Pennsylvania's Child Welfare Demonstration Project

Final Evaluation Report

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EXECUTIVE SUMMARY

The terms and conditions state that the "State will conduct an evaluation to test the hypothesis that the flexible use of title IV-E funds to develop a new case practice model focused on family engagement, assessment, and the expanded use of evidence-based practices (EBPs) driven by local needs will lead to improved safety, permanency, and well-being outcomes for children and families involved in the State's child welfare system."

At the start of the evaluation, we realized that achieving one cohesive evaluation across all the participating counties would present a challenge. Each of the six participating counties presented a unique evaluation landscape with distinct intervention implementation strategies applied to a particular child welfare context. Moreover, the lack of a Statewide Automated Child Welfare Information System (SACWIS) and the mid-waiver changes to county-level information systems presented extensive data limitations. Working with four different information systems across six counties was very challenging, particularly when a county went from one developer to another. Finally, the child level evaluation of the impact of EBPs was compromised by the lack of an identifiable target group and the lack of an agreement with the contracted providers to provide data on the child and family receiving the EBPs. We have kept the state and ACF abreast of these challenges through the progress reports and the Interim Evaluation Report.

However, despite the challenges, we feel confident that the evaluation presents valuable information about the experiences of **participating counties**. Because we identified the challenges early, we deliberately strengthened the process aspect of the evaluation in order to provide rich evidence about what did and did not change in the six counties under the waiver; moreover, we tried to answer the questions, "what changed?", "for whom did it change?" and "how did it change?" What caused any changes, as in more flexible funds or other outside factors, cannot be determined from this design. Nevertheless, we feel that the process evaluation findings will answer important questions for the Commonwealth as the Family First Prevention Services Act (FFPSA) is implemented.

The State's Child Welfare Demonstration Project (CWDP) sought to accomplish the following statutory goals:

- Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth;
- Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth;
- Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.

The target population for the project was Title IV-E eligible and non-eligible children aged 0-18 who were: (1) in placement, discharged from placement, or who were receiving in-home services at the beginning of the demonstration period; or (2) who were at-risk of or who entered placement during the term of the waiver demonstration.

The ***process evaluation*** used an implementation lens in examining the planning, organizational and staff factors, and service delivery systems. Documenting the larger contextual factors was

also part of this evaluation component. The process evaluation focused primarily on counties' readiness to implement the CWDP interventions, implementation of the interventions, and fidelity of implementation.

The ***outcome evaluation*** was comprised of the following:

- An interrupted time series design in which county changes in key child welfare outcomes were tracked over time using child-level data from the multiple county child welfare administrative data systems and assessment and engagement data collected as part of this evaluation. The outcome evaluation addressed changes in the following outcomes;

    - Maltreatment recurrence
    - Likelihood of placement following maltreatment
    - Out-of-home placement rates per thousand children in the population
    - Rate of placements in congregate/institutional care settings
    - Rate of placements in kinship care settings
    - Placement stability
    - Length of stay in out-of-home care (time to permanency)
    - Reentry from permanency

- County-level evaluations of specific interventions in each of the participating counties. If clearly defined population and criteria are identified by the counties for which children and families receive the EBPs, then comparison groups can be created to compare outcomes at the child and family level for effectiveness of EBPs.

The ***fiscal evaluation*** answered the questions: Did expenditure patterns for out-of-home care change over the five years of the CWDP, and if so, were the changes related to changes in unit costs, care days or both? Did the ratio of out-of-home care spending to spending for prevention and family preservation change over the five years of the project?

Process evaluation

- Multiple significant statewide and county-specific policy and organizational changes occurred during the course of the waiver. These included changes in leadership at the state and county levels, amendments to the Child Protection Services Law (CPSL), implementation of the phases of Pennsylvania's Child Welfare Information Solution (CWIS), and numerous county-level CWDP team changes. These contextual changes have impacted not only the implementation of the CWDP, but have also affected the evaluation. New leadership needed to be oriented to the waiver and the evaluation; changes at mid-level management also meant continual training and re-training, not only for the waiver activities, but for the evaluation. Changes in the laws meant that attention was diverted from the waiver activities to the substantial changes in the laws for reporting child maltreatment.
- Leadership in participating counties generally made the necessary structural changes in order to accommodate the new practice model. These ranged from reorganizing staff to creating new positions, revising job descriptions, creating new training, making changes to the information systems, and making policy changes. Many of these were still in place at the end of this evaluation reporting period (July 2018), but additional changes occurred over the five

year period as counties worked through installation and making it part of practice. These are described in detail in the "mid-course corrections" sections of the report.

- While many of the necessary communication and leadership activities occurred early in the development and installation of the CWDP, two groups stood out as having gaps in their understanding of the project. First, while many direct service staff (e.g., supervisors and caseworkers) could articulate some of the overarching goals and/or knew that a practice change was part of the CWDP, there was often little understanding of the project as a whole and how the specific activities fit with the projected outcomes. Second, legal and JPO informants, while potentially the most influential in terms of external stakeholders, were the least likely to know about the CWDP or to have only a superficial understanding of it; as such, they didn't necessarily understand the need for collaboration.
    - At the end of the reporting period, there was little evidence that this had changed for JPO and legal staff, although the evaluation activities were not as focused on assessing collaboration with JPO and legal as they were in the initial phases of implementation. JPO staff were involved on some level in family conferencing, but higher level collaboration did not change over time.
- Multiple data sources in the first two and a half years (i.e., focus groups, key informant interviews, Organizational Readiness for Change survey) revealed a child welfare workforce that perceived communication from leadership to be low, while simultaneously experiencing a high level of stress in the work climate, as workers were trained on new assessments and engagement practices. Additionally, there was some wariness about the practice shifts, as many workers anticipated that these new practices would be replaced by other new practices in another few years. However, work force turnover, while problematic in many ways, worked in the favor of counties in that new workers accepted this new practice model: "they have nothing to compare it to" said one CYF director in an interview at the end of the period. At the end of the reporting period, the practice model had been in place a sufficient amount of time in all of the waiver counties to now be considered "practice" and not a demonstration project.

Implementation of assessment, family conferencing, and evidence based practices was challenging, as described below:

- *Assessment*
    - Workers were often frustrated by the difficulty in achieving competence in the CANS/FAST assessments, and many struggled with how to utilize the assessments in practice (e.g., how to have "conversations" with the family in a manner congruent with the assessment process). That continued to be an on-going practice challenge. Some counties tried using "prep" conversations (Allegheny) but it remained an area for improvement in all counties in terms of training workers to have a conversation with parents and families.
    - Families and children are being assessed using the CANS, FAST, ASQ, and ASQ:SE with variation among the counties. This was particularly true in the first two years (see the Interim Evaluation Report), and an inability to assess according to time frames led to changes in policies in several counties. Variation was also due to the different policies of which children were assessed and when. However, over the five

years, the volume of assessments increased (with the exception of Lackawanna, who decreased the volume).

- Samples of FAST, CANS, and plans were analyzed from the second year of the waiver until 2018 to examine congruence between needs, strengths, and plans. Evidence of strengths from the FAST and CANS were rarely seen in the plans, and this did not change during the waiver period. High need FAST areas most likely to be addressed in plans were family safety, caregiver mental health, substance abuse, child regulation skills and caregiver involvement. In terms of the CANS, high need areas most likely to be addressed in the plan were family functioning, residential stability and living situation, school functioning, psychosis, and conduct behaviors. Safety and housing needs, along with acting-out and school functioning were prioritized. In some counties, even at the end of the demonstration period, there was still a tendency for plans to be "cookie cutter" rather than individualized. Further, they rarely capitalized on family or child strengths.

- *Engagement*
  - Although family conferencing (i.e., Family Group Decision Making; FGDM) had been in place in Pennsylvania since the 1990's, it was not offered to all families. When conferencing with families became part of the practice model for this waiver, all of the counties had to increase the scale of their conference practice to accommodate the increase. In Allegheny, the model changed from FGDM to Conferencing and Teaming, and every caseworker had to be trained to facilitate conferences. Yearly facilitator surveys of all facilitators and coordinators verified that training and on-going coaching was occurring, but that they experienced barriers in implementing the practice pieces. From a structural perspective, executing the model was time-consuming, and it was difficult to implement the model within the proscribed time frames when caseloads and referrals were high; this was particularly true for Allegheny, where facilitators were case-carrying workers. A practice barrier was getting family participation and engagement in the meetings when families were resistant and uncooperative. This was a consistent challenge across all conferencing models. A structural approach of finding ways to include reluctant participants was to offer a "titrated" model of conferencing (e.g., one where it is parents only and no family time, with the goal of later widening the circle to include family and friends). However, even with these options, workers consistently reported that they struggled to get parents to attend and actively participate in the meetings.

  - Fidelity to the family conferencing models, as measured by a participant survey, as well as a sub-sample of observations, was strong. Further, fidelity remained fairly constant over the duration of the entire waiver period.
  - Parents or family attended the conference the majority of the time. The percentage of family and friends at the initial conferences was generally greater than that of professionals, but there was some variation across counties.

- *Evidence-Based Practices*

    - Roll-out of EBPs occurred more slowly than counties initially anticipated, and uptake of those EBPs was also slower than expected. Providers were generally ready for an influx of child welfare referrals; however, caseworkers reported not always understanding or seeing the benefit of particular EBPs and so rarely made those referrals. Caseworker attitudes and behaviors toward EBPs stayed fairly constant for the duration of the CWDP.
    - Some counties felt that their initial identification and selection of EBPs for the CWDP ended up not being a good fit for their populations, whether that be from a cultural perspective or simply not meeting the needs of their families.
    - For families that participated in Triple P – and for whom we have child-level data – statistically significant improvements in both child and parent behaviors were noted, suggesting that this is a useful EBP for child welfare populations. While not all counties felt that Triple P was an appropriate fit for their specific needs, these two particular counties (Crawford and Venango) did find some success with it.

Outcome evaluation

The overarching question guiding the Outcome Study was: "*What was the impact of the Pennsylvania Title IV-E Waiver Demonstration Project on child and youth safety, permanency, and wellbeing outcomes?"* Therefore, the outcome evaluation focuses on placement and maltreatment outcomes for children who were experiencing either a foster care placement or a substantiated maltreatment investigation for the first time, prior to the waiver (SFY 2011 through SFY 2013) or during the five years of the waiver (SFY 2014 through SFY 2018). The unit of analysis is the county, and the outcomes are presented as county-level outcome trends comparing outcome performance between pre-waiver and waiver cohort groups. The pre-waiver years provided a baseline, capturing outcomes of entry or exit cohorts in the three fiscal years prior to the start of the waiver (SFYs 2011 through 2013). Waiver outcome comparisons came from entry or exit cohorts (for re-entry analysis) during the five years of the Waiver (SFYs 2014 through 2018). The analysis of entry and exit cohorts over time provided a descriptive look at maltreatment recurrence, placement rates, likelihood of placement following substantiated maltreatment, placement type, stability, duration, and re-entry in the pre-waiver and waiver years.

Lacking a true control group at the system level, the county-level child welfare outcomes analysis employed longitudinal cohorts, comparing outcome performance between pre-waiver and waiver groups. This historical comparison is unable to scientifically support or refute a hypothesis of improved outcomes due specifically to waiver efforts and initiatives. However, the findings provide a descriptive look at the way outcomes have changed over time, and in conjunction with process study information provide a framework for understanding how flexible funding may have changed the practice model. It is important to note that due to the lack of pre-waiver data, Dauphin was excluded from the maltreatment analysis, and Venango was excluded from the placement analyses. Crawford entered into the CWDP a year later than the other counties, and as such, SFY 2014 data is excluded from Crawford's waiver cohorts. Methods,

data details, outcomes, and outcome-specific cohorts are detailed in the report within the outcome study section.

Results

- Safety - Maltreatment recurrence within 6 months of first substantiation
    - All counties experienced increases in re-occurrence of maltreatment within 6 months of first substantiation. This ranged from an increase of 7.0% in Crawford to 1.2% and 1.3% in Allegheny and Lackawanna, respectively.
    - Logistic regression findings showed increased odds of reoccurrence at the .05 level of significance for Allegheny, Crawford, and Philadelphia.

- Safety - Placement within 6 months of first substantiation of maltreatment
    - All counties saw small shifts in this outcome with the likelihood of placement either remaining the same (Allegheny), increasing slightly (Lackawanna), or decreasing slightly (about 2% for Crawford and Philadelphia).
    - The decreased likelihood of a placement following maltreatment was significant for Crawford (OR=0.67, $p<.05$) and Philadelphia (OR=0.86, $p<.05$).

- Least restrictive placement - Likelihood of a first admission being placed in kinship care
    - The likelihood of entering a kinship placement as a first placement increased for all waiver counties for which we had data, ranging from a 4% increase in Dauphin to a 20% increase in Lackawanna. This increased use of initial kinship foster care for first entry children/youth is the strongest cross-county outcome difference observed during the waiver period.
    - The likelihood of entering kinship care significantly increased for Allegheny and Lackawanna (OR=1.86, $p<.05$) and Philadelphia (OR=1.42, $p<.05$).

- Least restrictive placement – Likelihood of a first admission being placed in congregate care
    - This decreased for all counties for which we had data, with Dauphin as the exception (Dauphin increased use of congregate care by 7%). Some counties that had high percentages pre-waiver (Crawford at 34%; 22% Allegheny; 27% Philadelphia) experienced decreases ranging from 11% and 8%. Lackawanna had a low percentage pre-waiver of approximately 5%, which decreased to approximately 4%. This is not a clear cross-county change, but it is trending in the direction of less congregate care usage for first placements.
    - The likelihood of a first admission being placed in congregate care decreased by half for Allegheny and Philadelphia (OR=0.50 and 0.59, respectively) and increased two times for Dauphin (OR=2.04). These were significant at the .05 level.

- Stability - Moving within 6 months of a first placement

    - For the counties for which we had data, all had reductions of movement within the 6 months of a first placement, thus improving early stability. However, despite seeing reductions in movement, the percentage of children moving within 6 months remained high (35% - 61%).
    - The likelihood of moving within 6 months was significantly reduced in Dauphin (OR=.58), Allegheny (OR=.77), and Philadelphia (OR=.85) at the .05 level.

- Permanency - Exiting within 6 months and 12 months of first placement
    - This was a mixed finding across counties. Dauphin and Lackawanna increased the percentages who left within the first six months whereas Philadelphia, Crawford, and Allegheny reported lower percentages leaving at 6 months post waiver than in the pre-waiver period. This same pattern was observed for exiting within 12 months.
    - The odds of leaving within 6 months was significantly increased for Dauphin (OR=1.58, $p<.05$) but reduced for Allegheny and Philadelphia (OR= 0.76 and OR=0.91 respectively). These two counties, along with Crawford, also saw a significant decreased in the odds of leaving within 12 months.

- Permanency - Reentering care within one year of exit from first admission
    - Allegheny and Philadelphia experienced no change in re-entry within a year, and Lackawanna had approximately a 5% decrease in re-entry. Crawford experienced a slight increase (approximately 5%) and Dauphin had a 13% increase.
    - The likelihood for re-entering care was 35 times greater for Dauphin. No other odds ratios were significant.

Placement rates, county, and age were examined using linear regression, with a significance level of .05. Philadelphia and Dauphin had significantly higher overall placement rates. However, placement rate changes differed by age of entrants. When placement is drilled down by first admissions by age group, in Philadelphia, all age groups except teens showed a significant increase in placement rate while the teens show a reduced, if non-significant, reduction. Dauphin had significantly high placement rate for the 1 to 5 year olds. Significantly lower placement rates were observed for 13-17 year olds for Allegheny and Lackawanna.

<u>Discussion of outcome findings</u>

These pre/post waiver outcome findings are consistent with the conversations that the evaluation team had with all of the counties each year of the waiver; in the final year we did a “long look” in which we interviewed them asking for their thoughts about the “what” and “why.” A few examples are provided below.

- After the first year of the waiver, there was a child death in Dauphin, a provisional license, and leadership change. There was a change to less in-home and more out-of-home care as the county struggled with keeping children safe while in the midst of media attention, leadership

and culture change, and turnover. Not surprisingly, there was an increase in placement of young children, and from both a fiscal and practice viewpoint, it seemed as though the county was struggling to find a middle ground that incorporated the practice model of the waiver while meeting all other demands. One of the leadership staff said that they realized that when they returned to the waiver principles with the renewed vigor of new staff, the county was able to "turn around" some aspects of their practice. In looking at the longitudinal trends, this narrative is evident in their data.

- All counties, with the exception of Dauphin, were successful in reducing the use of congregate care over the course of the waiver. Correspondingly, the use of kinship care increased during the waiver as well, although the level of usage still varied by county. This trend was also consistent with our conversations with the counties. The degree to which kinship care use can be linked to family conferencing for every family cannot be determined due to the non-experimental design. However, the evidence for cause and effect is promising, and we hypothesize that family conferencing is a likely mechanism for the observed increase in kinship care.

    - For example, Lackawanna confirmed that family conferencing played a large role in reducing congregate care and in increasing the use of kinship. Lackawanna put policies in place so that any referral to congregate care required approval from the director of human services. In addition, they implemented a range of family conferences, so that families could participate early and with a smaller circle of support and then, if the family was in agreement, have a family group decision making meeting. Most importantly, there was a cultural change which originated with the leadership and prioritized starting with families first and working through all other options before examining removal and other out-of-home care.

Fiscal evaluation

The waiver gave county administrators the opportunity to treat federal Title IV-E revenue as a predictable source of flexible funding that could be allocated to a broader range of child welfare services that normally could not be supported with Title IV-E funding. Therefore, the fiscal study involves a system-level study of aggregate expenditures and revenues which addresses whether, compared to pre-waiver years, there was a change in child welfare expenditure patterns subsequent to the system interventions (family engagement, structured assessments, and expanded use of EBPs) and fiscal stimulus and, if so, how have expenditure patterns changed. Specifically, the questions were:

- Did expenditure patterns for out-of-home care change over the five years of the waiver, and if so, were the changes related to unit costs, care days, or both?
- Did the ratio out-of-home (OOH) care spending to spending for prevention and family preservation change over the five years of the waiver?

The dependent variables used to answer these questions were:

- Total child welfare expenditures;
- Out-of-home expenditures and utilization (placement days);

- Out-of-home expenditures as a % of total child welfare expenditures; and
- Average daily unit cost (total out-of-home expenditures divided by total placement days).

The unit of analysis for the fiscal evaluation is the county. Due to the small sample size and significant differences among the six waiver counties, there are no models that pool the six counties together. The primary data sources for the Fiscal Evaluation are the counties' annual State Act 148 Invoices and county-level Special and Block Grant expenditure reports. These data sources capture the fullest possible picture of each county's child welfare expenditure and revenue activity, including local, state and federally supported expenditures and revenue. To augment the understanding of OOH Placement costs, we examine the counties' average daily OOH unit cost. To calculate this annual average per county, we utilized the cost data detailed above as well as OOH placement day counts calculated using each county's Multistate Foster Care Data Archive event file. These are the same data that were the basis for the outcome analysis.

The fiscal evaluation was limited in several ways:

- One limitation to the fiscal evaluation is the lack of SFY 2018 for all counties and SFY 2017 for Philadelphia. So, although all trends discussed here present the majority of the fiscal activity during the waiver, there is one year of fiscal activity unobserved in the fiscal study. However, we do not anticipate that any major fiscal changes occurred during this time.
- All waiver interventions were delivered by county staff, and isolating the costs of activities delivered by county staff is difficult to do without methods like a random moment survey or a time and cost study. Nevertheless, the state asked each CWDP county to allocate its CWDP revenue and track its intervention expenditures as part of its Act 148 submissions. However, we do not believe this information accurate enough to be useable for the evaluation.

<u>Results</u>

- Even when adjusting for inflation, all six demonstration counties saw total child welfare expenditures increase from SFY 2013 levels, although the magnitude of the increase varied by county. Crawford, Dauphin, and Venango saw double digit increases in overall expenditures, while Allegheny, Lackawanna, and Philadelphia saw more modest increases, between two to six percent.

- All demonstration counties saw an increase in All Other CW expenses (from 9% in Philadelphia to 37% in Crawford) over the course of the waiver which points towards all counties investing in greater capacity and/or new interventions during the waiver.

- The trend in OOH Placement costs and the relationship between changes in OOH Placement days, OOH Placement costs and the proportion of OOH Placement costs of all child welfare expenditures varied by county.

    - In Dauphin and Venango, OOH Placement costs increased by 38% and 139% respectively. Philadelphia also saw a small increase, 3%, in OOH Placement costs

through SFY 2016. The other three counties, Allegheny, Crawford, and Lackawanna saw decreases in OOH Placement costs of 11% to 42% from SFY 2013 baseline levels.

- In the three demonstration counties where the number of placement days increased by a large amount (a 43% waiver change in Philadelphia, 47% in Venango, and 59% in Dauphin), total OOH Placement costs increased as well. But, the proportion of OOH Placement costs to total child welfare expenditures only increased in Dauphin and Venango, indicating that OOH Placement expenditures rose at a greater rate than other child welfare expenditures in those two counties.
- Allegheny, Crawford, and Lackawanna saw a reduction in the total and proportion of OOH Placement costs when comparing the last observable fiscal year to the fiscal year immediately prior to the waiver.
- With the exception of Venango, all demonstration counties saw their average daily unit cost decline over the course of the waiver, which likely stems in part from a placement mix shift – a shift from more expensive care types (congregate care) to less costly placement types (kinship care).

- Over the course of the waiver, demonstration counties saw a consistent mix in the major revenue sources. Revenue mix varies slightly by county, but in general, state revenue accounted for approximately 60% of child welfare revenue, while federal revenue made up 25% and local about 15%.
- Only Lackawanna experienced a decrease in Title IV-E waiver-related revenue (7%), although the SY2017 total is within range compared to pre-waiver years.

Discussion of fiscal findings

Even controlling for inflation, all of the counties increased their total child welfare expenditures during the course of the waiver. In addition, the All Other CW category increased suggesting that the counties invested in greater capacity and/or new interventions during the waiver period. The trend in OOH Placement costs and the relationship between changes in OOH Placement days, OOH Placement costs and the proportion of OOH Placement costs of all child welfare expenditures varied by county. Although, with the exception of Venango, all demonstration counties saw their average OOH daily unit cost decline over the course of the waiver, most likely due to a shift in placement mix towards less restrictive, less costly placement types.

INTRODUCTION AND OVERVIEW

Pennsylvania's child welfare system is state-supervised and county-administered; thus, practice models can differ depending upon local vision, priorities, and goals. However, Pennsylvania's Office of Children Youth and Families (OCYF) wished to create a practice model which provided consistency in the practices, yet could at the same time adjust to local changes in client populations by allowing IV-E funds to be spent more flexibly. At the time of Pennsylvania's application for the waiver, point in time data from 2012 found that while there was a trend toward serving more families through in-home services, foster care, particularly for children under five and adolescents, remained high. In addition, Pennsylvania was one of ten states to rely heavily on congregate care for dependent adolescents. Thus, despite progress toward meeting the goals of safety, permanence, and well-being, the state had reached a point at which they needed to consider new funding strategies and models of practice. The issuance of the Child Welfare Waiver Demonstration projects in May of 2012 provided an opportunity for the state to improve outcomes.

Beginning July 1, 2013, five Pennsylvania counties (Allegheny, Dauphin, Lackawanna, Philadelphia, and Venango; a sixth county, Crawford, joined on July 1, 2014) agreed to replace fee-for-service federal revenue for Title IV-E foster care board, maintenance, and administration for eligible children in exchange for a capped allocation amount that could be used for purchasing child welfare services focused on prevention, aftercare, and therapeutic intervention. These counties also agreed to respond to this change in federal funding policy in specific ways: (1) develop a new case practice model using family engagement and structured assessment, and (2) the introduction or expanded use of evidence-based programs (EBPs). Additionally, counties could identify unique county system changes such as performance-based contracting to adopt as part of the project.

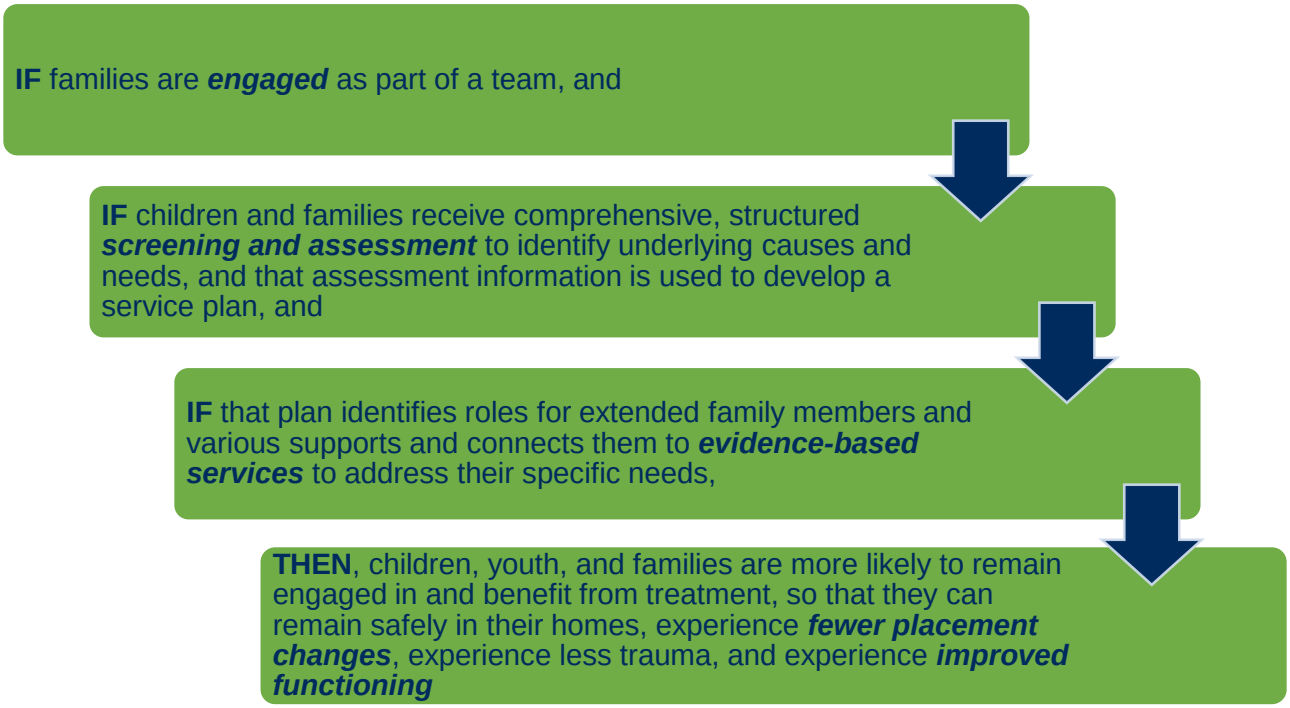
Under the Terms and Conditions, Pennsylvania is thus authorized to implement a demonstration project that involves the flexible use of Title IV-E funds to develop a new case practice model focused on family engagement, assessment and the introduction or expanded use of evidence-based programs. The State's Child Welfare Demonstration Project (CWDP) seeks to accomplish the following statutory goals (p. 4, Pennsylvania Terms and Conditions, 9/28/2012):

- Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth;
- Increase positive outcomes for infants, children, youth and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth;
- Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.

The target population for the project is Title IV-E eligible and non-eligible children aged 0-18 who are: (1) in placement, discharged from placement, or who are receiving in-home services at the beginning of the demonstration period; or (2) who are at-risk of or enter placement during the term of the waiver demonstration.

Theory of Change of Pennsylvania's Child Welfare Demonstration Project

The theory of change for the CWDP is illustrated below. This theory of change operated for the entirety of the CWDP. However, some changes were made in the specifics of the evidence-based practices and timing of assessments. This information is covered in greater detail in other sections of this report. However, the logic of the model remained the same. Child welfare should first engage with families and widen the circle of family support. There is research evidence and anecdotal evidence that family conferencing helps to engage families, build alliances, and widen the circle, which are important intermediate outcomes in child welfare (McCrae & Fusco, 2010; Pennell, Edwards, & Buford, 2010; Wang et al., 2012). In addition, engagement helps to build the alliance necessary to obtain accurate current information about needs and strengths of children and families. A structured functional assessment focusing on both needs and strengths helps to identify priority areas, as well as causal factors, which can be addressed through practices with supporting evidence. The final part of the logic model includes the longer-term outcomes of staying safely in home, or if in out-of-home care, reducing movement and duration and improved functioning.



The CWDP engages families, assesses and connects families, and provides families with evidence-based interventions toward the following two broad outcomes: (1) Improved child and family functioning, and (2) Improved placement outcomes. Pennsylvania identified indicators of improved child and family functioning to include: improved parent functioning as shown by improved parent functioning and improved parenting skill; improved child and adolescent functioning as shown by improved child and adolescent behaviors and improved functioning at home, school, and the community. Indicators of improved placement outcomes include: reduced likelihood of placement; shorter time in placement; reduced re-entry into out-of-home care.

During the first year of the CWDP (7/1/2013-6/30/2014) Allegheny, Dauphin, Lackawanna, Philadelphia, and Venango Counties (Cohort One) implemented structured assessment and

family engagement meetings. Beginning July 1, 2014 these counties started referring to or providing EBPs. Crawford County (Cohort Two) entered into the CWDP on July 1, 2014 and began implementing structured assessments and expanding family engagement; they began implementing EBPs July 1, 2015.

Overarching Research Methodology

The evaluation tests the hypothesis that the flexible use of Title IV-E funds to develop a new case practice model focused on family engagement, structured assessment, and the expanded use of EBPs driven by local needs will lead to improved safety, permanency, and well-being outcomes for children and families involved in the State's child welfare system. The evaluation uses a convergent mixed methods approach, combining qualitative and quantitative data collection and analysis at the same time, followed by comparing and relating the findings which then are used for interpretation.

The ***process evaluation*** uses an implementation lens in examining the planning, organizational, staff factors, and service delivery systems. Documenting the larger contextual factors is also part of this evaluation component. The process evaluation focuses primarily on counties' readiness to implement the CWDP interventions, implementation of the interventions, and fidelity of implementation.

The ***outcome evaluation*** was comprised of the following:

- An interrupted time series design in which county changes in key child welfare outcomes were tracked over time using child-level data from the multiple county child welfare administrative data systems, as well as assessment and engagement data collected as part of this evaluation. The outcome evaluation addressed changes in the following outcomes;
    - Maltreatment recurrence
    - Likelihood of placement following maltreatment
    - Out-of-home placement rates per thousand children in the population
    - Rate of placements in congregate/institutional care settings
    - Rate of placements in kinship care settings
    - Placement stability
    - Length of stay in out-of-home care (time to permanency)
    - Reentry from permanency

- County-level evaluations of specific interventions in each of the participating counties. If clearly defined population and criteria are identified by the counties for which children and families receive the EBPs, then comparison groups can be created to compare outcomes at the child and family level for effectiveness of EBPs.

For the outcome study, Entry Cohorts were created based upon the date that the first spell of out-of-home care occurred for IV-E waiver eligible children (target population). We used data as far back in time pre-waiver as was available. In the case of Allegheny, those data went back to 1998; however, other counties changed their information systems prior to the waiver or during the waiver, or experienced data warehouse problems. As a result, some data were not able to be recovered (Philadelphia, Venango).

Table 1. Timeframes for Data Coverage by County.

County	Placement data coverage began	Maltreatment data coverage began
Allegheny	January 1, 1998	January 1, 2009
Crawford	January 1, 2007	January 1, 2007
Dauphin	January 1, 2007	July 1, 2013
Lackawanna	January 1, 2006	July 1, 2011
Philadelphia	January 1, 1992	January 1, 1992
Venango	October 1, 2012	December 1, 2015

Population-level placement and maltreatment outcomes tend to be different by age at the initial event (entry into foster care, age at first maltreatment) and by whether the child is experiencing a first child welfare event or has a history of child welfare events. Since most children whom a child welfare system touches in a given year are experiencing a first child welfare event, the analysis of waiver impacts is only of those children. In addition, to the extent possible, the analysis is divided by age at initial event. Thus, any changes in case mix (more infants coming into care, for example) that may appear to change overall outcomes are controlled for.

The ***fiscal evaluation*** answered the questions: Did expenditure patters for out-of-home care change over the five years of the CWDP, and if so were the changes related to unit costs, care days or both? Did the ratio of out-of-home care spending to spending for prevention and family preservation change over the five years of the project?

Summary

The University of Pittsburgh's School of Social Work and Chapin Hall are the evaluators for Pennsylvania's CWDP. Please refer to the Initial Evaluation Plan for more information about the roles and the individuals comprising the evaluation team.

At the start of the evaluation, we realized that achieving one cohesive evaluation across all the participating counties would present a challenge. Each of the six participating counties presented a unique evaluation landscape with distinct intervention implementation strategies applied to a particular child welfare context. Moreover, the lack of a Statewide Automated Child Welfare Information System (SACWIS) and the mid-waiver changes to county-level information systems presented extensive data challenges and limitations. Working with four different information systems across six counties was very challenging, particularly when a county went from one developer to another. Finally, the child level evaluation of the impact of EBPs was compromised by the lack of an identifiable target group and the lack of an agreement with the contracted providers to provide data on the child and family receiving the EBPs. We have kept the State and ACF abreast of these challenges through the progress reports and the Interim Evaluation Report.

However, despite the challenges, we feel confident that the evaluation presents valuable information about the experiences of participating counties. Because we identified the challenges early, we deliberately strengthened the process aspect of the evaluation in order to provide rich evidence about what did and did not change in the six counties under the waiver; moreover, we tried to answer the questions, "what changed?", "for whom did it change?" and "how did it

change?" What caused any changes, as in more flexible funds or other outside factors, cannot be determined from this design. Nevertheless, we feel that the process and evaluation findings will answer important questions for the Commonwealth as the Family First Prevention Services Act (FFPSA) is implemented.

This Final Evaluation Report for the Pennsylvania CWDP covers the time period from July 1, 2013 to June 30, 2018 (exceptions to this timeframe are noted). The next section details the Assessment, Family Engagement, and EBP interventions for each county, as well as provides methodology information on the data collection tools used for the evaluation. Following that are sections on the Process, Outcome, and Fiscal evaluations.

Description of Interventions: Assessment

Structured Assessment: FAST

The Family Advocacy and Support Tool (FAST) is an assessment developed by Dr. John Lyons specifically for child welfare. The intention of the FAST is to collect information and integrate information about three "targets": the family as a unit, the individual caregiving adults in the family, and the individual children in the family. Because the FAST is used as part of the overall assessment of safety and future risk, as well as assessing child and family well-being, it is designed to capture the complexity of families and the changing nature of a family unit over time. For example, the caseworker or provider doing the FAST with a family can identify up to 10 caregivers and up to 10 children. The caregivers and children can change over the course of repeated administration. *Therefore, the FAST does not measure individual change over time, but rather, is a measure of the improvement or deterioration in the functioning of the family.* In practice, the FAST is used to plan services and supports and is not a research tool per se, but is being used in the evaluation to provide data on the outcomes of family functioning and child and caregiver well-being. In addition, the FAST enables individuals from different systems to discuss the child and family using a common language focused on action: the items in the FAST were selected because they lead down a pathway of planning actions rather than descriptively labeling or diagnosing the family.

The five counties in Cohort One, under the supervision of Dr. Lyons, and with financial support from the Casey Family Programs, created a Common FAST version which is used to assess the target population in the CWDP counties. The Common FAST includes three domains: *Family Together*, which consists of 11 common items about how the family functions as a unit; *Caregiver Status*, with 13 common items about the caregiver's functioning and needs (counties can have a maximum of 10 caregivers); and *Youth Status*, which has 11 common items (counties can have a maximum of 10 children). There is also a common trauma extension module if a caregiver has post traumatic symptoms; this includes 10 additional items. Please see Appendix A for a copy of the Common FAST. Each item is rated for the past 30 days on a 4-point scale. The FAST ratings are as follows: 0 means a clear strength OR no evidence of a need; 1 means there are opportunities for strength building OR watchful waiting (no need for service action); a 2 indicates that the need interferes with functioning and requires action; and a score of a 3 means that the need is disabling and requires immediate action.

In addition, counties could include extra items within domains as well as include additional extension modules. *Extension modules* are groups of related items that are asked if certain items were scored as 2s or 3s in a particular domain. There are also *departures* from the Common

FAST, which are Common FAST items that the counties did not include in their final version of the FAST. The additional items are detailed by domain in Table 2, and what follows are the extension modules by county, as well as departures by county.

Extension modules to Common FAST:

- Allegheny: Early Childhood Extension included if child is 5 or younger
- Philadelphia: Early Childhood Extension included if child is 5 or younger

Departures to Common FAST:

- Crawford does not ask trauma extension modules for caregivers

The FAST is typically administered by county caseworkers; some counties have a specific type of worker doing the FAST (e.g., Allegheny family advocates, as well as caseworkers, may complete the FAST. In Philadelphia, for CUA managed cases, the CUA staff administers the FAST; for DHS managed cases, providers complete the FAST and DHS staff are responsible for reviewing it. Regardless of CUA/DHS affiliation, it is expected that the FAST will be incorporated into the safety and risk assessments and plan). In order to administer the FAST, the worker must have been trained and achieved a level of competence. Table 2 outlines the target population, initial and reassessment schedule, and additional items and extension modules by county.

FAST mid-course corrections

Allegheny instituted many changes in the FAST and FAST administration over the course of the waiver, but particularly since 2016. Initially, family advocates administered the FAST. However, there was a disconnect between the advocates administering the FAST and the knowledge gained from it and the caseworker who was writing the plan. Therefore, starting in January 2016, caseworkers began administering the FAST. Another change for Allegheny was the target group. Starting in January 2016, the FAST was done on all families regardless of placement status. This shift in practice was “rolled out” to the different offices over a period of time.

The biggest change in Allegheny was the addition of the Prep/FAST to the assessment process in 2016. The Prep/FAST is the result of integrating the FAST assessment into the model of Conferencing & Teaming. One of the main components of Conferencing & Teaming is "prepping" the family and potential team members through conversation - identifying the needs and strengths of the family, their goals, and their family history. The prep conversation includes what to expect at the conference, who will be there based on family choice, and what will be discussed. Since the FAST conversation covers many of the elements of the Prep, staff were trained to see this as a tool that guides the prep with added questions to prepare the family for the actual conference. Additionally, it includes items on Intimate Partner Violence and Substance Use Risk because it was believed that these were areas not fully identified on the FAST, yet would be important to know about early in the process. Moreover, caseworkers often struggled with talking about these areas so the Prep/FAST helped to facilitate the conversation. The overall goal was to integrate the tool within the practice model so that the caseworker saw the assessment as a natural part of the engagement prep components of teaming and conferencing.

Ongoing efforts were made to streamline the FAST in KIDS (Allegheny's information system) to make it easier to complete by the caseworkers. By January 2018, The Prep/FAST was fully implemented into the KIDS system, rating options were made more flexible (added an "explore" option), adjusting the traumatic experiences module to reflect the conversational nature rather than clinical, separating the needs from the strengths ratings and providing staff with a user-friendly "flip" book, and innovative training practices (flash videos, for example) to support training and coaching.

Crawford made the reassessment FAST optional when the children were in substitute placement. This change went into effect August 2016.

Philadelphia requested and received permission from the Commonwealth to change the timing of assessments and the target group. Starting late August 2015, all FAST assessments were done within 60 days for children determined to be unsafe and moved to out-of-home care or those who remained at home with a plan. The FAST was not done on children with a goal of adoption or permanent legal guardianship.

The changes for Crawford and Philadelphia represent a narrowing of the target group over time as well as an acknowledgement by Philadelphia that they were unable to obtain a quality assessment in less than 60 days. On the other hand, Allegheny was covering the target group that they had intended to cover, but had initially been unable to do so due to volume. Both large counties had to balance the volume, work force, and training demands.

Table 2. Common FAST Administration Policies by CWDP County.

	Allegheny	**Crawford**	**Dauphin**	**Lackawanna**	**Philadelphia**	**Venango**
Target population	All families accepted for service with CYF with children remaining in the home (roll out dates by regional office 9/2013 to 7/2014) **As of 1/2016, the FAST will be done on all families regardless of placement status e.g. done on all families referred. (informally this was confirmed)** All families receiving a CYF investigation, and ongoing with families who are accepted for service. This policy went into effect in May of 2014.	All families accepted for ongoing services with CYS	All families accepted for service in CYS with children including cases with shared care responsibility with JPO	Families with substantiated allegations who are opened for services. FAST is being done at intake for all families regardless of placement status. Informally confirmed.	All children and youth in placement and receiving in-home services and all caregivers listed in the Safety Assessment. EXCEPTION: Children who have a court-approved goal of adoption or permanent legal custodianship will not have a FAST done.	Families referred two weeks prior to the case being accepted for ongoing CYS services based on safety assessment including shared case management with JPO

Initial Assessment schedule						
In home	60 days					
Out-of-home	30 days					
Either in home *or out-of-home*		40-60 days (completed when case is open for ongoing case management	30 days, ideally before conference	30 days, ideally before conference	**CUA**: Within 60 days after the placement of a child or youth or within 60 days of receipt of the referral to the CUA for in-home services. **DHS**: FAST done by contracted provider, and approved within 60 days of referral to a provider, & before the initial Family Service Plan (FSP), whichever comes first.	14 days (2 weeks of case opening). We also added the UNCOPE to the FAST Assessments The UNCOPE is an screening tool to determine if an individual is in need of a SAP Assessment. If an individual has 2 or more positive answers that indicates that they may benefit from a SAP Assessment, and a referral should be made. The UNCOPE will open in the FAST the same way that other modules are triggered in the FAST/CANS. Anyone with an elevated score for Caregiver's

						Substance Abuse will "trigger" an UNCOPE.
Reassessment schedule	6 months	6 months **Exceptions** If all of the children are in substitute placement beyond 6 months, the FAST is optional. If at least one child remains in the family home, even if the others are in out of home care, the FAST will be done at 6 months If the child(ren) returns home at any point during the life of a case and the FAST is older than three months, a FAST will be administered 30	6 months The FAST is completed 30 days prior to an FSP revision and not less than every 6 months.	6 months or major change	CUA: The FAST is done 30 days prior to FTC at which the Single Case Plan is created or reviewed, and must be approved by the CUA supervisor within ten days or prior to the FTC, whichever comes first. DHS: The FAST is completed by the provider 30 days prior to an FSP revision, and not less than every six months.	6 months (done at least 4 weeks before a plan is up for revision). We also added the UNCOPE to the FAST Assessments. The UNCOPE is an screening tool to determine if an individual is in need of a SAP Assessment. If an individual has 2 or more positive answers that indicates that they may benefit from a SAP Assessment, and a referral should be made. The UNCOPE will open in the FAST the same way that other modules are triggered in the FAST/CANS. Anyone with an elevated score for Caregiver's

		days prior to planned return home or 30 days after an unplanned return home				Substance Abuse will "trigger" an UNCOPE.
Discharge FAST	Yes	Yes	Yes	Yes	Yes, after the Safety and Risk Assessment and Closing Teaming Conference, if one is required.	Yes
Additional items in domains and/or extension modules	Yes; The major difference between the Common FAST and Allegheny FAST is that the trauma extension module (10 items) is required of all caregivers and all children regardless of a domain item score. Child functioning domain: 3 additional items (child high risk behavior, sleep & adjustment to trauma).	Yes; Caregiver functioning domain: 1 item, caregiver residential stability.	No; exactly the same as the common FAST and no extension modules.	Yes; Caregiver functioning domain: 1 item, caregiver residential stability. In the trauma extension module for caregivers, they have one additional item on witnessing or victim of community violence	Yes; while no additional items in Family together, Caregiver or child functioning, they do have an extension module for early childhood.	We also added the UNCOPE to the FAST Assessments The UNCOPE is a screening tool to determine if an individual is in need of a SAP Assessment. If an individual has 2 or more positive answers that indicates that they may benefit from a SAP Assessment, and a referral should be made. The UNCOPE will open in the FAST the same way that other modules are

	In 2016, additional items on IPV, household safety and an imbedded DA scale. Yes; one extension module for early childhood					triggered in the FAST/CANS. Anyone with an elevated score for Caregiver's Substance Abuse will "trigger" an UNCOPE.

Structured Assessment: CANS

The Child and Adolescent Needs and Strengths tool (CANS) was developed by Dr. John Lyons. The intention of the CANS is to collect information about the needs and strengths for a particular child as well as one caregiver. Thus, the units of analysis are one child and one caregiver. The CANS is organized by domain, and the Common CANS has a core set of 63 items that were agreed upon by all the Cohort One counties (see Appendix A for a copy of the common scoring sheet).

The CANS includes the following 8 domains: *Life Functioning, Youth Strengths, Caregiver Needs and Strengths, Trauma Experiences, Culture, Youth Behavior and Emotional Need, Youth Risk Factors, and Transition Age.* Counties could include additional items in a domain and extension modules beyond what is required by the CWDP (see Table 3). The CANS is scored similarly to the FAST using the past 30 days and a 4-point scale. However, strengths and needs items are scored separately, unlike the FAST. Therefore, on the needs items, a"0" means no evidence of a need; a 1 means some level of need/watchful waiting (no need for service action); a 2 indicates that the need interferes with functioning and requires action; and a score of a 3 means that the need is disabling and requires immediate action. On the strengths items, a 0 means a clear strength and one that can be a centerpiece of a plan; a 1 is a useful strength that can be part of a plan; a 2 is a strength that has been identified but not utilized; and a 3 is strength area that has not been identified and needs to be developed.

The target population for the CANS differs by county: each county created policies to identify the children who should be assessed with the CANS. For instance, Allegheny County policy is to complete CANS assessments for children and youth in out-of-home care only (e.g., foster care [kin or non-kin], residential treatment unit, shelter, group home). In other counties, the policy is that scores on the FAST determines whether a CANS is done. Thus, CANS target population is determined by individual county policy. Table 3 outlines county policies on the target population, initial and reassessment schedule, and additional items and extension modules for each county.

The CANS is typically administered by county caseworkers; some counties have a specific type of worker doing the CANS (e.g., Allegheny providers will administer the CANS. In Philadelphia, the CUA staff administers the CANS for cases managed by CUAS; contracted service providers administer the CANS for cases that continue to be managed by DHS). However, over the length of the CWDP this changed, as counties built the capacity to train caseworkers (see Table 3). The worker must have been trained and achieved a level of competence as determined by the Praed Foundation.

Counties could include additional items within domains as well as include extension modules. *Extension modules* are groups of related items which are asked if certain items were scored as 2s or 3s in a domain or if certain conditions exist (e.g., in residential treatment unit or a certain age). There are also *departures* from the Common CANS which are Common CANS items that the counties did not include in their final version of the CANS. The additional items are included in Table 3. Departures to Common CANS are:

- Philadelphia does not include the caregiver items on their Common CANS. As a result, caregiver items are not available for Philadelphia CANS files.

- Allegheny does not have School Behavior, School Achievement, or Attendance under the Life Functioning domain, but does include these items under a SCHOOL extension module. Additionally, they do not have an "attachment" item under Youth Behavioral and Emotional Needs module and do not include a "job functioning" item in the Transition Age Module.

CANS mid-course corrections

Philadelphia requested and received permission to change the timing of assessments and target group. Starting late August 2015, all CANS assessments were done within 60 days. In addition, the CANS was targeted for children in out-of-home placements only who had an indicated need on the FAST. The timing change for Philadelphia was due to an inability to complete a CANS within a shorter window of time.

Allegheny removed the FAST trigger for their CANS assessments, so that for children who are at home, even if there is a 2 or 3, a CANS is no longer done. In January 2018, the CANS assessment seemed to be incompatible with Allegheny's IT application such that it made the completion of the assessment time-consuming and there was redundancy/lack of use around certain items. Thus, they adjusted the CANS to reflect these issues and to increase the utility and efficiency of the assessment.

Table 3. Common CANS Administration Policies by CWDP County.

	Allegheny	**Crawford**	**Dauphin**	**Lackawanna**	**Philadelphia**	**Venango**
Target population	Children ages 5-17 in CYF and in out of home placement or need indicated on FAST Children ages 5-17 in CYF and in out of home placement. In 2014, Allegheny County eliminated the FAST triggering a CANS for children still at home.	Children ages 5-17 opened for CYS services in out of home placement or children 5-17 who are victims of substantiated abuse	Children ages 5-17 opened for CYS service in out of home or with need indicated on FAST and shared JPO cases	Youth identified by a supervisor to be in immediate or impending danger according to the PA safety assessment or need indicated on FAST	Children and youth in placement, ages **5 to 18;** All children and youth accepted for in-home services who received a score of "2" or "3" on four out of six items on the FAST EXCEPTION: Children who have a court-approved goal of adoption or permanent legal custodianship will not have a FAST done.	Children ages 5-17 opened for CYS services in out of home placement or need indicated on FAST

Initial Assessment schedule						
- *In home*		optional				
- *Out of home* *(foster care* *group home)*	30 days	30 days (before plan is written)	30 days	30 days	**CUA:** Within 60 days after the placement of a child or youth or within 60 days of receipt of the referral to the CUA for in-home services. **DHS**: within **60** days of a referral to provider and/or before the Family Service Plan	Within 10 days of placement
-*In home* ***AND** has 2 or 3 on FAST child functioning domain item*	NA – in 2014, Allegheny County decided to eliminate the FAST triggering a CANS.		30 days triggered by any of the items on child domain in FAST	30 days triggered by any of the items on the child domain in the FAST	**CUA:** Within 60 days after the placement of a child or youth or within 60 days of receipt of the referral to	30 days of FAST completion triggered by any items on any child (not just referred child) domain in FAST

					the CUA for in-home services. **DHS:** within 60 days of a referral to provider and/or before the Family Service Plan	
Reassessment schedule	6 months	6 months	6 months	6 months or major change	**CUA**: 30 days prior to the FTC at which the Single Case Plan is created, reviewed, and approved within 10 days or prior to the FTC, whichever comes first. **DHS**: The CANS is completed 30 days prior to an FSP revision, and not less than every six months	6 months (4 weeks prior to FSP review). Also if the reassessment FAST indicates a need, then a CANS is done even though it was not done at entry to CYS

Discharge CANS	Yes	Yes	Yes	Yes	Yes	No
Additional items in domains and/or extension modules	Yes; Life Functioning: 3 items (recreational, employment & natural supports); Youth Strengths: 3 items (Hopefulness, Involvement with Care, & Social Resources); Caregiver Strengths and Needs: 10 items: (Health, Family Stress, Cultural Stress, Employment/Education, Emotional Responsiveness, Legal, Financial, Transportation, Military, and PTSD); Trauma Experiences: 3 items (Community, War, and Terrorism); Culture: 3 items (Identity, Traditions, & Stress); Youth	Yes; Life Functioning: 4 items (Recreational, Employment, Self-Regulation, & Natural Supports); Youth Strengths: 1 item (Hopefulness); Culture: 2 items (Identity & Stress).	No additional items in domains.	Yes; Life Functioning: 2 items (Recreation & Natural Supports); Youth Strengths: 1 item (Hopefulness); Caregiver Strengths & Needs: 1 item (Family Stress); Trauma Experiences: 1 item (Community); Culture: 2 items (Identity & Culture Stress).	No additional items in domains. Caregiver Strengths and Needs is not included. There is a Transition Module for youth ages 14 and older.	Yes; Life Functioning: 2 items (Recreational, Natural Supports); Youth Strengths: 2 items (Hopefulness and Social Resources); Caregiver Strengths and Needs: 9 items (Health, Family Stress, Employment/Education, Parenting Capacity, Legal, Financial Resources, PTSD Reactions, Substance Abuse, and Transportation); Culture: 2 items (Identity & Culture Stress); Youth Behavioral Needs: 1 item (Eating Disturbances); Youth Risk: 2 items (Bullying & Current

	Behavioral Needs: 1 item (Eating Disturbance); Youth Risk: 3 items (Bullying, Environ Stress, & Gang Involvement); Transitional Age: 9 items (Residential Stability, Transportation, Health, Self-Care, Educational Attainment, Resiliency, Resourcefulness, Financial Resources, & Military Transition)					Environmental Stressors).

Structured Assessment: ASQ and ASQ:SE

The Ages & Stages Questionnaires® (ASQ) and Ages & Stages Questionnaires®: Social-Emotional (ASQ:SE) were developed by Jane Squires, Diane Bricker, & Elizabeth Twombly from the University of Oregon. The ASQ detects concerns in five major developmental areas: communication, fine motor, gross motor, problem solving, and personal social. The ASQ:SE specifically looks for social-emotional concerns in seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Both the ASQ and the ASQ:SE can be used with children from three months to five years in age. The measures contain developmentally appropriate items for each age range and are rated on the presence or absence of the items in the target child. The ASQ and ASQ:SE can be administered by a child welfare professional, an Early Intervention (EI) provider, or completed as a self-report by the family. Training is coordinated by the counties: some use community EI providers, whereas others use a training offered by the CWRC.

Some counties are using the ASQ Version 3 while others are using the ASQ Version 2. Version 3 has an earlier screening age start (age 2 months compared to age 4 months in Version 2). Those using ASQ Version 2 are indicated with an * in the table, and those using ASQ Version 3 are indicated with a **. All counties began the waiver using ASQ:SE; however, a new edition was released in 2016. The new version added several items related to autism and other social-emotional delays; additionally, it has updated cut-off criteria and an expanded age range. Currently, Allegheny and Venango are using the ASQ:SE 2; the remaining counties are still using the original ASQ:SE. Because of the differences in the versions, dichotomous variables were created to indicate developmental and emotional concerns, rather than relying on domain scores.

The target population for the ASQ and the ASQ:SE differs by county. Pennsylvania issued a statewide bulletin with guidance on the target population for initial and follow-up ASQ and the ASQ:SE assessments. According to the bulletin, the target population for the ASQ and ASQ:SE is all children under age 3 opened for CYS services with substantiated maltreatment. However, CWDP counties have interpreted and implemented the guidelines differently. Table 4 outlines county policy on the target population, initial, and reassessment schedules.

The number of screenings per year decreases with the child's age (e.g., younger children receive more frequent screenings than older children). For example, if two children of different ages (18 months old and a 4 year old) enter into care, and remain in care for a year, the younger child will have a greater number of screenings than the older child, even though they were in care for the same amount of time.

Finally, the method of administration of ASQ assessments differs by county. Allegheny and Venango contract with EI providers to complete the ASQ assessments; the remaining counties use in-house staff (caseworkers or workers assigned to an assessment team).

Results of the ASQ and the ASQ:SE indicate the presence or absence of developmental concerns in a target child. Concerns then result in a referral to an EI agency for further assessment to determine if the child is in fact experiencing a developmental delay. If the full assessment indicates a developmental delay, then the child is offered services and the EI agency will continue screenings. If the ASQ screening indicates a delay and the child is assessed by the EI

agency, but not found to have a delay, then child welfare will continue to screen the child using the ASQ at the expected intervals.

ASQ and ASQ:SE mid-course corrections

Allegheny utilized The Alliance for Infants and Toddlers to administer these assessments. However, the referral process was not efficient nor integrated. In the time period between January 2016 and June 2016, a new ASQ referral process was implemented. Caseworkers were required to review this new process with families during the initial family conference. Additionally, DHS' CYF Health Enrollment Unit has included the ASQ/ASQ:SE into their own tracking of health screening and tracking. This change was to better serve families and children through an integrated approach.

