ProtectOHIO
Final Evaluation Report

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ProtectOHIO Final Evaluation Report: Ohio's Title IV-E Waiver Demonstration Project

Covering the Third Waiver Period, 2010-2015

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Background and Context

The child welfare waiver demonstration authority provides states with an opportunity to address the prevailing belief that restricting IV-E funds to foster care incentivizes foster care as a placement option, which is in direct conflict to an extensive amount of research that suggests that keeping children in their homes or placing them in the care of relatives is in the best interest of the child.[1] States implementing waiver demonstrations are able to use IV-E funds – traditionally allocated for foster care services – flexibly to explore innovative approaches for services and supports that promote safety, permanency, and well-being for children involved in child protective services. Ohio was one of the first states to implement a waiver demonstration in 1997. It has operated continuously since then, providing a unique context for understanding both the short and long term impacts of flexible funding on service delivery systems and child- and family-level outcomes.

Child welfare agencies in Ohio are county-administered with state oversight and are therefore relatively autonomous in their decisions. Out of the 88 Ohio counties, 14 volunteered to join the demonstration in 1997 and, because of their shared belief that this shift in practice would increase the safety and well-being of families involved in Ohio's child welfare system, named the demonstration "ProtectOHIO." During the second waiver period an additional 4 counties joined the demonstration, and during the third waiver period, one of those same counties made the decision to withdraw. One additional county withdrew from the waiver due to a merger with a non-ProtectOHIO county agency, bringing the total number of demonstration counties to 16.

Ohio's waiver has now been operating continuously through three 5-year phases punctuated with a 2-year funding bridge. Over the three waiver periods, ProtectOHIO's practice focus has become increasingly targeted and well-defined. The first waiver period, 1997-2002, allowed the participating counties maximum flexibility in how they chose to use the federal funds; the second waiver period, 2004-2009, targeted waiver activities to five intervention strategies, with each county required to implement the core intervention, Family Team Meetings (FTM), and at least one other. The third waiver period, which is the explicit focus of this evaluation report, further narrowed the focus to just two strategies: FTM and Kinship Supports.

This executive summary documents the results of the evaluation of Ohio's third waiver period.

Evaluation Design

The evaluation examines the effectiveness of flexible funding through three required studies – a Process, Fiscal, and Outcomes Study, with the goal of answering four key questions:

1. How have demonstration counties made organizational and practice changes, compared to the group of comparison counties?
2. In what ways have the demonstration counties varied in their implementation of waiver activities, compared to each other?

[1] Metzger, 2008, Doyle, 2007

3. How have agency expenditure patterns changed, in demonstration counties compared to comparison counties?
4. In what ways do the interventions specifically and waiver flexibility overall impact outcomes for children and families involved in Ohio's waiver compared to similar children and families in comparison counties?

Answers come first from the analyses of ProtectOHIO's two targeted intervention approaches – FTM and Kinship Supports—which seek to understand the specific effects of these strategies for families and children. In addition a Trajectory Analysis and a Placement Outcomes Analysis seek to understand the "waiver effect," or the difference in child outcomes that occur as a result of flexible funding, regardless of whether the families or children received the FTM or Kinship Supports interventions.

The evaluation of ProtectOHIO uses a quasi-experimental design, comparing practices and outcomes in the 16 demonstration counties and 16 similar comparison counties located throughout Ohio with a target population of all children served by the participating Public Children Services Agencies (PCSA).

Process Study: State and County Context

The following describes the context in which counties implemented the waiver strategies. It should be noted that process information related specifically to the FTM and Kinship Supports interventions is located within the FTM and Kinship specific sections of the Executive Summary.

Social, Economic and PCSA Context

During the course of the waiver, the study team gathered qualitative data through online surveys as well as in-person site visits and telephone interviews conducted in 2012 and again in 2014. Directors, supervisors, and caseworkers were asked questions about the local context in which their agencies operated and the impact it had on their respective agencies and casework. The following provides highlights of some of the responses to our questions.

Economic Environment

Both the PCSAs and the families they serve were impacted by the 2008 – 2012 global recession; poverty rates in Ohio remained above the national average from that period through 2014[2], causing strains on social service systems. As a result several counties decided to combine their freestanding Children Services Board with the local Department of Job and Family Services, and several clusters of counties in the state opted to merge their Job & Family Services operations together.

In Ohio, some PCSAs rely heavily on local levies to supplement state and federal funding. Many of these levies were on the ballot for renewal in 2014, which caused agencies some concern toward the conclusion of the waiver. Although all counties with levies managed to maintain them, actual dollars contributed to Children's Services decreased due to decreasing property values. Further, in some counties this decrease in actual dollars was exacerbated by increasing agency costs related to the utilization of out-of-network foster homes and increasing provider rates. The combination of these

[2] The most recent, annual poverty data supplied through the U.S. Census Bureau continues only as far as 2014

expenditure increases and revenue decreases resulted in continued fiscal austerity for some PCSAs throughout the waiver.

Substance Abuse

Staff from the majority of PCSAs reported an uptick in substance use (particularly, opiates) within their counties, which some attributed to the increased poverty being experienced across the state. As a result agencies saw an increase in the number of infants born with signs of opiate addiction, causing an increase in placement rates in some counties. At least one county described a shift in resources – having to spend more casework time and money on substance-affected families, increasing the pressure on ongoing workers and units.

Changes in PCSA Staffing

Across the third waiver period the majority of demonstration and comparison counties experienced staff turnover. In 2012, midway through the third waiver period, 11 demonstration and 10 comparison counties described major staffing changes among experienced top managers and agency directors, attributed in part to changes in state retirement benefits. While 3 additional demonstration counties experienced major changes among top level leadership staff in 2014, the majority of PCSAs reported increased leadership stability toward the end of the third waiver period.

Caseworker turnover was also experienced in ways that were distinct from normal retirement or attrition. This was attributed in part to changing leadership, low pay, and high case/workloads resulting in worker stress and burnout. Turnover resulted in some loss of experienced staff, and since new staff carry lower caseloads during their extensive training period, additional strain was placed on the more experienced staff. However, in several counties, staff turnover resulted in the hiring of new caseworkers who were enthusiastic about and bought into the FTM and Kinship Supports interventions.

Service Array and Other Initiatives

Several counties opted to continue ProtectOHIO interventions that had been implemented during the first and second waiver periods in addition to the two core strategies of FTM and Kinship Supports that were implemented by all counties during the third waiver period.

Enhanced Visitation was continued by three counties. This initiative was designed to help parents tailor activities during visits to their specific family needs. All three counties adjusted their model during the third waiver period: one county developed a visitation unit; one county moved its program in-house, increased visitation length, and began providing in-home visits; one county began contracting out for visitation services, increased visitation length, and began providing a visitation orientation for parents. These three counties decided to continue enhanced visitation as a ProtectOHIO intervention for a variety of reasons:

- The opportunity to continue to offer a homelike setting where families can have positive meetings with their children
- Families can be stepped down more easily to less restrictive hours and visitation locations
- Specialized visitation staff
- Opportunity for longer visits

- Mechanism for identifying baseline behaviors and opportunity to coach parents

Enhanced Mental Health and Substance Abuse Services was continued by two counties. This initiative is characterized by drug screenings and referrals to behavioral health providers for in-home assessments; however, one county later discontinued the intervention because the contracted community agency changed ownership, at which point the services no longer resembled those initially provided. A drug court component within this agency continues, but the county does not view that as a ProtectOHIO intervention.

Managed Care was continued by one county. Under this intervention waiver funds are used to contract with private agencies that serve a portion of the ongoing services caseload. The goal is to enhance system efficiency and effectiveness by relieving pressure on ongoing services caseloads. The county made three important changes over the course of the third waiver period: (1) it established a Performance Incentive Program, with each agency receiving a full or partial bonus depending on how closely it meets seven measures related to contact, safety, permanency, and reunification; (2) the contractors now keep the PPLA cases until they close and the PC cases until the parental rights are terminated and the case transfers to adoption,; and (3) if the case needs to be reopened within 24 months it is now returned to the original contractor (without additional payment).

Over the course of the past 5 years several additional, non-ProtectOHIO initiatives were implemented in demonstration and comparison counties. These included, but were not limited to:

- Permanency Roundtables
- Wendy's Wonderful Kids
- Safe Teams
- Intensive Reunification
- Strengthening Families
- Family Search or Family Finding
- Drug Court
- School-based staffing

One of the most commonly discussed and implemented new initiatives was the Ohio Fatherhood Initiative (implemented in 10 demonstration and 5 comparison counties), which is designed to increase the inclusion and engagement of fathers' involvement in child welfare cases.

In addition to the implementation of the above programs the major systematic change across the state was the completed roll-out of Differential Response. This two-track system has been whole heartedly embraced by some counties while it is viewed with some reticence by others. There is similar variation in community buy-in for the initiative from the courts, local law enforcement and schools.

The integration of Differential Response resulted in agency structural changes in many demonstration and comparison counties, with some county agencies requiring Alternative Response (AR) cases to be served by one caseworker throughout the entirety of the case. In at least 6 of the demonstration counties AR workers are housed in AR-only units. Across the demonstration counties that had implemented DR through 2012, nearly all noted that changes had occurred in intake; certain workers carried cases a little longer, thereby reducing the need to open the case to ongoing services. In 2012, 9

demonstration counties and 5 comparison counties said they expected or had already seen a decrease in cases transferring to ongoing services. And in 2014, 4 of the demonstration and 5 of the comparison counties suggested that diversion of families to the AR pathway had resulted in a decrease in the number of families being transferred to ongoing services.

Cultural Responsiveness

County agencies in Ohio work with diverse families; during 2014 site visits, staff mentioned engaging with Amish, Appalachian, Latino, African American and African refugee families. These counties implemented various tools and practices to enhance their cultural competency, including:

- Staff trainings on diversity and culture
- Adapting hiring practices to reflect diversity of clients
- Using internal practices to ensure staff of color feel safe
- Commissioning a third-party survey of closed cases to assess how culturally responsive the agency is, and
- Adjusting agency policies to account for culture.

Several counties noted that the flexibility embedded within the ProtectOHIO strategies allows practices to be individualized to accommodate family culture.

ProtectOHIO and Well-Being

Although child and family well-being has always been a focus in demonstration counties, more attention was given to ways in which this could be independently measured and assessed during the third waiver period. As a result a pilot well-being study was implemented in July 2014 in 10 of the demonstration counties to:

1. Assess the impact of ProtectOHIO on child and family well-being, and
2. Assess the feasibility of the inclusion of a well-being tool in future practice.

Using portions of the Child and Adolescent Needs and Strengths (CANS) Comprehensive and Child Welfare assessments, data were gathered during the initial FTM and again at the 3rd FTM or at case close, whichever occurred first, by facilitators. During the pilot, data were collected for 52 children and 77 caregivers. Although the numbers were relatively limited in size several interesting results were obtained.

For children, well-being increased significantly in the following domains:

- School attendance
- Community life
- Relation permanence
- Well-being.

For caregivers, well-being increased significantly in the following domains:

- Knowledge
- Organization
- Substance use.

Staff did not find the process overly burdensome—a concern at the start of the pilot— but had reservations about the usefulness of the tool for practice. The pilot was completed in January 2015; at that time, considering the reservations of the usefulness of the tool, the Consortium made the decision not to proceed with expanding upon the well-being pilot.

County Exit from the Waiver

One demonstration county withdrew from the waiver toward the end of the third waiver period. The request was made due to high caseloads and radically increased placement days. During the economic recession a major employer in the county laid off 19% of the county population. Staff believe this contributed to the increased drug use and child welfare involvement in the county. In this relatively small county staff described out-of-home placements as being twice as high as when the county had first entered the waiver. And Intergenerational substance use was limiting the ability of the agency to place with kin.

Caseloads were also impacted and were considered to be a reason for extremely high staff turnover. At the time of the exit interviews in 2015, the entire ongoing unit was comprised of caseworkers who had been in their positions for no more than two months.

Waiver Strategies

Two core strategies were implemented as part of ProtectOHIO: Family Team Meetings and Kinship Supports. The process and outcomes components of the FTM intervention are presented first, this is followed by process and outcome findings related to the Kinship Supports intervention.

Family Team Meetings

Six research questions guide the evaluation of FTM under the ProtectOHIO waiver:

1. How is FTM implemented across the demonstration counties?
2. How does practice in demonstration counties compare to practice in comparison counties?
3. What level of fidelity to the ProtectOHIO model is achieved in demonstration counties?
4. What occurred across demonstration counties in regards to the volume and nature of FTM activity?
5. Do children and families receiving FTM in demonstration sites experience different outcomes than children and families with similar characteristics in comparison sites?
6. Do demonstration children and families receiving high-fidelity FTM experience different outcomes than children and families with similar characteristics in comparison sites?

These questions were answered using data from site visit PCSA interviews, parent focus groups, web-based surveys to FTM facilitators and caseworkers, data captured in a standalone system designed specifically for FTM related data entry, and State Automated Child Welfare Information System (SACWIS) data.

FTM Process Study

Refinement of Practice: In the third waiver period, the demonstration counties undertook several primary activities to promote a more consistent and informed FTM practice.

- Early on in the waiver period, a workgroup of FTM facilitators developed an FTM practice manual, outlining core components, fidelity measures, and detailed instructions related to all aspects of the model.
- Shortly after the completion of the manual, the Ohio Child Welfare Training Program (OCWTP) worked with several facilitators to develop a training based on the practice manual and on general facilitation skills; staff from all counties were formally trained by spring 2011.
- In 2013, data-entry for meeting-level information transitioned from the ProtectOHIO Data System (PODS) to SACWIS, allowing counties to more easily self-monitor implementation of the intervention.
- In 2014, a high fidelity subcommittee was established and made recommendations for FTM best practice.

In addition, as the third waiver period comes to a close, FTM facilitators are in the beginning stages of reviewing the practice manual with the goal of further refining practice and improving consistency in FTM implementation across agencies. Volunteer facilitators are also in early stages of working with OCWTP staff to develop a web-based training on the FTM practice manual.

Comparison County Practice: The core components of ProtectOHIO FTM include: 1) all cases that transfer to ongoing services are eligible to receive FTM, 2) meetings are led by a trained, neutral facilitator, 3) meetings include a range of participants, and 4) meetings are held on an ongoing basis throughout the life of the case. In a 2014 survey of comparison counties, administrators in nine counties indicated they are holding some sort of meeting that aligns with one or more components of the ProtectOHIO FTM model. However, only two comparison counties were implementing a practice very similar to ProtectOHIO FTM, in that all four core components listed above are utilized as a part of these counties' family meeting practices.

FTMs and Kinship Caregivers: Intersection of Strategies: PCSA staff noted an intersection between the two ProtectOHIO strategies. In many counties, the search for kin begins at the initial FTM. Once caregivers are identified, they are invited to FTMs. In 12 counties kinship staff are regularly invited to FTMs, and in five of these counties kinship staff can call an FTM or the caregiver can request an FTM through kinship staff. FTMs are also commonly used as a platform to meet caregivers' needs; staff noted they identify needed supports and services for caregivers during FTMs. Overall, staff indicated that both ProtectOHIO strategies accentuate family engagement and are underscored by an emphasis on least restrictive placements.

Barriers to and Strengths of the FTM Model: Ensuring parental attendance and family engagement in meetings remains a primary barrier to FTM practice, particularly when parents are actively abusing substances. Organizational or logistical challenges were also identified as barriers, including scheduling meetings, transportation issues, and lack of meeting space to meet FTM demand.

The most frequently cited strength of an FTM is the opportunity to use the meeting as a mechanism to "get everyone on the same page." The strengths-based approach that's inherent in FTMs was also indicated as a strength by both workers and parents who were interviewed. In general, buy-in to the model has increased since Ohio's second waiver period; facilitators and supervisors in the majority of counties indicated that caseworkers are on board and invested in the FTM model.

FTM Activity and Fidelity to the Model: The FTM study population includes cases that transferred to ongoing services and for which an initial FTM was held between Feb. 26, 2011 and Mar. 31, 2015. Overall, over 24,000 meetings were held for over 7,000 families and over 15,000 children. An average of 3 FTMs were held per family, over the study period.

