervention service delivery – a major goal of Waiver funding.

Sub-study

Family Centered Treatment (FCT) intervention effectiveness was measured from January 1, 2015-December 31, 2015. All children referred for FCT received services as indicated via the model. Fidelity was established via manualized training and certification of home based workers, supervision, consultation with national FCT Foundation clinicians, and monthly compliance checks on dosage of the intervention. The treatment group was matched via propensity scoring with children who received usual and customary care. Matching characteristics were age, gender, race, region, county, number of focus children, involvement status, permanency goal, CANS score, and risk score Once the probabilities were matched the dataset was created. Overall, 20, 779 children were within DCS between January 1, 2015 and December 31, 2015 and 230 of those children received FCT that were not involved in juvenile detention. Matching characteristics were too restrictive and we were unable to obtain sufficient number of pairs to conduct and analysis. Therefore, region and permanency were removed as they were the characteristics restricting matching. The final data set then included 187 children who received FCT and 187 children who did not receive FCT. Children who did and did not receive FCT demonstrated similar demographics with no significant differences. Outcomes: We answered research questions based on safety, well-being, permanency, and cost.

Safety: First we analyzed the difference in remaining home throughout DCS involvement. Children who had FCT were significantly more likely to remain in the home throughout (55.61% vs. 39.04%, $p < .001$.) Next we analyzed repeat maltreatment during and 6 months post DCS involvement. Children in FCT had higher rates of repeat maltreatment (10.61% vs. 5.98%), however, this was not statistically significant. Children in FCT did have a lower rate of repeat maltreatment 6 months after their involvement with DCS ended but again this was not statistically significant (1.68% vs. 4.35%).

Finally, we assessed re-entry into DCS following involvement FCT children had higher rates of re-entry than non-FCT children however; again, this was not statistically significant (56.42% vs. 50%).

Permanency: First we analyzed total days of DCS involvement and number of days elapsed to reunification for each group. Children in FCT had fewer days on average than children who did not have FCT but this was not statistically significant (331 vs. 344). Children in FCT did have statistically significantly fewer days on average until reunification than non-FCT children (341 vs. 417, $p < .05$).

Well-being: To analyze well-being we analyzed risk level for children in both groups. Children who participated in FCT had a lower rate of being classified as "very high risk" as compared to children who did not (50.8% vs. 51.87%) and a higher rate of being classified as "low risk" (1.6% vs. 0.53%). Neither was statistically significant. We analyzed CANS scores for each group and found that FCT children had a slightly higher average CANS score but it was not a statistically significant difference (1.27 vs. 1.22). To clarify the well-being assessment we assed changes in child's safety rating. Children who had FCT had a statistically significantly higher rate of being rated as safe (35.71% vs. 28.49%, $p < .001$) and conditionally safe (39.56% vs. 27.93%, $p < .001$), and a significantly lower rate of being rated as unsafe (24.73% vs. 43.58%, $p < .001$) than children who did not participate in FCT.

Cost: We analyzed total case cost and cost per child for each group. The average total cost of the case was statistically significantly higher for children in FCT ($19,673 vs. $17,719, $p < .05$), the cost per child was not statistically significant ($10,277 vs. $6,481).

Limitations

Overall, the Waiver evaluation team experienced some difficulty obtaining data over time. The initial message that the Waiver is "simply a fiscal mechanism" initially sold the potential of the Waiver opportunity short. Once Casey Family Programs intervened data sharing and messaging improved. Since this Waiver involved statewide implementation there was no opportunity to use random assignment as a sampling technique. The sub-study did use propensity scoring to find a like comparison group. Further study with larger numbers for this intervention is warranted. There is really no way to determine at this point the impact of the national opioid crisis and increase in substance abusing families on the data to date. DCS needs to develop mechanisms to identify the impact of this crisis and to provide timely services across the state.

Opportunities

Use of formative evaluation strategies by Waiver evaluation teams may provide child welfare agencies with the opportunity to learn to use data more effectively in their day-to-day practice. This evaluation team attempted to develop the trust necessary to help the agency to learn to use data. Over time, the agency did see the benefit of data collection and assisted the team in writing and surveying case managers and stakeholders. Of great import is the development and use of an active continuous quality improvement program within the agency.