Table 4. ASQ and ASQ:SE Administration Policies by CWDP County

	Allegheny **V3**	**Crawford** **V3**	**Dauphin*** **V2**	**Lackawanna*** **V2**	**Philadelphia**** **V3**	**Venango**** **V3**
Follows PA Bulletin Target population <u>recommendations</u>: **Acceptance for CYS services and under age five**	Starting 9/1/2015	No (see below)	Yes	Yes	Yes	Yes
Initial Assessment schedule						
In home	60 days for all children under 5 accepted for service in home			Within 30 days for children 5 and under once the case is accepted for further assessment		Within 30 days for children 5 and under once the case is accepted by CYS
Out-of-home	30 days for all children placed in foster care			Within 30 days for children 5 and under once the case is accepted for further assessment.		Within 30 days for children 5 and under once the case is accepted by CYS

	Allegheny **V3**	**Crawford** **V3**	**Dauphin*** **V2**	**Lackawanna*** **V2**	**Philadelphia**** **V3**	**Venango**** **V3**
Either in home *or out-of-home*		60-90 days after acceptance for services and under age 3.	30 days or sooner for children under age 5	Within 30 days for children 5 and under	Within 30 days for children 5 and under once accepted for service; within 30 days of the determination date for children 3 and under who are subjects of a substantiated abuse report, but not accepted for service.	Within 5 days of case being opened, referral made to EI contractor who sees child within 15 days (around 25-30 days)
Reassessment schedule	Intervals determined by age of child; ASQ:SE yearly	Intervals determined by age of child; ASQ:SE yearly	Intervals determined by the age of the child; ASQ:SE yearly	Intervals determined by the age of the child; ASQ:SE yearly	Intervals determined by age of child; ASQ:SE yearly. When a child has completed a program of EI services, is under 5 & case	Intervals determined by age of child; ASQ:SE yearly

					remains open with CYF, screenings continue	
Discharge ASQ?	No	No	Yes	No	No	No; uses the last ASQ as discharge ASQ

Description of Interventions: Family Engagement

Counties either expanded the use of or implemented new family engagement practices. Below are descriptions of each county's family engagement practice; please also see Table 5, which outlines county policy on the target population, timing of conferences, facilitator types, key elements, and expected immediate outcomes for each county.

Allegheny County: Conferencing and Teaming. All families accepted for CYS services beginning July 1, 2013 (in home or out-of-home care) with children ages birth to 17 are the target population for participation in the Conferencing and Teaming process. There are initial conferences, as well as teaming meetings. For children in out-of-home care, an initial conference is held within 30 days of accepting the family into CYS services. When the children are living in the home, then the time frame is 60 days from accepting the family into CYS services. Preparation for the initial meeting is the first step: prior to the initial meeting, the family services caseworker completes a record review to ensure that he/she has a good understanding of significant life events, the reason for agency involvement, and what the parents/youth feel that they need. At the preparation meeting with the family, the worker talks about reasons for agency involvement, AFSA, rights and responsibilities of the parents and youth, as well as the rights and responsibilities of the agency. The caseworkers will then meet with each family member, discuss life events, clarify information from the record review, and ask the family about their goals for the upcoming family conference. It is during this preparation meeting that the worker conducts the FAST assessment to obtain a comprehensive picture of the family as communicated by the family members. When age appropriate, the ASQ is introduced during this conversation. The family determines who they wish to invite to the initial conference. A family plan is the outcome of the initial conference. After the plan has been written and agreed upon by all participants, teaming meetings occur every 90 days. The teaming meetings include the family along with all the individuals who are providing support or a service to the family. Teaming meetings will continue to occur until the goals are reached and child welfare services can safely close. The caseworker for the family facilitates the initial conference as well as the teaming meetings. *Allegheny County is collecting data on a stratified sample of families rather than the entire population. See Appendix B for the sampling plan for Allegheny County.*

Crawford County: First Meeting; Family Finding; Family Group Decision Making (FGDM); Family Team Conference (FTC); High Fidelity Wraparound (HFW). The target groups for the different engagement strategies are as follows FGDM, Family Finding, and FTC target IV-E eligible families who are opened for CYS services beginning in July1, 2014. The target group for the First Meetings is CYS involved families, also IV-E eligible, but the children are placed at a resource home. The target group for HFW is children 8-18 with a behavioral health disorder and complex behavioral needs, and who are involved in two or more systems (such as CYS and behavioral health), or youth at risk of being placed in a treatment facility. These youth may or may not be IV-E eligible.

The First Meeting is considered to be a phase or component of FGDM in that if children are placed in a resource home, one of the first actions of the FGDM intervention would be to quickly bring the family and the resource families together for a meeting to introduce them and to arrange for transportation and visitation, and if needed, draft a permanency plan. Similarly,

Family Finding can be considered an adjunct intervention in that it widens the circle to help to identify supports and extended family prior to having a FGDM. If the family does not have enough family or refuses a FGDM, they are offered a FTC. A FTC is similar to a FGDM but there is no private time for family; however, parents can invite any number of family and friends to the meeting. Finally, if the family refuses a FTC then a meeting will be held with CYS, parents, child, and service providers. Although included in the Crawford family engagement intervention continuum, HFW-only cases are not included in the CWDP evaluation, and neither Family Finding nor HFW are being monitored for implementation fidelity in this evaluation.

The goal is to have a FGDM or a FTC within 45 days of case acceptance into CYS. If a child is placed outside the home in a kinship or resource home, the First Meeting occurs within 72 hours to develop a plan for visitation and communication. The outcome of the FGDM and FTC is to develop their family service plan. Follow-up meetings are scheduled prior to a plan review (child permanency plan or family service plans) and include the family, youth, service providers and CYS. Follow-up meetings can be held anytime a plan is being revised or reviewed or if the family requests to have a meeting.

Dauphin County: Family Group Conference (FGC). Similar to Crawford, Dauphin has a range of family engagement meetings: Pre-court meeting; Family Engagement Meeting; Family Group Conference; Blended Perspective Meeting; Team Meeting and Restorative Practices. These meetings and groups have different purposes (e.g., a Blended Perspective meeting is held after family finding has occurred and individuals not involved in the child/youth's life are invited to learn more about his/her situation). While a family in the CWDP could participate in any or all of these meetings, the FGC is the engagement intervention being evaluated in this study; Dauphin felt the purpose (engaging with family during periods when decisions are needed to be made and the family creating a plan) was the most consistent with the other counties' family engagement interventions. The target group for a FGC is a child/youth and family opened for services after 7/1/2013. Dauphin was doing FGCs prior to the start of the CWDP, but for the purposes of this evaluation, only new referrals after 7/1/2013 are part of the evaluation. A referral for a FGC can be made at any time, but it is typically held when planning and consensus building are needed to create a family plan. The coordination and facilitation are done by a dedicated Dauphin worker who is not the family's caseworker or supervisor. The parents, children (if appropriate), service providers, and family supports are invited to attend in person or by phone. The FGC usually happens within 60 days of the family being opened for ongoing services. During the FGC, the family develops the family service plan with help from the caseworkers and providers. Follow-up meetings are offered at any significant event and at case closure, and there is also a post-conference check in meeting.

Lackawanna County: Family Finding, Family Team Conferences, (FTC), Teaming Meetings (TM) and Family Group Decision Making (FGDM). Lackawanna has a continuum of groups being used for engagement intervention: Family Finding, to widen the circle prior to holding a conference or meeting, FTC, TM, and FGDM. The target population for engagement interventions is the families of youth determined to be in immediate danger ("unsafe") on the Pennsylvania Safety Assessment Protocol and/or at high or moderate risk on the Risk Assessment starting July 1, 2013.

A FTC is triggered as soon as placement occurs due to safety or risk concerns identified and/or when a decision must be made. A FTC must occur within 30 days, but ideally it should be as

soon as possible. A FTC includes youth/children, family, friends, caseworkers, supervisors, and service providers that are already involved with the family and may be able to assist. The purpose of the meeting is to focus on needs and services only (and to make important decisions with regard to placement and movement of the child/children). A FTC makes the process of planning transparent, and it provides the opportunity for parents and other family members to have a voice early in the planning process. Immediate needs and services are the focus, but the FGDM coordinator is at every FTC and discusses with families what a FGDM meeting is and how it is an opportunity for families to have a meeting not just focused on immediate needs and decisions, but also to plan for keeping their child safe at home once reunification occurs. As is standard, private time is included in the FGDM, whereas it is not included in the FTC. The FGDM coordinator then follows up with the family to schedule a FGDM if the family agrees to have one and may continue to have FGDM groups as long as the group feels is necessary. The case may be closed after having a FTC without having a FGDM conference. Families may also be referred to FGDM without having a FTC. Ongoing FGDMs are held when a decision in the case needs to be made or when the plan that was previously developed has to be changed or updated.

Finally, a TM is held when a major decision must be made, but a FTC or FGDM cannot be held because the parent's whereabouts are unknown, or the parents refuse to participate. The purpose of a TM is to avoid the situation in which one caseworker and/or supervisor make a major decision about a child/children without considering all of the potential options. The people attending this meeting include caseworkers, supervisors, high-level administrators (such as the executive director of the Office of Human Services), and advocates. FTCs and FGDMs are included in the CWDP evaluation but TMs are not because TMs do not engage the youth, parents or family members.

Philadelphia County: Family Group Decision Making (FGDM); Family Team Conferencing (FTC). Philadelphia's family engagement interventions for the CWDP are FGDM and FTC. Since 2013, Philadelphia has been transitioning from a dual case management model to a single case management model. The system transformation, known as Improving Outcomes for Children (IOC), allows for Community Umbrella Agencies (CUAs) to provide ongoing service delivery to children and families in a community-based setting. DHS will continue to oversee the hotline, conduct investigations, provide permanency support, and provide other supportive functions (e.g., DHS psychologists for consultation).

Since July 2013, the target population for FTC is all families accepted for formal child welfare services. The target population for FGDM is families who are not assigned to a CUA, for whom DHS staff (Children and Youth Division) is still providing case management services. FGDM is a voluntary intervention for these families. Families receiving case management services from CUAs, who participate in a FTC, would not traditionally participate in FGDM. However, DHS is participating in a pilot with the Family Court of Philadelphia to incorporate the use of FGDM for all families whose cases are heard in two court rooms at the point of adjudication of dependency.

There are four types of FTCs that occur throughout the life of the case. The first type of conference is a Child Safety Conference that reviews the safety decision that was made during the CPS/GPS investigation. A Family Support Conference occurs for families in need of in-home services and the purpose is to develop the Single Case Plan for the family to assist with family stabilization. A Permanency Conference occurs for children who were removed from their

homes and the Single Case Plan is developed to ensure that the child attains permanency. The final type of conference is the Placement Stability Conference which is designed to offer supports to the child, resource parent, and/or group home provider in order to prevent placement disruption. Conferences typically occur every three months until the family is stabilized or until the child attains permanency. *Philadelphia County is collecting data on a stratified sample of families rather than the entire population. Please see Appendix B for the sampling plan.*

Venango County: Family Team Meetings (FTM); Family Group Decision Making (FGDM). Venango has contracted with a provider, Child to Family Connections (CFC), who is responsible for coordinating and facilitating both engagement meetings. After the FAST is completed, the intake caseworker explains FGDM to the family. If the family accepts, then a referral is made to CFC. If the family refuses FGDM then CFC offers the family a FTM. The two differ in that FTMs do not include private family time and may not use as wide a circle of family and friends. For both types of meetings, participants include parents, youth/children, friends, CYS staff, and providers. The purpose of both types of conferences is to create a family service plan and/or a child permanency plan. About 45 days following the initial meeting the process for reviewing the family service plan begins and a follow up meeting is planned with CFC in order to review progress on the plan. Subsequent FTM meetings are held every 6 months to review and revise the plan until the family has met the goals in their service plan.

Family Engagement mid-course corrections

In the period of January to June 2016, **Allegheny** incorporated the Prep/FAST into their Conferencing and Teaming model so that it had to be completed prior to initiating the conference. With the addition of the Prep/FAST, as well as the items on substance abuse and intimate partner violence (IPV), beginning in 2018 they began to realize the challenges that the data were suggesting in engaging with families with IPV and substance abuse. Moreover, they realized that workers were struggling with discussing these issues and working through them with families. In their last SAR, they said that their Teaming Institute is in the process of exploring the ways in which they can possibly modify Conferencing and Teaming to better engage these families.

In the period of January to June 2016 **Philadelphia** changed their process of a Child Safety Conference. They changed the timing, and instead hold a permanency conference within 20 days after a child is removed. The change in the meeting and timing facilitated the presence of a family advocate at the conference.

Lackawanna also made changes in their conferencing starting in the period of July 2016 and continuing to the end of the waiver. They added a post FTC meeting to identify barriers in permanence, and in 2018, the last year of the waiver, added a crisis and rapid response meeting, motivational interviewing, and family finding to the FTC intervention. The crisis and rapid response and family finding meetings occur when there is a threat that a child/youth might be removed from the home. It was a "rapid" intervention put into place prior to FTC meetings.

Crawford noted in July to December 2016 that their families were expressing a preference for a team meeting rather than a FGDM conference. They still offered the range of options but deferred to family preferences.

Table 5. Comparison of Family Engagement Interventions by CWDP County.

	Offered to target within 60 days	Target population	Timing of meetings	Strengths discussed	Family private time	Facilitator type	Expected immediate outcome
Allegheny Conferencing & Teaming	Yes (30 days if out of home)	Children birth to 17 accepted for in or out of home services since 7/1/2013	Initial & every 90 days or if significant event	Yes	Offered	Caseworker for the family	Family plan or plan revision
Crawford FGDM & FTM Family Team Meeting	Yes; (45 days is expectation)	Children birth to 17 accepted for in or out of home services since 7/1/2014	Initial & follow up at planning due dates or if family requests	Yes	Required for FGDM; Offered for Family Team Meeting	CYS staff (FGDM program specialists) but not the family's caseworker	Family service plan Child Permanency Plan, or plan revision (first meetings may create visitation or permanency plans)
Dauphin FGC	Yes	Children birth to 17 accepted for in or out of home services since 7/1/2013	Initial & significant event & at closure	Yes	Required for FGC	CYS staff but not the family's caseworker	Family service plan or revision

	Offered to target within 60 days	Target population	Timing of meetings	Strengths discussed	Family private time	Facilitator type	Expected immediate outcome
Lackawanna FTC & FGDM Family Inter-systems Team (FIT) 2017 Family Engagement Initiative (FEI) 2018	Yes. FTC within the first 30 days of placement, FEI within 24 to 48 hours of crisis and FGDM from the identification of service eligibility, FIT will be begin within 60 days.	Families of children determined to be in immediate danger and/or at high and moderate risk starting July 1, 2013. Children (10-17yr) who are eligible for a Family Home Based recommendation and are in congregate or are at significant risk for congregate care or OOH placement. FIT transitions with the child from congregate care or foster care placement through to reunification. FIT service authorization is for 12 months. FEI – all children at high risk for placement.	FTC are held within thirty days of placement and when a significant decision needs to be made. FGDM – eligibility can be determined at an FTC or after a referral is reviewed. Meetings are arranged by the FTC Coordinator. FIT – eligibility is determined, and meetings are held either biweekly or monthly thereafter. FEI – If a crisis response is needed a family meeting occurs within 24 hours. If a rapid response is warranted a family meeting will occur within 72 hours. Family Meetings will then occur within two weeks. Inter-agency Permanency Team Meetings (PTM) are held at 2 month intervals. Weekly PTM's are also held to review any other case.	Yes At every meeting	Required for FGDM	Consultant for FTC CYS staff for FGDM FIT Program is facilitated by OSSRD/OYFS Research Analyst, the Program Director of FHB through Scranton Counseling Center (SCC), and a member of Community Care and Behavioral Health (CCBH) FEI – FE Specialist, FE worker	FTC: family service plan with family voice in major decisions and transparency of process; FGDM: child permanency plan or service plan revision FIT -Preventing congregate care/foster care placement and/or step-down from the same. Placement stability. FEI – Family has a voice and is the main decision maker

Philadelphia FTC & FGDM	Yes	FTC: All families accepted for formal child welfare services FGDM: All families still receiving DHS case management services	FTC: Child Safety: Within 72 hours of removal or safety threat or within three days of a determination of "safe with a plan" Family Support and Permanency: Initial meeting within 20 days of Child Safety conference and every three months thereafter Placement Stability: Within three days of removal or potential placement disruption. Or, in non-emergency situations, within 10 days of the determination that a move may be necessary FGDM: One time	FTC & FGDM	FGDM only	FTC: DHS staff FGDM: Contracted provider staff	FTC & FGDM: Family stabilization and permanency
Venango FTM & FGDM	Yes	Children birth to 17 accepted for in or out of home services since 7/1/2013	Initial & every 6 months (prior to plan revision)	Yes	Required for FGDM; Offered for FTM	Provider	Family service plan or plan revision & Child permanency plan

Description of Interventions: Evidence-Based Practices

Each county was free to choose which EBPs they wished to implement (see the Interim Evaluation Report and the SARs). Table 6 outlines the EBP type, start date and target population, referral process and changes by county.

Allegheny identified 4 EBPs to start: PCIT; MST; Homebuilders; and TF-CBT. The target populations were children of the appropriate ages (younger for PCIT) or families who were active with CYF. All of these EBPs were provided outside of Allegheny County DHS by contracted providers and the caseworker was the point of referral with supervisor and resource coordinators approving and facilitating the referral. The county information system (KIDS) is not co-shared with the providers, although they are able to refer to some providers electronically. A mid-course correction was made in 2017 when MST was no longer part of the EBP array. According to the county, the use of MST did not seem to reduce readmissions to residential care, and so the contract was discontinued.

Crawford identified Triple P as their waiver EBP, along with Family-Based Therapy (FBT). Triple P: Level 4 (both Standard and Teen) was implemented by a provider; the target group was caregivers with children ages birth to 17 who had parenting challenges. A mid-course correction occurred in that conditions for discharge from Triple P were clarified and components of the practice began to be delivered with greater fidelity. For FB,T, the target groups were caregivers with children under age 18 who exhibited substance abuse problems. Referrals are made by the caseworkers to service providers who are trained in these EBPs.

Dauphin identified three EBPs: PCIT, Triple P: Levels 4 and 5 and DBT. The target populations were determined by age, with DBT targeted to adolescents with serious emotional disturbances. Referrals are made by CYF caseworkers and supervisors and in the case of DBT, juvenile probation officers, but there are identified program specialists (behavioral health, program intervention) to act as a liaison between the providers and CYF and to attend treatment team meetings. In addition, there are monthly implementation meetings in which CYF, the liaisons, and providers participate. No-mid course corrections were made.

Lackawanna was the only county to not implement Triple P, but instead chose SafeCare, feeling that it was a better fit for their target populations and for their workers. The also implemented PCIT. A referral for PCIT is made from the worker or supervisor directly to the provider; the target population is caregivers with children ages 2-7. SafeCare targets families with children from birth to age 5 and is provided by Lackawanna DHS after a referral is made by the caseworker. Family Intersystem Teams (FIT) were implemented starting August 2017; FIT targets youth ages 10 to 17 who are stepping down from a more restrictive out of home placement (residential, residential treatment facility) to a less restrictive placement or for a youth in foster care who is at risk of disrupting. Another target group is a youth in foster care with a history of placement disruptions. This is an intersystem team (CYF, MH etc.) and a referral by the caseworker or supervisor is made and the permanency team makes a decision about the referral. If it is appropriate, then it is transferred to the FIT team which is a cross systems team. No mid-course corrections were made.

Philadelphia offers PCIT, and Functional Family Therapy (FFT). Triple P (Levels 3 and 4) 4 were available starting in Fall 2015, with three CUAs as providers via private grant funding. Originally, Philadelphia had planned to release a formal RFP in order to continue to offer Triple P; however, due to concerns about sustainability and lack of fit with their population, they submitted a request to OCYF on 7/7/17 asking for permission to terminate Triple P as a waiver intervention. This was approved by the State. PCIT was phased in and expanded in 2016. It was offed to CYF-involved families from 2.5 to 7 years of age both in and out of home. The referral could come from a variety of sources and prior authorization was not needed. Functional Family Therapy (FFT) has been available in Philadelphia since 2002; however, pre-authorization is required. This targets youth ages 11-18 living at home with delinquent behaviors.

Venango has offered PCIT, Triple P, and Parents as Teachers/Home Nurse Visitation. Venango uses a clinical review team at the intake or at the time of referral (for a case that is not newly opened) to review for the appropriateness of these EBPs for the family. A service coordinator then discusses the options with the family. Despite having a standard referral procedure, there was a problem with some children who were referred to PCIT in that the provider was screening out appropriate children. A new procedure was put into place and, over the course of the waiver, the agency has worked in collaboration with the provider to formulate a referral process that now includes communication for referrals that are not accepted into treatment. In 2017-2018, Triple P providers expanded their programming to include educational groups at the local Child Development Centers. Additionally, the Program Specialist running the program has attended training, and has been certified in Teen Triple P, and has implemented this part of the program. Referrals have continued to come in consistently with this new component, and the agency plans to expand the program further by adding an additional worker, which will create capacity for ten additional families to be served. Finally Parents as Teachers has been successful to the point of a waiting list, so other services (Early Head Start) have been added.

Table 6. Selected EBPs by CWDP County.

	EBP Type	Start date	Target Population	Referral Process	Policy/Procedure changes regarding use of EBP
Allegheny	PCIT	May 2015	Any family active with CYF with a child ages 2-7 with externalizing behaviors.	Caseworker identifies that the service is appropriate, makes a request of their Supervisor and Resource Coordinator. If approved, CW makes direct referral to the provider of choice.	NA
	MST	Started before CWDP, but for these purposes, January 2014. **No longer offered through CYF contract, ended July 2017**	Any family active with CYF with a child ages 11-18 and behavioral problems in multiple settings.	Electronic referral through the case management system (KIDS).	NA
	Homebuilders	January 2015	Any family active with CYF who has a child at imminent risk of being removed from the home OR who has a child returning home from OOH care.	Caseworker identifies that the service is appropriate, makes a request of the Resource Coordinator via the KIDS system. Resource Coordinator and CW Supervisor approve and referral is sent to the provider of the service.	NA
	TF-CBT	Started before CWDP, but for these purposes, January 2014.	Any family active with CYF with a child ages 3-18 with significant emotional challenges stemming from traumatic life events.	Caseworker identifies that the service is appropriate, makes a request of their Supervisor and Resource Coordinator. If approved, CW makes direct referral to the provider of choice.	NA

Crawford	Triple P Level 4 Standard and Teen	July 2016	Caregivers of children aged 0-17 who exhibit parenting deficits.	Crawford County CYS refers families who are being served by CYS to direct care service providers who are trained in the Triple P model.	Mid-course corrections on discharge procedures and more clearly defined components of the practice.
	FBT (Adult Focused Family Behavioral Therapy)	May 2016	Caregivers of children aged 0-18 who exhibit substance abuse concerns	Crawford County CYS refers families who are being served by CYS to direct care service providers who are trained in the FBT model	No changes
Dauphin	PCIT	January 2015	Target population is a child 2.5 years to 7 years with a behavioral problem and a parent or other caretaker who is able to participate in the program	Referrals are made to the Dauphin County providers directly by Children and Youth Caseworkers and Supervisors as they identify a child or family on their caseload whose needs match the services provided. A C&Y Behavioral Health Program Specialist is assigned as a liaison to the providers and participates on a Dauphin County implementation team that meets quarterly.	No changes
	Triple P *Levels 4 & 5*	January 2015	Target population includes those parents interested in general information about promoting their child's development (prevention/public health initiative), parents with a specific, targeted concern about their child's behavior (i.e., bed-wetting, tantrums, lying), and parents of children with	Referrals are made to the Dauphin County providers directly by Children and Youth Caseworkers and Supervisors as they identify a child or family on their caseload whose needs match the services provided. A Prevention/Intervention Program Specialist is assigned as a liaison to the 5 Dauphin County Triple P providers and coordinates monthly	No changes

			moderate to severe behaviors that require intensive parent training and education.	implementation team meetings. All providers are required to attend.	
	DBT	August 2016	Target population is adolescents diagnosed with a significant mental health issue, such as borderline personality or borderline personality traits, who have a caretaker willing to participate in the treatment	Referrals are made to the Dauphin providers directly by Children and Youth Caseworkers and Supervisors as well as Probation Officers and their Supervisors as they identify a child or family on their caseload whose needs match the services provided. A C&Y Behavioral Health Program Specialist is assigned as a liaison to the providers and participates on a Dauphin implementation team that meets quarterly.	No changes
Lackawanna	PCIT	January 2014	2-7 years	Referral process to provider agency from Caseworker or Supervisor	No recent policy or procedure changes
	SafeCare	May 2014	0-5 years	Referral process is internal and directly from the Caseworker and/or Supervisor to the Clinical Director.	No recent policy or procedure changes
	FIT	August 2017	10-17 years Stepping down from a more restrictive placement such as RTF; or in foster care and at risk of disruption; or has a history of placement disruptions; willing caregiver	Referral from caseworker; case then referred to a permanency team meeting and group then makes decision for the appropriateness of referral. If so, then case transferred to the Family Intersystem Team (FIT)	No recent policy or procedure changes

Philadelphia	PCIT	PCIT has had a phased implementation. It was first offered as a pilot in 2010 and later expanded in 2014. It was again expanded in 2016.	Young children ages 2.5 to 7 years old who have disruptive and/or oppositional behaviors. PCIT may be offered to children with both in-home and placement services.	Families, schools, daycares, child welfare workers, and professionals may identify a family who could benefit from PCIT. Families, and any of these stakeholders, may directly refer for PCIT. Prior authorization from CBH is not required. When CUA workers refer for PCIT, they notify the Intervention Director for tracking purposes.	There have been no changes to the policies or procedures regarding the use of PCIT in Philadelphia since the Demonstration Project began.
	Triple P *Level 3 & 4*	Fall, 2015	All CUA-involved families are eligible to receive Triple P. It is offered to parents who need extra support with parenting.	CUA case workers may refer, or families may self-refer, directly for this EBP through one of the CUAs providing Triple P.	Since the fall of 2015, three CUAs have been providing Triple P via private grant funding. Due to sustainability concerns, Philadelphia County submitted a request to OCYF on 7/7/17 to not proceed with releasing a formal RFP for Triple P.
	FFT	FFT has been offered in Philadelphia since appx. 2002	Youth aged 11-18 years with severe behavior problems, chronic delinquency, and co-morbid diagnoses, as well as youth at risk for these problems. FFT is predominantly offered to families receiving in-home services.	Pre-authorization from CBH is required for FFT. CUA workers refer for FFT through the Intervention Directors, who help prepare the referral for submission to the DHS Liaison at CBH.	There have been no changes to the policies or procedures regarding the use of FFT in Philadelphia since the Demonstration Project began.

Venango	PCIT	2013	The children that can be referred range from 2 to 7 years of age. The focus is to decrease external child behaviors, increase child social skills and cooperation, improve parent and child interactions, and improved the parent and child interaction while promoting a warm and nurturing relationship.	During a CASSP Meeting, a Clinical Review Team Review (CRT) at the intake level, or during supervision at the intake or ongoing level the service can be identified as an appropriate intervention. The service coordinator then discusses the service with the family to gain their ability to participate in the program. At that level, the service coordinator must have the target child/parent sign the release. Once the release is obtained, the service coordinator fills out the referral for the program and submits it with a service authorization that is reviewed by the supervisor and the CYFS Systems Manager. Once approved, the release and referral are sent to the Regional Counseling Center to initiate the service.	Issues have been identified regarding the criteria for parents/children accepted into PCIT treatment. The provider has screened out referrals based upon the child not residing with the parents; this lead to confusion with child welfare staff. Through communication with the provider, notification will be given to the Children and Families System Manager when a referral is not accepted by the provider; accommodations may be made or another service selected. This will ensure that all referrals made to PCIT who are eligible receive the service and accommodations are made when appropriate. The agency has worked in collaboration with the provider to formulate a referral process that now includes communication for referrals that are not accepted into treatment.
	Triple P *Level 3 and Teen*	2013	Standard Level 3 Triple P works with children, ages two to twelve years of age	During a CASSP Meeting, a Clinical Review Team Review (CRT) at the intake level, or during supervision at the intake or ongoing level the service can be identified as an appropriate	In 2017-2018 Triple P has expanded its program to include educational groups at the local Child Development Centers.

			with mild to moderate behavioral concerns. Implemented Teen Triple P in 2017-2018. The age range for this is from 12-17 years old.	intervention. The service coordinator then discusses the service with the family to gain their ability to participate in the program. At that level the service coordinator must have the target child/parent sign the release. Once the release is obtained, the service coordinator fills out the referral for the program and submits it to the program director with a service authorization that is reviewed by the supervisor and the CYFS Systems Manager. The referral and release are then submitted to the CYFS Program Manager to be assigned to the Triple P Program Specialist.	Additionally, the Program Specialist running the program has attended training, and has been certified in Teen Triple P, and has implemented this part of the program. Referrals have continued to come in consistently with this new component, and the agency plans to expand the program further by adding an additional worker, which will allow ten additional families to be served.
	PAT/NHV	2013	The target population is to serve pregnant women, infants, and toddlers up to age five in Venango County. This is an in home visitation program that provides education for parents and children regarding child development, health, community resources, safety, nutrition, and mental health.	During a CASSP Meeting, a Clinical Review Team (CRT) at the intake level, or during supervision at the intake or ongoing level the service can be identified as appropriate. The service coordinator then discusses the service with the family and has them sign the release. Once the release is obtained, the service coordinator fills out the referral for the program and submits it with a service authorization that is reviewed by the supervisor and the CYFS Systems Manager. Once approved, the release and referral are sent to Community Services of Venango to initiate the service.	PAT continues to function at capacity, sometimes running a waitlist. If there is a waitlist for Early Head Start, families will be referred to PAT.

Data Sources: Description of Quality Procedures for Data

Pennsylvania does not have a Statewide Automated Child Welfare Information System (SACWIS). The state is implementing a statewide Child Welfare Information Solution (CWIS) that supports the administration of child welfare programs across the state and allows PA to meet all federal reporting requirements. Phase 1 of CWIS is the first step in the development of a statewide child welfare information solution for PA. Phase 1 focuses on the intake and investigation stage of child welfare and improves the state's efficiency and effectiveness in sharing information statewide. It also incorporates the many policy and practice changes brought about by PA's amendments to its Child Protective Services Law (CPSL). This approach allows counties to operate their own system, as long as it meets the minimum requirements set forth by the state. Crawford, Dauphin, and Venango all use the same vendor for their system, AVANCO, and use the Child Accounting and Profile System (CAPS), and share most, but not all, variables. Philadelphia and Allegheny each have their own system. In addition, some counties also have changed information systems during the course of the CWDP period (e.g., Venango transitioned to CAPS, Dauphin transitioned to CAPS, Lackawanna transitioned from CAPS to ACYS in February 2016).

Evaluating the waiver interventions was very challenging in the absence of a SACWIS, as well as with multiple information systems and systems that changed mid-waiver. As a result, historical data was lost in Venango and data were maintained in spreadsheets for a period of time. In Philadelphia there was a lengthy period in which no data were obtained, due to the collapse of their information system. Master Client Index (MCI) numbers (the unique identifier) were difficult to obtain from some counties, and almost impossible to obtain from providers. Consequently, we established internal protocols to ensure that the assessment data received from each county information system met a minimum quality standard. Despite processes in place to communicate with counties about data, some data were not corrected by the counties and were thus omitted from analyses. Table 7 summarizes the sources of data and the volume of data submitted over the course of the CWDP.

Table 7. Volume and Types of Data Submitted by Counties Over the Duration of the CWDP.

	Cohort 1					Cohort 2	Demonstration Project Total
	Allegheny *	Dauphin	Lackawanna	Philadelphia *	Venango	Crawford	
FAMILY ENGAGEMENT (Last Submission Date)	07/19/18	07/17/18	07/12/18	07/12/18	07/17/18	08/06/18	
Total # of Meetings Held (Initial and Follow-Up)	236	390	488	874	856	617	**3461**
# Cases That Closed**	58	69	152	90	82	79	**530**
# of Children Who Had at Least One Meeting (Based on Non-Duplicate MCI	219	429	496	414	402	372	**2329**
# of Missing MCIs	0	0	0	0	0	0	**0**
AGES AND STAGES (Last Submission Date)	06/30/18	09/19/18	09/25/18	06/30/18	09/13/18	06/21/18	
# of ASQ	3204	923	2225	8270	357	182	**15161**
# of ASQ:SE	1502	450	1702	4559	278	139	**8630**
# of Missing MCIs on ASQ	0	13	1	0	0	0	**14**
# of Missing MCIs on ASQ:SE	0	7	0	0	0	0	**7**
CANS (Last Submission Date)	06/30/18	05/21/18	06/30/18	06/30/18	06/30/18	06/30/18	
# of CANS	19597	1498	1140	9137	441	522	**32335**
# of Missing MCIs	3962	0	0	0	0	0	**3962**
FAST (Last Submission Date)	6/30/2018	5/21/2018	6/30/2018	6/30/2018	6/30/2018	6/30/2018	
# of Family Together Assessments	20410	1713	5393	18527	625	659	**47327**
# of Caregiver Assessments	20409	1713	5393	18392	623	659	**47189**
# of Child Functioning Assessments	20409	1713	5393	18392	623	659	**47189**
# of Child Records With No MCIs	1228	1	0	0	0	0	**1229**

***Allegheny and Philadelphia are using a sampling strategy for the Family Engagement Study. Allegheny implemented this strategy in February of 2014**

**** This number includes cases that have been closed for children who had an initial/follow up meeting.**

Quality procedures for the FAST, CANS and ASQ. The six counties submit their FAST data files monthly using a ShareFile platform. After the raw data file is downloaded it is then exported into Excel and undergoes a first level quality review to ensure the minimum standard dataset. This includes the following: all three tables are present (Family Together, Caregiver, Child); at least one child in the FAST has a Master Client Index Number (MCI); the MCI is the correct number of digits, and all column headers are present. Other quality audits include: at least 50% of questions have responses, all records have a date of 7/1/2013 or later, status of assessment is complete or closed, and there is a family ID and assessment ID which appear in all three tables.

Finally, the records are searched for duplicates. The database administrator and the evaluation coordinator confer about any problems, document them, and then the coordinator attempts to get corrections from the county. This process is documented; there is a 30-day period to obtain corrections. The clean and corrected data are moved into the research database, and the data that cannot be corrected goes into a "graveyard". The graveyard is a separate database in which the evaluation team stores unusable data or duplicate data. The graveyard exists for tracking purposes as well as data accountability. The second level of auditing is done by the statistician, who audits for missing follow-up assessments or patterns or themes that seem problematic (e.g., some respondents producing a consistent pattern of not applicable or missing). The same procedure is followed for the CANS assessment data submitted from the counties. The difference is that the CANS is a less complex measure so the minimum data set is smaller. However, the process is the same. Quarterly, we audit the volume of data submitted, comparing to other quarters to see if it is similar or different; if differences in volume are noted, the evaluation coordinator follows up with the county to inquire about possible reasons or errors. We also submit a quarterly report to the counties that provides them with an updated total number of assessment data, family engagement data forms, and EBP data packages that we have received over the last quarter.

Allegheny and Philadelphia query the ASQ and ASQ:SE data from their information systems. The other four counties use an application for entry which is supported by the University of Pittsburgh's Child Welfare Resource Center (CWRC). Regardless of how it is submitted, the ASQ data is checked for the following minimum data set: MCI number with the correct number digits, child case number, date of birth, gender, substantiation status, maltreatment type, ASQ screening date, which ASQ was used (ASQ screenings are specific to the child age), ASQ concern types, who screened, EI referral date, and scores for each domain. For the ASQ:SE the same minimum dataset applies except that it is ASQ:SE screening date, type of ASQ:SE, who administered, concern types, domain scores and early intervention referral date. A similar process to that of the CANS and FAST is followed in terms of communication and documentation of errors with this first level auditing and moving corrected data into the research database.

In the second stage of auditing, we look for duplicate screenings as well as the number of screenings per child and if screenings are being done at the correct month using the correct tool. For example, it is not uncommon for a worker to use a 12-month assessment on an 18-month child because the worker neglected to get the correct form. We then contact the county evaluation liaison to let them know if we see any patterns of this mistake by a specific administrator of the ASQ. We also look at the number of cases, the number of new and follow-up screens and compare them to prior months. We then follow up with the county about any

discrepancies in volume, both to let them know of the difference and to check and see whether there was an intervention reason that could account for a difference (e.g., a county "fires" a provider who was doing the screens and is in the process of finding a new one, so few screenings were done).

Quality Procedures for the Family Engagement Study. This is a study that is done on paper with a scanning (Teleforms) application. Our evaluation specialist is dedicated to monitoring the family engagement study and reviewing and tracking the study forms. The first step is to log the forms received and conduct a visual inspection for the following minimum dataset on all the forms: MCI is entered, MCI is the correct number of digits, and all identifying information is complete and consistent across the set of forms (including Family ID and Conference ID). The evaluation specialist also checks for the "completeness" of a set of forms (i.e., it includes a Facilitator Face Sheet, Family Conference Surveys, and a Baseline or Follow-Up Form). If forms are missing an important variable (e.g. MCI or date of conference), the evaluation specialist contacts the family engagement point person at the county in order to obtain the correct information for the form. Finally, problem areas specific to forms are checked and corrected (e.g., on the Family Conference Survey, respondents often write in their relationship to the child as "other" rather than checking the correct box on the survey form).

The second level of quality assurance occurs when the forms are scanned and the items are verified by Teleforms' prompting. Scanning is not a fool-proof method of entry, particularly when people are not careful with writing and/or are using copies of copied forms. Optical scanning often misreads characters and so any discrepancies with the scanned data are resolved by looking at the paper forms and the Teleforms log and then re-scanned or corrected in the database. Designated team members meet weekly with the evaluation specialist to resolve specific issues (e.g., "orphan" forms that are not part of a set, forms with mismatched information, dates that are wrong but not picked up on the first level of quality review).

We leave a large window of time (60-90 days) to try to get corrected forms or completed sets so that the data can be finalized. However, when there are multiple problems that cannot be easily fixed by an email or phone call, or mistakes are made by multiple individuals, then we conduct remediation training with the county staff on the data collection protocol for the study.

Quality Procedures for EBP data.

EBP "Basics" Spreadsheet

Since counties were implementing a variety of EBPs we need a standardized way in which to collect some "basic" referral and dosage information for children and families who were referred to EBPs by child welfare. Lacking a unified statewide information system as well as a single source of invoicing information (e.g., some are paid for with special grants, others through managed care), we held conference calls with each county in order to craft a strategy. Working with the counties and with Chapin Hall, we created a spreadsheet which included all of the variables needed to answer the research questions. This also helped to clarify the referral process and to clarify the feasibility of getting the variables requested. We created a "flat" spreadsheet that could be used by the larger counties who opted to obtain information from a variety of sources and then export the file directly to us. We also created an Excel-based application that the smaller counties with lower volume used to enter this information. Training calls were held

with each county to review the variables and data entry process, and a July 1, 2015 date was given for start-up. Counties were asked to collect these data on an on-going basis and submit semi-annual uploads to the evaluation team, who then completed a QA process. Counties were often asked to clarify or fix information.

PCIT and Triple P Sub-study

One person on the evaluation team was assigned to document and review the data received from providers and to do follow-up visits and calls to encourage submission of data at the child level (data packages). Providers were contacted when there were questions or missing data. Paper data were reviewed for errors and entered. Any data submitted electronically was reviewed. Table 8 summarizes the number of EBP packages that were received and cleaned. A problem that was encountered and reported in the SARS was the inability to obtain child level data from Philadelphia county. The County and the Office of Behavioral Health were unable to reach an agreement despite almost a year of ongoing correspondence. In addition, Allegheny (as discussed in the semi-annual reports) did not submit to the evaluation child level data on a consistent basis.

Table 8. Number of data packets received PCIT and Triple P sub-study from 4/21/15 to 6/30/18.

Total Received	**Allegheny**	**Crawford**	**Dauphin**	**Lackawanna**	**Philadelphia**	**Venango**
Initial Packets	5	27	3	7	0	53
Final Packets	4	24	1	6	0	53

Quality Procedures for the Outcome Data Files (a.k.a. "administrative data"). Chapin Hall (CH) worked with each of the Information Technology administrators in the six counties to obtain child level baseline data on maltreatment and placement, updated yearly, as well as table structure documentation for each of the administrative data systems. CH followed their standard set of procedures used in the Multistate Foster Care Data Archive for cleaning and creating files (http://www.chapinhall.org/research/report/update-multistate-foster-care-data-archive). *The data required from each county's information system can be found in Appendix C along with details on how the files were created and data dictionaries.*

Some issues specific to Pennsylvania were how unsubstantiated investigations and victim and non-victim children were managed. While we had hoped to include unsubstantiated investigations in our analysis, because of issues with expungement, they will not be included in the analysis. The state requires unsubstantiated Child Protective Service investigations to be expunged after a year plus 120 days after the investigation. Individual counties also had expungement policies for general protective investigations. Also with the future changes in expungement due to the changes in the Child Protective Services Law (CPSL), the record of unsubstantiated investigations for the CWDP is likely to reflect policy changes and individual county practice over the five year evaluation period. In addition, Allegheny, Dauphin, and Lackawanna's maltreatment data contained limited information about non-victim children associated with a given investigation.

During each year of the waiver, Chapin Hall and the University of Pittsburgh conducted conference calls with each county to review the files created for the outcome analyses, verify pre-waiver trends, and resolve any errors or differences. Counties had varying amounts of historical baseline data, with Allegheny and Philadelphia having the greatest number of pre-waiver data years. The raw data files along with profiles were then given to each of the counties annually, as well as at the end of the waiver period.

Quality Procedures for the Fiscal Data Files. In the early stages of the evaluation, CH and the University of Pittsburgh determined all the sources of child welfare revenues and expenditures and developed a methodology which included: (1) identifying key budget personnel at the state and in each of the counties and conducting phone interviews to determine all sources of data and the accuracy; and (2) developing an expenditure and revenue tool to use going forward. We utilized the State Act 148 Invoices, as well as Special and Block Grant expenditures, created files, and then verified the files with each county fiscal officer. Any discrepancies were followed up and corrections made in the files. As part of ongoing quality assurance, we continue to be part of the fiscal subcommittee calls so that we are aware of any changes in the reporting of expenditures and revenues as well as changes in key personnel.

Based on expenditure type and county feedback, the county expenditures were grouped into summary categories for further analysis. In the system-level study of the aggregated expenditures and revenue, county activity will not be compared directly between counties. Appendix D.1 presents a mapping of the Act 148 Invoice cost centers to the summary categories utilized by the evaluation.

Analysis of the State Act 148 data and conversations with fiscal officers and state staff in the first year of evaluation led to the conclusion that the more detailed categories on the Act 148 Invoice (for example, "Counseling" or "Service Planning" or "Protective Service General") should probably not be used for the evaluation because the rules governing their uses were broad enough that they could be used differently in different years. The ability to use those categories to analyze spending is limited by the variance both within county and between counties in interpretation of those categories.

The state did make efforts to isolate the costs associated with CWDP interventions on the Act 148 Invoice, but evaluators stated these efforts were unlikely to yield information accurate enough to be useable for the evaluation.[1] Isolating the costs of activities that are delivered by county staff is difficult to do without methods like a random moment survey or a time and cost study. In the second half of the waiver and evaluation, investment in different methods of capturing the costs of interventions could be considered by evaluators.

As of the time of preparing this final report, all Act 148 Invoices and Special and Block Grant information from SFY 2011 through SFY 2017 were finalized except for Philadelphia's SFY 2017 Act 148 Invoice, which is excluded here due to incomplete invoicing activity. Also

[1] Counties were asked to show any increased expenditures or a re-allocation of effort associated with the interventions in the "Service Planning" category. However, it does not appear that this is being done in all counties. In addition, within the Act 148 invoice, each CWDP county was also asked to communicate to the state the amount of money they spent on each waiver intervention. These data were analyzed, and as expected, were not accurate enough to support an analysis of the costs of the interventions.

excluded are all counties' SFY 2018 Act 148 Invoices which were in-process and not finalized at the time of this analysis.

Other Data Sources. The remaining data for the evaluation consists of data collected by the evaluation team. These data were entered into Access databases, SPSS files, or spreadsheets and reviewed for accuracy. The following section details the procedures, including quality control procedures, associated with each measure.

Measures (Note: copies of each measure can be found in Appendix E)

Document Review (Process Evaluation). A document review is one of the tools we used to determine readiness of the counties to implement the components of the CWDP (i.e. assessment, engagement, and EBPs). The review is completed either on site or via electronic transmission of documents, with two raters who reach consensus after independently reviewing the documents. We completed document reviews for counties in Cohort One between August 2013 and June 2014. Cohort Two was completed in September 2015. Please see the Interim Evaluation Report for more details on this initial document review.

We completed an additional document review focused on readiness to implement the EBPs in between January 2016 and June 2016. We also completed a less structured review in the spring/summer of 2017. This informal review asked for documentation about new policies and procedures for engagement, assessment, and EBPs, as well as any new positions and supports for those new positions (e.g., training, coaching). This final review was not scored.

In terms of procedures, the Evaluation Team contacted each county evaluation liaison and provided instructions about the purpose of the review and the questions we sought to answer, as well as examples of potential source documents they should provide to us. Please refer to the Interim Evaluation Report for more information about the document review tool and process. The document review measure was created specifically for this evaluation. It is based on the work of the National Implementation Research Network (NIRN) and has six domains that cover essential components of effective implementation: (1) recruitment and selection; (2) training and supervision; (3) decision support; (4) culture; (5) collaboration with other systems; and (6) evidence-based practice preparation.

Recruitment and Selection

- Right people/organizations are hired or contracted to implement EBPs

Training and Supervision

- Staff/supervisors who make referrals receive information about the EBP;
- Staff/supervisors are being coached on how to make a referral and work with EBP clinicians;
- Staff are evaluated on behaviors and practices as part of performance appraisals.

Decision support

- Tools are available to identify appropriate EBP;
- Support tools provide leaders with access to information to make decisions about EBPs;
- Systems are in place to monitor implementation.

Culture

- Leaders communicate the value of the EBPs through presentations, meetings and marketing;
- Administrative practices and procedures have been altered to accommodate needs;
- Organizational and administrative structures have been altered;
- Administrative staff and stakeholders received explicit training about the use of EBPs.

Collaboration

- Policies and procedures are in place to enable sharing of information across systems.

EBP preparation

- The county systematically prepared for EBPs by examining client need, fit, organization resources and workforce.

The items are scored in the following manner based on documentation provided by the county:

- In place = 2. There is/are document(s) that provide the evidence that there are policies and procedures in place;
- Partially in place/initiated = 1. There are documents that provide evidence that policies and procedures have been initiated but are not fully in place or are inconsistently being implemented;
- Not in place/absent = 0. There is no documented evidence that policies and procedures are in place.

Scores were then averaged for multiple-item domains (e.g., training and supervisor). A discussion of findings can be found in the Process Evaluation section.

Key Informant Interviews (Process Evaluation). One-hundred individuals from the six counties were interviewed starting in August 2013 and continuing into October 2014 (informants in Crawford County were interviewed in September/October 2014 after they joined the CWDP). See Interim Evaluation Report for methods and findings on these initial interviews.

Since that time, we conducted two additional sets of key informant interviews: one set with PCIT and Triple P providers and the other with county and state leaders about plans for sustainability once waiver funding ended.

County and State leaders. Interviews were conducted with County Human Service administrators or CYF directors, as well as with a few individuals at the state. At least two people per county were recruited to participate in a 45-minute telephone interview. All but two individuals were able to participate. In the Office of Children Youth and Families, the financial director, the bureau director and a consultant were interviewed as well as the Deputy Secretary. In total, twenty-one individuals were interviewed. The interviews occurred in May and June 2018 and were conducted by an MSW student who was supervised by a senior researcher. All interviews were digitally recorded and transcribed by the student. The telephone interviews lasted between twenty and sixty minutes. The questions that were asked were:

- What have been the biggest successes of the CWDP?
- What have been the biggest challenges of the CWDP?
- What would you do differently if you were to do this again?
- (*If not addressed in any of the above*) How did the CWDP change collaboration between child welfare and other child/family-serving systems in your county
- (*If not addressed in any of the above*) Did the flexible federal out-of-home maintenance and administration funding of the CWDP change the way your county made spending decisions during the waiver period? If so, how?
- What are your county's plans for sustainability after the completion of the CWDP and the extension?
- What supports do you need from the state, the CWRC, or other sources in order to sustain your county's efforts?

The interviews were transcribed and read independently by three Ph.D. level researchers, all of whom had varying levels of involvement in the evaluation of the project. Open coding was done by question, counting how often a theme was mentioned, and any major differences between counties or between informants was noted. Discrepancies between the readers were resolved though re-reading the text and coming to consensus.

Triple P and PCIT Providers. Key informant interviews with PCIT and Triple P providers were completed. The findings from these interviews provide information about the extent of the adoption of these EBPs, as well as facilitators and barriers associated with implementation.

Our county Evaluation Liaisons prepared contact information for 22 provider agencies that offered at least one of these EBPs, and 18 agencies agreed to participate. Informants were then contacted by evaluation staff and if they agreed to the interview, oral and then written assent were obtained. In Philadelphia, eight individuals were initially contacted and five agreed to the interview. In Dauphin county five individuals were initially contacted and four agreed to the interview. In two counties the interviewee was accompanied by a colleague who also provided information.

Table 9. Number of PCIT and Triple P Provider Interviews by County

County	PCIT Provider Agencies	Triple P Provider Agencies*	Total
Allegheny	5		5
Dauphin	2	2	4
Lackawanna	2		2
Philadelphia	5		5
Venango	1	1	2
Total	15	3	18

*shading indicates Triple P is not part of the county's IDIR.
Note: due to limited resources of the evaluation team, we were unable to complete KIIs with providers in Crawford

The interview questions were open-ended. Respondents were asked to describe their understanding of the following issues:

- the CWDP
- how children and families were referred to them by Children, Youth, and Families (CYF)
- agency training and on-going coaching in PCIT/Triple P
- barriers to engagement at the agency and family level
- strategies for engaging families
- types of communication with caseworkers regarding CYF-referred families

Finally, respondents were given the opportunity to provide their own thoughts on what county decision makers needed to know in order to fulfill the task of getting the right families to the right services at the right time.

Interviews were conducted by phone or in person, and digitally recorded. The length of interviews ranged from a minimum of 20 to a maximum of 45 minutes. Interviewers then listened to the recording and created detailed tape-based notes from each interview. The notes were organized by county and sub-organized according to the interview questions. Three researchers (1 Masters and 2 PhD level) then independently read the notes and identified themes that were dominant in each county's notes as well as across all the counties. These topics were discussed and consensus was reached about what themes were present.

Focus Groups (Process Evaluation). A series of focus groups were held with three groups of key stakeholders in each county in the first two years of the waiver: caseworkers, supervisors, and families/youth. Each group was asked questions that focused on their understanding of the CWDP, their experiences with the engagement models and assessment tools, and their experiences with referrals to additional services. See the Interim Evaluation Report for methods and findings.

In Spring 2016, we conducted additional focus groups with caseworkers and supervisors to gain a better understanding of their perspectives on EBPs. Focus groups were held in all CWDP counties (with the exception of Dauphin, who was unable to participate) with caseworkers and supervisors. The goal of the focus groups was to learn more about the knowledge and awareness of EBPs by these groups, as well as their attitudes and behaviors around referrals to EBPs. Additionally, we sought to understand their perspectives on potential barriers and facilitators to families' successful work with EBPs. We also asked a few questions specifically around PCIT and Triple P, since these two EBPs are the focus of a sub-study for the evaluation.

We worked with each county's evaluation liaison to recruit participants for the focus groups. In Allegheny, we requested a participant from each of the regional offices; similarly, in Philadelphia, we requested for participants from each of the CUAs. Groups were held in a place convenient for participants, typically a conference room in their administrative building. Two members of the Evaluation Team facilitated each of the groups. Caseworker and supervisor groups were held separately. The number of participants in each group can be seen in Table 10. Discussions were digitally recorded. Upon completion of the groups, a facilitator listened to the recording and created detailed tape-based notes from each group. The notes were organized by county and sub-organized according to the interview questions. Two PhD level Evaluation Team

members then independently read the notes and identified themes that were dominant in each county, as well as any themes that were common across all counties. These topics were discussed and consensus was reached about what themes were present.

Table 10. Number of focus group participants by county.

County	# Supervisors	# Caseworkers	Total
Allegheny	5	5	10
Crawford	4	5	9
Lackawanna	10	11	21
Philadelphia	9	8	17
Venango	4	5	9
Total	**32**	**34**	**66**

The Organizational Readiness for Change Survey (ORC) (Process Evaluation). The ORC was developed by Texas Christian University's Institute for Behavioral Research (Lehman, Greener & Simpson, 2002). It was originally created for providers of substance abuse treatment, and additional versions have been developed for other agencies including social service providers.

The ORC has 20 subscales which measure items in four domains related to the organization: Motivation for Change; Resources; Staff Attributes; and Organizational Climate. The Motivation for Change scale includes items regarding program needs, training needs, and pressures for change. The Resources scale includes items regarding offices, staffing, training, equipment, and Internet. The Staff Attribute scale focuses on the individual worker and includes items regarding opportunities for growth, efficacy, influence, adaptability, and satisfaction. The Organizational Climate scale includes items regarding mission, cohesion, autonomy, communication, stress, change, and leadership. The instrument has been psychometrically validated and the studies confirmed the factor structure (Lehman, Greener, & Simpson, 2002). *Please see the progress report for Pennsylvania from July 2014 for additional information about the ORC including examples of items*. Additional information about the process and the findings can be found in the Interim Evaluation Report.

The Service Process Adherence to Needs and Strengths (SPANS) (Process Evaluation). The SPANS is a companion measure to the CANS and the FAST; it measures the degree to which the needs and strengths identified in the assessments are represented in family service plans and implemented in services and supports. Therefore, it measures an important process outcome question which is part of our theory of change.

The SPANS was developed in Allegheny as part of their SAMHSA System of Care Evaluation to measure the fidelity of wraparound. Since that time it has been used in Allegheny as part of contract monitoring of mental health service providers. Additional information about the measurement properties of the SPANS can be found in the book Behavioral Health Care: Assessment, Service Planning and Total Clinical Outcomes management, 1st edition, 2007. Chapter 20, Service Process Adherence to Needs and Strengths: A quality improvement tool (Dollard, Rauktis, Vergon & Sliefert, 2007).

Cases were reviewed using the SPANS on an ongoing basis throughout each calendar year of the CWDP. Prior to the on-site review, a county was asked to randomly select a specific number of cases for each the following categories: New CANS; Ongoing CANS; New FAST; Ongoing FAST (see Table 11 for the number of cases per county per year). For each selected case, two independent evaluators used the SPANS-CANS or the SPANS-FAST to assess the degree to which there was congruence between the assessments and what was in the service plans and documentation. All raters were trained by Allegheny County's trainers on the SPANS-CANS and the SPANS-FAST. All evaluation team raters were certified on the CANS and achieved an acceptable level of consistency on the SPANS as determined by Allegheny County Assessment Unit Trainers. However, one of the limitations of the SPANS is simply the amount of time that it takes to read and score. As counties transitioned to electronic records, the amount of time required to do the SPANS was reduced. In addition, over time the reviewers became more efficient. Nonetheless it is a time-intensive process.

