

Child Welfare Title IV-E Waiver Demonstrations Interim Evaluation Report

August 23, 2016

Child Welfare Title IV-E Waiver Demonstration Interim Evaluation Report

Table of Contents

Executive Summary

Introduction and Overview	1
1. Background and Context	1
2. Title IV-E Waiver Demonstration Purpose	2
3. The Evaluation Framework	3
A. Evaluation Overview	3
B. Theory of Change/Logic Model.....	4
C. Data Sources and Data Collection Methods.....	5
D. Study Population	6
E. Data Analysis Plan.....	8
F. Limitations	9
4. Evaluation Timeframe and Implementation Status	10
A. Evaluation Timeframe	10
B. Implementation Update, Challenges and Changes	11
The Process Evaluation	15
1. Key Questions	15
2. Data Sources and Data Collection	15
A. Interviews	15
B. Focus Groups.....	15
C. Annual Surveys	16
D. Network Management Tool	18
E. Provider Record Reviews	18
F. Performance Measures.....	18
3. Analysis Methods	18
A. Interviews and Focus Groups	19
B. Annual Surveys.....	19
C. Network Management Tool	19
D. Provider Record Reviews	19
E. Performance Measures.....	19
4. Results	19
A. Key Question 1: How are Caring Together integrated services working?	19
B. Key Question 2: How are the Caring Together integrated regional management teams working?	29
C. Key Question 3: Are Caring Together integrated services and management implemented/working as planned? [Fidelity]	31

The Outcome Evaluation	39
1. Key Questions	39
2. Caring Together Population.....	39
A. Formative Caring Together Population: Descriptive Characteristics	41
B. Summative Caring Together Population	41
C. Historical Comparison Group.....	42
D. Methodology for Matched Comparison Group.....	42
3. Data Sources and Data Collection	43
A. Outcome Measures	44
4. Data Analysis	45
A. Preliminary Results: Descriptive Data on Initial Congregate Care Experiences	45
The Fiscal/Cost Study	50
1. Key Questions	50
2. Data Sources and Data Collection	50
3. Data Analysis	51
4. Results	51
Summary, Lessons Learned, and Next Steps.....	53
1. Summary	53
A. Strengths.....	53
B. Areas for Improvement	54
2. Programmatic/Implementation Lessons Learned and Recommendations	55
3. Evaluation Lessons Learned and Recommendations.....	55
4. Next Steps.....	56
A. Process Evaluation	56
B. Outcomes Evaluation	56
C. Cost Study	56

List of Figures

Figure 1. Caring Together Logic Model Summary	4
Figure 2. Youth served in Follow Along by month, January 2014-December 2015.	22
Figure 3. Youth served in Stepping Out by month, January 2014-December 2015.	22
Figure 4. Youth served in Continuum by month, June 2014-December 2015.	23
Figure 5. Youth served in congregate care by month, January 2014-December 2015.	23
Figure 6. Parent/Caregiver satisfaction.....	27
Figure 7. ITP goals reviewed quarterly.	32
Figure 8. ITP revised based on findings of the quarterly ITP review.	32
Figure 9. Percentage of youth with completed entry and exit CANS.....	33
Figure 10. Treatment plans are comprehensive (i.e., cover all domains of the youth and family's life that are relevant to the needs identified for focal treatment).....	34
Figure 11. Treatment plans are strength-based (i.e., treatment strategies build on family and youth strengths).	34
Figure 12. Treatment goals, objectives, and/or interventions reflect use of natural supports and family resources.....	35

Figure 13.	Intervention(s) and rehab strategies chosen take into consideration the youth's strengths/needs/barriers.	35
Figure 14.	Parent/Caregiver ratings of treatment planning.....	35
Figure 15.	Youth participated in quarterly ITP review.....	36
Figure 16.	Parent/caregiver participated in quarterly ITP review.....	36
Figure 17.	Youth/families have a voice in provider decisions about how the provider plans and delivers its services.....	37
Figure 18.	Parent/caregiver ratings of cultural competency.	38

List of Tables

Table 1.	Frequency of Data Collection Activities	5
Table 2.	CT surveys administered to date and response rates, by respondent group.....	17
Table 3.	Average length of stay for youth in and exiting congregate care by quarter, 2015.	25
Table 4.	For youth entering Follow Along or Stepping Out, average length of stay for most recent congregate care placement by quarter, 2015.	25
Table 5.	Caring Together Title IV-E Waiver Youth	40
Table 6.	Characteristics of Caring Together Title IV-E Waiver Youth (Formative Entry and Exit Cohort)	41
Table 7.	Services Received by Caring Together Title IV-E Waiver Children (Formative Entry and Exit Cohort).....	46
Table 8.	Caring Together Title IV-E Waiver Children - Time in First ^a Caring Together Episode as of 5/2016 (Formative Entry and Exit Cohorts).....	47
Table 9.	Caring Together Episode End Reasons	47
Table 10.	Use of Restraint on Caring Together Title IV-E Waiver Youth (Formative Period, 2014-2015)	48
Table 11.	Stability: Psychiatric Hospitalizations Among Caring Together Title IV-E Waiver Youth (Formative Period, 2014-2015)	49
Table 12.	Preliminary summary by total cost, units, and cost per unit for Caring Together services, FY 2013-2015	51
Table 13.	Preliminary summary by service type: Cost per unit for Caring Together services, FY 2013-2015.....	51

Child Welfare Title IV-E Waiver Demonstration

Interim Evaluation Report

Executive Summary

Through the Title IV-E Waiver Demonstration, the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS), the Department of Children and Families (DCF) and the Department of Mental Health (DMH) embarked on a joint undertaking to create an integrated service delivery system for children and families. Caring Together (CT), the Title IV-E Waiver Demonstration, is a joint purchasing model for congregate care and community-based services system that offers children, young adults and families continuity of services, care and treatment teams, regardless of whether youth receive congregate care or community-based services. Caring Together services are designed to support youth during transitions in and out of the community and to strengthen child and caretaker capacity, thereby enabling more youth to remain in the community through increased home-based services.

In developing Caring Together, EOHHS, DCF, and DMH envisioned a system that provides Massachusetts children and families with individualized, timely, and integrated in-home and out-of-home services. Caring Together was designed to offer youth and families, including foster, kinship or adoptive families, the right level of care at the right time, building on individual family strengths while being responsive to youth and family voice and choice. Caring Together promotes family engagement in all aspects of a child's care and treatment, unless there are safety concerns that require alternative planning. In so doing, Caring Together aims to support youth's abilities to live successfully in their communities, by enabling families to manage their children successfully at home and by providing families and caregivers with the support needed to sustain their child's well-being.

1. Evaluation Overview

The Caring Together evaluation was designed to assess DCF's overarching hypothesis that the implementation of flexible funding with utilization and quality management in an integrated set of family-driven, youth-guided, and trauma-informed services will achieve more desirable outcomes for children, young adults, and families than the system could previously achieve. Services are targeted toward children, young adults, and their families who are in, or would otherwise require congregate care placement, which includes youth and young adults who are: 1) in congregate care settings preparing for and following their return to their home/community; 2) transitioning to living independently after receiving Pre-Independent Living and Independent Living Group Home Services; and 3) at risk for residential or group home placement.

The Caring Together evaluation is a mixed-method, rapid cycle evaluation with a two-year implementation period and three-year outcomes evaluation aimed at: 1) observing the services, management, and financing changes being implemented; 2) documenting the experiences and number of children and families served by each program; 3) determining whether Caring

Together is implemented as designed; 4) identifying outcomes among youth receiving Caring Together services as compared to a matched group that received services in the identified pre-Title IV-E Waiver period; and, 5) assessing whether Caring Together's integrated services, regional management, and flexible financing are accomplishing the intended goals. The evaluation combines three main research strategies, a Process Evaluation, an Outcome Evaluation, and a Cost Study. DCF worked with the DMA Health Strategies (DMA) evaluation team, which includes Westat, to identify a set of postulates that provide the underlying framework for CT and informed the development of a Logic Model and a comprehensive Evaluation Plan.

The Process Evaluation, which began during the formative two-year implementation period and is continuing throughout the three-year Outcome Evaluation period, includes focus groups, group interviews, surveys, document reviews, and an examination of DCF performance reports. The Process Evaluation seeks to describe DCF and DMH systems changes. As part of this effort, the Process Evaluation is monitoring CT implementation and its impact on the service delivery system, while documenting the successes and challenges, including staffing of the program and participant experience and satisfaction. The Outcome Evaluation is using a pre- and post-Waiver matched sample method to test the hypothesis that youth served through Caring Together will have better permanency, well-being, and safety outcomes compared to those served prior to the Title IV-E Waiver. The Cost Study uses DCF payment authorizations and billing to assess DCF's utilization and spending for services as well as to determine the cost neutrality for CT's congregate care and community-based services.

The target population for the Massachusetts Title IV-E Waiver study consists of most youth at risk of or in congregate care placement in DCF's child welfare system,¹ who either enter or exit congregate level services during the evaluation period. The target population consists of youth meeting the criteria for residential level of service including:

- Youth who have not yet been placed in congregate care ("at risk") who are served through Continuum services;
- Youth in a congregate care setting (i.e., group home, residential treatment); and,
- Youth who are transitioning out of congregate care either back to their home or foster care placement (served with Follow Along) or to an independent living setting in the community (served with Stepping Out).

The Outcome Evaluation is examining the entire study population meeting the eligibility criteria who entered (entry cohort) or exited (exit cohort) congregate level services during the evaluation period (thus, our "sample" equates to our defined population). The use of an entry cohort allows estimation of time in congregate care whether or not the youth left care (without bias toward short-stayers), to see how they compare to previous entry cohorts. The exit cohort allows examination of outcomes for youth ending CT to see how their experience in and after congregate care differs from previous youth who returned to the community (including whether or not they return to congregate care).

¹ Although DMH children may be served by Caring Together, our evaluation will only include children receiving DCF funds (Waiver funds). The evaluation will not include outcomes for DMH children who are funded through separate appropriations and federal funding streams. Data for DCF children served by Caring Together will come from FamilyNet. DMH tracks DMH-funded children with separate data systems.

2. Evaluation Activities to Date

Over the past two and a half years, the evaluation team has developed an array of qualitative and quantitative data collection tools to support the aims of the Caring Together Process Evaluation. To date, DMA has conducted eight stakeholder surveys: two DCF staff surveys, two provider surveys, one DMH staff survey, two parent/caregiver surveys and one youth survey. DMA received supplemental funding from DMH and DCF to add the DMH staff survey as well as the parent/caregiver and youth surveys.

To date, DMA has also conducted 20 stakeholder focus groups as well as 16 DCF and DMH leadership group interviews and CTCS team group interviews. The evaluation team has also conducted two rounds of the annual network management survey, worked with DCF to develop an interactive performance measurement tool and create a system for conducting monthly provider record reviews.

As part of the rapid cycle evaluation approach, DMA has presented preliminary data findings on several occasions to Caring Together leadership as well as to members of the CT Implementation Advisory Committee, including representatives from the Child Advocate's Office and the EOHHS Secretary's office, and to members of the Family Advisory Council.

3. Major Evaluation Findings to Date

The major Caring Together evaluation findings to date include the following:

A. Strengths

- Caring Together is having positive system-wide impacts, including increased family engagement and improvements in treatment planning and clinical practice.
- Across respondent groups, there is agreement and support for the Caring Together vision and the Building Bridges Initiative principles.
- Caring Together has promoted system-wide standards of care and a uniformity of practice that allow for flexibility of care, while addressing individual needs.
- There is evidence of increased interagency collaboration among leaders as well as broader stakeholder involvement in implementing CT's joint system of care.
- DCF and DMH staff and providers widely agree that CT trainings have prepared them to manage and/or provide services according to Caring Together values and principles.
- Caring Together's community-based services are viewed positively and have enabled more high-risk youth to remain at home, despite lower than expected utilization of Follow Along and Stepping Out.
- Respondent groups widely acknowledged improvements to the treatment planning process, including increased parent/caregiver and youth involvement. In addition, there is evidence that treatment teams generally work well together, though consistency could improve.
- CT has increased parent/caregiver and youth engagement, with some families feeling more empowered to have a voice in placement and treatment decisions.

- Parent/caregiver survey respondents widely reported that CT is helping them to develop the skills needed to help their children function better while CT services are helping their children to function better, with the majority also reporting that they feel hopeful about the care their child is receiving.

B. Areas for Improvement

- Enrollment in Caring Together's congregate care services is significantly higher than planned, while enrollment in the community-based services is lower than anticipated.
- A range of factors appear to be impeding enrollment at the desired levels, including a rate structure that does not fully support the intensity of the service models, particularly for transportation-related costs in Follow Along services.
- Risk management concerns need to be addressed through additional staff and provider trainings, particularly in the context of DCF's decreased risk tolerance over the past few years. Leadership changes and concerns about youth safety have limited the agency's full adoption of Caring Together principles and have made family engagement more difficult.
- DCF and DMH need to continue efforts to address joint governance and management as well as increase collaboration and coordination, while reducing operational redundancies. CT leadership needs to make a joint commitment to strengthen and support the CTCS teams.
- Length of stay and level of care oversight need to be addressed in order to ensure that youth served through CT receive the right level of care at the right time.
- There is an ongoing need for training across respondent groups. Providers, staff, and CTCS teams have expressed a desire for trainings on topics including trauma-informed care, CT requirements, best practices, and other topics. DCF staff reported an interest in trainings on joint standards around alternative to physical restraints.
- Caring Together needs to develop a comprehensive, multi-pronged communications plan and materials that will serve to educate DCF Area staff, expand enrollment and address any misinformation that exists about Caring Together.
- While parent/caregivers and youth report some increased involvement and voice, there is still room for improvement, as frustrations around accessing appropriate levels of services and quality of care persist.

4. Changes to the Demonstration or Evaluation Design

Caring Together has encountered a number of implementation related challenges, though none which have significantly impacted the demonstration or evaluation design. In response to the various challenges, Caring Together leadership and the evaluation team have identified a number of necessary modifications, including:

A. Family Partner service implementation delay.

As described in the most recent Semi-Annual Report, the Family Partner service has not yet been implemented statewide. The pilot program is coming to the end of its second year and the service is currently available at 12 Community Support Agencies. The evaluation team will implement Title IV-E Waiver-funded Family Partner evaluation activities once the service is implemented statewide.

B. Other implementation and evaluation recommendations.

Recent challenges surrounding CT implementation and recommendations include:

- i) Agency staff, providers, parents/caregivers and youth are largely unaware of the name Caring Together. Caring together leadership and staff are working to increase familiarity and recognition of the name Caring Together, which is the new program name for the network of residential and community-based services purchased with a statewide procurement and as part of the Title IV-E Waiver. Given this lack of familiarity, evaluation materials, from recruitment flyers to focus group protocols, now list the names of the individual Caring Together services and reference services received rather than using the words Caring Together.
- ii) There is no automated process for identifying Title IV-E Waiver versus non-Waiver youth. As such, lists of youth are reviewed on a quarterly basis to determine Title IV-E Waiver inclusion, which impedes DCF's ability to run monthly reports and delays quarterly reporting. The evaluation team reviewed this issue and determined that producing data for the most recent quarter (e.g., reporting on Oct-Dec 2015 in January 2016) was inefficient, resulting in incomplete data. The team agreed that a three-month reporting lag (e.g., reporting on Oct-Dec 2015 in April 2016) would be more efficient and result in the most complete performance reports.
- iii) Defining where a Congregate Care Episode begins and ends for the analytic file. The evaluation team further specified a congregate care episode, and this definition will be used in the analysis file to identify Caring Together episodes (inclusive of Continuum, Follow Along and Stepping Out, as well as congregate care), CT congregate care episodes, and historical congregate care episodes. The operational definition of a congregate care episode is described in the Outcome Evaluation.
- iv) The lower than anticipated utilization of CT's community-based services, particularly Follow Along and Stepping Out. With respect to the Outcome Evaluation, low utilization of these services impacts the exit cohort and subgroup analyses, though not CT's entry cohort. The evaluation team will assess needed changes to the evaluation plan in subsequent semi-annual reports, based on information obtained during the pilot study.
- v) Historical matches and efforts to ensure that the pool of matched youth follow the same inclusion and exclusion criteria as the Caring Together population. Evaluators and DCF staff are exploring possible codes that may help identify youth for exclusion or provide additional matching variables.
- vi) Fewer CANS than expected, thereby making it difficult to match baseline CANS and to use them as indicators of well-being among the Caring Together population (pre-post). The evaluation team is discussing strategies to address this issue.
- vii) The CT evaluation team is still exploring the feasibility of obtaining Mobile Crisis Intervention incidents data from MassHealth, complicating efforts to assess outcomes that rely on this dataset.

The Caring Together evaluation is entering an exciting phase. With the Implementation Period behind us, the evaluation team will begin to assess whether youth receiving Caring Together services experience different outcomes than those who received congregate care services during the five years prior to Caring Together.

Child Welfare Title IV-E Waiver Demonstration

Interim Evaluation Report

Introduction and Overview

Through the Title IV-E Waiver Demonstration, the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS), the Department of Children and Families (DCF) and the Department of Mental Health (DMH) embarked on a joint undertaking to create an integrated service delivery system for children and families. Caring Together (CT), the Title IV-E Waiver Demonstration, is a joint purchasing model for congregate care and community-based services system that offers children, young adults and families continuity of services, care and treatment teams, regardless of whether the youth is served in a congregate care or a community-based program. Caring Together services are designed to support youth during transitions in and out of the community and to strengthen child and caretaker capacity, thereby enabling more youth to stay in the community through increased home-based services.

1. Background and Context

In developing Caring Together, EOHHS, DCF, and DMH sought to ensure that children in need of congregate care and community-based services and their families became the focal point of the service delivery system. Together, the agencies envisioned a system that provides children and families with individualized, timely, and integrated in-home and out-of-home services. Caring Together offers youth and families, including foster, kinship or adoptive families, the right level of care at the right time, building on individual family strengths while being responsive to youth and family voice and choice. With its emphasis on full family engagement, Caring Together aims to support youth's abilities to live successfully in their local communities. CT provides families and caregivers with the support needed to sustain their child's well-being, thereby enabling them to manage their children successfully at home. This approach promotes family engagement in all aspects of a child's care and treatment, unless there are safety concerns that require alternative planning.

By transforming the Commonwealth's congregate care system, DCF and DMH are seeking to establish an important framework for strengthening families through an integrated Child Welfare and Behavioral Health system of care that enables more youth to remain at home by providing both congregate care and community-based services. Caring Together's core activities include:

- Providing services that are youth-guided and family-driven, responsive to needs, and utilize evidence-informed practices.
- Offering trauma-informed services and using positive behavioral supports and interventions as needed.
- Ensuring that families experience "No Wrong Doorway" into residential care, regardless of agency affiliation.
- Ensuring that children and families have access to the right level of service at the right time and for the right duration.

- Integrating services in a manner that provides continuity and consistency of treatment across community and congregate care settings.
- Measuring treatment success according to which improvements are sustained following discharge from the last level of service.
- Establishing reimbursement methods that support innovation and improved outcomes.
- Developing performance measures through a consensus building process with providers and families.
- Ensuring that agency processes and structures maximize administrative efficiencies.

2. Title IV-E Waiver Demonstration Purpose

Caring Together was designed to transform the Commonwealth's residential care systems by providing integrated services, integrated regional management, and flexible financing. Caring Together consists of five main integrated services, each with a different focus, including: Congregate Care, Continuum, Follow Along, Stepping Out, and Family Partners. In implementing these services, CT seeks to offer youth and parents/caregivers a system of care that includes: comprehensive service planning; continuous and stable treatment teams that bridge transitions between congregate care and community-based services; active incorporation of youth and family voice into planning and ongoing operations; and improved quality of services that are trauma-informed, culturally competent, and focused on family and youth skill-building. Lastly, through the Family Partner service, Caring Together fosters increased family engagement and supports families in coordinating services through DCF and other agencies.