During the study period, 89% of eligible cases received FTM, with individual counties serving between 63% and 100% of eligible cases.

The evaluation explored three specific fidelity components of the ProtectOHIO FTM model:

1. Initial FTM within 35 days of case opening
2. Subsequent FTMs held at least quarterly
3. Range of FTM participants: at minimum, one parent or primary caregiver, one PCSA staff, and one other type of person.

The majority of families had both their initial and subsequent meetings held on time: 80% of initial meetings were held on time, and approximately 75% of subsequent meetings were held on time. Ensuring that a range of attendees is present proved to be more challenging. Initial meetings were more likely than subsequent meetings to include the minimum grouping of attendees (53% at initial FTMs, versus 46% and 48% at second and third FTMs, respectively). When case-level fidelity was examined, 18% of families were found to have received high-fidelity FTM, 24% of families received medium-fidelity FTM, and 58% of families received low-fidelity FTM.

FTM Outcomes Study

In the FTM outcomes analysis propensity scores were used to adjust for difference between families and children in demonstration counties who received FTMS and their counterparts in comparison counties. To construct propensity scores demographic, historical and family assessment information were used. The complex samples module in SPSS was used to account for clustering of families within counties. For each analysis, outcomes were assessed for all families and/or children who received FTM and then again for families who had received FTM with high fidelity. Primary outcomes findings included:

- Significant differences in length of case for demonstration families experiencing FTMs with high fidelity when compared with their comparison county counterparts. The median time to case close for high fidelity demonstration families was approximately 140 days (CI approx. = 110 to 240), while for comparison cases it was approximately 290 (CI approx. = 210 to 460).
- No differences were found in the likelihood of cases having a substantiated or indicated re-report within 6, 12 or 18 months of the families' transfer to ongoing services, nor within 6, 12 or 18 months of the case closing, regardless of level of fidelity.
- No differences were found in proportions of children entering out-of-home care regardless of fidelity level.

- Significantly more children in demonstration counties were placed with kin as their first, last and longest placement if placed in out-of-home care, regardless of fidelity level,
- No differences were found between demonstration and comparison children exiting to reunification, custody to kin, adoption, emancipation or aging out regardless of fidelity level.
- No differences were found between demonstration and comparison children in their length of stay in out-of-home care regardless of fidelity level.
- Significant differences were found between demonstration children and comparison children in the likelihood of re-entry into out-of-home care after the initial placement ended. Demonstration children were significantly less likely to experience re-entry into out-of-home care within 6, 12 and 18 months.

In summary, demonstration families experiencing high fidelity FTMs had shorter case episodes on average. Children in FTM families remained no more or less safe than their comparison counterparts. If placed in out-of-home care, demonstration children were more likely to be placed with kin and less likely to experience re-entry into placement after the placement ended.

Kinship Supports Intervention

Five research questions guide the evaluation of Kinship Supports under the ProtectOHIO waiver:

1. How is the intervention implemented across the demonstration counties?
2. How do the intervention efforts in the demonstration counties differ from the various kinship support efforts in the comparison counties?
3. What level of fidelity to the ProtectOHIO kinship supports model is achieved in demonstration counties?
4. Do children receiving the intervention experience different outcomes than children with similar characteristics in comparison counties?
5. Do children receiving the intervention with varying service model types experience different outcomes than children with similar characteristics in comparison counties?

Kinship Supports Process Study

Refinement of Practice: The intervention builds upon an initial intervention employed by six counties during Ohio's second waiver period. At that time, the aim was simply to increase the use of kinship settings for children in those counties. The third waiver period marked an expansion of the intervention to all 16 counties. Demonstration counties carried out several primary activities to promote consistent and informed practice:

- In 2011, a workgroup of designated kinship staff developed an intervention practice manual, outlining core components, fidelity measures, and detailed instructions related to all aspects of the waiver.
- A kinship workgroup with representatives from all 16 demonstration counties meets quarterly to discuss practice, policy, and data collection challenges.
- OCWTP developed a training based on the practice manual and the general needs of kinship caregivers; staff from all demonstration counties were trained by spring 2013.

- In 2015, OCWTP developed a web-based training entitled "Implementing the ProtectOHIO Kinship Manual," allowing for immediate training of any newly hired staff.

In addition, as the third waiver period came to a close, the kinship workgroup began discussions about consistently implementing the caregiver support plan component of the intervention, one of the more loosely defined model components at this time. The workgroup is also in discussions with SACWIS staff regarding building a kinship module in SACWIS.

Kinship Supports Intervention Direct Service Models: While all demonstration counties have a designated kinship expert and have ensured that all direct and indirect model components listed in the manual are occurring, three primary direct service models have been implemented across the demonstration counties: a two-worker model, a one-worker model, and a hybrid approach.

- **Two-Worker Model:** In this model, implemented by six demonstration counties, all kin caregivers have a kinship specific staff member that provides ongoing support in addition to the ongoing caseworker assigned to the case. The ongoing caseworker follows the traditional child welfare model of working a reunification plan with the biological parents, and also supporting the kin caregiver to the extent that he or she can, while the primary responsibility of the designated kinship staff is to support the caregiver. This model represents the most significant variance from practice as usual.
- **One-Worker Model:** In this model, implemented by four demonstration counties, ongoing caseworkers assigned to the case are the primary source of support for both biological parents and kin caregivers. This approach is not practice as usual, because the agency has a kinship expert and caseworkers may be trained on the intervention; however, it is the model most closely aligned with practice as usual.
- **Hybrid Approach**: In this approach, implemented in six demonstration counties, designated kinship staff may act as an additional, kinship specific resource for caregivers on a case-by-case or as-needed basis, depending on staff capacity or the level of caregiver need. In these counties, caregivers may have varying experiences of the model; depending on the caregiver there may or may not be a secondary staff member beyond the ongoing caseworker to provide kinship-specific support.

Comparison County Practice: There appears to be a much greater emphasis on kinship care overall in demonstration counties than in comparison counties. Whereas all demonstration counties have, at a minimum, a designated kinship expert, only a quarter of comparison counties indicated they have staff dedicated to serving kin in some capacity beyond home studies.

Case Services Utilization: Although there were limitations to the case services data in SACWIS, the results of the analyses suggested that demonstration county staff provided significantly more services to kinship families than comparison county staff. And, the types of services provided to kinship families varied substantially between demonstration and comparison counties. Among comparison counties, the most common non-case management service provided to kin families was Independent Living/Transitional services. By contrast, the most common non-case management service provided to kin families in demonstration counties was financial support, likely a result of IV-E waiver flexibility.

Challenges and Successes: While the majority of staff have noted an increased focus on kinship practice and finding the best possible kinship placement, staff in some counties have noted that their agencies may not be bought into the kinship intervention, or kinship placements in general. And, staff in a few counties have noted that staffing and capacity issues present barriers.

Alternatively, staff in several counties noted that managers and supervisors support kinship staff by emphasizing the importance of kin care and encouraging the use of kin care. Caregivers interviewed noted the two primary benefits of the intervention were designated kin staff, who were viewed as accessible and supportive, and services and supports. Staff agreed; across demonstration counties staff emphasized the benefits of having the ability to provide caregivers with assistance in ways they would not otherwise be able to do without ProtectOHIO – that is, providing the types of assistance that foster parents would be eligible for under the traditional federal funding stream – such as beds, child care assistance, and financial support.

Kinship Activity, Fidelity to the Model, and Family Resource Scale Findings: The intervention served over 2,700 kinship households, reaching approximately 60% of all eligible kinship families. The Home Assessment Parts I and II, which are used to ensure that caregivers can support the child in their care, were completed for nearly every kinship household served (97% and 90%, respectively). The Family Resource Scale (FRS), an assessment used to identify needed services and caregiver strengths, was also completed for the majority of kinship households served (89%).

A smaller proportion of families received the assessments within 35 days of placement, the formal fidelity marker: 69% of kinship households received Part I on time, 59% of kinship households received Part II on time and 59% of families received their initial FRS assessment on time. Follow-up FRS assessments are intended to be completed quarterly; however, fewer families received follow-up FRSs. Overall, 56% of eligible families received a second assessment, 43% of eligible families received a third assessment, and 35% of families received a fourth assessment; a smaller proportion of these families received them on time.

However, the FRS data that was collected yielded encouraging findings. Kinship caregivers' most basic household needs were most often indicated as being "always" met. There were some slight significant decreases in access to resources—all of which would be naturally expected as additional children enter the home (e.g., money for utilities/bills); however, the change was not substantial. Access to certain other resources, particularly those that kinship staff can assist with, increased significantly (e.g., access to public assistance, daycare, and medical insurance for the child in care). Overall, kinship caregivers who received follow-up assessments were largely able to maintain or increase access to the vast majority of resources necessary to maintain life quality.

Kinship Supports Outcomes Study

A primary mission of the intervention is to promote kinship care as best practice. As such, an initial set of analyses were examined to explore the differences in the extent to which kinship care was used in demonstration and comparison counties. The results showed that, among demonstration and comparison county children in out-of-home care:

- Demonstration county children were more likely to be placed with kin

- Demonstration county children were more likely to be initially placed with kin (i.e., avoid temporary emergency placements)
- Demonstration county children spent a greater proportion of their days in out-of-home care with kin

Further analyses examined:

1. Outcomes for children served by the intervention compared with children in foster care placements in comparison counties, to assess the impact of kinship versus foster care
2. Outcomes for children served by the intervention compared with children in kinship placements in comparison counties, to assess the impact of the intervention
3. Outcomes for children served by kinship service models implemented most closely aligned to practice as usual (one-worker model) and those served by kinship models most different from practice as usual (two-worker model), to assess the impact of intervention model types.

In the Kinship Supports outcomes analysis propensity scores were used to adjust for differences between families and children in demonstration counties and their counterparts in comparison counties. To construct propensity scores demographic, historical and family assessment information was used.

Findings are described below:

Children Served by the Kinship Supports model Compared with Comparison County Children in Foster Care Placements	**Children Served by the Kinship Supports model Compared with Comparison County Children in Kinship Care**
Intervention children were less likely to experience a substantiated or indicated re-report during placement, and were also less likely to experience a substantiated or indicated re-report within 6, 12 or 18 months of the placement ending than their counterparts in foster care in comparison counties.	No significant differences were found between demonstration and comparison children placed with kin in re-reports during or after the placement episode ended.
Intervention children experienced significantly more placement stability than children in foster care in comparison counties.	Intervention children experienced significantly more placement stability than kin counterparts in comparison counties.
Intervention children spent significantly less time in out-of-home care than children in foster care in comparison counties (median time in placement = 280 vs. 350 days respectively).	Intervention children spent significantly less time in out-of-home care than children in kin care in comparison counties (median time to placement = 290 vs. 325 days respectively).
Intervention children were significantly less likely to re-enter out-of-home care after permanency	No significant differences were found between likelihood of re-entry into out-of-home care after

Children Served by the Kinship Supports model Compared with Comparison County Children in Foster Care Placements	Children Served by the Kinship Supports model Compared with Comparison County Children in Kinship Care
when compared with comparison children in foster care.	permanency for demonstration or comparison county children.
Kinship children were significantly less likely to reunify, significantly more likely to have permanent custody assigned to kin, significantly less likely to be emancipated, age out or to be adopted than were children in foster care in comparison counties.	No significant differences were found between demonstration and comparison children in the exit types to permanency after placement.

As described above, some demonstration counties employed a two-worker Kinship Support model while others utilized a one-worker model. Follow-up analyses explored whether the two-worker model showed better outcomes for children than the one-worker model for a) placement stability and b) time in out-of-home care when compared with children placed with kin in comparison counties.

Two-Worker Kinship Support Model Compared with Kinship Placements in Comparison Counties	One-Worker Kinship Support Model Compared with Kinship Placements in Comparison Counties
Demonstration county children in kin care served by a two-worker model experienced significantly less moves than their counterparts in comparison counties[3].	No significant differences were found between demonstration children in kin care served by a one-worker model and comparison children placed with kin in the number of placement moves.
Demonstration county children in kin care served by a two-worker model experienced significantly less time in out-of-home kin care than their counterparts in comparison counties (median time in out-of-home care = 265 days versus 325 days respectively).	Demonstration county children in kin care served by a one-worker model experienced significantly less time in out-of-home kin care than their counterparts in comparison counties (median time in out-of-home care = 264 days versus 325 days respectively).

In sum, demonstration county children were more likely to be placed with kin, were more likely to experience an initial placement with kin (i.e., avoid temporary emergency placements), and to spend a significantly greater proportion of their placement days with kin than children in comparison counties.

[3] Although significant, the mean number of moves for demonstration and comparison groups was very small (m=.19, SD=.53 and m=.27, SD=.51 respectively).

The demonstration counties also furthered the evidence base for best practice. Children in demonstration counties served by the intervention and placed with kin, compared to children placed in foster care in comparison counties:

- Were significantly less likely to experience subsequent abuse or neglect,
- Experienced significantly fewer placement moves,
- Spent significantly fewer days in out-of-home care, and
- Were significantly less likely to re-enter out-of-home care.

Significant findings also emerged in favor of children placed with kin that received intervention services compared with children placed with kin in comparison counties:

- Children served by the intervention experienced significantly fewer placement moves, and
- Children served by the intervention spent significantly fewer days in out-of-home care.

Finally, direct service model type did not appear to be a driving factor in the shorter placement lengths seen in children receiving intervention services; however, it may be a factor in placement stability. When children receiving intervention services under a two-worker model (the model type most different from practice-as-usual) were compared to children placed with kin in comparison counties, the difference in number of placement moves was more prominent than the overall kin-to-kin comparison findings. By contrast, when children served by a one-worker model (the model type closest to practice-as-usual) were compared to children placed with kin in comparison counties, the difference in the number of placement moves was no longer significant.

Fiscal Study

The fiscal analysis examined changes in spending patterns over time as a result of flexible funding. As in prior waiver periods, the evaluation team used county budget documents, which were clarified through interviews with county officials, to compile annual county-level aggregate expenditure data for child welfare services from demonstration and comparison counties. Data collected from 2011 through 2014 were compared to the baseline year of 2010 on the five dependent variables documented below:

- **Paid placement days**: The evaluation team hypothesized that in order to reduce foster care expenditures, demonstration counties would need to reduce the number of paid placement days and/or reduce the average daily cost of foster care. Across both demonstration and comparison counties patterns of increase and decline were shown in placement days; however there were no significant differences overall between demonstration and comparison counties in the distribution of average annual changes in paid placement days. It is important to note however that some counties had dramatically reduced placement days in the previous waiver period and therefore a further reduction would have been all but impossible.
- **Average daily cost of placement**: Average daily cost of placement was calculated by dividing total number of paid placement days by foster care expenditures. Across demonstration and comparison counties approximately two-thirds of the counties had an average annual increase

in unit costs; however, there were no significant differences *between* demonstration and comparison counties in the average change in costs.

- **Foster care board and maintenance expenditures**: These expenditures were calculated by multiplying the number of placement days by the average daily cost of placement. Nine demonstration and ten comparison counties saw a growth in expenditures; however, demonstration status was not sufficient to explain the variation in foster care expenditures.
- **All other child welfare expenditures:** Nine demonstration and seven comparison counties reduced other child welfare expenditures, which is consistent with information presented in chapter 2 regarding the services and revenue challenges counties faced. The remaining counties increased expenditures, though there were no significant differences between demonstration and comparison counties in this area.
- **Proportion of foster care board and maintenance expenditures relative to all child welfare expenditures**. Once again, no significant differences were found between demonstration and comparison counties.

A final analysis estimated the amount of money a county *would* have received under the traditional Title IV-E mechanism and compared these amounts to those that were received under the flexible funding of the waiver. Eleven demonstration counties received more revenue than they would have received under the traditional funding stream. Taken together, these eleven counties had an additional $50.5 million to spend on non-foster care services over the four years of the third waiver.