Table 11 displays the number of SPANS projected to be done by county. A lower than projected number were collected due to: (1) an inability to review records in Dauphin 1, due to their unavailability; (2) phasing in of the FAST in most counties (3) the amount of time and county coordination needed to review records. As of June 30, 2018, 130 SPANS-CANS were completed, and 107 SPANS-FAST were completed.

Table 11. Projected and Completed Number of SPANS per County.

County	Cases with New CANs	Cases with NEW FASTs	Cases with ONGOING CANs	Cases with ONGOING FASTs	Projected Total per year	Actual Total
Allegheny	5 (1 from each regional office)	5 (1 from each regional office)	5 (1 from each regional office)	5 (1 from each regional office)	20	30 SPANS-FAST 40 SPANS CANS
Crawford	2-3	2-3	2-3	2-3	8-12	11 SPANS-FAST 12 SPANS-CANS
Dauphin	2-3	2-3	2-3	2-3	8-12	9 SPANS-FAST 7 SPANS-CANS
Lackawanna	2-3	2-3	2-3	2-3	8-12	11 SPANS-FAST 16 SPANS-CANS
Philadelphia	5 (1 from each CUA)	5 (1 from each CUA)	5 (1 from each CUA)	5 (1 from each CUA)	20	32 SPANS-FAST 39 SPANS-CANS
Venango	2	2	2	2	8-9	14 SPANS-FAST 16 SPANS-CANS

The steps in completing the SPANS are as follows: (1) transfer scores of 2s and 3s for needs and 0s and 1s for strengths from the CANS and FAST to the SPANS; (2) review plans and service documentation to examine how service and supports were used to address needs and build on strengths; and (3) rate the degree to which needs were met and strengths utilized using the SPANS scoring algorithm and following the instructions in the manual. Lower scores on the SPANS indicate that the needs and strengths identified in the assessment are being addressed or utilized as part of the interventions. After raters independently establish their scores, a consensus is reached by the two raters collaborating on a final set of SPANS scores for each case. Scores are then entered into an access database.

The SPANS-CANS uses a scoring scheme of 0 to 2. A "0" means that there is evidence that documents that the need or strength is mostly/consistently in the plan or in the record, a "1" some partial or inconsistent evidence and 2 "no evidence". The scores were recoded so that "0" and "1" were coded as "evidence is present that the needs or strengths are in the plan or record", and a SPANS score of 2 as "not present in the plan or record". In the CANS, the needs domains – Life Functioning, Caregiver Needs, Culture, Youth Behavior/Emotional Needs, Transition Age Module, and Trauma Experience – were recoded so that "no needs" and "watchful waiting" were scored as "no need" and the scores for "need" and "high level of need" were scored as "need". For youth strengths, "a strength" or "potential strength" were recoded as a strength and when no strength was identified, or if there was little sign of a strength, it was recoded as "no strength identified".

The FAST is structurally different than the CANS. Whereas the CANS focuses on one child, the FAST assesses the entire family. Multiple children and caregivers are assessed in order to reflect the complexity of the family system. In the scoring of the SPANS-FAST all children and caregivers are considered. However, since typically the target child and target caregiver are Child A and Caregiver A, the domains included in this analysis are the "family together", "Caregiver A" and "Child A". The SPANS-FAST uses a scoring scheme of 0 to 2. A "0" means that there is evidence that documents that the need or strength is mostly/consistently in the plan or in the record, a "1" some partial or inconsistent evidence and 2 "no evidence". The scores were recoded so that "0" and "1" were coded as "evidence is present that the needs or strengths are in the plan or record", and a SPANS score of 2 as "not present in the plan or record".

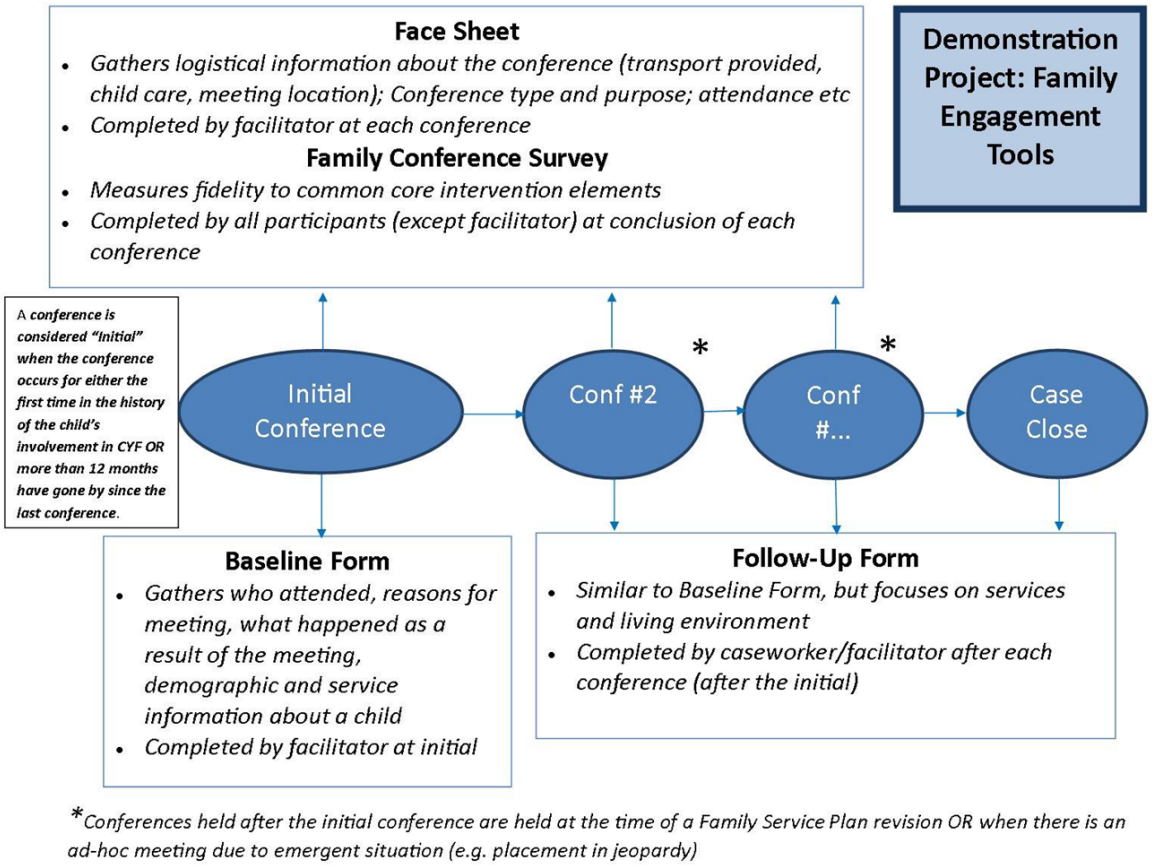
Family Engagement Study Measures (Process and Outcome Evaluation). The family engagement study (FES) fulfills three purposes: (1) it provides a view of the family engagement intervention from the perspective of the stakeholders; (2) it monitors fidelity to the core components of the family engagement interventions; and (3) it provides additional information to complement the administrative data about the outcomes of children referred for maltreatment and the trajectory of placement and services. See Figure 1 for a visual representation of the study design and measures.

The FES collects information at the case level; for example, the level of restrictiveness of living environment prior to the conference for an identified child, where in the pathway the child and family are when they participate in a conference, the purpose of the conference, and the immediate outcomes of the conference. It also provides information about the conference itself, including who attended, who facilitated, and where it was held. Additionally, follow up information about subsequent meetings provides context about what type of services were in the plan. This information, in combination with number of episodes in care obtained from the

administrative data, gives us a more complete understanding of the process of engaging a family and helps to make the case for the impact of this intervention.

Training sessions for family engagement facilitators were held in 2013 by the Principal Investigators. Each individual received a copy of the Family Engagement User's Guide and a FAQ sheet, along with contact information for our Family Engagement evaluation specialist point person for any questions. Additionally, we created an online training that reviews the study and walks the viewer through each form. This video is located at http://www.pacwrc.pitt.edu/CWDPVideo.htm. We encourage counties to have new staff involved in facilitating or coordinating family engagement conferences to view the video and contact us with questions. We also conduct regular in-person training sessions as needed. *The FES User's Guide is included in Appendix E; it includes all of the measures and has extensive instructions on how to complete each one.*

Figure 1. Overview of Family Engagement Study



The forms for the FES are completed on paper, mailed to the Child Welfare Resource Center, and scanned using Teleforms software. With the exception of the Family Conference Survey (FCS), these measures were created specifically for the CWDP.

Facilitator Face Sheet is completed for each conference by the facilitator/coordinator. The form provides contextual information about the conference itself such as the location, facilitator type, as well as general questions about who attended and any supports offered to the family to enable them to participate.

Baseline Form is specific to the child or youth whose needs are discussed at the conference (there is a procedure to randomly select a child if needs of multiple children are part of the conference) and is completed for an initial conference. Prior to the conference the facilitator/coordinator fills out a portion of the form and completes the remainder immediately following the conference. The form provides information about the reasons for the meeting; who attended the meeting/conference; living arrangements for the child before and after the conference; what services/supports were included in the resulting plan and where the family is in the service pathway. Multiple sources may be used to complete this form (e.g. records, caseworker, verbal report, family report).

Family Conference Survey (FCS) is distributed by the facilitator at the close of each conference. It is completed by each of the individuals who attended the conference (this includes the youth, family members, and professionals, but does not include the facilitator). This survey asks for the participant's perspective of the process of the meeting.

The FCS used in this evaluation is an adapted version of a measure used in the evaluation of family group decision making study in Pennsylvania (Rauktis, Bishop-Fitzpatrick, Jung, & Pennell, 2013). Factor analyses revealed a three factor model. However, for this evaluation, the FCS was revised in order to account for the different models of family engagement besides Family Group Decision Making. Preliminary exploratory factor analyses combining family member, friends and professional surveys (N=4391) suggest that three factors also underlie this revision of the FCS: family inclusion and ownership; supportive and respectful behavior of the professionals and facilitator; and satisfactory process and outputs of the conference/meetings. We also have a Spanish version of this survey.

Follow-Up Form is completed by the individual who has access to records and the most knowledge about the family (caseworkers and/or facilitators) at each follow-up conference (including conferences related to case closures).The completion of the Follow-Up Form often coincides with a conference held to revise the family service plan. The form has questions about what services are in the plan and the level of restrictiveness of living arrangement for the child and is completed every four to six months.

An individual at each county assigned to this study downloads the measures from the CWRC website. He/she is responsible for completing or distributing and then mailing the completed measures to the Evaluation Specialist at CWRC. We encourage this as a monthly practice.

It is our expectation that these forms will be collected for every child in the CWDP who has an engagement event (see User's Guide for instructions when multiple children are the subject of a conference). However, the exceptions to this are Allegheny and Philadelphia. Both counties were concerned about the volume of families served (and therefore number of forms to be completed); we agreed to utilize a stratified sample of families instead. A sampling plan was created by a biostatistician in the University of Pittsburgh's School of Public Health for both counties. The plan utilizes a stratified systematic sampling design to ensure that the final sample will be

representative and account for possible seasonality or other time effects. *Please see Appendix B for the sampling plans.* Allegheny began collecting data in Spring 2014; Philadelphia began in Fall 2014.

Family Engagement Conference Observations (Process Evaluation). We observed a sample of family engagement conferences held in each county. The purpose of the observations is to provide additional information about the five core elements of family engagement conferences.

The Conference Observation Form used to evaluate fidelity was created for this evaluation. It was informed by observation forms used by other researchers of family conferences, in particular, the IV-E evaluation of Ohio. The form was then tailored to the Pennsylvania family engagement practices. It documents the indicators of the five core elements of family engagement across the different county conference formats. Domains in the form include: information about the conference (model; facilitation type; role of the facilitator relative to the family; attendees) and indicators of the five core elements for family engagement Practices (also see the Initial Evaluation Plan for additional information). The five core elements are as follows:

- Conferences are facilitated by neutral and trained staff
- Effective partnerships are promoted among the child welfare agency and private/community services;
- Outreach to kin and/or other supportive people as potential caregivers or supports to the birth parents/family;
- Families and support persons are prepared for the conference;
- Families are helped to identify and access appropriate and meaningful services.

Several indicators of how we measure these domains follow. For example, to measure whether *kin and supports are present*, we tally attendees and count how many are family and provider supports compared with the number of child protection staff and provider staff. To gauge *preparation* we observe the facilitator to determine if in the course of facilitation or prior to, they explained the rules and guidelines and the roles of the participants, and if the individuals appear to be prepared for the conference. *Neutral facilitation* is measured by an item "remained neutral/respectful of family and supports" with a score range from 1=none of the time to 4=all of the time. *Families being encouraged to identify and access services* is scored using the same range and measures the degree to which family members were included in discussions about which supports and services will be included in the plan. We also take detailed notes about the environment and observe and document the body language of the participants and conversations that help to support the ratings.

The evaluation team and the county family engagement coordinator work together in scheduling observations. Families are first approached by the family engagement coordinator to see if they would permit observers in their conference. If they agree to have observers, written consent is obtained and the coordinator contacts the evaluation team about the date/time/location of the conference. Observations are completed by two members of the evaluation team who sit outside the family "circle"; while the observers are generally introduced to the group before the meeting starts, they are not part of the conference process. Each rater scores the observation form independently, and a consensus score is obtained through discussion between the raters after the

meeting. The group of raters on the evaluation team have been trained in observation and in the scoring of the form. Although kappa coefficients are not being calculated, all raters have achieved a similar level of consistency in rating for the presence of, and the degree of, an indicator. Table 12 shows the number of observations completed and the timeframes in which they were completed. A total number of 105 conferences were observed.

Table 12. Number of Family Engagement Observations and Corresponding Date Ranges.

County	**Total number of groups observed**	**Date ranges of observation**
Allegheny	20	November 2014 to 7/1/2018
Crawford	15	May 2015 to 7/1/ 2018
Dauphin	14	May 2014 to 7/1/2018
Lackawanna	19	May 2014 to 7/1/2018
Philadelphia	18	July 2014 to 7/1/2018
Venango	19	November 2014 to 7/1/2018

Facilitator Survey (Process Evaluation). The facilitator survey gives us a view of family engagement groups and professional training and coaching from the perspective of the facilitator/coordinator of these groups. This measure was created specifically for the CWDP and is one of the measures of fidelity to the core elements of family engagement, as well as a measure that speaks to training and coaching of staff, which is an implementation component. See the section on process evaluation for information about the methods of this survey and the findings.

All facilitators/organizers were interviewed at the beginning of the CWDP as part of the Key Informant Interviews. The open-ended questions from those interviews provided significant information that helped to create the survey questions. A draft set of items underwent cognitive interviewing/testing with stakeholders and items were repeatedly revised. Because there are several models for how family engagement occurs, the challenge was creating a survey that captured all potential types of activities across the different models. The final survey includes the following domains: type and nature of training in the family engagement model; ongoing training and coaching methods; and critical preparation and facilitation steps prior to and during a conference/meeting for those invited to the conferences.

The format of the questions varies depending upon the domain. One example is that respondents are asked to prioritize from a list what they feel are the five most important things to do when facilitating or co-facilitating a conference. Examples of some of the possible responses to this question are listed (e.g., “explain purpose”, “consider family strengths” etc.). This question speaks to the core element that *families and supports are prepared for the conference/meeting.* Other questions use a yes/no response as in an item about the types of training and coaching activities that would be an indicator of the core element (e.g., *conferences are facilitated by neutral and trained staff).* Depending upon the role one has in the intervention (coach, facilitator or coordinator or a combination), respondents were permitted to skip questions.

Starting in 2015, every summer the counties provided us a population list of all of individuals responsible for facilitating and/or coordinating family engagement meetings. A web-enabled survey (Qualtrics) was created and the link to the survey was emailed to these individuals the last

week in May 2015 in June 2016 and in June 2017. The surveys were open for six weeks, with regular reminder prompts sent to those who did not respond. Table 13 displays the number of usable surveys.

Table 13. Facilitator Surveys by County by Time Point (N=351)

	Time 1 (5/2015)	**Time 2 (6/2016)**	**Time 3 (6/2017)**	**Total**
Allegheny	68	71	65	**204**
Crawford	3	2	3	**8**
Dauphin	3	3	5	**11**
Lackawanna	3	9	6	**18**
Philadelphia	30	25	41	**96**
Venango	4	5	5	**14**
	111	**115**	**125**	**351**

A respondent could complete a survey at more than one-time point if they remained in that position. However, the number of individuals who had completed a survey at all of the time points was small, so the sample was treated as a longitudinal cohort rather than as repeated measures. Moreover, Allegheny and Philadelphia contributed the largest number of surveys (not surprisingly as they are the largest counties and Allegheny trained all caseworkers), so three subgroups were created for the analyses: Allegheny, Philadelphia, and then all other counties. See the Process Evaluation section for findings.

Evidence Based Practice Attitudes Scale (EBPAS; Process Evaluation). Caseworker attitudes to evidence based practices were assessed by asking how a worker feels about referring children and families to new types of therapies, interventions, and treatments using the Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004). The EBPAS section of the EBPQ elicits caseworkers' thoughts and attitudes towards the adoption of evidence-based practices. Respondents are asked to rate items using a 5 point scale that ranges from "Not at All," to "To a Very Great Extent." The EBPAS was done annually, starting in Year 2, using Qualtrics. Over the period of the waiver, only 38 workers completed all three administrations reflecting problems with turnover as well as response rates. Therefore, what is reported is point in time rather than longitudinal data. As seen in Table 14, response rates declined in the last year, with the exception of Venango.

Table 14. EBPAS Response Rates by Year.

County	**2015 (%)**	**2016 (%)**	**2017 (%)**	**2018 (%)**
Allegheny	43	27	32	7
Crawford		78	50	52
Dauphin	42	39	30	29
Lackawanna	88	48	41	34
Philadelphia	20	15	26	12
Venango	64	86	52	54

The EBPAS is comprised of four subscales: Appeal, Requirements, Openness, and Divergence.

- **Appeal** – refers to the intuitive appeal of an EBP (e.g., "I would be likely to refer to an intervention that was new to me if it was intuitively appealing", "I would be likely to refer to an intervention that was new to me if I felt I had enough training to make appropriate referrals").
- **Requirements** – level to which a staff member would adhere to requirements regarding referrals to EBPs (e.g., "I would be likely to refer to an intervention that was new to me if it was required by my supervisor", "I would be likely to refer to an intervention that was new to me if it was required by my state").
- **Openness** – openness to change and innovation (e.g., "I like to refer to new types of therapy/interventions to help my clients", "If I was providing the services, I would try a new therapy/intervention even if it were very different from what I was used to doing").
- **Divergence** – degree to which there are perceived differences between current and new practices and resistance to the idea that EBPs can be clinically useful (e.g., "I know better than academic researchers how to care for my clients", "Clinical experience is more important than using manualized therapy/interventions").

See the Process Outcome section for findings.

EBP "Basics" Spreadsheet.

Since counties were implementing a variety of EBPs, we need a standardized way in which to collect some "basic" referral and dosage information for children and families who were referred to EBPs by child welfare. Lacking a unified statewide information system as well as a single source of invoicing information (e.g., some are paid for with special grants, others through managed care), we held conference calls with each county in order to craft a strategy. Working with the counties and with Chapin Hall, we created a spreadsheet which included all of the variables needed to answer the research questions. This also helped to clarify the referral process and to clarify the feasibility of getting the variables requested. We created a "flat" spreadsheet that could be used by the larger counties who opted to obtain information from a variety of sources and then export the file directly to us. We also created an Excel-based application that the smaller counties with lower volume used to enter this information. Training calls were held with each county to review the variables and data entry process, and a July 1, 2015 date was given for start-up. See Table 15 for a summary of EBP data submitted.

Table 15. Number of Children Referred to and Receiving an EBP by County

Number of children referred to and receiving an EBP

	July 1-Dec 31, 2015		*Jan 1-June 30, 2016*		*July 1-Dec 31, 2016*		*Jan 1-June 30, 2017*		*July 1-Dec 31, 2017*		*Jan 1-June 30, 2018*		*Total*	
Allegheny*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*
PCIT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Homebuilders	163	163	138	138	134	134	145	145	110	110	36	36	726	726
MST	48	48	32	32	32	32	2	2	0	0	0	0	114	114
TF-CBT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	July 1-Dec 31, 2015		*Jan 1-June 30, 2016*		*July 1-Dec 31, 2016*		*Jan 1-June 30, 2017*		*July 1-Dec 31, 2017*		*Jan 1-June 30, 2018*		*Total*	
Crawford	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*
Triple P	N/a	N/a	1	1	11	11	9	9	5	5	7	7	33	33
FBT	18	18	2	2	13	13	15	15	14	14	18	18	80	80

	July 1-Dec 31, 2015		*Jan 1-June 30, 2016*		*July 1-Dec 31, 2016*		*Jan 1-June 30, 2017*		*July 1-Dec 31, 2017*		*Jan 1-June 30, 2018*		*Total*	
Dauphin	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*
PCIT	0	0	2	1	2	2	5	3	Missing	Missing	0	0	9	6
Triple P	1	1	0	0	8	4	5	0	9	5	6	6	29	16
DBT	N/a	N/a	0	0	0	0	2	2	Missing	Missing	0	0	2	2

	July 1-Dec 31, 2015		*Jan 1-June 30, 2016*		*July 1-Dec 31, 2016*		*Jan 1-June 30, 2017*		*July 1-Dec 31, 2017*		*Jan 1-June 30, 2018*		*Total*	
Lackawanna	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*
PCIT	5	3	8	6	7	7	4	4	0	0	2	2	26	22
SafeCare	15	13	13	10	7	7	20	16	19	8	13	13	87	67

	July 1-Dec 31, 2015		*Jan 1-June 30, 2016*		*July 1-Dec 31, 2016*		*Jan 1-June 30, 2017*		*July 1-Dec 31, 2017*		*Jan 1-June 30, 2018*		*Total*	
Philadelphia*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*
PCIT	15	2	13	4	14	12	13	2	9	5	13	3	77	28
Triple P	19	7	22	20	35	15	55	15	10	7	0	0	141	64
FFT	61	35	62	36	61	38	80	52	47	15	32	13	343	189

	July 1-Dec 31, 2015		*Jan 1-June 30, 2016*		*July 1-Dec 31, 2016*		*Jan 1-June 30, 2017*		*July 1-Dec 31, 2017*		*Jan 1-June 30, 2018*		*Total*	
Venango	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*	*Referred*	*Received*
PCIT	0	0	1	1	0	0	3	3	0	0	0	0	4	4
Triple P	3	2	3	3	13	13	10	10	12	12	7	7	48	47
PAT-NHV	2	2	0	0	7	6	2	2	2	2	7	7	20	19

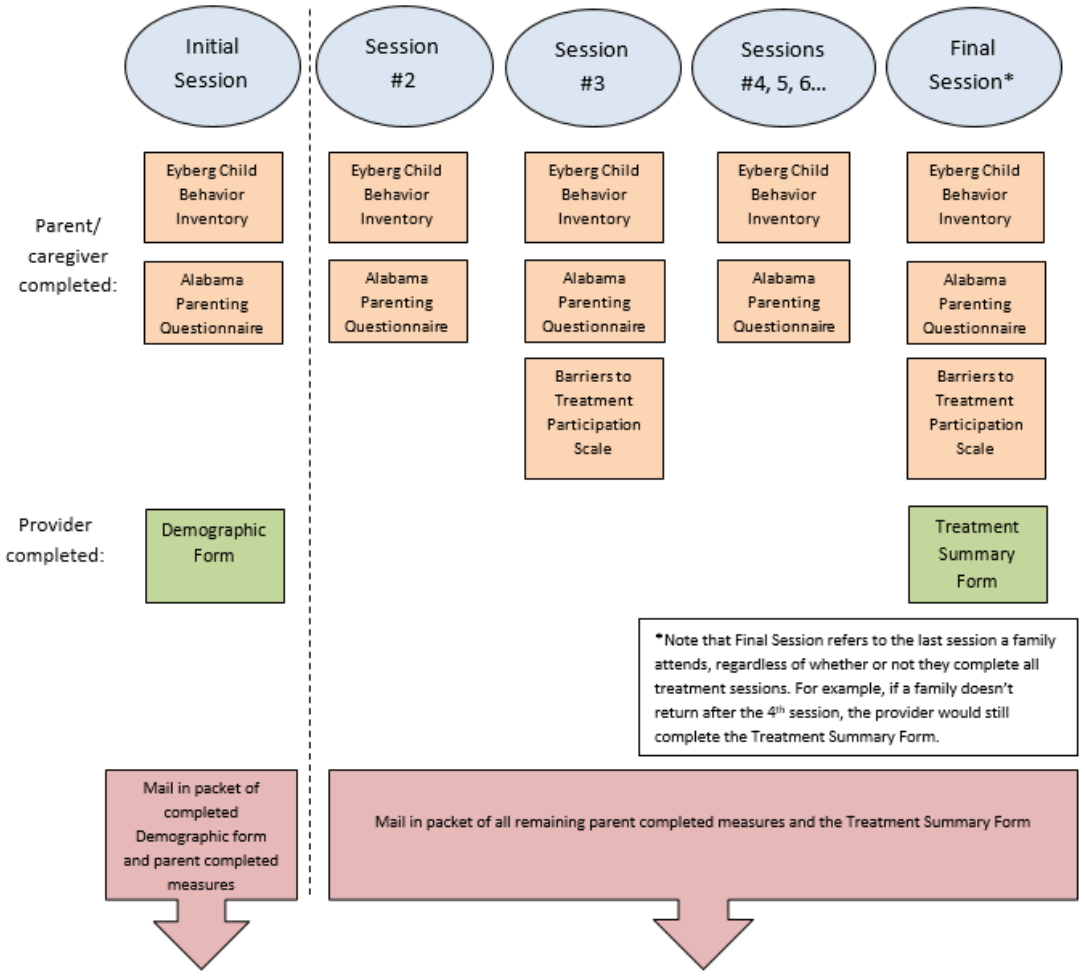
* Indicates counties where there may be additional EBP referrals made that were not counted on this table due to missing or incomplete data reported to the Evaluation Team.

PCIT and Triple P Sub-study.

We trained 38 individuals (including PCIT providers, Triple P providers, and implementation team members in Dauphin, as well as CWRC practice improvement specialists so that they could support participating counties in this sub-study) on the process of collecting child and family level child-level data for two evidence based practices (PCIT and Triple P). Please see the Final Evaluation Plan for details on the logic model and indicators; the measures will be reviewed here. We created a User's Guide (see Appendix F) for the data tools to be collected and posted

the training video to the Child Welfare Resource Center website so that individuals who were unable to attend a live session could access this training at a later date. Web access to the training also provided a resource to individuals who attended a live session and would like to revisit specific content. Initial data collection "packets" were sent to all of the providers with instructions and the measures needed. Figure 2 illustrates the timing of the measures, as well as the respondent. An evaluation team member was assigned to this sub-study; this individual made frequent contact with providers in order to establish relationships and to offer additional support and training. We coordinated with an existing research study (Herschell, et al., 2015) so as to not create duplication of data collection for providers who happened to be involved with both projects. The measures collected were congruent across both projects.

Figure 2. Data Collection Process for PCIT and Triple P Sub-Study



Alabama Parenting Questionnaire-Short Form (APQ-9; Elgar, Waschbusch, Dadds, & Sigvaldason, 2007). The APQ-9 is a brief assessment of parenting practices consisting of nine items. It is thought to be helpful in differentiating parents of children with disruptive behavioral disorders from those parents of children without behavioral problems. That is, the APQ-9

measures parenting practices that are considered to consistently relate to disruptive child behaviors (Elgar et al., 2007). The factor structure reported by Elgar has three supported factors: Positive Parenting, Inconsistent Discipline, and Poor Supervision. Further studies verified the construct validity and reliability. In this study, the overall alpha coefficient was 0.76; the alphas for the subscales were 0.80 (Positive Parenting), 0.71 (Inconsistent Discipline), and 0.91 (Poor Supervision). The measure is used as an assessment and outcome tool when delivering parenting interventions targeting harsh and negative parenting practices, and the short form is suitable for intensive and repeated measurement.

The APQ-9 used in this study includes the 9 items which parents rate as to how typically an action/behavior occurs in the home: "Never", "Almost Never", "Sometimes", "Often" and "Always". A sample item is "You let your child know when he/she is doing a good job with something". For items that did not apply to younger children (e.g., "your child is out with friends that you don't know"), the parent had the option to mark as "Not Applicable". Parents/caregivers were asked to complete this at every session.

Eyberg Child Behavior Inventory (ECBI; Eyberg, 1999). The ECBI is a brief measure used to identify children at risk for serious conduct problems. It has many uses in community practice (e.g. brief pediatric screening measure for physicians) but is most commonly associated with the interventions Parent Child Interaction Therapy (PCIT) and in this waiver, with the Triple P Parenting Program. Both interventions target parenting practices that can result in negative behavior by the child, and the ECBI parent rating form is actually an integral part of the PCIT intervention itself. The psychometrics of the ECBI are summarized in the test manual (https://www.parinc.com/products/pkey/97), and is reported by the publisher to have high internal consistency and stability as well as convergent and discriminant validity with other rating scales and observational measures. Other sources verify the soundness of the measure (http://pluto.rbhs.rutgers.edu/vinj/vaid/TestReport.asp?Code=ECBI), reporting internal consistency reliability alphas in the mid .80's to high .90's. A 2001 study verified its ability to discriminate and identify children at risk of developing conduct disorder (Rich & Eyeberg, 2001).

The ECBI Parent Rating form used has 36 items, and parents are asked to describe how often their child engages in the behavior: "never", "seldom", "sometimes", "often" and "always", using the "current" time frame. Parents are then asked to answer using a yes/no item whether this is a problem for them. For example, a parent would rate how often their child "refuses to go to bed on time" and then to indicate "yes" or "no" as to whether the behavior is currently a problem for them. Therefore, the scoring of the ECBI produces two subscales: an Intensity scale and a Problem scale. The Intensity scale is the frequency of behaviors and the Problem scale is how much the parent sees it as a problem. This study found internal consistencies of 0.97 for both subscales. Because it is a copyrighted measure, it is not included in Appendix X; however, it can be found here: https://www.nctsn.org/measures/eyberg-child-behavior-inventory

Barriers to Treatment Participation Scale (BTPS; Colonna-Pydyn, Gjesfield, & Greeno, 2007). The BTPS was developed by Kazdin for children and their families referred to out-patient treatment. (Kazdin, Holland, Crowley, & Breton, 1977). The purpose was to measure perceived barriers to participation in treatment, to examine whether perceived barriers were related to indices of participation in treatment, and to test whether perceived barriers could be distinguished from other constructs that are related to dropping out of treatment. The constructs

which were identified as: stressors and obstacles that compete with treatment (20 items); treatment demands and issues (10 items); perceived relevance of treatment (8 items); relationships with the therapist (6 items); critical events (14 items). However, additional studies did not consistently confirm factor structure and the length of 58 items limited its usefulness in community settings. There was a need for a brief instrument with good psychometric properties, a clear factor structure and the ability to measure barriers.

Therefore, a 20-item BTPS was created for use with a community sample (Colonna-Pydyn, Gjesfjeld & Greeno, 2007), and this BTPS is used in the study. This 20-item scale has two factors: Treatment Expectations (e.g. "the treatment was not what I expected") and External Demands (e.g., "my job got in the way of coming to sessions)". Parents are asked to rate the degree to which it was a problem: "never a problem", "once in a while", "sometimes a problem", "often a problem" and "very often a problem". The authors report good internal consistency for both subscales: 0.90 for Treatment Expectations and 0.80 for External Demands. In this study, the alpha coefficients were 0.70 (Treatment Expectations) and 0.78 (External Demands). Parents/caregivers were asked to complete the BTPS at the third and tenth (or final) session.

Treatment Summary Report (TSR; adapted for this project from Herschell, et al., 2015). The TSR was developed to summarize the service involvement of the family in either PCIT or Triple P, and was to be completed by the clinician at the end of treatment. It was based upon a similar form used by Amy Herschell Ph.D., in her study of the implementation of PCIT. The TSR was used for either PCIT or Triple P and was specific to the content of the intervention in summarizing treatment. The clinicians were asked to summarize the treatment time line, the content delivered, target behaviors, the ECBI scores pre- and post-treatment, the total number of hours spent in therapy over the total number of weeks, and information about the case disposition. The clinicians were also asked to provide information about other services that the family received from their agency in addition to PCIT or Triple P and finally, their opinion about the reasons for why families ended treatment if the full dosage was not delivered.

Note: All of the parent/caregiver measures, if not already available in Spanish language format, were translated into Spanish and Nepali language formats.

PROCESS EVALUATION

Readiness to Implement

Readiness to implement is defined as the degree to which organizations and systems are ready to support, establish, and maintain a successful implementation of a specified set of activities or evidence-based practices (Fixsen et al., 2005). In the Pennsylvania CWDP, this translates to being able to adopt and maintain standardized assessment practices in Years One through Five, as well as adopt and maintain specific EBPs in Years Two through Five. Our overarching process evaluation questions help frame the big picture of the evaluation – they provide a broad overview of the overall context of the CWDP and the implications of that context for readiness, as well as fidelity (the section on fidelity begins on p. 54). The overarching process evaluation questions are as follows:

1) *Do expected/necessary structures, roles, and relationships exist to support family engagement strategies, assessment, and EBPs?*

2) *To what degree do the drivers of successful program implementation exist?*
    a. *Are staff and supervisors prepared to support and implement the project?*
    b. *Is leadership engaged?*
    c. *Do decision supports exist in the form of data systems, CQI processes?*

In order to answer these questions and our sub-questions (grouped by intervention in subsequent sections), we used information gleaned from our Key Informant Interviews (KIIs) with key stakeholders, as well as focus groups with caseworkers and supervisors. We also utilized data from the document reviews, the Organizational Readiness to Change (ORC) tool, and the Evidence Based Practices Questionnaire (EBPQ). Finally, we utilized the progress reports generated by the participating counties.

It is important to note that multiple significant state-wide and county-specific policy and organizational changes occurred during these first two years of the CWDP. These changes have impacted not only the implementation of the CWDP, but have also affected the evaluation. Figure 3 illustrates what those changes were and when they occurred. In terms of statewide changes, 23 amendments to the Child Protection Services Law (CPSL) went into effect as of January 1, 2015. Amendments were made to the Crimes Code, the Domestic Relations Code and the Judicial Code. Major changes to the Child Protective Services Law included a broadening of the definition of abuse, who is considered a perpetrator, failure to act and who is a legally mandated reporter. Education for mandated and permissive reporters of abuse became required for licensed professionals and readily available to both professionals and the general public. A number of statutory changes related to definitions, timeframes and procedures impacted the practices and daily routines of child welfare professionals. As public recognition grew, referrals of suspected abuse and neglect increased as much as 200% in many jurisdictions. While many jurisdictions have increased the size of their workforce, most have not been able to keep pace with the increasing demand. The resulting increase in work demands, new requirements and multiple changes within a short period of time added to the stress of an already taxed child welfare system. Leadership in one county remarked, "*We were very fired up to begin the Demonstration Project, but honestly, if I would have known all of the changes that would be required by the new CPSL, I don't know if we would have become a Demonstration Project county.*"

Additionally, a new Governor took office in January 2015; this change in administration brought shifts in organizational structure and staff departures in the Department of Human Services (DHS) and major delays in the approval of a state-wide budget. These factors, along with the aforementioned legislative changes left the CWDP without a consistent state-level point person, and the budget delays left the state and counties with significant gaps in their funding.

Counties participating in the CWDP also experienced organizational shifts during the first two years. Four out of the six counties had administrators and/or directors retire or resign (i.e., Crawford, Dauphin, Philadelphia, Venango). Several counties re-organized their staffing structures either coinciding with the start of the CWDP (i.e., Allegheny, Philadelphia) or as a result of the onset of the CWDP (i.e., Dauphin). One county (Dauphin) experienced the death of a child in the child welfare system, resulting in a grand jury investigation and continued organizational upheaval (e.g., the resignation of multiple staff at all levels, a second restructuring of staff). One county (Lackawanna) experienced a brief labor strike. Finally, in five of the six counties, our evaluation liaisons changed, resulting in occasional lapses in communication and the need for re-training and orientation of new liaisons (i.e., Allegheny, Dauphin, Lackawanna, Philadelphia, Venango). All of these events impacted the readiness and/or early implementation of the CWDP.

In addition, implementation of the first phase of Pennsylvania's Child Welfare Information Solution (CWIS) launched in late December of 2014. Phase One focuses on referrals and screening functions and includes system changes at Childline and development of data exchanges with county systems. There have many challenges, both technical and practice-related, that have impacted staff at the state and county level.

In terms of preparation for the CWDP as a whole, key informants from many of the counties discussed the benefits of having integrated human services agencies. They stated that this structure would be helpful in terms of collaboration and communication across various human service systems.

> *"We are a human services model county, based on a systems- of-care platform. I think it will help with the CWDP because we have a lot of resources to bring to the table."*

> *"We have a human services structure…We do a lot of work across human service systems. We implemented a cross-systems protocol so that any family who is being served by more than one system is not receiving duplicate services and we are all on the same page. Our structure will be a great benefit to the CWDP."*

> *"Having a human services model we don't have to negotiate; we can have the same priorities."*

Additionally, other county committees or communication structures were sometimes in existence prior to the CWDP that would support its implementation. For example, Crawford noted having an advisory group that has members from child welfare, juvenile court, behavioral health, education, and early intervention. It was thought that these existing structures would help facilitate communication across systems, thereby helping the entire project be successful.

However, notably absent in the discussions was the role of managed care and how they could help to sustain an organizational culture for EBPs.

In the early stages of the CWDP, all of the county administrators were actively involved in communicating the vision of the CWDP to their staff, partners, and stakeholders. They all believed that the focus on prevention and reduction in out of home care, which flexible spending would support, was consistent with how they were changing practice. In terms of understanding the challenges to full implementation, most of the administrators believed that because their agencies were already moving in this direction, and that this was a good "fit", the practices of family engagement and assessment would not be a change in direction for the CYS staff. Most of the counties chose to treat it as part of practice evolution and emphasized the commonalities or the natural progression of the demonstration interventions with their current models of practice:

> *"My vision since I started here was to make sure staff doesn't feel like they are involved in twenty different initiatives. I have tried to tie it all together so it's just how we do business."*

> *"Our vision was to create an agency that was research-based, clinically grounded, using the inherent strengths of families to sustain change. That was pretty much our overarching vision, and that fits in perfectly with the way the demonstration project is evolving."*

In their communications to caseworkers and systems stakeholders, CYS administrators focused on the goals or outcomes (reducing out-of-home care) rather than the practice changes and the process. This was echoed in the responses of other system stakeholders (judges, guardians ad litem, probation officers, and service providers) who also focused on these goals when asked about what they knew about the CWDP. In fact, when asked what they knew about the CWDP, those who did know of it knew of the goals of reduction of placement, reduced re-entry, and reduced use of congregate care. This last goal was one that was particularly noted by the administrators of non-profit agencies providing services for children and families. While in agreement with the philosophy, values, and mission of the CWDP, several of the directors of non-profits were aware of how the CWDP could financially impact their agencies (e.g., reduced use of residential care, foster care).

Leaders in other systems, as well as the leadership in CYS, acknowledged the challenges of collaborating with each other's systems, particularly with the legal system. Judges have considerable power in determining the trajectory of a child/youth's stay in care. The CYS administrators all believed that while they had positive relationships with the system, there are cultural differences that make it challenging to collaborate and communicate.

> *"A lot of work still needs to be done, with assessment tools, since they are not diagnostic tools. The court likes to know, "what are the answers?" And, these tools do not do that. There will be a learning curve, the delinquency system, need to work with DA, to ensure community safety, but what is the alternative if the child cannot be detained, what is the alternative and making sure that community safety will be assured?"*

Across all the counties, the legal and JPO informants were the mostly likely to not know of the CWDP, or to have only a superficial understanding of it. It did seem that of all the stakeholder groups that the legal system, potentially the most influential, was also the least likely to have an understanding of the CWDP. One exception to this was a judge in Venango, who seemed to have a fairly comprehensive understanding of the CWDP. Another exception to this was Dauphin, where there is shared case management across CYS and JPO. As shown in the fiscal findings, the remaining child welfare agencies either have low juvenile justice proportions of juvenile spending or a low penetration of Title IV-E revenue to fund that population.

While leadership understood all aspects of the CWDP, including the goals and the hypothesized mechanisms to reach those goals, understanding was more limited among caseworkers and supervisors. While many were able to articulate some of the overarching goals (i.e., reducing placement numbers), or knew that a practice change was part of the CWDP (i.e., the new assessment tools), there was little understanding of the project as a whole. While some understood that there were financial implications of the CWDP, there was confusion about what that actually entailed (e.g., "*Part of the block grant. They give us a large sum, and we have to figure out where to put it to make things work better*", "*It has a lot to do with the FAST assessment and with money*", and "*We hear, 'we're doing this because of the Demonstration Project', but we don't know what the Demonstration Project is, exactly, or what parts of the Demonstration Project they are talking about. It is used as an umbrella instead of the specifics*."). In all counties there was some sort of structural reorganization and/or leadership change that came along with, or soon after, the implementation of the CWDP. Such changes are often accompanied by fear and frustration among staff that are lower on the hierarchy, and this was evident in varying levels in both groups across all counties. There was often a sense of frustration or helplessness in the groups – sometimes this was voiced overtly, while other times it was just a pervasive tone in the discussion (e.g., "*There is a lot of disconnect between leadership. On paperwork it all looks great. We need bottom up change, not top down. Why aren't we doing this with a social work perspective? The right hand isn't talking to the left, but we get in trouble for it*", "*They bit off more than we could chew*.").

Figure 3. Timeline of Significant State and County Events Impacting the CWDP.

CWDP Timeline	
2013	
June	CWDP Starts
November	New Deputy Director at Allegheny County OCYF
December	New Administrator in Venango County
2014	
February	Venango Director resigns
July	Cohort Two joins CWDP

	Cohort One begins to implement EBPs
August	Philadelphia Administrator resigns
November	Additional Philadelphia leadership resigns; new team installed
2015	
January	CPSL takes effect (many counties experience a sharp increase in referrals)
	New Governor installed
	CWIS Phase 1 implementation
March	Dauphin Administrator resigns
May	Lackawanna evaluation liaison resigns
	Dauphin County Grand Jury releases report on child death investigation
	Crawford Administrator retires
	Lackawanna labor strike
June	Additional Dauphin leadership and evaluation liaison resign
	PCG implementation consultant resigns
July	Cohort Two begins to implement EBPs
	Governor and PA Legislature fail to agree on budget
July - December	PA budget impasse continues
2016	
February	Dauphin hires Director of Program Division
April	Dauphin Assistant Administrator is hired
September	Philadelphia decreases caseload sizes for CUAs to one CUA Case Manager to ten families.
	New Commissioner of the Philadelphia Department of Human Services is hired
December	"Kinship Navigators" are placed into each of Allegheny County's Regional offices.
2017	
January- June	Dauphin hires 22 new caseworkers

February	Philadelphia hires Operations Director for IOC
March	Philadelphia DHS hires Intervention Development Director
September	Lackawanna is selected to participate in the newly formed Family Engagement Initiative (FEI)
2018	
May	Allegheny County and American Federation of State, County and Municipal Employees (AFSCME) union finalizes contract to raise salaries for Caseworker I and II positions

Sustainability of the practice model developed through the waiver demonstration.

Context changes continued in the second half of the waiver. As the timeline displays, in Dauphin County the leadership changed and over half of their workforce turned over in 2016. Another leadership change occurred in Philadelphia with a new Commissioner of Human Services and an operations director to focus on Evidence Based Practice implementation. In 2017 Lackawanna expanded their use of family conferencing by becoming part of the Family Engagement Initiative in order to do more prevention work. Allegheny County hired kinship navigators to help in moving older youth out of residential care and into foster care, or from foster care into kinship care. However, in the last year of the waiver the focus shifted from implementation to sustainability – determining which interventions will be sustained and how they will be sustained. Moreover, we were interested in finding out more about the process and the "lessons learned" as the Commonwealth plans for Family First Prevention Services Act.

The key informant interviews with county and state leaders provided rich information about these plans for sustainability, as well as successes and challenges that were faced over the course of the waiver. A success identified by all of the counties was that the waiver solidified the practice model. Although a few counties had been using structured assessment prior to the waiver, and all had been doing some family group decision making, their involvement in the waiver supported these activities and standardized the practice. Several referred to it as a culture change in that workers no longer believed these activities to be optional. Moreover, it became standard practice of working with families through policies and procedures. As one described, it became their agency's "business process" and the way in which work was approached. Culture change also occurred because assessment and family conferencing has changed how families and caseworkers interacted. The structured assessment processes resulted in conversations with families that were less adversarial and that identified needs that the workers may not have been aware of. Many of those interviewed felt that the assessment and engagement interventions led to multiple positive outcomes, including improved quality of casework, more individualized plans, quicker case closure, less use of congregate care, and an increase in kinship care.

One of the directors felt that the waiver transformed their county's practice entirely and helped him to implement the vision of an integrated Department of Human Services. On the other end of the spectrum, another director believed that while their county's involvement helped to stabilize their practices, and the biggest success was that it gave the county flexibility in how they were spending IV-E dollars. He noted that the waiver "stopped the bleeding" for their funding. While

this was the only respondent focusing on the fiscal successes, several did mention that the waiver experience opens the possibility for braided funding in the future. For the most part, respondents identified infrastructure successes such as enhanced data management and collection capacity due to their participation, a more engaged, savvy and competent workforce, and more collaboration across systems – these should be considered huge successes of the CWDP.

The challenges were sometimes part of the successes. While the workforce was more knowledgeable about assessments, and the assessments helped to improve the practice, administering them according to policy timeframes was very challenging. Also, how the assessments were implemented was not always in keeping with the best practice of an engaged conversation with a family, instead sometimes being used as a checklist rather than a means for conducting a more informed conversation. This was complicated by the turnover of casework staff which resulted in continually training caseworkers carrying high caseloads on the CANS and FAST, further increasing the work burden. On the other hand, several informants believed that while these challenges existed, the assessments helped caseworkers to have difficult conversations that they would have otherwise struggled to have with families and youths. Another challenge was what to do when caseworkers did not "buy-into" assessments informing decisions and service planning, preferring to use their own professional judgment. The high turnover did have a positive indirect benefit of bringing in new workers who accepted the use of enhanced assessments and engagement strategies as the de facto practice model. Turnover was a challenge at the leadership level as well: Only two directors involved in the first year of the waiver were still directors at the end of the five years.

Fully implementing family engagement conferences was also identified as a success and a challenge. Although all of the waiver counties had been practicing some form of family engagement practice, primarily family group decision making, the practice was voluntary and with a subset of families. The increase in scope to all families, and the shift from voluntary to some form of family conferencing was a challenge for every waiver county. Some structural changes were made subsequent to the change in scope of every family: Allegheny chose to train and coach all caseworkers in teaming and conferencing, whereas in Venango, the contracted provider hired and trained additional staff. Although this change in practice seemed on the surface to be easier to implement than assessment, engaging reluctant families remained a struggle for every county, with varying degrees of success in engaging all families.

The participation in the waiver highlighted the inadequacies in the data management infrastructures of all of the counties. Even though two of the six counties had long-standing and well-developed information systems, all struggled to varying degrees with administrative tasks for billing and reporting, getting accurate data into the system, as well as getting it out in a usable fashion. Because each county maintains their own information system, any changes needed for the waiver implementation or evaluation incurred programming costs. Several counties switched information systems mid-waiver which also led to time "off-line" as they moved their legacy data in the new system which did not have immediate capacity for financial or clinical reporting. Philadelphia also experienced a lengthy period mid-waiver in which they had to rebuild their information system. Finally, sharing data between providers and child welfare was difficult for many counties, and meant that information was not always "real time" or shared.

All of those interviewed identified that selecting, implementing and, sustaining EBPs was the most challenging practice model component to implement and get to scale. Whether this was due

to finding ways to fund it, communicating with the funder, finding competent providers to deliver it, managing issues such as transportation to appointments for families, or their engaging in the service, all found this to be challenging. The intensity of many EBPs (e.g., number of sessions) also appeared to influence uptake.

Finally, the informants, particularly those in Dauphin, mentioned the challenges of implementing a practice model change within the context of larger social forces. The opioid crisis was identified as one outside pressure on the system, as were the changes in the Child Protective Services Law. There was also a renewed focus on safety after these laws were passed, and in Dauphin, the death of a child resulted in workers focusing almost exclusively on safety. While these outside forces are not within the control of the directors, they do have an impact on how well they felt they could implement a new practice model. As one noted, when workers were overwhelmed with cases and had to be focused on safety, it was hard to also focus on well-being.

In terms of what they would do differently, one director said "Nothing—the benefits outweighed the risks". However, most informants had several thoughts about "doing things differently". One informant reflected on the tradeoffs of focusing on one strategy versus the approach of a "whole system over-haul" that was required to change the practice model and the need for a "heightened and consistent state focus "on the waiver. As noted above, the waiver coincided with a major change in child protection laws and a heightened public focus on the child welfare system. At least two informants said that they would have waited for the context to stabilize if they were able to do it over again. There was consensus among all county respondents that they would have gone about the process of selecting EBPs differently. At the time, they had not thought through all the associated costs, the time needed to train or find providers, and the impact that turnover at the staff and provider level would have. If they could do it over again, respondents said that they may have added decision tools to facilitate the EBP selection and referral process, selected more in-home EBPs, and/or selected EBPs more focused on substance abuse and/or engagement. The time frames, particularly for assessment were ambitious; these were another area for potential change. Finally, managing data and more importantly working to create knowledge from data "in house" is something that one director would do differently.

Informants were also asked how the waiver changed how they collaborated within and across systems and how they made decisions about spending. Several informants concurred that the family engagement intervention successfully brought different providers together, enhanced relationship-building, and helped them to better understand different agency cultures and missions within their communities. This "encouraged the cohesion of the human service delivery", improved communication and engagement across systems. For one county, it strengthened their relationship with the provider of family conferencing, for others, with mental health and managed care. Providers not always at the table prior to the waiver (e.g., early intervention, substance abuse, schools) were described as more involved as a result of the family engagement component of the practice model. Some noted that relationships with the juvenile justice system remained challenging; however, one respondent reported that it increased collaboration with their court system. Both of the larger counties felt that the waiver enhanced what they had already been doing as a department of integrated services or as a community-focused system.

The majority believed that their participation in the waiver did not impact their decisions regarding spending, but it did modify how they invoiced for certain services. Many continued to

use special grants and not waiver money to pay for nontraditional services or EBPs. One director said that funding was not the reason for their involvement and that the practice changes and learning opportunities were the primary motivator. On the other side of the spectrum, one director said the primary reason for participating was flexibility of funding and the ability to use money in nontraditional areas and draw down funds for non-IV-E eligible children.

Finally, informants were asked about their plans for sustainability and what supports were needed. One director replied "good practice pays for itself" suggesting that he believes that the changes in the practice model and the outcomes have been an investment that will continue to pay off and be sustained. At least six of those interviewed said that the practice model was part of their culture, built into their needs-based budgets, and will be sustained. One county created a department of evaluation and research to continue some of the work of the evaluation and to monitor data quality. While there was general consensus on continuing assessment and family engagement, there was a sense that the counties would revisit which EBPs they would continue post-waiver. Interestingly, while some counties were leaning toward discontinuing particular EBPs, other counties were leaning toward expanding those same EBPs; this illustrates the importance of finding the right fit between EBPs and jurisdictions and needs. Other issues raised related to sustainability included potential changes in the array of EBPs and streamlining some of the timing of the assessments.

In reference to supports, counties stated that they would like support from the state, Casey Family Programs, and the PA Child Welfare Resource Center as they continue to implement this model of practice and put new practices into place, particularly EBPs under Family First. Training on the assessments remains a challenge and is an area counties identify as needing ongoing support to sustain an improved practice. There is openness to using the FAST or combining the FAST to be part of safety and risk assessment. One director hoped that the flexibility in funding would continue whereas another hoped for expanded funding for family conferencing. There was also a desire that the state provide more funding for additional positions and direct more resources toward educating the public about what child welfare work really is about—preserving families and ensuring safety.

The document review data supported these findings. Table 16 displays the average scores for each county. All counties appeared to have systematically prepared for EBPs by examining client need, fit, organizational resources, and their workforce capacity. The documents reviewed suggested that recruitment and selection of staff to implement EBPs is in place, but that training and coaching on how to make a referral and the tools to do so are in the implementation phase were not fully in place at the time of the review. Creating a culture conducive to EBPs is in the mid-range, with greater variation than is seen in other domains. Finally, decision support systems appeared to be in place, but the policies and procedures needed to share information across systems are not.

Table 16. EBP Document Review Mean Scores by County (possible range = 0 - 2).

	Allegheny	**Dauphin**	**Lackawanna**	**Philadelphia**	**Venango**	***Mean by domain***
Recruitment and Selection	2.00	2.00	2.00	2.00	2.00	**2.00**
Training and Supervision	1.33	1.50	1.00	1.66	1.83	**1.46**
Decision Support	2.00	2.00	1.00	2.00	2.00	**1.80**
Culture	1.50	2.00	.375	2.00	2.00	**1.57**
Collaboration	1.00	1.00	0.00	1.00	1.50	**0.90**
EBP Prep.	1.50	2.00	2.00	2.00	2.00	**1.90**
Mean by county	**1.55**	**1.75**	**1.06**	**1.77**	**1.88**	**----**

*Note. Due to timing, Crawford's Time 2 document review was combined with the document review "check in", as described in the following section.

In Spring 2017 the evaluation team did a document review "check in" which did not include scoring but did cover the areas of recruitment, training and supervision, decision support, communication and structure, systems collaboration for EBPs. EBP support was a particular focus of this document review

In **Allegheny**, after initial implementation of Multi-Systemic Therapy (MST) for a 12-month period through a subcontracted provider, it was decided to end the service. The success rate for MST as delivered by the program was lower than expected and so a decision was made to end the contract and the EBP in the county. However, systems collaboration increased in the implementation of Homebuilders in that the referral system was expanded beyond shelter staff to all CYF supervisors so that more referrals could be made. PCIT training was expanded into an Early Childhood Wellness initiative. Information was created in order to inform caseworkers and home visitors about these programs.

Crawford completed an implementation drivers assessment for Family Behavioral Therapy and was moving towards implementation, but has found that Triple P level four has not been well-supported by the developer at the provider level. Family-Behavioral Therapy, on the other hand, seems to be well-supported and supervised with a consultant and on-going fidelity management.

Philadelphia saw infrastructure support for Functional Family Therapy (FFT) and for PCIT due in part to a partnership with Community Behavioral Health as the payer for services. This infrastructure support was in the form of tracking referrals and a new position. Additional positions include a behavioral health implementation advisor to be a liaison between behavioral health and child welfare, and an intervention director who was over-seeing the waiver implementation and supporting the community umbrella agencies in their implementation of

EBPs. Other infrastructure supports include quarterly training for mastery in the PCIT model, consultation calls, and rate increases for PCIT providers. This has resulted in more trained therapists.

Lackawanna's planning efforts were aided through consultation with Allison Metz from NIRN. Internal EBP efforts were focused on SafeCare and included trainings, webinars and re-training for new staff. SafeCare staff came from headquarters and trained for three days in Scranton. Lead OCYF workers were involved in a two day training on being the coach for all staff assigned to Safe Care. Nurturing Parenting Program (NPP) was introduced in 2017 and there was a three day training with subsequent certification in nurturing parent. Although not an EBP, ongoing training noted for all three assessment interventions.