Caring Together's integrated regional management activities were designed to include peer reviewed level of service assessments, network management, rehab option review, and intensive utilization and quality management aimed at improving and restructuring oversight of the state's residential and community-based care service system. In addition, through the more flexible funding permitted by the Title IV-E Waiver, DCF has sought to implement a financing structure necessary to divert youth from residential treatment to community-based services and to more rapidly move youth requiring residential services back into the community with the supports and services they need. Caring Together Clinical Support (CTCS) teams were created to provide ongoing utilization review based on treatment plans and telephonic case reviews. Caring Together's Coordinators of Family Driven Practice support Family Partner's and serve as a bridge between the management roles of the CTCS teams and the hands-on roles of the Family Partner service. In order to support the goals of joint management and governance between DCF and DMH, the agencies conduct Executive Team joint planning meetings on a bi-weekly basis.

Caring Together aims to prevent or reduce the length of time a youth spends in out-of-home treatment services and promote the successful functioning of youth. This is done through support for the development of daily living skills and social, emotional, academic and pre-vocational competencies; preparing families to manage their children successfully at home, and promoting families' capacity to sustain their child's and the family's well-being.

Caring Together's desired outcomes include:

- Improved permanency through increased reunification and other permanent placements;
- Reduced lengths of out-of-home placement and improved placement stability;

- Increased community tenure;
- Improved safety through reduced risk and rates of subsequent maltreatment;
- Increased child well-being and positive youth outcomes;
- Strengthened families; and
- Cost neutrality.

Caring Together's desired goals include:

- Maximizing the Commonwealth's fiscal resources by eliminating redundancy in administration and management;
- Promoting innovation and creativity among service providers;
- Transforming the residential treatment system from a primarily placement oriented service to one that is primarily community-based; and
- Increasing family and youth satisfaction with the residential care system.

The Caring Together evaluation was designed to assess DCF's overarching hypothesis that the implementation of flexible funding with utilization and quality management in an integrated set of family-driven, youth-guided, and trauma-informed services will achieve more desirable outcomes for children, young adults, and families than the system could previously achieve. Services are targeted toward children, young adults, and their families who are in, or would otherwise require congregate care placement, which includes youth and young adults who are: 1) in congregate care settings preparing for and following their return to their home/community; 2) transitioning to living independently after receiving Pre-Independent Living and Independent Living Group Home Services; and 3) at risk for residential or group home placement.

3. The Evaluation Framework

A. Evaluation Overview

The Caring Together evaluation is a mixed-method, rapid cycle evaluation with a two-year implementation period and three-year outcomes evaluation aimed at: 1) observing the services, management, and financing changes being implemented; 2) documenting the experiences and number of children and families served by each program; 3) determining whether Caring Together is implemented as designed; 4) identifying outcomes among youth receiving Caring Together services as compared to a matched group that received services in the identified pre-Title IV-E Waiver period; and, 5) assessing whether Caring Together's integrated services, regional management, and flexible financing are accomplishing the intended goals. The evaluation combines three main research strategies, a Process Evaluation, an Outcome Evaluation, and a Cost Study. DCF worked with the DMA Health Strategies (DMA) evaluation team, which includes Westat, to identify a set of postulates that provide the underlying framework for CT and informed the development of a Logic Model and a comprehensive Evaluation Plan.

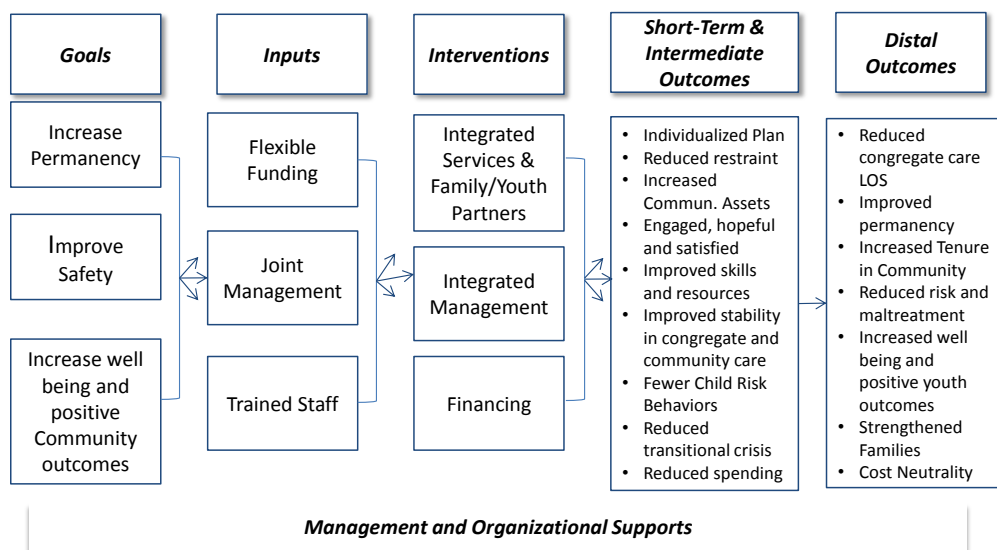
The Process Evaluation, which began during the formative two-year implementation period and is continuing throughout the three-year Outcome Evaluation period, includes focus groups, group interviews, surveys, document reviews, and an examination of DCF performance reports. The Process Evaluation seeks to describe DCF and DMH systems changes. As part of this effort, the Process Evaluation is monitoring CT implementation and

its impact on the service delivery system, while documenting the successes and challenges, including staffing of the program and participant experience and satisfaction. The Outcome Evaluation is using a pre- and post-Waiver matched sample method to test the hypothesis that youth served through CT will have better permanency, well-being, and safety outcomes compared to those served prior to the Title IV-E Waiver. The Cost Study uses DCF payment authorizations and billing to assess DCF’s utilization and spending for services as well as to determine the cost neutrality for CT’s congregate care and community-based services.

B. Theory of Change/Logic Model

The purpose of Caring Together is to create a more family-driven and youth-guided community-based system of services that improves safety, permanency, and well-being through reduced lengths of stay in out-of-home placement, increased success in the community, and greater provision of care within a child’s home and community. The three primary goals (first column) are to increase permanency, improve safety, and increase well-being and positive outcomes in the community. Using flexible Title IV-E funding, joint management and governance, and trained staff (second column), DCF is implementing integrated services (including Follow Along, Stepping Out, Continuum, Congregate Care, and Family Partners), integrated regional management, and new financing methods (third column) to serve the target population of children and young adults in or at risk of congregate care placement. Through Caring Together services, governance, and management changes (third column), DCF anticipates that children and families will experience better short-term, intermediate (fourth column) and long-term outcomes (last column).

Figure 1. Caring Together Logic Model Summary



Through the Title IV-E Waiver, Massachusetts redesigned its residential program and created new community-based services for youth and families involved in the Child Welfare and Mental Health systems. Caring Together’s community-based services, which include Follow Along, Continuum, and Stepping Out, are all designed to provide stable treatment teams and family-driven, youth-guided services to ensure smooth transitions for youth returning home

or to prevent residential episodes for youth at risk of out-of-home placements. The community-based services are designed for youth in cases where the family is identified as able to care for the child at home, or work toward return home, with intensive supports.

Caring Together services include:

- *Congregate Care*- The re-procured congregate care system includes a new set of service standards based on Positive Youth Development, family-driven and youth-guided services, trauma-informed care, permanency, reduced use of restraint, and effective transitions.
- *Follow Along*- Intensive home-based family intervention and support to youth 18 and younger and their families, both while they are being prepared to return home from a residential setting and after the return has occurred. The focus is on comprehensive family skill-building to improve parent/caregiver capacity to support youth and effectively utilize available services.
- *Stepping Out*- Services for young adults who are transitioning to living independently after receiving Pre-Independent Living and Independent Living Group Home Services. Stepping Out provides ongoing individual supports during this transition period to help youth achieve independence, build relationships, and sustain lifelong connections.
- *Continuum*- Services for youth 18 and younger at risk of residential placement where the family is identified as able to care for the child at home or work toward a return home with intensive supports. Continuum is responsible for family treatment, care coordination, outreach, and crisis support within the community even when the child receives out-of-home services. In addition, families receive youth and family outreach, crisis prevention and intervention support, and long-term and short-term out-of-home respite care if needed.
- *Family Partners*- A voluntary service for families, intended to increase family engagement with other Caring Together services. Families can only be referred if they are receiving a CT service and if the goal is reunification. Family partners have lived experience with the child welfare and/or child behavioral systems and support families during the congregate care experience and, when requested, stay with the families during a child's transition home.

C. Data Sources and Data Collection Methods

The Caring Together evaluation includes a range of mixed-method data collection activities, including interviews, focus groups, surveys and a review of agency management data. The frequency of specific data collection activities are detailed in the table below:

Table 1. Frequency of Data Collection Activities

Activity	Frequency	
	Implementation Period Jan. 2014-Dec. 2015	Outcomes Period Jan. 2016-Dec. 2018
<i>Interviews</i>		
CTCS Team	Quarterly	Semi-annually
DCF leadership	Semi-annually	Annually
DMH leadership	Semi-annually	Annually

Table 1. Frequency of Data Collection Activities

Activity	Frequency	
	Implementation Period Jan. 2014-Dec. 2015	Outcomes Period Jan. 2016-Dec. 2018
<i>Focus Groups</i>		
DCF staff	Semi-annually	Annually
DMH staff*	Annually	Annually
Providers	Semi-annually	Annually
Parents/Caregivers	Semi-annually	Semi-annually
Parents/Caregivers*	Annually	Annually
Youth	Semi-annually	Semi-annually
Youth*	Annually	Annually
Family Partners ⁺	Postponed	Post-pilot
<i>Surveys</i>		
DCF staff	Annually	Annually
DMH staff*	Annually	Annually
Providers	Annually	Annually
Parents/Caregivers*	Annually	Annually
CTCS Team*		Fall 2016
Youth		Annually
Family Partners ⁺	Postponed	Post-pilot
<i>Management Tools</i>		
Network Management Survey	Annually	Annually
CT Record Reviews	Ongoing	Ongoing
CT Performance Measures	Quarterly	Quarterly
<i>Administrative Data</i>		
FamilyNet data files (DCF submits to evaluation team)	Annually	Annually
Family Partner database		Jan/Feb 2017 and 2019
MassHealth/MBHP data		Jan/Feb 2017 and 2019

* DMH-funded activities

+ ^{Family} Partner evaluation activities will begin following the completion and evaluation of the Family Partner pilot program currently being implemented.

D. Study Population

The target population for the Massachusetts Title IV-E Waiver study consists of most youth at risk of or in congregate care placement in DCF's child welfare system,² who either enter or exit congregate level services during the evaluation period. The target population consists of youth meeting the criteria for residential level of service including:

- Youth who have not yet been placed in congregate care ("at risk") who are served through Continuum services;
- Youth in a congregate care setting (i.e., group home, residential treatment); and,

² Although DMH children may be served by Caring Together, our evaluation will only include children receiving DCF funds (Waiver funds). The evaluation will not include outcomes for DMH children who are funded through separate appropriations and federal funding streams. Data for DCF children served by Caring Together will come from FamilyNet. DMH tracks DMH-funded children with separate data systems.

- Youth who are transitioning out of congregate care either back to their home or foster care placement (served with Follow Along) or to an independent living setting in the community (served with Stepping Out).

The target population for the Title IV-E Waiver study excludes a subset of youth receiving Caring Together services from the study due to substantial developmental delays, highly specialized needs, or severe physical disabilities. The target population also excludes youth if they only receive Short-Term Assessment and Rapid Reintegration (STARR) congregate level service. Eligibility for the study is determined by DCF program staff. For youth referred to CT services, staff members review each case to identify whether the youth meet the exclusion criteria or, conversely, are eligible for the study. DCF staff persons enter the Title IV-E Waiver status (in the Title IV-E Waiver or not in the Title IV-E Waiver) and Waiver date (when they were eligible) into the FamilyNet system and provide this information to evaluators in the demographic file.

The Outcome Evaluation is examining the entire study population meeting the eligibility criteria who entered (entry cohort) or exited (exit cohort) congregate level services during the evaluation period (thus, our “sample” equates to our defined population). The use of an entry cohort allows estimation of time in congregate care whether or not the youth left care (without bias toward short-stayers), to see how they compare to previous entry cohorts. The exit cohort allows examination of outcomes for youth ending CT to see how their experience in and after congregate care differs from previous youth who returned to the community (including whether or not they return to congregate care).

The entry cohort and exit cohort were derived from the FamilyNet demographic file (Title IV-E Waiver status and date), service referral file (placements and community based services), and flow data (placements and other locations, including hospitalizations, non-DCF group homes or institutions, and on the run). After merging the files, consecutive congregate level services are combined into congregate level “episodes” (see Outcome Evaluation section for detailed definition). The congregate level episodes are then used in identifying youth in the entry and exit cohorts. For the formative evaluation (pilot test using data from the implementation period), the **entry cohort** consists of youth with waiver status “in the Title IV-E Waiver” who received qualifying Caring Together services (Continuum, congregate care, Follow Along, Stepping Out) with an episode start date between 1/1/2014 and 12/31/2015.³ The **exit cohort** consists of youth with waiver status “in the Title IV-E Waiver” who received qualifying CT services with an episode end date between 1/1/2014 and 12/31/2015 (see Outcome Evaluation section).⁴ For the main outcome analysis, or summative evaluation, the entry and exit cohorts will be based on services beginning or ending during the summative evaluation period, between 1/1/2016 to 12/31/2018.

The **comparison population** will consist of youth served historically, during a five-year period prior to the implementation of Caring Together services, matched to the study population based on similar characteristics (see Outcome Evaluation section 2.C and 2.D for information about the comparison population and matching process).

³ If the youth has more than one congregate level episode with a start date during the study period, we select the first episode that begins during the period.

⁴ If the youth has more than one congregate level episode with an end date during the study period, we select the first episode that ends during the period.

Sample size estimates. As noted, we plan to examine an entry and an exit cohort. Prior to the study, we estimated an entry cohort of 1,700 youth and an exit cohort of 1,700 youth. The formative entry cohort exceeds the estimate, with over 2,100 youth. The formative exit cohort also exceeds the estimate (around 1,800) *after* revising the definition. Initially, we assumed that most youth leaving congregate care would receive community-based services (Follow Along or Stepping Out), which we specified in the exit cohort definition. However, during the formative period, the data show that many youth leave congregate care without Follow Along or Stepping Out services, which would provide a very small sample for the exit cohort. CT includes re-designed congregate care services, in addition to the community-based services, thus we broadened our definition of the exit cohort to include youth ending congregate level services whether or not they received community-based services.

Data for the formative period will be used in the pilot test of the matching and outcomes analysis. In the final year, the main outcome analysis will examine outcomes for youth served during the summative period, once Caring Together services have been fully implemented. Assuming similar numbers are in the summative period as in the formative period, and with the revision to the exit cohort definition, we anticipate having adequate power to detect differences between the treatment and matched comparison groups for most analyses. That is, we anticipate that the sample size of well over $n=1,700$ matched pairs would be sufficient to detect relatively small differences between children served in Caring Together and children served with the traditional congregate care services. However, due to the combined effect of matching and potential time trends on the analysis, it is possible that this sample size would only detect somewhat large differences between the two groups. We will examine this fully during the pilot study and make recommendations as needed.

E. Data Analysis Plan

- i) Process Evaluation. The Process Evaluation coincides with the implementation of the Title IV-E Waiver and continues over the entire five-year project period. The Process Evaluation includes a review of the new CT services and documentation of the eligibility and enrollment process, the numbers served, and data on the length of service. It provides extensive implementation data over time, including trend measures that track enrollment on a regional and statewide basis, youth and family demographics, lengths of stay, total average costs of care, distributions of costs, CANS measures, distribution of services, family involvement, and satisfaction measures. Many of these data are the same administrative data that are being used as a part of the more comprehensive and controlled outcomes evaluation. The Process Evaluation includes both qualitative and quantitative data analysis strategies. The Process Evaluation relies on interviews, focus groups and surveys with agency staff, providers, parents/caregivers and youth to document the array of services available, describe stakeholder experiences and participant satisfaction, and identify program improvement recommendations. Qualitative data from the interviews, focus groups, and surveys were coded according to theme and content. Quantitative data from the surveys of staff, providers, and parents/caregivers; the Network Management Survey; and Caring Together Provider Record Reviews were analyzed using descriptive tools, frequencies, and mean scores.

In sum, the process evaluation will provide extensive data on program implementation over time.

- ii) Outcome Evaluation. The Outcome Evaluation is designed to examine Caring Together's short-term and intermediate outcomes (see Logic Model), as well as test the hypothesis that CT will result in the following long-term outcomes for children, young adults, and families receiving CT services as compared to those who received pre-Waiver congregate care services, including:
- Reduced lengths of out-of-home placement;
 - Improved permanency;
 - Increased tenure in the community;
 - Reduced risk and rates of repeat maltreatment;
 - Increased child well-being; and
 - Strengthened families.

For each outcome, the Outcome Evaluation will examine differences between matched samples of children discharged from congregate level services prior to the implementation of the Title IV-E Waiver and those children discharged after the implementation; some measures will examine differences between matched samples of children who entered congregate level of services prior to the implementation to those who entered after the implementation.

Descriptive and multivariate statistics will be used to analyze outcomes, comparing outcomes for Caring Together children with matched children from the pre-Waiver period to test the hypothesis that children receiving Caring Together will have better outcomes than pre-Waiver children. For the interim report, we conducted preliminary descriptive analyses to describe the Caring Together population and their congregate care experience during the formative period.

- iii) Cost Study. The Cost Study includes both qualitative and quantitative analysis of CT's financing structure. Summary tables that track utilization and spending by type of service will be prepared. DMA continues to monitor any efforts to develop performance based contracts with financial incentives while gathering data regarding provider and state concerns about rates. Much of this information will be analyzed qualitatively.

F. Limitations

DMA has identified a number of limitations that have impacted Caring Together implementation as well as efforts to adhere to the original evaluation plan, including:

- i) Lack of pre-Waiver data for the Process Evaluation. Process Evaluation data collection tools (i.e., interview and focus group protocols, surveys, performance measurement tool, Network Management tool) were developed as part of the evaluation and data on these measures were not collected prior to CT implementation. As such, the evaluation team is using these measures as a baseline and to track progress over the course of the evaluation, but it is not possible to compare process

data collected during the evaluation to the pre-Waiver period. The team will also compare DCF's expectations and discuss differences from both periods.

- ii) Resource limitations in tool development. Many of the data collection tools developed for the Process Evaluation (e.g., performance measurement tool, Network Management tool) were intended to embed the regular collection and review of these data within DCF. Given resource constraints and competing priorities among DCF staff, the development and evaluation of these measures was moderately delayed.
- iii) Chapter 257 rate increases. As part of the cost study assessment of utilization and spending resulting from the Title IV-E Waiver's all-inclusive rates, implementation of Massachusetts Chapter 257 has emerged as a parallel and potentially confounding process in that it mandates cost-based rates for human service programs purchased by EOHHS, including Caring Together. The Chapter 257 rate increase went into effect at the same time as DCF began implementing Caring Together, which requires the evaluation team to develop a cost adjustment factor to account for Chapter 257's impact. This process is still underway.

4. Evaluation Timeframe and Implementation Status

The original evaluation design and timeframes are on track. Delays in certain implementation tasks and some changes in data collection have been incorporated and any outstanding issues in assessing the Implementation Period will be addressed over the next six months.

A. Evaluation Timeframe

The evaluation timeframe covers the pre-Waiver period and the Caring Together implementation and outcome periods.