Placement Outcomes Study

The placement outcomes analysis examined the overall effects of flexible funding for children placed in care. For these analyses demonstration children may or may not have been specifically involved in FTM or the kinship supports interventions. Weighted propensity scores were used to balance differences between groups and Taylor Linearization methods were used to account for clustering within counties (SAS 9.3; SUDAAN add-on).

- Children experience similar exit types in demonstration and comparison counties: There were no statistically significant differences in the types of exits experienced by children in demonstration and comparison counties.
- Children in demonstration and comparison counties exit out-of-home care to permanency at similar rates, except during the initial time in care when it appears that comparison children exit to permanency more quickly in the first 30 days and especially in the first 4 days.
- Certain subgroups of demonstration children are more likely to exit more quickly to permanency, and more specifically to reunify in demonstration counties, including:
    - Children whose predominant placement type is a group home in a demonstration county reach permanency, or reunify, more quickly than children with the same predominant placement type in a comparison county.
    - Children whose predominant placement type is an adoptive home in a demonstration county reach permanency more quickly than children whose predominant placement type is an adoptive home in a comparison county.

- Black children in demonstration counties are more likely than Black children in comparison counties to re-enter care within 12 months.
- The percent of children experiencing early placement disruption is similar in demonstration and comparison counties, each around 2.7%.
- Children in demonstration and comparison counties experience similar rates of placement disruption, about 4 moves per 1,000 days in care (placement disruption was defined as the number of moves per 1,000 days in care for each 12 month period, based on the federal measure).

Trajectory Analysis

The trajectory analysis examined whether demonstration counties were able to reduce entry into out-of-home care without increasing safety risks, either prior to placement or after leaving foster care, regardless of whether the child was involved with either the FTM or Kinship Supports strategies. In other words, this analysis examined a 'waiver effect' of flexible funding. Clustering of data was accounted for with the use of a multilevel discrete time hazard model controlling for county population and size. The results indicated no evidence of an overall 'waiver' effect:

- Although there was variation among counties, overall, children in the demonstration counties were no more or less likely to experience placement following an initial substantiated report. Likelihood of placement was greatest within the month following the substantiated report and declined thereafter.
- Recurrence of maltreatment was greatest within the first 3 months of the initial substantiated report but did not differ between demonstration and comparison children.
- No differences were shown between demonstration and comparison children in likelihood of maltreatment following discharge from out-of-home care.

In all, analyses suggested that demonstration children remained equally safe under the waiver as they would have been under usual Ohio child welfare practices (as represented by the comparison counties).

Impact of the Waiver

Overall, the findings from the evaluation of Ohio's third waiver period have supported findings from other waiver demonstrations over the past 18 years, in that flexible funds alone aren't likely to achieve significant improvements in child and family outcomes, but targeted use of flexible funds for specific prevention, placement stability, and reunification efforts can, and do promote improved outcomes. Ohio's third waiver period analyses failed to detect significant differences when examining the overall "waiver effect," but did see improved outcomes related to the FTM and Kinship Supports interventions, specifically. And, considering the overlap between the two interventions, as cited by both staff and family members interviewed, it is likely that the intersection of these strategies led toward improving outcomes for children and families that received these interventions.

Over the course of the past 18 years, ProtectOHIO demonstration counties have fully embraced the waiver. Because it was first implemented in 1997, the operation of the demonstration PCSAs under a flexible funding approach became practice-as-usual long ago. As the looming conclusion of IV-E waivers approaches—particularly given the positive findings of the third waiver—widespread concerns have emerged among demonstration staff. County directors and managers expressed uncertainty about the

future and concern about how a return to traditional reimbursement for foster care board and maintenance costs would impact placement rates. Counties are reliant on waiver funds and anticipate a wide array of negative outcomes if flexible funding is lost.

There is also a general anxiety amongst the counties about the waivers coming to an end. New bills proposed to date have their own set of restrictions and requirements, and while these bills would offer states currently operating under the traditional funding stream an option that is better for the children and families they serve, ProtectOHIO agencies would have to take a step backward to comply with the bills' requirements. Consortium members have shared that because they have operated their PCSAs under a flexible funding approach for 18 years and demonstrated improved outcomes for children and families, the most flexible, lenient bills that are currently being proposed should be considered.

Chapter 1. Introduction and Overview

A great disparity exists between what research suggests is best for children and families and the strategy behind the federal funding approach to the child welfare system in America. In traditional child welfare practice, the large majority of federal funds are title IV-E, designated for foster care services, and only a fraction of federal dollars can be spent on prevention and reunification services. This is in direct conflict with an extensive amount of research that suggests that keeping children in their homes or placing them in the care of relatives is in the best interest of the child[4]. However, in 1994 Congress passed Public Law 103-432, which established Section 1130 of the Social Security Act, and authorized child welfare demonstration projects that waived certain requirements of title IV-E funds. As a result, states could implement demonstration projects to flexibly use funds traditionally allocated solely for foster care maintenance and administration, with the ultimate goal of improving safety, permanency, and well-being for children and families involved with child protective services. Since then, over 30 states have been experimenting with Child Welfare Waiver Demonstration projects.

In October of 1997, Ohio became one of the first states in the country to implement a IV-E Waiver Demonstration Project. Fourteen counties volunteered to join the waiver demonstration and, because of their shared belief that this shift in practice would truly increase the safety and well-being of families involved in Ohio's child welfare system, named the demonstration "ProtectOHIO." The first ProtectOHIO waiver demonstration program operated for five years, from Oct. 1, 1997 through Sept. 30, 2002. A "bridge period" of two years followed, wherein the Ohio Department of Job and Family Services (ODJFS) negotiated with the federal Children's Bureau to obtain a five-year extension. The extension was granted in January 2005, retroactive to Oct. 1, 2004, and scheduled to end Sept. 30, 2009.

In February 2009, ODJFS formally requested another five-year extension; in March, the Children's Bureau granted a short-term extension through September 2010, to allow for full consideration of the final evaluation report findings from the second waiver period. Authorization was received in March 2011, retroactive to Oct. 1, 2010. This current waiver was originally scheduled to end on Sept. 30, 2015; Ohio has since applied for a fourth waiver, set to last through 2019, and has been granted another short-term waiver extension to allow for full consideration of the third waiver findings. This report constitutes the Final Evaluation Report for the third waiver period of ProtectOHIO.

Ohio maintains a unique position among the more than 30 states that have had Title IV-E Waiver Demonstration programs. It is the only state whose waiver demonstration project has operated continuously since 1997 and has not altered in design—serving the entire child welfare population in a limited number of counties (that nonetheless represent a substantial portion of the state's child welfare population). Consequently, it provides a strong basis for a comparison county evaluation design.

Perhaps most significant about Ohio's waiver is that, over the three waiver periods it has been in place, the practice focus has become increasingly targeted and well-defined. The first waiver period, 1997-2002, allowed the 14 participating counties maximum flexibility in how they chose to use the flexible federal funds; the second waiver period, 2004-2009, targeted waiver activities to five intervention strategies, with each county required to implement the core intervention, Family Team Meetings (FTM),

[4] Metzger, 2008, Doyle, 2007

and at least one other. The third waiver period, which is the explicit focus of this evaluation report, further narrowed the focus to just two strategies: FTM and Kinship Supports. This evolution of ProtectOHIO captures the essence of one of the clearest messages that emerged from waiver evaluation findings over the past 18 years: flexible funds are necessary but are not sufficient to achieve significant improvements in child/family outcomes; a clear focus on using those funds for specific placement-prevention and placement-reduction activities is also required.

As stated in the DHHS May 2012 Information Memorandum inviting states and tribes to apply for Title IV-E Waivers:

> While there has been significant emphasis in child welfare discussions in recent years related to financing mechanisms, it is unlikely that reorganizing funding mechanisms alone to support children and families prior to or after leaving foster care will improve outcomes for children … HHS's recognition that funding flexibility alone cannot improve outcomes for children and families has informed the greater emphasis placed by HHS under the new waiver authority on the implementation of established or emerging evidence-based programs and practices (EBPs).[5]

1.1 Evaluation Design

The goal of ProtectOHIO is to reduce use of foster care through the flexible use of a capped Title IV-E allocation that "may be spent for a range of child welfare purposes."[6] The core hypothesis is that "the flexible use of Title IV-E funds to provide individualized services to children and families will assist in prevention of placement, increase reunification rates for children in out-of-home care, decrease rates of re-entry into out-of-home care, and reduce length of stay in out-of-home care."[7]

The evaluation of ProtectOHIO uses a quasi-experimental design, comparing practices and outcomes in the 16 demonstration counties and 16 comparison counties located throughout Ohio (Figure 1.1). As explained in the June 2011 evaluation plan[8], the comparison counties were chosen to maximize comparability with demonstration counties (Table 1.1). The target population is all children served by the participating Public Children Services Agencies (PCSAs), the county-level child welfare agencies.

[5] ACYF-CB-IM-12-05, to State and Tribal title IV-E agencies.

[6] DHHS/ACF/ACYF, Ohio Amended Terms and Conditions, 8/13/10, section 2.0.

[7] Ibid., section 3.0.

[8] Human Services Research Institute, 2011

Figure 1.1: Map of ProtectOHIO Counties

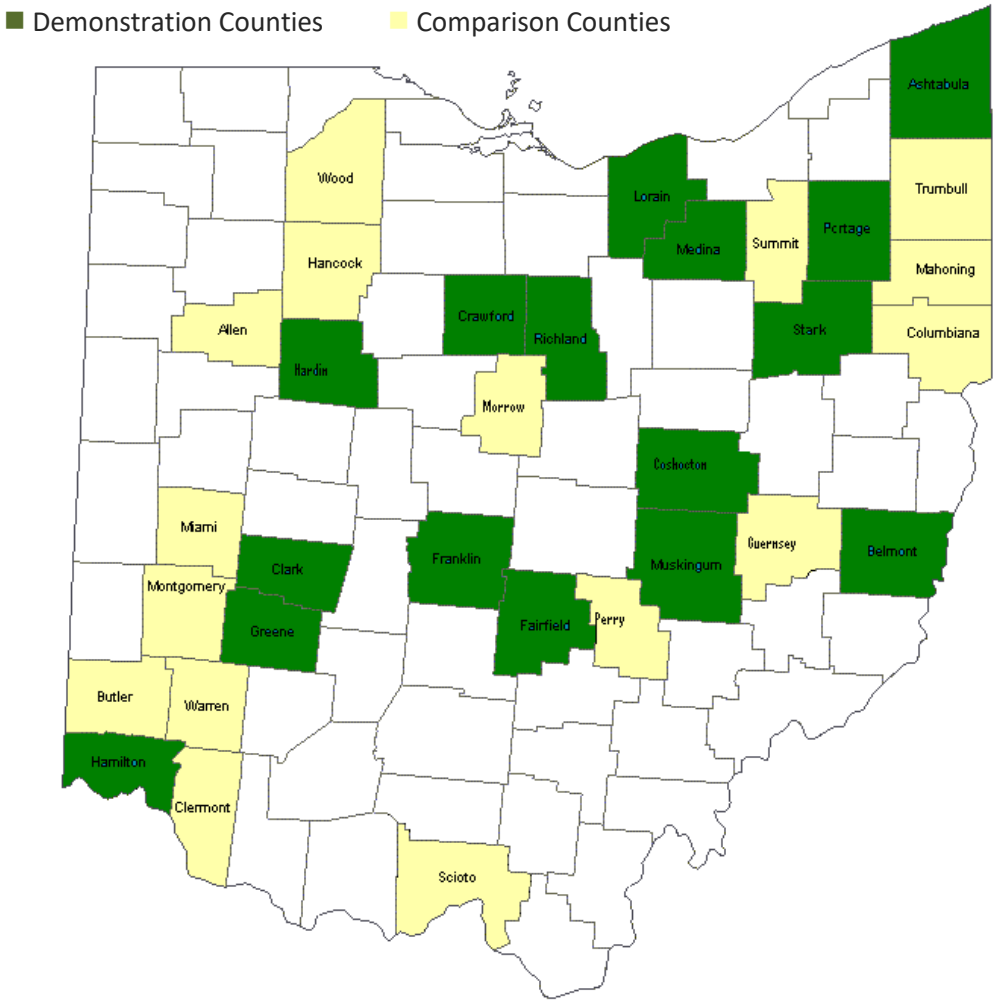


Table 1.1: Variables Used in Choosing Comparison Counties[9]
• County population • Percent of county considered rural • Percent of children in population on Aid to Dependent Children (ADC) • Percent of child welfare spending coming from local government • Child abuse and neglect reports per 1,000 children in county population • Out-of-home placements per 1,000 children in the county • Median placement days

[9] More information can be found on page 2 of the *ProtectOHIO* Phase II Evaluation Plan.

Because Children Services in Ohio are county-administered, much variation exists among the participating PCSAs. The waiver provides an opportunity for PCSAs to explore innovative approaches to meeting the needs of children and families in their local communities. Over the course of the three waiver periods, the waiver-generated activities within the demonstration counties have become increasingly consistent and consolidated. During the first waiver period, each demonstration county developed its own plan for reducing reliance on out-of-home placement; as a group, the counties shared ideas and experiences and, by the end of the waiver period, had identified some promising avenues for improving child and family outcomes. During the bridge period between the first and second waivers, ODJFS and the demonstration counties discussed the evaluation findings and their own experiences, and began to recognize the benefits of adopting some common strategies. For the second waiver, they agreed to focus on five strategies: Family Team Meetings (FTM), Kinship Supports, supervised visitation, enhanced mental health and substance abuse services, and managed care contracting. Each county agreed to implement the FTM intervention and at least one other intervention; some counties chose to implement more than two strategies. The evaluation examined not only the overall impact of the waiver on the child welfare population but also the impact of each individual intervention on children and families in the particular counties that participated in each initiative.

During the third waiver period, the demonstration counties chose to further narrow their focus, specifically because they wanted to contribute to the development of evidence-based practices for child welfare. The 16 demonstration counties decided to implement two strategies, FTM and Kinship Supports, not only because they had already made substantial commitment to these activities during second waiver period but also because of the positive evaluation findings from that period. All the counties agreed to implement the two strategies using more explicitly defined models and incorporating common training for staff. At the same time, individual demonstration counties could also choose to continue other strategies begun during the second waiver period, such as supervised visitation.

The shift from five strategies to two strategies enables the counties to concentrate their attention on fully implementing the specific service interventions, converting the financial flexibility of the waiver into concrete practice changes that are expected to improve child and family outcomes. In turn, the evaluation can more clearly assess the impact of the waiver through the effectiveness of the two core strategies, and it can expand the evidence base for FTM and Kinship Supports.

The overall waiver Logic Model (Table 1.2) illustrates the basic premises of ProtectOHIO, establishing expected relationships between waiver conditions, county activities, and desired outcomes for children and families served through the waiver.

Table 1.2: ProtectOHIO Logic Model (Third Waiver Period)			
INPUTS	**PROCESS (SYSTEM & CASE LEVEL)**	**OUTPUTS**	**CHILD & FAMILY OUTCOMES**
Funding for any services, any clients Funds upfront, and ability to redirect savings PCSA experience with waiver since 1997 Existing partners in the community	Internal organization Services availability Financing patterns Waiver strategies: FTM and Kinship Supports Optional strategies: MH/SA enhancement, visitation, managed care Interagency relationships	Families more engaged Kinship caregivers more supported More services provided, and services completed in a more timely manner Staff more supported	Decreased placement days Increased permanency Decreased re-abuse Decreased re-entry to care Greater placement stability

The core evaluation questions are:

1. How have demonstration counties made organizational and practice changes, compared to the group of comparison counties??
2. In what ways have the demonstration counties varied in their implementation of waiver activities, compared to each other?
3. How have agency expenditure patterns changed, in demonstration counties compared to comparison counties?
4. In what ways do the interventions specifically and waiver flexibility overall impact outcomes for children and families involved in Ohio's waiver compared to similar children and families in comparison counties?