Finally, **Venango** focused on training on PCIT and enlisted NIRN's help. They continued to meet with PCIT providers and caseworkers in an effort to stimulate referrals to the service. One infrastructure/contracting issue was availability of evening hours which the county was able to encourage the provider to do. Triple P support was evident. Triple P is provided in-house, with clinicians from DHS but they experienced difficult decisions when it came to expanding the program: additional staff was expensive to "on board" and train and it was expensive to send staff out of state to train.

Dauphin was not available to complete a document review.

In summary, the "growing pain" of EBPs was clear in this document review. After early optimism about the selection of the EBPs, and training in implementation science, all of the counties experienced challenges in implementation as observed in this document review. When counties were contracting with providers, they needed to re-work contracts after initial implementation due to poor performance, rate changes or due to a poor fit between what the provider wanted to provide and how, and what a family involved with child welfare needed. Hiring, training and supervising were in evidence, as was communication. Less evident were information infrastructure support and decision making support. In addition, counties struggled with the cost of some of the EBP's (Triple P) and the training involved, or even being able to communicate with the training division of the developer. As noted with Allegheny County, there were some early decisions (MST) that did not provide the expected outcomes relative to costs and were dropped.

Family Engagement.

- *Are counties ready to fully engage families and supports through FGDM and FTC?*
  - *Staff recruitment, training, and supervision?*
  - *Facilitative administration (e.g., practices and procedures to support the new model, such as coaching and transfer of learning)?*
- *What are the perceptions of county partners (i.e., judicial systems) regarding the utility of family engagement practices?*

Counties selected several models of family engagement. These included Family Group Decision Making (FGDM), Family Team Conferencing (FTC), Family Group Conferencing (FGC), and Conferencing and Teaming (C&T) (Table 5 for an overview of family engagement models by county). The implementation of these models differed across counties as well. Target groups

varied, timeframes for initial and follow-up meetings varied, and the type of facilitator varied. While, overall, caseworkers and supervisors were in support of family engagement as a general concept, there was variability across groups and across counties in terms of understanding of their county's specific family engagement model and whether or not it was helpful or beneficial in their work with families. In some counties (e.g., Venango, Crawford), there was simply an expansion of an existing model to include more families; in others (e.g., Allegheny), a new model was introduced, and job roles and duties were changed in order to accommodate the new model. These differences seemed to relate to feelings about engagement. In counties where there was an expansion of an existing model, concerns were primarily around capacity (e.g., could the providers handle the additional volume of families?). Additionally, there were concerns about applying a model to all families, when the model used to be voluntary; there was a feeling that it wouldn't be as effective with families for whom it was not voluntary (e.g., "*I think up until now it has worked well. There have been some problems since the CWDP. Before it was totally voluntary. Now if they are reluctant to do family group, we can do family teaming, but there will be a meeting. So, I'm working with more reluctant clientele. I totally believe in the process of family group; I don't even put the idea of teaming out there unless they are really reluctant to do family group. It is best for the family to be able to privately come up with their plan.*"). In counties where there was a larger practice shift, there were some of these concerns as well. However, the larger issues were related to role confusion and feeling overwhelmed by the added roles and responsibilities (e.g., "*So, they are telling all of us different things, and we have to do their jobs!*", "*We're overwhelmed, we will burn out and lose the best people…And we're dealing with the most fragile people, the ones that need the most help, and it's not fair to put this amount of pressure on us and then say you're doing a good job, so we'll throw as much at you as we want*…"). Much of the discussion on engagement also focused on what engagement actually looks like, and on how much time and effort quality engagement takes. Staff sometimes felt like engagement practices outside of a specific meeting type weren't valued or seen as engagement; they felt that a large part of their work was therefore under-valued and "didn't count" as engagement (e.g., "*I still feel that there is a push to get the 'numbers' for funding or whatever, and they play down the engagement happening outside of those meetings. They will still tell us that we need to have a conference this week so that we meet numbers, and that downplays the spontaneous engagement happening outside of the conferences*."). Additionally, there was a sense for many that with the additional assessment and formal engagement responsibilities, there wasn't enough time for actual day-to-day engagement with families.

Counties embarked on some hiring and training for their engagement interventions, though this varied slightly, depending on whether or not they had engagement interventions in place and whether or not they were using an outside provider to facilitate meetings. For example, Lackawanna reported hiring an additional Family Group coordinator, and Crawford reported hiring an additional Family Group facilitator. Facilitators from all counties reported participating in multi-day trainings on family engagement. The amount of coaching and follow-up training varied from occasional refresher trainings to structured procedures to move from shadowing to co-facilitating to leading (with observation and coaching) to facilitating groups independently.

Our document review process showed quite a range of preparation for family engagement in terms of recruitment and selection, as well as training and supervision (see Table 16). Scores for recruitment and selection ranged from 0.000 to 2.000, indicating that while some counties had little to no documentation about those processes, others had documentation that recruitment and

selection procedures were fully in place. The range for training and supervision was almost as wide, with scores ranging from 0.667 to 2.000. Again, this illustrates significant variability in terms of documentation of policies and procedures related to training and supervision. The overall average across counties for both of these areas was just a little over 1 (1.250 and 1.339, respectively), indicating some policies and procedures were partially in place toward the beginning of the project.

Not all judicial/legal staff that were interviewed talked specifically about engagement, but the ones that did talked about the positive impact it could have. One judge stated, "*…we have always used Family Group, but now it is being used to create family plans, so there is more input from them*." Another respondent said, "*I think using Family Group to create family service plans will be so much better. The old 'one size fits all' model of the same family service plan for everyone didn't really work*." Other responses included, "*…we have learned that when people can have input into what is happening, they are invested more in the beginning…that is a big difference from the previous model of 'you need to jump through this hoop'*.", "*Successful FGDM processes may result in fewer court hearings. And those cases that do come to court, the court would consider recommendations for everyone to be participating in the decision-making process*.", and "*FGC benefits the entire county – just having the family around the table can be a success. It can be an opportunity to educate the family and get their buy-in*."

Staff Recruitment, Training and Supervision: Findings from the Facilitator Survey. For all of the counties, increasing the scale of family conferencing so that all families had a conference was a challenge. In Allegheny County the model changed to teaming and conferencing and every caseworker had to be trained. All other counties had to increase their facilitating and coordinating capacity. All six counties had to discover ways of encouraging reluctant family members to engage in the process.

Sample Characteristics and Differences: tenure and years implementing the model.

There were some distinct patterns and differences between the subgroups. Allegheny and Philadelphia respondents had been employed for the longer periods of time. Approximately 50% of the Allegheny respondents and 68% of the Philadelphia had been employed for 10 years or more. This is in contrast to the other counties which had approximately 37% falling in into the 10 years or more, but also 25% employed five or fewer years, and 25% six to eight years. However, the respondents in Allegheny and Philadelphia were the newest to the conferencing practice (75% had received training within the past five years) so the profile of individuals in these counties were those with experience in the field of child welfare, but not with family conferencing. This is consistent with the model that both of these counties were using in which all caseworkers or CUA staff were trained to facilitate family conferences. This next five subsections summarize the open-ended and close-ended questions.

Training for facilitation and coordination

One of the process questions of the evaluation was whether workers were trained to their particular model. There is no omnibus "evidence-based" training curriculum and methods for every form of family conferencing (personal communication with J. Pennell and L. Merkel-Holguin, December 5, 2018) but common methods for the initial training of FGDM is typically a combination of face-to face training in a group, observing meetings and being observed.

Viewing video tapes of groups and on-line content is also common. Joan Pennell reports that in her practice at North Carolina State what has been helpful is having a partnership model of training by someone who has experienced child welfare services and someone who had delivered these services.

According to the survey, face-to-face multi-day training for the initial training was the most frequently endorsed training method (average percentage across the three groups was 96.3%), and this remained the delivery method of choice over the three time points. This initial training included role play (76.2%) and written materials (77.8%). The respondents from Philadelphia and the other counties also reported that the initial training included on-line resources whereas Allegheny county respondents did not highly identify this as part of the initial training. Webinars as a training method does not appear to be used, nor did this change over time. We asked respondents what transfer of learning activities they experienced after initial training. Observing "live" conferences prior to facilitating was a common method reported by all of the respondents (average percentage was 90%); co-facilitating with a trainer or coach was highly endorsed by Allegheny respondents 72.8%, and 76.5% of the other respondents reported this as transfer activity, whereas a little over a quarter or 28.1% of the Philadelphia respondents endorsed that they co-facilitated with a coach. Video-taping and critique was not highly endorsed as a transfer activity.

While many respondents expressed wanting to change nothing in their training, others described wanting to adjust the training model and structure. This included learning the family engagement model as part of on the job training and adapting the training curriculum to reflect actual practice. Some suggested that facilitators and team coordinators should be trained together to better understand the roles of both positions. Others suggested that supervisors should be trained first and training should be from an actual facilitator.

Respondents suggested ways in which the content of the trainings could be changed to reflect the reality of implementation. They wanted trainings to focus more on the logistical aspects of the conference process, strategies in engaging resistant families, cultural sensitivity and diversity, facilitation skills, different family engagement models, and how to widen the family circle. Some respondents also expressed having the trainings use more realistic families and scenarios when teaching the model. Additionally, respondents wanted to add more follow up and booster trainings. They also wanted more opportunities to observe conferences in the field, shadow facilitators, and have roleplaying and practice sessions. They also wanted more time, access, and availability of trained coaches as well as consistency in coaching. This was because some respondents described getting conflicting feedback from different coaches on how they were doing.

Follow-up on the training activities

43% of Allegheny respondents said that they met with their supervisor, compared to 82% for Philadelphia and 58% for the Lackawanna, Dauphin, Crawford and Venango group. It is very probable that Allegheny workers' contact was with their coaches rather than supervisor as Allegheny used a coaching model. Allegheny respondents reported follow up with their coaches (80.8%) instead. Booster sessions after initial training were more common for Philadelphia, Lackawanna, Dauphin, Crawford and Venango than for Allegheny. Once again, the coaching in

Allegheny may have substituted for booster sessions. It was not clear from the survey the average number of coaching sessions.

After the initial training, respondents reported attending big group meetings such as the regional and state FGDM meetings. Some also described engaging in transfer of learning activities, such as having ongoing supervision from administrators and coaches and observing conferences. Others described participating in ongoing webinars.

Strategies for successful meetings

Although different kinds of conferencing were being implemented, we identified 18 potential facilitator actions which were common to all of the conferencing models (see facilitator survey in the appendix). We then analyzed this at all time points and then by county and time point (see Appendix G). For all counties across all time points, the most important facilitator action was explaining the purpose of the meeting, followed by discussing the family's strengths. The third most endorsed action was that the facilitator helps the participants to develop a specific and concrete plan. Other important actions were making the environment safe and helping the group to identify the people and the roles to support the plan. The tables in Appendix G drill down into the counties and across time points. Explaining the purpose remains the most important action that the facilitator takes in order to ensure the success of the meeting, with the exception of Allegheny, in which discussing family strengths was the most important for Time 1 and Time 2. Family Strengths was a highly endorsed item but again Allegheny endorsed it slightly lower on the last time point with developing plans as the second highest rated.

Crawford/Dauphin/Lackawanna had variation on the first two time points but by time 3 were more similar to the other counties. Because these are not the same respondents across time but are different cohorts (particularly in Philadelphia and Allegheny), interpretations should be made with caution. However, it seems as though there is consensus among those doing the intervention that the important tasks of facilitating, no matter what the particular model, are making sure that participants know the purpose for the meeting, that strengths are discussed and that the participants are helped to develop a specific plan, and this evolved to be the case over the course of the waiver period.

Strategies for preparing families and professionals

An important aspect of a successful conference, no matter the specific model, is preparing the families and the professional for the conference itself. This is sometimes the facilitator's role and in other models the preparation is primarily done by a coordinator. All of the counties in the waiver had a model of facilitators coordinating and preparing all participants. Similar to the question about what makes a meeting successful, the respondents were asked to prioritize strategies/tasks that they use to prepared **families** (e.g., explain the purpose; explain the roles; explain the stages of the meeting and review agenda; help participants to identify strengths and concerns; identify supportive people to invite, clarify concerns; review meeting logistics; meeting before the meeting; pledging emotional safety). In truth all of these are probably done, but we asked the respondents to prioritize five. Responses from all counties over the three time points can be seen in Appendix G. By the third time point, purpose remained a priority task of preparation followed by helping the family to enlarge the circle by identifying supportive people to invite and then working with those participants to identify the strengths and concerns.

Reviewing the agenda tied with identifying strengths and concerns, followed by role clarification and clarifying concerns about child welfare involvement. Allegheny followed this trend at the third time period but Philadelphia did not in the sense that a highly endorsed item (help identify supportive people to invite) was the fifth most endorsed priority, whereas for the other counties it was first, second or third. Philadelphia historically has struggled with widening the circle and having family and supports at the conferences (see mean number of family and friends in the family engagement study on p). Perhaps Philadelphia needs to stress this aspect of engagement – widening the circle—and ways of doing so in their training curriculum and in supervision. Crawford, Dauphin, Lackawanna and Venango on the other hand, rank helping to identify family and friends as the highest priority and this is also observed in their average number of family and friends at conferences as noted in the section on family engagement intervention results.

The respondents were asked to identify the five most important things that they do to prepare **professionals**. While explaining the purpose was still endorsed, it was not perceived to be the priority that it was in preparing families. Rather "encouraging professionals to identify possible resources for the family and to bring this information to the meeting" was highly endorsed for all counties by the third time point with the exception of Philadelphia where it was the second most endorsed item. This is highly consistent with the "developing a plan" which was highly endorsed as a facilitation task. Thus, while those involved in family conferencing value the importance of strengths and widening the circle, explaining purpose and rules, this suggests that resourcing the plan is what professionals are being prepped to do in the meeting. One notable difference between the larger counties (Philadelphia and Allegheny) and the smaller counties (Crawford, Dauphin, Lackawanna and Venango) is that the smaller counties endorsed meeting with professionals prior to the meeting in order to prepare them. This was not in the "top five" for Allegheny or Philadelphia.

The results from three years of facilitator surveys supports some of the findings from the family engagement study on which counties have greater number of families and supports attending, the value placed on creating plans with family input as well as the families' report that strengths are identified. It is impossible to know the impact of time on training and priorities since the number of repeat respondents is so small, but there is an indication that variation across counties was reduced by the third time point.

Challenging barriers in implementing the family engagement model

One challenging barrier that many respondents expressed in the open-ended comments was not having enough time or resources to implement their respective models with fidelity. It was hard for facilitators to effectively engage families when time was limited. Consequently, the issue of high caseloads was frequently brought up by the respondents, and they described how it affected how much time and effort they were able to put into conference preparation. Thus, it was also stated that executing the model was time consuming and that it was difficult to implement the model within the proscribed time frames when caseloads and referrals were high.

Another barrier was getting family participation and engagement in the meetings, especially when engaging resistant and uncooperative families. Many described how families were not showing up to the meetings or that when they did show up, there was little to no participation. Respondents expressed having issues with keeping families, especially natural supports, motivated and engaged throughout the process (e.g. beyond initial meetings). This proved to be

difficult when there were frequent meetings that families were required to attend. Thus, some respondents felt that the low attendance was a result of the frequency of meetings and families ceasing to invite natural supports because of it.

Coordinating and scheduling meetings was also a major barrier in implementation. Respondents expressed the challenge in coordinating times for all parties to be present, especially in short time periods, when working around different schedules, and dealing with the availability of family and their natural supports. Inviting natural supports to the meetings proved to also be a challenge as well. Some families did not have any supports or there were challenges in locating them. Other families were unwilling to invite their natural supports because they did not want them to know they were involved with CYF and were uncomfortable with having others know about their problems.

Moreover, conflicts between the agency and family's expectations was a challenging barrier as well, especially when balancing court orders, non-negotiables, and family outcomes. While the expectation is that the agency and family work together to develop the family plan, some respondents expressed the concern of ownership of plan, the challenge of getting families to address the underlying issues that brought them to the attention of CYF, and that families often wanted CYF to tell them what to do. Additionally, some had expressed the issue of families not following through with the plan or them having unrealistic expectations.

Other challenges in model implementation included working with complicated family dynamics, father engagement, getting staff and parent buy in for the model, staff turnover, staying neutral as a facilitator, navigating agency protocol and policy, and having the space and equipment to conduct meetings. Respondents expressed having issues with providers and stakeholders impeding on the model process as some would bring in their own agendas, hinder family plan development, and have negative attitudes towards the meeting and families. However, other respondents expressed working with caseworkers and other staff as challenge in facilitating the model. Challenges included engaging apathetic caseworkers and supervisors, getting caseworkers to come to the meetings, and working with inexperienced and poorly trained staff/caseworkers on the model.

Challenges in facilitation and supervision/coaching

One typical challenge in facilitation and coaching that many respondents described was helping families identify the underlying issues that brought them to CYF's attention. This included the family not agreeing with concerns that triggered agency involvement (especially when it came to the non-negotiables), inability for some families to identify the problems, and getting families comfortable talking about their concerns. Additionally, it was also expressed by facilitators the difficulty in ensuring team members, including the staff, were focusing on family strengths and supports and making sure families were addressing tangible, realistic, and focused goals.

Another typical challenge involved keeping families on task during the meetings, especially when keeping the family's focus on strengths and the purpose of the meeting. Respondents expressed dealing with disagreements that pushed the meeting off topic, families coming to the meeting with a different agenda, discussions becoming deficit based, and parents being fixated on a specific issue. Additionally, getting family to participate in the meeting and maintaining consistent participation and attendance over time also proved to be a challenge. This was

especially true when it came to engaging with families who had past history with the agency, were tired of the redundancy, had teenagers, and who had members with intellectual and learning disabilities.

Other typical challenges in facilitation that respondents described included engaging resistant and uncooperative families, role overload, lack of natural supports at meetings, making sure all the necessary parties were present, and navigating conflict within families and staff/professionals. They also noted having to deal with providers and stakeholders who impeded on the facilitation process. This included professionals taking over meetings, having their own agendas, wanting families to meet their expectations, lack of involvement and preparation, poor attitude, and not understanding their roles in the process. Other facilitators described similar sentiments about caseworkers as well.

In summary, these findings are reminiscent of the responses from the focus groups held in the first year and a half of the waiver implementation. Engaging families is a task that requires patience and time as well as skill which does not develop immediately after an initial training. The objective priorities that should assist in engaging, (focusing on strengths, widening the circle and families creating their plans) were consistently identified across time and cohorts, but structural barriers such as higher caseloads challenge the practice implementation. In terms of engaging families "where they are", Dauphin, Lackawanna, Venango and Crawford have "titrated" models which give families choices as to how wide they wish the circle to be, and if they want private family time. In conversation with Venango County, some of their lessons learned over the course of the waiver was the critical importance of ongoing communication and co-training with/ between facilitators and caseworkers. Also important was challenging workers' a priori assumptions that families won't want to be involved, which then becomes a self-fulfilling prophecy. Because Pennsylvania has a long history of using Family Group Decision Making, there is a philosophy that anything less than a very wide family circle and private family time is not family engagement. Counties like Venango and Lackawanna who involved the FGDM coordinators in the other models provided a "bridge" to a deeper level of engagement in future meetings. Moreover, Venango closely monitored rates of FTM and FGDM conferences; they reported that this helped implement the intended model, which was to offer FGDM first (instead of assuming a family would refuse – or didn't need FGDM – and offer only FTM). That is, they approached every family with the goal of FGDM and then reduced the level of engagement as directed by the family. This is a good example of how "family-driven" can take different formats.

Comprehensive, structured assessment.

- *Is county staff prepared to comprehensively assess families and children?*
- *What are the perceptions of county partners (i.e., judicial systems) regarding utility of structured assessments and their ability to connect to appropriate services?*

Implementing comprehensive assessment tools was a significant shift for all counties (please see Tables 2, 3, and 4 for an overview of the assessment tools, as well as target populations and timeframes for each county). For over ten years, Allegheny has implemented the CANS for children in foster care placement, as well as children in residential care, and has a structured assessment unit with a team of trainers and coaches. Philadelphia has had experience with providers using the CANS, and, while Crawford had previously utilized the CANS, it had been

some time since they had done so. Thus, this was a new practice for the majority of staff across all six CWDP counties. All counties participated in CANS and FAST training with Dr. John Lyons, and some opted for a train-the-trainer model, so that they could continue to train and support new and on-going staff. The larger counties, in particular, struggled with training their entire workforce and getting their staff certified to conduct the CANS assessments. Even Allegheny, with an existing infrastructure, found that expanding the assessment process to all children was a challenge. For all of the counties, this process took longer and required more ongoing support and coaching than anticipated. In five of the six counties, caseworkers were responsible for conducting both the CANS and FAST assessments; the sixth county (Allegheny) revised job descriptions for Child and Family Advocates to complete the FAST; additionally, they trained over 40 caseworkers in the FAST to improve understanding of the tool and its utilization in the planning process. The earlier sections on mid-course corrections detailed how counties had to adjust timing schedules and practices over the waiver period.

Initially, the staff in all six counties had mixed opinions about the utilization of the CANS and FAST assessments. Despite familiarity with the tools, there was not always an understanding of why those tools were being used and how they could or should inform practice. This varied slightly between supervisors and caseworkers, with supervisors often (though not always) having greater understanding of the tools; they often talked about how the CANS and FAST could be used with families and how they could inform Family Service Plans (FSPs). There was also some appreciation among supervisors about how the assessment tools created a common language across practitioners in different organizations (e.g., "*It's helpful to speak the same language. Drug & alcohol, mental health, psych evaluations, Head Start – they all know what the CANS and FAST are.*"). There were some caseworkers and supervisors who were very enthusiastic about the new tools, and who were eager to utilize them in their day-to-day practice. However, many caseworkers were frustrated by the process, both in terms of the time it took to become trained and certified, and in terms of the time they took to complete with families. This was exacerbated by the feeling that they already asked these types of questions, but the tools made the conversations more awkward and cumbersome and covered the same information as the safety assessment and the risk assessment. The assessments were just another piece of paperwork to complete.

Additionally, they found the timelines for completion to be challenging, and felt that the tools interfered with other casework and paperwork responsibilities. The fact that the CANS and FAST only look back 30 days was also troublesome for both groups, as both were accustomed to (and found value in) looking at a lifetime history with a family (e.g., "*The focus is on the past 30 days, and I struggle with it because you have to look historically at what's been going on. In just the past 30 days, it's great if they've been drug free, but if for the past 15 years it's been going on, it's important to know*"). Another common issue that arose was how to handle it if a family didn't identify something as a problem (e.g., drug use); they were unsure how to then rate it on the CANS and/or how to include it in a service plan. Supervisors were often aware of how much their caseworkers were struggling, but struggled themselves with how to support them. Sometimes this was because they felt equally as inexperienced with the new tools, and sometimes this was because they did not see the value in the tools and thus had trouble getting their caseworkers to buy in to the new process. In general, there was a sense that newer staff were more open to the new tools than more seasoned staff, with seasoned staff often seeing the CANS and FAST as a new fad that would eventually go away (e.g., "*In five years, there will be a*

new fad. In the 80's, it was one program, in the 90's another", "*All of us have many years here and we've seen things come and go, and when this goes, when a new thing comes, it will be when everyone is comfortable with this…Sometimes things come and go and make a full circle…this is great, but I'm tired of learning new things. If I were a caseworker who has only been here for five years, it's not a big deal*").

Our document review suggested that counties were slightly more prepared for assessment than for family engagement in terms of recruitment and selection and training and supervision (please refer to Table 16). The average score for recruitment and selection was 1.792, showing a relatively high level of documentation of policies and procedures related to these activities. Many counties had a score of 2.000 on this item, indicating that these policies and procedures were fully in place at the time of the review. The score for training and supervision was 1.472, indicating that policies and procedures were partially in place for these activities. There was a wider range of scores here (0.667 to 2.000).

Judicial and legal system partners as a group did not talk very much about assessment. Again, however, the thoughts they did share were primarily positive. For example, "*I really believe in assessments. You can start to accumulate data, and if it's done the same way, it becomes the most valid data you will ever have*.", and "*My hope is that the new assessments will bring about an overall better culture. There are still some caseworkers and supervisors who are stuck in a top down way of thinking with the families – their attitude is 'we know what you need better than you know what you need' with the families*." Another respondent believed that knowledge gained through assessments would help drive understanding of cases.

<u>*Evidence-Based Practices (EBPs).*</u>

- *Can county provider networks sufficiently address identified needs and/or provide additional EBPs? Scale back some practices?*

According to the EBP "Basics" data that counties, submitted, all of their selected EBPs received at least some referrals (see Table 17). The majority of these referrals came from the child welfare agency, with the exception of Triple P, where referrals were made by the provider. While some of the determination data were incomplete, the majority of data we do have shows that targeting of referrals was appropriate, with eligibility determination being 'yes' for most referrals. At the censure date, most cases were either currently continuing with treatment or had ended prematurely (though there is a large portion of missing data here as well).

Table 17. EBP "Basics" Data Submitted by Counties

	PCIT (n=841)	Triple P: Level Four (n=276)	Triple P: Level Five (n=17)	Home-builders (n=700)	MST (n=218)	FBT (n=67)	TF-CBT (n=64)	Safe Care (n=86)	FFT (n=379)	PAT/NHV (n=13)
County										
Allegheny	87.5	0.0	0.0	100.0	100.0	0.0	0.0	0.0	0.0	0.0
Crawford	0.0	8.3	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Dauphin	1.2	3.6	35.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lackawanna	3.3	0.0	0.0	0.0	0.0	0.0	100.0	100.0	0.0	0.0
Philadelphia	7.8	72.8	64.7	0.0	0.0	0.0	0.0	0.0	100.0	0.0
Venango	0.1	15.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0
Referral Agency										
County	91.7	27.2	29.4	100.0	100.0	100.0	100.0	100.0	1.3	100.0
MCO	0.7	0.4	0.0	0.0	0.0	0.0	0.0	0.0	86.5	0.0
Provider	7.6	72.5	70.6	0.0	0.0	0.0	0.0	0.0	11.6	0.0
Missing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0
Determination										
Yes	95.2	48.2	64.7	100.0	100.0	100.0	100.0	97.7	51.7	100.0
No	2.5	6.9	0.0	0.0	0.0	0.0	0.0	2.3	12.9	0.0
Missing	2.3	44.9	35.3	0.0	0.0	0.0	0.0	0.0	35.4	0.0
End Status										
Premature	3.0	12.3	17.6	0.0	0.0	7.5	62.5	57.0	5.0	15.4
Completed	0.4	22.1	0.0	0.0	0.0	32.8	0.0	18.6	3.7	23.1
Ongoing	88.8	7.6	0.0	99.3	9.6	34.3	37.5	23.3	1.1	46.2
Missing	4.0	51.4	82.4	0.7	90.4	0.0	0.0	0.0	76.0	0.0
Other	3.8	6.5	0.0	0.0	0.0	25.4	0.0	1.2	14.2	15.4

While most counties, even the rural ones, reported having extensive service arrays, all counties reported having gaps in those arrays, according to interviews with leadership. Frequent gaps included concrete resources such as housing and transportation. Service gaps included mental health (frequently this had more to do with lengthy waiting lists than an absolute lack of services, though one county noted a lack of mental health services for older youth), drug and alcohol, and services for families with multiple needs. A respondent from one of the smaller, rural counties did note a lack of resources, but reported hopefulness about how the CWDP could help with that: "*…one of the reasons we got into the Demonstration Project is that we need to get a better array of services. We need to get the provider base a little more solid…We need to have better services and have providers better trained…We are looking at partnering with another county to see if we can meet the needs. For example, with MST you have to have a certain number of clients. Being a smaller county, sometimes we can't meet that. If we identify other EBPs, how do we sustain them in a smaller county? We are looking at partnerships with other groups, providers, and counties.*" There was some concern voiced by individuals in a couple of the counties that focusing heavily on EBPs may limit what other services were offered and utilized.

Evidence-based practices were supposed to be implemented starting in July 2014 (July 2015 for Crawford); however, this was a slow process for all counties. Two primary difficulties are related to finding and/or keeping EBP providers and very slow rates of referrals from child welfare to the EBP providers. While several EBPs were implemented by the child welfare agency itself (e.g., Triple P in Venango, SafeCare in Lackawanna), the majority are being provided by outside providers. A few providers were already established in certain counties; however, in general, counties have needed to contract with new providers. Even when providers have been established, referrals from child welfare have been few and far between. The reasons for this are not entirely clear, though we hypothesize that this is due primarily to a practice shift for caseworkers who have grown accustomed to referring families to particular services and/or particular providers. Caseworkers (and supervisors) may not be familiar with certain EBPs, and may not know for whom they might be appropriate or how to refer to them.

EBPs, including Trauma-Focused CBT, MST, and PCIT, have been in Pennsylvania for at least a decade, but anecdotal reports from child welfare administrators and providers are that the services are under-utilized by child welfare caseworkers. Attitudes toward innovation can be a precursor to a decision about whether or not to use the innovation (Rodgers, 2003). Therefore, we implemented the EBPQ survey which included the Evidence Based Practice Attitude Scale (EBPAS) as one way of determining caseworker attitudes about new or innovative practices.

Alpha coefficients for the four EBPAS subscales were adequate: Appeal (α=.88); Requirements (α=.96); Openness (α=.86) and Divergence (α=.75). Scores from the Divergence subscale were recoded to be in the same direction as the other three subscales and all were combined to create a total score. Figure 4 displays the total and subscale scores by county. Please note that there is some overlap which makes individual county circles difficult to distinguish (e.g., Venango and Allegheny circles overlap on Openness). In general, the respondents from all of the counties reported positive attitudes about EBPs. Additionally, scores on the Requirements subscale indicate that to a "great extent" the workers in all these counties would refer to the EBPs if required. Respondents from Lackawanna, in particular, felt that Appeal was important, and workers in Philadelphia had greater concerns about how the EBPs are different from current

practices. But for all of the counties, worker attitudes about Divergence were on the low side suggesting that they did not view EBPs as being inconsistent with their practice model.

To summarize the major findings in reference to making referrals, we found that caseworkers turned to their co-workers and supervisors as sources of information to make referrals to services and supports for the families on their caseload. We also found a high degree of variation among the counties in the ease of referral to services. Some of the barriers to referral had easy "fixes" such as lacking a form or number to call whereas others such as family "not meeting requirement" suggests that other systems play a role in what families and children are eligible to receive. We are unable to discern if child or family characteristics (e.g., presenting problems, diagnoses, household composition) or funding and policies were the barriers. In their conceptual model of EBP implementation in public service sectors (e.g., child welfare), Aarons et al., (2011) propose that "outer context" factors such as inter-organizational networks within a given service system are critical in transitioning from policy to implementation. Effective inter-organizational networks can facilitate appropriate referrals, information sharing and support for workers making the referrals to EBPs (p. 12). It is important to use informal networks and the central connections within a system to champion new practices, as well as utilizing the connections of individuals who span several systems. Having champions and inter-system experts work together could be one solution to this. However, more information is needed about the specific nature of "not meeting requirements". Finally, there was some suggestion that the work climate, specifically the feeling that there was inadequate work space, few training resources and equipment may present barriers to referring to services.

The Total scores across time and for all waiver counties show little variation. Likewise, subscale scores show little in terms of change as well. The lack of variation across time periods may explain some of the difficulty in getting EBP's implemented in the demonstration project counties. With the impending implementation of the family first legislation, the demonstration project can be seen as a lesson learned in the uptake of new practice in the field of child welfare. More communication and buy-in from direct line workers is necessary to improve the rates of referral to new evidence based practices. Having a champion within the agency, someone who believes in the treatment, has seen its effectiveness, and can spread the information on to their colleagues, would be a beneficial addition to aid in the uptake of new initiatives. An important component of championing a practice is really understanding what it targets and how the treatment/change process works. Otherwise, an EBP is nothing more than a checklist item (like "homemaker services") and a referral becomes more about a compliance function than facilitating a meaningful intervention (the right treatment for the right family or child). Since front line caseworkers are most knowledgeable about what their families truly need, involving them in the decision making process could help county child welfare agencies select evidence based practices that are best suited to their target families. This is echoed in the Key Informant Interviews in the earlier section in which the directors and leaders talked about the lessons learned in introducing EBPs.

Table 18. Average Subscale Scores for the Evidence Based Practices Attitudes Scale (Three Administration Periods (2015-2018); Point in Time Cohort)

	Time 1: Mean	Time 2: Mean	Time 3 Mean	Time 4 Mean
Allegheny				
Requirement	2.89	2.85	2.90	3.00
Appeal	2.60	2.66	2.70	2.78
Openness	2.30	2.38	2.36	2.44
Divergence	1.20	1.37	1.16	1.26
Total EPBAS	2.64	2.62	2.68	2.73
Crawford				
Requirement		2.78	3.12	2.47
Appeal		2.68	3.00	2.74
Openness		2.34	2.60	2.64
Divergence		1.07	0.88	0.85
Total EPBAS		2.69	2.95	2.72
Dauphin				
Requirement	2.60	2.63	3.15	2.49
Appeal	2.63	2.62	2.96	2.73
Openness	2.51	2.46	2.45	2.83
Divergence	1.05	1.07	1.25	1.07
Total EBPAS	2.70	2.65	2.81	2.76
Lackawanna				
Requirement	3.31	2.95	3.13	3.33
Appeal	3.11	3.01	3.05	2.97
Openness	2.80	2.69	2.77	2.67
Divergence	1.01	.87	.91	1.01
Total EBPAS	3.06	2.94	3.00	3.01
Philadelphia				
Requirement	2.90	3.03	3.01	3.05
Appeal	2.74	2.86	2.78	2.84
Openness	2.63	2.58	2.56	2.61
Divergence	1.68	1.57	1.58	1.59
Total EBPAS	2.65	2.71	2.67	2.72
Venango				
Requirement	3.12	2.82	2.87	3.11
Appeal	2.73	2.80	2.90	2.89
Openness	2.26	2.25	2.64	2.57
Divergence	1.05	1.02	1.17	1.24
Total EBPAS	2.76	2.69	2.79	2.82

Findings from focus groups with caseworkers and supervisors provided additional information about attitudes and behaviors around EBPs.

Knowledge and Awareness

Most participants could list various EBPs though they were not necessarily EBPs that are included in the CWDP. However, at least a few participants were confused and listed community interventions (e.g., parenting classes or Head Start) and/or the county's family engagement model, none of which were actually EBPs. It was rare that group members could clearly define what constituted an EBP, though some knew that research was somehow involved or "*it's got something to do with statistics*."

Impediments to Awareness of Evidence-Based Practice

The level of understanding and training about EBPs varied widely. Some participants reported that their agencies held "lunch and learn" sessions, where providers visited to raise awareness of their services, as well as the eligibility criteria. Formal training had not been provided to most caseworkers and supervisors. If a training had been offered, it was not mandatory, so not all staff had received it, nor had it been offered regularly as a core piece of training for new staff.

Caseworkers reported that much of their exposure to EBPs was simply through brochures that were left at their agencies. They recognized their lack of knowledge and training and felt burdened by the expectation to refer based on minimal information. While every supervisor and caseworker received multiple emails for different types of trainings about EBPs, they were given no guidance as to which trainings to attend. Further, given the volume of trainings, it was hard for them to prioritize which were the most important for them to attend. Cross-system understanding is crucial in order to help collaborative relationships between systems move forward.

Barriers to successful referrals

Case flow. Each case was described as being "*an organism of its own*", unfolding with a series of pressures and a timeline that was not always under the control of the CYF agency. Given that most families arrived at CYF for services related to protection from harm or neglect, and that there were mandates concerning what the caseworker needed to accomplish within a specific timeframe, it is not clear where in the life cycle of the case an EBP might be introduced. In some counties, an EBP referral had to come as part of a family team conferencing recommendation; however, if there was also a need for other services, such as drug and alcohol or housing, it was unclear if an EPB could be added after these other issues had been resolved.

A confounding issue is that with some EBPs, the case must be or remain open with the county child welfare agency in order for the family to be eligible for the EBP. This practice varies across counties and across EBPs. This variation seems to be a function of who pays for the EBP (insurance or the county agency), as well as county agency policies and practices. In one county, it was necessary for the case to be opened as a child welfare case in order for PCIT or Triple P services to be included as part of the service plan. A participant shared an example of one family that was reluctant to become an open case in child welfare and, given the choice, then refused the EBP that was recommended. CYS staff expressed concern that cases would be closed by the

provider immediately when the case was closed in child welfare. In choosing where to refer, caseworkers made an effort to work with providers that were able to keep the case open after CYS closed and that could be counted on to continue to provide less intensive, ongoing services for families.

Uncertainty about roles. There seemed to be some confusion about whose responsibility it was to ensure that families' basic needs were met. Caseworkers reported that they were most likely to refer families to providers who could help with concrete resources (e.g., Social Security or housing). Caseworkers were concerned that those needs would be overlooked or delayed if an EBP was also implemented. From their perspective, this interrupted the flow of a case which was often focused around more critical needs for safety and provision of concrete goods.

An example that illustrates this point occurred in an exchange among supervisors about the use of a particular EBP. Role confusion and misunderstandings were evident and there seemed to be little supervisor awareness about the limits of what this EBP had to offer. What supervisors observed were EBP personnel that worked in the home for six weeks or less. They saw providers that dealt with family dynamics and often "stirred up issues" without giving the family tools to cope with those feelings. In the meantime, concrete needs were not taken care of and an additional set of services needed to be instituted after the family was discharged from the EBP. Caseworkers indicated that because this EBP had such a small time window they were less likely to make a referral. They saw families go through the upheaval of establishing new relationships and expose their family dynamics only to have EBP workers leave quickly. Caseworkers thought this was damaging for families and led to a lack of trust between families and providers.

Referral process. Counties generally had a straightforward referral system in place**.** The referral procedure in most counties involved the caseworker making contact with the provider agency to provide basic demographic details. The provider agency would then make contact directly with the family to set up a screening appointment with an intake worker. In one county, because of the large numbers of families and caseworkers involved, a centralized system had been developed where referrals were made using an electronic system. They entered the needs of the family and recommendations into a service board and then providers were allowed to pick the families with whom they would like to work. The services were matched without any input from the case manager.

We found that caseworkers were most likely to refer to services or providers they knew from past experience would be responsive to them. They also relied on word of mouth with their caseworker colleagues to determine which providers would be responsive and understand caseworker time constraints (i.e., the mandate about what needed to be accomplished within 30 days). They appreciated providers who returned calls and communicated with them in a timely manner. Lack of transportation was widely recognized as problem for many families. In setting up a referral caseworkers took into account the level of difficulty involved for the family in being able to get to the services and were more likely to set up services with an in-home component.

Engagement. It was expected that once a referral was made and the family contact information was shared, providers would then engage the family for treatment. Caseworkers expressed concern that some EBP providers do not have enough experience with child-welfare involved families so their ability to engage with families would be minimal. Caseworkers predicted that engagement of child welfare-involved families with EBP providers would likely be a non-linear

process with many stops and starts. Caseworkers believed that providers were ill-prepared to work with families whose life circumstances interfered with their ability to consistently attend treatment sessions and complete homework that was part of the intervention. Caseworkers and supervisors were sympathetic to families and their difficult circumstances. They disliked the fact that some referrals did not result in a treatment intervention. They noted that to be accepted into some EBPs, the family had already to be very engaged. Caseworkers had stories of providers who said that the family had not shown up for a couple of appointments, therefore the case would be dropped. This caused one supervisor to note that *"providers quit on the families"*.

There was little discussion on how to encourage families to participate in specific EBPs. The ideas expressed were of ways to encourage families to participate in services in general. One caseworker recommended sharing success stories and talking about how a service had helped families with similar situations to their own. This caseworker indicated that it was important not to over promise. It was a set-up for disappointment for the families if they were led to believe that all their problems would be resolved with a particular intervention. In a close-knit community caseworkers believed families were likely to get an understanding of different services and interventions from other families.

Along these lines, participants spoke frequently about how it didn't really matter if a family was involved in an EBP or not; what mattered most was their level of motivation and how much they wanted help. They believed that if families were open to assistance, they were more likely to succeed, period. Conversely, if a family was reluctant to engage or even hostile, then they were unlikely to succeed, even if they participated in the highest quality EBPs.

Finally, in terms of engagement, caseworkers noted the importance of the kind of language used to describe an intervention. For instance, they suggested making a recommendation to "positive parenting practices" as opposed to telling parents they were being sent to "classes in parenting". If a service name sounded more positive or like something that anyone could benefit from, then they hypothesized that families would be more willing to engage in those services.

Family Reluctance. Not all families are willing to acknowledge the importance of involvement in treatment. Caseworkers observed that in order to re-unify with their children, some families felt a pressure to "look perfect" to the court system and CYS. They suggested that these families were unlikely to agree to an intervention such as PCIT or to get involved with mental health services in general. Families were reluctant to believe that treatment was truly confidential and that providers wouldn't share their "business" with their caseworker. In one county, we learned that PCIT was more likely to be used in foster homes because foster families were more likely to acknowledge that they were having difficulties with their child's behavior and they were open to intervention.

Barriers in the Court System

Caseworkers may make recommendations about services; however, they reported that services are often determined by the court. Added to this impediment, it was noted that judges are often unaware of different EBPs, the way they work, and the process of obtaining insurance coverage for such services. In one case, a participant recounted that a judge ordered two services be put in place for a family. The caseworker was aware that the insurance coverage for the family allowed only one of those services. She raised this with the judge, who ordered both services anyway.

Knowing that the insurance would deny coverage for both services, the caseworker was obliged to submit information to the insurance company, wait until that was denied, and only then could an intervention be put in place. In one county, we found what appeared to be a disincentive for caseworkers in providing EBP services to families: when a case was presented at court some judges made the caseworker responsible for the outcome and berated them if the family had not attended sessions with providers. This judge equated treatment with compliance. Caseworkers were unwilling to take the risk of making a referral since as was described there is a high probability that the family will be unable to attend sessions consistently or at all.

Attitudes - Relevance of EBPs

We found that some supervisors were wary of EBPs. One comment we heard was "*how will this help my family be safe?*", suggesting that EBPs were not viewed as directly related to the vital functions of child welfare services. There was discussion about the need for cultural competence and a view that it was not possible to apply services that were developed in a middle class, academic environment to a low-income, child welfare population and assume that they would be effective or even useful.

In one county, there was skepticism about the process by which an evidence based intervention passed the threshold to become labelled "effective". In another county, participants talked about cases that they referred for services, but were rejected by the providers for reasons that were unclear to child welfare staff. The lack of transparency with EBP providers led to suspicion on the part of supervisors that providers were "cherry-picking" families in order to demonstrate that their outcomes were successful. They felt that there was not enough accountability for EBPs; participants from one county were also critical of their county, who had contracted with services they considered ineffective.

Some caseworkers considered EBPs as "*buzz-words*". They talked about how this was a fad and it would be easier to allow this fad to come and fade out than to get "*all involved with it*". They frequently reported that their caseloads were too high; they felt that there "*wasn't enough time to breathe*" and found it difficult to see what the families could gain from EBPs. There was a culture with a feeling that they were never caught up, without much sympathy from their administrators and with no place to voice concerns.

When asked to reflect on their caseloads and the kinds of referrals made in their agencies, a mismatch appeared evident between the EBPs chosen by counties for the CWDP and what they saw as the needs of families. There were discussions of the prevalence of cases with drug and alcohol issues, as well as cases with high mental health needs. One county saw the high incidence of drug addicted infants, as well as truancy, as a major problem. Others were concerned that the EBPs in the CWDP did not serve the needs of adolescents and their families.

Discussion of Findings Related to EBP Implementation

Referrals to EBPs, particularly PCIT and Triple P, from child welfare were significantly lower than projected. While factors such as worker turnover, high caseloads and leadership change present ongoing challenges for all child welfare systems, we believe that the massive changes in Pennsylvania's child welfare context over the past several years had a significant impact on the uptake of EBPs. There has been discussion of this issue at the state/county level and at the two

Pennsylvania Casey convenings; additionally, Casey Family Programs secured consultation for the counties with the National Implementation Research Network (NIRN). However, the situation remained unchanged over the course of the waiver. Using multiple sources of information (document reviews, interviews with providers, focus groups with caseworkers and supervisors, surveys from caseworkers and supervisors), the findings identify several issues of concern.

First, child welfare staff, particularly caseworkers, need more information about what EBPs are, which ones are available in their communities, and how they might benefit the families on their caseload. Beyond this surface knowledge piece in order to refer, child welfare staff would do well to have an in-depth understanding of the selected EBPs, so that they can effectively collaborate with providers and with the families receiving the services. For example, it would benefit the family and the caseworker when all parties understand the goal of PCIT and when they can use a shared language to talk about how things are going and how a family's work in PCIT relates to their work with the child welfare system (as well as how it will help them reach and sustain their longer term goals once their involvement with child welfare ends). This knowledge and understanding would also help to clarify the role confusion that was discussed in the focus groups (e.g., what is the EBP provider's responsibility and what is the caseworker's responsibility). Further, it would strengthen the resource network that caseworkers most commonly use; namely, their peers and their supervisors. The more that the knowledge base of this crucial constituent group can be strengthened, the more families will be connected to appropriate, targeted, EBPs.

Second, but related to the above, multiple stakeholders discussed the importance of family engagement, beyond the more formalized conferences that are part of the CWDP. Helping families understand how EBPs can help them reach their goals is a critical component of engaging them in the process. In the focus groups, many participants voiced the opinion that it didn't matter if a service was evidence-based or not; what was more important was how engaged in services the family was. If the family wanted help, they were more likely to benefit from services; conversely, if they were reluctant or hostile, then they were unlikely to benefit from any service, even an EBP. Perhaps nurturing engagement and motivational skills in the workforce would, in turn, help more families see the ultimate benefit of participating in EBPs.

Third, both child welfare staff and EBP providers cited communication as a significant barrier in working together. In the focus groups, caseworkers talked about their tendency to refer to service providers whom they knew would communicate with them in a timely manner. Both providers and caseworkers voiced confusion about what kinds of information was shareable and what kinds were not. This also impacted the evaluation, as we were only marginally successful in collecting basic dosage information on child welfare-involved families who were referred to EBPs. Some data were collected by behavioral health, while other data were collected by child welfare, but neither necessarily felt that the other had permission to see, share, or use those data. Counties may want to work with their EBP providers and/or behavioral health systems to develop formalized communication protocols that delineate which information can be shared, how it can be shared, and with which groups of individuals (parents, foster parents, providers, evaluators, etc.)

However, even as we list these issues of concern and offer suggestions for changing referral practice, we acknowledge that there are many factors which make changing caseworker practice

challenging. For example, Dorsey, Kerns, Trupin, Conover & Berliner (2012) found that training caseworkers about EBPs increased knowledge, but did not significantly increase the rate of referrals to services. They could not identify the reasons why the training and consultation model did not change behaviors, but did identify some contextual factors which may have made it less successful. They suggest that future interventions include a more active organizational intervention component or supervisor involvement. The process evaluation findings suggest that learning how to engage reluctant families, triage, and manage crises and then motivate those families to participate in an EBP, as well as advocate for the family with multiple systems, is a sophisticated set of skills. Then, when the demonstration counties experience the turnover of caseworkers, they lose someone with this skill set, who is replaced with someone with basic skills. If it takes time to hire and train new caseworkers, then existing workers then take on cases, increasing caseload size.

PCIT and Triple P Sub-Study

We conducted a sub-study on two of the selected EBPs: PCIT and Triple P. Both process and outcome evaluations were conducted, although, as stated earlier, both were on a smaller scale than originally anticipated. This was due to multiple factors; the two primary obstacles were (1) slow and modest uptake of these particular EBPs and (2) difficulty accessing providers and/or child level data. These challenges are addressed elsewhere in this report [link to where can find challenges]. The majority of data we did receive was from Triple P providers in Venango and Crawford counties, with a smaller amount of data from PCIT providers in Allegheny and Lackawanna counties.

The process study findings discussed here are guided by the following research questions:

1) Is PCIT reaching the intended target population; are referred families receiving a sufficient amount of the intervention and, if not, why not?
2) Is Triple P reaching the intended target population; are referred families receiving a sufficient amount of the intervention and, if not, why not?
3) Are PCIT and Triple P being delivered with fidelity?
4) In what ways does the implementing environment affect implementation and operations?
    - Are the necessary resources available at the provider level to implement PCIT and Triple P?
    - Are the necessary resources available at the public child welfare agency level to support the implementation of the EBPs?

While we are unable to determine whether or not PCIT or Triple reached the intended target populations, both the EBP spreadsheet data and the child-level data from PCIT and Triple P providers can provide information on the dosage of the interventions. Additionally, the child-level data provides some additional information about the types of families participating in the intervention.

According to the EBP spreadsheet (see Table 17), 841 families were referred to PCIT between 7/1/2014 and 12/31/17. Of these, 801 were determined to be eligible for services, and 750 either completed services or were continuing with the service at the censure date. These numbers suggest that counties (particularly Allegheny, from where the majority of cases came) were

successful in targeting appropriate families – families that would be eligible for services and be engaged with and complete those services.

The EBP spreadsheet (see Table 17) shows that 276 families were referred to Triple P: Level Four between 7/1/2014 and 12/31/17. Of these, at least 133 were determined to be eligible for services (note that eligibility data were missing for 124 families), and at least 82 either completed services or were continuing with the service at the censure date (end status data were missing for 142 families). For Triple P: Level Five, 17 families were referred. Determination and end status data for these families were incomplete. The majority of Triple P data came from Philadelphia, with lesser amounts from Crawford, Dauphin, and Venango. Because eligibility and end status data are incomplete for Triple P, we are unable to make any determinations about the success of counties in targeting appropriate families for these services.

As described earlier, participating providers were asked to complete Treatment Summary Forms for families involved in PCIT and/or Triple P. We received Treatment Summary Forms for only 9 children-caregiver dyads who participated in PCIT. These came from Allegheny (n=4) and Lackawanna (n=5). While demographic data is presented in Table 19, given the low number of participants, no further descriptive information is included here.

We have a larger sample of Treatment Summary Forms for Triple P participants (n=70), allowing for some further inspection of these data. The majority of these are from Philadelphia (64%), with a smaller number from Crawford (34%) and one from Dauphin (1%). Demographic information for these participants can be seen in Table 19.

Families participated in an average of 9.27 home visits (range 0-24 visits) which lasted an average of 14.67 hours in total (range 3-49 hours) over an average of 12.91 weeks (range 2-31 weeks). A variety of family members participated during this timeframe, with 91.4% of the focus child/youth participating, 87.1% of female caregivers, 42.9% of male caregivers, 50.0% of siblings, 11.4% of grandmothers, and 2.9% of grandfathers. Providers indicated that these families were involved in some, but not many, additional services during the same time frame. The most frequent were School-Based Counseling/Consulting (11.4%) and Family-Based Mental Health Services (10.0%); a few providers indicated that their families were also involved in parenting services and/or truancy programs.

The Treatment Summary Form asks for providers' views on why Triple P was terminated. The most frequent reasons were disinterest/low motivation (15.7%), frequent cancellations (15.7%), and non-compliance during sessions (11.4%). The caregiver-completed Barriers to Treatment Participation Scale (BTPS) gives a different perspective on this, with moderately low scores on both subscales (Treatment Expectations and External Demands) at two time-points (see Table 20). As described in the section on Measures, this scale asks about different obstacles to participating in services on a Likert scale of 1 (Never a Problem) to 5 (Very Often a Problem). Higher scores suggest more barriers. The wide range of scores on both subscales is notable, however, and suggests that there were at least a few outliers who indicated that both Treatment Expectations and External Demands were major obstacles to their participation treatment. However, it is also likely that families who were not motivated, cancelled frequently, and/or were non-compliant, did not complete the BTPS and/or didn't remain in treatment long enough to complete it at Time 2.

Table 19. Demographics of Participants in PCIT and Triple P Sub-Study.

	PCIT (n=13)	Triple P (n=80)
Mean CG age at birth of target child	24.0 years (range 16.8 – 31.8)	26.0 years (range 16.7 – 57.5)
CG identifies as Spanish, Hispanic, or Latino	14.3%	0.0%
CG Race		
Black/African American	21.4	2.5
White/Caucasian	64.3	95.0
American Indian/Native Alaskan	0.0	1.3
Asian	0.0	0.0
Hawaiian/Pacific Islander	7.1	0.0
Multi-racial	0.0	1.3
Other	7.1	0.0
Highest Educational Degree of CG		
Less than High School	21.4	18.4
High School Equivalency (GED)	7.1	25.0
High School Diploma	28.6	39.5
Vocational Tech Diploma/Certificate	21.4	3.9
Associates Degree	14.3	5.3
RN Diploma	0.0	0.0
Bachelor's Degree	0.0	0.0
Master's Degree	0.0	0.0
Professional Degree (MD, PhD, Law, Dental)	0.0	0.0
Other	7.1	7.9
CG Marital Status		
Single/Never Married	57.1	33.3
Married	21.4	26.9
Separated/Divorced/Widowed	14.3	21.8
Living with Someone	7.1	17.9
CG's Current Occupational Status		
Work Full-Time (35 hrs/week or more)	28.6	22.8
Work Part-Time (less than 35 hrs/week)	21.4	11.4
Work when work is available	7.1	0.0
Unemployed, looking for work	14.3	12.7
Don't work b/c of family responsibilities	14.3	15.2
Don't work b/c retired	0.0	2.5
Don't work b/c of illness or disability	14.3	22.8
Don't work b/c don't want to work	0.0	3.8
Don't work b/c currently a student	0.0	0.0
Other	0.0	8.9
Target child is living with CG	35.7	78.8
Child is Spanish, Hispanic, or Latino	21.4	3.8
Child Race		
Black/African American	35.7	3.8
White/Caucasian	50.0	92.3
American Indian/Native Alaskan	0.0	0.0
Asian	0.0	0.0
Hawaiian/Pacific Islander	0.0	0.0
Multi-racial	7.1	2.6
Other	7.1	1.3

Table 20. Mean BTPS subscale scores over time

	Time 1 (n=64)	Time 2 (n=43)
Treatment Expectations	13.90 (range 10-35)	13.23 (range 10-20)
External Demands	12.60 (range 10-33)	12.93 (range 10-32)

On the Treatment Summary Form, providers were asked to rate the caregiver's overall commitment to services on a scale of 1 (Very Low) to 5 (Very High). The mean rating (n=67) was 2.79 (SD=1.18), suggesting that providers felt this group of clients were marginally committed to the process of treatment. Only about one-third (31.4%) of participants completed treatment within an agreed upon timeframe; the remainder left services prematurely/outside of an agreed-upon time (62.9%) or did not have an end status given (5.7%). However, in a text box, nine providers indicated that additional authorizations were needed in order to complete treatment; while they didn't necessarily state that those authorizations were received, it suggests that a slightly larger number of families were engaged and invested in the intervention (i.e., they would continue/finish if additional sessions were authorized by their insurer).

Key informant interviews were held with PCIT and Triple P providers to gain an understanding of their perspectives of the CWDP.

Awareness of the CWDP and knowledge of referral process

In general, there was limited awareness of the CWDP. Providers spoke about being contacted by county CYF representatives about interest in providing EBP's to child welfare-involved families, but had no knowledge of the Title IV-E waiver. Due to turnover in provider agencies, contact people often knew little about the referral process for CYF-referred children and families. Some positive signs were noted in reports of CYF caseworkers and provider connections, as well as caseworker field trips to PCIT provider agencies to learn more about the intervention.