- The pre-Waiver period includes data from services received by an exit cohort who were discharged from care during the five years prior to the Title IV-E Waiver or the start of the new CT contracts, whichever occurred first. The pre-Waiver period includes selected process and descriptive measures for the 12 months prior to the Title IV-E Waiver as well as data from a matched sample for the full five-year pre-Waiver period.
- The Caring Together Implementation Period includes the first two years of the IV-E Waiver implementation (January 1, 2014 – December 31, 2015), primarily focused on process evaluation activities, and fidelity-related measures for both the integrated services and the regional CTCS teams. As part of the Implementation Period, the evaluation team worked with DCF to identify performance measures, finalize the two utilization and network monitoring tools, and develop and seek DCF Administrative Review approval for surveys, interviews and focus group protocols. Data from the implementation period will be used for the pilot test of the matching process and outcome analysis.
- The Outcome Evaluation is the summative period spanning Year 3 to Year 5 of the Title IV-E Waiver, while the main outcomes analyses will focus on youth served from January 2016 through December 2017 of the Waiver period. The Outcome Evaluation is designed to compare Title IV-E Waiver youth with pre-Waiver youth

matched from a pool of children served during the five years prior to the Title IV-E Waiver period and Caring Together Implementation (July 1, 2008 through June 30, 2013). Youth will be followed for a period of 12 months in order to observe key events (e.g., permanent placement, subsequent child maltreatment). For outcomes that do not require a follow-up period, the study sample will be expanded to include children served in Year 5.

B. Implementation Update, Challenges and Changes

- i) Leadership changes. Since the Title IV-E Waiver was approved and Caring Together was first implemented, there have been four DCF Commissioners and two Caring Together Directors, as well as other staff changes. Specifically, during this past year, CT experienced a significant leadership transition following the Commonwealth's Employee Retirement Incentive Program that resulted in the early retirement of Caring Together's remaining original visionaries.

Caring Together has a joint leadership structure, including a Director of Caring Together and two Assistant Directors, one employed by DCF and one employed by DMH. In addition to the Director and Assistant Directors, there are key managers from both DCF and DMH who are involved with leadership and oversight in the initiative. For both DCF and DMH, the managers connected to Caring Together transitioned quickly, with only a month overlap between the current leadership and those retiring. For DCF, in addition to the joint CT leadership, the managerial team now includes the Director of Program Operations, all of whom are regular participants in the monthly Evaluation Team meeting.

With the retirement of Caring Together's Director in June 2015, one of Caring Together's Assistant Directors served as the Interim Caring Together Director for almost a year until the new Caring Together Director, was hired in April 2016.

In addition, DMH's Deputy Commissioner for Child and Adolescent Services was named DMH Commissioner, after serving as Interim Commissioner for several months. The appointment left a vacancy in DMH's Deputy Commissioner role, which had previously been active in Caring Together's joint governance efforts. While the Deputy Commissioner position is still vacant as of June 2016, DMH currently funds both the Caring Together Director and an Assistant Director position, both of whom regularly participate in Caring Together Evaluation Team's monthly meetings.

- ii) Delays in achieving the vision of the CTCS teams. The role of the CTCS teams has shifted from what was originally envisioned to better meet the needs of DCF and Caring Together. This change in CTCS team responsibilities is further described in Section 4.B (Key Question 2). However, as a result of the modified role for CTCS teams, the evaluation team needed to revise the DCF staff survey between Years 1 and 2 to accurately reflect the CTCS team activities.
- iii) Caring Together marketing and communications. As described above, Caring Together is the new program name for the network of residential and community based services purchased with a statewide procurement and as part of the Title IV-E

Waiver. It applies to a system of over 200 interagency contracts for CT services with a long list of providers and more than 21 discrete service types. Agency staff, providers, parents/caregivers and youth are largely unaware of the name Caring Together, though there appears to be increasing familiarity with CT's individual community-based services, particularly Continuum. Focus groups and surveys indicate that there continues to be confusion and uncertainty about what CT is, what services it includes, what the eligibility requirements are, and how to access CT services. CT leadership are aware of the issue and over the last year have made increasing efforts to improve marketing and communications to Area Offices, families, and other state staff. In addition, CT evaluation materials, from recruitment flyers to focus group protocols, now list the names of all the Caring Together services and reference services received rather than using the words Caring Together.

- iv) Family Partner service implementation delay. As described in the most recent Semi-Annual Report, the Family Partner service has not yet been implemented statewide. The pilot program is coming to the end of its second year and the service is currently available at 12 Community Support Agencies. DCF and DMH are conducting a separate evaluation of the Family Partner pilot. As such, DMA and CT leadership postponed the Title IV-E Waiver-funded Family Partner evaluation until the service is implemented statewide.
- v) Delays and challenges in data reporting. There is no automated process for identifying Title IV-E Waiver versus non-Waiver youth. As such, CTCS teams manually review lists of youth on a quarterly basis to determine Title IV-E Waiver inclusion, which impedes DCF's ability to run monthly reports and delays quarterly reporting. The evaluation team reviewed this issue and determined that producing data for the most recent quarter (e.g., reporting on Oct-Dec 2015 in January 2016) was inefficient, resulting in incomplete data. The team agreed that a 3-month reporting lag (e.g., reporting on Oct-Dec 2015 in April 2016) would be more efficient and result in the most complete performance reports. In addition, demand for other reports has delayed the implementation of performance measurement; however, a new performance measurement tool is being rolled out now for Area- and provider-level reports.
- vi) Focus group scheduling. Scheduling focus groups presents numerous challenges, particularly for youth and parents/caregivers, with groups often needing to be rescheduled or cancelled due to low or no registration, even after offering \$20 Visa gift cards and dinner. DMA is now working to broaden the pool of potential focus group hosts by (a) seeking additional support from DCF and DMH staff and their direct connections with providers, (b) working with Family Advisory Council members who expressed an interest in convening groups in other regions of the state, and (c) reaching out to some of the state's Family Resource Centers and the Administrative Service Organization as potential focus group hosts.
- vii) Parent/caregiver and youth survey sampling strategy and response rate. The parent/caregiver and youth surveys were sent to Caring Together providers, the CT Implementation Advisory Committee, the Family Advisory Council, and CTCS teams

on May 23, 2016. Despite providing more guidance on survey administration, the initial survey response was very low; by June 17, 2016, 12 youth and 27 parents/caregivers had responded to the survey. DMA strategized with DCF and DMH and subsequently implemented additional strategies, including having CT leadership encourage Family Partners to work with families and their youth to complete the survey, while also offering to host an ice cream party for the Community Service Agency with the highest number of completed surveys. While the strategy for increasing youth and parent/caregiver survey completion has served to increase the response, the strategy likely results in oversampling parents/caregivers and their youth who have worked with Family Partners. For both the Year 1 and Year 2 surveys, survey data will be used for descriptive purposes and will not be considered representative of the overall CT service population, due to both the low response rate and the inherent limitations of the sampling strategy.

- viii) Other survey-related limitations. Given the resource limitations for administering the parent/caregiver and youth surveys, the evaluation team is not in a position to conduct telephonic survey administration, which would both facilitate a greater response and serve to randomize the survey sample. Resource limitations also prevent the team from hosting regional survey completion parties with food and stipends.

In addition, provider and internal agency annual surveys serve as competition for CT's survey distribution efforts. Providers are often more vested in achieving high response rates for their own internal surveys, with one provider sharing that the agency offers an ice cream party to the group with the highest response rate, which sometimes approaches 40%. Some surveys also include an individual monetary reward, with parents/caregivers reporting that they received a survey in the mail with a \$5 bill stapled to the front and that they thought was the CT survey. With multiple surveys in circulation, often simultaneously, parents/caregivers may be confused about which survey to complete and may also feel over-sampled.

- ix) Other challenges. Recent challenges surrounding Caring Together implementation include:
- a. Defining where a Congregate Care Episode begins and ends for the analytic file. The evaluation team further specified a congregate care episode, and this definition will be used in the analysis file to identify Caring Together episodes (inclusive of Continuum, Follow Along and Stepping Out, as well as congregate care), Caring Together congregate care episodes, and historical congregate care episodes. The operational definition of a congregate care episode is described in the Outcome Evaluation section.
 - b. The lower than anticipated utilization of CT's community-based services, particularly Follow Along and Stepping Out. With respect to the Outcome Evaluation, low utilization of these services impacts the exit cohort and subgroup analyses, though not CT's entry cohort. The evaluation team will assess needed changes to the evaluation plan in subsequent semi-annual reports, based on information obtained during the pilot study.
 - c. Historical matches and efforts to ensure that the pool of matched youth follow the same inclusion and exclusion criteria as the Caring Together population.

Evaluators and DCF staff are exploring possible codes that may help identify youth for exclusion or provide additional matching variables.

- d. Fewer CANS than expected, thereby making it difficult to match baseline CANS and to use them as indicators of well-being among the CT population (pre-post). The evaluation team is discussing strategies to address this issue.
 - e. The CT evaluation team is still exploring the feasibility of obtaining Mobile Crisis Intervention incidents data from MassHealth, complicating efforts to assess outcomes that rely on this dataset.
- x) Previously reported implementation updates. During previous reporting periods, implementation updates and challenges included: a delay in administering the Year 1 DCF staff survey due to a competing DCF survey, a longer than anticipated process for developing the Network Management Survey and the CT Provider Record Review tool, and the DCF Administrative Review Board initially needed more time than anticipated to review the CT data collection tools. Finally, the evaluation team initially encountered some challenges around the variable specification process related in part to redundancies in FamilyNet service data.

The Process Evaluation

The Process Evaluation examines the organizational and system changes DCF has made in implementing Caring Together, including: the successes and challenges involved in implementing CT, program staffing, and participant experience and satisfaction. In addition, the Process Study assesses the successes and challenges of interagency collaboration.

1. Key Questions

The Process Evaluation has three core research questions. The core questions are:

- 1) How are Caring Together integrated services working?
- 2) How are the Caring Together integrated regional management teams working?
- 3) Are Caring Together integrated services and management implemented/working as planned?

2. Data Sources and Data Collection

The Process Evaluation relies on data from interviews, focus groups, and surveys involving multiple stakeholder groups, as well as data from three DCF-administered management tools: the Network Management Tool, CT Provider Record Reviews, and Performance Measures. Key information on data collection activities, frequencies, and respondent groups are included in this report, with additional details for each category provided in the Results Attachment.

A. Interviews

- i) DCF Leadership. Between June 2014 and May 2016, DMA conducted nine interviews with DCF leadership, including retrospective interviews with key informants and one group interview with current CT leadership.
- ii) DMH Leadership. Between October 2015 and May 2016, DMA conducted two interviews with eight members of DMH leadership, including current CT leadership, to assess issues relating to the joint management of Caring Together.
- iii) CTCS Teams. For the CTCS team group interviews, DMA rotates the groups to ensure adequate regional representation. Since transitioning from quarterly to semi-annual interviews, the interviews now combine regions to ensure that each regional team participates at least once annually. DMA held six group interviews with 37 CTCS team members from the Northern, Boston, Southern, and Western regions between November 2014 and May 2016. In January 2016, DCF created a new Central region, and members of the newly formed Central CTCS Team will participate in a future interview.

B. Focus Groups

Focus group recruitment strategies varied by respondent group. For DCF staff, DMA has worked to ensure regional representation of Area Offices, including a range of position categories. For provider focus groups, DMA has sought to organize around existing provider

meetings in order to obtain broad representation. Parent/caregiver and youth focus groups have posed the greatest recruitment challenge, despite efforts to schedule focus groups on convenient days and times and despite offering food and \$20 gift cards.

From January 2014 to July 2016, evaluators held a total of 20 focus groups with various respondent groups: four with DCF staff, one with DMH staff, four with providers, five with parents/caregivers, and six with youth. As described in the Introduction and Overview, DMA sought representation across Areas and agencies. Focus group participants are described further below.

- i) DCF Staff. Evaluators held four focus groups with 53 DCF staff members between December 2014 and May 2016.
- ii) DMH Staff. DMA held one focus group with four DMH Child and Adolescent Directors and one Research Analyst on October 22, 2015.
- iii) Providers. DMA convened four provider focus groups, including 34 individuals, between November 2014 and June 2016.
- iv) Parents/Caregivers. DMA held five focus groups with 28 parents/caregivers of youth who were receiving or had previously received CT services. At the time of the focus groups, their children ranged in age from 10 to 29 years old and had received services through DCF, DMH, or both agencies. All Title IV-E Waiver funded parent/caregiver focus groups were co-led with a DCF family representative.
- v) Youth. DMA held six focus groups with 52 youth who were receiving or had previously received CT services, ranging in age from eight to 18 years old. All participants received services through DCF, DMH, or both agencies. All Title IV-E Waiver funded youth focus groups were co-led with a DCF family representative.

C. Annual Surveys

DMA uses SurveyMonkey to administer all of the CT surveys. DMA conducted the first annual survey of DCF staff and providers at the end of Year 1 (Jan-Dec 2014) to assess participants' experience with Caring Together integrated services and integrated regional management. In Year 2 (Jan-Dec 2015), DMA conducted the second annual DCF staff and provider surveys and added surveys of DMH staff and parents/caregivers. The DMH staff survey was designed to parallel the DCF staff survey. In Year 3, DMA conducted a second parent/caregiver survey and added a youth survey, which closed in July 2016. DMA will include findings from these two surveys in the January 2017 semi-annual report. Table 1 summarizes the surveys conducted to date, the number of individuals who received the survey, the number of respondents, and the survey response rates. Given the distribution methods for the parent/caregiver and youth surveys (described in the Introduction and Overview, Section C), DMA is unable to determine the total number of individuals who received the surveys, and as such, cannot calculate the response rate.

Table 2. CT surveys administered to date and response rates, by respondent group.

Respondent Group	Date	Total Receiving the Survey	Total Respondents	Response Rate
DCF Staff	Jan-Feb 2016	1,954	535	27%
DCF Staff	Jan 2015	1,494	391	27%
DMH Staff	Dec 2015	75	52	69%
Providers	Dec 2015	250	109	44%
Providers	Dec 2014	238	140	59%
Parents/ caregivers	July-Nov 2015	Unknown	55	-
Parents/ caregivers ¹	May-July 2016	Unknown	115	-
Youth ¹	May-July 2016	Unknown	161	-

¹ Findings from the 2016 parent/caregiver and youth surveys are not included in this report.

- i) DCF Staff. Two annual surveys of DCF staff were conducted. In January 2015, DMA electronically distributed the 25-item Year 1 survey to 1,494 DCF staff members who (a) had been employed by DCF for at least six months as of November 26, 2014, and (b) were assigned to or oversaw a primary worker assigned to a Caring Together case. Three hundred ninety-one staff members responded, and 175 met the inclusion criteria (i.e., reported that they had been involved in at least one CT case in the past year). From January to February 2016, DMA electronically distributed the 22-item Year 2 survey to 1,954 DCF staff members, using the same criteria as the Year 1 survey (i.e., staff who had been employed by DCF for at least six months and were assigned to or oversaw a CT case). Five hundred thirty-five staff members responded, and 131 reported that they had been involved in at least one CT case in the past year.
- ii) DMH Staff. In December 2015, DMA electronically administered a 22-item survey to 75 DMH staff members who (a) had been employed by DMH for at least six months as of November 2, 2015, and (b) had knowledge of Caring Together, as assessed by the Directors of Child/Adolescent Services. Fifty-two staff members responded, and 48 reported that they had been involved in at least one CT case in the past year.
- iii) Providers. DMA conducted two annual Caring Together provider surveys. In December 2014, DMA electronically administered the 28-item Year 1 survey to 238 providers: all Executive Directors and CT Program Directors, managers who oversee CT programs, and any other CT managerial level staff person at the Program Director level or above. One-hundred forty provider staff responded, and 122 reported that their program had served at least one CT case in the past year. In December 2015, DMA electronically administered the 25-item Year 2 survey to 250 providers. One-hundred nine providers responded, and 99 reported that their program had served at least one CT case in the past year.
- iv) Parents/caregivers. DMA administered a 31-item survey to parents/caregivers whose youth were receiving services at the time of survey administration and those who had previously received CT services. For the first parent/caregiver survey, DMA created a survey flyer in English and Spanish, which was indirectly disseminated to parents/caregivers through providers and others due to the lack of parent/caregiver

email addresses. Fifty-three parents/caregivers responded to the survey. Of those, 50 (94%) used the English version. More than half of respondents' children received services from DCF (59%), 34% received services from DMH, and 8% received serviced from both agencies. Forty percent of respondents' children received Continuum services, 31% received group home services, 29% received residential school services, 6% received Follow Along, and 4% received Stepping Out. Thirteen percent of respondents were unsure which CT service(s) their child received.

D. Network Management Tool

The Caring Together Network Management tool is intended to (a) monitor quality assurance relative to contractual requirements outlined in the Caring Together Joint Standards, and (b) gather data as required by Title IV-E reporting regulations. Providers complete the tool annually, reporting on the previous fiscal year, which runs from July 1 through June 30. For FY 2015, 53 out of 63 contracted CT providers (84%) completed the tool. Providers completed the FY 2016 tool in July 2016, and DMA will include the findings in the next semi-annual report.

E. Provider Record Reviews

DMA receives data from the Caring Together Provider Record Reviews on a monthly basis. The reviews include ratings on adherence to standards for individualized treatment plans (comprehensiveness of the plan, use of natural supports, strength-based treatment planning, family and youth involvement in treatment planning, and stability of the treatment team) and quarterly individual treatment plan reviews (frequency of reviews, family and youth involvement, implementation of findings from last review). CTCS teams reviewed 599 records for 94 sites between January and June 2015, and 681 records for 124 sites from July 2015 to June 2016.

F. Performance Measures

DMA is continuing to work with DCF on developing and implementing performance measures for use in monthly and quarterly reports. DCF has developed a software tool to provide the performance measurement data in a more interactive format. At present, 8 of the 12 measure categories have been fully developed and incorporated into the interactive tool, accessible to program leadership for oversight. To date, DMA has analyzed the performance measure data from January 1 to December 31, 2015.

3. Analysis Methods

The Process Evaluation includes both qualitative and quantitative descriptive data analysis strategies. Qualitative data from the interviews, focus groups, and surveys were coded according to theme and content. Quantitative data from (1) staff, provider, and parent/caregiver surveys; (2) the Network Management Tool; and (3) CT Provider Record Reviews were analyzed using basic descriptive methods, such as frequencies and mean scores, and as repeated measures where applicable.

A. Interviews and Focus Groups

Notes from interviews and focus groups were reviewed and summarized semi-annually. Findings from the focus groups and interviews are included in the results section below.

B. Annual Surveys

Questions solicited feedback from respondents regarding their experience with Caring Together integrated services and integrated regional management. Most items used a four-point Likert scale to assess respondent agreement with statements (*1 = strongly disagree, 4 = strongly agree*); there were also items that solicited open-ended responses. Throughout this report, general disagreement refers to “Strongly Disagree” and “Disagree” and general agreement refers to “Agree” and “Strongly Agree.”

The descriptive survey results and comparisons are not intended to imply statistical significance. While survey responses cannot be generalized to all providers, DCF staff, DMH staff, or parents/caregivers, they nonetheless provide important information about provider and staff perceptions and may provide clues to the changes that may be occurring.

C. Network Management Tool

DMA analyzed the Network Management data in aggregate and assessed strengths and areas for improvement in the Caring Together system as a whole. In addition, CTCS teams examined each provider’s data to inform ongoing quality improvement efforts and promote any promising practices; however, individual provider data is not reported here.

D. Provider Record Reviews

Records were reviewed for their adherence to specified criteria and given a score of 2 (met standard), 1 (partially met), 0 (not met/missing), or N/A (not applicable). For each criterion, the number and percentage of records in each category was calculated.

E. Performance Measures

The performance measures include enrollment data, percentages of youth with a completed CANS at entry and exit, and mean length of stay.