The evaluation examines the key outcomes through three required studies – the Process Study, the Fiscal Study, and the Participant Outcomes Study. Together, the three studies address all parts of the logic model. They are summarized briefly here, with full details presented in subsequent chapters of this report.

- The Process Study examines the overall implementation of the waiver in the demonstration counties and compares it to typical child welfare practice in the comparison counties. Special attention is given to the implementation of the two core waiver strategies, FTM and Kinship Supports. The findings address (a) changes in PCSA structure, service array, and interagency relationships, especially as related to the strategies; (b) fidelity to the intervention models; and (c) any other county-specific initiatives or prioritized activities.

- The Fiscal Study continues the work done in prior waiver evaluations. Primary data on child welfare expenditures for calendar years 2011 through 2014 from all 32 counties continues to be collected. Combining this information with data from ODJFS on placement day utilization, the evaluation examines whether and how expenditure patterns change under the third waiver. The core hypothesis is that, as demonstration counties take advantage of the waiver flexibility and build alternatives to foster care, they will lower utilization of foster care and increase expenditures for non-placement services and other supports.
- The Participant Outcomes Study consists of four separate sets of analyses:
    - The Placement Outcomes analysis focuses on the outcomes for children entering placement beginning in calendar year 2011, and examines placement stability, length of stay in care, types of permanency exits, and re-entry to care.
    - The Trajectory analysis addresses safety and permanency outcomes for all children with intakes beginning in 2011, and examines the likelihood of placement and re-abuse for demonstration county cases compared to cases in the comparison counties.
    - The Intervention analyses are composed of two separate sets: FTM and Kinship Supports. These analyses examine the impact of the two core interventions, specifically focusing on cases that transfer to ongoing services beginning in 2011. For these sets of analyses, children and families receiving one or both of the strategies are compared with similar counterparts in the comparison counties, in terms of placement utilization, permanency, and safety.

Table 1.3 lists the research topics and major outcomes included in each study, and notes the links between the evaluation outcomes and measures used at the federal level to assess the performance of public child welfare systems.

Table 1.3: ProtectOHIO Evaluation Focus					
			Participant Outcomes Study		
Research Topic/Outcome Domain	**Process Study**	**Fiscal Study**	**Placement Outcome Analysis**	**Trajectory Analysis**	**Intervention Outcome Analyses**
Organizational aspects	x				x
Service delivery system	x				x
Relationship between PCSA and partner agencies (e.g., juvenile court)	x				
Contextual factors, barriers & successes	x				
Likelihood of children entering care				x	x
Length of stay in care[+]			x		x
Rates of children having good permanency exits (reunification, adoption, legal custody to kin) [+]*			x		x
Placement stability*			x		x
Rates of re-entry to care after reunification or custody to kin*			x		x
Rates of subsequent maltreatment after permanency exit *				x	x
Family Team Meeting intervention: differences in implementation and availability & intensity of services *	x				x
Kinship Supports: differences in implementation and availability & intensity of services; among those placed, the proportion placed with kin*	x				x
Of children with substantiated CAN report, proportion who go to placement*				x	x
Rates of change in expenditures on placement/non-placement activities		x			

[+] Related to Adoption and Foster Care Analysis and Reporting System (AFCARS) measures
* Related to Child and Family Services outcomes, derived from AFCARS measures

1.2 Highlights of Prior ProtectOHIO Findings

Before presenting findings related to activities during the third waiver period of ProtectOHIO, it may be helpful to reflect on the major findings from the first and second waiver periods, spanning 1997 to 2010.

The Final Comprehensive Report of the first waiver period[10] found that the waiver "did not appear to be strong enough to alone generate fundamental reform of the state's child welfare system." It pointed to

[10] Human Services Research Institute, 2010

several issues: (a) program initiatives were "neither sufficiently large-scale nor sufficiently targeted," (b) reform efforts lacked "well-articulated logic models targeting specific outcomes," and (c) characteristics inherent in the Ohio child welfare system (e.g., county-administered child welfare programs that relied heavily on local levy funds) presented particular challenges to systemic reform. Additionally, the report authors noted that, "with further time to address some of the barriers and limitations, the evaluation can be expected to bring to light more varied effects of waiver participation in the demonstration county group [and to] supply deeper information [about] the complex dynamics of systemic reform."

The Comprehensive Final Report of the second waiver period[11] identified some key systemic changes that occurred substantially more in demonstration counties than in comparison counties, such as better communication with juvenile courts and the delivery of a broader array of programs for unruly/delinquent youth; greater use of specialized visitation staff and support for structured activities during the visits; and more frequent use of designated kinship support staff. Perhaps most significant was the evidence of a shift in PCSA spending patterns, with demonstration counties making significantly greater reductions in the share of child welfare expenditures going to foster care board and maintenance relative to comparison counties.

The 2010 final report also found statistically significant yet modest waiver effects on child outcomes:

- In terms of safety, children were not at increased risk as a result of the waiver. Looking at all cases served between 1994 and 2006, the evaluation found very little change in the percentage of children with a subsequent CAN investigation among either the demonstration or comparison county groups, suggesting that the waiver did not affect children's safety. By the end of 2006, demonstration counties were serving a substantially larger portion of children in-home than were comparison counties (19% versus 11%), and these children were no more likely to be the subject of a subsequent maltreatment investigation than were comparison county children. Similarly, looking at placement cases that closed during the first waiver, the evaluation found no difference in re-entry to foster care among children who exited their first foster care placements to the custody of either parents or kin, suggesting the waiver did not compromise child safety. Finally, children in demonstration counties were significantly less likely to have subsequent case openings within a year of case closure than children in comparison counties, although the effect was slight (11% versus 12%).
- In terms of length of placement and permanency, the outcome analyses revealed modest improvements: minor improvements were seen in the reduced length of the first placement, and the wait for adoption was shortened (by 2 months); significant waiver effects were found for children in placement who exited to custody of kin (2% more did so under the waiver) and who exited to reunification (4% less); exits to adoption increased slightly (1% more) relative to pre-waiver conditions, suggesting that exits to adoption increased very slowly over the two waiver periods. In addition, the FTM analysis showed that children in demonstration counties had significantly shorter case episodes than did comparison county children; and demonstration county children were significantly less likely to go to placement than were comparison county

[11] Human Services Research Institute, 2010

children (2% less), though no significant difference was found with regard to length of stay in placement.

In sum, the second waiver period offered clear evidence of systemic change at the county level, in terms of agency philosophy and culture, service options, and collaboration. There was evidence of an overall maturation in the demonstration counties, as they learned from their experiences and became more comfortable with the flexibility/risk proposition intrinsic to the waiver. By the end of the second waiver period, the shift in PCSA spending toward non-foster care activities finally emerged as a statistically significant change. The very modest effects of the waiver on child-level outcomes were notable: more children served in-home, some shorter duration in placement and in case length, and equal safety under the waiver were positive signs; however, the waiver alone did not yield large gains in child outcomes. The bottom line seemed to be that demonstration counties had taken advantage of the flexibility afforded by the waiver for agency-level and county-level improvements; and children were not at any greater risk of maltreatment.

1.3 Project Management Activities

1.3.1 Collaboration with the State and Counties

In order to successfully conduct Ohio's Process, Fiscal, and Participant Outcome studies, as outlined above, the evaluation team works closely with state and county stakeholders. This collaboration allows the evaluators to stay informed about waiver developments and to share valuable information generated by the evaluation promptly as activities occur.

ProtectOHIO Consortium: The Consortium consists of representatives of each of the 16 demonstration counties, relevant ODJFS staff, and the evaluation team. It was formed in 1997 at the onset of the first ProtectOHIO waiver period. At least one member of the evaluation team attends each bi-monthly Consortium meeting and provides Consortium members with updates on evaluation activities. It is important to recognize the central role the Consortium has played in the evolution of Ohio child welfare practice under the waiver. Representatives of the demonstration counties have attended the bi-monthly meetings of the Consortium for the past 18 years, beginning even before the evaluation contract was awarded in April of 1998. In a survey of the Consortium counties conducted in 2008, these PCSA representatives were asked to describe their involvement with the ProtectOHIO Consortium group. Half of the managers (nine) reported significant involvement and a third (six) reported moderate involvement. The counties described the following benefits of Consortium involvement:

- Information sharing, especially with regard to learning about other counties' creative approaches;
- Networking with colleagues;
- Troubleshooting common challenges, especially with regard to the SACWIS transition; and
- Maintaining active commitment to and enthusiasm for ProtectOHIO goals.

Intervention Workgroups: To formally develop the two core ProtectOHIO strategies—FTM and Kinship Supports—the Consortium formed two workgroups, each focused on one intervention. These

workgroups include representatives from several ProtectOHIO county PCSAs (any who volunteer), ODJFS, and the evaluation team. The workgroups met over a period of several months to refine the intervention practice models and develop manuals to guide the counties in consistently implementing the strategies. The evaluation team provided technical assistance and coordination, helping the workgroups to clearly define the strategies and reach consensus on practice and measurement expectations (i.e., fidelity). The workgroups continue to meet on a regular basis to share on-the-ground experiences and to discuss challenges that have emerged related to policy, practice, and data collection. Additional information on the intervention workgroups is included in Chapters 3 and 4.

1.3.2 Data Management

A critical task for the evaluation team is obtaining, organizing, and understanding data from a variety of sources. Two data sources provide the information used for the outcome analyses and parts of the process analysis: the Ohio State Automated Child Welfare Information System (SACWIS) and HSRI's ProtectOHIO Data System (PODS), an electronic data collection system implemented by HSRI as a complement to SACWIS. Additional information on SACWIS and PODS is included in Chapters 3 and 4.

1.3.3 Institutional Review Board Process

In keeping with national standards of good evaluation practice, the evaluation team submits its data collection plans to a formal review by an Institutional Review Board (IRB). The IRB process assures that research methods respect the confidentiality and the privacy of research subjects, with particular attention to service recipients. HSRI's IRB reviews issues related to the protection of human participants for all research activities to be conducted by HSRI. The IRB follows standard practices for review and approval of evaluation studies, ensuring that risk to human subjects is minimized.

For the evaluation of ProtectOHIO during its third waiver period, the process between the research team and HSRI's IRB members has been iterative: After a full committee review, initial approval was granted for the evaluation plan and its related activities and procedures in June 2012, thus assuring that human participants and their associated data would be protected and confidentiality would be preserved. As required by the IRB, annual continuation reviews of study documentation were conducted. Also as required by the committee, additional reviews were conducted on an ad-hoc basis for all modifications to research procedures or activities. This was done each time a new data collection activity was implemented. Each modification proposal included a rationale for the modification and draft protocols related to the data collection activity (e.g., interview guides, surveys, etc.).

HSRI's subcontracting partners, Westat and Chapin Hall School of Social Services (University of Chicago), both submit annually to their respective in-house IRB committees. Since their components of the evaluation involve the study of secondary data, without names or any other direct identifiers, both have continued to receive exemption status.

1.3.4 Reporting

Since the beginning of the third ProtectOHIO Waiver, the evaluation team has provided an evaluation update in each of the semi-annual progress reports submitted by ODJFS to the Children's Bureau. The evaluation team also provided an interim report in 2013, and annual reports in 2012, 2014, and 2015.

1.4 Organization of the Report

The following seven chapters of this Final Evaluation Report present the activities and findings for each major study within the evaluation, offering an overview of each, a description of the research methodology and findings, and an interpretation of the results.

- Chapters 2 through 4 describe the overall implementation findings and the specific findings from each of the two intervention studies that compose the Process Study. These analyses offer results at the county level, comparing practices used in the demonstration counties to those in comparison counties. Chapters 3 and 4 also include intervention outcome findings for children and families participating in FTM and Kinship Supports, as a part of the Participant Outcomes Study.
- Chapter 5 contains the Fiscal Study, reporting on county-level changes in spending patterns over the third waiver period, in demonstration counties compared to comparison counties.
- Chapter 6, the Placement Outcomes Analysis, and Chapter 7, the Trajectory Analysis, present child-level outcome findings, also as part of the Participant Outcomes Study.
- Chapter 8 briefly recaps the findings in the preceding chapters and offers a synthesis of the impact of the third ProtectOHIO Waiver Demonstration.

Chapter 2. State and County Context

2.1 Overview and Introduction

Ohio's Title IV-E Waiver (ProtectOHIO) operates as one input into Ohio's overarching state child welfare system. In this way, it works in concert with various other policy and practice shifts and initiatives occurring across the state. As shown in the logic model (Chapter 1, Section 1.1), participation in the waiver is expected to lead to reforms at the child welfare system level in the demonstration counties—particularly in such areas as internal organizational structure, the array of available services, financing practices, and interagency partnerships. Consequently, this chapter focuses on the context surrounding the waiver, such as the service delivery system environment and broad county cultural and demographic details. Where applicable, it also provides concurrent and comparable information from comparison counties; these data help illuminate the underlying statewide child welfare situation.

This chapter also includes details about the three optional ProtectOHIO strategies implemented in a handful of demonstration counties—Supervised Visitation, Enhanced Mental Health and Substance Abuse, and Managed Care. The two core strategies that were operationalized and embraced in all demonstration counties during the third waiver period—Family Team Meetings and the Kinship Supports intervention—are described in Chapters 3 and 4. Additionally, information about the well-being pilot is incorporated. Lastly, information about Highland County's exit from the waiver is provided, as it further illuminates the complicated context of the waiver, particularly in a small, rural county. In sum, the chapter expounds on the existing and shifting context in demonstration and comparison counties. Factors related to organizational aspects of Family Team Meetings and the Kinship Supports strategies, including administrative structures, monitoring activities and training components, and barriers to implementation of those interventions, are primarily highlighted in Chapters 3 and 4.

Organization of the Chapter. The following sections of this chapter are:

Section 2.2 Data Collection

Section 2.3 Social, Economic and PCSA Context (demonstration and comparison counties)

Section 2.4 Demonstration County Environment

- Other ProtectOHIO Interventions
- Well-Being Pilot
- Highland County Exit Information

Section 2.5 Impact of the Waiver

Section 2.6 Summary

2.2 Data Collection and Methods

To conduct the analysis necessary for this portion of the Process Study—those contextual components not directly related to the two primary strategies, FTM or Kinship—the evaluation team relied primarily on site visits, a survey and telephone interviews.

- **Site visits:** In fall 2012, site visits were conducted in each of the then-17 demonstration counties and in 4 comparison counties. The fall 2014 site visits were conducted in 15 demonstration counties and 6 comparison counties. One site visit was cancelled due to inclement weather and the county alternatively participated in telephone interviews. And, Highland County received a site visit in 2015 for the purpose of exit interviews, but was no longer in the demonstration at that time.

  Site visits included interviews with various staff. Directors, managers and supervisors were the primary source for the analyses presented in this particular chapter.

  Prior to the 2014 site visits, the evaluation team administered a brief online survey designed to streamline the site visit process and enhance the richness of the information gathered during the visits. The survey, which elicited basic county contextual details, was completed by all 16 demonstration counties and by 14 out of 16 comparison counties.

- **Telephone interviews**: Telephone interviews were conducted in 2012 with 13 comparison counties. In 2014, telephone interviews were conducted with 10 comparison counties and 1 demonstration county. Interview protocols were used to document comparison county policies, practices, strengths, and barriers. The evaluation team collected information from key staff in each county.

Additional data collection informed the Process Study; those data are presented in Chapters 3 and 4 alongside FTM and kinship intervention-specific implementation analyses.

For both demonstration and comparison county data presented in this chapter, the evaluation team used Dedoose, a web-based qualitative analysis software, to code interviews for themes or units of meaning and sub-themes. Coding was done primarily by one evaluator; however, it was systematically and thoroughly discussed with the evaluation team. The evaluation team consolidated all interviews at the county level by assigning to each county categorical thematic codes for all inputs, processes, activities and outputs that were examined. The evaluation team searched for correlations among the different variables and for differences between demonstration and comparison counties, indicating practice differences and nuances resulting from participation in the Title IV-E Waiver Demonstration.