Providers have not noticed an increase in referrals from child welfare since the CWDP began. We found centralized referral processes in most provider agencies and it was the provider that determined the type of treatment that the family would receive. When referrals occur, providers expressed concern about the details of the case history provided to them.

> *"There have been instances where we find how the case was presented to us was actually completely different. Specifically, the caseworker identified that the parents have parenting issues, but they've failed to identify that the parents have substance abuse issues, which plays a huge key role in parenting. You're definitely not going to parent the same way as a sober person than you are when you are when you are under the influence."*

Training

We found that thorough and systematic training in both EBPs had occurred. In all but two agencies the clinicians had been trained in PCIT free of charge through an NIMH funded grant through the University of Pittsburgh. The rest of the clinicians were certified through PCIT

International and Triple P International. Some clinicians are now certified to train others in their agency through a "train the trainer model". However, since all clinicians are so recently trained, there is concern among providers about sustainability in the face of high turnover rates in mental health agencies. One provider described a 12 month period in which 3 separate people were trained, but two left the agency:

> "As *far as the agency and staff goes, our biggest barrier is that [clinician name] will be staff number three in a year. So we only have one Triple P worker. [Clinician name] works for me under another parenting program that I supervise too, so she's going to be transitioning from that program to Triple P and when the first person had left she filled in until we hired the second person"*

Investment in resources is lost when a trained a clinician leaves, as costs of training a replacement are high. Providers also expressed concern that high staff turnover rates in their agencies are an issue with clinical implications, particularly for children who have experienced loss:

> *"For kids who have disrupted attachments and disrupted relationships, you really don't want a situation where they're going to get treatment and go through four different therapists in a year. That's not good thing for them either and I think sometimes makes things worse rather than better. "*

Barriers at the agency, system and family level

In contrast to families who are not involved with the child welfare system, providers noted the high level of basic needs experienced by CYF-referred families. Clinicians may become aware of additional child needs, and the lines of responsibility may become blurred as to who ensures that other necessary services (e.g., medical care, speech therapy) are in place for children coming for treatment. EBP clinicians describe CYF-referred cases as labor-intensive, requiring additional paperwork, as well as mandatory communication with and/or appearances in court. The additional time spent on these tasks is not compensated by insurance companies, and this creates a financial disincentive for the provider.

One provider thought their county put restrictions on who could receive PCIT [i.e., families who receive Behavioral Health Rehabilitative Services (BHRS - wraparound) are not allowed to receive both services]. Even if formal restrictions aren't in place, participating in multiple therapeutic services can often be too much for families.

> *"So there was no way that wraparound and PCIT were going to happen at the same time. It was pretty clear that the family was not going to drive to outpatient when they had someone coming to their house. It's just a lot of effort for a family to come and participate with us. So, I didn't blame them."*

There are logistical barriers for CYF-referred families who experience multiple social stressors. For example, they may have problems attending treatment sessions due to lack of reliable transportation or lack of child care for their other children. PCIT requires quite a bit from participating families, including an extensive time commitment, structured sessions, homework, and documentation completed by parents to demonstrate mastery of skills in order to graduate. Some parents are unable to commit to this level of involvement due to time restrictions or

logistical issues (such as those identified above). Providers note the difficulties in asking families to keep up with the tasks of the interventions when a staff member is not present.

> *"Family-level barriers would be motivation, I think, getting them to do the homework and to watch the video when we're not there. It's easier to engage them when we're there than when we're not there. So getting them to monitor a behavior for a week at a time, to use the monitoring tools, that's been a barrier. It's really difficult getting family to do the homework piece of it and then getting them to move forward, because you can't move forward until they're doing their portion of it."*

A theme specific to CYF and the implementation of both PCIT and Triple P is the difficulty of identifying which caregiver should be engaged in treatment. In addition, if it is unclear whether a child is to be re-unified with a parent or continue in out-of-home care, clinicians are wary of accepting them for services. The focus of both interventions is on building strong relationships between parent and child, which can be jeopardized if a judicial decision is then made to continue out-of-home care or to change the goal to adoption. Logistical issues can interfere with family completion of the requirements of the intervention, which can then create consequences for families involved with the judicial system. For example, an inability to complete all steps for PCIT/Triple P could be viewed unfavorably by the court. Finally, completion of homework is an issue for a biological parent allowed limited time with their child when they are receiving supervised visitation.

Engaging families

Not all families show a readiness for change and may lack the prerequisites to succeed in these EBP treatments.

> "*I think, as a facilitator of Triple P you have to start with where the family is at and be willing to help them through their barriers, like if they can't read, you have to help them get the information the best that they can."*

Clinicians in one agency were trained in motivational interviewing. Their process was to speak with the family prior to treatment to preemptively solve logistical barriers and provide resources to help make the family successful. Effective resources included transportation, childcare, and Saturday or evening appointments. Agencies frequently widened the team to support these families, by providing an additional staff member for child care. One agency provided a gift card incentive. Providers have also undertaken marketing strategies with system partners, such as Head Start and school districts, to increase awareness of the interventions.

All providers acknowledged the difficulty of engaging any family in treatment. The manner in which the intervention is communicated can impact both interest and compliance. If it is communicated enthusiastically by a knowledgeable person who explains the specific benefits to them, then a family likely becomes curious and commitment improves. This type of communication depends on caseworkers having knowledge of the appropriateness of an intervention for a particular family. Providers expressed concern about expectations of caseworkers who are not knowledgeable about treatments.

> *"Caseworkers hear parenting program or positive parenting program and they think that Triple P does everything. And that's definitely not what Triple P's about. We need*

appropriate referrals such as not referring us people who are not as high functioning as you would like to see someone who is actually able to practice Triple P."

Communication between providers and CYF

While we found evidence of close collaboration between providers and caseworkers around difficult cases, no formal communication protocols exist. Interaction is sporadic and varies by individual caseworker. Family Service Plans and goals are generally not shared with providers. Caseworker accessibility was voiced by many as a concern. Providers recognized the time constraints on caseworkers and pointed to the structure of their own work days with back-to-back appointments leaving little time or opportunity for connection.

"Accessibility is often a huge problem. Not being able to leave messages because their voicemail is full. I know they have too many kids and you know, it's a really tough, tough job. It would be great to be able to engage them, and get them to call back, and be able to participate with us."

In one county where the provider and CYF were housed in the same building, communication was good. In another county with the same physical set-up, there were large gaps in communication. This may be a question of scale. The county where communication gaps were noted is quite large, while the better communication occurred in a much smaller county. One new provider noted the difficulty of contending with established providers to be recognized as an alternative place for referrals from CYF.

How to get the right families to the right services at the right time

The providers interviewed frequently noted that there seems to be an assumption held by CYF staff that the more services that are offered to a family, the more their lives will improve. This belief results in the authorization of multiple, simultaneous services in an attempt to determine which might take hold ("service snowballing"). However, from their perspective, providers see families that are often overwhelmed and confused by the number of service providers in their lives and feel drained by the energy needed in order to keep up with appointments.

"When some parents are trying to keep their kids or get their kids back, their whole lives are appointments, making sure they get from appointment to appointment, especially if they don't have the transportation, is so tough. Maybe the goals are unrealistic because there's so many in the family and they have to get housing and drug and alcohol treatment and do like a million things. If you don't do all of them and do them well, you won't get your kids back. I just think that that's very difficult when these families already have so many barriers."

We found that providers had admiration for caseworkers. They expressed empathy for the families, as well as empathy for the caseworkers and the difficult situations they encounter on a daily basis. Providers urge child welfare agencies to take care of their workforce and emphasize the need to address caseworker trauma and burnout.

Next we wanted to know about the effectiveness of PCIT/Triple P with child welfare referred populations. Again, we did not receive enough child-level data on PCIT to determine effectiveness with child welfare-referred populations. For Triple P, however, we can look at the

APQ-9 and ECBI scores over time to help us answer this question. As described on pp. XXXX, the APQ-9 has three subscales: Positive Parenting, Inconsistent Discipline, and Poor Supervision. Ideally, over the course of treatment, one would hope that Positive Parenting would improve, while Inconsistent Discipline and Poor Supervision would decrease. Paired samples t-tests were conducted between sessions 1 and 5 and sessions 1 and 10 to see if and how these scores varied (see Tables X and X). Results suggest that while prosocial parenting behaviors do not significantly improve over the course of participation in Triple P, negative parenting behaviors – particularly poor supervision – do significantly decrease.

Table 21. Paired Samples T-Test for APQ Subscales at Sessions #1 and #5.

APQ-9 Subscale	Session 1		Session 5		N	95% CI for Mean Difference	r	t	df
	M	SD	M	SD					
Positive Parenting	12.98	1.91	12.70	2.40	54	-0.23, 0.79	0.64**	1.09	53
Inconsistent Discipline	7.80	2.60	7.09	2.50	55	0.14, 1.30	0.63**	2.39*	54
Poor Supervision	6.54	4.14	5.21	3.13	28	0.28, 2.36	0.76**	2.61*	27

* $p < .05$; ** $p < .001$.

Table 22. Paired Samples T-Test for APQ Subscales at Sessions #1 and #10.

APQ-9 Subscale	Session 1		Session 10		N	95% CI for Mean Difference	r	t	df
	M	SD	M	SD					
Positive Parenting	13.10	1.90	13.59	1.57	29	-1.19, 0.23	0.44*	-1.40	28
Inconsistent Discipline	8.10	2.50	6.26	2.86	31	0.69, 2.99	0.32	3.26**	30
Poor Supervision	7.79	4.37	4.93	2.02	14	0.56, 2.69	0.42	2.69*	13

* $p < .05$; ** $p < .01$.

The ECBI can also tell us about improvements (or lack thereof) in challenging child behaviors over time. Providers were asked to indicate pre-treatment ECBI scores and ECBI scores at the last session (whether or not the family completed treatment). Again, a paired t-test was conducted to determine if there were any changes in either of the ECBI subscale scores over

time. The Intensity score reflects the severity of behavior problems, while the Problem score reflects the number of behavior problems. As seen in Table X, both Intensity and Problem scores decreased significantly over the course of participation in Triple P, indicating improvements in the child's externalizing behaviors. .

Table 23. Paired Samples T-Test for ECBI Subscales.

ECBI Subscale	Pre-Treatment		Last Session		N	95% CI for Mean Difference	r	t	df
	M	SD	M	SD					
Intensity	58.62	14.42	50.52	14.56	63	5.21, 10.98	0.69*	5.61*	62
Problem	59.22	13.89	51.75	13.24	63	4.88, 10.01	0.71*	5.76*	62

* p < ..001.

Fidelity of Implementation of Assessment and Family Engagement Conferences

In addition to readiness to implement, we also looked at fidelity of implementation of assessment and family engagement. The interim evaluation found that changing the practice model was challenging. To determine if the six counties have implemented these interventions, we looked at the number of children receiving an intervention and then counts of specific types of assessments.

In this next section, please keep in mind the following definitions and general contextual factors:

- Unless otherwise noted, the data are in Fiscal Years;
- Crawford has one less year of data coming into the waiver in the second year;
- For the FAST assessment tables, some of the counts/percentages are of *family level* assessment and in other tables, the FAST will be counts/percentages of *child level* assessment. This distinction will be indicated;
- The ASQ, ASQ:SE, and CANS counts/percentages are always *child level* assessments;
- The counties have different policies about which children and families receive assessments, as well as the frequency of assessment (refer to the tables for each county outlining the frequency). The frequency of the ASQ and the ASQ:SE administration is also determined by the age of the child.

The following sections provide counts or percentages of the specific assessment by year and county, as well as type.

Are children and families being assessed?

Although the ASQ and the ASQ:SE are different assessments, with the SE version focused on socio-emotional development, these counts include both types of assessments in the table. In Table 24 the number of assessments increased by year, with the exception of Lackawanna county where the volume decreased. There are policy changes that did occur; Allegheny increased their targets beyond children in out of home care, for example. Because the volume of ASQs is also impacted by the age of the child and the need for continued screening, it is difficult to know for sure if the waiver led to the increased volume. However, we can say that the number of young

children involved in child welfare being screened for social and emotional delays increased during the five year period.

Table 24. Count of ASQ and ASQ-SE Assessments by Year

County	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Allegheny	433	857	951	795	803	
Crawford		22	15	61	110	
Dauphin	59	85	98	260	319	17
Lackawanna	313	708	487	358	455	33
Philadelphia	905	1867	1761	2114	3257	
Venango	31	77	84	80	99	7

The CANS, which is done at the child level, shows a trend of increasing number of assessments, particularly for Crawford, Venango and Philadelphia. Lackawanna experienced a decrease in the volume. When the same data are looked at by the type of CANS, we generally see more initial than reassessments, and only Allegheny indicating End of Service (EOS; this was a failure on the part of the other information systems to indicate EOS).

Table 25. Count of CANS Assessments by Year

County	FY2014	FY2015	FY2016	FY2017	FY2018
Allegheny	3527	4186	4331	3916	3637
Crawford		106	85	123	208
Dauphin	341	302	413	273	169
Lackawanna	448	391	102	98	102
Philadelphia	767	1701	1512	1787	3614
Venango*		58	32	153	198

* Venango's first submission was 5/28/15

Table 26. Count of CANS Assessments by Type

County	EOS	Initial	Reassess	(Unknown)
Allegheny	216	1641	2273	56
Crawford		80	24	2
Dauphin		185	96	21
Lackawanna		256	109	26
Philadelphia		1283	417	1
Venango		25	32	1

EOS= End of Service

The FAST assessments were counted for the "family" (e.g., the "family together") rather than each individual child assessed and each caregiver assessed. Therefore, the unit of analysis is the family, not the child or caregiver.

Table 27. Count of FAST Assessments by Year

County	FY2014	FY2015	FY2016	FY2017	FY2018
Allegheny	226	977	2899	8082	8192
Crawford		143	140	150	226
Dauphin	368	343	546	290	146
Lackawanna	1638	1425	981	870	464
Philadelphia	1839	3480	3419	3997	5614
Venango	132	57	44	172	207

Once again, the trends suggest an increase in volume by year for Allegheny, Crawford, Philadelphia, and Venango. Dauphin was increasing the volume until FY2017 when the volume decreased (it is not clear from policy why this is the case). Consistent with their trend, Lackawanna decreased the volume of FAST assessments.

Table 28. Count of FAST Assessments by Type

County	miss	1st assessment	2nd assessment	3rd assessment
Allegheny		226		
Dauphin		264	59	45
Lackawanna		1333	128	177
Philadelphia	53	1585	201	
Venango		93	39	

In summary, these data support the findings from the Interim Evaluation Report in terms of readiness to implement assessment. A process had to occur to train new and existing staff or contracts created and then providers trained to do the assessments. The larger counties used a "rolling" implementation so that district offices or CUA staff was gradually trained over the course of the first year. The number of assessments generally increased from FY2014 to 2015 although there were some exceptions (e.g., Lackawanna was over-assessing young children using the ASQ and had to be instructed on the proper timing intervals). It is likely that the increase in assessments in most counties is also the result not only of more children and families being assessed, but also better recording and data submission.

Is the intervention reaching the target population? How are assessment and family engagement events interacting with substantiation and placement? *[note this question was answered by Chapin Hall]*

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Pennsylvania Title IV-E Waiver Evaluation – Assessment Targeting Section

1/9/2019

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Chapin Hall is an independent policy research center at the University of Chicago focused on providing public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of children, families and communities.

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Using a sample of the second to last fiscal year of the waiver (SFY 2017), this section describes the point at which child welfare populations received the first of each of the interventions, relative to their child welfare history. The key question is how counties targeted each assessment once assessments were well integrated into county work with families. At the individual level, the analysis indicates when the assessment occurred in the child's child welfare history. Children's CW history was grouped into three populations:

1. children without any prior substantiated allegations or placements
2. children with at least one substantiated allegation or placement but were not in placement at the time of the assessment
3. children were in placement when the assessment took place.

The first ever assessments of each type in SFY 2017 was included in the analysis.

One significant limitation is the lack of case opening or closing events. The case open and close events were integral in many of the county's target population definitions (see Tables 2-5). However, the evaluators were not able to collect that data from all of the counties given the challenges already involved in collecting a data from four different information systems. Thus, the evaluation team could not analyze how counties made decisions about whether to begin serving families or not or county fidelity to targeting protocols, almost all of which reference the acceptance of cases for ongoing services.

The data sources, described in other sections, were the dates of county-provided reports of Family Engagement, FAST, CANS and ASQ/AQSE assessments and the dates of substantiated investigations and placements from county-provided child welfare data. There were some differences in each county's available child welfare history, described in Table 1 (County-specific maltreatment and placement data coverage - first complete fiscal year by data type). Assessment and child welfare events were analyzed in sequence.

Due to the requirements of the data submissions to University of Pittsburgh, all assessment events had MCI IDs, but not all child welfare events did. Table 29 and Table 30 show the proportion of child welfare events with populated MCI IDs. Allegheny is not included in this analysis due to a high percentage of both placement and maltreatment events with missing MCI numbers. Allegheny's internal ID was considered as a proxy linking identifier but issues with using that identifier were not able to be resolved. Due to missing MCI IDs in the substantiated investigation data in Dauphin, Philadelphia, and Venango, the proportion of assessments for children who had had no prior child welfare involvement is probably overstated and the proportion with child welfare involvement history but not in placement is probably understated.

Table 29. In Each Demonstration County, What Proportion of Substantiated Investigations during the CWDP (7/1/13 - 6/30/18) had MCIs Populated?

County	Total # Children	% w/ all events having an MCI ID	% w/ events missing an MCI ID
Allegheny	13,154	65%	35%
Crawford	1,975	97%	3%
Dauphin	4,698	83%	17%
Lackawanna	4,794	93%	7%
Philadelphia	27,539	77%	23%
Venango	897	68%	32%

Table 30. In Each Demonstration County, What Proportion of Placement Spells that Began during the CWDP (7/1/13 - 6/30/18) had MCIs Populated?

County	Total # Children	% w/ all events having an MCI ID	% w/ events missing an MCI ID
Allegheny	5,236	81%	19%
Crawford	330	99%	1%
Dauphin	1,125	100%	0%
Lackawanna	737	96%	4%
Philadelphia	12,688	100%	0%
Venango	244	97%	3%

Only a sample of family engagement events were submitted for Allegheny (already excluded) and Philadelphia. However, since this analysis asks, of all the assessments that occurred, when did they occur in the child's child welfare history, a representative sample of assessments is appropriate.

For events that took place on the same day, the following hierarchy was used:

1. Substantiation
2. FAST
3. CANS
4. ASQ/ASQSE
5. Family Engagement
6. Placement

For example, if a child had an investigation begin (for an investigation that was substantiated) and a FAST completed on the same day, that child would fall into the second category, "Children with at least one substantiation or placement, but not in care at the time of this FAST event." Or, if a child was placed on the same day as the FAST, they would also fall into the second category.

Results

Table 31. Histories of Children with a first FAST Done in SFY 2017

	Crawford		Dauphin		Lackawanna		Philadelphia		Venango	
Child Welfare History Category	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Children with no prior substantiations or placements prior to this FAST event	117	25%	190	27%	246	33%	2,718	28%	115	34%
Children with at least one substantiation or placement, but not in care at the time of this FAST event	283	61%	319	46%	427	57%	4,677	47%	193	56%
Children in care at the time of this FAST event	65	14%	190	27%	70	9%	2,472	25%	35	10%
Total First FAST Events in SFY 2017	**465**	**100%**	**699**	**100%**	**743**	**100%**	**9,867**	**100%**	**343**	**100%**

While the precise description varied by county, generally all families who were accepted for services were to receive a FAST assessment. Since families accepted for services could either have had a substantiated investigation, an unsubstantiated investigation, or have come to the attention of the agency by another path, it is consistent that the largest proportion of children whose families received an initial FAST assessment were not in placement. It is notable that in Philadelphia (25%) and Dauphin (25%), a larger proportion of first FASTs were given after a child was in placement. Philadelphia explicitly included children in placement in their target population.

Table 32. Histories of Children with first CANS Done in SFY 2017

	Crawford		Dauphin		Lackawanna		Philadelphia		Venango	
Child Welfare History Category	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Children with no prior substantiations or placements prior to this CANS event	10	10%	34	15%	3	4%	91	6%	35	28%
Children with at least one substantiation or placement, but not in care at the time of this CANS event	26	27%	72	31%	35	44%	142	10%	62	50%
Children in care at the time of this CANS event	60	63%	125	54%	41	52%	1,247	84%	26	21%
Total First CANS Events in SFY 2017	**96**	**100%**	**231**	**100%**	**79**	**100%**	**1,480**	**100%**	**123**	**100%**

County target populations were also broad for CANS assessments, within the appropriate age ranges. However, the data above shows that the majority of initial CANS assessments (with the exception of Venango) were done for children in placement at the time of the CANS. For example, in Philadelphia, 84% of first CANS assessments in SFY 2017 were done for children in placement.

Table 33. Histories of Children with first ASQ/ASQ:SE Done in SFY 2017

	Crawford		Dauphin		Lackawanna		Philadelphia		Venango	
Child Welfare History Category	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Children with no prior substantiations or placements prior to this ASQ event	4	8%	30	18%	202	59%	264	19%	24	35%
Children with at least one substantiation or placement, but not in care at the time of this ASQ event	34	64%	55	34%	113	33%	303	21%	36	53%
Children in care at the time of this ASQ event	15	28%	79	48%	26	8%	846	60%	8	12%
Total ASQ Events in SFY 2017	53	100%	164	100%	341	100%	1,413	100%	68	100%

Each county intended to use ASQ/ASQSE assessments for both in-home service and placement populations. As shown in the table above, these assessments were experienced by all three groups, but in different proportions. For example, 60% of Philadelphia's initial ASQ/ASQSE were done for children in placement, whereas 59% of these assessments were done prior to substantiation or placement in Lackawanna.

Table 34. Histories of Children with first Family Engagement Meeting Done in SFY 2017[2]

	Crawford		Dauphin		Lackawanna		Philadelphia		Venango	
Child Welfare History Category	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Children with no prior substantiations or placements prior to this FE event	138	28%	64	41%	3	4%	27	13%	24	18%
Children with at least one substantiation or placement, but not in care at the time of this FE event	259	52%	73	46%	15	19%	90	45%	81	60%
Children in care at the time of this FE event	100	20%	21	13%	62	78%	84	42%	31	23%
Total FE Events in SFY 2017	497	100%	158	100%	80	100%	201	100%	136	100%

[2] Philadelphia submitted a sample of Family Engagement meetings.

With the exception of Lackawanna, generally all families who were accepted for services were to have a Family Engagement meeting, and the data reflects a distribution of meetings among all three groups. Lackawanna's focus included children at imminent risk for placement and had the highest proportion of children in-placement when the meeting took place (78%).

The final table uses an inception cohort and asks "Of children who experienced a substantiated investigation as a first event in SFY 2017, what was the next event most likely to be (as observed through June 30, 2018)?" Philadelphia is excluded because not all children had a family engagement event in the data, due to an agreement to submit sample data. Allegheny is excluded for the same reason, as well as because of issues with IDs. Venango is excluded because it was not possible to accurately identify first maltreatment events because maltreatment data was only available starting in SFY 2017.

For Crawford, Dauphin and Lackawanna, the most common next event observed through June 30, 2018 was no next event. This means that each of these three counties decided the child (the child's family) did not need assessment or placement for 48% to 62% of these children. A second substantiation was the next most common event, with 17% to 25% of children experiencing a second substantiation as a next event. [3] The proportion of children who were placed without an intervening assessment was low, ranging from 3% to 10%. For all three counties, the percent of children whose families had a FAST event was the most common among assessment events, though an ASQ/ASQSE was nearly as likely in Lackawanna, and the overall likelihood of any assessment event as the next event was lower in Dauphin. Adding all the assessment events together, the percent of children who had any assessments as a next event was 22% (Crawford and Lackawanna) and 11% (Dauphin).

Table 35. Next Event Following First Substantiation in SFY 2017

	Crawford		Dauphin		Lackawanna	
Next Event	**#**	**%**	**#**	**%**	**#**	**%**
FAST	53	14%	57	5%	66	11%
CANS	3	1%	12	1%	5	1%
ASQ/ASQSE	6	2%	17	2%	62	10%
Family Engagement Conference	19	5%	27	3%	2	0%
Start out of home placement	12	3%	107	10%	47	8%
Substantiated investigation	97	25%	185	17%	134	22%
No second event observed in window of time	198	51%	672	62%	296	48%
Total	**388**	**100%**	**1,077**	**100%**	**612**	**100%**

[3] This view of children and families' experience with waiver interventions is different from the outcome analysis in two key ways. First, there is a longer window of observation – 1-2 years. This will increase the percent of children placed and with a second substantiation since the likelihood of these events goes up with time. Second, it addresses the sequence of all the events, including assessments. This will decrease the percent of children placed and with a second substantiation, since there may be other intervening events before this occurs. As a result, it is not possible to directly compare the results, but they differ in these expected ways.

Discussion:

These analyses of who was assessed, relative to their child welfare history, as well as where assessments fit in to a trajectory beginning with a first substantiation, show that counties were using assessments in a variety of ways relative to formal child welfare involvement. The FAST was used the most numerous times and most children were not in care at the time the FAST was conducted. As a next assessment event following a first substantiation, the FAST was the most common, though in Lackawanna, it was followed quickly by ASQ/ASQSE. The rest of the patterns of use described above were varied, and reflected the decisions made by counties in each individual case. Counties clearly adopted the assessment tools but applied them as needed and in different ways. Their targeting plans were sufficiently broad to allow these choices. And, as is shown by Table 35 (Next Event Following First Substantiation in SFY 2017), counties determined that a majority of families did not need assessments or child welfare services.

Are assessments resulting in individualized plans?

The source of data used in answering this question is the SPANS-CANS (see earlier section on Measures for details on the SPANS and the data collection schedule; see Appendix E for the SPAN-CANS tool). The SPANS-CANS is a fidelity tool designed for use in conjunction with the Child and Adolescent Needs and Strengths (CANS). The SPANS determines the degree to which child and family needs and strengths identified in the CANS are being addressed or used in service planning. The SPANS is a particularly useful evaluation tool within the context of the CWDP because it quantifies the relationship between assessment and individualized service planning. By examining the case record, the SPANS-CANS allows the reviewer to determine if actionable identified needs in the CANS assessments were: a focus of the plan; addressed though services and supports which are a focus of the plan; and if child and family needs were monitored. Any item rated a 2 or a 3 on a CANS needs domain or a 0 or 1 in a strengths domain is then flagged as an "actionable item" for the SPANS. After reading the CYS record, the reviewers then assign a score as to how well the record demonstrates a need was addressed or a strength used by answering three questions: (1) Was the child/family need a focus of the plan; (2) were recommended services and supports a focus of the plan; and (3) were child and family needs monitored. An assigned SPANS score of a 0 suggests that the information in the record allows the reviewer to see the links between appropriate assessment, plans, activities and child and family outcomes with regard to this item. A score of 1 suggests that in reviewing the record, there were questions for the reviewer because there is not enough information to see the full linkages between assessment, planning implementation, and outcomes. Finally a 2 indicates that there is little or no evidence that the efforts are being made to address the needs or utilize strengths as pertains to this CANS item. Additional information about the SPANS and its use in other program evaluations can be found in Behavioral Health Care: Assessment, Service Planning, and Total Clinical Outcomes Management (Lyons & Weiner, 2009). The records being accessed in scoring the SPANS are CYS records, not provider records, documenting the perspective of how the caseworker is using the information obtained from the CANS to direct service planning and delivery.

Descriptive analyses were run to examine the percentages of how frequently a need or strength is identified and how frequently it is addressed. We established a benchmark of 75%. That is, using the SPANS, we would expect that an identified need or strength would make it into plans 3 out of 4 times. This benchmark was based upon Allegheny County's experience. Because of the small number of SPANS-CANS and SPANS-FAST we were not able to divide into cohorts e.g. first admissions, follow up) or look at it by county, or over time.

An earlier analysis of the SPANS-FAST at interim, using data collected from January 2015 to April 2016, found good congruence between the FAST and plans in terms of addressing safety issues, serious mental health problems of the parents and children and family functioning and living situations. However, when the SPANS-CANS was analyzed, the analysis did not find utilization of youth strengths in plans, little attention paid to trauma and for youth who were transition aged, few references to jobs and independent living. The SPANS-CANS was also more likely to document externalizing child MH issues and action on them rather than internalizing issues. This is supported by research that tells us that externalizing behaviors are more likely to get the attention of everyone in the child/youth's sphere: teachers, caregivers, and caseworkers (refs). Further, caseworkers do not have expertise in differential diagnosis and

assessment and are more prone to focusing on the most immediate needs at hand. The conclusion was that while there was evidence of child welfare focusing on critical issues of safety raised through the assessments, less attention was being paid to child well-being. However, the size of the sample was very small (53 SPANS-CANS and 25 SPANS-FAST), and the implementation of assessment still relatively new. These results were presented as part of a series of "Flashtalks" with the counties and the evaluation team continued to collect data using the SPANS-CANS and SPANS-FAST. See Appendix H for the Flash Report.

Figure 4 illustrates the analysis of the results of the 107 SPANS-FAST. Recall that the FAST is done for all target populations and focuses on the entire family rather than a target child. High need FAST items found in the plan 75% or more of the time were family safety, caregiver's mental health and substance abuse, child regulation skills and school and caregiver involvement with care. It seems that workers are prioritizing and focusing on immediate safety and serious caregiver problems that would put children at risk such as parental substance use. In addition, school problems and child regulation issues often bring children to the attention of adults and place the child at risk. High need items appearing in the plans at least half of the time were more focused on family conflict and communication, caregiver characteristics (organization, knowledge, post-traumatic response, relationships), and child physical and mental health status. High need items that were found in the plan less than half of the time were the parent/caregiver relationship, finances, collaboration with partners, the child's relationship with birth father (see appendix for full list).

Figure 4. Distribution of High Need Items on the SPANS-FAST.

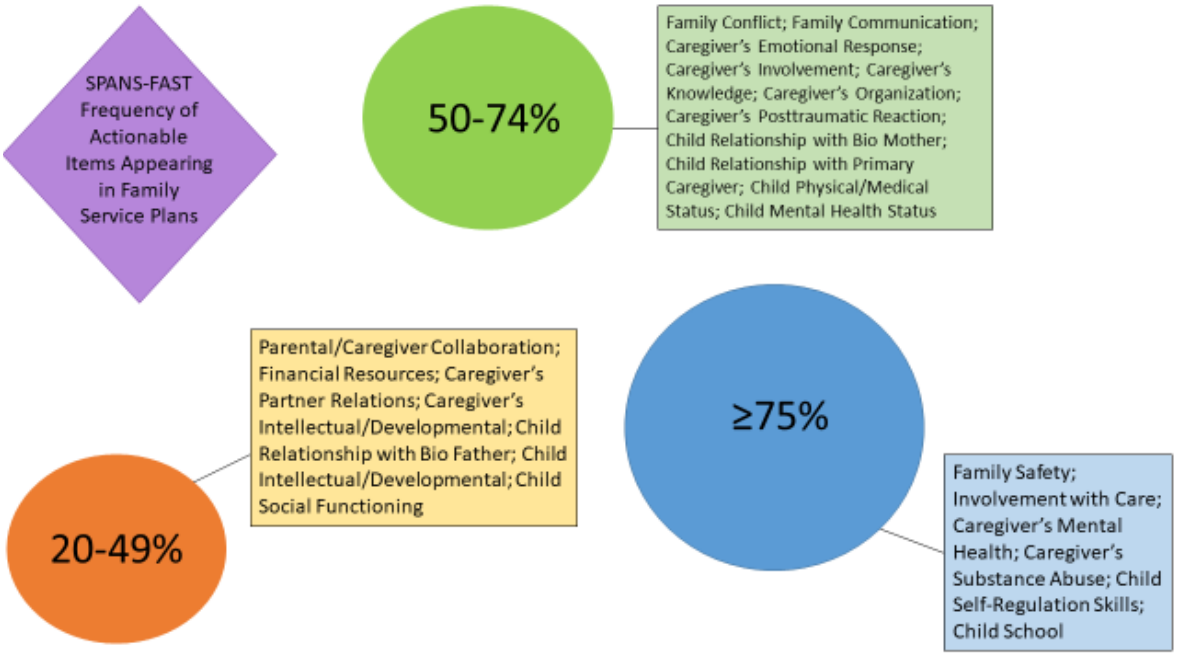
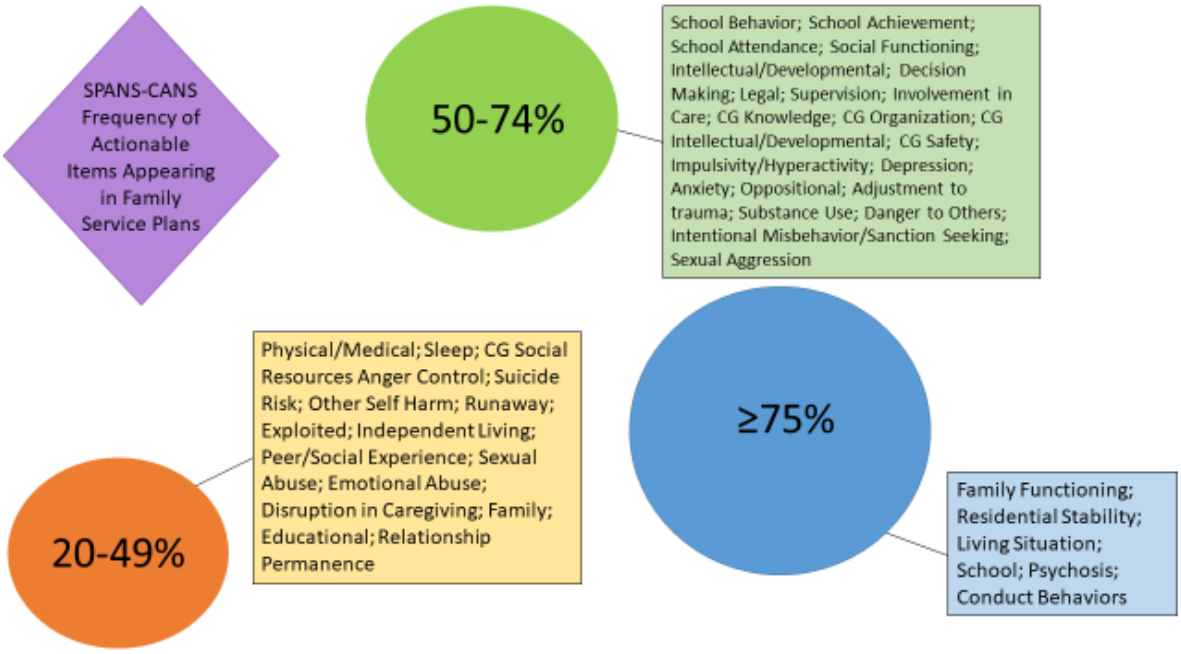


Figure 5 illustrates the results of 130 SPANS-CANS, the total for the waiver period. High need items from the CANS found in the plan 75% or more of the time were family functioning, residential stability, living situations, school, psychosis, and conduct behaviors. Present, but at a lower percentage (at least half of the time) were items related to school, social functioning

mental health and substance abuse, safety of the caregiver, intellectual disabilities, depression and anxiety, adjustment to trauma. Items identified as high need but included in the service plan less than half to a quarter of the time were sleep, physical and medical problems, Runaway/exploitation, independent living, peer/social experiences and disruption in caregiving, caregiver resources, relationship permanence (again, refer to Appendix H for the full list).

Figure 5. Distribution of high need items on the SPANS-CANS.



The answer to the question posed is that yes, assessment is informing the plans but which "high needs" make it into the plan seems to be prioritized by the worker. The FAST is informing the plan in the domains of safety and parental and child behaviors that place the child/ren at risk or in danger are making into the plan. This is not surprising since the lens of child welfare is one of safety. On the other hand, the CANS high need items most likely to be addressed in plans are family functioning and housing and living situations and behaviors which are externalizing or psychotic. The pattern for how the CANS is informing plans is not as clear as with the FAST but it also may be that workers are assuming that the more mental health high needs may be addressed in mental health provider plans.

Although the numbers were too small to analyze by county, the SPANS raters did find some differences between counties. Some counties had very well developed plans which corresponded to the assessments and others had plans with little congruence with the assessments and little variation.

Are families engaged (i.e., participating in family engagement meetings/conferences)?

The sources of data used in answering this question are from the Family Engagement Study (FES). Please refer to the methods section for a description of the data sources and procedures. All of the counties involved in the CWDP collect process-related data for all meetings or conferences held (initial and follow-up). Following the meeting or conference, the information is

sent to the CWRC. **As documented in the methods section, both Allegheny and Philadelphia are sampling instead of providing data on every conference. As a result, the numbers reported for Allegheny and Philadelphia are for a subset rather than the entire population of families receiving family engagement group interventions. The date range of the data used in these analyses is 7/1/13 through 6/30/18**.

As seen in Table 36, the volume of meetings increased substantially in Crawford, almost doubling in volume each year of the waiver. Were the data to have continued for the full twelve month period in FY 17-18, Crawford is likely to have continued that trend. A very similar upward trend is seen in the volume for Venango, with a less dramatic increase in volume, but continuing a steady increase. The volume in Lackawanna was fairly flat and stable throughout the waiver period. The volume in Dauphin has the most variation. While Dauphin and Venango started in FY 13-14 at very similar volumes, Venango increased over the course of the waiver, while Dauphin decreased. The context for this trend is not clear. As described in other parts of this report, Dauphin certainly had many contextual factors that could have contributed to this decrease. It is possible that (1) conferencing decreased due to prioritization of other child welfare practice strategies or initiatives or (2) conferencing continued at pre-waiver levels, but was undocumented through the lack of submission of study forms. After discussions with Dauphin leadership, it seems that the first, less prioritization, was the reason. However, as validated with other sources of data, once Dauphin began to re-invest in the practice model (and with only six months of data available), they submitted data on twice as many conferences in FY 17-18 as they had for the preceding 12-month period.

Table 36. Total Number of Family Engagement Meetings Held (Initial and Follow-Up) by County

	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Allegheny*	19	83	74	29	31
Crawford		66	105	211	233
Dauphin	134	56	71	46	83
Lackawanna	107	114	100	102	65
Philadelphia*	0	112	225	406	131
Venango	146	153	155	214	188

* Allegheny and Philadelphia are only submitting data for a sample of families served

Because family engagement is an intervention offered to every IV-E eligible family involved in CYS, an implementation question is *what is the **primary** purpose of the initial conference?* How is the intervention of family engagement conferences being used to meet the goals of the CWDP: increase permanency, reduce time spent in foster placement and promote transition to adulthood; prevent reoccurrence of abuse and increase positive outcomes for children and families? To answer this question we examined the primary purpose that the family was referred for their initial conference (see Table 37). For the cases for which an initial conference was held, and for which a purpose was indicated, over half of the conferences were for the purpose of developing a plan or revising an existing plan (57.2%). This purpose is consistent with the expected immediate outcomes of the conferences according to county policy (refer to Table 5).

Table 37. Reasons for Initial Family Engagement Conference.

FY 2013-FY 2018	Allegheny	Crawford	Dauphin	Lackawanna	Philadelphia	Venango	All conferences
	Valid N=139	Valid N=271	Valid N=363	Valid N=357	Valid N=297	Valid N=319	Valid N=1746
Planning purposes							
Develop/revise service/treatment plan	56.8	58.7	6.3	81.8	66.0	78.4	57.2
Develop a plan to keep child safe in home	5.0	3.0	43.3	6.2	8.1	2.8	13.0
Placement							
Considering a change in placement	0.7	3.0	3.0	0.0	0.3	0.9	1.4
Prevent a placement	0.0	1.5	6.6	1.4	0.0	0.3	1.9
Prevent disruption of present placement in home	0.0	0.4	0.6	0.6	0.0	0.0	0.3
Permanency							
Plan/assist in reunification	0.0	3.7	11.0	4.5	3.4	0.9	4.5
Develop a permanency plan	0.0	22.5	0.3	3.1	1.0	8.8	6.0
Transitioning out of care	0.7	1.1	3.6	1.1	0.0	0.3	1.3
Well-being							
Child health	3.6	0.4	3.4	0.0	3.0	2.5	2.0
Parent health	10.8	0.7	1.9	0.3	3.7	0.6	2.2
Communication/conflict	8.6	2.6	4.7	0.0	1.6	0.3	2.4
Transportation/housing	5.8	0.7	2.0	0.0	1.0	0.6	1.3
Truancy/ delinquency	5.8	1.8	4.7	0.3	8.7	2.2	3.7
Develop parent supports	0.7	0.0	8.5	0.6	0.7	0.6	2.2
Enhance adult supervision skills	1.4	0.0	0.3	0.3	2.4	0.6	0.7

When individual county patterns are examined, there is some variation, although service planning remains the primary reason for engaging in a conferencing process for five of the six counties. The variation reflects the individual county practice and climate. For example, service planning was not a primary reason in Dauphin; instead, “Developing a plan to keep a child safe in a home” was the primary reason. This makes sense given Dauphin’s context during much of the course of the waiver. None of the counties reported calling for meetings prior to placement changes or for disruptions in placements. Crawford reported the highest percentage of using conferencing to develop permanency plans (22.5%) compared to the average (6.0%). Despite the goal of increasing well-being as part of the waiver, it was not a primary purpose of conferencing. However, this may also reflect training in the counties in terms of both conferencing itself as well as in completing the forms. Creating service plans is certainly part of the practice model and tends to be a default response. Future iterations of this study will work to better clarify these “purpose” options, as well as better train workers to not automatically default to this purpose.

What is the level of extended family participation and family empowerment at the initial meeting?

As documented in the intervention section (Table 5), parents in some counties are offered staged or tiered options for the engagement conference. The counties offering this type of tiered model are Crawford, Lackawanna, Venango, and Philadelphia (note: the target population to whom FGDM is offered in Philadelphia is different from the other counties and will therefore not be included in this discussion). Families are first offered FGDM, which involves a larger circle of family and supports and includes private time with the family authoring the plan. Conferences with private family time require more preparation to ensure safety, to identify and invite a large circle, and to ensure that participants understand their roles and are prepared to participate fully. If families are not comfortable with this approach, they are then offered the option of a Family Team Meeting, a Family Team Conference, or a Family Group Conference (depending on the county). These interventions are all quite similar in that the number of family and supports attending is fewer and there is no mandatory private family time although it is offered (please see the intervention section for a full discussion of each model and a table outlining differences/similarities). Table 38 gives the number and the percent of each type of initial conference for all counties.

Table 38. Type of Initial Family Engagement Meetings/Conferences (7/1/2013 to 6/30/2018).

Type	Frequency	Percent
FTC	604	33.7
FGDM	202	11.3
FGC	352	19.6
Conferencing/Teaming	167	9.3
FTM	468	26.1

One approach to answering the question about being engaged at the correct level is to examine the percentages of FGDMs held relative to the other engagement models in counties offering a tiered model. *If the assumption is that FGDM, with the family authoring the plan during private family time is the most family-driven of the models, then for the counties who offer a tiered approach, you should see a mix of both FGDM and other models*. Not all families will have the depth or quality of social networks to hold a FGDM, nor will all of them wish to have that level of involvement. However, some proportion of families will engage at that level.

FTC and FTM are the predominant initial family engagement interventions for the counties using a tiered approach to engagement (see Table 39). Taking a tiered approach when working with CYS-involved families is a sound strategy when families are reluctant to contact their extended families or when they lack the family supports to participate in a FGDM. In the focus groups and interviews with parents, some reported that they were reluctant to invite extended family members because they believe that their family and friends would not attend, or they will attend, but be more of a hindrance or negative influence than a support. Similarly, youth reported reluctance about involving family members in groups, stating that the adults wouldn't attend or would be negative or ineffective. As a result, parents, as well as older youth, may choose to participate in an intervention with less involvement of extended family and less family control over the plan.

Table 39. Types of Engagement Conferences Held by Counties Offering a Tiered Approach.

Meeting Type	Crawford %(n)	Lackawanna %(n)	Venango %(n)
FGDM	5.6% (15)	16.9% (60)	35.0% (117)
FTC	--	83.1% (296)	--
FTM	94.4 % (251)	--	65.0% (217)
FGC	--	--	--

However, all of the engagement interventions require the presence of one or both of the parents. A parent was present in at least 80% of the initial conferences in all counties except for Philadelphia, where slightly less than half of initial conferences had a birth parent present. Table 40 displays the percentage of initial family conferences where at least one birth parent was present.

Table 40. Percent of Initial Conferences with at Least One Birth Parent Present.

	At least one birth parent present
Allegheny(n=153)	88.9%
Crawford (n=271)	93.0%
Dauphin (n=362)	88.7%
Lackawanna (n=356)	84.8%
Philadelphia (n=323)	47.7%
Venango (n=324)	87.7%

Another approach to answer the question about the level of engagement is to ask the following: ***How many people are invited and attended the first conference? What is the proportion of family attending relative to the paid professionals?***

One goal of family engagement conferences is to "widen the circle" (Pennell & Anderson, 2005) so that the family has access to both paid professional, community, and extended family supports and services. Maximizing the number of relevant individuals invited to and attending the conference increases the chances that the circle will be widened. Having a diversity of participants, paid professionals, as well as family and friends, increases the opportunity for multiple perspectives and multiple ideas to be explored and proposed as possible solutions. For all initial conferences, the average number of individuals *invited* to the conference was 8.16 (SD=4.16) and the average number who *attended* was 6.88 (SD=4.36). When examined by county, some patterns are observed (see Table 41). Dauphin and Lackawanna cast the widest net in invitations (an average of 10 individuals invited; approximately 9 attending), whereas other counties invited fewer individuals. While Philadelphia and Allegheny invited comparable numbers of individuals, slightly higher numbers attended in Allegheny.

Table 41. Average Numbers of Individuals Invited To and Attending Conferences.

	Invited *x* (SD)	Attended *x* (SD)
Allegheny	5.03 (2.9)	4.39 (5.5)
Crawford	8.86 (3.8)	7.41 (3.2)
Dauphin	10.26 (4.2)	8.71 (3.2)
Lackawanna	10.11 (4.0)	9.00 (5.5)
Philadelphia	5.22 (2.4)	3.07 (1.8)
Venango	7.63 (3.7)	7.15 (2.9)

However, widening the circle by only including professionals will not achieve the goal of the family "owning" the plan to have children live safely in their homes and communities. Therefore, the number or percentage of family (including children/youth and parents), relatives, friends, and paid professionals relative to the total number of individuals present at the conference is an important consideration.

As can be seen in Table 42, the percentage of family and friends at the initial conferences was greater than that of professionals for all of the counties. The exception to this is Philadelphia, where approximately equal numbers family/friends as professionals were invited, but almost three-quarters of attendees were professionals.

Table 42. Percentage of Family/Friends Invited to and Attending Initial Conferences.

	Percentage of those *invited* who were family/friends	Percentage of those who *attended* who were family/friends
Allegheny	85.8	79.5
Crawford	62.5	71.2
Dauphin	85.6	82.0
Lackawanna	93.4	91.9
Philadelphia	49.3	28.0
Venango	53.8	52.2

Are engagement activities delivered with fidelity?

One way that we are assessing fidelity is through the Family Conference Survey. Looking at the average total score of these items gives a sense of the fidelity overall (see Table 43). Average survey scores indicate that the majority of participants agreed or strongly agreed with all survey statements, suggesting moderate to high fidelity to core principles of family engagement. As found in previous research (Rauktis, Huefner, & Cahalane, 2011), scores for professionals are slightly higher than those for friends or family members.

Table 43. Mean Family Conference Survey Scores by Model and Respondent Type.

	Family and Friends		Professionals		Overall*	
	Mean # respondents	Mean score (n)	Mean # respondents	Mean score (n)	Mean # respondents	Mean score (n)
FTC	2.4	3.19 (n=342)	2.1	3.23 (n=446)	3.8	3.19 (n=504)
FGDM	4.3	3.36 (n=184)	2.6	3.50 (n=189)	7.2	3.41 (n=194)
FGC	4.7	3.42 (n=332)	2.1	3.56 (n=295)	6.7	3.46 (n=340)
Conferencing/Teaming	2.4	3.21 (n=114)	1.8	3.26 (n=80)	3.5	3.24 (n=126)
FTM	2.9	3.31 (n=402)	2.3	3.42 (n=430)	5.4	3.36 (n=444)
Overall	**3.4**	**3.30 (n=1400)**	**2.2**	**3.39 (n=1467)**	**5.2**	**3.32 (n=1639)**

* Note that because respondents did not always indicate their relationship to the focus child, their category (i.e., Family/Friends or Professionals) was not always able to be determined. These respondents are included in the Overall category, but not the Family/Friends or Professionals categories.

In order to determine whether or not there was any drift over time in fidelity, we also looked at conference scores over the course of the waiver (see Table 44). Scores for both family/friends and for professionals remained fairly stable across all five years of the waiver.

Table 44. Survey Scores (Family/Friends, Professionals, and Overall) by Year and Model.

	FTC	FGDM	FGC	C&T	FTM
2013	n=22	n=26	n=55		n=33
FF	3.11	3.35	3.40		3.21
Prof	3.03	3.45	3.47		3.36
All	3.08	3.40	3.42		3.29
2014	n=74	n=45	n=50	n=44	n=43
FF	3.26	3.28	3.39	3.25	3.21
Prof	3.16	3.46	3.48	3.26	3.37
All	3.20	3.34	3.42	3.24	3.33
2015	n=60	n=35	n=43	n=10	n=66
FF	3.06	3.39	3.41	3.09	3.76
Prof	3.26	3.55	3.58	3.31	3.38
All	3.15	3.43	3.45	3.14	3.59
2016	n=85	n=21	n=53	n=10	n=123
FF	3.23	3.49	3.39	3.17	3.30
Prof	3.27	3.52	3.62	3.30	3.41
All	3.25	3.50	3.44	3.26	3.33
2017	n=43	n=40	n=42		n=98
FF	3.15	3.43	3.50		3.37
Prof	3.22	3.53	3.63		3.51
All	3.17	3.46	3.53		3.43
2018	n=14	n=12	n=44		n=27
FF	3.24	3.18	3.48		3.23
Prof	3.48	3.46	3.58		3.45
All	3.40	3.34	3.51		3.36

Note: Shading indicates fewer than 10 cases for that cell; however, the numbers were still included in the All column.

Another way of examining fidelity over time is to look at survey scores across multiple meetings for the same families. Table 45 shows survey scores (by family/friends and professionals, as well as overall) for participating families with numerous conferences. Again, scores appear to be fairly stable over time, again suggesting relatively high fidelity.

Table 45. Survey Scores over Time by Model for Families who had Multiple Meetings.

	FTC	FGDM	FGC	C&T	FTM
Initial	n=504	n=194	n=340	n=126	n=444
FF	3.19	3.36	3.42	3.21	3.31
Prof	3.23	3.50	3.56	3.29	3.42
All	3.20	3.41	3.46	3.24	3.36
2nd	n=193	n=58	n=28	n=28	n=185
FF	3.30	3.27	3.34	3.06	3.27
Prof	3.35	3.39	3.57	3.13	3.47
All	3.29	3.30	3.42	3.07	3.37
3rd	n=106	n=61		n=10	n=160
FF	3.20	3.24		3.23	3.23
Prof	3.22	3.35		2.85	3.42
All	3.17	3.30		3.12	3.31
4th	n=59	n=33			n=85
FF	3.14	3.48			3.20
Prof	3.25	3.45			3.43
All	3.15	3.43			3.31
5th	n=31	n=24			n=53
FF	2.97	3.44			3.37
Prof	3.23	3.38			3.38
All	3.12	3.33			3.39
6th	n=19	n=15			n=27
FF	3.16	3.17			3.26
Prof	3.21	3.38			3.43
All	3.22	3.23			3.30

Note: Shading indicates that there were fewer than 10 cases for that cell.

As another perspective on fidelity, we conducted a small number of conference observations in each county annually (see earlier section for a description of the methodology). This allowed us to get a sense of the overall tone and process of each of the models. As can be seen in Table 46, there was considerable variability in where conferences were held, with FGDM and FTM conferences more frequently being held in neutral locations (e.g., community centers, libraries). FGC meetings were largely in the child welfare agency, while FTC and C&T conferences were also held in agency settings or homes.

Table 46. Characteristics of Observed Meetings, by Conference Type.

	FTC N=32	FGDM N=26	FGC N=14	C&T N=20	FTM N=13
Meeting location					
CYS/CYF	43.8%	23.1%	78.6%	55.0%	46.2%
Agency setting	18.8%	7.7%	14.3%	15.0%	0.0%
Neutral/Offsite	31.3%	69.2%	7.1%	5.0%	53.8%
Placement Setting	0.0%	0.0%	0.0%	5.0%	0.0%
Parent/Caregiver/Foster Home	0.0%	0.0%	0.0%	20.0%	0.0%
Other	6.3%	0.0%	0.0%	0.0%	0.0%
Mean length, in minutes (SD)	82.50 (40.2)	98.46 (38.1)	143.57 (54.5)	85.20 (28.9)	75.08 (30.9)
Total number in attendance (SD)	7.81 (3.5)	8.54 (24)	9.71 (3.5)	8.40 (3.5)	7.85 (3.0)

The observation tool asks the rater to indicate the presence or absence of specific facilitator behaviors. Facilitators across all models were observed to discuss the purpose of the meeting. Relatively fewer facilitators explained their roles or the roles of participants; however, it should be noted that some models (e.g., FGDM) have a preparation phase, and it is possible that these discussions happened prior to the initial meeting. Only FTC (and, to a lesser extent, FGC) were directive in nature, with some of these facilitators being observed to tell the families what to do. Generally speaking, these trends seem to be consistent with the family engagement models outlined by the counties.

Table 47. Frequency of Observed Facilitator Behaviors.

	FTC N=32	FGDM N=26	FGC N=14	C&T N=20	FTM N=13
Presented agenda	65.6	76.9	92.9	80.0	84.6
Recapped decisions and plan	75.0	80.8	85.7	75.0	61.5
Discussed purpose of meeting	84.4	96.2	100.0	90.0	100.0
Recapped assignments at end	62.5	64.0	78.6	80.0	23.1
Explained rules and guidelines	56.3	92.3	100.0	90.0	84.6
Facilitator explained his/her role	65.6	61.5	64.3	40.0	46.2
Explained roles of participants	53.1	46.2	85.7	60.0	46.2
Told the family what to do	50.0	0.0	21.4	0.0	0.0
Explained confidentiality	37.5	65.4	71.4	95.0	84.6

Facilitators of observed meetings were also rated on a set of behaviors on a Likert scale of 1 (None of the Time) to 4 (All of the Time). As seen in Table 48, facilitators of FGC meetings were generally rated high on all behaviors. On average, ratings on all behaviors for all models were at least “moderate”, with the exception of FTC; both ‘supported discussion about strengths’ and ‘encouraged families to be involved in decisions’ rated an average of approximately 2.5. Again, this is consistent with the stated county policies and goals of FTC.