4. Results

Using the interview, focus group, survey, and DCF administrative data, the evaluation team has assessed Caring Together’s progress to date in addressing the Process Evaluation’s three core research questions. The results section includes detailed responses and supporting data to address the three key research questions. Additional data is provided in the Results Attachment.

A. Key Question 1: How are Caring Together integrated services working?

There are four key types of measures that the evaluation team has focused on to assess how CT services are working, including: (1) a timeline of the key implementation steps and relevant events that have affected CT implementation, (2) enrollment data, (3) length of stay, and (4) staff, provider, parent/caregiver, and youth perceptions of CT implementation.

- i) Timeline. The timeline was created using information gathered through key informant interviews, IV-E Executive Team meetings, evaluation team meetings, and document reviews. It provides a visualization of the key events and contextual factors leading up to CT implementation and during the first two and half years following implementation (see Results Attachment).

Pre-implementation. The DCF and DMH Commissioners began planning for Caring Together in 2008. In 2011, Title IV-E Waiver Demonstration projects were signed into law, authorizing up to 10 demonstration projects FY12-14; MA's Title IV-E Waiver proposal was submitted in July 2012. The Caring Together RFR was released in August 2012, and the first CT contracts (for redesigned congregate care, Follow Along, and Stepping Out) went into effect July 1, 2013. By October 2013, DCF intake counts were increasing, following a set of high profile child fatalities.

Implementation. As the Title IV-E Waiver took effect in January 2014, DCF intake counts and placement numbers continued to increase. That month, the Commissioner issued a "directive requiring all Area Offices, when there is a reportable condition, to 'screen-in' for investigation any report alleging abuse or neglect of a child five years of age or younger in which the parent(s) presents" with certain risk factors. This continued to increase the numbers of children in custody. CTCS teams were close to being fully staffed when additional CT contracts (for Continuum, STARR, and Teen Living) were executed in July 2014. DCF and DMH signed an MOU in October 2014, and in December 2014, there was a Caring Together Kickoff conference.

In 2015, there were a number of significant changes in leadership: a new governor took office in January; a new DCF Commissioner was appointed in February; in June, the Director of Caring Together and the Assistant Commissioner for Planning and Program Development retired; and the Caring Together Assistant Director for Performance Management assumed role of Interim Director of Caring Together in July. Also in 2015, Caring Together launched the Family Partner Pilot and the Level of Service Review Process Pilot. The Family Partner Pilot has since expanded, while the Level of Service Review Process pilot has ended.

Discussion. The timeline highlights two challenges that have impacted CT implementation: changes in leadership and reduced risk tolerance within DCF.

- Changes in leadership/Vacancies in executive leadership. CT focus groups and interview data suggest that the leadership changes over the past year have had a notable impact on implementation efforts, with respect to ensuring clarity of roles, supporting and promoting CT services, and working to achieve CT's joint governance goals. In addition, after Governor Charlie Baker took office on January 8, 2015, he issued a hiring freeze for all state positions, excluding direct care positions like social workers. Caring Together also experienced major staffing changes resulting from the implementation of the Early Retirement Incentive Program in June 2015. To date, the DCF Assistant Commissioner for Planning and Program Development position and the DMH Deputy Commissioner for Child and Adolescent Services remain vacant.

- **Reduced tolerance of risk** - In fall 2013, the tragic death of a child whose family had an open DCF case brought intense media and oversight attention to DCF. As a result, DCF initiated a new directive to ensure safety, particularly in cases involving young children whose families were facing multiple challenges. The directive resulted in more abuse and neglect reports being screened in, leading to increased case openings, which in turn led to increased caseloads and numbers of youth in placements. Not surprisingly, case workers were concerned about the directive, the firing of DCF staff involved in the case, and the intense negative media attention that the Department received. Many respondents reported that that the department became more risk averse and less likely to look toward innovative services such as Follow Along, Stepping Out, or Continuum, which aim to divert youth from placement or return them more quickly to the community.

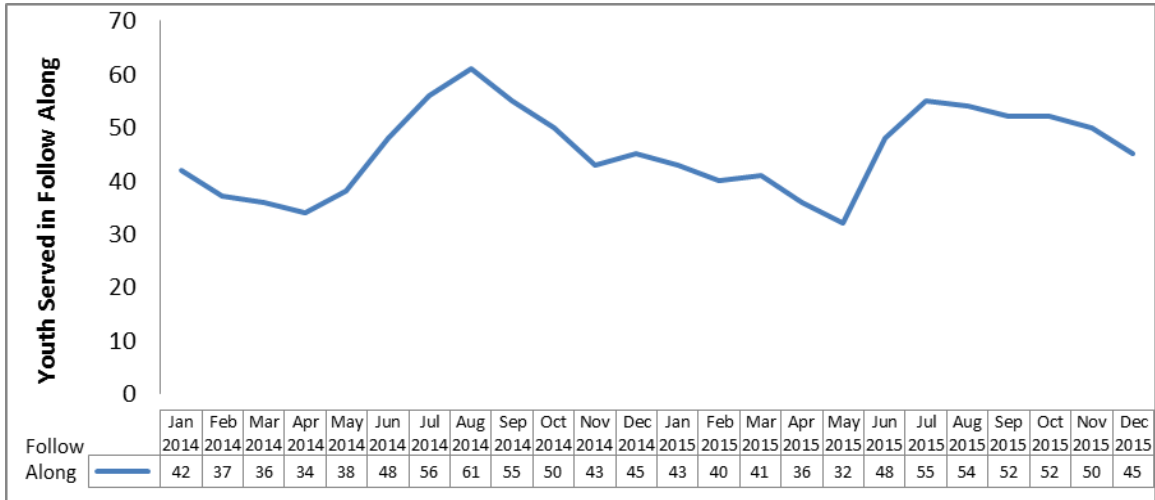
As a result, placement in congregate care grew, and social workers across the state are reporting difficulty in finding placements for youth in DCF custody. Multiple providers lack capacity of beds in all levels of care. CTCS teams are now spending time troubleshooting referral and placement issues for DCF offices and are finding it difficult to focus on quality improvement initiatives with providers. In an effort to address the issue of high caseloads, DCF has implemented an Agency Improvement Leadership Team to look at all the ways the system is impacted by high caseloads, assess what the needs are, and work toward developing solutions that will be most impactful in the shortest amount of time. DCF has evaluated its policies and made changes or created new ones to create a better procedure for the work, including a new Intake Policy and Supervision Policy.

DCF recently revised its organizational structure by re-instating the Central Region within DCF. In 2010, DCF shifted from six to four Regional Offices to maximize efficiencies. In so doing, they created one very large Western Region, and in 2016, this decision was reversed to bring back the Central Region and provide additional field support. DCF has also expanded capacity in its emergency placement model, STARR, in order to address some of the issues related to the lack of placements across the state.

- ii) **Youth served.** Between January and December 2015, 17,887 children were in DCF custody, and 2,577 (14%) received one or more CT services. Enrollment data indicate that Follow Along and Stepping Out have not served as many youth as initially anticipated, and the number of youth receiving congregate services has increased.

Follow Along. Enrollment in Follow Along has fluctuated since implementation, but has not changed dramatically since then (Figure 2). Monthly enrollment increased 7% from January 2014 to December 2015, from 42 to 45. In 2015, 167 youth received Follow Along services. The original estimate from the Title IV-E Waiver evaluation plan submitted in August 2013 was that DCF would serve approximately 582 children with Follow Along each year, so enrollment in Follow Along is significantly lower than the original estimates.

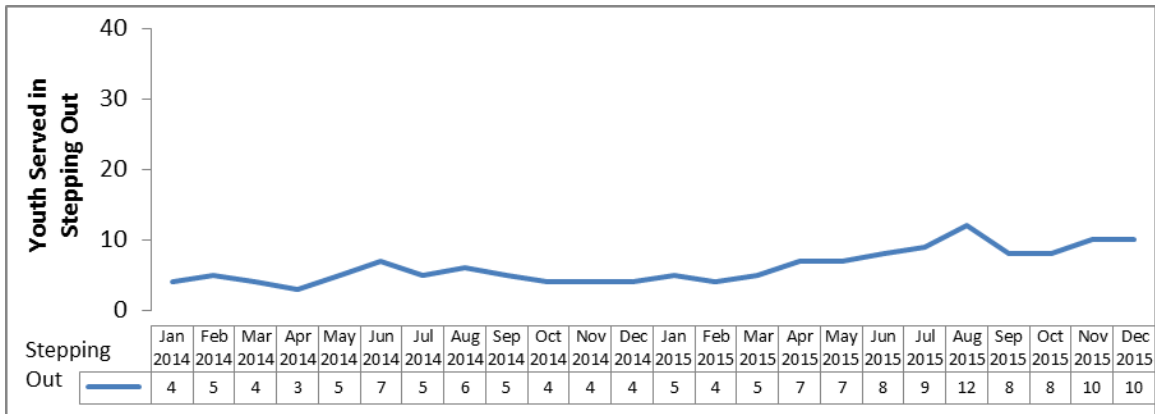
Figure 2. Youth served in Follow Along by month, January 2014-December 2015.



Source: DCF Caring Together Performance Measurement tool, data as of June 2016.

Stepping Out. Enrollment in Stepping Out increased from 4 youth in January 2014 to 10 youth in December 2015 (150%), but remains much lower than anticipated (Figure 3). The original estimate from the Title IV-E Waiver evaluation plan submitted was that 93 youth would receive Stepping Out each year; however, 23 youth received Stepping Out services in 2015.

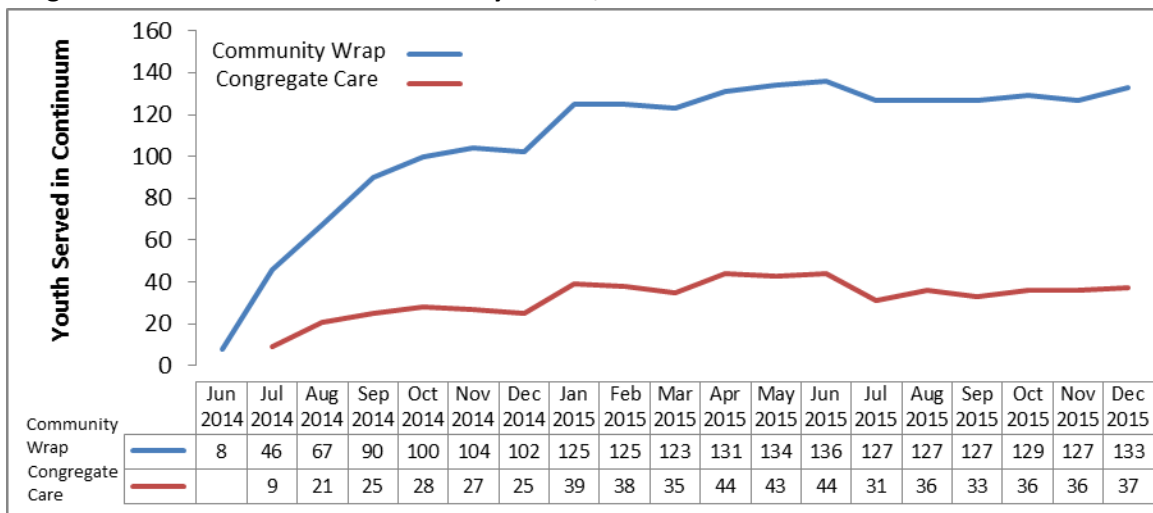
Figure 3. Youth served in Stepping Out by month, January 2014-December 2015.



Source: DCF Caring Together Performance Measurement tool, data as of June 2016.

Continuum. The number of youth served in Continuum Community Wrap increased steadily from June 2014 to January 2015 before leveling off (Figure 4). Enrollment in Continuum congregate care paralleled enrollment in Continuum Community Wrap. In 2015, 262 youth received Continuum Community Wrap services and 104 youth were in Continuum congregate care. Overall, Continuum enrollment has exceeded the original estimate of 175 youth per year.

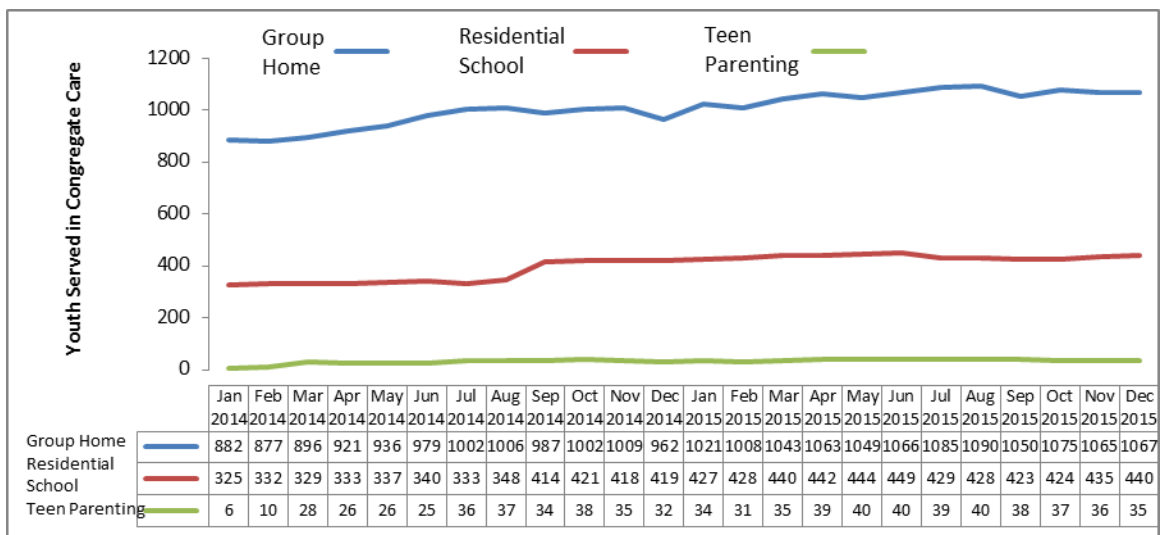
Figure 4. Youth served in Continuum by month, June 2014-December 2015.



Source: DCF Caring Together Performance Measurement tool, data as of June 2016.

Congregate Care. Enrollment in congregate care increased 27% from January 2014 to December 2015, but the majority of this increase occurred in 2014 (Figure 5). The number of youth served in congregate care increased 16% from January to December 2014, compared with a 4% increase from January to December 2015.

Figure 5. Youth served in congregate care by month, January 2014-December 2015.



Source: DCF Caring Together Performance Measurement tool, data as of June 2016.

With the exception of Continuum, the community-based Caring Together services have served fewer youth than planned, and enrollment in congregate care has increased. As a result, CT leadership are increasing their focus on Follow Along and Stepping Out services. They have held focus groups with providers on these topics and intend to develop a training plan that includes both models.

Family Partners. The Family Partner Pilot began on July 1, 2015, in eight DCF area offices; four offices were added in December 2015, so the pilot now covers a total of 12 area offices. From July 1- March 31, 2016, a total of 67 families were served.

Length of Stay. DCF's performance measurement tool monitors the length of stay in specific types of congregate care placement services (e.g., Group Home 1:4). The evaluation team is distinguishing between length of stay in a specific type of congregate care placement, a performance measure, and length of stay in a congregate care episode, an outcome measure. For this section of the report, length of stay in each type of congregate care placement service was assessed with two different measures: average length of stay for youth currently in congregate care at the end of the measurement period and the average length of stay for youth who have exited congregate care during the measurement period.

In tracking length of stay within Caring Together, the evaluation team anticipates an initial increase in time across quarters, because CT services only began in July 2013, and an increase in observation time naturally results in an increase in average length of stay, initially. In 2015 Q1, the maximum time a youth could be in a CT placement service was approximately 1.5 years (July 2013 – January 2015/March 2015), but by the end of Q4, the maximum possible time was almost 2.5 years. Over time, this effect should level out. Moreover, for a subset of youth the performance measurement system currently does not include the full length of stay in a congregate care placement for youth who were already in a congregate placement service when Caring Together services began. The start date of service for youth who received congregate care services prior to CT was reset when the new CT contracts went into effect in July 2014 for congregate care (i.e., the length of stay in pre-CT services did not carry over). Consequently, the potential length of stay for youth served in Q4 of 2015 may be approximately four quarters longer than those served in Q1 of 2015. In July 2013, there were 630 youth who had a Family Networks Service referral that became a Caring Together service referral. Of those, 327 youth were in Caring Together in 2015 through the present. DCF is working to quantify the effect of these 327 youth on lengths of stay in Q1 vs Q4, but have not yet completed this analysis.

To date, the CT performance measures are still in development. Table 3 presents the performance measure data on length of stay by type of congregate care as a preliminary view of the data, knowing the caveats referenced above, and conclusions should not be made at this time.

Group Home. The average length of stay for youth in Group Home 1:4 increased from 215 days in Q1 to 236 days in Q4. The average length of stay for youth in Intensive 1:3 also increased, from 238 days in Q1 to 251 days in Q4. The average length of stay for youth *exiting* Group Home 1:4 congregate care each quarter increased over the course of 2015, but the length of stay for youth exiting Intensive 1:3 remained about the same.

Residential. The average length of stay for youth in Residential School increased from 272 to 343 days from Q1 to Q4, while the average length of stay for youth *exiting* increased nearly the same amount from 260 days in Q1 to 329 days in Q4.

Table 3. Average length of stay in congregate care placement service, by type, for youth in and exiting congregate care by quarter, 2015.

	Average LOS for youth in congregate care				Average LOS for youth exiting congregate care			
	Jan-Mar 2015, Q1	Apr-Jun 2015, Q2	Jul-Sep 2015, Q3	Oct-Dec 2015, Q4	Jan-Mar 2015, Q1	Apr-Jun 2015, Q2	Jul-Sep 2015, Q3	Oct-Dec 2015, Q4
Group Home 1:4	215	227	225	236	199	189	252	234
Intensive 1:3	238	252	238	251	239	245	225	236
Residential School	272	298	321	343	260	278	325	329
Continuum Adjusted GH 1:3	103	118	136	194	80	118	101	199
Continuum Adjusted GH 1:3 Subcontract	89	87	79	71	137	77	78	58
Continuum Adjusted GH 1:4 Subcontract	61	90	139	210	36	-	7	109

n = 1,799 unique youth served in Group Home (including Group Home 1:4, Intensive 1:3, Intensive 1:1 Supported Living, Intensive 1:2 Group Home, Intensive 1:3 Group Home with Expanded Nursing, and Medically Complex Needs Group Home) in 2015.

n = 665 unique youth served in Residential in 2015.

n = 104 unique youth served in Continuum placement in 2015.

Continuum, Follow Along, and Stepping Out. The average length of stay for youth served by Continuum in 2015 and the average length of stay for youth *exiting* care fluctuated, in part because these services did not begin until July 2014 or later. Likewise, for youth entering Follow Along or Stepping Out, the average length of stay for their most recent congregate care placement did not exhibit a consistent pattern (e.g., large increases and decreases) in 2015 (Table 4). However, many fewer youth were served by these services than by group home or residential in 2015, and it is likely that the average length of stay each quarter showed so much variability due to the small sample size.

Table 4. For youth entering Follow Along or Stepping Out, average length of stay for most recent congregate care placement by quarter, 2015.

	Jan-Mar 2015, Q1	Apr-Jun 2015, Q2	Jul-Sep 2015, Q3	Oct-Dec 2015, Q4
Follow Along – Residential	348	314	340	405
Follow Along – Group Home	266	290	301	272
Stepping Out – Group Home	119	90	326	263
Stepping Out – Independent Living	393	339	339	211

n = 167 unique youth served in Follow Along in 2015.

n = 23 unique youth served in Stepping Out in 2015.

iii) Perceptions of the Caring Together implementation

CT leadership, DCF staff, DMH staff, providers, and CTCS teams. DCF staff, DMH staff, CTCS teams, and providers all agreed that the Caring Together vision was good, though there have been operational challenges around implementation.