2.3 Social, Economic and PCSA Context in Demonstration and Comparison Counties

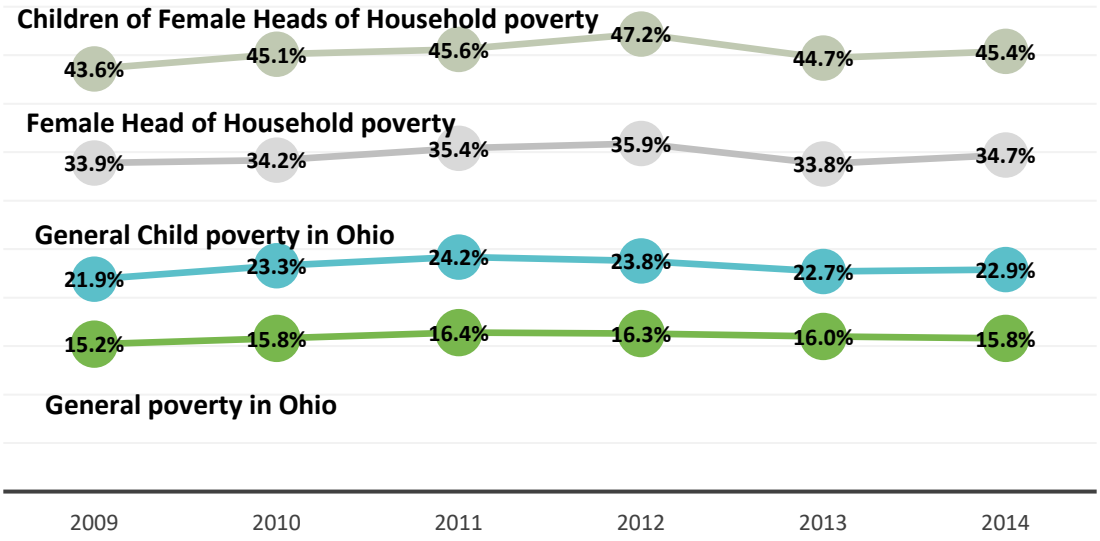
Ohio has had a Title IV-E Waiver since 1997. The child welfare environment and the overall state context have changed considerably over the past 18 years. In each of the prior waiver evaluation reports, the evaluation team identified factors that had the potential to impact counties' behavior under the waiver, and ultimately children and families served by the PCSA. Similar factors are explored in comparison counties. These factors may be within and outside of the service delivery system, spanning from county economy changes to PCSA structural changes. During the 2012 and 2014 site visits, the evaluation team similarly explored the social and economic contexts in which both demonstration and comparison counties were operating. This section synthesizes the information gathered.

2.3.1 Economic Environment

The nationwide recession that began in December 2007 deeply affected state and local budgets during the second waiver period, and this impact continued throughout the third waiver. At the beginning of the third waiver Ohio was suffering from an unemployment rate of 9.7%, just above the national average at that time. Although the rate of unemployment is now comparable with the national rate, many families in both demonstration and comparison counties remain underemployed or work in jobs that fail to pay enough for adequate family support. Blue-collar communities were particularly hard hit during this current waiver period, as major factories closed and local employers who depended on those factories for their own viability were lost in consequence. As a result many families that Children Services help have yet to recover from the economic downturn experienced earlier in the third waiver period. Lack of affordable housing and homelessness continue to cause concern in some parts of the state, this even in regions where new employment opportunities from industries such as fracking have emerged. Indeed, these industries may complicate and strain social service systems, as they may contribute to inflated housing prices, making low-income housing to be even more challenging to find than it was in the past, and, in some cases, temporary workers involved in these industries have become involved with Children Services.

Figure 2.1 illustrates poverty rates across the state of Ohio from 2009 through 2014 (taken from the U.S. Census Bureau). Across this period, Ohio's rates remained slightly above national averages during the periods shown, and as can been seen, are particularly dire for female head of households and their related children.

Figure 2.1: Ohio Poverty Rates 2009-2014



The economic downturn and its consequences impacted both demonstration and comparison counties. The very structure of the PCSA system has been threatened, with several counties deciding to combine their freestanding Children Services Board with the local Department of Job and Family Services, and several counties in the state opting to merge all of their Job & Family Services operations together. The

latter phenomenon led one demonstration and one comparison county to leave the waiver early on during the third waiver period, as their offices had merged and were each no longer eligible to participate as either a demonstration or comparison county.[12]

2.3.2 County Funding

The economic environment described above interacts with county funding levels and expenditures. As families need services and supports—and other systems of support were strained by limited funding during the recession and recovery—more families may have come to the attention of Children Services. This influx of families could increase county expenditures, though counties continue to endeavor to decrease placement rates by keeping children in home when possible. Further, staff note that though their goal is to maintain children in their homes, there remains a pool of children who may require restrictive and expensive placements, which may limit how much counties can decrease expenditures. Other factors that counties indicated have increased their expenditures include the use of out-of-network foster homes and increased provider rates. One county noted that contract provider rates were frozen through 2012 due to the county's financial situation, but increases were granted after that. To control expenses, one county has imposed performance-based contracts for all providers.

To supplement state and federal revenues, PCSAs rely heavily on local levies and funds that flow through local Job and Family Services agencies. As previously noted, Children Services agencies in some counties are combined with county Job and Family Services agencies, and this may streamline county access to PRC and ESSA funds. The vast majority of both demonstration and comparison counties have levies in place: 14 comparison and 12 demonstration counties reported local levies in 2012, and levies that were set to expire during the third waiver period were all successfully renewed. Current levies are now set to expire as early as 2016 and as late as 2020. Demonstration PCSAs have a bit more stability in that a higher number have a local levy compared to comparison sites (14 versus 12). In 2014, one demonstration county without a levy was in conversation within the agency about seeking a human services levy that would include funding for Children Services. And staff in another demonstration county without a levy noted that the county does receive funding from the county's general fund. Some demonstration and comparison counties have more than one levy.

Although all counties have maintained their levies over the course of the waiver, actual dollars contributed to Children Services have decreased during this waiver due to decreasing property values. While property values may now be on the rise, counties may continue to feel the impact of the decrease that occurred during the economic downturn, due to property value assessment processes. At least one comparison county secured a replacement levy at a higher millage, which resulted in an increase in actual dollars for Children Services.

In addition to local levy funding, counties also draw down PRC funds (Prevention, Retention and Contingency funds) and ESAA (Emergency Services Allocation Act) funds. During the waiver, access to PRC and to ESAA[13] remained comparable between demonstration and comparison counties, and more

[12] Vinton and Hocking

[13] PRC = Prevention, Retention and Contingency Fund; ESAA = Emergency Services Assistance Act

counties in general have access to PRC funds. Counties note that these funds are used for hard goods, rent, utilities, and community-based contracts.

One funding mechanism that emerged in 2014 was a state innovation fund of $6.8 million made available to Children Services agencies across the state; in 2014, PCSAs were invited to submit proposals for funding for innovative programs, though staff in at least one county noted that these grant funds supplanted funding typically allocated to counties for operations. At the time of 2014 site visits, counties were receiving notification of whether or not their proposals would be funded. Counties could apply independently or in partnership with neighboring counties. Demonstration and comparison counties applied for a range of activities, including funding for hard goods for families, visitation space to limit travel time for families, validated assessment tools to track parent-child relationships, family preservation services, staff trauma training, and additional Alternative Response workers.

2.3.3 Substance Abuse

Perhaps one consequence of the increased economic stress experienced by Ohio families over the past several years has been the increase in the numbers of drug-affected families that county agencies are seeing. The majority of both demonstration and comparison counties described opiates as a problem impacting families and agency resources. During 2014 site visits, staff noted that opiate use is up across Ohio and fatality rates from heroin have increased. Counties are experiencing increased numbers of babies who are born opiate-addicted and placement rates—particularly for younger children—have been driven up due to drug-related issues. An interviewee in one county noted, "It's not uncommon to see staff crying in their cubicle because their client just OD'd." Staff in one county noted that Children Services is drug-testing more and more families at the court's request, and staff in another county noted the addition of a Suboxone clinic.

> *"It's not uncommon to see staff crying in their cubicle because their client just OD'd."*
>
> *- Demonstration County Administrator*

The rise in opiate use has resulted in increased pressure on both the front and back end of child welfare services, with greater demand on one end and sometimes loss of funds on the other (due to things such as shifts in resources toward prisons or spending on longer-term services for these families). Increases in drug-use may add additional pressure to ongoing workers or units; despite the fact that all counties have integrated Alternative Response into their practices, counties may not divert cases involving drugs or alcohol as a risk factor to AR. (Additional details about Differential Response can be found in Section 2.3.6.1) Philosophies toward substance addiction vary from county to county. While several counties have taken a progressive approach by implementing drug courts or focusing on prevention and education in the schools, one interviewee described her county as being "stuck in the 90s," in that the justice system does not support treatment.

2.3.4 Changes in PCSA Leadership, Structure, and Staffing

Just as external factors, such as poverty and substance abuse, impact county behavior and the ability to deliver services, so do internal changes. In 2012, the most dramatic change was in leadership, with the

vast majority of both the demonstration and the comparison PCSAs (11 and 10 counties, respectively) having faced multiple personnel changes among top managers and agency directors. This huge loss of experienced leaders has occurred at least partly in response to changes in the state retirement benefits. Additionally, a minority of PCSAs (two demonstration and five comparison counties) noted changes in the unit structure of the agency. These changes included merging departments or combining units, moving toward a one worker/one family model, putting more reliance on case-carrying staff in place of support staff, or more specialization (e.g., creating a unit or staff to handle after-hours or to focus on preventing recidivism).

While decreasing staffing levels and hiring freezes were reported in 2012, fewer were reported in 2014, perhaps underscoring a return to a healthier and more stable economy. In 2014, two counties indicated recent decreases in staff levels due to layoffs, though both counties noted that casework staff were not eliminated and layoffs occurred primarily at the management or clerical levels. More commonly in 2014, counties noted growth and the addition of new staff, such as additional kinship coordinators, FTM facilitators or more intake caseworkers—five counties indicated such positive staffing changes. Counties continued to report some changes in top managers and directors, though leadership was more stable than in 2012. One neutral change that occurred in at least one county was a shift from specialist caseworkers to more generalist caseworkers.

As is consistent across child welfare agencies nationally, caseworker turnover continues to present a challenge for both demonstration and comparison counties. Multiple counties note that casework turnover—distinct from normal attrition or retirement—occurred during the third waiver period; turnover was alternately attributed to changing leadership or administrators, low pay, high caseloads or workloads resulting in stress, or poor fit (inability to successfully complete job duties and paperwork). In some counties, turnover was more significant among intake staff; by contrast, other counties experienced higher turnover among ongoing staff.

Staff in one county noted that turnover results in ongoing "ripple" issues; even when new workers are brought on board, they may not carry a full caseload due to the lengthy training periods required. In this way, PCSAs may feel the impact of turnover continuously. Alternately, staff in some counties viewed the turnover that occurred as "healthy," resulting in caseworkers who are more bought-in and invested to current initiatives; rather than viewing FTM or the Kinship Support strategies as "extra steps," they simply see them as practice as usual. While most turnover was related to casework staff, one county experienced turnover of county attorneys who represented children involved with Children Services; this turnover resulted in attorneys who were less familiar with the PCSA but more invested in cases. Another county experienced turnover of specialized staff, including a family meeting coordinator. At least one comparison county noted that turnover during the third waiver period has been low due to the county's ability to compensate staff well.

Turnover may be due in part to workload or initiative fatigue. Staff in multiple counties noted that high caseloads and/or multiple initiatives presented challenges for casework staff. Counties are attempting to address initiative fatigue by limiting the number of new programs simultaneously introduced to staff and working to better understand the administrative burden that prevents staff from completing their mandated duties. Staff in one county noted that new requirements resulting from Medicaid expansion have resulted in additional workload and strain.

2.3.5 Community Relationships

Partnerships with key community partners may also play a role in the ability of the agency to protect children. As counties reduce their use of out-of-home placement, the children still needing placement tend to have more complex issues that cut across agency boundaries. In 2012 and 2014 site visits, the evaluation team asked about the relationship between the PCSA and its main partner agencies—the juvenile court; the Alcohol, Drug Addictions and Mental Health Services (ADAMHS) Board (or two separate boards, in the few counties where such exist); and the Family and Children First Council (FCFC). Little difference emerged between the demonstration and the comparison counties: On average, PCSA managers judged their relationship to all three partners to be in the high range, a score of 4 on a scale of 5 in both 2012 and 2014. In past years more variation was evident, both within each group and between the groups, when this question was asked; in a 2009 survey, for instance, two-thirds of the demonstration counties perceived the waiver as having a positive impact on the PCSA's relationship with the juvenile court and with the ADAMHS service system. The current data may suggest that tough economic times have brought agencies closer together, or it may reflect lowered expectations for how good the relationship can be. In addition to discussing their relationships with the aforementioned partners, counties also noted collaborative relationships with local school districts and developmental disabilities boards, Help Me Grow, domestic violence shelters, and law enforcement entities.

While, on average, PCSA managers indicated that relationships with the courts are strong, individual demonstration county scores ranged from 1 to 5, indicating significant variance in the strength of these relationships. Indeed, managers noted that relationships with the courts or judges can be tense and can have significant bearing on the number of out-of-home placements an agency has. For example, in one county, the number of juvenile court cases (delinquency) released to child welfare—impacting the PCSA's out-of-home placement numbers—has fluctuated depending on the judge. In other counties, the judge and magistrate prefer to give custody to the agency rather than kin caregivers. Guardians ad litem, too, may have influence on placements; the director in one county noted that GALs can be biased toward kin caregivers and may recommend that children stay in foster care. Additionally, in one county the judge requires the PCSA to provide annual check-ins with children in kin care, even after the case is closed, until the child is eighteen—a requirement that places a significant demand on staff time.

The influence that local judges have on placement rates has been an ongoing topic of conversation throughout the third waiver period, with directors often expressing frustration over their lack of control over increases or decreases seen in placement days. In one county, placement days had steadily decreased for a 12-year period but dramatically increased when a new juvenile judge was appointed in 2013. This rise was not due to any change in agency practice; instead, it reflects the particular judge's preference for extending authority over families by mandating that the court or agency take custody of children served by the agency.

This dilemma over placement rates changing due to circumstances outside of the agency's control is a challenge PCSAs are faced with on an ongoing basis, particularly when it comes to mandated evaluations that often accompany new initiatives or even federal measures. Directors often feel they are unfairly penalized for decisions made outside the agency, yet it is outside their capacity to take any type of corrective action that may remedy the situation.

2.3.6 Service Array and Other Initiatives

Just as collaborative relationships can shift, changes in the availability of services occur often. Providers may open or close their doors, and PCSAs may decide to contract out or handle internally a variety of service activities. For example, one county brought its visitation program back in-house in 2014. During the third waiver period, a few PCSAs noted the loss of specific services such as Kinship Navigator or kinship units, school-based services, and in-house behavioral health services. However, PCSAs also noted the addition of Permanency Roundtables, expanded Alternative Response efforts, and Wendy's Wonderful Kids. In addition, 10 demonstration counties have participated in the Ohio Fatherhood Initiative, as have 5 comparison counties. Counties also mentioned a variety of other service options to prevent placement and ensure permanency, such as Safe Teams, Intensive Reunification, Strengthening Families, front-loading services, Family Search or Family Finding, intensive home-based therapy for kinship providers, kinship units, Drug Court, and school-based staffing.