Table 48. Mean Ratings of Observed Facilitator Behaviors

	FTC N=32	FGDM N=26	FGC N=14	C&T N=20	FTM N=13
Supported discussion about needs	3.43	3.54	4.00	3.85	3.77
Brought all participants into discussion	3.72	3.04	3.86	3.30	3.08
Supported discussion about strengths	2.56	3.77	3.93	3.85	3.85
Kept the conference focused	3.81	3.15	3.79	3.15	3.46
Encouraged family to be involved in decisions	2.53	3.31	3.93	3.74	3.46
Remained neutral/respectful of services	3.72	3.88	4.00	4.00	4.00
Remained neutral/respectful of family and supports	3.03	3.85	4.00	3.95	3.92

Taken together, the Family Conference Survey and observation tool data suggest that, in general, the selected family engagement models were implemented with fidelity. This is consistent with findings from the Interim Evaluation Report.

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AT THE UNIVERSITY OF CHICAGO

Pennsylvania Title IV-E Waiver Evaluation – Outcome Study Sections

12/19/18

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Chapin Hall is an independent policy research center at the University of Chicago focused on providing public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of children, families and communities.

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Introduction & Key Questions

The overarching question guiding the Outcome Study was: What was the impact of the Pennsylvania Title IV-E Waiver Demonstration Project on child and youth safety, permanency, and wellbeing outcomes?

As described in the evaluation plan, county outcomes prior to implementation of the waiver and outcomes during the course of the waiver were evaluated with a longitudinal time series analysis. Within the Outcome Study section, we compare the child welfare outcomes specified in the evaluation plan and indicate whether there is evidence of change during the five years of the waiver when compared to the baseline period. This section describes placement and maltreatment outcomes for children who were experiencing either a foster care placement or a substantiated maltreatment investigation for the first time, prior to the waiver (SFY 2011 through SFY 2013) or during the five years of the waiver (SFY 2014 through SFY 2018). The following outcomes are presented by county:

- Maltreatment recurrence
- Likelihood of placement following maltreatment
- Out-of-home placement rates per thousand children in the population
- Rate of placements in congregate/institutional care settings
- Rate of placements in kinship care settings
- Placement stability
- Length of stay in out-of-home care
- Reentry from permanency

The county-level outcome analyses of child welfare outcome trends used cohort comparisons, comparing outcome performance between pre-Waiver and Waiver cohort groups. This historical comparison, while unable to provide clear evidence of a causal relationship for changes in the outcomes of interest, provided a descriptive look at the way outcomes have changed over time. The pre-Waiver years provided a baseline, capturing outcomes of entry and exit cohorts in the three fiscal years prior to the start of the Waiver (SFYs 2011 through 2013). Waiver outcome comparisons came from entry and exit cohorts during the five years of the Waiver (SFYs 2014 through 2018). Focusing on first substantiations or admissions into care, the cohorts either represent an entry cohort of children coming into care or an exit cohort of children exiting care within the given timeframe. Outcome-specific cohorts are detailed in Table 49.

Key Outcome Study Outcomes

The county-level outcome variables and indicators of Waiver impact for the analysis of child welfare safety and permanency trends among first admission entry and exit cohorts are included in Table 49. Due to the observation window necessary for each outcome, cohort-specific end dates are also provided.

Table 49. Key Outcome Variables for the Analysis of Placement Spell Trends among First Removal Admission Entry and Exit Cohorts

Outcome Variable	Variable Type	Indicator	Cohorts[4]
Maltreatment recurrence			
Likelihood of a 2nd substantiation (SUB) w/in 6 months of an initial SUB	Binary	First substantiation is followed within 6 months by a second event of a SUB	Pre-Waiver entry cohorts through 12/31/13 and Waiver entry cohorts through 12/31/17 observed through 6/30/18
Likelihood of placement			
Likelihood of a placement w/in 6 months of an initial SUB	Binary	First substantiation is followed within 6 months by a second event of a placement	Pre-Waiver entry cohorts through 12/31/13 and Waiver entry cohorts through 12/31/17 observed through 6/30/18
Placement rate per 1,000 children	Continuous	Number of first admissions into care per 1,000 children in the underlying child population	Pre-Waiver and Waiver quarterly entry cohorts through 6/30/18
Least restrictive out-of-home placement use			
Likelihood of placement in kinship care as a first placement type	Binary	First admission OOH spell has a first placement type of kinship or relative care	Pre-Waiver and Waiver entry cohorts through 6/30/18
Likelihood of placement in congregate care as a first placement type	Binary	First admission OOH spell has a first placement type of congregate care	Pre-Waiver and Waiver entry cohorts through 6/30/18
Out-of-home placement stability			
Likelihood of moving within six months of first placement	Binary	First admission OOH spell has a second placement within six months of spell start date	Pre-Waiver entry cohorts through 12/31/13 and Waiver entry cohorts through 12/31/17 observed through 6/30/18

[4] Crawford entered into the CWDP a year later than the other counties, and as such, SFY 2014 data is excluded from Crawford's Waiver cohorts.

Time to permanency			
Likelihood of exiting within six months of first placement	Binary	First admission OOH spell ends within six months of spell start date	Pre-Waiver entry cohorts through 12/31/13 and Waiver entry cohorts through 12/31/17 observed through 6/30/18
Likelihood of exiting within one year of first placement	Binary	First admission OOH spell ends within one year of spell start date	Pre-Waiver entry cohorts through 6/30/12 and Waiver entry cohorts through 6/30/17 observed through 6/30/18
Distal permanency outcome			
Likelihood of re-entering care within one year of exit from a first admission permanent exit	Binary	First admission OOH spell that exited to reunification, relatives, or guardianship re-enters care within one year of spell end date	Pre-Waiver exit cohorts of exits to reunification, relatives, or guardianship through 6/30/12 and Waiver exit cohorts of exits to reunification, relatives, or guardianship through 6/30/17 observed through 6/30/18

Outcome Study Cohorts

The county-level outcome analyses of child welfare outcome trends used cohort comparisons. Lacking a true control group at the system level, the county-level child welfare outcomes analysis employed longitudinal cohorts, comparing outcome performance between pre-Waiver and Waiver groups. This historical comparison is unable to scientifically support or refute a hypothesis of improved outcomes due specifically to Waiver efforts and initiatives. However, the findings can provide a descriptive look at the way outcomes have changed over time.

The pre-Waiver years provided a baseline, capturing outcomes of entry and exit cohorts in the three fiscal years prior to the start of the Waiver (SFYs 2011 through 2013). Waiver outcome comparisons came from entry and exit cohorts during the five years of the Waiver (SFYs 2014 through 2018). Focusing on first substantiations or admissions into care, the cohorts either represent an entry cohort of children coming into care or an exit cohort of children exiting care within the given timeframe. Outcome-specific cohorts are detailed in Table 49.

The size of each county's child welfare system varied across waiver counties. Looking at the number of children entering out-of-home placement for the first time, first entrants ranged from 53 in Crawford to 2,017 in Philadelphia in SFY 2018. In most years for each county, children entering out of home care for the first time represented 70-80% of all entrants.

Outcome Study Sample

For the pre-Waiver and Waiver cohort comparison of child welfare outcomes, all initial substantiations and first admission child-level removal spells in the six counties were included in the sample. No spells were excluded based on duration although multiple spells were bridged into one if the gap between the two spells was 30 days or less. Logistic regression models controlled for child-level demographic characteristics (child age at placement and race/ethnicity). The only exception to these sample criteria is for the re-entry outcome cohorts where the included spells were limited to those that exited to relatives, guardianship, or reunification.

The unit of analysis for the outcome evaluation is the county. Results are grouped by outcome area and presented by county. As such, in our analysis, each county has its own model, so the covariates are allowed to vary by county. This means there is not one estimate for the covariates that pools the estimates across all the counties. As detailed in the in the following section, due to the lack of pre-waiver data, Dauphin was excluded from the maltreatment analysis, and Venango was excluded from the placement analysis. Crawford entered into the CWDP a year later than the other counties, and as such, SFY 2014 data is excluded from Crawford's Waiver cohorts.

Data Sources & Data Collection

Pennsylvania does not have a Statewide Automated Child Welfare Information System (SACWIS). Instead, each of the counties operates their own information system. Allegheny, Crawford, Dauphin, and Venango all use the same vendor for their system, AVANCO, and use the Child Accounting and Profile System (CAPS), and share most but not all variables. In addition, some counties also have changed information systems during the course of the CWDP period (e.g., Venango transitioned to CAPS, Dauphin transitioned to CAPS, Lackawanna transitioned away from CAPS to ACYS).

Chapin Hall worked with each of the Information Technology administrators in the six counties to obtain child level data on maltreatment and placement, updated yearly, as well as table structure documentation for each of the administrative data systems. Chapin Hall followed their standard set of procedures used in the Multistate Foster Care Data Archive for cleaning and creating files[5].

All maltreatment and placement was collected through a censor date of June 30, 2018. However, each county's placement and maltreatment data coverage begins on a different start date, detailed in Table 50. Due to the lack of pre-waiver data, Dauphin and Venango were excluded from the maltreatment analysis, and Venango was excluded from the placement analysis. The Lackawanna pre-Waiver maltreatment analysis does not include SFY 2011.

Table 50. County-specific Maltreatment and Placement Data Coverage - First Complete Fiscal Year by Data Type

County	**Maltreatment data coverage begins**	**Placement data coverage begins**
Allegheny	SFY 2011	SFY 2011
Crawford	SFY 2011	SFY 2011
Dauphin	*SFY 2014*	SFY 2011
Lackawanna	SFY 2011	SFY 2011
Philadelphia	SFY 2011	SFY 2011
Venango	*SFY 2017*	*SFY 2014*

[5] http://www.chapinhall.org/research/report/update-multistate-foster-care-data-archive

While we had hoped to include unsubstantiated investigations in our analysis, because of expungement requirements, they will not be included in the analysis. The state requires unsubstantiated Child Protective Service investigations to be expunged after a year plus 120 days after the investigation. Individual counties also had expungement policies for general protective investigations. Also with the future changes in expungement due to the changes in the Child Protective Services Law (CPSL), the record of unsubstantiated investigations for the CWDP is likely to reflect policy changes and individual county practice over the five-year evaluation period rather than changes in the underlying likelihood of investigation.

Each year from 2015 onward, Chapin Hall and the University of Pittsburgh conducted conference calls with the six counties to review outcome analyses, verify pre-waiver trends, and resolve any errors or differences. The raw data files along with outcome profiles were then given to each of the counties. The data were updated for this final report through June 30, 2018, and analyzed outcomes regarding the likelihood of repeat maltreatment, placement, placement type, stability, duration, and re-entry.

Data Analysis

The analysis of entry and exit cohorts over time provided a descriptive look at maltreatment recurrence, likelihood of placement following substantiated maltreatment, placement type, stability, duration, and re-entry in the pre-Waiver and Waiver years. This analysis utilized each county's child-level out-of-home maltreatment and placement data from the FCDA. The FCDA data was censored as of June 30, 2018, and the analysis limits its focus to the data within the three years prior to the beginning of the Waiver (SFYs 2011 through 2013) and the full five years of Waiver activity (SFYs 2014 through 2018), with Crawford's SFY 2014 data removed from the Waiver cohorts due to their late entry.

Using a linear regression model, placement rates into OOH care per 1,000 children in the general population were examined by county. Placement rates were calculated on a quarterly basis, and the trend was examined comparing the Waiver period to the pre-Waiver period.

Using a logistic regression model, the other key child welfare outcome findings present the odds ratios for each county's outcomes. An odds ratio is a relative measure of effect that compares outcome likelihoods in the Waiver period to the pre-Waiver period. An odds ratio of one implies there is no difference, while an odds ratio above one implies a that the Waiver period was associated with an increase in the outcome (for example, regarding duration, an increase in the likelihood of exiting within a specified window or, on the flip side, an increase in the likelihood of recurrence) and an odds ratio less than one implies that the Waiver period was associated with an decrease in the outcome (again, regarding duration, a decrease in the likelihood of exiting within the window or a decrease in the likelihood of recurrence).

Sensitivity analysis was also conducted utilizing two additional models. The first was a year-by-year model wherein each Waiver year was compared individually to the pre-Waiver baseline; results are mentioned within the discussion of significance of outcomes to enrich the understanding of what Waiver years may be driving the overall finding. The second was an interrupted time series (ITS) model wherein the baseline pre-Waiver cohort was compared to the Waiver cohort while controlling for the historical trend. Results from these sensitivity analyses are shared within our discussion as part of comments on overall trends and takeaways.

Results

Outcome Summary Tables

Table 51 below shows the average outcome measure for the Pre-Waiver and Waiver cohorts for each county and the difference between the two periods. As described above, each measure is expressed as the percentage of children who experienced the outcome, of all children who were at risk of the outcome. For example, in Allegheny County in the pre-waiver period, an average of 41% of children moved in the first six months of placement.

Table 51. Outcome Difference Summary: Average Likelihood by Outcome and County of First Substantiations or Admissions in Pre-Waiver and Waiver Periods

Outcome & County	Pre-Waiver	Waiver	Difference
Secondary Maltreatment within 6 Months of First Substantiation			
Allegheny	2.5%	3.7%	1.2%
Crawford	4.5%	11.5%	7.0%
Dauphin			
Lackawanna	14.4%	15.7%	1.3%
Philadelphia	5.4%	7.4%	1.9%
Placement within 6 Months of First Substantiation			
Allegheny	17.1%	17.2%	0.1%
Crawford	8.9%	6.7%	(2.2%)
Dauphin			
Lackawanna	4.9%	6.2%	1.3%
Philadelphia	22.4%	20.7%	(1.7%)
Entering an Initial Kin Placement			
Allegheny	35.8%	50.4%	14.6%
Crawford	20.9%	34.6%	13.7%
Dauphin	20.3%	24.7%	4.4%
Lackawanna	32.6%	52.2%	19.7%
Philadelphia	31.1%	40.0%	8.9%
Entering an Initial Congregate Care Placement			
Allegheny	22.2%	13.6%	(8.6%)
Crawford	34.3%	23.7%	(10.6%)
Dauphin	13.7%	20.9%	7.2%
Lackawanna	4.8%	3.6%	(1.2%)
Philadelphia	26.9%	18.5%	(8.3%)

Moving within Six Months of First Placement			
Allegheny	40.5%	34.9%	(5.6%)
Crawford	37.0%	35.5%	(1.5%)
Dauphin	54.4%	40.3%	(14.1%)
Lackawanna	35.5%	30.5%	(5.0%)
Philadelphia	64.4%	61.4%	(3.0%)
Exiting within Six Months of First Placement			
Allegheny	44.3%	38.8%	(5.5%)
Crawford	43.0%	33.7%	(9.3%)
Dauphin	27.1%	38.6%	11.6%
Lackawanna	48.1%	54.4%	6.3%
Philadelphia	22.8%	20.8%	(2.0%)
Exiting within One Year of First Placement			
Allegheny	57.4%	53.7%	(3.7%)
Crawford	54.7%	47.1%	(7.6%)
Dauphin	46.6%	53.3%	6.7%
Lackawanna	63.2%	68.3%	5.1%
Philadelphia	37.2%	34.5%	(2.7%)
Reentering Care within One Year of Exit from First Admission			
Allegheny	16.7%	16.5%	(0.2%)
Crawford	17.4%	22.1%	4.7%
Dauphin	4.6%	17.2%	12.6%
Lackawanna	10.8%	6.2%	(4.6%)
Philadelphia	16.7%	16.5%	(0.2%)

Table 52 uses the data and methods described above to examine these same outcomes with multivariate logistic regression models. Following this table, each outcome is discussed in its own section and the trend over time of each outcome is graphically displayed. For the two larger counties (Allegheny and Philadelphia) the figures show the outcome by quarter and for the four smaller counties, by fiscal year.

Table 52. Logistic Regression Estimates by Outcome and County

Outcome	Odds Ratio comparing the Pre and Post Waiver Period[6] & Confidence Interval Allegheny	Crawford[7]	Dauphin	Lackawanna	Philadelphia
Likelihood of secondary maltreatment following maltreatment					
Likelihood of a 2nd substantiation (SUB) w/in 6 months of an initial SUB					
Pre-Waiver	1.00	1.00		1.00	1.00
Waiver	1.47*	3.34*		1.12	1.61*
Upper CI	1.19	2.09		0.94	1.42
Lower CI	1.81	5.32		1.34	1.82
Likelihood of placement following maltreatment					
Likelihood of a placement w/in 6 months of an initial SUB					
Pre-Waiver	1.00	1.00		1.00	1.00
Waiver	1.01	0.67*		1.27	0.86*
Upper CI	0.92	0.45		0.96	0.80
Lower CI	1.11	0.99		1.67	0.92
Least restrictive OOH placement use					
Likelihood of Entering an Initial Kin Placement					
Pre-Waiver	1.00	1.00	1.00	1.00	1.00
Waiver	1.86*	1.51	1.32	1.86*	1.42*
Upper CI	1.67	0.93	0.98	1.45	1.32
Lower CI	2.06	2.45	1.78	2.38	1.53
Likelihood of Entering an Initial Congregate Care Placement					
Pre-Waiver	1.00	1.00	1.00	1.00	1.00
Waiver	0.50*	0.52	2.04*	0.81	0.59*
Upper CI	0.42	0.25	1.41	0.43	0.53
Lower CI	0.59	1.09	2.95	1.51	0.66
Out-of-home placement stability					
Likelihood of Moving within Six Months of First Placement					
Pre-Waiver	1.00	1.00	1.00	1.00	1.00
Waiver	0.77*	0.96	0.58*	0.92	0.85*
Upper CI	0.69	0.61	0.44	0.70	0.79
Lower CI	0.86	1.53	0.75	1.21	0.92
Time to permanency					
Likelihood of Exiting within Six Months of First Placement					
Pre-Waiver	1.00	1.00	1.00	1.00	1.00
Waiver	0.76*	0.70	1.58*	1.08	0.91*

[6] The data has a censor date of June 30, 2018. Age at time of placement as well as race are included in the model as covariates. Each county has their own individual model. Significance is indicated (*) at the 0.05 level.

[7] Due to their entrance into the Waiver on July 1, 2014, Crawford's SFY 2014 data is excluded from the Waiver cohorts.

Upper CI	0.68	0.44	1.19	0.84	0.83
Lower CI	0.85	1.11	2.09	1.40	0.99
Likelihood of Exiting within One Year of First Placement					
Pre-Waiver	1.00	1.00	1.00	1.00	1.00
Waiver	0.82*	0.59*	1.19	0.97	0.88*
Upper CI	0.72	0.36	0.89	0.72	0.81
Lower CI	0.92	0.96	1.58	1.31	0.95
Distal permanency outcomes					
Likelihood of Reentering Care within One Year of Exit from First Admission					
Pre-Waiver	1.00	1.00	1.00	1.00	1.00
Waiver	1.00	1.32	32.52*	0.68	1.11
Upper CI	0.82	0.59	4.47	0.38	0.94
Lower CI	1.21	2.91	236.67	1.23	1.32

And, a linear regression approach was taken to examine the change in placement rates into OOH care per 1,000 children in the general population by county. Table 53 looks at the overall placement rate of first admissions in the county and then shows first admissions by age group.

Table 53. Linear Regression Placement Rate Analysis[8] – by Placement Rate and County

	Allegheny	Crawford	Dauphin	Lackawanna	Philadelphia
Overall placement rate					
t-value	0.81	0.33	**2.83***	-0.85	**3.44***
p-value	0.451	0.749	**0.030**	0.426	**0.014**
R-Squared	0.10	0.02	**0.57**	0.11	**0.66**
Placement rate - under 1					
t-value	1.07	0.09	2.08	0.35	**3.40***
p-value	0.328	0.928	0.083	0.737	**0.015**
R-Squared	0.16	0.00	0.42	0.02	**0.66**
Placement rate - 1 to 5 year olds					
t-value	1.06	0.20	**2.99***	-0.57	**3.74***
p-value	0.329	0.846	**0.024**	0.591	**0.010**
R-Squared	0.16	0.01	**0.60**	0.05	**0.70**
Placement rate - 6 to 12 year olds					
t-value	1.71	2.23	1.89	-0.39	**4.08***
p-value	0.137	0.067	0.108	0.708	**0.007**
R-Squared	0.33	0.45	0.37	0.03	**0.73**

[8] Significance is indicated (*) at the 0.05 level.

Placement rate - 13 to 17 year olds					
t-value	**-2.47***	-1.38	2.30	-2.43	0.76
p-value	**0.049**	0.217	0.061	0.051	0.475
R-Squared	**0.50**	0.24	0.47	0.50	0.09

Repeat Maltreatment

Each fiscal year children come to the attention of the child welfare system for the first time with a substantiated allegation. What happens next to the children with a first event of a substantiated allegation? How did those subsequent events differ for children who experienced the substantiation prior to and during (2014) the Waiver demonstration period?

Repeat maltreatment is measured in the following way. Of the children who experienced an initial substantiated maltreatment, what proportion experienced a second substantiation within six months?

Figure 6. Allegheny - Proportion of Initial Substantiations with a Second Substantiated Maltreatment within Six Months

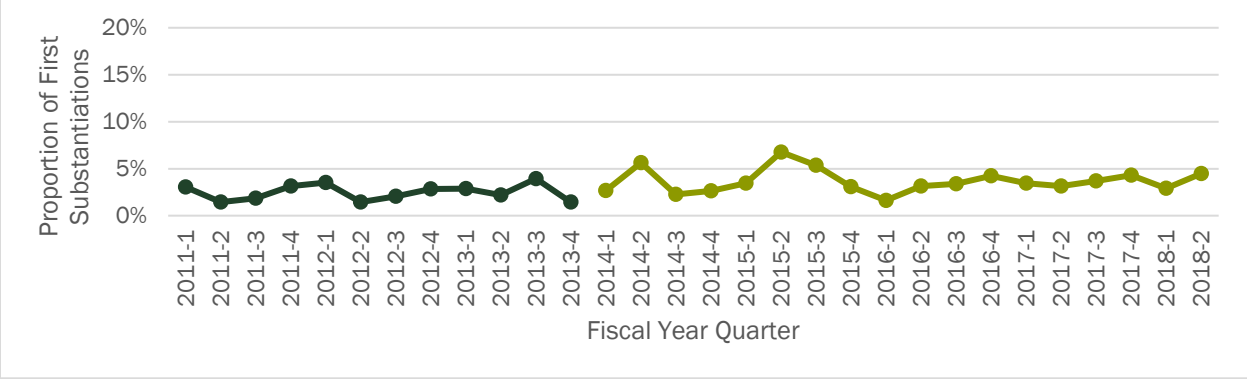


Figure 7. Crawford - Proportion of Initial Substantiations with a Second Substantiated Maltreatment within Six Months

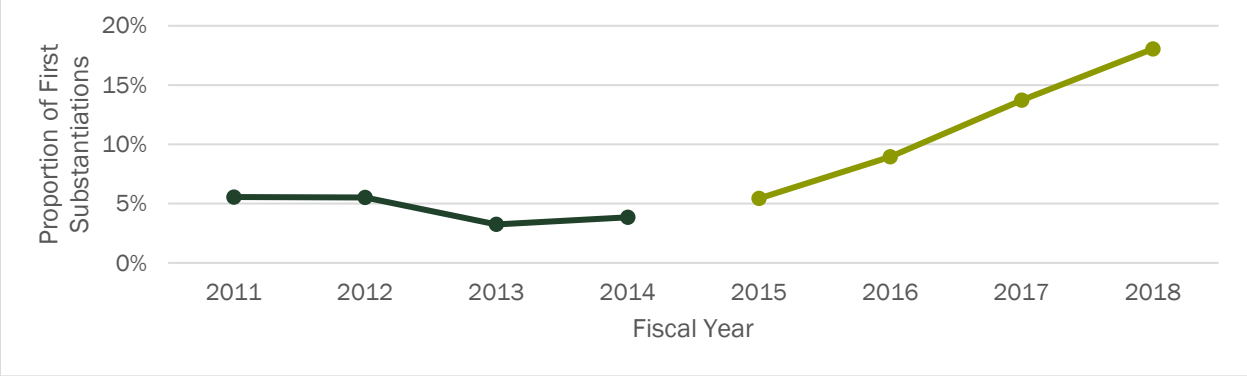


Figure 8. Lackawanna - Proportion of Initial Substantiations with a Second Substantiated Maltreatment within Six Months

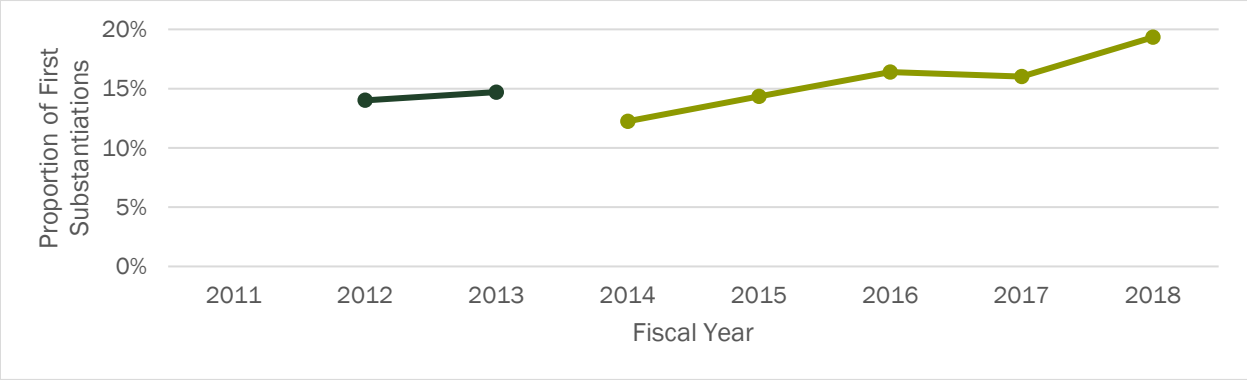
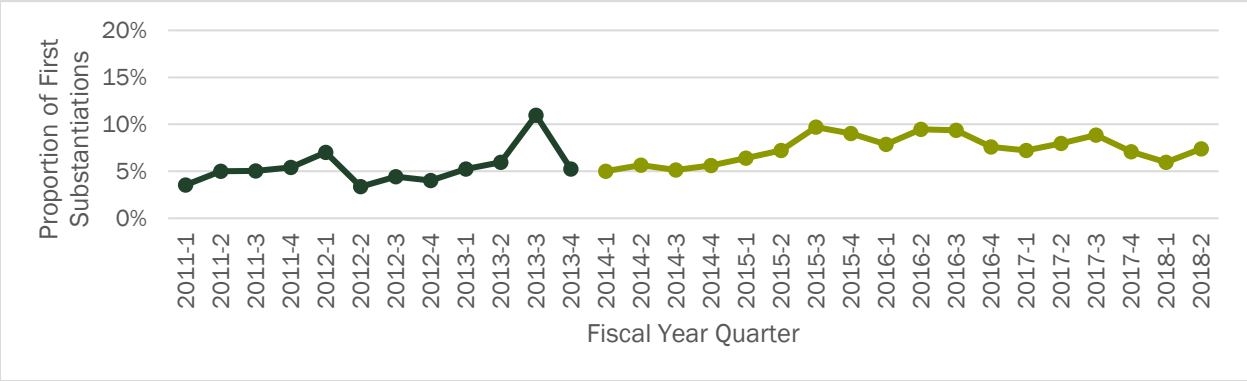


Figure 9. Philadelphia - Proportion of Initial Substantiations with a Second Substantiated Maltreatment within Six Months



All four observed counties (Allegheny, Crawford, Lackawanna, and Philadelphia) show an increase in the proportion of substantiations going on to a second substantiation within 6 months. Additionally, Allegheny, Crawford, and Philadelphia's shifts rose to significance at the $p < 0.05$ level (Table 52). This indicates that children coming to the attention of the system due to an initial substantiation have a higher likelihood of experiencing repeat maltreatment within a relatively short period of time, although the actual proportions are still low (4-14%). In discussions with the counties, many counties cited the possible impact of the new Child Protective Services Law that went into effect in 2013 on this outcome.

Likelihood of Placement

Placement after Substantiated Maltreatment

Another trajectory for children who experience a substantiated investigation is to be placed into out-of-home (OOH) care. Of the children who experienced an initial substantiated maltreatment, what proportion were placed into OOH care within six months? The figures below display how that proportion varied by county and fiscal year.

Figure 10. Allegheny - Proportion of Initial Substantiations with an OOH Placement within Six Months

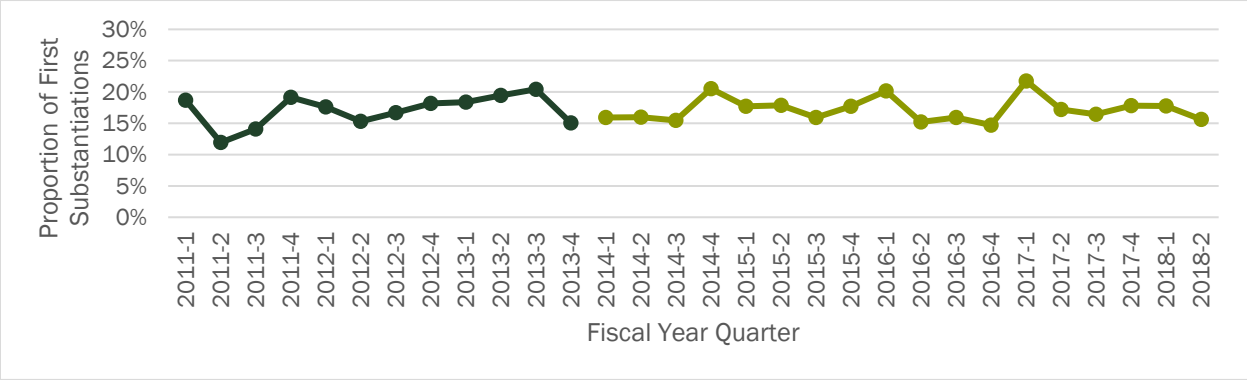


Figure 11. Crawford - Proportion of Initial Substantiations with an OOH Placement within Six Months

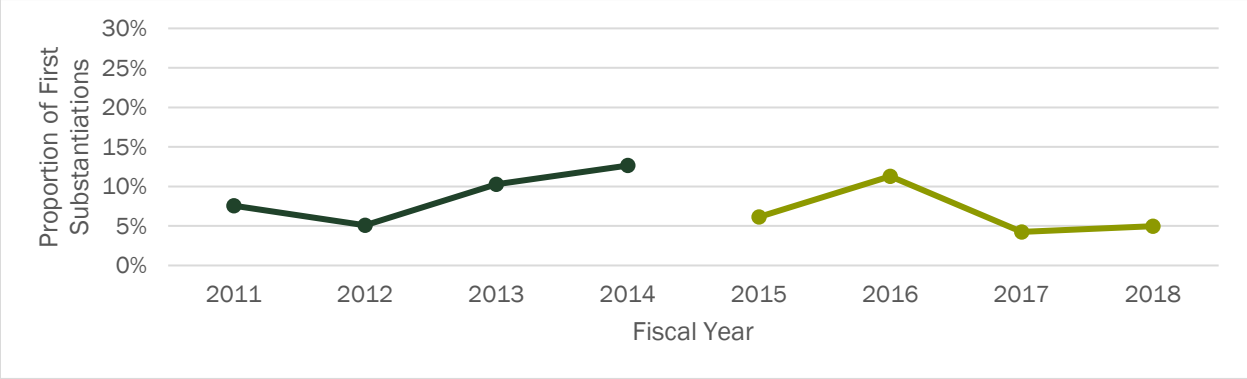


Figure 12. Lackawanna - Proportion of Initial Substantiations with an OOH Placement within Six Months

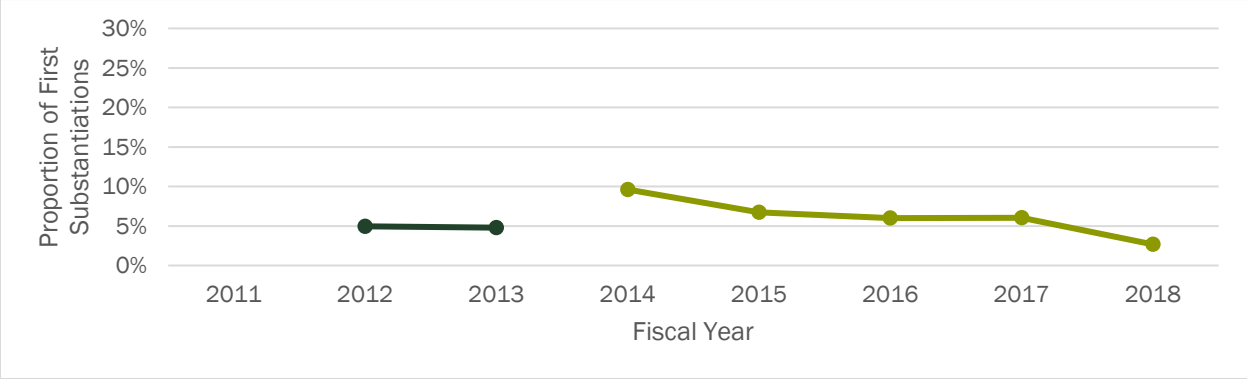
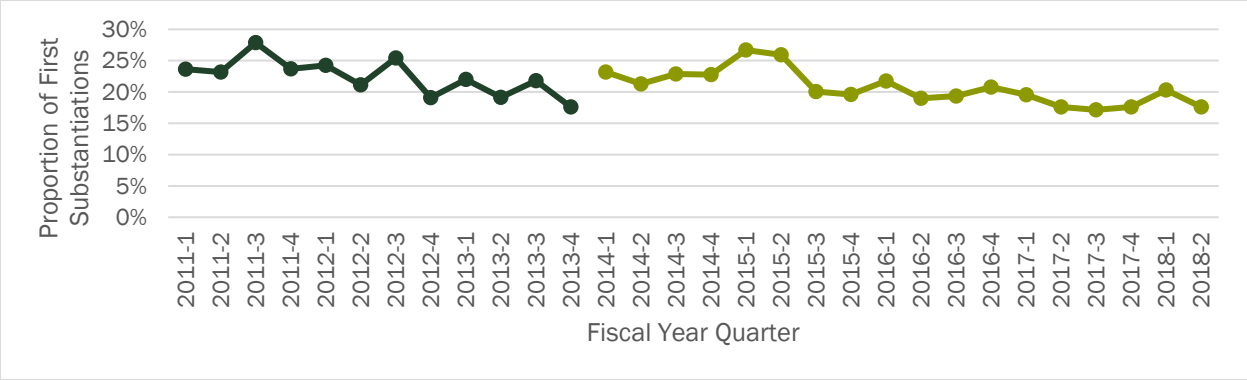


Figure 13. Philadelphia - Proportion of Initial Substantiations with an OOH Placement within Six Months

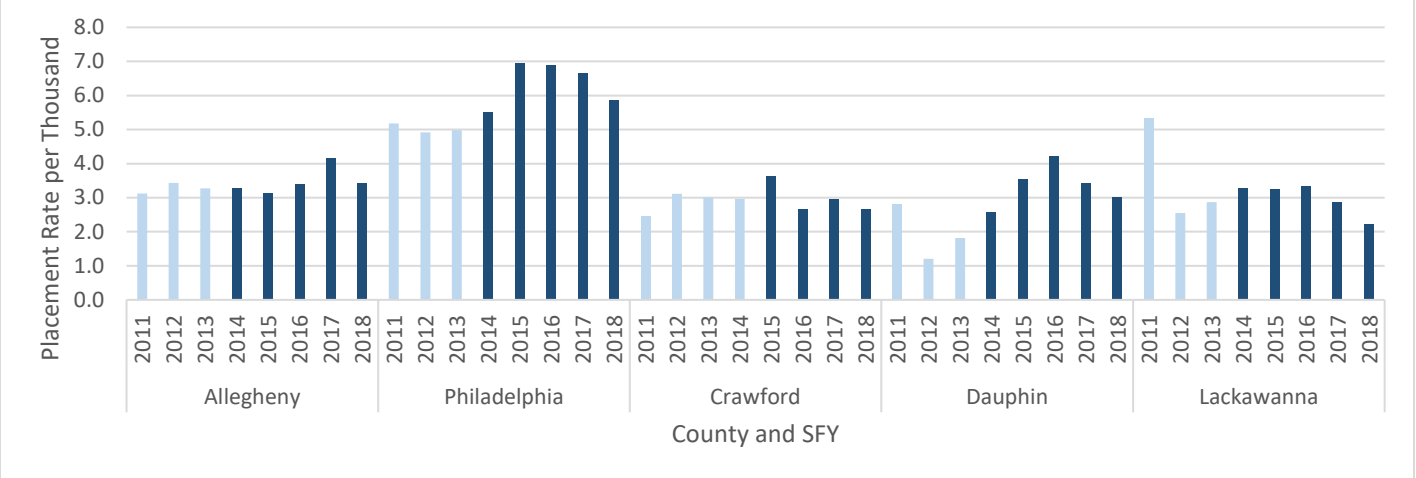


Two of the counties, Crawford and Philadelphia, which saw a significant increase in a second substantiation also saw a significant decrease in the likelihood of a placement following an initial substantiation. While children in these counties were less likely to move on from an initial substantiation to a placement, they were more likely to experience substantiated maltreatment showing that this decreased likelihood may be linked to reduced safety.

Placement Rates

Another way to look at the likelihood of placement is to examine the rate at which children in the underlying population are placed. Figure 14 below looks at the rate of first admissions into care per 1,000 children in the underlying child population for the Waiver counties. Official 2010 census child population totals were used to generate the denominators by county.

Figure 14. Placement Rate per 1,000 by County and SFY



As one might guess from looking at the overall placement trends in Figure 14, two counties, Philadelphia and Dauphin, saw a statistically significant increase in placement rates when

comparing pre-Waiver to Waiver fiscal years (Table 53). Philadelphia's rose from 4.9 in SFY 2013 to 5.87 in SFY 2018. Dauphin's placement rate rose from 1.82 in SFY 2013 to 3.01 in SFY 2018. However, the trend upwards in placement rate was not consistent across age groups. Table 53 displays the results from a linear regression analysis of placement rates by fiscal year, comparing pre-Waiver to Waiver years. Table 53 looked at the overall placement rate of first admissions in the county and then drills down into first admissions by age group.

Dauphin saw increased placement rate trends in each age category, although only the placement rate for one to five year olds rises to significant. In Philadelphia, all age groups except teens showed a significant increase in placement rate while the teens show a reduced, if non-significant, reduction. Allegheny showed a significant decrease in the placement rate for teens only. This reduction in placement rate tracks with their observed demographic shifts in placement. Thirteen to seventeen year olds went from making up 31% of first admissions in SFY 2013 to 21% of first admissions in SFY 2018.

Least Restrictive Placement

Children entering out-of-home care may be placed in different settings. Besides foster homes, group homes, and residential facilities, a child may also be placed with relatives (in kinship care). One goal of the Waiver was for counties to use kin placements and settings less restrictive than congregate care when placement is necessary. The hope was that children placed with relatives would see improved outcomes around permanency, safety, and well-being.

The placement types analyzed here are grouped in one of four settings: conventional foster care, kinship care (certified and non-certified), congregate care (e.g., group homes, residential care), and other settings (e.g., independent living). During an out-of-home care spell, a child may experience multiple placements and changes in placement settings. Analysis of placement type may examine either the first or predominant placement type of a child's time in care. The focus of this analysis is on the first placement type since across the Waiver counties, the type of the placement between initial and predominant does not vary more than 10% for any of the three major placement types (foster care, congregate, or kinship) in SFY 2018 for any of the counties. In all but Lackawanna, the difference is less than 5%.

Initial Kin Placements

Figures 15-19 present the proportion of initial kin placement for first admissions by Waiver County by fiscal year smaller counties and by fiscal year quarter for the larger counties, Allegheny and Philadelphia. As summarized in Table 51, each Waiver county saw an overall increase in the proportion of children initially entering a kinship placement when comparing pre-Waiver to Waiver fiscal years.

Figure 15. Allegheny – Proportion of First Admissions Initially Placed with Kin by Fiscal Year Quarter

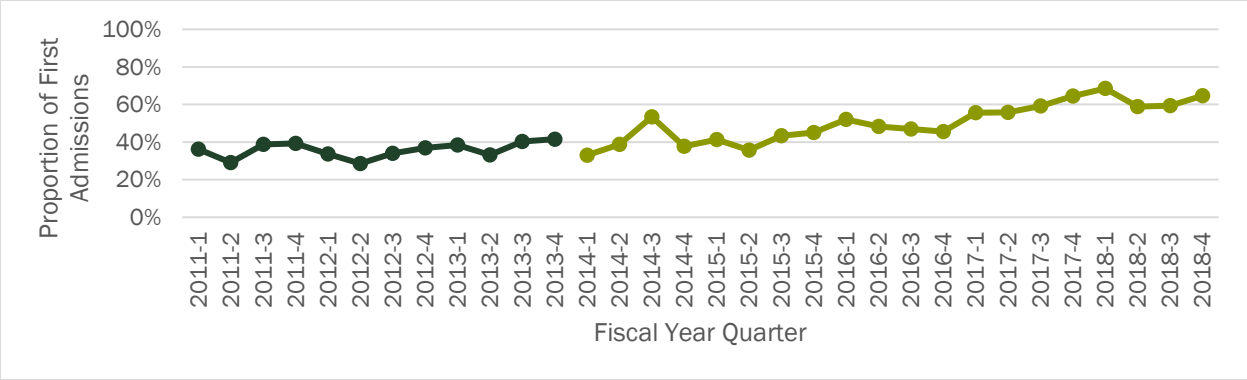


Figure 16. Crawford – Proportion of First Admissions Initially Placed with Kin by Fiscal Year

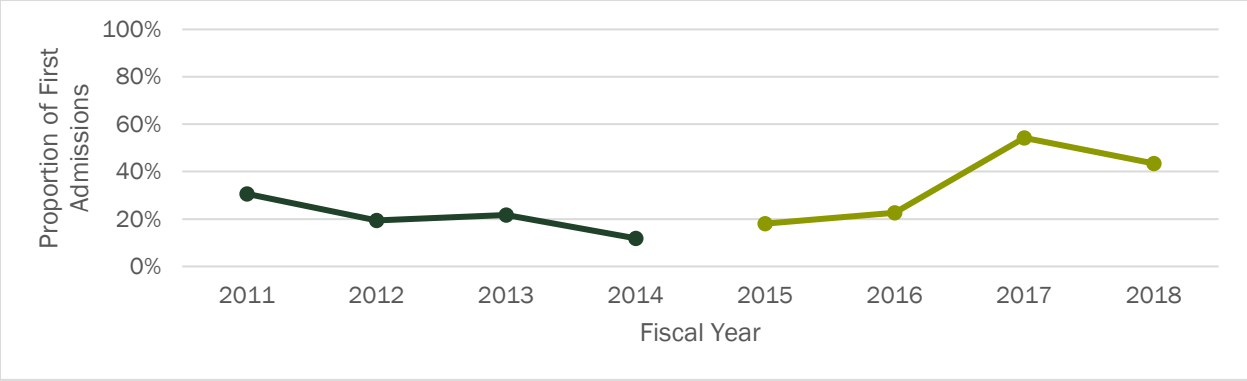


Figure 17. Dauphin – Proportion of First Admissions Initially Placed with Kin by Fiscal Year

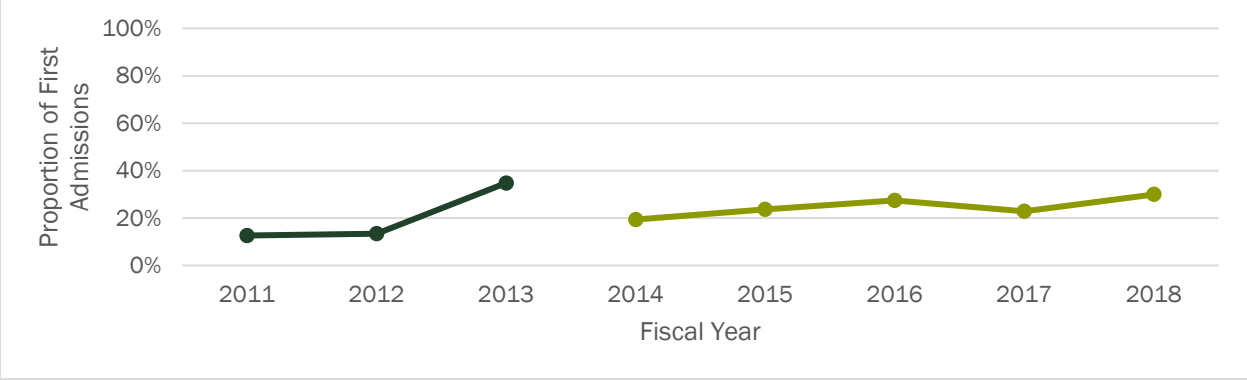


Figure 18. Lackawanna – Proportion of First Admissions Initially Placed with Kin by Fiscal Year

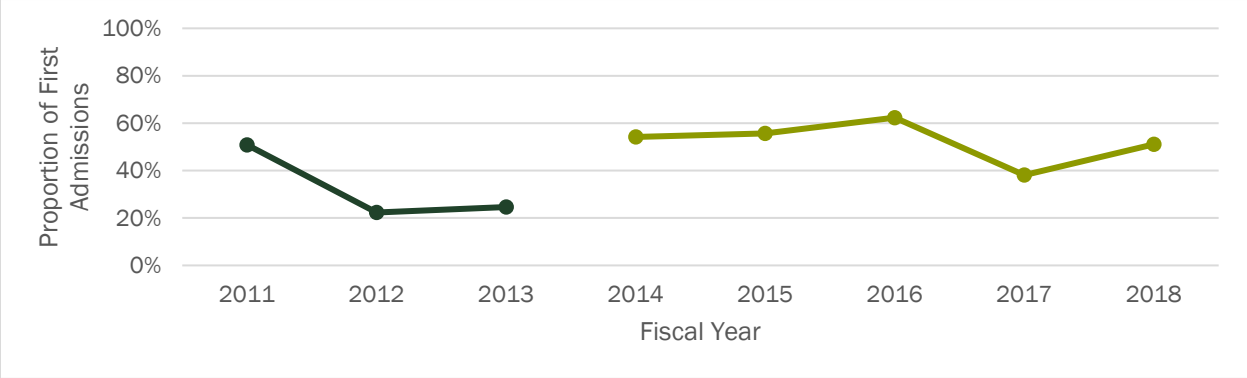
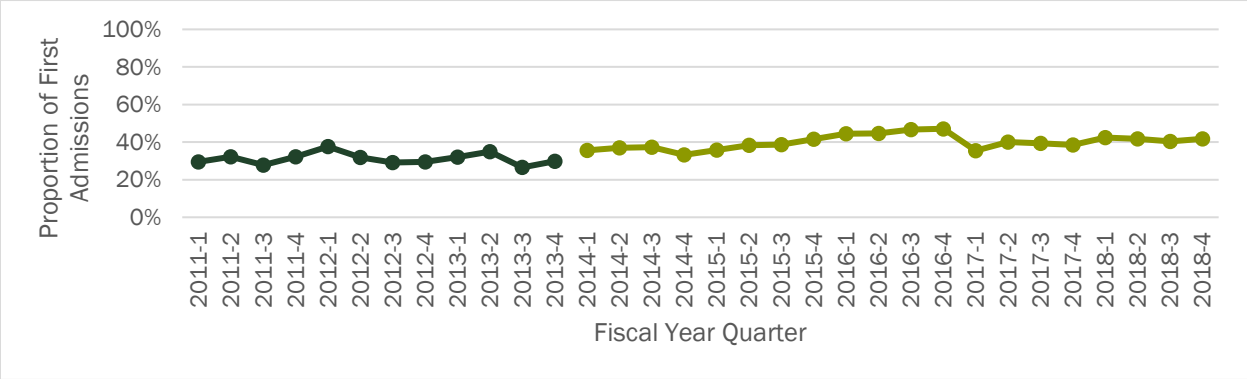


Figure 19. Philadelphia – Proportion of First Admissions Initially Placed with Kin by Fiscal Year Quarter



Although they experienced increasing likelihoods of initial kinship placement, Crawford and Dauphin's trends were not statistically significant in the overall pre- post-model (Table 52). However, both counties saw a significant increase in the last (Dauphin) or last two (Crawford) waiver fiscal years when we looked at the year-by-year sensitivity analysis. Allegheny, Lackawanna, and Philadelphia not only saw a significant increase in initial kinship likelihood in when comparing pre-Waiver and Waiver fiscal years, they each also saw a significant increase in each individual Waiver fiscal year when compared to the pre-Waiver baseline of SFY 2011 through SFY 2013.

Initial Congregate Care Placements

Viewed from another perspective, the likelihood of entering the least restrictive placement type is impacted by the proportion of children entering a congregate care placement type. All counties with the exception of Dauphin saw an overall increase in the proportion of children initially entering a kinship placement when comparing pre-Waiver to Waiver fiscal years (Table 51). Although, as can be seen in the following figures, Dauphin has seen a steady decrease in initial congregate care placements from SFY 2014 onwards. Figures 20-24 present the proportion of initial congregate care placement for first admissions by Waiver County by fiscal year.

Figure 20. Allegheny – Proportion of First Admissions Initially Placed in Congregate Care by Fiscal Year Quarter

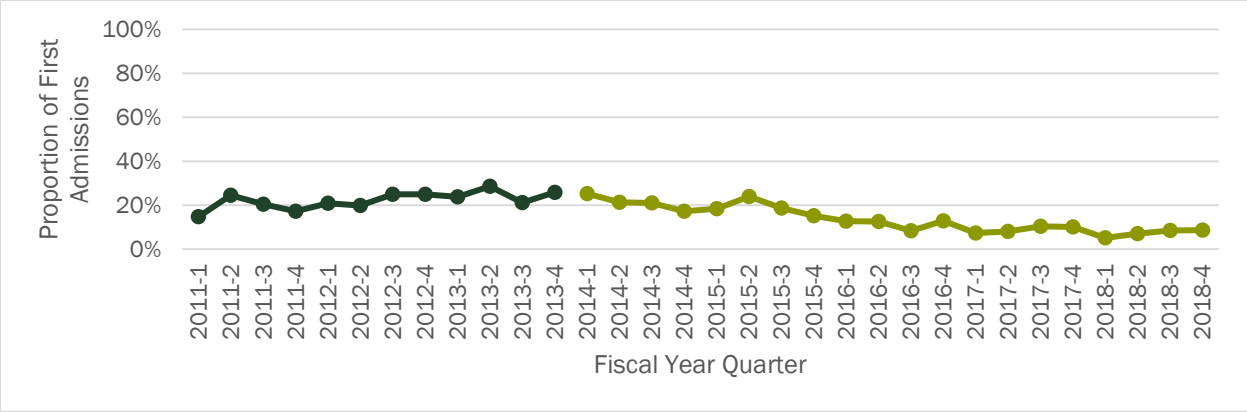


Figure 21. Crawford – Proportion of First Admissions Initially Placed in Congregate Care by Fiscal Year

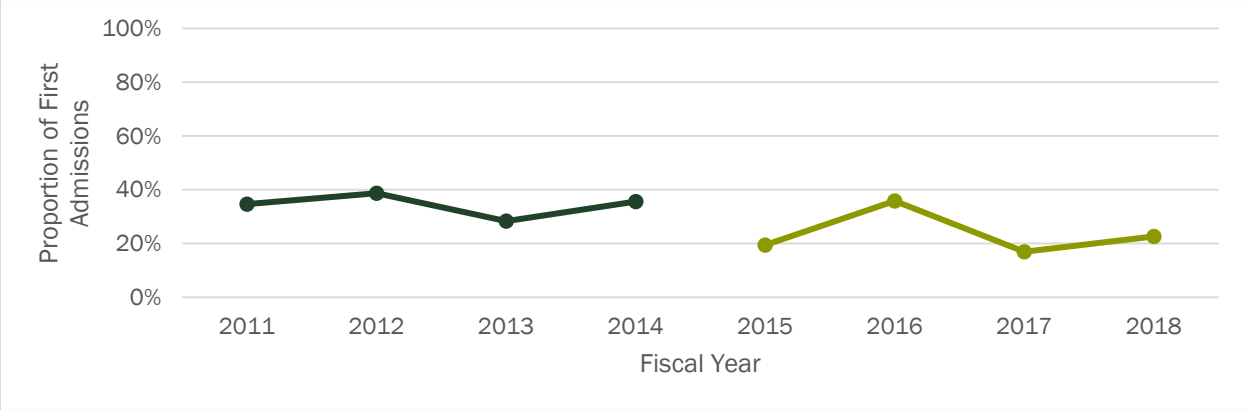


Figure 22. Dauphin – Proportion of First Admissions Initially Placed in Congregate Care by Fiscal Year

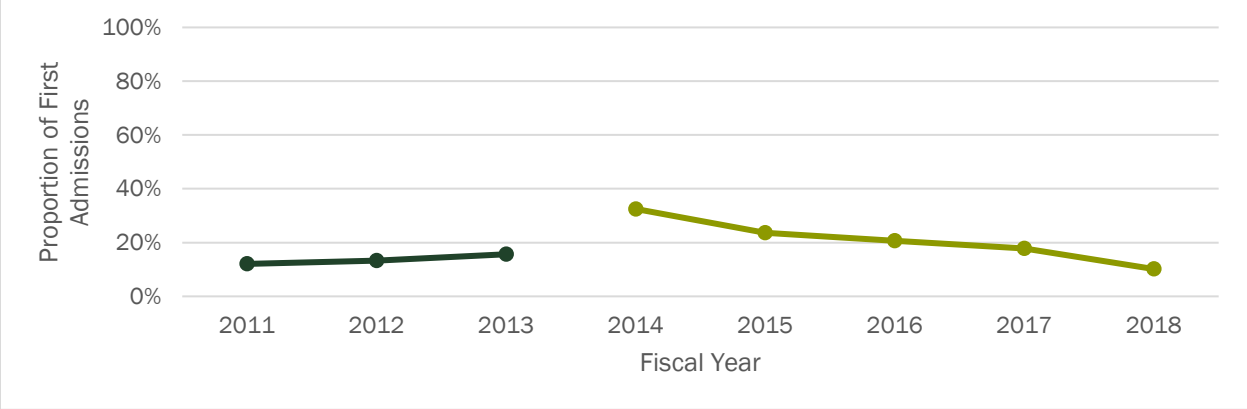


Figure 23. Lackawanna – Proportion of First Admissions Initially Placed in Congregate Care by Fiscal Year

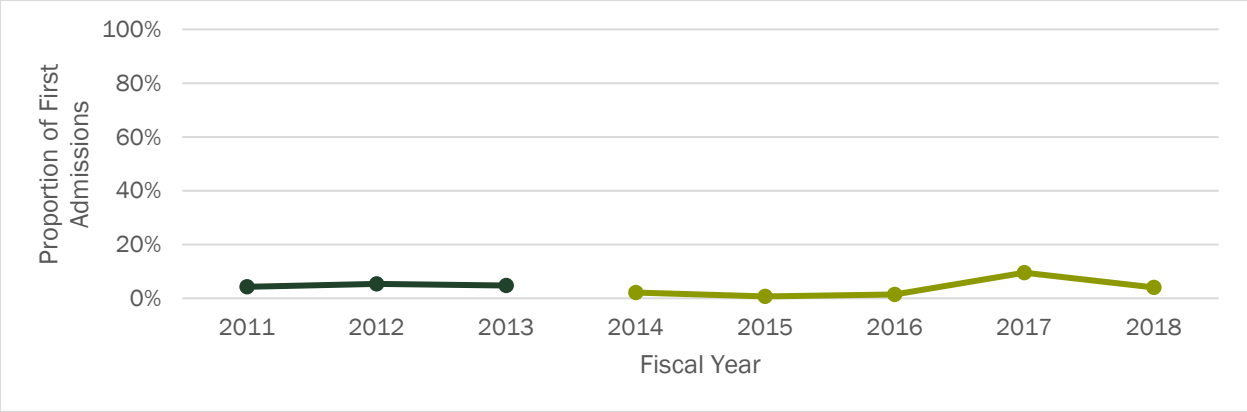
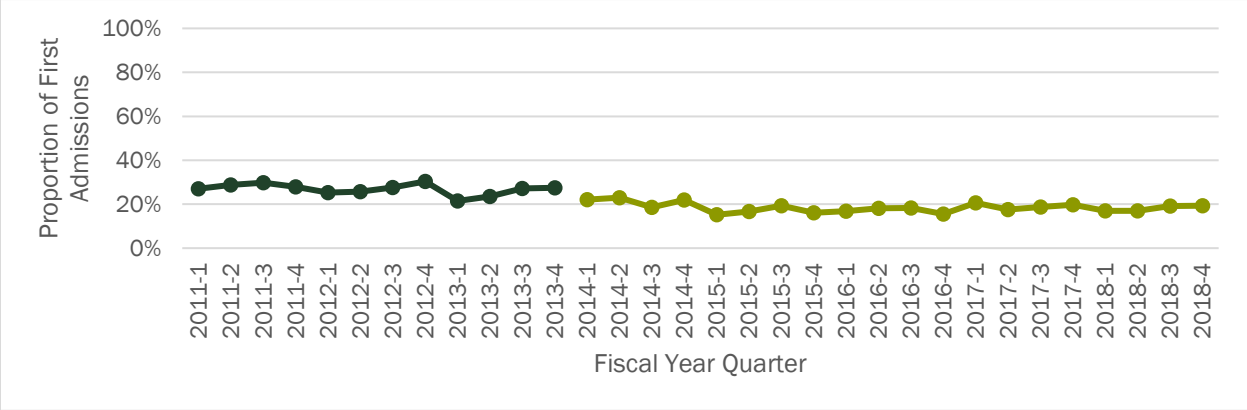


Figure 24. Philadelphia – Proportion of First Admissions Initially Placed in Congregate Care by Fiscal Year Quarter



Of the counties which saw an overall decrease in the likelihood of initial congregate care placements, Allegheny, Crawford, Lackawanna, and Philadelphia, both Allegheny and Philadelphia had that reduction shown as statistically significance in the logistic regression analysis (Table 52). Similar to their kinship placement trends, although in the year-by-year model Dauphin saw statistically significant increases in the likelihood of an initial congregate care placement in the first three years of the Waiver, the county saw trends in the right direction for the last two years of the Waiver.