Focus groups and interviews identified the following strengths:

- Caring Together has promoted system-wide standards of care and a uniformity of practice that allow for flexibility of care, while addressing individual needs. Through CT, the treatment planning process has improved, with more consistent treatment teams and greater family voice in the process.
- There is evidence of increased interagency collaboration as well as broader stakeholder involvement in designing and implementing Caring Together's joint system of care.
- Caring Together's community-based services are viewed positively and have enabled more high-risk youth to remain at home, despite low utilization for Follow Along and Stepping Out.

Focus groups and interviews also identified a number of areas for improvement:

- Numerous respondent groups commented that challenges related to joint governance between two agencies with different operational missions are impeding implementation efforts.
- Across respondent groups, there is concern that the statewide bed shortage is a key factor in driving placement decisions, with kids being stepped up or down according to bed availability. There is also a sense that level of care decisions and bed availability are changing the nature of residential placements, such that youth are "stepped up" to more intensive placements due to the lack of beds at the preferred level of care.
- There continues to be insufficient or inaccurate information at the consumer, provider and agency levels. As such, what Caring Together is and what services are available remain unclear across respondent groups.
- According to providers, joint oversight by DCF and DMH is creating duplicative reporting requirements, unclear assessment goals, and an unclear chain of command.

Further, survey respondents provided suggestions to improve Caring Together. In both Year 1 and Year 2, the two most frequently mentioned areas for improvement among providers were: more training for providers and DCF staff around CT requirements/objectives, trauma-informed care, referrals, and best practices, as well as streamlined documentation requirements.

Among DCF staff, in both Year 1 and Year 2, the two most frequently mentioned areas for improvement were: (1) more training with clearer expectations and (2) better communication and collaboration between programs, CT, and DCF/DMH. In Year 1, 20% of DCF staff respondents reported that they wanted increased availability of and access to services, but this request decreased to 7% in Year 2.

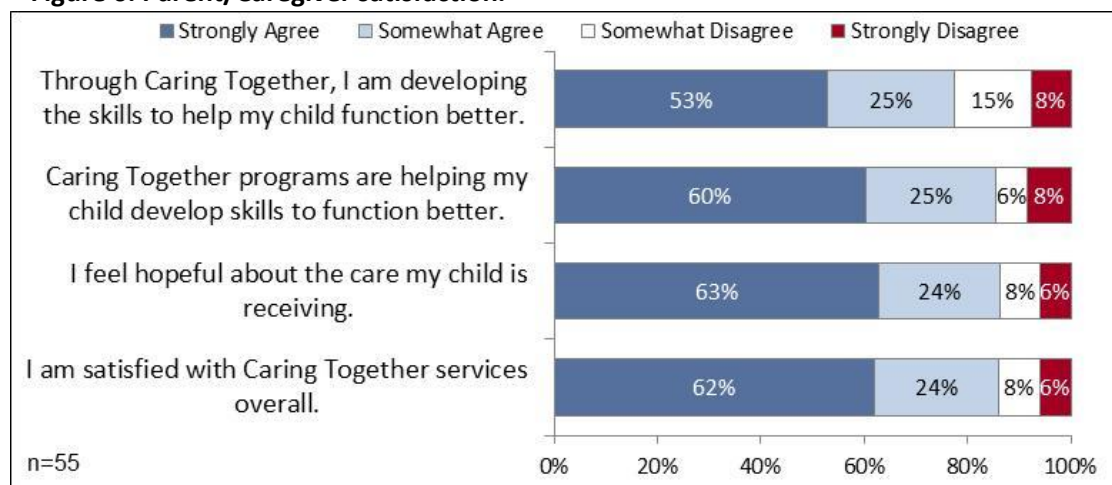
The three most frequently mentioned areas of improvement among DMH staff (Year 2 only) were: (1) services implemented consistently, promptly, and in accordance with contracts; (2) availability of/access to services; and (3) greater availability of respite.

CT leadership and DCF staff reported that at times some of the joint requirements have complicated interagency relationships, even impacting those areas that have traditionally worked well. For instance, DMH leadership reported that despite joint responsibility, investigations of provider complaints about abuse or neglect often only involve DCF in discussions with providers.

However, in pursuing better collaboration and joint governance, DMH CT leadership reported that they are now having regular meetings with the Commissioners every other month, in line with the goals of joint governance. DMH CT leadership also reported the creation of several working groups, including an outcomes and a documentation group. The latter is working to develop recommendations on how to reduce duplication and redundancies in reporting.

Parents/caregivers and youth. The parent/caregiver survey and focus groups with parents/caregivers and youth were used to assess how families experienced the Caring Together implementation. More than 85% of parents/caregivers were satisfied with CT services overall, felt CT programs were helping their child develop skills to function better, and were hopeful about the care their child was receiving (Figure 6). In addition, parents/caregivers reported that CT worked well in providing support to the family and teaching parents how to care and advocate for their child (Figure A-1, Results Attachment). Further, parent/caregiver survey respondents reported that Caring Together has increased family involvement and engagement, with some families now feeling more empowered to have a voice in their youth's placement and treatment decisions.

Figure 6. Parent/Caregiver satisfaction.



Source: Parent/caregiver survey, 2015.

Parents/caregivers also reported a number of ways in which CT has not worked well (Figure A-2, Results Attachment). In particular, 30% of parents/caregivers survey respondents reported not feeling involved enough or like they had enough of a voice. Parents/caregivers also mentioned that staff turnover and lack of experience was an issue, though this was only mentioned by 9% of respondents.

In focus groups, parents/caregivers reported struggles around accessing services. One focus group participant reported that a provider denied the existence of Caring Together, saying that “no one would admit that there was such a program between DCF and DMH.” Parent/caregiver accounts included difficult transitions from one service to another, inadequate or minimal communication with case workers, lack of clear decision-makers, lack of continuity of care, poor quality of care (e.g., providers ill-equipped to provide trauma-informed care, untrained staff, poor prescription management), insufficient treatment access, inadequate treatment planning, poor crisis management with an overreliance on emergency services, unwillingness to accept family and youth voice, and being unable to secure services from DCF or DMH when needed. In addition, several parents/caregivers described how residential placements across the state were placing undue financial and logistical hardship on family members.

Parents/caregivers raised many important concerns and areas for improvement, particularly around communication, access to services, and quality of care (Figure A-3, Results Attachment), but overall, the survey findings indicated that they had more positive than negative attitudes toward CT services.

Youth survey findings are not yet available, but in focus groups, youth raised similar issues and concerns as parents/caregivers. A majority of youth described not having consistent treatment teams, with a couple describing having developed close and trusting relationships with providers but then being forced to switch clinicians when they transitioned to Continuum. Some youth described not having a treatment plan. Others complained of not being involved in the process or not having a say in their treatment plan, with a couple describing their placement goals and others reporting that they do not have treatment goals and or a clear sense of where they might go or what work they need to do. Youth expressed a desire to hear from their DCF workers more frequently and to feel as though they care more as well as to be more involved in the treatment team and decisions.

Among parents/caregivers and youth, particularly for focus group respondents, quality of care and full family and youth engagement remain issues of concern.

- iv) Readiness to provide CT services. DCF has been providing trainings to DCF staff, providers, and others since the early planning stages of Caring Together in 2010. This ongoing training has covered a range of topics and continues through the present time. Training topics have included overviews of Caring Together, introductions to pilot programs (LOS tool, Family Partner Pilot), and service-specific trainings (Continuum, Follow Along). A summary of the trainings (by date, topic, and audience) is included in the Results Attachment (Table A-1).

DCF staff, DMH staff, and providers reported needing better training in what Caring Together is and what the services are as well as how to improve the quality of services. From Year 1 to Year 2, DCF staff and providers reported some improvement in feeling they had the training and/or preparation needed to integrate joint standards in their work.

In both Year 1 and Year 2, 43% of DCF staff respondents reported that trainings did not prepare them to manage services according to Caring Together values and principles. However, providers felt more prepared to deliver CT services in Year 2 than in Year 1 with 85% of providers reporting in Year 2 that the trainings they received prepared them to manage or provide services according to CT values and principles, compared to 69% of providers in Year 1 (Figure A-4, Results Attachment).

About 60% of DCF staff respondents reported that they did not receive sufficient training or orientation in how to improve the quality of CT providers (62% in Year 1, 57% in Year 2); 30% of DMH staff reported the same (Figure A-5, Results Attachment).

From Year 1 to Year 2, DCF staff and providers showed a slight increase in feeling they had the training and/or preparation needed to implement the joint standards (trauma-informed care, cultural competency, strengths-based treatment planning, and alternatives to physical restraint) in their work (Figures A-6 and A-7, Results Attachment). However, DCF staff members were still largely untrained in alternatives to physical restraint; 52% in Year 2 and 61% in Year 1 reported not having the training or preparation needed to integrate this standard into their work.

- v) Perceptions of Family Partners. Both agencies continue to believe in the importance of Family Partners. However, the implementation of the Family Partner service was delayed due to challenges in establishing a contract/payment structure for enlisting the current Children's Behavioral Health Initiative (CBHI) providers of this service. This situation was resolved by creating a pilot for this service, which began July 1, 2015. In the past six months, efforts have been made within the area offices to increase the number of referrals. These efforts include having the Coordinators of Family Driven Practice increase their involvement in the implementation of the service by attending meetings at the DCF area offices to review potential referral cases, as well as discussing the service with residential providers to promote referrals for youth already receiving Caring Together services. Second, DCF has suggested that area offices, in the case where a family might have initially declined the Family Partner service, discuss the service again with the family after the first 30 days of the youth being placed in the residential program.

In focus groups, parents/caregivers reported wanting more access to Family Partners. The 2016 parent/caregiver survey included items assessing experience and satisfaction with Family Partners, but these data have not yet been analyzed.

B. Key Question 2: How are the Caring Together integrated regional management teams working?

The Caring Together Clinical Support Teams are integrated, regionally based teams consisting of DCF and DMH employees. Each regional CTCS team includes:

- Clinical Supervisor (1)
- Integrated Practice Specialist (1)

- Clinical Social Worker (at least 1)
- Network Specialist (1)
- Coordinator of Family Driven Practice (1)
- Psychiatrist (1)

This section includes a detailed description of how the regional management teams are working, what role they serve, what aspects of their role are working well, and what areas need improving. The CTCS teams were originally created to:

- Review all referrals for Caring Together services based on a system wide Level of Service screening tool and accompanying documentation of need that were prepared by DCF area offices.
- Provide on-going utilization review based on treatment plans and telephonic case reviews as well as assist in reviewing provider documentation for Medicaid rehabilitation option claiming.
- Develop and implement continuous quality improvement plans with providers
- Assist providers and agency staff with clinically complex families.
- Ensure that providers are complying with all requirements of a family-centered organization.
- Provide training on the new system to state agency staff and to providers.

Since implementation, DCF and DMH have adapted the CTCS team roles, which now include the following responsibilities:

- Support and assist the DCF and DMH Area Offices and programs in assessing appropriate placement levels.
- Monitor quality improvement and provide feedback on processes to the DCF and DMH Area Offices and the providers. The CTCS teams oversee quality improvement plans and monitor the quality site review processes.
- Seek staff and provider feedback on the effectiveness of quality management. CTCS teams informally seek feedback on regionally-driven projects through program meetings and Advisory Councils.
- Ensure that all CT programs meet documentation standards pertaining to assessment, clinical formulation, treatment planning, and service delivery.
- Assess provider adoption of Building Bridges principles.
- Ensure services in the network are comprehensive and available. CTCS teams ensure that the network includes comprehensive services via Network Specialists and a streamlined contract review and approval process. To ensure the availability of services and beds, Network Specialists monitor and manage service referrals, facilitate the quarterly CT contract submission process, conduct ongoing capacity assessments, and assist with new program development for DCF and DMH.
- Support the team during placement emergencies, by helping to find placements for youth in emergency situations or when there are problems with providers accepting referrals.

In focus groups, CTCS team members expressed frustration with the different expectations communicated by each agency, the lack of standardization across regions, and the differences in operating procedures. They also expressed a need for more implementation time and conveyed frustration that they are “swimming upstream” unsupported. The CTCS team members feel that their expertise and insights are not appreciated, while DCF staff and

providers reported feeling that CTCS team members interfere with their process and historical working relationships, adding another level of communication. While the CTCS teams have been involved in ongoing management and quality improvement activities, their role remains unclear among DCF staff, providers, and CTCS team staff themselves. In interviews, focus groups, and surveys, respondents agreed that CTCS teams need more clearly defined roles, as they are currently duplicating some Area Office responsibilities.

DCF staff acknowledged that “they really don’t know all that CTCS does,” and CTCS team members expressed a desire for more clearly articulated job descriptions and a more well-defined understanding of what work they are empowered to do. CTCS team members want area offices to be clear about their roles, what meetings CTCS team members may attend and that team member feedback should be incorporated.

DCF and DMH staff survey respondents reported different experiences with the CTCS teams. Compared with DCF staff, DMH staff rated CTCS teams as being more responsive to requests for consultation around level of service placement decisions, help addressing contract compliance issues, and technical assistance (Figure A-8, Results Attachment). Also relative to DCF staff, DMH staff rated CTCS teams as being more collaborative around utilization management activities to ensure that youth/families access the right CT service to meet their individual clinical needs. However, DMH staff felt CTCS teams were somewhat less collaborative in ensuring CT services were provided at the right duration and intensity for the youth/family (Figure A-9, Results Attachment).

Efforts are underway to revise CTCS team job descriptions, but the process has been complicated by Union negotiations. Nonetheless, providers have reported that things are a little more settled in terms of how they work with CTCS teams and that the greater clarity is helping with the treatment planning process.

C. Key Question 3: Are Caring Together integrated services and management implemented/working as planned? [Fidelity]

- i) Provider challenges in accessing and coordinating community services. Providers have encountered a number of challenges in operationalizing CT’s community-based services, including challenges related to the low number of referrals for Follow Along and Stepping Out. A member of CT leadership commented that “we’re now over-engineering the system and putting extra onus on providers to meet both sets of standards. Providers are asked to follow two different assessment aims, though some providers have limited resources and do not have the capacity to reconcile all the different requirements. Providers no longer know who to call when things are not working.”

Providers also shared a number of issues with the CT community-based services.

- One provider reported that “it appears that DMH is using Continuum as its preferred placement choice. They’re not buying Group Homes outside of Continuum.” While another added that “Continuum has become a catch-all, if you’re not sure what to do, put the kid in Continuum.”

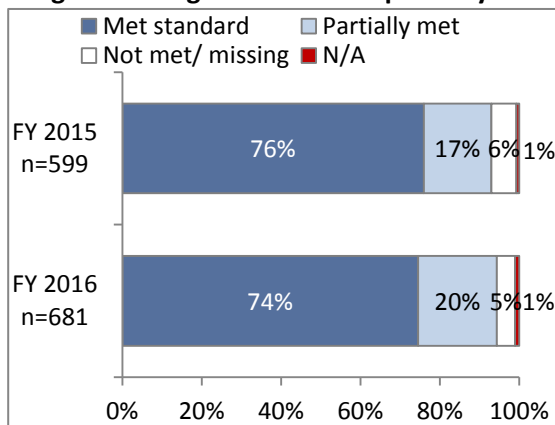
- Other funding offers some of the same services as Follow Along and Stepping Out, so providers are sticking with those. These include support and stabilization services and medical services in the Children’s Behavioral Health Initiative.
- The rate does not support the intensity and requirements of Follow Along and Stepping Out services.

Notably, about 30% of provider respondents (31% in Year 1, 27% in Year 2) reported that CT referrals were not appropriate for their program or level of care (Figure A-10, Results Attachment). However, provider respondents felt youth in or at risk of out-of-home placement had greater access to CT services in Year 2 (76%) than in Year 1 (69%) (Figure A-11, Results Attachment).

- ii) Provider adherence to CT program protocols. Overall, some Caring Together integrated services are being implemented as planned, as well as some aspects of the integrated regional management teams. According to CTCS team members, providers are working hard to ensure that treatment plans meet CT standards, and they are meeting the requirements of putting them on virtual gateway on time. Provider record reviews indicate that providers are generally adhering to standards for the development of individualized treatment plans (ITP). Most providers met or partially met the standard for developing an ITP within 30 calendar days of the youth’s enrollment and for updating it quarterly (Figure A-12, Results Attachment). In addition, most records (75% in FY 2015, 81% in FY 2016) met the standard that the ITP reflected the Clinical Formulation and the needs (goals) identified in the assessment(s) (Figure A-13, Results Attachment). However, DCF staff reported that providers are still not clear on the timeframe of submitting treatment plans and how plans are supposed to look.

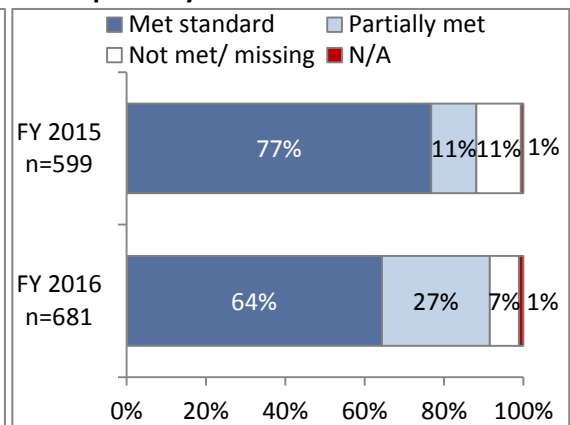
In addition, record reviews indicated that most providers met standards for conducting quarterly treatment plan reviews. About 75% of records demonstrated that the progress and current status in meeting the goals set forth in the ITP are reviewed quarterly (Figure 7). In FY 2015, 77% of records showed that the ITP (i.e., the youth’s goals and objectives, rehabilitative interventions and target dates for achievement) was revised according to the findings of the quarterly ITP review; 64%

Figure 7. ITP goals reviewed quarterly.



Source: Caring Together provider record reviews.

Figure 8. ITP revised based on findings of the quarterly ITP review.



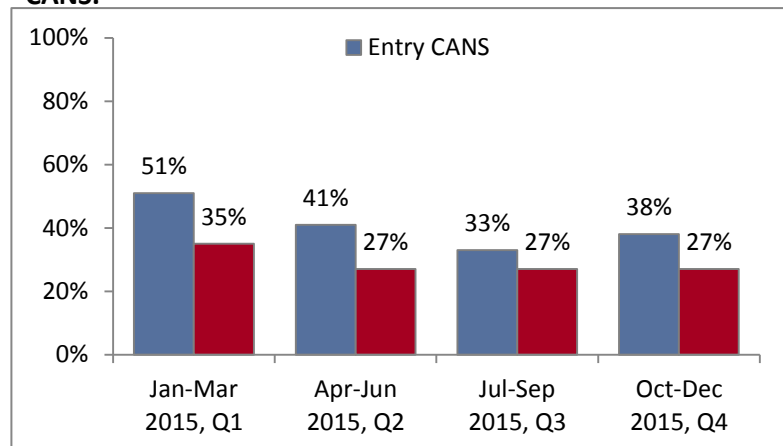
Source: Caring Together provider record reviews.

of records met this standard in FY 2016 (Figure 8). However, DCF staff reported that some providers attend review meetings without bringing treatment plans, which is the primary aim of the meetings. DCF staff also reported that some programs are resistant to providing certain services, such as transportation and visits home. They commented that families may expect providers to offer a particular service, while providers are instead limited by financial resources and distance.

The record review data indicate that overall, providers are meeting standards related to individualized treatment planning and quarterly individual treatment plan review, but focus group participants had many complaints about providers' adherence to program protocols. This discrepancy suggests that while focus group findings may have highlighted some important issues between providers and DCF staff, they are not representative of providers' performance overall.