2.3.6.1 Differential Response

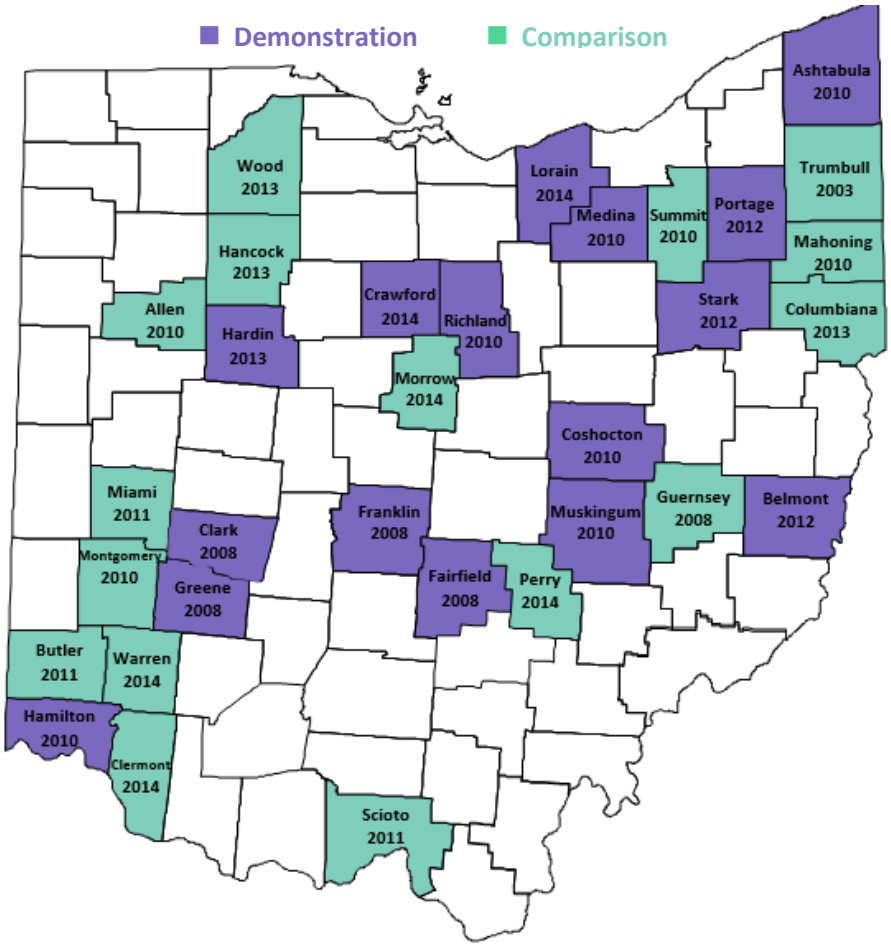
In addition to the changing services described above, one overarching programmatic shift has been the expansion of Differential Response (DR) to all counties during the third waiver period.

DR offers county child welfare agencies a two-track option when assessing incoming reports of abuse or neglect. Based on state rule, certain types of high-risk cases must be assigned to the traditional investigation track, known as the traditional response (TR). However, families identified as being of lower risk may be offered an Alternative Response (AR)—depending on local county policies. AR is designed to quickly engage families, making the family integral to the service-planning process. Services are identified and 'front-loaded' for these families as swiftly as possible. Unlike TR cases, AR cases do not receive a disposition unless more severe risks are uncovered during the assessment process (in these circumstances, the case would change tracks to TR). AR represents a philosophical shift in the way workers are trained to approach families with lower-risk reports of abuse or neglect, seeking to 'engage' them rather than investigate them.

The initial rollout of DR occurred in 2008, in the context of a randomized control trial conducted by the Institute of Applied Research and sponsored by the Ohio State Supreme Court and the Ohio Department of Job & Family Services (Loman, et al., 2010). This pilot study, in ten counties, investigated the effects of DR on outcomes for children and families. Four of the counties were ProtectOHIO demonstration counties and two were comparison counties. Subsequently, in 2010, the Quality Improvement Center on Differential Response (QIC-DR), funded by the Children's Bureau, began a three-site randomized control study, which included another five of Ohio's counties,[14] in addition to multi-site projects in Colorado and Illinois. Since 2010, ODJFS has continued to expand the use of DR through a series of rollouts across the state (Figure 2.2). As the map shows, ProtectOHIO demonstration and comparison counties implemented this approach at various times, contributing to an ever-changing context in which to understand the impact of the two discrete waiver strategies, FTM and Kinship Supports.

[14] Clark county was included in the pilot study on DR as well as the QIC-DR study

Figure 2.2: Dates of Entry into Differential Response for ProtectOHIO Counties



During the 2012 site visit interviews, managers and directors were asked about major changes in service offerings in the past four years. Differential Response was the most frequent response, not surprisingly since 14 of the demonstration counties and 13 of the comparison counties had implemented the practice or were on the verge of doing so. At the point of the 2014 site visits, all counties had implemented DR to some degree. Several counties were still struggling with buy-in to the new program from some workers. One comparison county representative stated that her county would only rarely assign a case to the AR track because of the director's wariness of the approach. Other counties were struggling with gaining buy-in from the local community, including local law enforcement, the court, and schools. Counties with more program maturity described DR as now being business as usual; some even indicated their overall philosophy hasn't changed since the implementation of DR, in that their agencies had always emphasized engaging and assessing families.

Based on the information gathered during the 2014 site visits, there has been wide variation in the way DR has been implemented. Counties have taken various paths to add AR workers to their existing unit structure: Some counties say they have grouped AR workers together in pure AR units or as part of a larger unit; others have spread the AR caseworkers throughout the intake and ongoing units; still others say that AR fits easily into their existing one worker-one family approach. Table 2.1 highlights some of

the ways that units and casework have been differently structured to accommodate the AR track; these are based on interview responses from the 2014 site visits. Note: The numbers shown in the rows below are not mutually exclusive. For example, AR workers who hold the case through its entire length may or may not be in AR-only units. And workers who carry both alternative and traditional cases may also carry their AR cases through the length of their entire case.

Table 2.1: Structural Differences in Agency Units		
	Demonstration Counties	**Comparison Counties**
One AR worker per family model	6	5
Workers carry alternative and traditional cases	6	7
AR-only worker units	6	3

Programs have evolved differently across the early implementers of DR: One county had to reduce the number of cases it could assign to the AR track because of high staff turnover; another had doubled the number of cases assigned to AR; and two comparison counties hired new staff to explicitly increase the number of families they could assign to AR.

Across the waiver evaluation counties that had implemented DR through 2012, nearly all noted that changes had occurred in intake; certain workers carried cases a little longer, thereby reducing the need to open the case to ongoing services. At that time, nine demonstration counties and five comparison counties said they expected or had already seen a decrease in cases transferring to ongoing services. Table 2.2 highlights the perspectives of agency staff who were interviewed in 2014. Note: Only 10 of the 16 demonstration counties and 9 of the 16 comparison counties commented on this topic.

Table 2.2: Changes in Case Flow Attributed to DR Implementation		
	Demonstration Counties	**Comparison Counties**
Counties noting an increase in cases transferring to ongoing services	0	1
Counties noting a decrease in cases transferring to ongoing services	4	5
Counties noting no impact on number of cases transferring to ongoing cases	6	3

2.3.6.2 County Cultural Responsiveness

In addition to the implementation of DR, counties have also integrated culturally specific and responsive practices to mitigate racial disproportionality. Six demonstration counties and six comparison counties noted that their agencies do not experience racial disproportionality, since their counties are predominantly or all white. However, some of these same counties, as well as others, identified specific cultural groups with whom they work, including Amish and Appalachian families. Other counties noted that they work with Latino families, African American families, and African refugee families. Demonstration and comparison counties both face some challenges in meeting family and children's cultural needs. Counties describe a shortage of Spanish-speaking staff to serve a growing Latino

population, scarcity of racially matched foster parents for children of color, and challenges in ensuring that foster parents adhere to biological parents' religious or cultural preferences. Yet, there are general ways in which demonstration and comparison counties seek to provide culturally relevant services and case planning:

- Holding staff trainings on diversity and culture (cited in 2 demonstration counties, 7 comparison counties).
- Adapting hiring practices to reflect diversity of clients, such as employing Spanish-speaking caseworkers (cited in 1 demonstration county, 3 comparison counties).
- Using internal practices to ensure staff of color feel safe. For example, in one county, a black caseworker was removed from the case of a family with confederate flag tattoos at the worker's request (cited in 1 demonstration county).
- Commissioning a third-party survey of closed cases to assess how culturally responsive the agency is (cited in 1 demonstration county).
- Adjusting particular policies in recent years to account for culture, such as no longer considering household overcrowding a standalone risk factor for children, as this may reflect family culture, and allowing for medical decisions—such as child vaccinations—based on culture (cited in 2 demonstration counties).
- Maintaining a diversity committee to hold ongoing trainings and provide topics of conversation for staff on an ongoing basis (cited in 2 comparison counties).

Additionally, staff in one county noted that its ProtectOHIO Supervised Visitation provider contract includes requirements around diversity and cultural responsiveness, to ensure all families participating in visitation services feel safe and accommodated.

Two counties expressly indicated that they don't purposely pair families of color with caseworkers with similar identities. One county views this as prohibited by the Federal Multiethnic Placement Act and Interethnic Adoption Provisions; however, in this county, caseworkers choose their cases, so this may tacitly increase the chances of caseworkers being culturally matched with the families on their caseload. On the other hand, one comparison county purposefully engages African American male youth involved with their agency with African American male mentors.

Demonstration county staff were also asked about the role that the two ProtectOHIO strategies play in their efforts to become culturally competent or relevant and to address racial disproportionality or inequity. Specific links drawn between the strategies and culturally specific services are noted in Chapters 3 and 4 of this report. One county noted that the flexibility embedded within the ProtectOHIO strategies allows practices to be individualized to accommodate family culture, even when delivered with fidelity. This attention to FTM and the Kinship Supports strategies as mechanisms for culturally specific services may explain why comparison counties are more likely than demonstration counties to have undergone training specially focused on diversity or hiring practices that reflect the diversity of clients; efforts within demonstration counties may be focused on FTM and the Kinship Supports intervention.

2.4 Other ProtectOHIO Strategies

Apart from those initiatives and efforts occurring across the state and outlined above—and in addition to the implementation of Kinship Supports and Family Team Meetings—some ProtectOHIO demonstration counties carried over other strategies implemented during the prior waiver period. During the second waiver, demonstration counties focused on two or more specific interventions, each choosing from: Family Team Meetings, Supervised Visitation, Kinship Supports, Enhanced Mental Health/Substance Abuse Services, and Managed Care. Counties implemented a combination of these interventions, with every county implementing FTM. During the third waiver period, as ProtectOHIO became more focused and defined, all demonstration counties agreed to solidify and continue the FTM and Kinship Supports models. In addition, some counties that had ingrained and incorporated practices from one of the remaining three interventions opted to continue those as well. Table 2.3 demonstrates county participation across the various intervention strategies during the third waiver period.

Table 2.3: ProtectOHIO Strategies Implemented in Demonstration Counties

Demonstration County[15]	ProtectOHIO Service Interventions				
	Family Team Meetings	Kinship Supports	Visitation	Enhanced MH/SA Services	Managed Care
Ashtabula	X	X			
Belmont	X	X		X	
Clark	X	X	X		
Coshocton	X	X		X	
Crawford	X	X			
Fairfield	X	X			
Franklin	X	X			X
Greene	X	X			
Hamilton	X	X	X		
Hardin	X	X			
Lorain	X	X			
Medina	X	X			
Muskingum	X	X	X		
Portage	X	X			
Richland	X	X			
Stark	X	X			
TOTAL	16	16	3	2	1

As noted in Table 2.3, six demonstration counties chose to continue to use some of the waiver strategies begun during the second waiver throughout the third waiver. However, Highland County, which was implementing the Supervised Visitation intervention, exited the waiver at the start of 2015 (retroactive

[15] In 2015, Highland County exited the waiver. As such, Highland's data is not included, except in the focused exit interview section. During the third waiver, Highland County implemented Supervised Visitation in addition to FTM and the kinship supports intervention.

to Oct. 1, 2014), decreasing the number of counties implementing the optional waiver strategies to six. Sections 2.4.1 through 2.4.3 describe these strategies and summarize the evaluation team's findings related to each.

2.4.1 Supervised Visitation

Supervised Visitation involves regular, structured visits between parents and their children who have been placed in out-of-home care. These visits provide opportunities for parents to spend time with the children, to improve parent-child interactions, and to speed the return home. Three counties continued this intervention throughout the entirety of the third waiver. The counties offer varied reasons for continuing the work, reflecting their varying perspectives on the value of their particular approach:

- Opportunity to continue to offer a homelike setting where families tend to have positive meetings with their children.
- Option of stepping down families to less restrictive hours and location for visitation.
- Designated visitation staff.
- Opportunity for longer visits.
- Vehicle for identifying baseline behaviors and opportunity to teach parents.

As these reasons indicate, the visitation programs differ from many standard PCSA visitation models wherein multiple families meet simultaneously in a large area of the agency where a few staff are present to keep an eye out. In particular, these three agencies offer: (a) professional staff observing and interacting with parents, developing rapport that enables them to coach and educate parents, with a focus on child development; (b) visits in the home; (c) visits in a homelike setting, without the security surveillance and bag checks that are common in agencies; (d) pre-visitation preparation of parents; and/or (e) activities, such as crafts and playrooms, for parents and children.

Compared to the common ProtectOHIO supervised visitation model used during the second waiver, the counties' current programs have evolved into distinctive versions. Two counties have made changes in location, in frequency and length of visits, in staffing, and in the use of structured activities during the visits. Two now have freestanding visitation centers; one provides visitation in-home; two have increased the length of typical visits to 3 or 4 hours; two have increased the number of professional staff; and, in all three sites, staff help parents to tailor activities to their particular family needs and interests. During the third waiver period, one agency transitioned to a fully provider-based, contracted visitation service; conversely, one agency moved the bulk of the visitation program back in-house. The remaining agency maintained the visitation program in-house.

Among the challenges and concerns they face in providing supervised visitation, the counties mentioned: (a) getting providers to offer more flexible locations and hours, (b) having sufficient space and enough time to help with parenting (when utilization is high), and (c) referring parents for the most appropriate level of supervision.

2.4.2 Enhanced Mental Health/Substance Abuse Services

Various improvements in the availability and timeliness of assessment and treatment for families with mental health and/or substance abuse issues seek to reduce the need for out-of-home placement and continued involvement with the public child welfare agency. Two counties continued the enhanced mental health or substance abuse services they began under the second waiver period, though one of those counties discontinued the initiative at the end of the second waiver period. In the county where services are continuing, the initiative is characterized by drug screenings and referrals to a behavioral health provider for in-home assessments. In the county that discontinued the intervention, the initiative included a contract with a behavioral health center, as well as a Family Dependency Treatment Court (drug court). However, toward the conclusion of the waiver, the behavioral health center was sold out to a large company, at which point contracted services no longer resembled those initially provided. The drug court component continues, but the county does not view that as a ProtectOHIO intervention.

2.4.3 Managed Care

Case rate contracting gives private agencies full responsibility for case management and service delivery for children in ongoing PCSA cases. This is an approach still being used by one PCSA to enhance system efficiency and effectiveness.

Since the start of ProtectOHIO, one county has used waiver funds for managed care contracts with private agencies that serve a portion of the ongoing services caseload. The goal is to enhance system efficiency and effectiveness by relieving pressure on ongoing services caseloads. These private agencies receive a capitated payment for each case they serve, with a monthly limit of cases. In general, the managed care agencies combined have received approximately a third of the cases determined to need ongoing services.

The county has made three important changes over the course of the third waiver period: (a) it established a Performance Incentive Program, with each agency receiving a full or partial bonus depending on how closely it meets seven measures related to contact, safety, permanency and reunification; (b) the contractors now keep the PPLA cases until they close and the PC cases until the parental rights are terminated and the case transfers to adoption; and (c) the contractor gets the case back (without additional payment) if the case needs to be reopened within 24 months. The PCSA has consistently tracked case outcomes and found process and outcomes to be fairly comparable between the PCSA cases and the contractors' cases. A challenge of this intervention includes facilitating conversation between the PCSA and the contracted agencies.