Placement Stability

During their time in care, children may experience disruptions to their placement and move from one placement to another. These placement moves can be damaging to a child's well-being and should be minimized. In the Waiver counties, as in most jurisdictions, placement moves are most likely to occur in the first six months after placement. So, this section discusses the changes in the likelihood of moving during placement in the first six months of placement between pre-

Waiver and Waiver entry cohorts. Figures 25-29 present the proportion of first admissions which moved within six months of placement by Waiver County by fiscal year.

Figure 25. Allegheny - Proportion of First Admissions That Experience a Placement Move within the First Six Months of Placement by Fiscal Year Quarter

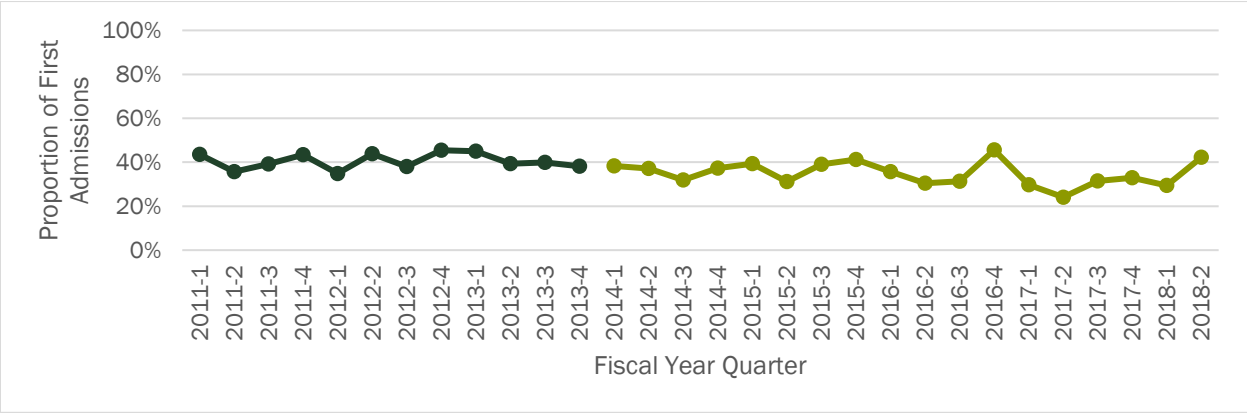


Figure 26. Crawford - Proportion of First Admissions That Experience a Placement Move within the First Six Months of Placement by Fiscal Year

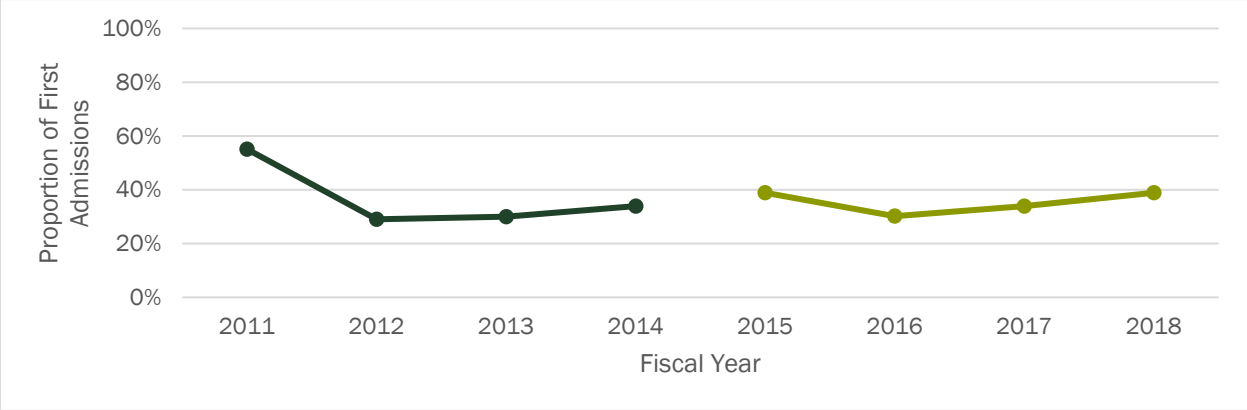


Figure 27. Dauphin - Proportion of First Admissions That Experience a Placement Move within the First Six Months of Placement by Fiscal Year

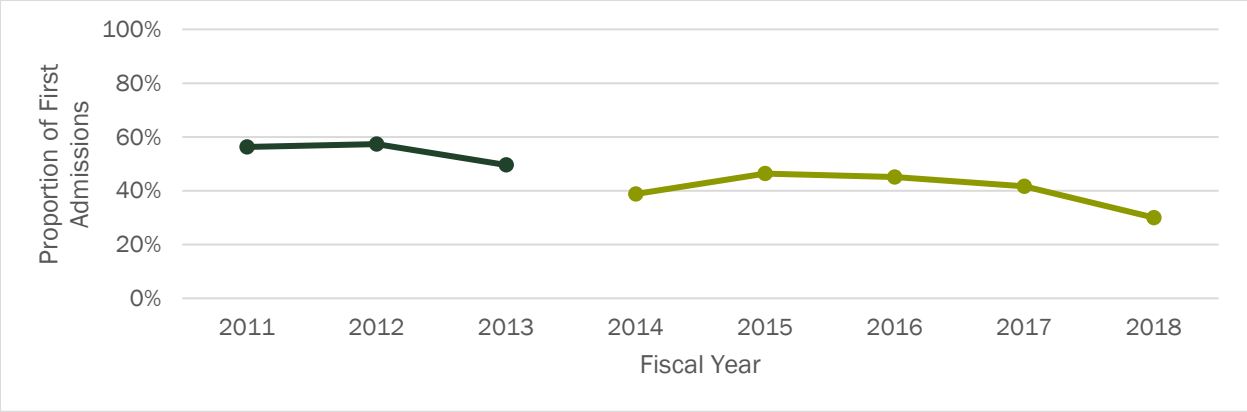


Figure 28. Lackawanna - Proportion of First Admissions That Experience a Placement Move within the First Six Months of Placement by Fiscal Year

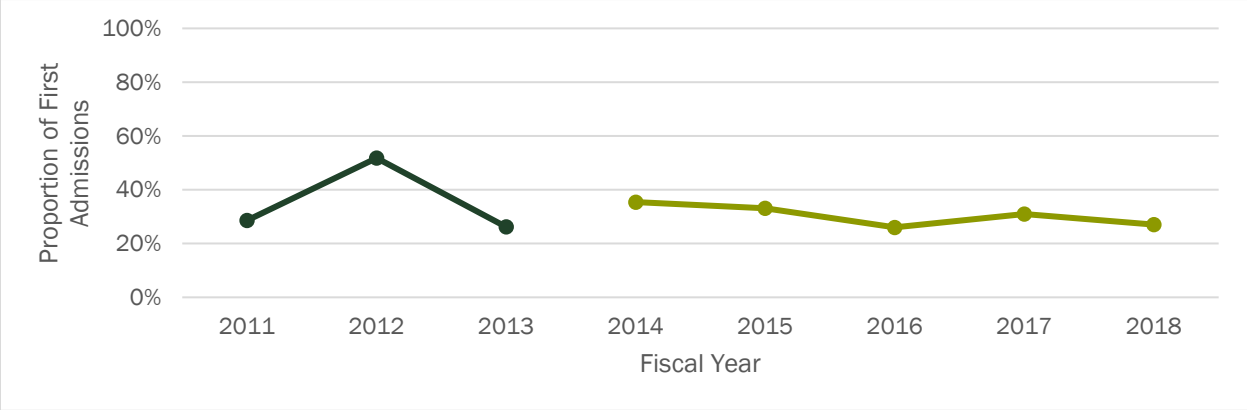
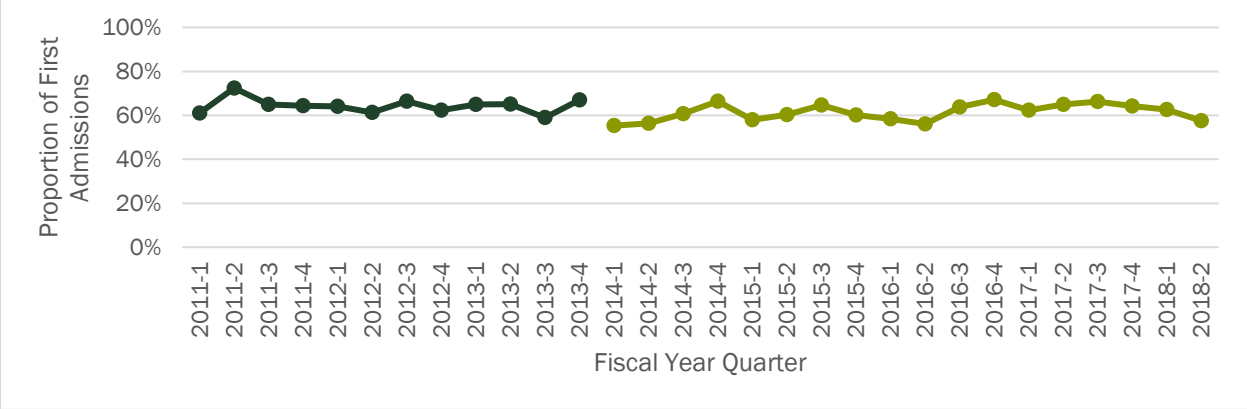


Figure 29. Philadelphia - Proportion of First Admissions That Experience a Placement Move within the First Six Months of Placement by Fiscal Year Quarter



As summarized in Table 51, each Waiver county saw an overall decrease in the proportion of children moving within six months of their first placement admission when comparing pre-Waiver to Waiver fiscal years. Allegheny, Dauphin, and Philadelphia saw these reductions rise to statistical significance at the .05 level in the regression analysis (Table 52). Given the placement mix shift in all counties, a sensitivity analysis was conducted to control for placement type, and even when controlling for initial placement type, the significant improvements in placement stability remain.

Time to Permanency

The length of time that children spend in out-of-home care is a key outcome of interest in child welfare. The quantity of time that a child spends out of their home impacts both the child's well-being and the resources required to support that child's stay in care. The focus within this outcome analysis is on duration for children entering care for the first time, from a lens of likelihood of exit, within a six-month and one-year window. In the Waiver counties, in SFY 2018, the median duration for ranged from 5.8 months in Lackawanna to 22 months in Philadelphia. Figures 30-39 below present both the proportion of first admissions exiting six months and one year. They figures are grouped by county.

Figure 30. Allegheny - Proportion of First Admissions Exiting within Six Months by Fiscal Year Quarter

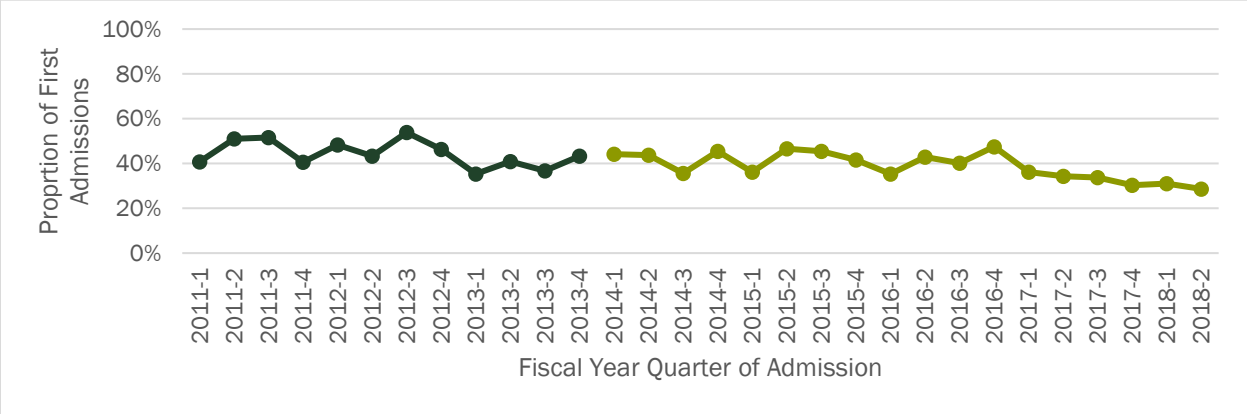


Figure 31. Allegheny - Proportion of First Admissions Exiting within One Year by Fiscal Year Quarter

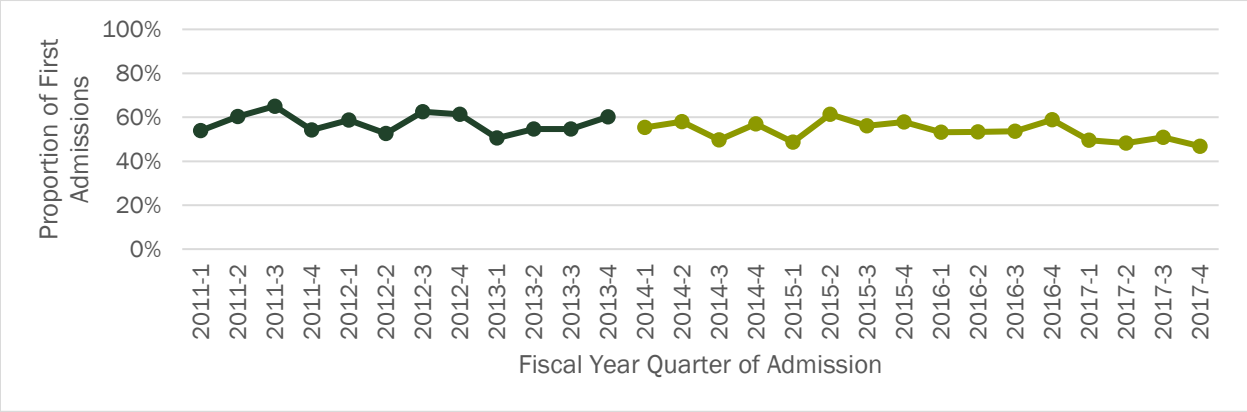


Figure 32. Crawford - Proportion of First Admissions Exiting within Six Months by Fiscal Year

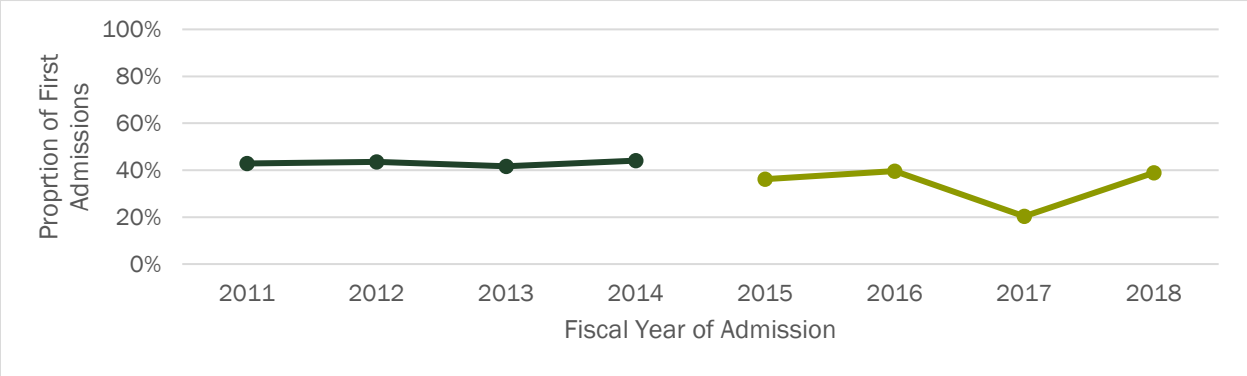


Figure 33. Crawford - Proportion of First Admissions Exiting within One Year by Fiscal Year

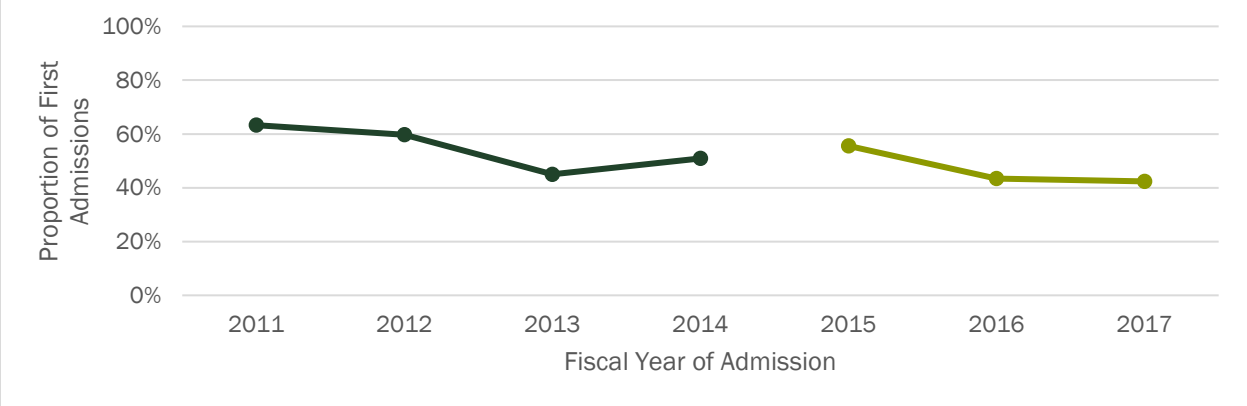


Figure 34. Dauphin - Proportion of First Admissions Exiting within Six Months by Fiscal Year

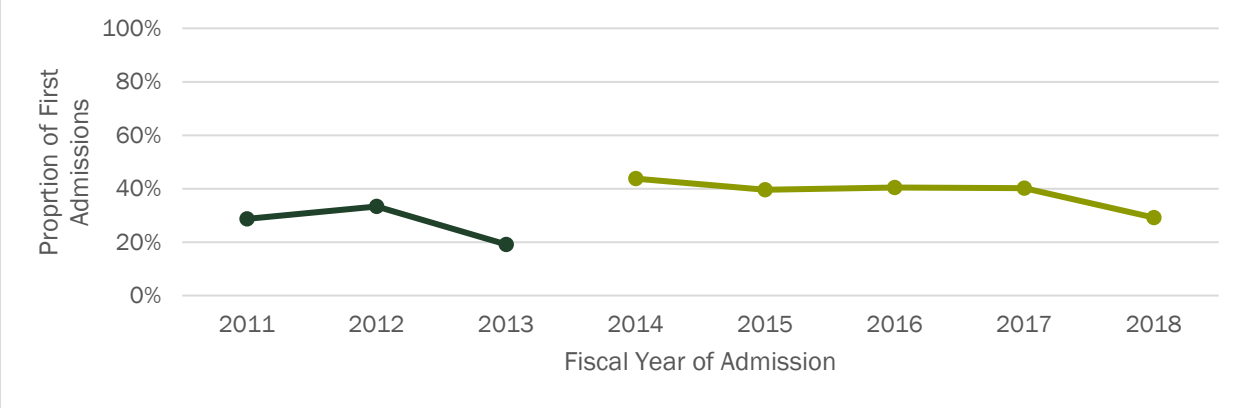


Figure 35. Dauphin - Proportion of First Admissions Exiting within One Year by Fiscal Year

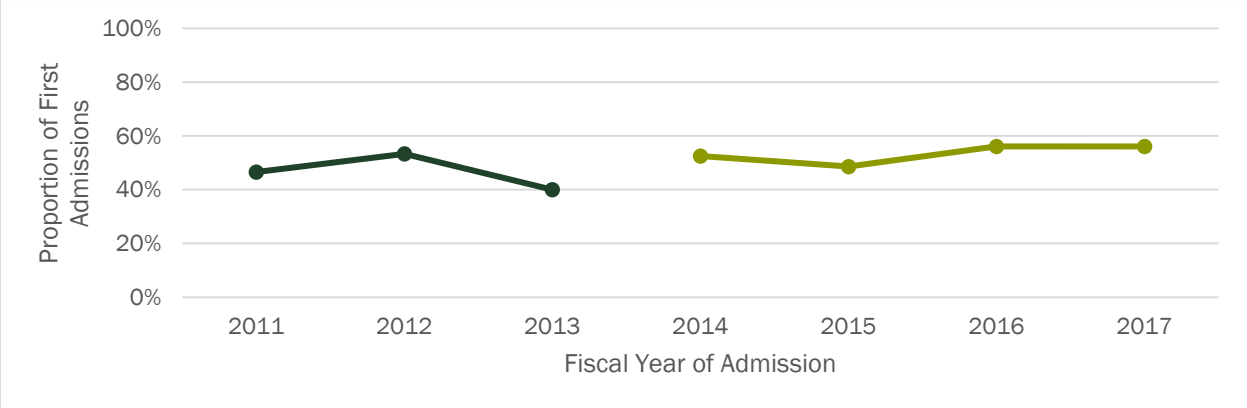


Figure 36. Lackawanna - Proportion of First Admissions Exiting within Six Months by Fiscal Year

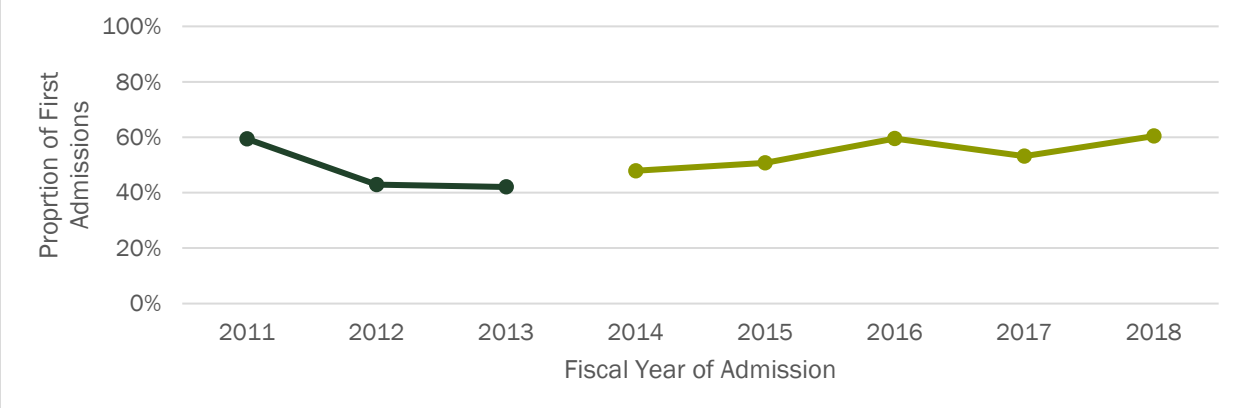


Figure 37. Lackawanna - Proportion of First Admissions Exiting within One Year by Fiscal Year

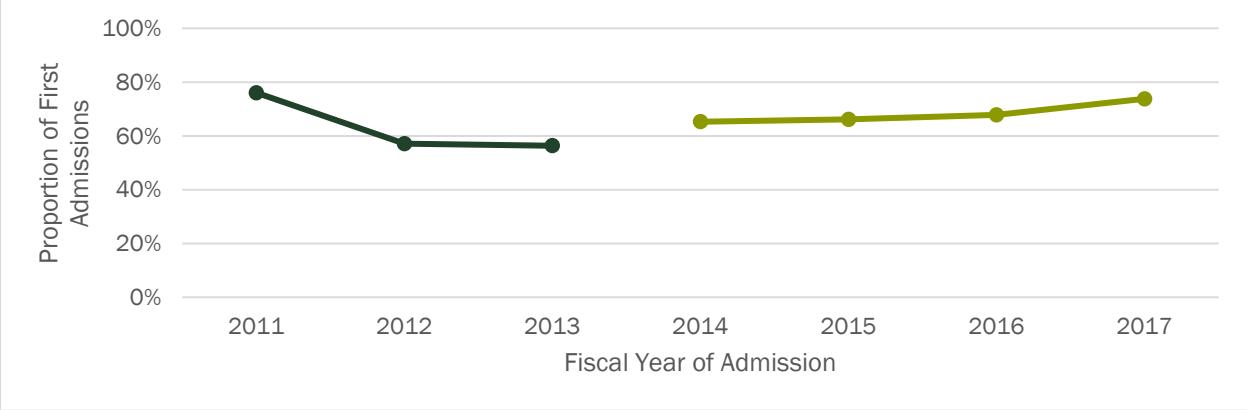


Figure 38. Philadelphia - Proportion of First Admissions Exiting within Six Months by Fiscal Year Quarter

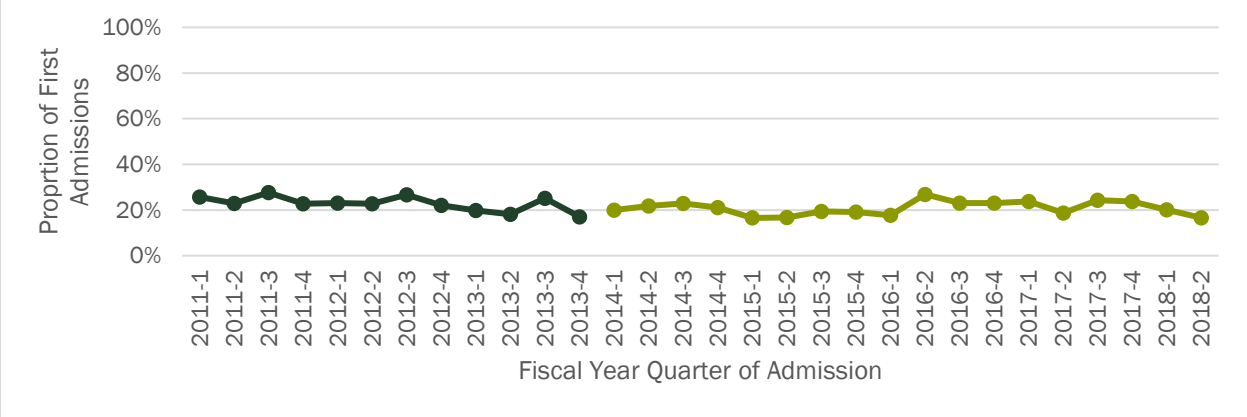
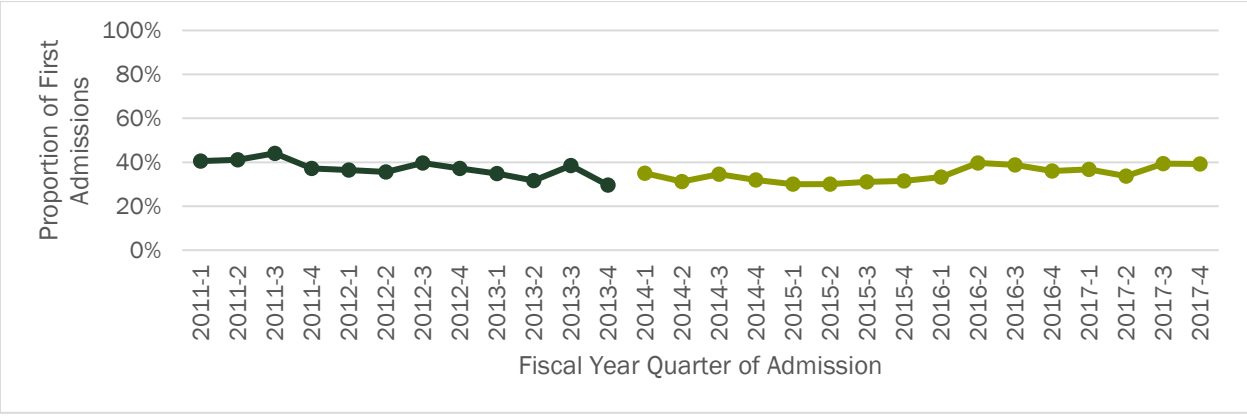


Figure 39. Philadelphia - Proportion of First Admissions Exiting within One Year by Fiscal Year Quarter



Across the Waiver counties, overall duration measure trends varied. However, within counties, the trends for the two permanency likelihoods moved in tandem (Table 51). Meaning, counties with an increased likelihood of children exiting within six months of placement also saw an increased likelihood of children exiting care within one year of placement and vice versa. Three counties (Allegheny, Crawford, and Philadelphia) saw a decreased likelihood of exiting within each window of time. Additionally, each of those there counties had at least one of their time-to-permanency outcomes show significance (Table 52). Both Dauphin and Lackawanna displayed an increased likelihood of first admissions exiting care within six months or a year, although only Dauphin's likelihood of exiting within six months showed significance.

Sensitivity analyses were conducted to understand whether this change in duration may have been linked to the shift in placement mix towards less restrictive placement types. When controlling for initial placement type, Allegheny and Dauphin's findings remained steady. However, this additional independent variable wiped out the significance of Crawford and Philadelphia's results. This finding indicates that much of the decreased likelihood of exiting within the prescribed windows of time was due to a shift in placement mix in Philadelphia and Crawford.

Reentry

Especially in an environment with significant shifts in policy and practice, particularly around placement type, it is important to examine re-entries to gain insight into the apparent success or failure of the initial discharge from care. Re-entry may be a signal that the discharge was inappropriate or premature; however, from the available data, it cannot be determined why any given child is returned to care. Nonetheless, analysis of re-entry rates should help, at the aggregate level, to evaluate the success of discharges. Figures 40-44 show the proportion of reentries from permanent exits with one year for children who exited from a first admission spell within the SFYs of 2011 through 2017.

Figure 40. Allegheny - Proportion of Permanent Exits Re-Entering Care within One Year by Fiscal Year Quarter

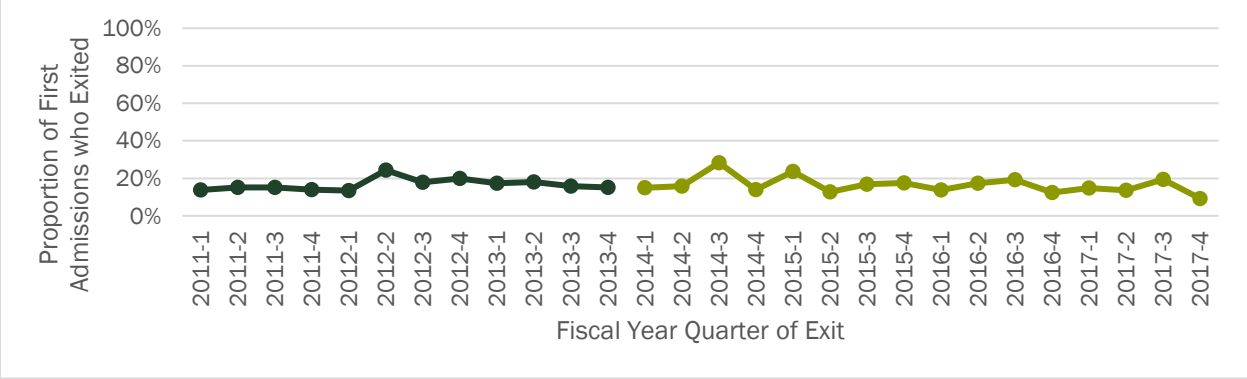


Figure 41. Crawford - Proportion of Permanent Exits Re-Entering Care within One Year by Fiscal Year

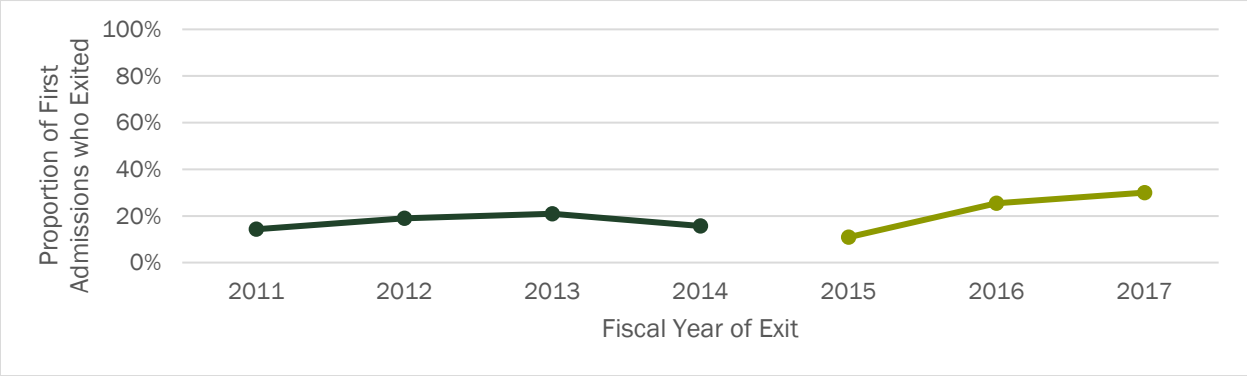


Figure 42. Dauphin - Proportion of Permanent Exits Re-Entering Care within One Year by Fiscal Year

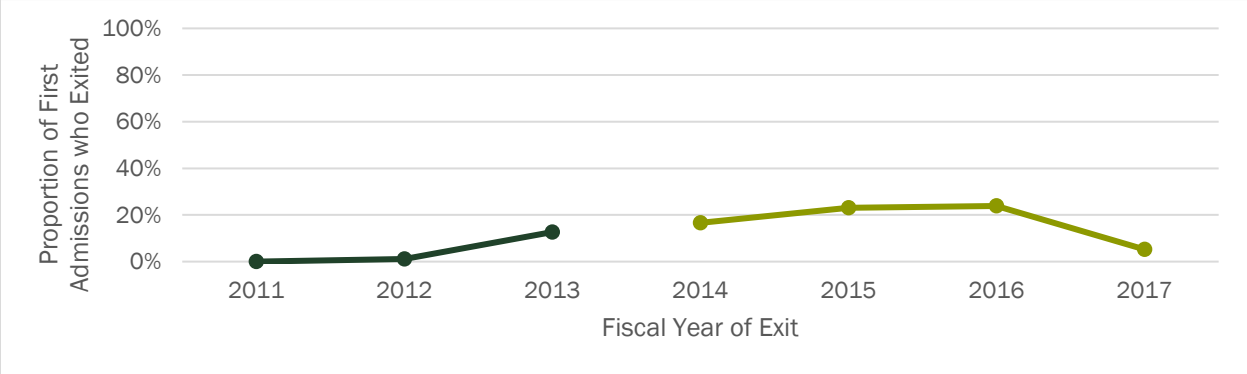


Figure 43. Lackawanna - Proportion of Permanent Exits Re-Entering Care within One Year by Fiscal Year

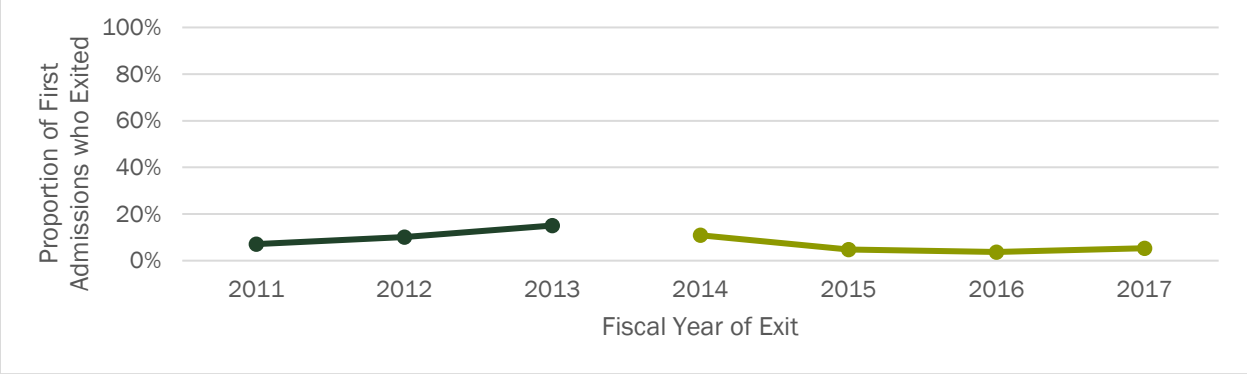
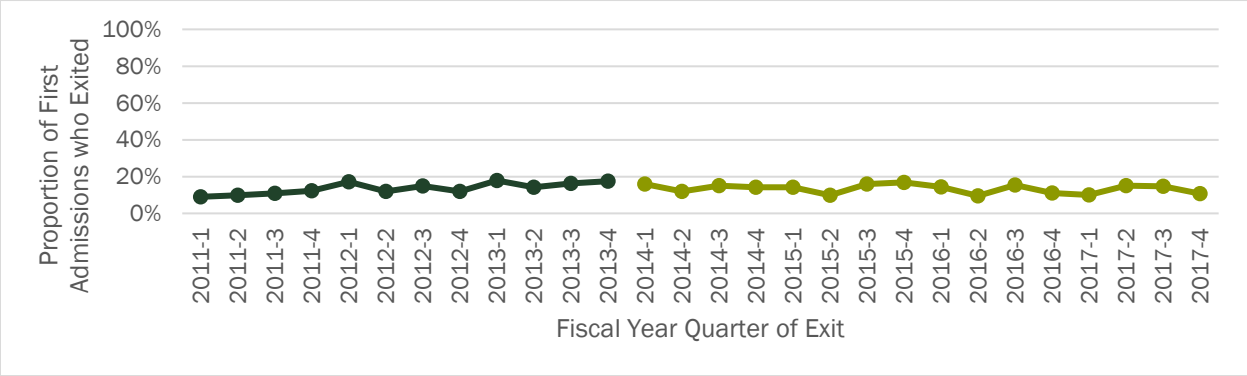


Figure 44. Philadelphia - Proportion of Permanent Exits Re-Entering Care within One Year by Fiscal Year Quarter



On the whole, counties showed no real change around the reentry measure (Table 50). A reduction or non-change in re-entries is a positive sign that the changes to the system under the Waiver did not negatively impact the success of permanent exits. Allegheny and Philadelphia saw no change in overall proportion of exits who reentry when comparing the pre-Waiver to Waiver years. Lackawanna and Crawford saw shifts which proved non-significant (Table 52). Dauphin experienced a significant increase in reentries, but the significance here was impacted by the very low rates of reentries for exits in SFY 2011 and SFY 2012.

Discussion

Lacking a true control group at the system level, the state-level child welfare outcomes analysis employed longitudinal cohorts, comparing outcome performance between pre-Waiver and Waiver groups. This historical comparison cannot scientifically support or refute a hypothesis of improved outcomes due specifically to Waiver efforts and initiatives. However, the findings can provide a descriptive view of how outcomes changed over time before and during the Waiver period.

The discussion below highlights the outcomes of each county individually and incorporates the interviews with counties and the evaluation team about their outcomes.

Allegheny – One of the strongest shifts in Allegheny during the waiver was the shift to less restrictive placement settings. Allegheny saw a significant increase in the likelihood of initial placement with kin as well as a significant decrease in initial congregate care placements. County officials attribute this change in placement mix to a shift in focus at the leadership level combined with increased reporting, a focus on data analytics, and the creation of a best practice team dedicated to reducing placements in congregate care. The county's effort to get youth in the right, least restrictive placement at the start may also be a driver behind the increased placement stability findings. However, Allegheny did see significant decreases in likelihood of exiting care which may be due to overwhelmed caseworkers and kinship workers at the time of admission growth in the last couple years of the Waiver. The sensitivity analysis showed that these were the years that had the greatest impact on time to permanency findings.

Crawford – As the Waiver county with the smallest child welfare system, Crawford experienced greater variability in their outcomes and trends were harder to pin down. However, during the Waiver there appeared to be some significant change centered on the trajectory for children experiencing their first substantiation. Children were significantly less likely to be placed within six months of an initial substantiation but were also more likely to experience a repeat substantiated maltreatment within the same period of time. Crawford also experienced a reduction in the likelihood of children exiting OOH care within one year being. Although the findings did not rise to significance, Crawford saw favorable trends in the areas of least restrictive placement type and placement stability.

Dauphin - Dauphin showed clear, significant positive findings around increased stability and reduced time to permanency. But, when looking at the Waiver period overall, findings were less positive related to significant increases in the placement rate and significant increases in the use of congregate care as an initial placement. However, From SFY 2016 through SFY 2018, Dauphin experienced a turnaround in many outcome areas with system shift around total placements and placement mix in particular. The

placement rate in Dauphin rose from 1.82 in SFY 2013 to 4.20 in SFY 2016, but SFY 2017 and 2018 saw steady decreases with the placement rate lowering to 3.01 in SFY 2018. In addition, while initial congregate care placements hit a peak at 33% in SFY 2014, this proportion dropped steadily to 10% in SFY 2018. Looking at the year-by-year model, SFY 2018 was also the first year that the likelihood of initial kin placement was significant when compared to pre-Waiver years. Talking about this system shift, county officials talked about a renewed focus on the goals of the CWDP. Citing assistance from the state under a placement reduction plan and the vision of the CWDP, Dauphin was able to reprioritize their agency and send a consistent message of what should be done in terms of service delivery.

Lackawanna – Although only increased likelihood of an initial kin placement rose to significance, Lackawanna's outcomes saw overall improvement in measures of placement rate, less restrictive placement, placement stability, likelihood of exit, and reentry when comparing pre-Waiver to Waiver periods. County officials cite several philosophy and policy changes behind these systems shifts. For one, caseworkers were encouraged to spend more time with families and investigate preventive services before placement which they believe was bolstering their improved placement rate and placement mix outcomes. Also, congregate care was avoided if at all possible. In addition, Lackawanna credits their improved likelihood of exit outcomes and decline in median duration (which has dropped from 8.6 months in SFY 2013 to 5.82 months in SFY 2018) to the initial CANS and FAST assessment guiding their permanency process.

Philadelphia - Philadelphia showed clear, significant positive findings around increased stability and placement mix. One of the strongest shifts in Philadelphia during the Waiver period was the shift to less restrictive placement settings. Philadelphia saw a significant increase the likelihood of initial placement with kin as well as a significant decrease in initial congregate care placements. However, the county also saw a significant increase in placement rates and a decreased likelihood of exiting care within six months or a year, but each of these findings requires some context to fill in the narrative. Regarding the increase in placement rates, although SFY 2015 and SFY 2016 saw a spike in first admissions, SFY 2017 and SFY 2018 saw steady reductions. Regarding duration, sensitivity analyses were conducted to understand whether this change in duration may have been linked to the shift in placement mix towards less restrictive placement types. When controlling for initial placement type, Philadelphia's significant findings were eliminated. This finding indicates that much of the decreased likelihood of exiting within the prescribed windows of time was due to a shift in placement mix in Philadelphia. Looking at an additional sensitivity analysis, with an interaction term for the Waiver period and first placement type, it was revealed that Waiver period impacted kinship placements differently than congregate care placement, with initial kinship placements had a significant reduced likelihood of exiting within one year while initial congregate care placements actually had an increased likelihood of exiting within the same window.

Overall, the two most common positive changes during the Waiver period involved placement mix and placement stability. Counties moved away from restrictive congregate care settings and towards less restrictive placement settings such as kinship care. In addition, counties saw an overall reduction in the likelihood of movements with the first six months of placement. While these findings cannot be linked casually to the CWDP, they point towards a strong practice and policy shift during that time.

CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

Pennsylvania Title IV-E Waiver Evaluation – Fiscal Study Sections

11/26/18

Laura Packard Tucker
Britany Orlebeke

Chapin Hall is an independent policy research center at the University of Chicago focused on providing public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of children, families and communities.

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Introduction

The fiscal study involves a system-level study of aggregate expenditures and revenues which addresses whether, compared to pre-CWDP years, there was a change in child welfare expenditure patterns subsequent to the system interventions (family engagement, structured assessments, and expanded use of EBPs) and fiscal stimulus and, if so, how have expenditure patterns changed. If the theory of change is correct, then one would expect to see lower utilization of foster care and residential and group home care and a concomitant increase in expenditures for non-placement services and supports without sacrificing child safety.

The six demonstration counties participating in the CWDP traded unlimited, fee-for-service federal revenue foster care board and maintenance and administrative costs for certain children for a capped allocation. The fixed amount of money or capped allocation was intended to provide each county with at least as much federal Title IV-E revenue as the county would have received under normal Title IV-E reimbursement rules in the absence of the waiver. The cap was based on the average of each county's historical foster care expenditures in four federal fiscal years: FFY 2008 through FFY 2011, from October 1, 2007 through September 30, 2011. The administrative cap was held steady for the waiver period, but the maintenance cap decreased by 6.48% each year.

The waiver gave county administrators the opportunity to treat federal Title IV-E revenue as a predictable source of flexible funding that could be allocated to a broader range of child welfare services that normally could not be supported with Title IV-E funding. The waiver addressed the prevailing belief that restricting the use of Title IV-E funding to foster care created a disincentive for reducing foster care expenditures. Without the waiver, counties would "lose" federal Title IV-E funding if the county agency was able to reduce foster care expenditures. Under the waiver, counties retained this federal Title IV-E funding for other child welfare purposes. As a result, administrators in demonstration counties were expected to take more action to reduce foster care expenditures in ways that were favorable to children, families, and communities, and the waiver interventions described in this report were expected to be part of these changes.

The waiver also exposed county administrators to new risks. At a minimum, county administrators risked that the amount of money received through the waiver would be less than the county would have received under normal Title IV-E reimbursement rules. If foster care expenditures did not change as hypothesized and as rapidly as was presupposed by the annual 6.48% reduction in the waiver maintenance cap, the county would lose revenue as a result of waiver participation. In addition, county administrators risked the amount they had invested in services intended to reduce foster care expenditures. If foster care expenditures did not go down, these investments would not be paid for by reductions in foster care and would have to be funded by another source of revenue.

The state allocated Title IV-E revenue to each demonstration county on an annual basis. After holding a portion at the state-level for waiver administration costs, the state managed the Title IV-E Waiver maintenance and administration allocations at the county-level by annually assigning to each CWDP participating county a maintenance and administration cap. Each county's caps were calculated by applying that county's percentage of applicable expenditures within the base years (FFY 2008 - FFY 2011) to the state's annual allocation caps. Just as at the state-level, the counties' administration caps stayed stable across the waiver years while their maintenance caps declined 6.48% annually. As the waiver proceeded, counties were allowed to move revenue from the maintenance to the administrative cap since the state's agreement with the federal government was for total revenue. While the state gave various instruction to the counties on which spending to allocate their Title IV-E revenue to, as with any flexible revenue stream, counties could allocate their Waiver revenue as they chose to.

Key Questions

Using available data, the fiscal study examined whether or not the demonstration counties showed evidence of different child welfare spending during the CWDP compared to before the CWDP. If a different range of expenditures patterns is observed, then we can hypothesize that the differences may have arisen because of the waiver and its combined influences of fiscal flexibility and practice changes evaluated in the previous section. In this section, we have two primary questions:

- Did expenditure patterns for out-of-home care change over the five years of the Demonstration Project, and if so, were the changes related to unit costs, care days, or both?
- Did the ratio of out-of-home care spending to spending for prevention and family preservation change over the five years of the Demonstration Project?

The unit of analysis for the fiscal evaluation is the county. Due to the small sample size and significant differences among the six waiver counties, there are no models that pool the six counties together.

Data Sources & Data Collection

Data Sources

Primary Expenditure and Revenue Data

The primary data sources for the Fiscal Study are the counties' annual State Act 148 Invoices and county-level Special and Block Grant expenditure reports. These data sources capture the fullest possible picture of each county's child welfare expenditure and revenue activity, including local, state and federally supported expenditures and revenue. The State Act 148 invoices are extensive workbooks which each county submits to the state on an annual basis to report on and request reimbursement for child welfare expenditures activity in the county. Some additional child welfare spending was captured via information from the Special and Block Grant expenditure reports which summarizes funding awarded to counties for specific child welfare activity.

CWDP Intervention Spending Data Limitations

Almost all waiver interventions were delivered by county staff, and isolating the costs of activities delivered by county staff is difficult to do without methods like a random moment survey or a time and cost study. Nevertheless, the state asked each CWDP county to allocate its CWDP revenue over several different expenditure categories as part of its Act 148 submissions. Counties were asked to provide CWDP expenditure details on the "Title IVE CWDP Summary Tab." The intention was for the county to communicate to the state the amount of money they were spending on each waiver interventions.

Predictably, although the process and outcome studies show that counties were actively participating in these activities, the reported expenditure levels remained low, with some counties, such as Lackawanna, Philadelphia, and Crawford, reporting no intervention expenditures at all in some fiscal years. We do not believe this information accurate enough to be useable for the evaluation

On a separate section of the Act 148 Invoice, counties were also asked to put intervention expenditures in the Service Planning cost center. However, this appears to a similarly unreliable source of intervention expenditures as well. While all counties participated in the waiver interventions, only a couple counties saw this subcategory of expenses increase. Interviews with county fiscal staff confirmed our suspicion that this subcategory was inconsistently used for this purpose.

OOH Placement Days

To augment the understanding of OOH Placement costs, we examine the counties' average daily OOH unit cost. To calculate this annual average per county, we utilized the cost data detailed

above as well as OOH Placement day counts calculated using each county's Multistate Foster Care Data Archive event file. These are the same data that were the basis for the outcome analysis.

Data Collection

In the early stages of the evaluation, Chapin Hall and the University of Pittsburgh determined all the sources of child welfare revenues and expenditures and developed a methodology which included: (1) identifying key budget personnel at the state and in each of the counties and conducting phone interviews to determine all sources of data and the accuracy; and (2) developing an expenditure and revenue tool to use going forward. We utilized the State Act 148 Invoices, as well as Special and Block Grant expenditures described above, created files, and then verified the files with each county fiscal officer. Any discrepancies were followed up and corrections made in the files. As part of ongoing quality assurance, we were a part of the fiscal subcommittee calls so that we were aware of any changes in the reporting of expenditures and revenues as well as changes in key personnel.

Based on expenditure type and county feedback, the county expenditures were grouped into summary categories for further analysis. At the highest level category, revenue splits between local, state, and federal funding. And, expenditures fall into categories which distinguish between Out-of-Home (primarily foster care maintenance), Adoption & Guardianship Subsidies, and All Other Child Welfare (CW) expenditures. Appendix D presents a mapping of the Act 148 Invoice cost centers to the summary categories utilized by the evaluation.

Analysis of the State Act 148 data and conversations with fiscal officers and state staff in the first year of evaluation led to the conclusion that the more detailed categories on the Act 148 Invoice (for example, "Counseling" or "Service Planning" or "Protective Service General") should not be used for the evaluation because the rules governing their uses were broad enough that they could be used differently in different years. The ability to use those categories to analyze spending is limited by the variance both within county and between counties in interpretation of those categories.

As of the time of preparing this final report, all Act 148 Invoices and Special and Block Grant information from SFY 2011 through SFY 2017 were finalized except for Philadelphia's SFY 2017 Act 148 Invoice which is excluded here due to incomplete invoicing activity. Also excluded are all counties' SFY 2018 Act 148 Invoices which were in-process and not finalized at the time of this analysis.

Data Analysis

Variables for Analysis

Using the data available to date, we examined the following dependent variables:

- Total child welfare expenditures;
- Out-of-home expenditures and utilization (placement days);
- Out-of-home expenditures as a % of total child welfare expenditures; and
- Average daily unit cost (total OOH expenditures divided by total placement days).

For each dependent variable listed above, we compare the change in the indicator from the pre-waiver period SFY 2011 through 2013 to the waiver period of SFY 2014 through 2017. (Fiscal data from the last year of the waiver, SFY 2018, is excluded as noted in the previous section.)

Delinquent Expenditure Exclusion

Across the six counties being studied in the Pennsylvania Title IV-E Waiver cost analysis, delinquent expenditures varied in proportion to total child welfare expenditures and in source of funding. In Dauphin County, delinquent expenditures made up 36% of child welfare costs. In the other five counties the total proportion of expenditures in delinquent cost categories averaged 16%. About 12-16% of total child welfare expenses in Crawford, Lackawanna, and Venango were geared toward delinquent cost categories, and in Allegheny and Philadelphia, the proportions were 22% and 27%, respectively.

More importantly, the amount of Title IV-E revenue funding the delinquent expenditures was low to non-existent in these four counties. Allegheny and Lackawanna claimed almost no Title IV-E federal funds against delinquent costs, while Philadelphia and Venango claimed only 2-5%. In Crawford and Dauphin, claims averaged 8% of all delinquent expenditures. This low level of Title IV-E funding existed due to federal shared case management requirements. To claim Title IV-E for a delinquent expense, the county must be able to show shared-case management between delinquency and child welfare staff. Interviews with county financial representatives indicated that due to mandatory court orders and restrictions, the shared-case management requirements on delinquent cases were rarely met, leading to low Title IV-E claims on delinquent expenditures.

Due to the low level of Title IV-E funding for delinquent expenditures in the demonstration counties, the delinquent expenditures were excluded from the fiscal study.

Title IV-E Waiver Revenue and Savings

A key benefit of waiver financing is that counties could utilize savings on out-of-home board and maintenance (from reducing placement costs) for other child welfare activities. The expenditure analysis shows any spending reductions in out-of-home board and maintenance within participating counties. Another way to examine the question of how participating

counties have used waiver savings is to look simply at federal waiver revenue received by each county from SFY 2014 through SFY 2018 and compare it to what would have been received under traditional IV-E reimbursement rules. To estimate the additional revenue each demonstration county received to spend on services other than out-of-home board and maintenance, the fiscal study team reviewed the amount of Title IV-E reimbursement each claimed as a traditional Title IV-E expenditures on their Act 148 Invoice during the waiver period from SFY 2014 through SFY 2017. This amount was compared to the county's annual allocation amount to determine how much (if any) was left over for flexible spending.