With regard to CANS administration, performance measure data indicate that many providers are not following DCF standards. CANS administration was examined for youth entering and exiting CT. For youth admitted to CT, they were considered to have an entry CANS if they had a CANS completed within the prior 90 days or in the first 30 days for youth with a new entry to CT or a placement move (provider or level of care) within CT. Youth exiting were considered to have an exit CANS if they had a CANS completed within the eight weeks prior to discharge or in the first 14 days post discharge. Overall, the percentage of youth with entry and exit CANS decreased from first quarter of calendar year 2015 to the last quarter (Figure 9). Half (51%) of youth admitted to CT had an entry CANS in the first quarter, decreasing to 33% in the third quarter, and then increasing slightly to 38% in the last quarter of the year. Fewer youth received exit CANS; 35% of youth exiting CT had an exit CANS in the first quarter compared with 27% for the rest of the year.

Figure 9. Percentage of youth with completed entry and exit CANS.



Source: DCF Caring Together Performance Measurement tool, data as of June 2016.

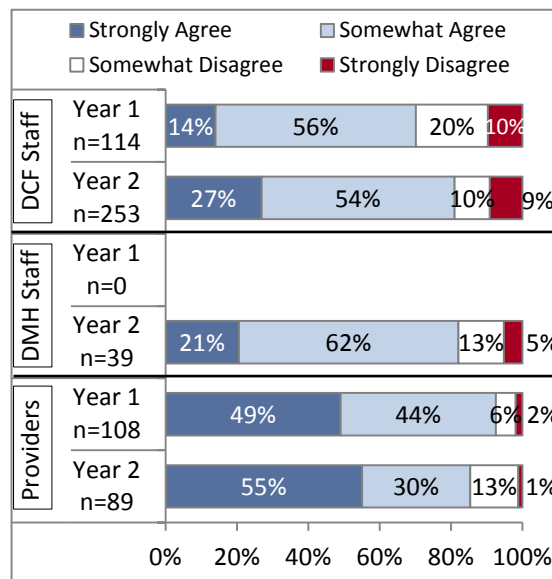
CT leadership have provided some insight into why not all youth have CANS data. DCF, DMH, and CBHI all use different versions of the CANS. In addition, providers cannot enter CANS conducted by other clinicians as part of the referral into the i-FamilyNet record, as this creates a false record that the CANS was conducted by the Caring Together clinician. There is currently no way to upload completed DMH or CBHI versions of the CANS into the i-FamilyNet record. As a result, CANS received as part of the referral are not being entered into the i-FamilyNet record at entry. Further, at exit, providers only have access to a client's record in i-FamilyNet for two weeks

following discharge, so there is short timeframe for them to enter the exit CANS data. In an effort to increase the CANS administration rate, DCF has conducted five different trainings on this topic, including recommending that providers begin entering exit CANS data in advance of the discharge. The evaluation team will continue to monitor the CANS completion rates.

Other key components of integrated services include comprehensive service planning and continuous and stable treatment teams that bridge transitions between congregate care and the community. In Year 2, 81% of DCF staff, 83% of DMH staff, and 85% providers agreed that treatment plans and processes were comprehensive (Figure 10). Compared with Year 1, DCF staff felt that treatment plans were more comprehensive in Year 2, while providers felt they were slightly less comprehensive.

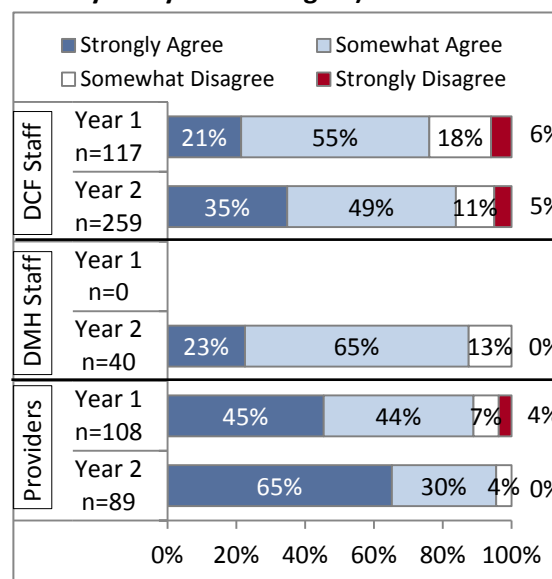
In Year 2, 79% of DCF staff, 85% of DMH staff, and 93% of providers agreed that the treatment teams in Continuum, Follow Along, or Stepping Out had at least one consistent key clinical service staff following and/or coordinating youth/families across residential and community-based care (Figure 11). However, 69% of parents/caregivers reported being able to work with a consistent clinical staff member when their child moved between residential and home treatment services (Figure A-15, Results Attachment). DCF staff recognized that there is room for improvement and reported that effort is being made to establish more consistent treatment teams (Figure A-14, Results Attachment).

Figure 10. Treatment plans are comprehensive (i.e., cover all domains of the youth and family's life that are relevant to the needs identified for focal treatment).



Source: Annual Caring Together Survey of DCF staff, DMH staff, and providers, 2014-2015.

Figure 11. Treatment plans are strength-based (i.e., treatment strategies build on family and youth strengths).



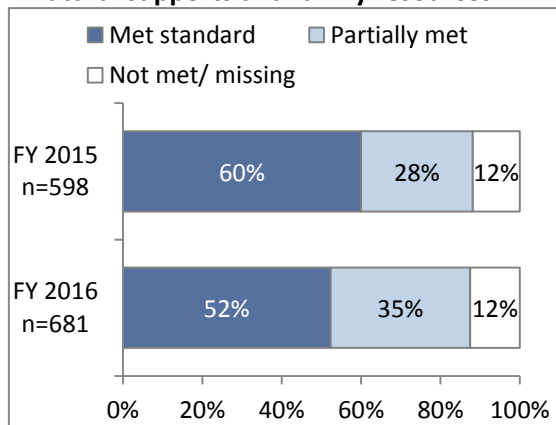
Source: Annual Caring Together Survey of DCF staff, DMH staff, and providers, 2014-2015.

- iii) **Adherence to CT Principles.** Overall, findings from the surveys, provider record reviews, and interviews and focus groups indicated that most providers are following guidelines for service in terms of focusing on family and child skill building, trauma-informed care, and providing culturally competent services that are family-driven and youth-guided.

Family and child skill building. DCF staff, DMH staff, and provider survey respondents indicated that treatment plans and processes were strength-based (Figure 11).

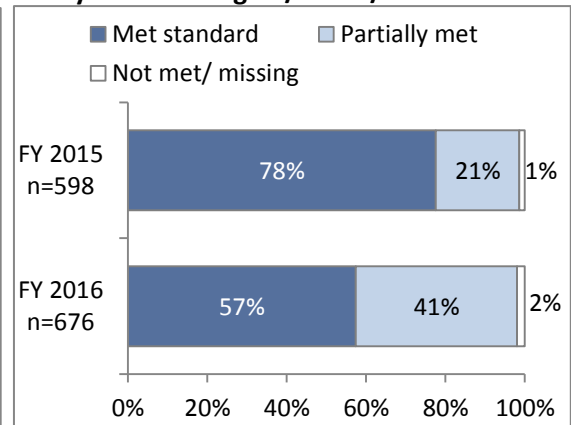
In addition, provider record reviews indicated that individual treatment plans reflected the use of natural supports and family resources, and considered the youth's strengths, needs, and barriers (Figures 12 and 13).

Figure 12. Treatment goals, objectives, and/or interventions reflect use of natural supports and family resources.



Source: Caring Together provider record reviews.

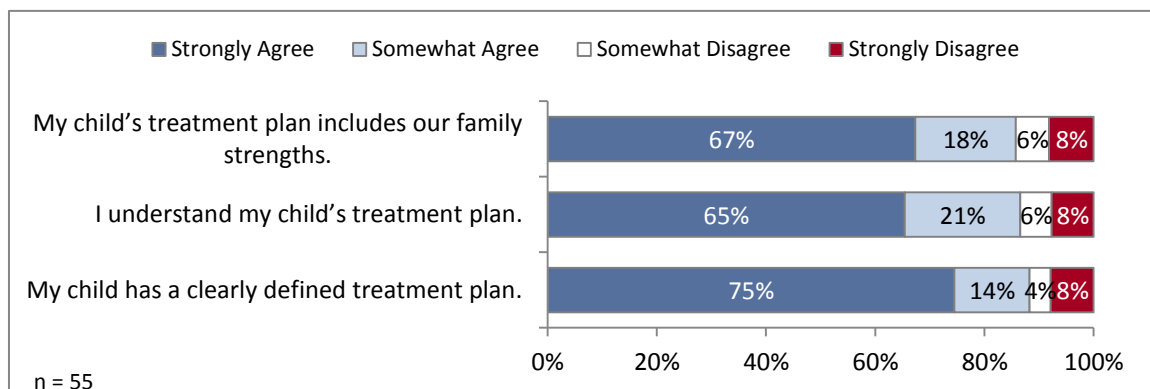
Figure 13. Intervention(s) and rehab strategies chosen take into consideration the youth's strengths/needs/barriers.



Source: Caring Together provider record reviews.

Parents/caregivers also reported that their child's treatment plan included family strengths (Figure 14).

Figure 14. Parent/Caregiver ratings of treatment planning.



Source: Caring Together survey of parents/caregivers, 2015.

Family-driven and youth-guided. Integrating family and youth voice into clinical and governance practices was a core CT postulate aimed at shifting the organizational culture to foster more effective family team meetings, more individualized treatment planning, and greater engagement of families and children.

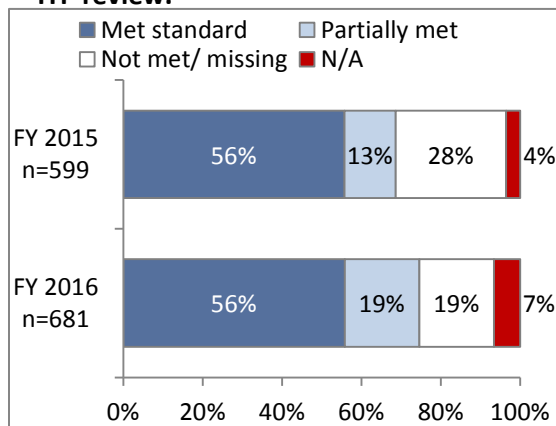
DCF staff, DMH staff, and providers indicated that treatment plans and processes were family-driven and youth-guided, but provider record reviews suggested room for improvement, at least in terms of including youth and parent/caregiver signatures on treatment plan reviews. Parent/caregiver survey respondents reported being engaged and involved in their child’s treatment (Figure A-19, Results Attachment), but focus group participants were more negative about their experiences.

More than 80% of Year 2 survey respondents (80% of DCF staff, 82% of DMH staff, and 85% providers) agreed that treatment plans and processes were family-driven and youth guided (Figure A-16, Results Attachment); this represented a slight increase from Year 1.

Similarly, provider record reviews indicated that youth and parents/caregivers were generally involved in treatment planning, as indicated by youth or parent/caregiver signatures on the treatment plan. Between 60% and 72% of treatment plans included youth and parent/caregiver signatures (Figures A-17 and A-18, Results Attachment).

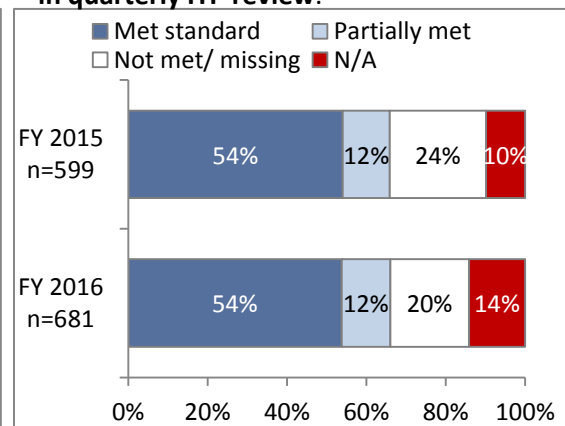
However, fewer records (54% - 56%) included youth and parent/caregiver signatures for the quarterly treatment plan review than did for treatment plan development (Figures 15 and 16). Further, one fifth to one quarter of records did not meet the standard for parent/caregiver participation in the quarterly review. Similarly, 28% of records did not meet the standard for youth participation in the quarterly review in FY 2015, but this decreased to 19% in FY 2016.

Figure 15. Youth participated in quarterly ITP review.



Source: Caring Together provider record reviews.

Figure 16. Parent/caregiver participated in quarterly ITP review.

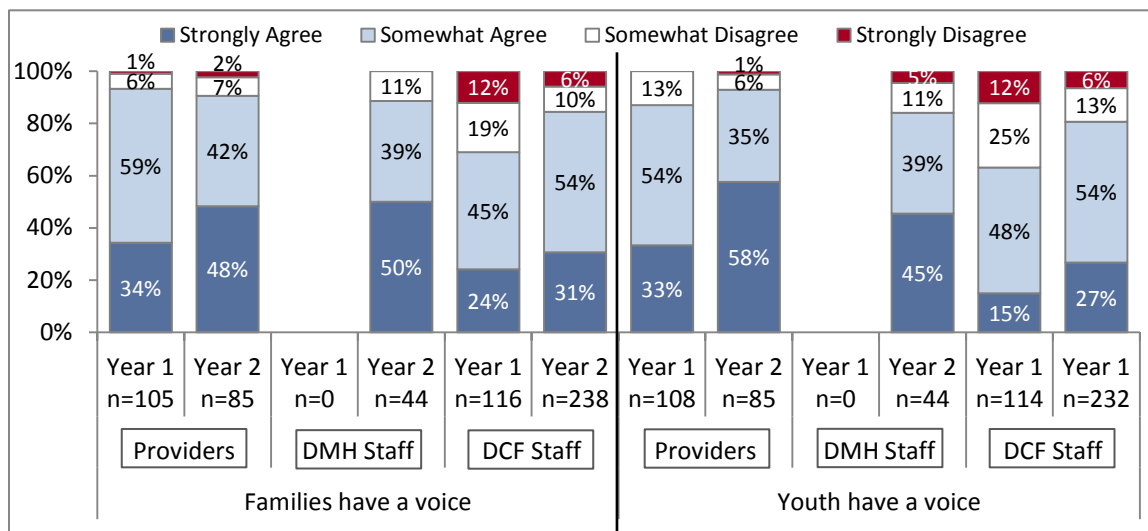


Source: Caring Together provider record reviews.

While missing parent/caregiver or youth signatures may be indicative of other factors, like providers overwhelmed by paperwork, some focus group participants reported feeling excluded from the treatment planning process. Parent/caregiver focus group respondents reported being generally dissatisfied with their treatment planning experiences, and youth focus group participants often described not feeling that they had a choice or a say in their treatment plans.

With regard to including youth and family voice in provider decisions on how the program operates, DCF staff reported that both youth and families had more voice in Year 2 than in Year 1; providers also reported increased youth voice (Figure 17).

Figure 17. Youth/families have a voice in provider decisions about how the provider plans and delivers its services.



Source: Annual Caring Together Survey of DCF staff, DMH staff, and providers, 2014-2015.

In addition, the Network Management survey indicated that 54% of providers included youth on advisory boards or committees where CT matters are addressed, and 52% of providers included family members on such boards or committees.

Despite some inconsistencies across sources in the degree of youth and parent/caregiver involvement, it appears that youth and parents/caregivers are included in treatment planning and given a voice more often than not; in fact, most parents/caregivers reported being engaged in and listened to about their child's treatment. Further, 85% of parents/caregivers felt they were being listened to and had a say in their child's treatment, 86% felt heard when they asked for help, and 94% were involved in their child's treatment (Figure A-19, Results Attachment).

Trauma-informed. Providing trauma-informed services and client-specific positive behavioral supports and interventions is another core CT postulate aimed at ensuring that children and young adults use more adaptive techniques during times of dysregulation so that they experience fewer crises, improved stability in congregate care, shorter lengths of stay in placement, and increased tenure in the community.

DCF and DMH staff reported that providers were sensitive to the influence of past trauma in assessment, care planning, and their use of behavior support strategies. In Year 2, 89% of DCF staff and 98% of DMH staff felt CT providers were sensitive to how past trauma influences youth behavior and use this knowledge in assessment and care planning (Figure A-20, Results Attachment). In Year 2, 85% of DCF staff and 90% of DMH staff felt CT providers used behavior support strategies shaped by an understanding of how past traumatic experiences can trigger problematic youth behavior (Figure A-21, Results Attachment).

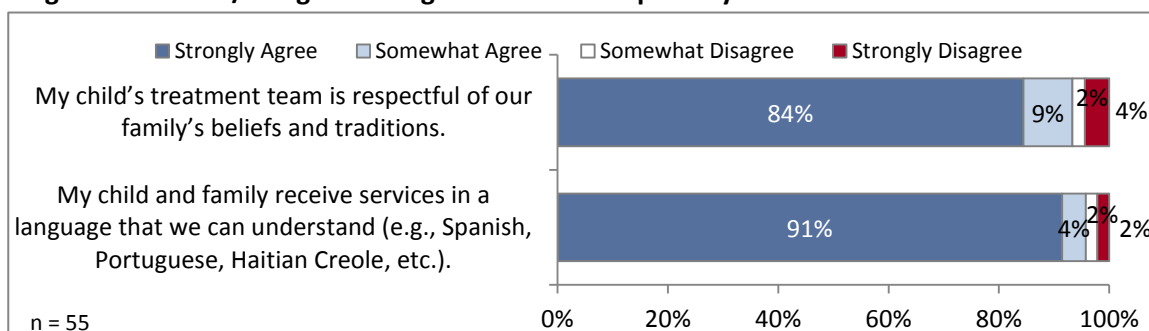
In addition, Network Management data indicated that providers were working to address the Six Core Strategies, including the following efforts:

- 1) Eighty-six percent of providers reported that organizational leadership reviewed restraint prevention plan activities and outcomes at least quarterly.
- 2) Ninety-one percent of organizations used restraint data to improve practice.
- 3) On average, each staff person completed 14.2 hours of restraint prevention training.
- 4) Fourteen percent of providers involved youth/families in the prevention of restraint, but 74% were working on involving youth/families.
- 5) Ninety-eight percent of providers conducted debriefings after a restraint, and 79% documented the debriefings.

The outcomes analysis will assess the extent to which youth experience fewer crises, improved stability in congregate care, shorter lengths of stay in placement, and increased tenure in the community, but these data indicate that services are trauma-informed and providers are using appropriate supports and interventions.

Cultural competency. Caring Together seeks to ensure that services are delivered by culturally and linguistically competent staff. In Year 1, 64% of DCF staff felt staffing for CT programs reflected the cultural, racial, and ethnic backgrounds of CT families, while 76% of DCF staff felt this way in Year 2 (Figure A-22, Results Attachment). Similarly, 56% of DCF staff felt staffing for CT programs reflected the linguistic differences of the populations they serve, but this improved to 76% of DCF staff in Year 2 (Figure A-23, Results Attachment). In addition, most parents/caregivers reported that they received services in a language they could understand and that their child's treatment team was respectful of their family's beliefs and traditions (Figure 18). It appears that services are, for the most part, being delivered by culturally and linguistically competent staff.

Figure 18. Parent/caregiver ratings of cultural competency.



Source: Caring Together survey of parents/caregivers, 2015.