2.5 ProtectOHIO and Well-Being

Apart from implementing additional ProtectOHIO strategies, some demonstration counties participated in a well-being pilot during the third waiver period. Since the beginning of Ohio's third waiver period, well-being has been an ongoing topic of conversation among Consortium members. While members agreed that improving the well-being of children and families is integral to child welfare practice, they struggled to determine if, and in what capacity, the measurement of well-being should occur. The major issue to be considered before adding such a measure to Ohio's waiver evaluation was the data collection

burden placed on PCSA staff, and what could be done to minimize this burden to acceptable levels for frontline staff. Initial discussions included adding a well-being component to the Kinship Supports intervention; however, when the Consortium considered the extent to which agency practice was already changing to get the intervention up and running (e.g., hiring new staff or creating new positions, learning practice manual tools and data-entry procedures), it was agreed that a rigorous measure of well-being would not be advantageous at that point in time. Instead, the Consortium decided to revisit the idea at a later point in time.

In early 2014 the ProtectOHIO Consortium once again began discussing the idea of potentially designing a well-being component for the waiver and the ProtectOHIO sustainability subcommittee was tasked with recommending a plan to propose to the Consortium. Evaluation team members shared research on a variety of well-being and family functioning assessments—including the areas assessed, the person responsible for completing the tool, the time to complete it, and the overall advantages and disadvantages of each assessment (Appendix A). Evaluation team members also explored the viability of utilizing existing SACWIS data to measure well-being; however, the large majority of well-being information was in narrative format, which would not be viable for large-scale analysis. The quantitative information available was also problematic, often appearing in dichotomous format (e.g., risk contributor/no risk contributor), which would not capture nuanced changes that are crucial in detecting differences; additionally, multiple well-being components are often combined into one data element (e.g., physical/cognitive/social/developmental). Ultimately, the subcommittee recommended to pilot a well-being assessment based on the Child and Adolescent Needs and Strengths (CANS) Comprehensive and Child Welfare assessments (Appendix B), and instead of incorporating the pilot into the kinship supports intervention, to utilize the FTM component of ProtectOHIO, given its more established nature as an intervention.

Overall, the agreement was that the pilot would be short: families that took part in initial, case-planning FTMs in July 2014 would receive baseline assessments; follow-up assessments would be conducted for each family at their third FTM (most often held six months after the initial FTM) or at case closure—whichever came first. The idea was to pilot the process to assess the feasibility of incorporating a well-being tool into the waiver evaluation, and ultimately to decide whether Ohio would include a specific well-being component as a part of the waiver evaluation.

2.5.1 Implementation Findings

The evaluation team collected qualitative information related to the processes that counties implemented to conduct this well-being pilot. Data was collected during 2014 site visits from both caseworkers and facilitators. In some counties, few caseworkers may have been involved because of the short duration of the pilot; this posed a challenge for evaluators as they sought to gain caseworker feedback or perspectives. Nevertheless, the evaluation team presents the process findings here, including barriers and successes identified as a result of participating in the pilot.

2.5.1.1 Well-Being Pilot Training

An evaluation team member who is also a certified CANS trainer created a web-based training and assessment manual for PCSA staff. Thirteen counties agreed to participate in the pilot, and representatives from all thirteen counties participated in one of the three web-based trainings.

The trainings were primarily attended by FTM facilitators and, in some cases, supervisors. Counties indicated that facilitators did not necessarily train caseworkers on the well-being assessment but rather provided guidance, and in some cases reviewed the manual together, during the completion process. Staff in some counties found the training helpful, indicating that it provided insight on the rating scale and how to utilize the manual. However, there were also perceived barriers. For example, some staff felt the manual provided plenty of guidance and that the training was unnecessary. Other staff felt that the training's usefulness would be increased with additional operationalization examples of how to apply the tool to a particular family and which rating to choose. And staff in one county felt that the training did not make it clear that the tool was validated, and were therefore concerned about different workers completing the baseline and follow-up well-being assessment. Overall, while staff in some counties felt the training was useful, others felt it was confusing rather than illuminating.

2.5.1.2 County Implementation Processes and Impact on Staff

While there was some variance in the implementation processes across counties, Family Team Meeting facilitators always took the lead in completing the well-being assessments. Because a primary reason for conducting this pilot was to explore the viability of implementing a well-being assessment, counties were given flexibility in their implementation process. In this way, various processes could emerge naturally and be assessed in terms of strengths and challenges.

Facilitators often sat with caseworkers (intake and/or ongoing), and sometimes supervisors, after the FTM to complete the assessment. In at least one county, the facilitator completed the assessment without input from the caseworker(s), utilizing case documents as a reference. In another county, the facilitator used the information gathered during the FTM to complete the assessment independently. In one county, the facilitator and worker(s) completed the well-being assessment for all cases that transferred within a specified period of time at once. Another county employed an electronic process wherein facilitators emailed the incomplete assessment to workers prior to the FTM.

Staff noted that completing the assessment right after the FTM worked well, as it ensured the facilitator and worker(s) (and, in some cases, supervisors) were present; it also mitigated some of the burden to caseworkers. Similarly, the facilitator may have completed all the demographic info in advance to streamline the assessment completion after the FTM. Another noted strength is that the assessment may be unique (to other case planning documents) in capturing optimism and community life components.

Staff also identified barriers or drawbacks to the assessment or their county's assessment processes. For instance, some staff felt the assessment was seen as redundant, capturing information already gathered in the risk and safety assessment process. Some staff felt that the same information would have emerged in other ways during the assessment and FTM process, so an independent well-being assessment was duplicative. Still other staff felt the assessment was useful, but that the Likert scale did

not include enough options and the domains assessed were too narrow to be useful. If cases were closed at the point of follow up (many were), the well-being assessment was sometimes viewed as irrelevant. Some staff indicated that choosing the score was challenging and the collaborative process around scoring a family took a while. Also, in some smaller counties, only a handful of cases transferred to ongoing during the one-month baseline data collection period, making it challenging for counties to determine and concretize assessment processes.

A primary concern identified prior to the implementation of the pilot was the potential burden to caseworkers and the impact on caseworker workload. Following the pilot, caseworkers and facilitators reported that the assessment usually took between 5 and 25 minutes to complete (including utilizing the manual). Most noted that completion was in the 5 to 10 minute range and that the process became faster each time the worker(s) completed the assessment. Workers also reported that while the assessment did add a small amount of work, it was less complex and time-consuming than other responsibilities, noting "It's one of the easiest things on the workload." To ease the burden on caseworkers, facilitators may have completed the identifying information portion of the tool in advance, so that workers only had to complete the caregiver needs and youth strengths sections. Most workers felt the time it took to complete the well-being assessment was reasonable.

2.5.1.3 Family Involvement in the Well-Being Assessment

Counties were given autonomy to determine whether and how to involve families in the well-being assessment completion process. While some opted to involve parents or families, the majority did not. Some staff noted that the length of the pilot did not allow facilitators/workers to become comfortable enough with the tool to use it with families, and one county was concerned that the tool might inhibit family engagement if the manual was not accessible to or understood by families. Similarly, staff in one county were concerned about parental capacity. Staff also noted that completing the assessment during the FTM did not fit into the agenda. In counties where parents were involved, family members may have been invited to stay after the FTM to complete the assessment with staff once other meeting attendees had left. In this way, the tool was used as a family engagement mechanism. The assessment was viewed as more accessible and understandable than other case paperwork for families and is also perceived as being strengths-based, which is a key FTM value. One worker mentioned that the assessment is a "tool for families to think about themselves."

2.5.1.4 Measure Usefulness

Staff were asked about their overall experience of the tool, including its usefulness and impact. One positive impact they noted was the collaborative and creative approaches to services and case planning that emerged from discussion which the assessment prompted between workers, facilitators and, in some cases, supervisors. In this way, some staff felt the assessment was the vehicle for needed conversation. Additionally, the assessment allows workers to orient themselves to a family and to tell if the parent/caregiver has progressed. By contrast, some counties felt that the nuances and fullness of well-being cannot be captured by a tool: "You can tell if families are improving by the progress they're making, not by completing a form."

Often the assessment was completed by the worker under the facilitator's supervision and then stored by the facilitator until the follow-up CANs was due; it was not referenced or utilized during case planning or FTMs. In this way, perhaps because of the pilot's short duration and evaluation focus, workers and facilitators did not necessarily give thought to the ways the well-being assessment could be used creatively in practice or with families in the long-term. However, some did identify ways the assessment could be used in the future:

- The intake and ongoing workers could complete the assessment together at the case transfer meeting as a warm handoff tool and to share knowledge of the case.
- The assessment may be a helpful tool to measure case progress.
- The assessment may be an appropriate tool for caseworkers to design their interviews with families around.

2.5.2 Well-Being Outcomes

In all, baseline and follow-up data were collected for 52 children and 77 caregivers across 10 counties. Because the child portion of the CANS assessment is intended for children over the age of five, families with children under the age of five received the parent portion only. Additionally, while 13 counties agreed to pilot the assessment, 1 county exited the waiver, 1 did not provide follow-up data, and 1 did not have any eligible cases transfer from intake to ongoing during the baseline period.

Children were assessed on seven domains: Family, Interpersonal Skills, Optimism, School Attendance, Community Life, Relation Permanence, and Well-Being (i.e., child psychological strengths). As demonstrated in Table 2.4, for each domain, the average child follow-up score was improved in comparison to baseline scores, with children showing statistically significant improvements in School Attendance, Community Life, Relation Permanence, and Well-Being ($p<.05$).

Scoring: 0 = centerpiece strength, 1 = useful strength, 2 = identified strength, 3 = no strength identified

Table 2.4: Child Well-Being Outcomes

Child Well-Being Domains	Baseline Mean Score	Follow-Up Mean Score
Family	1.39	1.20
Interpersonal	1.38	1.15
Optimism	1.42	1.41
School Attendance*	**.94**	**.63**
Community Life*	**1.71**	**1.29**
Relation Permanence*	**1.58**	**1.31**
Well-Being*	**1.48**	**1.17**

Caregivers were assessed on eight domains: Supervision, Knowledge, Organization, Resources, Mental Health, Substance Use, Developmental Ability (in relation to parenting abilities), and Intimate Partner Violence. Similarly, as Table 2.5 illustrates, the average caregiver follow-up scores showed improvement over the baselines scores in all but one domain, and caregivers showed statistically significant improvements in the Knowledge, Organization, and Substance Abuse domains ($p<.05$).

Scoring: 0 = no evidence, 1 = minimal needs, 2 = moderate needs, 2 = severe needs

Table 2.5: Parent Well-Being Outcomes		
Parent Well-Being Domains	**Baseline Mean Score**	**Follow-Up Mean Score**
Supervision	1.33	1.24
Knowledge*	**1.47**	**1.25**
Organization*	**1.47**	**1.25**
Resources	1.30	1.27
Mental Health	1.38	1.27
Substance Use*	**1.06**	**.91**
Developmental Ability	.29	.31
Intimate Partner Violence	.87	.79

* Indicates statistically significant improvement between baseline mean and follow-up mean.

2.5.3 Well-Being Summary

Overall, the results demonstrate improved well-being outcomes for both children and caregivers served by demonstration county PCSAs, although due to the small nature of the pilot the results may not be generalizable beyond the sample used. However, the findings were unsurprising to Consortium members, as they had indicated from the start that care provided to families by their workers *does* improve the well-being of families, and that it's a natural consequence of improving safety and permanency measures for families. And, in some cases, the immediate work they do, including linking families to needed services, improves the well-being of families, *leading to* improved safety and permanency measures—in this way it is an iterative process.

While the outcome findings were generally positive, the process findings were mixed. Although most staff who provided feedback did not report the process to be overly burdensome, staff were mixed on how useful the tool is for practice. Additionally, because participation in the pilot was voluntary, the level of burden on PCSA staff may not have been accurately reported: Most counties that chose not to participate in the pilot did so because they did not feel they could ask their staff to complete yet another assessment. In an age where evaluations are often required to secure funding for new child welfare initiatives, caseworkers and other PCSA staff are often saddled with countless extra assessments to complete, on top of their normal casework practice which already includes a heavy assessment and data-entry workload. While it's understood that evaluations are valuable in understanding the impacts of these initiatives, caseworkers often feel the required tools take away from time that should be spent with families. And, in a county-administered system where counties may be participating in any number of other initiatives and where caseload sizes vary, the impact of implementing a new assessment is felt differently across counties.

Interestingly, at the state level, well-being has also been a topic of interest for several years. At the same time as ProtectOHIO was experimenting with its well-being pilot, the state initiated a separate well-being pilot also using a version of the CANS to assess the viability of implementing the CANS as a state-wide required assessment. Because the state has yet to issue its long-term plans, the Consortium feels that it would be better to hold off on adding a well-being component to the waiver. Instead, the

evaluation will continue to explore the various methods that counties are already using to measure well-being and—though these measures may vary from county to county—to use existing measures to the greatest extent possible.

2.6 County Exits from the Waiver

During the third waiver period, two demonstration counties (Vinton and Highland) and one comparison county (Hocking) exited the waiver. Due to financial constraints, Vinton County merged its administrative operations with Ross County in 2012; in 2013 Hocking County joined those two agencies. This required both Vinton and Hocking to exit the waiver; as the careful selection of matched demonstration and comparison counties were impacted by these merges. Separately, Highland County's withdrawal request was officially approved by ODJFS in November 2014 and by DHHS in March 2015, retroactive to Oct. 1, 2014. Highland County requested to leave the waiver demonstration due to high caseloads and high placement days. In light of this request, the evaluation team replaced Highland County's regular site visit with one for the purpose of holding exit interviews. Information was gathered from agency administrators with a focus on understanding the basis for Highland County's desire to exit the demonstration, including contextual factors and the county's fiscal environment. The evaluation team also interviewed ProtectOHIO intervention staff to determine how the practices might be impacted with the loss of flexible funding. Highland County's insights on the impacts of flexible funding on a medium-to-small county may shed light on the nature of waivers and their applicability to other counties or states.

In 2012, during the first site visit to Highland County conducted in the third waiver period, the county indicated it was in the preliminary stages of implementing the Kinship Supports intervention and hoped that the combination of the Kinship Supports and Family Team Meetings would decrease foster care placement days, which had already begun to increase. At that point, the county specified multiple contextual factors that were impacting the number of placements, including a heightened unemployment rate and increased drug use within the county—contextual factors generally occurring across the state, as noted previously. Indeed, Highland County experienced over 10% unemployment in 2012, compared to Ohio's average of 7.4%[16]. During the economic recession, a major employer in the county laid off 8,000 individuals (19% of the county population[17]). Staff indicated that, associated with these layoffs came depression and financial necessity, which increased drug use and child welfare involvement. During the 2012 site visits, at least one staff member mentioned concern about losing flexible funding in the future if placement rates did not decrease.

While the unemployment rate has decreased in Highland County since 2012, it remains higher than the state average. At the time of Highland's request to exit the waiver, the county unemployment rate remained about two percentage points higher than the state, at 7.6%[18], placing it among the top 12 Ohio counties with the highest unemployment rates (of 88 counties in total)[19]. During the exit interviews

[16] U.S. Census Bureau, 2015

[17] United States Department of Labor, 2015

[18] Ibid

[19] Ibid

conducted in 2015, staff reported a confluence of complex economic and social issues that resulted in increased out-of-home placements—rates roughly twice as high as those experienced by the agency when it first entered the waiver. The primary factors leading to increased placement days and the county's subsequent request to exit the waiver were drug use and high caseloads/staff turnover. In addition to these major factors, staff had some insight on funding formulas. Staff noted that the upfront payment through ProtectOHIO was helpful and, ultimately, if there had been some flexibility of funding based on caseload size, the county might have continued in the waiver.