County-Level Analysis and Standardization of Change

As stated previously, the unit of analysis for the fiscal evaluation is the county. Due to the small sample size and significant geographic and programmatic differences among the six waiver counties, there will be no models that pool the six counties together. Within the Results section of the Fiscal Study, findings will be organized by analysis topic with each county's results listed separately. Attempts to standardize and compare the waiver trends between the counties have been made in some sections through one of two approaches:

1. Waiver Change – The waiver change is defined in this section as the percent difference of the last observable annual value to the annual value immediately preceding the beginning of the waiver (the baseline year). For example, in Allegheny County, the waiver change is calculated by looking at the percent difference between the values in SFY 2018 compared to SFY 2013. However, in Crawford County where the county joined the Demonstration Project in SFY 2015, SFY 2018 is compared to SFY 2014.
2. Year-by-Year Change from Baseline - Graphically, we present the percent change from the baseline year for each county and each year of the waiver where data is available. This allows a comparability among counties as well as years.

However, grouping the analysis by county can facilitate understanding that county's specific fiscal narrative. To provide that view and further context to the analysis in the main body of this report, individual county fiscal profiles are included as Appendix I.

Inflation Adjustment

An adjustment for inflation was made to allow comparability of expenditures across years. All expenditures, unless otherwise noted, have been adjusted to constant dollars using SFY 2018 dollars as the base year and adjusting previous years' expenditures by the Consumer Price Index (CPI)[9].

[9] United States Department of Labor. (2018, Sep.). Consumer Price Index. Bureau of Labor Statistics. Retrieved September 23 from http://www.bls.gov/cpi/. Constant costs are calculated using the following equation: Current Year Real Cost = (Base Year CPI/Current Year CPI)*Current Year Nominal Cost. All constant costs are converted into SFY 2018 dollars, so the Base Year is SFY 2018. The CPI for SFY 2018 is calculated by taking the average CPI of the monthly CPIs for the period July 2017 through June 2018 (248.13).

Results

Overall Child Welfare Expenditures

Total Child Welfare Expenditures

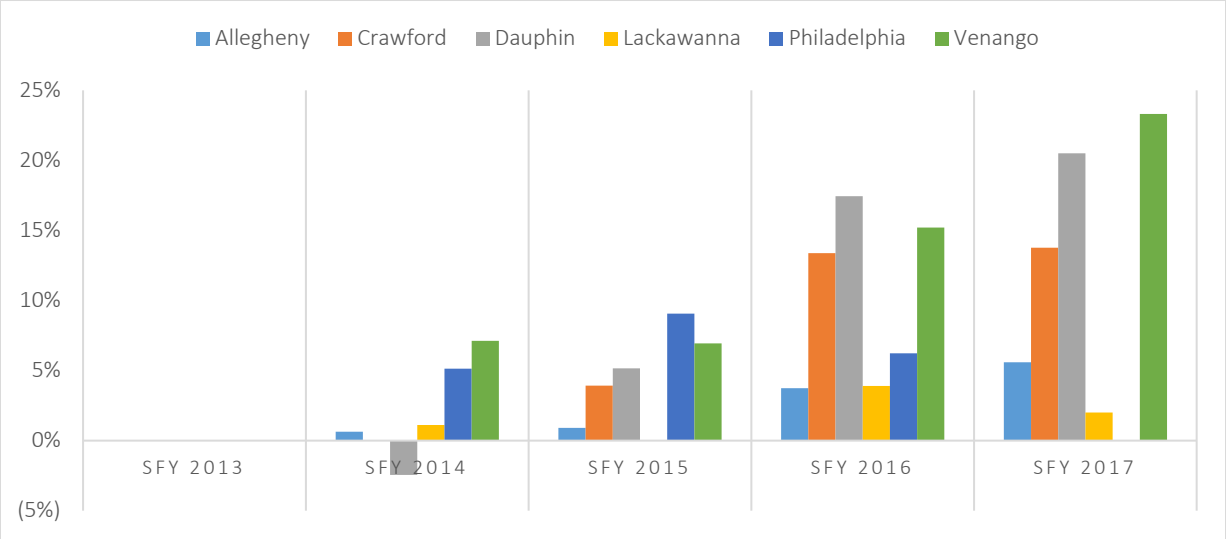
First, we report on the total child welfare expenditures for demonstration counties. These are displayed below in Table 54 from SFY 2011 through SFY 2017 (which covers the period July 1, 2010 through June 30, 2017). Figure XX presents the year-by-year change by county for total child welfare expenditures.

Table 54. Total Child Welfare Expenditures by County and State Fiscal Year – in Thousands of Dollars, Adjusted for Inflation

County	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Waiver Change
Allegheny	$198,417	$184,653	$183,770	$184,927	$185,460	$190,647	$194,057	6%
Crawford	$9,586	$9,535	$9,410	$9,025	$9,378	$10,232	$10,267	14%
Dauphin	$32,752	$30,202	$29,066	$28,356	$30,562	$34,137	$35,025	21%
Lackawanna	$17,575	$17,588	$16,753	$16,939	$16,757	$17,405	$17,087	2%
Philadelphia	$539,887	$512,191	$507,244	$533,245	$553,182	$538,910		6%
Venango	$6,466	$6,229	$5,886	$6,305	$6,295	$6,781	$7,258	23%

Even when adjusting for inflation, all demonstration counties saw total child welfare expenditures increase from SFY 2013 levels, although the magnitude of the increase varies by county. Crawford, Dauphin, and Venango saw double digit increases in overall expenditures, while Allegheny, Lackawanna, and Philadelphia saw more modest increases, between two to six percent. Figure 45 graphs the year-by-year changes from each county's baseline fiscal year.

Figure 45. Total Child Welfare Expenditure Year-by-Year Change from Baseline by County



Expenditures by Major Category

As described in the data sources and data collection section, child welfare expenditures can be divided into four broad categories:

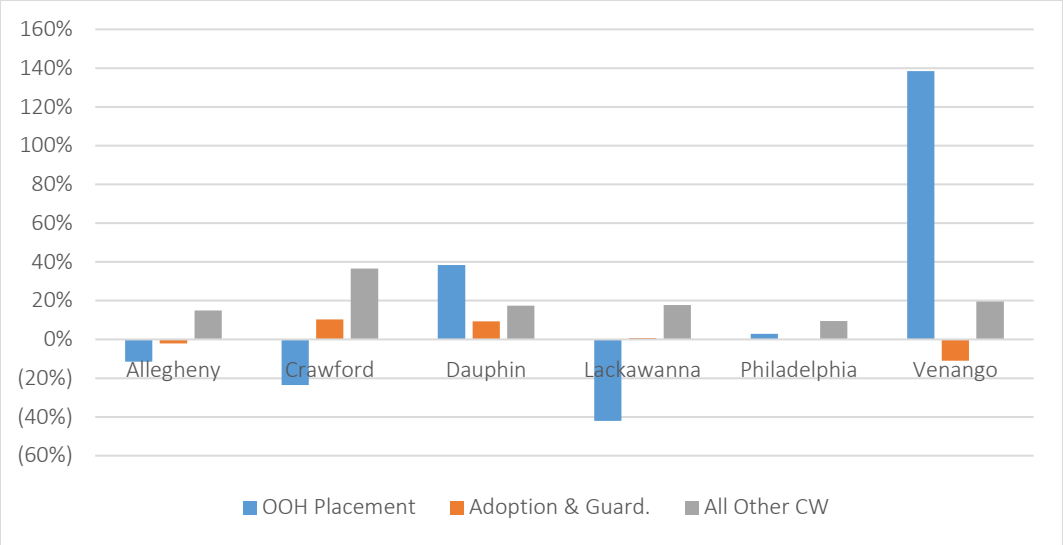
- **OOH Placement Costs** - These are purchased expenditures for all out-of-home board and maintenance costs.
- **Adoption and Guardianship Subsidies** - These are expenditures for adoption and guardianship subsidies.
- **All Other CW Expenditures** - These are all remaining child welfare expenditures which include everything the county does for children and families besides those board and maintenance and subsidy payments such as general administration of all child welfare programs, as well the management and services provided under the adoption, out-of-home and in-home programs.

As seen in Table 55 and Figure 46, total child welfare expenditures have increased for all counties during the waiver, but expenditure trends varied by category of expense.

Table 55. Child Welfare Expenditures by Major Category, County, and Fiscal Year – in Thousands of Dollars, Adjusted for Inflation

Major Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Waiver Change
Allegheny								
OOH Placement	$49,236	$42,785	$42,441	$43,088	$39,691	$37,268	$37,564	(11%)
Adoption & Guard.	$34,684	$37,125	$35,167	$34,018	$34,235	$34,759	$34,447	(2%)
All Other CW	$114,497	$104,744	$106,163	$107,821	$111,534	$118,620	$122,046	15%
Total	**$198,417**	**$184,653**	**$183,770**	**$184,927**	**$185,460**	**$190,647**	**$194,057**	**6%**
Crawford								
OOH Placement	$3,010	$2,584	$2,520	$2,923	$2,724	$2,387	$2,237	(23%)
Adoption & Guard.	$1,058	$1,136	$1,129	$1,156	$1,211	$1,230	$1,274	10%
All Other CW	$5,518	$5,815	$5,761	$4,946	$5,443	$6,615	$6,755	37%
	$9,586	**$9,535**	**$9,410**	**$9,025**	**$9,378**	**$10,232**	**$10,267**	**14%**
Dauphin								
OOH Placement	$10,413	$7,215	$6,524	$5,625	$6,824	$8,550	$9,027	38%
Adoption & Guard.	$5,073	$5,285	$5,636	$6,044	$6,006	$6,082	$6,159	9%
All Other CW	$17,267	$17,702	$16,906	$16,687	$17,733	$19,505	$19,839	17%
Total	**$32,752**	**$30,202**	**$29,066**	**$28,356**	**$30,562**	**$34,137**	**$35,025**	**21%**
Lackawanna								
OOH Placement	$3,420	$3,389	$3,274	$2,883	$2,895	$2,244	$1,896	(42%)
Adoption & Guard.	$3,804	$3,919	$3,936	$4,237	$3,995	$4,067	$3,963	1%
All Other CW	$10,352	$10,281	$9,543	$9,819	$9,867	$11,094	$11,228	18%
Total	**$17,575**	**$17,588**	**$16,753**	**$16,939**	**$16,757**	**$17,405**	**$17,087**	**2%**
Philadelphia								
OOH Placement	$186,623	$154,680	$147,498	$145,789	$145,543	$151,787		3%
Adoption & Guard.	$54,670	$72,576	$71,946	$69,408	$71,572	$72,015		0%
All Other CW	$298,594	$284,935	$287,800	$318,048	$336,066	$315,108		9%
Total	**$539,887**	**$512,191**	**$507,244**	**$533,245**	**$553,182**	**$538,910**		**6%**
Venango								
OOH Placement	$1,252	$879	$400	$398	$387	$666	$954	139%
Adoption & Guard.	$650	$819	$826	$811	$807	$772	$735	(11%)
All Other CW	$4,564	$4,531	$4,660	$5,096	$5,100	$5,343	$5,570	20%
Total	**$6,466**	**$6,229**	**$5,886**	**$6,305**	**$6,295**	**$6,781**	**$7,258**	**23%**

Figure 46. Waiver Change by County and Major Category – Adjusted for Inflation



All six demonstration counties saw an increase in All Other CW expenses (from 9% in Philadelphia to 37% in Crawford) over the course of the waiver which points towards all counties investing in greater capacity and/or new interventions during the waiver. For a more detailed dive into the makeup of the All Other CW expense category, see the county fiscal profiles in Appendix I.

However, the trend in OOH Placement costs varied wildly. For two of the counties which experienced a higher increase in child welfare expenditures over the course of the waiver, Dauphin and Venango, OOH Placement costs increased by 38% and 139% respectively. Philadelphia also saw a small increase, 3%, in OOH Placement costs through SFY 2016. The other three counties, Allegheny, Crawford, and Lackawanna saw decreases in OOH Placement costs of 11% to 42% from baseline levels.

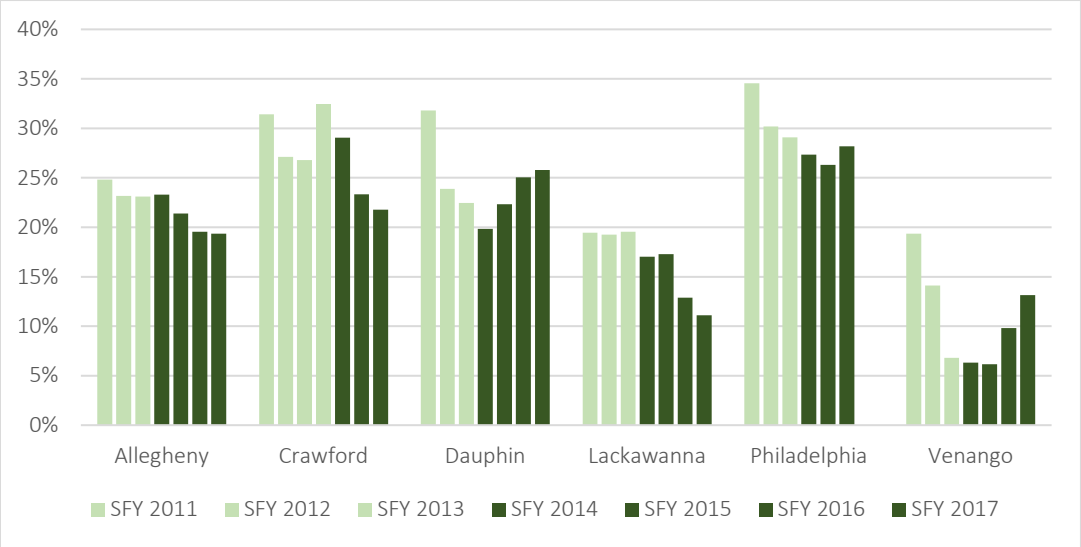
OOH Care Board and Maintenance Expenditures

In order to reduce OOH Placement expenditures, counties would have had to reduce the number of paid placement days, reduce the average daily cost of care, or both. This section presents data on trends in OOH expenditures, placement days, and unit costs, as well as the proportion foster care expenditures represented of all child welfare expenditures.

OOH Placement Expenditures as a Proportion of Total Child Welfare Expenditures

Looking at Figure 47, we can see that OOH Placement expenditures declined during the waiver for all but two demonstration counties. OOH expenditures can be viewed not only as a total dollar amount but also in the context of total child welfare expenditures trends. Figure 47 presents OOH Placement expenditures another way – as a proportion of total child welfare expenditures.

Figure 47. OOH Placement Costs as a Proportion of Total of Total Child Welfare Expenditures by County and SFY



One observation to draw from this figure is the variation in proportion of OOH Placement costs to total child welfare expenditures across demonstration counties. In SFY 2018, OOH Placement proportions ranged from 11% in Lackawanna to 26% in Dauphin.

OOH Placement cost increases in Dauphin and Venango over the course of the waiver corresponded with increases in the proportion of OOH Placement expenses to total child welfare expenses when comparing SFY 2017 to SFY 2013. This means that Dauphin's and Venango's OOH Placement costs increased in total and more than their All Other CW expenses. However, it is worth noting that despite Venango's proportional increase in OOH Placement expenses, the county is the demonstration county with the second lowest proportional value of OOH Placement costs (13%). Additionally, of all the demonstration counties, Venango has the lowest county population and correspondingly the lowest volume of child welfare days. This low volume of child welfare OOH activity can contribute to greater natural variation in annual expenditures since just a few expensive child welfare placements can have a significant impact on the county's bottom line.

The remaining counties (Allegheny, Crawford, Lackawanna, and Philadelphia) experienced a decrease in the proportion of OOH Placement expenditures during the waiver. For Allegheny, Crawford, and Lackawanna, OOH Placement costs decreased as All Other CW expenditures were increasing, resulting in a larger decrease in the proportion of OOH Placement expenditures. In Philadelphia, OOH Placement costs increased, but at a slower rate than All Other CW expenses.

OOH Placement Expenditure Structure

To understand shifts in OOH placement costs, one must take into account their expenditure structure. Total OOH placement expenditures are influenced by two components: price of care

and quantity of care days. In other words, how much a child welfare system spends on OOH placements (expenditures) is a function of how much that collection of services costs per day (price) and the number of care days for which it is provided (quantity).

OOH Expenditures = Price * Quantity

In short, a change in the average cost per care day or in the number of care days would affect the total OOH expenditures. In the following section, we will examine how the days, costs, and average daily unit costs have varied by county over the course of the waiver.

Average Daily Unit Cost

Average unit costs are calculated by dividing the total annual OOH expenditures by total placement days for each fiscal year. Below, Table 56 displays the average daily unit cost by county and fiscal year alongside OOH Placement costs and placement days inputs for each county. Figure 48 graphically presents how the average daily unit costs have changed over time.

Table 56. OOH Placement Expenditures, OOH Placement Days, and Average Daily Unit Cost by County and Fiscal Year – Adjusted for Inflation, OOH Placement Expenditures in Thousands

Allegheny	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**Waiver Change**
OOH Expenditures	$49,236	$42,785	$42,441	$43,088	$39,691	$37,268	$37,564	(11%)
Placement Days	636,121	586,628	575,345	572,578	539,595	534,752	560,026	(3%)
Avg. Daily Unit Cost	$77.40	$72.93	$73.77	$75.25	$73.56	$69.69	$67.07	(9%)

Crawford	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**Waiver Change**
OOH Expenditures	$3,010	$2,584	$2,520	$2,923	$2,724	$2,387	$2,237	(23%)
Placement Days	38,318	35,399	33,543	36,377	38,032	34,428	36,128	(1%)
Avg. Daily Unit Cost	$78.55	$73.01	$75.12	$80.35	$71.63	$69.34	$61.92	(23%)

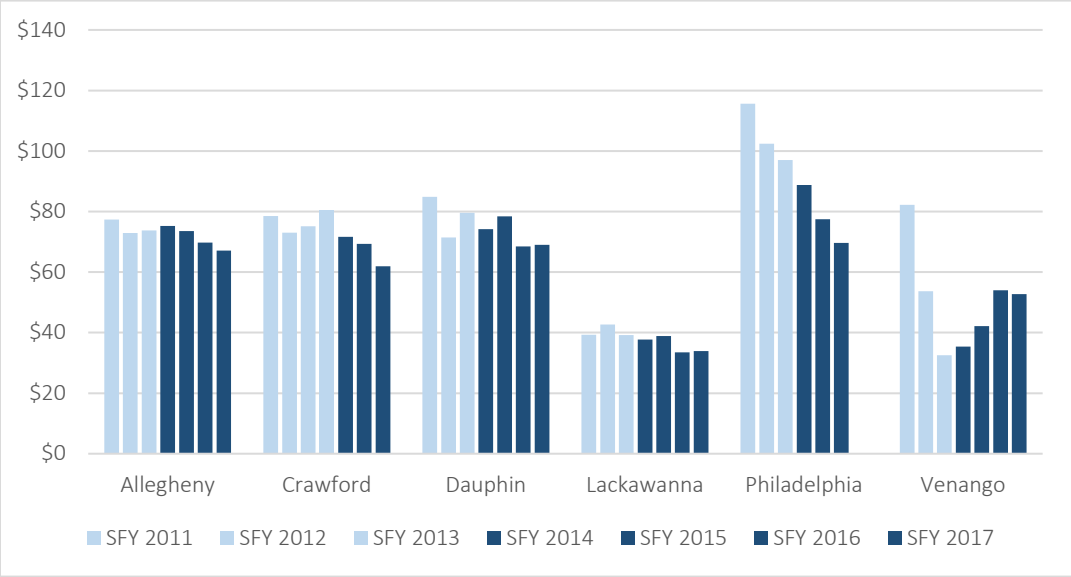
Dauphin	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**Waiver Change**
OOH Expenditures	$10,413	$7,215	$6,524	$5,625	$6,824	$8,550	$9,027	38%
Placement Days	122,737	100,993	82,035	75,871	87,017	124,894	130,726	59%
Avg. Daily Unit Cost	$84.84	$71.44	$79.52	$74.14	$78.42	$68.46	$69.05	(13%)

Lackawanna	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**Waiver Change**
OOH Expenditures	$3,420	$3,389	$3,274	$2,883	$2,895	$2,244	$1,896	(42%)
Placement Days	87,107	79,322	83,516	76,535	74,428	67,123	55,890	(45%)
Avg. Daily Unit Cost	$39.26	$42.72	$39.20	$37.67	$38.90	$33.44	$33.92	(13%)

Philadelphia	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Waiver Change
OOH Expenditures	$186,623	$154,680	$147,498	$145,789	$145,543	$151,787		3%
Placement Days	1,614,389	1,510,230	1,520,178	1,641,724	1,878,420	2,178,567	2,245,929	43%
Avg. Daily Unit Cost	$115.60	$102.42	$97.03	$88.80	$77.48	$69.67		(28%)

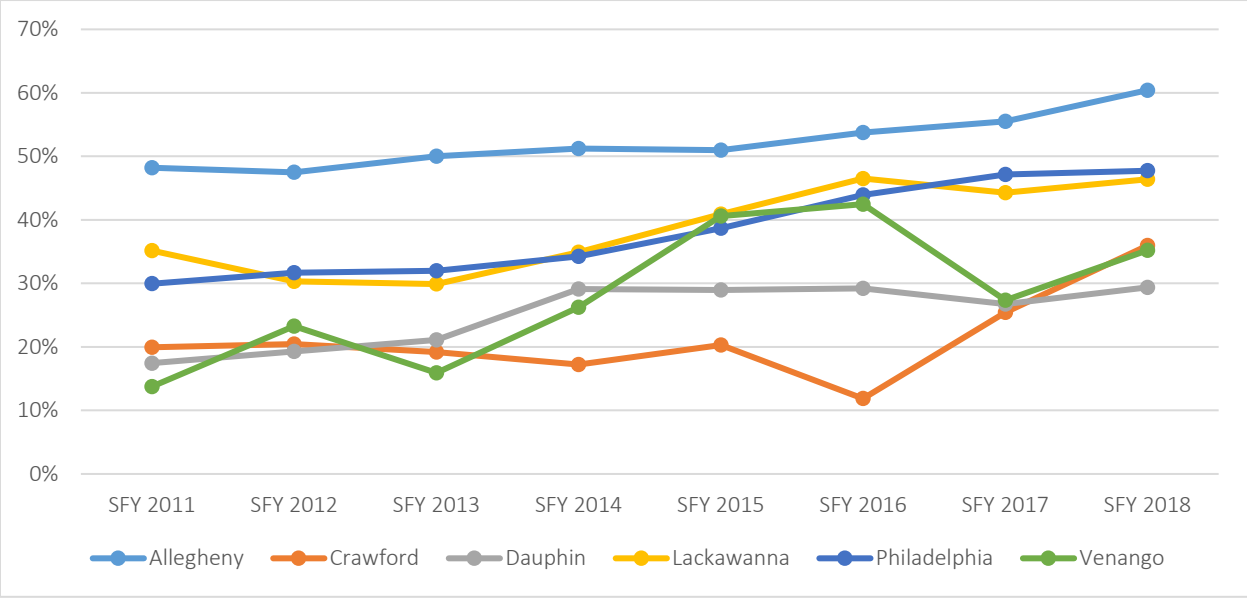
Venango	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Waiver Change
OOH Expenditures	$1,252	$879	$400	$398	$387	$666	$954	139%
Placement Days	15,221	16,362	12,291	11,255	9,194	12,342	18,074	47%
Avg. Daily Unit Cost	$82.24	$53.70	$32.53	$35.36	$42.13	$53.97	$52.76	62%

Figure 48. Average Daily OOH Placement Unit Cost by County and Fiscal Year – Adjusted for Inflation



With the exception of Venango, all demonstration counties saw their average daily unit cost decline over the course of the waiver, from a 9% reduction in Allegheny to a 28% reduction in Philadelphia. This decline in average daily unit cost likely stems in part from a placement mix – a shift from more expensive care types (congregate care) to less costly placement types (kinship care). In Figure 49, we see that the proportion of kinship care days increased for each demonstration county when comparing their baseline year to SFY 2018. This change occurred for lower and higher kinship utilization counties, although the largest shifts did occur in counties with lower kinship utilization in SFY 2013. See the county fiscal profiles in Appendix I for a breakdown of annual placement days totals by care type for each county.

Figure 49. Proportion of Total Placement Days with a Kinship Care Type by County and Fiscal Year



The expenditure analysis of the fiscal study points to a few key observations about the county fiscal experience. First, all demonstration counties increased total child welfare expenditures and, in particular, All Other CW expenditures, during the waiver. However, the trends in OOH Placement costs varied considerably, and the relationship between changes in OOH Placement days, OOH Placement costs and the proportion of OOH Placement costs of all child welfare expenditures varied by county.

Revenue

General Revenue Trends

Over the course of the waiver, demonstration counties saw a consistent mix in the major revenue sources. Table 57 looks at each county and the proportion of federal, state, and local revenue applied to the county's child welfare expenditures. Revenue mix varies slightly by county, but in general, state revenue accounted for approximately 60% of child welfare revenue, while federal revenue made up 25% and local about 15%. Within the 25% of revenue made up by federal funds, the greatest proportion of that revenue for each county was Title IV-E revenue making up 65-83% of total federal revenue in SFY 2018 (Table 58).

Table 57. Demonstration County Child Welfare Revenue Proportion by Type and SFY – Adjusted for Inflation

County	Revenue Type	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Allegheny	State w/ Grants	61%	61%	62%	62%	62%	62%	64%
	Federal	25%	26%	25%	25%	24%	24%	23%
	Local	14%	12%	13%	13%	13%	14%	13%
Crawford	State w/ Grants	55%	57%	57%	57%	56%	60%	61%
	Federal	32%	30%	29%	28%	31%	27%	26%
	Local	13%	13%	15%	15%	13%	13%	13%
Dauphin	State w/ Grants	59%	60%	61%	59%	60%	61%	61%
	Federal	28%	27%	25%	28%	26%	25%	25%
	Local	13%	13%	13%	13%	14%	14%	14%
Lackawanna	State w/ Grants	64%	65%	63%	63%	63%	64%	63%
	Federal	21%	21%	23%	24%	23%	22%	22%
	Local	15%	15%	14%	14%	14%	14%	15%
Philadelphia	State w/ Grants	60%	59%	61%	59%	59%	59%	
	Federal	22%	23%	21%	24%	23%	23%	
	Local	18%	18%	18%	18%	18%	18%	
Venango	State w/ Grants	62%	62%	64%	64%	64%	65%	65%
	Federal	25%	25%	24%	24%	23%	22%	21%
	Local	13%	13%	12%	12%	13%	12%	14%

Table 58. Demonstration County Child Welfare Federal Revenue Proportion by Sub-Type and SFY – Adjusted for Inflation

County	Fed. Rev. Type	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Allegheny	Title IV-E	76%	75%	75%	76%	76%	75%	77%
	TANF	16%	17%	17%	17%	17%	18%	17%
	Title IV-B	3%	3%	3%	3%	3%	3%	3%
	Prog. Income	2%	4%	2%	2%	2%	2%	1%
	Title XX	2%	2%	2%	2%	2%	2%	2%
	Medical Asst.	0%	0%	0%	0%	0%	0%	0%
Crawford	Title IV-E	73%	73%	73%	75%	78%	74%	76%
	TANF	10%	10%	10%	11%	9%	10%	10%
	Title IV-B	8%	7%	7%	6%	7%	9%	6%
	Prog. Income	7%	7%	5%	5%	4%	4%	5%
	Title XX	3%	3%	3%	3%	3%	3%	3%
	Medical Asst.	0%	0%	0%	0%	0%	0%	0%
Dauphin	Title IV-E	81%	80%	81%	80%	79%	75%	77%
	TANF	8%	8%	8%	8%	10%	11%	11%
	Title IV-B	7%	7%	7%	8%	7%	10%	9%
	Prog. Income	2%	2%	3%	2%	2%	2%	2%
	Title XX	1%	1%	2%	1%	1%	1%	1%
	Medical Asst.	0%	0%	0%	0%	0%	0%	0%
Lackawanna	Title IV-E	76%	79%	80%	80%	81%	82%	83%
	TANF	14%	10%	9%	11%	9%	7%	5%
	Title IV-B	5%	5%	5%	4%	4%	4%	5%
	Prog. Income	3%	4%	5%	3%	4%	5%	4%
	Title XX	2%	2%	2%	2%	2%	2%	2%
	Medical Asst.	0%	0%	0%	0%	0%	0%	2%
Philadelphia	Title IV-E	77%	80%	71%	77%	75%	75%	
	TANF	12%	11%	18%	15%	18%	17%	
	Title IV-B	3%	3%	4%	3%	3%	3%	
	Prog. Income	4%	3%	4%	3%	2%	3%	
	Title XX	3%	3%	3%	2%	2%	2%	
	Medical Asst.	0%	0%	0%	0%	0%	0%	
Venango	Title IV-E	67%	64%	69%	72%	72%	72%	65%
	TANF	12%	13%	11%	11%	12%	10%	13%
	Title IV-B	9%	10%	11%	7%	8%	10%	10%
	Prog. Income	8%	9%	6%	6%	4%	4%	8%
	Title XX	4%	4%	3%	4%	4%	4%	4%
	Medical Asst.	0%	0%	0%	0%	0%	0%	0%

CWDP Title IV-E Waiver-Related Revenue

Did counties receive more Title IV-E revenue during the waiver as they would have if they claimed maintenance and administration costs under normal reimbursement rules? Any additional revenue received could have been spent on services other than foster care board and maintenance. The evaluation cannot directly answer that question because counties did not have to calculate or report how much Title IV-E revenue they would have received under normal reimbursement rules. In the absence of counterfactual revenue figures, trends in OOH expenditures in Table 59 provide the one view of whether counties generated savings, discussed above.

The table below shows the amount of Title IV-E waiver-related revenue each demonstration county received before and under the Title IV-E Waiver. This includes all Title IV-E revenue less the Title IV-E revenue applied to Adoption & Guardianship-related expenses.[10]

Table 59. Estimated Title IV-E Waiver-Related Revenue by County and Fiscal Year – Adjusted for Inflation, in Thousands of Dollars

County	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Waiver Change
Allegheny	$22,701	$21,917	$19,563	$22,351	$21,993	$20,444	$21,583	10%
Crawford	$1,686	$1,585	$1,613	$1,518	$1,887	$1,604	$1,557	3%
Dauphin	$5,190	$4,351	$3,656	$3,841	$3,965	$3,817	$4,233	16%
Lackawanna	$1,434	$1,628	$1,779	$1,725	$1,688	$1,697	$1,647	(7%)
Philadelphia	$67,048	$65,377	$45,532	$72,102	$73,694	$66,743		47%
Venango	$767	$648	$631	$762	$723	$766	$730	16%

Only Lackawanna saw a decrease in Title IV-E waiver-related revenue, although the SFY 2017 total is within the range of normal when looking back to SFY 2011 and SFY 2012. The remaining counties saw an increase in total Title IV-E waiver related revenue when compared to their pre-waiver baseline year. However, as noted, Table 59 does not show whether or not these counties would have received more or less Title IV-E revenue in the absence of the waiver. This would depend on how much foster care board and maintenance expenditures the county had, compared to available revenue.

[10] In the waiver years, this includes some non-waiver Title IV-E revenue and so these totals slightly overstate the amount of Title IV-E waiver-related revenue. But, in pre-waiver years, it was not possible to separate what would have been attributable to waiver-related expenditures in a more precise way with the available Act 148 data. In all but Crawford County, this non-waiver Title IV-E revenue accounts for approximately seven percent of total revenue. In Crawford County, it accounts for 29%.

An important question regarding the counties' CWDP allocations is not just did they spend them, but *how* did they spend them? After holding a portion at the state-level for waiver administration costs, the state managed the Title IV-E Waiver maintenance and administration allocations at the county-level by annually assigning to each CWDP participating county a maintenance and administration cap. Each county's caps were calculated by applying that county's percentage of applicable expenditures within the base years (SFY 2008 - SFY 2011) to the state's annual allocation caps. Just as at the state-level, the counties' administration caps stay stable across the waiver years while their maintenance caps decline 6.48% annually. And just as the state level, counties were allowed to move waiver funds between maintenance and administration despite the caps although there was some confusion for a time about whether this was allowable.

Counties were given the choice to spend their CWDP allocation usage on either traditional Title IV-E costs, waiver-based intervention costs, or other eligible child welfare costs. Counties that had traditional Title IV-E expenditures which exceeded their total available CWDP allocation would not have had the opportunity for any flexible funding opportunities. These are likely the counties, such as Lackawanna, who received less Title IV-E federal revenue during the demonstration project than prior to the waiver, or, counties where traditional Title IV-E expenditures grew above their levels from the base years used to determine their cap (SFY 2008 – SFY 2011).

Discussion

The fiscal study allows us to make a few fundamental statements about the county fiscal experience and decision-making process. First, all demonstration counties increased total child welfare expenditures during the waiver. Even when controlling for inflation, counties increased total expenditures by 2 to 23%. Furthermore, all six demonstration counties saw an increase in All Other CW expenses (from 9% in Philadelphia to 37% in Crawford) through the last observable fiscal year which points towards all counties investing in greater capacity and/or new interventions during the waiver. However, the trends in OOH Placement costs varied considerably.

The relationship between changes in OOH Placement days, OOH Placement costs and the proportion of OOH Placement costs of all child welfare expenditures varied by county. In the three demonstration counties where the number of placement days increased by a large amount (a 43% waiver change in Philadelphia, 47% in Venango, and 59% in Dauphin), total OOH Placement costs increased as well. But, the proportion of OOH Placement costs to total child welfare expenditures only increased in Dauphin and Venango, indicating that OOH Placement expenditures rose at a greater rate than other child welfare expenditures in those two counties. Allegheny, Crawford, and Lackawanna saw a reduction in the total and proportion of OOH Placement costs when comparing the last observable fiscal year to the fiscal year immediately prior to the waiver.

However, all counties except for Venango saw a reduction in their average daily unit cost. This decline in average daily unit cost likely stems in part from a placement mix – a shift from more expensive care types (congregate care) to less costly placement types (kinship care). The proportion of kinship care days increased for each demonstration county when comparing their baseline year to SFY 2018, and this change occurred for both lower and higher kinship utilization counties, although the largest shifts did occur in counties with lower kinship utilization in SFY 2013.

One limitation to these fiscal findings is the lack of SFY 2018 for all counties and SFY 2017 for Philadelphia. So, although all trends discussed here present the majority of the fiscal activity during the waiver, there is one year of fiscal activity unobserved in the fiscal study. We do not anticipate that any major fiscal changes occurred during this time.

SUMMARIZATION, LESSONS LEARNED, NEXT STEPS

Summary

Overarching Research Methodology

The CWDP evaluation tests the hypothesis that the flexible use of Title IV-E funds to develop a new case practice model focused on family engagement, structured assessment, and the expanded use of EBPs will lead to improved safety, permanency, and well-being outcomes for children and families involved in the child welfare system. The evaluation uses a convergent mixed methods approach, combining qualitative and quantitative data collection and analysis at the same time, followed by comparing and relating the findings, which then are used for interpretation.

Process Evaluation Questions

- Do expected/necessary structures, roles, and relationships exist at the county and state level to support family engagement strategies, assessment and EBPs?
- To what degree do the drivers of successful program implementation exist?
- Are families being assessed for strengths and needs?
    - Is this an ongoing process of assessment?
    - How are assessments being used?
- Are families engaged in the conference process?
    - Are conferences held with fidelity to the five core elements (facilitation by neutral staff; effective partnerships; outreach to kin/supports; families prepared; meaningful services identified)?
    - How are conferences being used in order to achieve the goals of the waiver?

Process Evaluation: Major Findings to Date: ***Updates since the interim.***

- Multiple significant state-wide and county-specific policy and organizational changes occurred during these first two years of the CWDP. These included changes in leadership at the state and county levels, amendments to the Child Protection Services Law, implementation of the first phase of Pennsylvania's Child Welfare Information Solution (CWIS), and numerous county-level CWDP team changes. These changes have impacted not only the implementation of the CWDP, but have also affected the evaluation. ***The consequences of these changes, particularly the Child Protection Services Law continued to be felt to the end of the waiver evaluation period.***
- Leadership in participating counties generally made the necessary structural changes in order to accommodate the new practice model of assessment and engagement. This ranged from reorganizing staff to creating new positions to revising job descriptions. Evidence based practice collaboration however was challenging. ***Some counties were able to make structural changes (e.g., new positions to facilitate referrals), but communication between CYF, providers, and other systems was challenging.***

- While many of the necessary communication and leadership activities occurred early in the development and installation of the CWDP, two groups stood out as having gaps in their understanding of the project. First, while many direct service staff (e.g., supervisors and caseworkers) could articulate some of the overarching goals and/or knew that a practice change was part of the CWDP, there was often little understanding of the project as a whole and how the specific activities fit with the projected outcomes. Second, legal and JPO informants, while potentially the most influential in terms of external stakeholders, were the least likely to know about the CWDP or to have only a superficial understanding of it; as such they didn't necessarily understand the need for collaboration. ***This was unchanged at the end of the waiver.***
- Multiple data sources (i.e., focus groups, key informant interviews, ORC survey) revealed a child welfare workforce that perceived communication from leadership to be low, while simultaneously experiencing a high level of stress in the work climate, as workers were training on new assessments and engagement practices. Additionally, there was some wariness about the practice shifts, as many workers anticipated that these new practices would be replaced by other new practices in another few years***. While turnover was frequently cited as a challenge, in some ways it was beneficial, because it was easier for new workers to accept the practice model, as they had no experience with previous practice models.***
- Early implementation was more challenging and took longer than anticipated with all three interventions. Counties struggled to scale up assessment and family engagement during the early implementation of the project, and then faced similar challenges with EBPs. While EBPs are in place in many of the counties, there are instances where providers are still being sought; additionally, referrals to EBPs are slow to be made. ***This was unchanged at the end of the waiver, although implementation of a few EBPs was more successful in some counties.***
- Training and coaching occurred fairly systematically for both assessment and engagement, but workers were often frustrated by the difficulty in achieving competence in the CANS/FAST assessments, and many struggled with how to utilize the assessments in practice (e.g., how to have "conversations" with the family in a manner congruent with the assessment process*). **Ongoing challenges were the quality of the assessments and their use in planning. Facilitators and coordinators of family groups wished for more coaching and training in how to work with families who were reluctant to participate in engagement.***
- The workforce (supervisors and caseworkers) had an overall positive attitude towards EBPs. Caseworkers turned to their co-workers and supervisors as sources of information to make referrals to services and supports for the families on their caseload. However, there was a high degree of variation among the counties in terms of the ease of referring families to services. Some of the barriers to referral had easy "fixes" such as lacking a form or number to call, whereas others, such as family "not meeting requirement", suggest that other systems play a role in what services families and children are eligible to receive.
- Families and children were assessed using the CANS, FAST, ASQ, and ASQ: SE with variation among the counties. This variation in assessment is due primarily to the different policies for assessment. ***Overall volume of assessments increased over the waiver period. Quality of the assessments was not directly evaluated, although the SPANS process did***

identify that case workers focused more on safety and risk and less on aspects of well-being. The SPANS process also identified instances of "underscoring" of items that records indicate should be a "need". Whether this was due to (1) lack of understanding of the assessment; (2) inadvertent underscoring due to time constraints; (3) insufficient attention at the supervisor level is unclear.

- Parents or family attended the conference the majority of the time. The percentage of family and friends at the initial conferences was generally greater than that of professionals, but there was some variation across counties.
  - Initial conferences seemed to be less focused on diverting from CYS and more focused on engaging with families for the purpose of creating a plan once they were accepted for CYS services, with the children living in the home, or out of the home. ***This remained consistent throughout the evaluation period.***
- Fidelity to the family conferencing models, as measured by a participant survey, as well as a sub-sample of observations, was strong. Further, fidelity remained fairly constant over the duration of the entire waiver period.

Outcome Evaluation Questions

- Are conferences and assessment having an impact on outcomes such as children remaining safely in-home, or if placed out-of-home, into settings of lesser restriction?
- What is the trajectory for children who come to the attention of the child welfare system for the first time with a substantiated allegation?

Outcome Evaluation: Findings to Date

Consistent with the interim findings, analyzing the counties individually was critical to understanding the impact of the waiver on child-level outcomes. Therefore, these questions must be looked at individually by county.

Lacking a true control group at the system level, the county-level child welfare outcomes analysis employed longitudinal cohorts, comparing outcome performance between pre-waiver and waiver groups. This historical comparison is unable to scientifically support or refute a hypothesis of improved outcomes due specifically to waiver efforts and initiatives. However, the findings provide a descriptive look at the way outcomes have changed over time, and in conjunction with process study information provide a framework for understanding how flexible funding may have changed the practice model. It is important to note that due to the lack of pre-waiver data, Dauphin was excluded from the maltreatment analysis, and Venango was excluded from the placement analyses. Crawford entered into the CWDP a year later than the other counties, and as such, SFY 2014 data is excluded from Crawford's waiver cohorts. Methods, data details, outcomes, and outcome-specific cohorts are detailed in the report within the outcome study section.

Results

- Safety - Maltreatment recurrence within 6 months of first substantiation
    - All counties experienced increases in re-occurrence of maltreatment within 6 months of first substantiation. This ranged from an increase of 7.0% in Crawford to 1.2% and 1.3% in Allegheny and Lackawanna, respectively.
    - Logistic regression findings showed increased odds of reoccurrence at the .05 level of significance for Allegheny, Crawford, and Philadelphia.
- Safety - Placement within 6 months of first substantiation of maltreatment
    - All counties saw small shifts in this outcome with the likelihood of placement either remaining the same (Allegheny), increasing slightly (Lackawanna), or decreasing slightly (about 2% for Crawford and Philadelphia).
    - The decreased likelihood of a placement following maltreatment was significant for Crawford ($OR=0.67$, $p<.05$) and Philadelphia ($OR=0.86$, $p<.05$).
- Least restrictive placement - Likelihood of a first admission being placed in kinship care
    - The likelihood of entering a kinship placement as a first placement increased for all waiver counties for which we had data, ranging from a 4% increase in Dauphin to a 20% increase in Lackawanna. This increased use of initial kinship foster care for first entry children/youth is the strongest cross-county outcome difference observed during the waiver period.
    - The likelihood of entering kinship care significantly increased for Allegheny and Lackawanna ($OR=1.86$, $p<.05$) and Philadelphia ($OR=1.42$, $p<.05$).
- Least restrictive placement – Likelihood of a first admission being placed in congregate care
    - This decreased for all counties for which we had data, with Dauphin as the exception (Dauphin increased use of congregate care by 7%). Some counties that had high percentages pre-waiver (Crawford at 34%; 22% Allegheny; 27% Philadelphia) experienced decreases ranging from 11% and 8%. Lackawanna had a low percentage pre-waiver of approximately 5%, which decreased to approximately 4%. This is not a clear cross-county change, but it is trending in the direction of less congregate care usage for first placements.
    - The likelihood of a first admission being placed in congregate care decreased by half for Allegheny and Philadelphia ($OR=0.50$ and 0.59, respectively) and increased two times for Dauphin ($OR=2.04$). These were significant at the .05 level.

- Stability - Moving within 6 months of a first placement
    - For the counties for which we had data, all had reductions of movement within the 6 months of a first placement, thus improving early stability. However, despite seeing reductions in movement, the percentage of children moving within 6 months remained high (35% - 61%).
    - The likelihood of moving within 6 months was significantly reduced in Dauphin (OR=.58), Allegheny (OR=.77), and Philadelphia (OR=.85) at the .05 level.

- Permanency - Exiting within 6 months and 12 months of first placement
    - This was a mixed finding across counties. Dauphin and Lackawanna increased the percentages who left within the first six months whereas Philadelphia, Crawford, and Allegheny reported lower percentages leaving at 6 months post waiver than in the pre-waiver period. This same pattern was observed for exiting within 12 months.
        - The odds of leaving within 6 months was significantly increased for Dauphin (OR=1.58, $p<.05$) but reduced for Allegheny and Philadelphia (OR= 0.76 and OR=0.91, respectively). These two counties, along with Crawford, also saw a significant decreased in the odds of leaving within 12 months.

- Permanency - Reentering care within one year of exit from first admission
    - Allegheny and Philadelphia experienced no change in re-entry within a year, and Lackawanna had approximately a 5% decrease in re-entry. Crawford experienced a slight increase (approximately 5%) and Dauphin had a 13% increase.
    - The likelihood for re-entering care was 35 times greater for Dauphin. No other odds ratios were significant.

Placement rates, county, and age were examined using linear regression, with a significance level of .05. Philadelphia and Dauphin had significantly higher overall placement rates. However, placement rate changes differed by age of entrants. When placement is drilled down by first admissions by age group, in Philadelphia, all age groups except teens showed a significant increase in placement rate while the teens show a reduced, if non-significant, reduction. Dauphin had significantly high placement rate for the 1 to 5 year olds. Significantly lower placement rates were observed for 13-17 year olds for Allegheny and Lackawanna.

Fiscal Evaluation Questions

- Do expenditure patterns for out-of-home care change over the five years of the CWDP, and if so, were the changes related to unit costs, care days or both?
- Does the ratio out-of-home care spending to spending for prevention and family preservation decrease over the five years of the CWDP?

Fiscal Evaluation: Findings to Date

- One limitation to these fiscal findings is the lack of SFY 2018 for all counties and SFY 2017 for Philadelphia. Therefore, although all trends discussed here present the majority of the fiscal activity during the waiver, there is one year of fiscal activity unobserved in the fiscal study. The fiscal study allows us to make a few fundamental statements about the county fiscal experience and decision-making process.
    - First, all demonstration counties increased total child welfare expenditures during the waiver. Even when controlling for inflation, counties increased total expenditures by 2 to 23%. Furthermore, all six-demonstration counties saw an increase in All Other CW expenses (from 9% in Philadelphia to 37% in Crawford) through the last observable fiscal year that points towards all counties investing in greater capacity and/or new interventions during the waiver.
    - However, the trends in OOH Placement costs varied by county. In the three demonstration counties where the number of placement days increased by a large amount (a 43% waiver change in Philadelphia, 47% in Venango, and 59% in Dauphin), total OOH Placement costs increased as well. However, the proportion of OOH Placement costs to total child welfare expenditures only increased in Dauphin and Venango, indicating that OOH Placement expenditures rose at a greater rate than other child welfare expenditures in those two counties.
    - Allegheny, Crawford, and Lackawanna saw a reduction in the total and proportion of OOH Placement costs when comparing the last observable fiscal year to the fiscal year immediately prior to the waiver. We were unable to answer the question about the ratio of prevention services to out-of-home costs because we were unable to obtain service data (as documented in the semi-annual progress reports).
- However, all counties except for Venango saw a reduction in their average daily unit cost. This decline in average daily unit cost likely stems in part from a placement mix – a shift from more expensive care types (congregate care) to less costly placement types (kinship care). The proportion of kinship care days increased for each demonstration county when comparing their baseline year to SFY 2018, and this change occurred for both lower and higher kinship utilization counties, although the largest shifts did occur in counties with lower kinship utilization in SFY 2013.
- Looking at both placement days and cost per day is critical. Increasing the days in out-of home-care while decreasing the costs may be a financial win but is not necessarily a win for children and families.

Programmatic/Implementation Lessons Learned and Recommendations

Overall project management

Pennsylvania's CWDP had an ambitious agenda: to change the child welfare practice model and to broadly include all IV-E eligible children. To achieve this agenda, counties had to change how they engaged with their staff, while their staff changed how they engaged with families; and the state had to change in terms of management and infrastructure. Consistent with the interim report, the communication among counties and between counties and the OCYF never progressed beyond what was observed in the first years of planning and implementation of the waiver.

- Any new multi-system collaboration requires a manager for system-barrier "busting", ongoing communication between the OCYF and counties and leadership of the collaboration itself. In other words, collaboration itself should be treated as an intervention and staffed accordingly. Future collaborative efforts should be intentional about including this position.

Assessment

The interim and final evaluation findings confirmed that assessment practices were in place but not consistent, nor of quality. The SPANS found that many well-being elements were not included in planning for families.

- A suggestion for future projects and/or jurisdictions might be to develop a statewide training and quality assurance office (e.g., like the State of Tennessee's, which partners with Vanderbilt University) for ongoing training, quality assurance, and supervision of assessment.
- It might be beneficial to target casework supervisors as the "keepers" of functional assessment, by not only giving them training and coaching, but also rewarding them for leadership in quality assessment practices in their units.

Family Engagement

Conferences were consistently in place; training and coaching on engagement was evident, but the potential of combining assessment and engagement to change placement practice was not fully in place. This remains the same at the final evaluation, although some counties have made progress in combining assessment and engagement.

- At the end of the waiver, conferences are still primarily being used to create or monitor family service plans. While this is an important and valuable use of conferences, counties might do well to consider their value in other areas, such as diversion.

Evidence-Based Practices

EBPs are in place in many of the counties.

- Timeframes for EBP implementation were ambitious and took longer than anticipated to be implemented, and some were implemented and then discontinued (e.g., MST in Allegheny).

- We learned from the EBPQ that caseworkers go most often to their colleagues for recommendations on services for families. Additionally, caseworker attitudes and behaviors toward EBPs stayed fairly constant over the course of the waiver, in that they were generally only likely to refer to EBPs if they were mandated to do so, otherwise opting to rely on their clinical judgment and/or recommendations from their peers. Counties may want to incorporate training and education for caseworkers on EBPs – what they are, who can benefit from them, etc. This could help to strengthen the knowledge-base of these peer networks.

Evaluation Lessons Learned and Recommendations *for the Post-Waiver World*

- *The state climate had an impact on both implementation and evaluation.* In the first two years, the tensions between the Governor and the General Assembly impacted the evaluation, primarily in those counties where administrators and providers are focused on finding ways to serve families when the political vision is fractured and the funding future is unclear. As a result, they had less time or energy to spend on the evaluation and several have delayed starting EBPs or left leadership roles. ***By the end of the evaluation, the political climate had stabilized, but the changing leadership in the early years impacted the degree to which people were open to learning what the evaluation offered in the last two years. The lack of investment up-front due to leaders who came in mid-evaluation impacted how the evaluation impacted practice. Going forward with new system-wide initiatives, the state and counties should think carefully about succession planning in leadership of these initiatives.***
- *The process evaluation has provided invaluable information*. While it has been time- and resource-intensive for the evaluation team, it provided useful contextual data that informed the rest of the evaluation and in some counties, the practice. ***We encourage the state to continue to collect process data in addition to outcome data in evaluating the impact of families first and the installation of EBPs. In addition, as inter-system collaboration will be part of Family First interventions, measuring collaboration as an outcome should be part of any evaluation plan.***
- *Obtaining high-quality, timely data has been a challenge in all components of the evaluation.*
    - There have been numerous changes in county information systems, challenging both the counties and the evaluation team when obtaining data about maltreatment and placement. Historical data is frequently lost when these changes are made. Counties need to be aware of this when contemplating and making changes in their information systems. ***While this was reduced in the last two years, ongoing tweaks continued to create information system challenges.***
    - The evaluation team struggled until the end obtain clean, accurate, timely data files from the counties, particularly for the assessment data, which impacts what we can do with our time and resources. ***In the last two years we did spend more time and energy working on getting family engagement data back to counties, as well as dissemination of findings, with an emphasis on usable and actionable information. While it was our hope that after this interim report and communication of the findings, counties will see the value of providing these data and that less effort will be needed for routine data activities.***

- The two larger counties have struggled to meet their projected sample numbers for the family engagement study and we have had some concerns about data quality. Since these two counties opted to utilize a stratified sample for this part of the project, the required forms are not completed for every conference. As such, the learning curve for relevant staff has been steeper than in other counties in terms of how to complete the forms. Utilizing a smaller sample also necessitates that the data that are submitted is of the highest quality possible***. Neither Allegheny nor Philadelphia achieved the N of their sampling plans. Any evaluation of their practices in the future will need to consider the challenge of collecting data in large volume.***

- ***Without a SACWIS, Pennsylvania will continue to struggle to implement new practices because it is without a standard way of measuring processes and impact in a "real time" manner. In addition, as the differences between counties was observed, it is critical that the OCYF identify standard outcomes (e.g., length of stay, first placements; as done in the outcome evaluation) and monitor those at the county, regional, and state levels.***

- *Some of the counties have more limited resources in terms of understanding and utilizing the foster care profiles and abuse and neglect trajectories; there has been a steep learning curve in some counties.* We anticipate that this will be easier with the next round of data, as it won't be as novel; we also continue to encourage counties to participate in Chapin Hall's data analytic workshops so that they have at least one staff member who has a more in-depth understanding of how useful this information can be in planning and evaluation. However, several of the county-level staff that were trained at the workshops in the first two years of the waiver have subsequently left for other employment, so this requires an ongoing outreach to counties and encouraging them to attend the workshops in order to ensure this kind of resource remains at the county. ***We were able to hold several "data slams" and ongoing learning opportunities for leadership. Understanding the profiles did become easier over time for the leadership. Directors and staff were better able to understand the differences between different cohorts and what you could determine from those cohorts. However, this is an important area for growth for the state in terms of supporting data in a format other than point in time.***

- *Engaging families and youth in the evaluation in order to have consumer voice was very challenging.* We found it difficult to find families and youth who would participate in focus groups or interviews, despite collaboration with staff members in all counties who tried to help with recruitment. What worked in some counties (e.g., incentives, transportation) did not necessarily work in others. Given the other challenges that we faced in these final years, we were not able to focus any extra attention on this component, despite our firm belief that that including the voices of those who were served by this project was crucial. ***As parents and families become more engaged in conferencing and assessment there may be opportunities for advocacy and self-help groups, as well as practice improvement at the county level. It was a missing part to this waiver and evaluation. In addition, the overall growth in family conferencing along with kinship foster care suggests that the OCYF and the counties look at ways of supporting kin caregivers through navigation, psychoeducational groups and practical supports. As we were unable to talk with them, we cannot verify this as a need, but the research literature supports this recommendation.***

- *The interim findings confirmed the need for within-county analysis and between county analyses*. This was time-and resource-intensive for the evaluation team, but critical to inform practice changes and explaining outcomes. ***These differences persisted over time and the evaluation continued within and between counties. We recommend this strategy for similar jurisdictions.***
- *The low numbers of referrals to Triple P and PCIT present a challenge to the evaluation design and analysis plan of the impact of these EBPs.* An ongoing challenge for all CWDP counties is the lack of referrals to PCIT and/or Triple P services as part of the evaluation sub-study. Referrals for these two services was much lower in comparison to other EBP services (and compared to what counties projected their referral numbers would be). Consequently, this may mean that the evaluation will have a smaller than projected sample for determining EBP impact unless recruitment to PCIT and Triple P greatly increases in the next year of the waiver. The evaluators will need to revisit the evaluation design for this sub-study with JBA if the current situation continues. ***This was indeed the case at the end of the evaluation. As Family First is implemented, we will need to examine the reward structure for providers in order to obtain child level data. Additionally, it may be beneficial to explore alternative models of EBPs that have been developed since the waiver – for example, a home-based version of PCIT: Intensive Family Coaching as developed by Dr. Amy Herschell in Pennsylvania.***

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