The Outcome Evaluation

1. Key Questions

The Outcomes Evaluation will test DCF’s hypothesis that children receiving Caring Together services will experience better safety, permanency, and well-being outcomes than children receiving services under the pre-Waiver congregate care system. There are five primary outcomes evaluation questions:

- 1) How does Caring Together affect short-term outcomes for children in or at risk of congregate care? This includes:
 - a. The extent to which treatment plans are individualized?
 - b. Use of restraints on children?
 - c. Use of family and community assets to support community care?
 - d. Skills and resources of the children and their families?
- 2) How does Caring Together affect the intermediate outcomes of children in or at risk of congregate care? Specifically how do Caring Together services affect:
 - a. Placement stability in congregated care? Stability once returned to the community?
 - b. Child risk behaviors?
 - c. “Transitional crisis” reactions when children return to the community?
- 3) Does Caring Together affect how long children are in placement? Specifically, compared to children receiving services prior to the Title IV-E Waiver, do children receiving Caring Together services have reduced lengths of congregate care placement?
- 4) How does Caring Together affect other distal outcomes of children served? Specifically, how do Caring Together services affect:
 - a. Permanency?
 - b. Tenure in the community?
 - c. Risk and rates of maltreatment once returned to the community?
 - d. Child well-being?
 - e. Family well-being?
- 5) How does Caring Together affect expenditures on services for children in or at risk of congregate care placement?

The evaluation team will use administrative child welfare data from FamilyNet, comparing eligible Title IV-E Waiver youth served during the summative evaluation period (2016-2018) to similar (matched) children from the historical population of kids in congregate care. The team will run a pilot test of the matching procedures and outcome analysis, comparing Title IV-E Waiver youth served during the formative period to historical matches in the Spring of 2017. This report includes a description of the methodology and preliminary descriptive data about eligible waiver youth served during the formative period (2014-2015), who will be the subject of the pilot study next spring.

2. Caring Together Population

The Caring Together population consists of youth at risk of or in congregate care placement in DCF’s child welfare system. This includes youth meeting the criteria for residential level of service who have not yet been placed (“at risk”) and who are served through Continuum services

rather than being placed in congregate care, youth in a congregate care setting (i.e., group home, residential treatment), and youth who are transitioning out of congregate care either back to their home or foster care placement (Follow Along) or to an independent living setting in the community (Stepping Out). The criteria for determining the need for an out of home placement involve assessing the youth’s behavior and ability to safely remain at home. This also includes identifying any specialized treatment needed to address a medical, developmental or behavioral concern. For the purpose of the Title IV-E Waiver evaluation, youth are excluded from the population if the only congregate service they receive is STARR, since STARR is a short-term assessment placement for either reunification or referral to other services and is not considered to be part of DCF’s congregate care system), or if they have substantial developmental delays, highly specialized needs, or severe physical disabilities (as identified by DCF program staff).

The Outcome evaluation includes two cohorts of Caring Together youth. The **entry cohort** is defined as **Title IV-E Waiver youth entering a congregate level of service** during the study period. This includes the large number of youth entering congregate care placement and also those that received a community-based treatment, through Continuum Wrap services (“at risk” of congregate care placement), Follow Along or Stepping Out. More specifically, after combining each child’s consecutive congregate level services into congregate level “episodes” (see detailed definition, pp. 44-45), we select the child’s first episode that begins during the study period (between 1/1/2014 and 12/31/2015 for formative period) for the entry cohort.

The **exit cohort** was initially defined to include youth exiting Caring Together from Continuum, Follow Along, and Stepping Out services, as it was anticipated most youth would use these services. Given the lower than expected utilization of these services, the evaluation team is re-assessing this definition, to include youth exiting congregate care whether or not they received Follow Along or Stepping Out. This approach will allow us to better understand the impact of the Title IV-E Waiver on all IV-E youth served by Caring Together – which includes redesigned congregate care and system level changes in addition to the new community treatment based approach. **For the purpose of this report, the exit cohort includes youth exiting a Caring Together care episode.** If the youth has more than one congregate level episode during the study period, we select the first episode that ends congregate level of service during the period (between 1/1/2014 and 12/31/2015 for formative period).

DCF program staff identified 3,390 youth as being in the Title IV-E Waiver, as of February 29, 2016. This number includes 3,247 youth with Title IV-E Waiver dates⁵ during the formative period (2014-2015) and 143 in the summative period (2016) (Table 1). Of the 3,247 youth served during the formative period, 2,127 were

Table 5. Caring Together Title IV-E Waiver Youth

Youth in Title IV-E Waiver (as of Feb 29, 2016)	3,390
Formative period (2014-2015)	3,247
Summative period (2016-2018)	143
Formative Period Study Cohorts	
Entry Cohort	2,127
Exit Cohort	1,824
Overlap Between Study Cohorts	
In both entry and exit cohort	1,166
In one cohort (entry OR exit)	1,719
Formative Waiver date but not in entry or exit cohort ^a	412

^aSome youth have a formative Waiver date, but are not in either cohort because the CT episode began in pre-Waiver period and lasted into 2016.

⁵ DCF staff review each youth to determine eligibility for the Title IV-E Waiver, and identify the date they became eligible. Title IV-E Waiver dates begin January 1, 2014, although some of these youth began receiving Caring Together services prior to the Waiver.

identified as being in the entry cohort, with Caring Together episodes beginning in 2014 or 2015. There were 1,824 youth in the exit cohort, with congregate care episodes ending in 2014 or 2015 (n=1,166 were in both entry and exit cohorts). There were another 412 youth with Title IV-E Waiver dates in the formative period but are not in the entry or exit cohorts because their CT episode began in pre-Waiver period and lasted into 2016.

A. Formative Caring Together Population: Descriptive Characteristics

Caring Together Title IV-E Waiver Youth are described in Table 2, including the entry cohort and exit cohort. Most youth in the Caring Together population are age 13-17 (69% in exit cohort⁶), and just over half are male (56%). Most youth are white (44%), Hispanic or Latino (29%) or black (18%). One quarter of the youth (24%) had been in a congregate care episode previously, excluding prior STARR or hospitalizations.

Table 6. Characteristics of Caring Together Title IV-E Waiver Youth
(Formative Entry and Exit Cohort)

Characteristic	Entry Cohort N=2,127		Exit Cohort N=1,824	
	N	%	N	%
Age				
0-5 year	19	1%	14	1%
6-12 years	486	23%	256	14%
13-17 years	1450	68%	1266	69%
18 years and over	172	8%	288	16%
Gender				
Female	949	45%	817	45%
Male	1178	55%	1007	55%
Race/Ethnicity				
White, NH	917	43%	808	44%
Black, NH	387	18%	329	18%
Hispanic/Latino	603	28%	528	29%
Other ^a	141	7%	103	6%
Race unable to be determined or declined	79	4%	56	3%
Prior congregate care episodes (excluding STARR)				
None, this is first	1635	77%	1379	76%
One or more prior congregate care episodes	492	23%	445	24%

*Other includes Native American, Asian or Hawaiian, or Multiracial (Non-Hispanic)

B. Summative Caring Together Population

In order to allow time for the full Caring Together intervention to become more stable, the Outcome Evaluation will examine youth served in the summative period, from 2016 to 2018. The Summative Caring Together Population will consist of Title IV-E Waiver youth entering (entry cohort) or exiting (exit cohort) a Caring Together episode from 2016 through 2018.

⁶ Text provides exit cohort %, which are similar to entry cohort. Both are provided in the table.

C. Historical Comparison Group

Outcomes for Caring Together youth will be compared to similar youth served historically, prior to CT implementation. This approach is necessary as a randomized controlled trial (RCT) was not proposed (or feasible) for this evaluation. In the absence of an RCT, we assume that there are differences in the characteristics of children receiving CT services during the Title IV-E Waiver period (intervention) and children served prior to the Title IV-E Waiver with congregate care services (comparison). These differences could lead to bias in estimating the impact of the CT intervention on the outcomes of children in the target population. In order to reduce bias, and thereby increase the rigor of the study, we plan to match children in the intervention group with children served prior to the Title IV-E Waiver period. Although it is convenient to think of the matching process as matching children, technically, an intervention child's congregate level episode from after the implementation of the intervention will be matched with another child's congregate care episode from before the intervention, based on characteristics at the start of the congregate level episode. We will refer to "child-episodes" to discuss the selection of matched congregate level episodes.

Matched child-episodes will be selected from a pool of congregate care episode associated with youth receiving congregate care services prior to the implementation of Caring Together. A challenge will be identifying exclusions in the historical pool. The evaluation team can easily identify youth receiving only STARR services and exclude them from the historical population, to be consistent with this exclusion from the Caring Together waiver population. However, identifying the subset of the congregate care population with substantial developmental delays, highly specialized needs or severe physical disabilities is a challenge. DCF uses a manual process of identifying which youth are eligible to be in the Title IV-E waiver, which it is only doing for the Caring Together population served from January 2014 forward. This approach poses a challenge to identifying similar youth in the historical population. It is likely that it will not be possible to exclude all historical youth with special needs (as defined) based on the administrative data. However, evaluators and DCF staff have discussed several codes that may potentially help identify some youth for exclusion, or as additional matching variables. In addition, we will examine characteristics of youth excluded from Caring Together in an effort to identify any additional variables that could be used to exclude similar youth from the historical pool. We continue to explore strategies to address this challenge.

D. Methodology for Matched Comparison Group

After reviewing alternate procedures, we expect to select matched child-episodes using propensity score matching. Although the design does not strictly allow testing for causality associated with propensity score matching, the propensity score provides a useful distance measure for matching congregate care episodes. Assuming a one-to-one match, the differences between the matched child-episodes, adjusting for any trends over time, can be used to assess the effect of the Title IV-E Waiver. Adjusting for trends over time can be done with linear regression, as part of the outcomes analyses, after matching has been completed.

The proposed matching variables include demographics (age, gender, race/ethnicity), service characteristics (e.g., permanency goals, custody status, region of the state), and covariates that may be related to outcomes (e.g., length of time in out-of-home placement prior to the start of CT or congregate care services, prior congregate care placements, time in placement,

and CANS scores assessing the child's strengths and needs). These data are available in FamilyNet. However, fewer baseline CANS records are available than expected. Given this, the evaluation team will evaluate a stratified matching approach in which: (a) child-episodes for youth with CANS are matched on demographic, placement, and CANS variables, and (b) child-episodes for youth without CANS are matched on demographics and placement variables. Also, for youth with CANS, the qualifying CANS (within 90/30 days) will be used or, if none meets the criteria, then the closest CANS available.

For this evaluation, we plan to match each treatment child-episode to one control child-episode (a one-to-one match). When matching, the control child-episode with the smallest distance may be somewhat different than the matched treatment child-episode. The analysis can use all matched child-episodes or be limited to those matches for which the distance is less than some critical distance. Because some analyses will focus on a cohort of children entering congregate care and some on a cohort of children exiting congregate care, the matching process will need to occur for both groups of child-episodes.

Once matching is achieved, an analysis of the outcomes will be conducted, entering each Caring Together child with his or her matched pre-Waiver child as a pair. Since the matching follows rigorous methodologies based on shared covariates of interest and because the outcomes analyses will include a variable accounting for the difference in time, such as years between the treatment and control children left care, any differences uncovered between the two groups of children will, more likely than not, be due to treatment effects rather than individual differences. The evaluation team will use SAS to perform the matching between Caring Together and pre-Waiver congregate care episodes for eligible children and to conduct the analyses.

The matching procedures will be finalized as part of the pilot study, using FamilyNet data provided by DCF. The pilot study will provide ample time to identify and resolve issues, while also preparing much of the code we will need to conduct the outcomes analyses for the final report. This pilot test, and the resulting code, will allow for a more efficient process when we conduct the outcomes study for the final report. The outcomes study team will obtain updated data files at the beginning of Year 6, update the code from the pilot test, and re-run file construction, data quality checks, matching procedures, and analyses with the outcomes sample.

3. Data Sources and Data Collection

Data for the Outcome Evaluation will come primarily from DCF's SACWIS system, FamilyNet, for all pre-Waiver and Caring Together participants. In addition, the evaluation team plans to obtain selected data from the MassHealth Massachusetts Behavioral Health Partnership (MBHP) data collection system for behavioral health and from a Family Partners project database that is being developed. Several intermediate outcomes will be assessed qualitatively through focus groups. Data sources were identified based on consultation with DCF staff. The evaluation team is assessing the quality of FamilyNet data and is discussing plans to obtain MassHealth MBHP data. Per the data sharing agreement, DCF has provided 13 FamilyNet data files on several occasions and will continue to provide the updated files in the beginning of each calendar year.

FamilyNet data used in this report includes data about service referrals (including Continuum, Follow Along and Stepping Out), placements (DCF congregate care, foster placements), non-DCF locations (hospitalization, non-DCF group homes or institutions, on the run), restraint incidents, demographics, and Title IV-E waiver status. Other data files are also under review and will be incorporated in the analysis file for the pilot study.

A. Outcome Measures

Measures for the outcomes study include measures of reduced use of restraint, improved stability (hospitalization, step ups, lateral moves, two or fewer moves), fewer child risk behaviors, reduced severity of “transitional crisis” reactions, reduced length of congregate care placement, improved permanency, increased tenure in the community after ending Caring Together services, and reduced risk and rates of subsequent maltreatment. The evaluation team is working to operationalize the measures using the FamilyNet data, developing and implementing detailed specifications for each measure in preparation for the pilot test of the outcomes analysis.

The outcome measures are based on entry and exit into a congregate care episode, and thus the team has worked to more specifically define a congregate care episode and where it begins and ends. The evaluation plan states: “The length of congregate care placement refers to the number of days children spend in a congregate care episode, which consists of one or more consecutive group home, residential, STARR, and/or hospital or institution placements, without any gaps in placement records lasting 14 or more days” (p.36). Youth in congregate care may have multiple consecutive congregate care level placements, moving between DCF group homes or residential placements, psychiatric hospitalizations, and non-DCF group homes or institutions. Some have absences from placement, such as time on the run or brief periods between congregate placements while waiting for an intake in another program. Others leave congregate care for foster homes or home and later return to congregate care. Using FamilyNet data, the evaluation team examined a series of scenarios and, guided by DCF, further specified a congregate care episode to mark the beginning and end of consecutive congregate care level placements. The evaluation team further defined a congregate care episode as follows:

- Beginning with a DCF congregate care placement (group home, residential placement) and including any consecutive group home, residential, STARR⁷ and/or hospital or institution placements (including non-DCF group homes and institutions).
- Occurring “without any gaps in placement records lasting more than 14 days.” If there are two consecutive congregate care placements with a gap between them and that gap lasts less than or equal to 14 days:
 - If end reason is youth returned home OR custody to other individual, it is the end of the congregate care episode.
 - If other end reason (e.g., new service referral), count the subsequent congregate placement as same congregate care episode. This provision accounts for a situation where (a) a program was shut down and the youth is waiting for an

⁷ The target population excludes DCF youth if STARR is the *only* congregate level service they receive. However, STARR placements, and also hospitalizations and non-DCF group home or institution placements, are included as part of the congregate care episode if they occur *after* a DCF congregate care placement and are part of a series of consecutive congregate level services.

intake into another program, went home for a week with plan to go back to congregate care, or (b) there is missing information.

- Including periods “on the run” (non-referral location record) from group home or other congregate care placement as part of a congregate care episode if it lasts less than or equal to 14 days, thereby treating the run like a gap in placement records. If the run lasts more than 14 days, the congregate care episode ends.

Using this definition, the analysis file will identify Caring Together Congregate care episodes and historical congregate care episodes. The file will also identify Caring Together episodes, which includes consecutive congregate care settings *and* qualifying community-based CT services (Continuum, Follow Along and Stepping Out). A Caring Together episode begins with a qualifying Caring Together community-based service (e.g., Continuum Wrap) or a congregate care setting, and ends with the last consecutive qualifying community-based service or congregate care setting.

4. Data Analysis

For the interim report, we conducted preliminary descriptive analyses to describe the Caring Together population and their congregate care experience. These analyses provide an early look at the data, as we continue to construct the analysis file. The data will inform discussions as we continue to operationalize the outcome measures. The pilot study will include preliminary data for each outcomes measure.

For the pilot study and final analysis, descriptive and multivariate statistics will be used to analyze outcomes, comparing outcomes for Caring Together children with matched children from the pre-Waiver period to test the hypothesis that children receiving Caring Together will have better outcomes than pre-Waiver children. The unit of analysis will be matched pairs of children’s congregate care episodes. Although the analyses focus on children’s congregate care episodes, it is important to note that most children are served with their biological, adoptive, and/or foster families, and some outcome measures pertain to their families. Linear regression analyses will estimate the difference between Caring Together and pre-Waiver children for continuous variables (e.g., average number of incidents). Cox regression will be used to test differences in time to event, examining both the timing and occurrence of key events (e.g., subsequent child maltreatment report, re-entry into congregate care). The Cox regression will use the matched pairs to define strata in the analysis. The Kaplan Meier procedure will provide a visual illustration of the time to event for each group (Caring Together, pre-Wavier). Conditional (or stratified) logistic regression will be used for categorical outcome variables (e.g. children receiving or not receiving Mobile Crisis Intervention responses), with the matched pairs used to define strata. In addition, we plan to test whether child strengths and needs change over time, using repeated measures analysis to examine change in CANS scores among the Caring Together population (not in the historical population, as post data are not available). Additional details about the outcome analysis are described in the Evaluation Plan.

A. Preliminary Results: Descriptive Data on Initial Congregate Care Experiences

Preliminary data regarding the Caring Together youth’s congregate care experiences are presented in this section, based on an initial analysis file. The preliminary data will inform

discussion of the continued construction of the analysis file and operationalization of each indicator. It is expected that some numbers will change as the team refines specifications to operationalize the measures and finishes constructing the pilot analysis file.

The evaluation will examine outcomes for an entry cohort and an exit cohort. The formative period entry cohort consists of 2,127 youth who began receiving a qualifying Caring Together service during 2014 or 2015; 891 (42%) of these youth remained in their congregate care episode as of May 2016. The exit cohort is comprised of 1,824 youth who left a Caring Together episode during the formative period (2014-2015). For both cohorts, if a child was in more than one Caring Together episode during the period, we select the first episode they entered (entry cohort) or exited (exit cohort) for the analysis.

The preliminary results indicate that youth have received a variety of Caring Together services (Table 7). Most youth spent time in a DCF congregate care placement (group home, residential, or teen parenting), including 90% in the entry cohort and 94% in the exit cohort.

Table 7. Services Received by Caring Together Title IV-E Waiver Children
(Formative Entry and Exit Cohort)

Congregate Level Services Received During First Formative Congregate Care Episode ^a	Entry Cohort N=2,127			Exit Cohort N=1,824		
	N	%	# times	N	%	# times
CT services received during the first CT episode						
Continuum Wrap	201	9%	1-2	85	5%	1-2
Continuum Congregate Care	94	4%	1-4	36	2%	1-4
Congregate Care ^b	1956	90%	1-5	1746	94%	1-8
Follow Along	129	6%	1-2	248	13%	1-3
Stepping Out	13	1%	1-2	24	1%	1-1
Non-CT locations during the first CT episode^c						
STARR	157	7%	1-7	124	7%	1-6
Psychiatric Hospitalizations	337	15%	1-9	351	19%	1-16
Non-DCF Group Home or Institution	69	3%	1-6	65	3%	1-10
On the Run	127	6%	1-10	136	7%	1-10

^aYouth often received multiple services, thus columns add to more than 100%.

^bExit cohort youth also received non-Caring Together congregate care, not presented here.

^cCount does not include initial STARR, hospitalization, non-DCF group home or institution, or run prior to the first qualifying DCF congregate level service.

In the entry cohort, 9% of the youth received Continuum Wrap services, whereas 5% of youth in the exit cohort received Continuum Wrap. The lower proportion in the exit cohort is to be expected for the formative period as some youth in the formative exit cohort began receiving Caring Together services before Continuum services were implemented. In the exit cohort, 13% received Follow Along services and 1% Stepping Out.

According to preliminary data, almost half (45%) of the Caring Together youth in the exit cohort spent more than a year in the Caring Together episode, and another quarter (28%) of youth were in the episode for at least 6 months (Table 8). The entry and exit cohort durations should not be compared, as a substantial number of entry youth are still in care, and some

have not yet been observed for a full year. In the pilot study, we will be able to follow all entry youth for the full 12 months. We will also use survival analysis to estimate the time to exit, including those who have not yet left. One-third of youth returned home or to the custody of another individual when the youth left the congregate care episode (Table 9).

Table 8. Caring Together Title IV-E Waiver Children - Time in First^a Caring Together Episode as of 5/2016 (Formative Entry and Exit Cohorts)

Duration in Episode	Entry Cohort N=2,127		Exit Cohort N=1,824	
	N	%	N	%
Caring Together Episode	2,127	100%	1,824	100%
Same day start and end	8	0%	8	0%
1-30 days	74	3%	62	3%
31-90 days	194	9%	172	9%
91-180 days	272	13%	267	15%
181-365 days	448	21%	514	28%
>365 days	240	11%	801	44%
Still in care	891	42%		
Congregate Care Episode^b	1,934	100%	1,748	100%
Same day start and end	12	1%	9	1%
1-30 days	73	4%	68	4%
31-90 days	184	10%	187	11%
91-180 days	268	14%	287	16%
181-365 days	403		486	28%
>365 days	195	10%	711	41%
Still in care	799	41%		

^a For Entry Cohort, the first entry into a CT episode during formative period. For Exit Cohort, the first exit from CT episode during the formative period.

^b Congregate care episode duration excludes time in Continuum, Follow Along, and Stepping Out, whereas Caring Together episode includes these community-based services as well as congregate care settings.

Table 9. Caring Together Episode End Reasons

End Reason ^a	Formative Exit Cohort - N=1,824	
	N	%
Returned home or custody to other individual	556	30%
New service referral, foster care ^b	217	12%
New service referral, other ^c	138	8%
Placement in non-referral location	226	12%
On the run >14 days	197	11%
Child 18 or older	169	9%
Services terminated as planned	159	9%
Custody to other agency	8	0%
Other end reasons	154	8%

^a The end reason associated with the last record in the Caring Together episode is provided, with the exception of Follow Along and Stepping Out services; for FA and SO the end reason associated with the prior record (e.g., congregate care) is provided.

^b New service referral, foster care refers to youth with end reason “new service referral” for whom the next placement setting occurs within 0-14 days and is foster care, family networks foster placements, or comprehensive foster care.

^c New service referral, other refers to youth with this end reason who do not have a foster placement within 0-14 days after.

A preliminary examination of several short-term indicators included use of restraints (Table 10) and psychiatric hospitalizations (Table 11) within 3 months and 6 months of the beginning of a Caring Together episode. According to preliminary exit cohort data, 30% of Caring Together youth experienced one or more incidents of restraints within 6 months of the beginning of the CT episode. Similarly, 28% of entry cohort youth experienced restraint within 6 months of entry. Two-thirds of the restraints lasted between 0 and 10 minutes, one-fifth lasted 11-20 minutes, and others lasted more than 20 minutes. Among youth in both the entry and exit cohorts, 8% experienced psychiatric hospitalization within 3 months of the start of Caring Together. In the exit cohort, 13% experienced psychiatric hospitalization within 6 months, with the number of hospitalizations ranging from 0 to 7.

Results from the pilot study, including these and additional outcomes, will be presented in a semi-annual report next year. In the final year, using data from the summative period (2016-2018), we will conduct the outcomes analysis to test DCF's hypothesis that children receiving Caring Together services will experience better safety, permanency, and well-being outcomes than children receiving services under the pre-waiver congregate care system.

Table 10. Use of Restraint on Caring Together Title IV-E Waiver Youth
(Formative Period, 2014-2015)

Use of restraints within 3/6 months of the start of Caring Together	Entry Cohort (N=2,127)				Exit Cohort (N=1,824)			
	Within 3 months		Within 6 months ^a		Within 3 months		Within 6 months	
	N	%	N	%	N	%	N	%
Proportion of children with one or more incidents of restraint reported	471	22%	594	28%	431	24%	543	30%
Number of restraints per child restrained	1-85		1-153		1-55		1-109	
Total number of restraint incidents	2,333		4,488		2,162		3,796	
Time youth spent in restraints								
0-5 Minutes	1,054	45%	2,038	45%	842	39%	1,515	40%
6-10 Minutes	619	27%	1,253	28%	590	27%	1,025	27%
11-20 Minutes	413	18%	768	17%	461	21%	782	21%
21-30 Minutes	95	4%	167	4%	111	5%	188	5%
>30 Minutes	84	4%	129	3%	145	7%	229	6%
Time not reported	68	3%	133	3%	13	1%	57	2%

^aFor the entry cohort, 6 month data are incomplete, as youth entering October to December 2015 were not observed the full 6 months. The pilot study will have the full observation for this subset of youth. All Entry cohort youth have been observed at least 3 months

Table 11. Stability: Psychiatric Hospitalizations Among Caring Together Waiver Youth
(Formative Period, 2014-2015)

	Entry Cohort N=2,217		Exit Cohort N=1,824	
	Within 3 months	Within 6 Months ^a	Within 3 months	Within 6 Months
Number with Psychiatric Hospitalizations	164	263	147	233
% with Psychiatric Hospitalizations	8%	12%	8%	13%
Among Youth Hospitalized:				
Average (Mean) Number of Psychiatric Hospitalizations	1.4	1.6	1.4	1.6
Standard Deviation	0.69	0.95	0.72	1.01
Range	1 - 4	1 - 5	1 - 4	1 - 7

^aFor the entry cohort, 6 month data are incomplete, as youth entering October to December 2015 were not observed the full 6 months. The pilot study will have the full observation for this subset of youth. All Entry cohort youth have been observed at least 3 months.

The Fiscal/Cost Study

The Caring Together Cost Study is focused on documenting changes in utilization and spending resulting from the Caring Together and Title IV-E. The study includes an evaluation of spending and utilization of services in Caring Together as a result of the Title IV-E Waiver's funding flexibility.

1. Key Questions

The Title IV-E Waiver Cost Study seeks to answer the following specific questions:

- 1) Is Caring Together costing DCF the same, more, or less per child than the previous program of congregate care?
 - i) Has Caring Together resulted in reduced utilization of more intensive levels of care (congregate care) and increased utilization of community services for child in or at risk of congregate care placement?
 - ii) What is the overall effect of Chapter 257 on provider rates for these services?
 - iii) Are Caring Together services being delivered to children, young adults and families for the same or lower cost per capita than the congregate care services for the pre-Waiver group after adjusting for extraordinary rate increases from Chapter 257?

In addition, the Evaluation Plan included the following research question if the state implements performance-based contracting:

- 2) What is the impact on providers of performance-based contracts with fiscal incentives?

DCF has recently indicated that it is not ready to pursue performance-based contracts with providers, due in part to existing structural issues, uncertainty around what outcomes to incentivize, and the need for additional analysis of the performance data and rate setting options.

2. Data Sources and Data Collection

DMA has worked closely with DCF to specify the Cost Study variables and data sources. DCF prepared a dataset for the period July 1, 2012 to June 30, 2015 that includes contract dates, agencies, programs, service models, rates, units, and total cost. DCF also provided unduplicated counts of youth in each specific service model by state fiscal year for the same time period. Preliminary results of the analysis of these data identified concerns about duplication of youth between some of the service categories. This confounds the comparisons between pre-and post-Waiver periods for one of the most important measures, cost per youth. As a result, DMA will work with DCF to identify unduplicated youth for categories of services and for the overall Title IV-E Waiver.

3. Data Analysis

DMA has conducted preliminary descriptive analyses, summarizing total cost by model and fiscal year. DMA examined pre- and post-Title IV-E Waiver spending and utilization. DMA looked at costs, units, and unduplicated clients for each service. Unfortunately, some of the duplication in youth receiving more than one service confounds calculations on cost per youth, so those data are not presented here. The costs and units overall and for each service category are summarized below.

4. Results

As shown in Table 12 below, the overall cost per unit increased by 6% in 2014 and then declined in 2015. The evaluation team also plans to examine the data at the level of units by service category or type because the lower cost units for community services (Follow Along, Continuum and Stepping Out) affect the data.

Table 12. Preliminary summary by total cost, units, and cost per unit for Caring Together services, FY 2013-2015

	2013	2014	2015
Total cost	\$136,809,354	\$157,952,095	\$180,476,119
Total units*	498,689	542,959	641,512
Cost per unit	\$274	\$291	\$281

* Units are defined as bed days for congregate care.

Table 13 outlines the cost per unit for each of the different service categories within Caring Together (Residential, Group Home, Follow Along, Continuum, and Stepping Out). From 2013 to 2014, residential cost per unit increased by 3% while Group Home costs showed an increase of 11%. Other costs for the CT community-based services were stable.

It was expected that there would be more substantial increases between 2013 and 2014 to 2015, because of the cost-based rate setting rules required by Chapter 257. However, the changes in and standardization of specific services appear to have moderated Chapter 257's impact.

Table 13. Preliminary summary by service type: cost per unit for Caring Together services, FY 2013-2015

	2013	2014	2015
Residential			
Cost	\$60,007,254	\$60,477,329	\$64,302,198
Units	205,263	201,835	207,176
Cost per unit	\$292	\$300	\$310
Group Home			
Cost	\$76,802,100	\$96,846,365	\$108,449,260
Units	293,426	331,186	374,582
Cost per unit	\$262	\$292	\$290
Follow Along			
Cost	0	\$573,636	\$914,760
Units	0	8,631	13,763
Cost per unit	-	\$66	\$66
Continuum			
Cost	0	\$0	\$6,731,196
Units	0	90	44,242
Cost per unit	-	-	\$152
Stepping Out			
Cost	0	\$54,765	\$78,705
Units	0	1,217	1,749
Cost per unit	-	\$45	\$45

The evaluation team will continue to analyze these data and address unduplicated youth and related questions in the cost analysis in coming months. DMA will summarize findings for the next semi-annual report.

Lastly, providers and others continue to express some underlying concerns that may put further pressure on rates. First, providers reported feeling that the rate setting process was not transparent, and while it raised rates in general, they consider some rates to be unfair, particularly for occupancy estimates. Second, Continuum rates were a factor contributing to Continuum's slow ramp-up. The Continuum payment design included: 1) a service payment paid for all children in Continuum, whether they were being served in the community or while in placement, and 2) a Continuum Adjusted (aka Skinny) Rate paid to the Group Home or Residential treatment program when a youth needs placement. This adjusted rate lowered the Group Home rate because the care coordination activities were duplicated between the home and the Continuum providers. To address this issue, DCF agreed to pay the full group home rate for children referred through the Continuum rather than the Continuum Adjusted Rate, effective January 1, 2015. DCF and the Continuum providers have been working to resolve this issue going forward and evaluate future rate options. In addition, one factor potentially contributing to low use of Follow Along services is that the model and pricing assumes that Follow Along rates will be paid to providers during the final month or two of placement. Area staff and others reported that this feels like a double payment and may inhibit referrals to Follow Along from DCF Area offices.

Summary, Lessons Learned, and Next Steps

1. Summary

The Title IV-E Waiver interim evaluation report provides a summary of the mixed method data collection activities designed to assess the implementation of Caring Together’s integrated services and integrated management teams, as well as the implications of flexible funding on service delivery, accessibility and overall service quality. CT promotes comprehensive treatment planning based on integrated family-driven, youth-guided, and trauma-informed care. Services are designed to ensure that congregate care and community-based services, including Follow Along, Continuum, and Stepping Out, enable youth to remain in the community or return home, thereby preventing congregate care episodes.

Over the past two and a half years, the evaluation team has developed an array of qualitative and quantitative data collection tools to support the aims of the Process Evaluation. To date, DMA has conducted eight stakeholder surveys: two DCF staff and provider surveys, one DMH staff survey, two parent/caregiver surveys and one youth survey. DMA received supplemental funding from DMH and DCF to add the DMH staff survey and the parent/caregiver and youth surveys.

DMA has conducted 20 stakeholder focus groups as well as 16 DCF and DMH leadership interviews and CTCS team interviews. The team has also conducted two rounds of the network management survey, worked with DCF to develop an interactive performance measurement tool and create a system for conducting monthly provider record reviews.

As part of the rapid cycle evaluation approach, DMA has presented preliminary data findings on several occasions to Caring Together leadership as well as to members of the CT Implementation Advisory Committee, including representatives from the Child Advocate’s Office and the EOHHS Secretary’s office, and to members of the Family Advisory Council.

With the formative Implementation Period behind us, the evaluation team will begin to assess whether youth receiving CT services experience different outcomes than those who received congregate care services during the five years prior to Caring Together. More specifically, the Outcome Evaluation seeks to determine if youth served through Caring Together have better permanency, well-being, community tenure, and safety as well as reduced out-of-home placements and rates of subsequent maltreatment. As part of the Cost Study, the evaluation team is working to assess whether CT is achieving its goal of cost neutrality.

The key Caring Together evaluation findings to date include:

A. Strengths

- Caring Together is having positive system-wide impacts, including increased family engagement and improvements in treatment planning and clinical practice.
- Across respondent groups, there is agreement and support for the Caring Together vision and the Building Bridges Initiative principles.
- Caring Together has promoted system-wide standards of care and a uniformity of practice that allow for flexibility of care, while addressing individual needs.

- There is evidence of increased interagency collaboration among leaders as well as broader stakeholder involvement in implementing CT's joint system of care.
- DCF and DMH staff and providers widely agree that CT trainings have prepared them to manage and/or provide services according to CT values and principles.
- Caring Together's community-based services are viewed positively and have enabled more high-risk youth to remain at home, despite lower than expected utilization of Follow Along and Stepping Out.
- Respondent groups widely acknowledged improvements to the treatment planning process, including increased parent/caregiver and youth involvement. In addition, there is evidence that treatment teams generally work well together, though consistency could improve.
- CT has increased parent/caregiver and youth engagement, with some families feeling more empowered to have a voice in placement and treatment decisions.
- Parent/caregiver survey respondents widely reported that CT is helping them to develop the skills needed to help their children function better as well as helping their children to function better, with the majority also reporting that they feel hopeful about the care their child is receiving.

B. Areas for Improvement

- Enrollment in Caring Together's congregate care services is significantly higher than planned while enrollment in the community-based services is lower than anticipated.
- A range of factors appear to be impeding enrollment at the desired levels, including a rate structure that does not fully support the service models, particularly for transportation related costs in Follow Along services.
- Risk management concerns need to be addressed through additional staff and provider trainings, particularly in the context of DCF's decreased risk tolerance. Leadership changes and concerns about youth safety have limited the agency's full adoption of CT principles and have made family engagement more difficult.
- DCF and DMH need to continue efforts to address joint governance and management as well as increase collaboration and coordination, while reducing operational redundancies. CT leadership needs to make a joint commitment to strengthen and support the CTCS teams.
- Length of stay and level of care oversight need to be addressed in order to ensure that youth served through CT receive the right level of care at the right time.
- There is an ongoing need for training across respondent groups. Providers, staff, and CTCS teams have expressed a desire for trainings on topics including trauma-informed care, CT requirements, best practices, and other topics. DCF staff reported an interest in trainings on joint standards around alternative to physical restraints.
- Caring Together needs to develop a comprehensive, multi-pronged communications plan and materials that will serve to educate DCF Area staff and expand enrollment and address any misinformation that exists about Caring Together.
- While parent/caregivers and youth report some increased involvement and voice, there is still room for improvement, as frustrations around accessing appropriate levels of services and quality of care persist.

2. Programmatic/Implementation Lessons Learned and Recommendations

A range of potential programmatic and implementation recommendations have emerged from the evaluation activities to date, including the following:

- CT has encountered a number of challenges related to joint governance and management, primarily with respect to aligning two agencies with different missions and operational approaches. The CTCS teams underscore these systemic challenges, as they represent the essence of joint management. CT leadership and CTCS team members need to take steps to foster team unity, operating in a manner not defined by the hiring agency but by CT's common operating and management principles.
- Given the importance of CT's community-based services to achieving the overall goals, CT leadership, providers and staff need to address low service utilization, particularly for Stepping Out and Follow Along, and identify strategies for overcoming financial issues.
- Length of stay in Caring Together services is potentially longer than desired, though preliminary data require further analysis to address a range of potentially confounding factors. CT leadership will need to address the length of stay issue, especially as it compounds problems with access and higher enrollment in congregate care, poor access, and spending increases.

In addition to the service-based recommendations, parents/caregivers offered a number of recommendations on changes they would like to see in order to improve CT implementation, service delivery and quality of care. Parent/caregiver survey respondents most commonly said they would like better communication (29%). Focus group recommendations included:

- Create a common treatment language across agencies and service providers.
- Improve the appropriateness of referrals both for program placement and for the right level of care at the right time, prioritizing regionally available services.
- Develop a concrete, system-wide approach to providing interpreting services.
- Create a checklist of available services and eligibility criteria, emphasizing those for transition-age youth.
- Establish more family-friendly services and a system for involving families in CT services, not just the youth being served, and make an effort to foster and support sibling relationships.
- Establish a more robust respite system, drop-in services, and day-hab services.

3. Evaluation Lessons Learned and Recommendations

As described above, a number of challenges have emerged to date in implementing and executing the evaluation, including a lack of name recognition for Caring Together, difficulty scheduling focus groups, and low response rates for parent/caregiver and youth surveys. The following are lessons learned from those challenges:

- Evaluation materials should reflect that not all respondent groups are familiar with the term Caring Together. Throughout the data collection period, lack of awareness and understanding of CT services has complicated participant recruitment among most respondent groups. To address this challenge, the evaluation team has removed most references to Caring Together from the data collection tools, instead referring to CT services by name (residential, Continuum, Follow Along, Stepping Out).

- The evaluation team needs to allow additional time for scheduling focus groups, particularly those for parents/caregivers and youth. DMA is working to broaden the pool of potential focus group hosts.
- Achieving an adequate number of parent/caregiver and youth survey respondents requires buy-in from providers and CTCS staff. In administering the 2016 parent/caregiver and youth surveys, DMA and CT leadership prepared providers to distribute the survey by sending instructions and holding a conference call to answer any questions. Similarly, DMA and CT leadership held a conference call with CTCS staff to review the surveys and the survey tracking form as well as to discuss how they could encourage providers to administer the surveys.

4. Next Steps

The Caring Together evaluation is entering an exciting phase, with the commencement of the Outcome Evaluation, the completion of the first youth survey, and the roll-out of the performance measure tool. In the coming months, the team anticipates the following next steps:

A. Process Evaluation

- Analyze the findings for FY 2016 parent/caregiver, youth, and network management surveys in fall 2016.
- Commence the Title IV-E Waiver Family Partner evaluation activities following completion of the Family Partner pilot and the forthcoming pilot evaluation.
- Administer a separate survey for CTCS team members in fall 2016, funded by DMH, which will provide unique insight into their evolving roles and perspectives.
- Analyze additional performance measure data as the interactive tool is completed.
- Continue to (1) conduct focus groups with DCF staff, providers, parents/caregivers, and youth; (2) interview CTCS team members and CT leadership; and (3) administer annual surveys of DCF staff and providers.
- Work with DCF to address confounding factors in the length of stay data and then complete a full analysis of available data.

B. Outcomes Evaluation

- Continue to work closely with DCF staff to operationalize all outcome measures, carefully assess the definition of the exit cohort for the purpose of the evaluation, and identify the optimal strategy to define the pool of eligible youth served historically.
- Finish the construction of the analysis file for the pilot study.
- Conduct the pilot matching process and finalize the matching plan.
- Conduct the pilot analysis, comparing Title IV-E Waiver youth served during the formative period to similar youth served historically, and finalize the analysis plan.

Much of this work will be completed once the updated data files are received in February 2017. The evaluation team anticipates reporting on finalized methods in the semi-annual report for the period ending in June 2017, and will provide a full report of the pilot study thereafter, likely as part of the December semi-annual report.

C. Cost Study

- Request unduplicated data for youth served by service type.
Conduct additional analyses to assess Chapter 257's impact on rates.