As Highland County staff discussed in 2012 and 2015—and has been reiterated in essentially all of the counties that the evaluation team visited in 2014— methamphetamine, heroin, and marijuana use continue to present challenges for families and, subsequently, PCSAs across Ohio. This increase in rural drug use (especially heroin) is not distinct to Ohio, and has been documented in neighboring states as well.[20] In particular, Highland County staff estimated that 90% of children are in care due to drug-related risk factors. Administrative and programmatic staff alike all identified drug use as the predominant factor for the increase in placements within the county. Not only are placements increasing, but intergenerational drug use may limit the usage of kinship caregivers. Kin who have a history of illegal drug use may be required to go to treatment and to pass a considerable amount of time drug-free prior to becoming eligible to care for youth; in fact, one staff said the agency prefers if kin have been sober for five to ten years. In addition to drug use impacting placement numbers, the County Probate & Juvenile Court maintains a zero-tolerance policy for parental drug use. In the past, children would be removed for parental marijuana use, as well as for the use of other illegal drugs. However, as placements became more unmanageable for the agency financially, the courts agreed to defer some marijuana cases to Alternative Response. Courts are giving parents longer to recover from drug use, which may increase reunification in the long-term, but has also increased placement numbers in the interim.

An additional confounding factor related to increasing drug use is limited county capacity to respond comprehensively and effectively to the issue. There is a dearth of treatment and AOD services options within the county; there are no inpatient drug treatment programs available, and outpatient services and classes have waiting lists. Additionally, because the county is small, county staff noted that parents may have personal relationships with the providers—for example, they may have gone to school together—and feel uneasy about receiving treatment from them.

Agency staff indicated that local AOD providers have said there's an epidemic in drug use in the county. The community is collaborating to respond; AOD providers are working hard to develop a federally qualified Suboxone clinic within the county and there's a drug taskforce that's doing routine busts and arrests—though these arrests often result in more children in care.

As a result of so many drug-involved cases, and the subsequent number of children coming into care, caseloads have increased. Caseworkers in Highland County carry caseloads of 24 and up—much more than the 13 reported in some of Ohio's other counties and the 17 maximum ongoing cases recommended by the Child Welfare League of America.[21] A supervisor also carries an intake caseload

[20] The Economist, 2015

[21] Child Welfare League of America, 1999

and there's a contracted, grant-funded employee carrying a small ongoing caseload. These high caseloads are considered to have impacted staff turnover rates; at the time of the exit interviews, the entire ongoing unit was comprised of caseworkers who had been in their positions for no more than two months. This staff turnover made it challenging for Children Services to sufficiently serve families and engage with cases.

Highland County's decision to exit the waiver demonstration was fiscal, not practice-related. However, the evaluation team explored how the county would continue to utilize or not utilize the two primary ProtectOHIO strategies in the absence of flexible IV-E funding.

- **Kinship Supports**: Kinship staff structures have not changed as a result of exiting the waiver. The kinship coordinator's responsibilities have shifted slightly to eliminate ProtectOHIO data collection responsibilities. However, the agency maintains an emphasis on locating and serving kinship caregivers. Perhaps the largest intervention-related change is that the agency now limits the hard goods and support it provides for kinship caregivers. Under the waiver, flexible funding allowed the agency to provide beds, car seats, and clothing vouchers. The agency also paid for potential kinship caregivers to get fingerprinted for home studies. Now, for the most part, the agency is unable to provide those items and must refer families to other community resources. Additionally, the agency can no longer pay for childcare for children living with kinship caregivers. At the time of the exit interview, kinship staff estimated that one or two kinship placements had disrupted because of a lack of support or resources.
- **Family Team Meeting**: The county's Family Team Meeting structure changed shortly after it exited the waiver; the agency ceased doing 90-day family meetings to eliminate burden on staff. However, the agency realized parents were more engaged and supported if they were meeting regularly. Additionally, families and area providers advocated for these meetings to return, which they have. Without flexible funding, the meeting facilitator will maintain her role, though other trained staff, including supervisors, may serve as meeting facilitators.

Highland County's decision to exit sheds light on some of the successes and challenges of the waiver, as well as the impact of the ProtectOHIO strategies. For example, county staff noted the positive impact of both the FTM and Kinship Supports strategies, and the county reinstated FTM to fidelity after exiting the waiver, recognizing its positive impact on families.

2.7 Impact of the Waiver

To better understand the impact of the waiver, the evaluation team, during the 2014 site visits, asked county directors about its effects on their agencies. Directors remain largely positive about the waiver, as they were in 2012, and continue to embrace the waiver strategies for their potential to reduce the need for placement—especially through providing increased supports for kinship caregivers and in helping families to reach permanency sooner—due to greater family engagement.

However, in 2014, more concerns emerged about the potential for Ohio's waiver to end after the completion of its third period, as well as the looming conclusion of Title IV-E Waiver Demonstrations overall in 2019. The evaluation team heard widespread concern about waiver funding. County directors

and managers expressed uncertainty about the future and concern about how a return to traditional reimbursement for foster care board and maintenance costs would impact placement rates. In demonstration counties the FTM and Kinship Supports strategies, fueled by flexible funding, have become practice-as-usual. Indeed, as illustrated in Chapter 4, significant effort and strides were made to solidify the Kinship Supports intervention during this waiver period; staffing structures, online training, and county support for kin have all been enhanced. FTM, too, remains a growing and expanding practice; as described in Chapter 4, one county that initially provided FTMs to a subset of cases has enhanced its internal capacity and extended FTM to all open cases because of FTM's positive impact on families, staff, and community partners. Counties are reliant on waiver funding to continue these practices with fidelity, so staff are concerned about the future, expecting negative outcomes if flexible funding is lost:

- An increase in out-of-home placements, higher caseloads, and subsequent staff attrition.
- Decrease in service array and preventative services; one county estimated the loss of 30 contracts with local providers.
- Decreased family engagement and family-centered decision-making, since the agency would have to take custody of so many children.
- Community support for the PCSA would dwindle as more and more kids were in care.
- Weakened community collaborations, as the PCSA could not contribute financially to the local Family Council.
- More out-of-county placements, since the number of in-network providers could not support the high numbers of kids in care.
- Kids who are currently with kin might move to foster care because the agency could no longer defray daycare costs for kin caregivers.
- Children would be removed from homes for poverty-related issues, such as poor housing or utilities, rather than just safety-related issues.
- Agencies would revert to only providing mandated services rather than preventative services.

Underscoring these concerns, staff in one county noted, "If the waiver ends, it would impact this community, and more importantly, it will impact the children we are mandated to serve—it would impact them very negatively." And another noted, "Before the waiver, with traditional IV-E, the agency was heavy backdoor—group homes, placements, foster homes—and it's just been flipped. Now it's more service oriented … You keep kids in the home, which reduces the number of kids you have in placement. That flexibility allows new things that we do today that otherwise we wouldn't be able to do through traditional IV-E reimbursements."

Even those counties with flexible dollars through local levies expressed concern about the conclusion of the waiver as these levy dollars are not substantial enough to sustain the interventions. One director expressed ambivalence about seeking a levy increase if waiver funding was lost, noting the precariousness of the local social and political climate. And, in another county, the director believes the community's continued support for the PCSA, including the community's willingness to fund Children Services, is at least in part due to the positive impact the waiver has had on placements, relationships, and the agency's image.

> *"Before the waiver, with traditional IV-E, the agency was heavy backdoor – group homes, placements, foster homes – and it's just been flipped. Now it's more service oriented… You keep kids in the home, which reduces the number of kids you have in placement. That flexibility allows new things that we do today that otherwise we wouldn't be able to do through traditional IV-E reimbursements."*
>
> *– Demonstration County Administrator*

The concerns noted above stem from the positive impacts that counties have seen as a result of waiver flexibility. ProtectOHIO continues to be seen by the demonstration counties as a vital funding source and impetus for creativity and partnerships. Several themes emerged clearly from discussions with PCSA directors and top management:

- It has been a validation of long-time processes and beliefs about best practice.
- In practice, it is the two strategies, FTM and Kinship Supports. These represent a better way of interacting with and engaging families, and at the same time provide more support for casework staff; both of these changes contribute to quicker permanency.
- It is an invaluable resource because it is flexible, enabling agencies to have more to offer families and kinship caregivers, providing an opportunity to do something different, challenging workers and agencies overall to be creative and to do nontraditional things, and allowing the agencies to do prevention and to front-load services.
- It is systemic reform in that funding is not tied to one model of intervention and it gets funders (state and federal) out of case-level decisions.
- It has meant a culture change, involving more people in case decisions and in responding to individual needs, looking at new possibilities in community networks and enabling the PCSA to partner with other agencies.

In addition to concerns about the end of waiver demonstrations in 2019, there is general unease about what might be implemented at a national level in 2020. Over 50 Ohio representatives attended the recent Casey Family Child Welfare Waiver Demonstration Convening in Seattle, Washington. At this meeting, it became clear that there are federal initiatives being considered that would alter the basic child welfare funding approach. While members of Congress are now realizing that the traditional federal funding structure is not in alignment with best child welfare practice, the general message received at the convening was that of waiver demonstrations being considered a "tool" for counties and states to implement innovative approaches. Yet, for Ohio, a state that has utilized this flexible funding

approach since 1997—for nearly 20 years— the waiver is no longer considered a tool. The waiver, including flexible funding and the related interventions, long ago became business as usual.

New bills proposed to date have their own set of restrictions and requirements. While these bills would offer states with the traditional funding stream a better option, ProtectOHIO agencies would take a step backward to comply with the bills' requirements. Consortium members believe that, because Ohio has been operating under a waiver demonstration for the past 18 years and has demonstrated that children and families served under a flexible funding approach are associated with positive or neutral outcomes, the most flexible, lenient bills that are currently being proposed should be considered.

2.8 Summary

In conclusion, the waiver has resulted in internal cultural changes, enhanced practice and partnerships, and better outcomes for children and families. This chapter explored not just the impact of the waiver and staff concerns centered on its conclusion, but also the broad context within which PCSAs operate in demonstration and comparison counties. Specific initiatives and efforts within demonstration counties were expounded on—such as the expansion of Differential Response and the Well-being Measure pilot. And, to provide a concrete picture of the waiver's successes and challenges, Highland County's exit from the waiver was explored. Overall, the dominant theme in the interim evaluation report was financial struggle, for both the PCSAs themselves and for the families they serve. Now, counties are returning to normalcy in terms of service provision, leadership consistency, and revenue, even while PCSAs report challenges with staff turnover and continued service gaps. This overall normalcy could be threatened by the loss of waiver funding, which counties believe would return PCSAs to high rates of placement and limited preventative services. The heart of the implementation work that has gone on in the demonstration counties is clearly their focus on the two waiver models, Family Team Meetings and Kinship Supports. These are the topic of the next two chapters of this report.

Chapter 3. Family Team Meetings

3.1 Introduction and Overview

Family Team Meetings (FTM) are a method for engaging family members and people who can support the family—including extended family, friends, service providers, advocates, etc.—in a process of shared case planning and decision-making. The approach involves regularly scheduled meetings that are facilitated by a trained professional. The goal of FTM is to come up with creative and effective solutions to case challenges, link families to more appropriate and timely services, and ultimately reduce the need for foster care placement and improve permanency outcomes.

3.1.1 History of ProtectOHIO's Family Team Meetings

In an effort to build the evidence base for particular service interventions, the second waiver authorization mandated that all counties participate in one core service intervention. The demonstration counties selected FTM as their common intervention because they were already experimenting with various forms of family meetings under the first waiver; therefore, staff were familiar with the philosophy and practice and believed it to be a potent intervention. Counties began implementing the ProtectOHIO FTM model in October 2005 under the second waiver and have continued implementation and data collection since.

During the second waiver, implementation of FTM was variable, but several positive outcomes emerged for children in the demonstration counties relative to the comparison group, suggesting an impact of the waiver and the FTM intervention (see Section 3.1.2.1). Under the third waiver, the demonstration counties undertook several primary activities to promote more consistent and informed practice. For example:

- In 2010, a workgroup of FTM facilitators developed an FTM Practice Manual, outlining core components and providing additional detail on the ProtectOHIO FTM model.
- During fall 2010, agency staff and the evaluation team held a series of conference calls to review and revise the case-level data elements to be collected for evaluation of the FTM intervention.
- In February 2011, the evaluation team provided training on the revised case-level data elements (in the ProtectOHIO Data System, or PODS), and facilitators then began collecting data using the revised elements, recording the data in PODS after each meeting.
- In May 2011, the Ohio Child Welfare Training Program developed a training based on the practice manual and began providing two-day training sessions, which included content on the ProtectOHIO FTM model and general facilitation skills. Staff in all counties participated in these training events.
- In March 2013, FTM data entry transitioned from PODS to SACWIS; trainings were held for FTM facilitators and other county staff involved in entering FTM data.
- In spring 2014, a High Fidelity Subcommittee was developed and tasked with collecting information on county strategies for increasing attendance and holding meetings in a timely

manner. After reviewing strategies and corresponding county-level fidelity data, the subcommittee made recommendations for best FTM practice.

3.1.2 Ohio's Family Team Meeting Model

As a result of the preceding activities, a more distinct and defined Family Team Meeting model has emerged in Ohio over time. Elements of this model are not dissimilar to Washington D.C.'s expedited Family Team Meeting model, which is the basis of several publications.[22, 23] Both include the use of structured planning and decision-making meetings that use trained neutral facilitators to engage families, family supports, and professional partners in creating plans for children's safety and permanency. In addition, both models employ shorter meetings (ranging from approximately 30 minutes to 2 hours) than typical of other meeting models—in particular, Family Group Decision Making or Family Group Conferencing.[24] However, like Family Group Conferencing—and unlike, for instance, Washington D.C.'s Family Team Meetings and Casey Family's Team Decision Making—Ohio's Family Team Meeting model mandates regularly held meetings over the life of the case. And the ProtectOHIO model, like Family Group Decision Making and Family Group Conferencing, emphasizes the presence of at least one support person, which is not necessarily possible in Washington's expedited meetings.[25]

In summary, Ohio's model carries both similarities and dissimilarities to other family meeting practice models; the adaptions ensure that it is realistic and operational in Ohio counties and appropriate for Ohio's child welfare population, while the similarities ensure that it maintains core family meeting elements that have been shown to enhance outcomes when delivered with fidelity. Given the considerable sample size available for analysis—a rarity in many family meeting practice evaluations—ProtectOHIO county FTMs can contribute to nationwide conversations around family meeting implementation, fidelity, and the development of evidence-based child welfare practices.

3.1.2.1 Highlights from the Evaluation of FTM during the Second Waiver Period

The evaluation of FTM during the second waiver included three major analyses: an implementation analysis, an outcomes analysis, and a fidelity analysis.

The implementation analysis found that the process for implementing the FTM initiative in the demonstration counties was loosely structured and largely left to individual counties to determine. It lacked strong training, supervision, and monitoring components. Despite the variation among the demonstration counties in aspects of implementation, there were notable differences overall between demonstration and comparison sites at the end of the second waiver:

- The demonstration counties appeared to have a broader initiative aimed at a larger population, while comparison counties' practice appeared more targeted (for example, only offering FTM to children at imminent risk of removal). Four comparison counties had no family meeting practice at all.

[22] Pennell, Edwards, & Burford, 2010
[23] Burford, Pennell, & Edwards, 2011
[24] Technical Assistance Partnership for Child and Family Mental Health, n.d.
[25] Pennell, Edwards, & Burford, 2010

- Sixteen of the seventeen demonstration counties had an independent FTM facilitator, compared to just five of the seventeen comparison counties.
- In the meetings observed by the evaluation team, facilitators, parents, and kin appeared to be more highly involved in the demonstration counties than in comparison sites.

The outcomes analysis used an "intent-to-treat" approach to evaluate differences between eligible children in the demonstration counties (i.e., children who transferred to ongoing services during the study period) and children in comparison counties, regardless of whether they were formally identified as having been served through the FTM intervention. Compared to comparison counties, demonstration counties' results indicated shorter case episodes, fewer placements, and a higher rate of placement with kin for those who were placed.

The evaluation team also examined case-level fidelity and its impact on outcome effects. The team found that children whose cases had higher levels of fidelity (in terms of the timing of meetings and meeting participants) had significantly shorter case episodes and lengths of stay in placement than those who received FTM with medium or low fidelity.

The findings from Ohio's second waiver suggest an impact of the waiver overall and of the FTM intervention. The third waiver evaluation is designed to reveal more about the effects of FTM; it uses a more targeted evaluation approach, comparing outcomes for children who received the intervention with closely comparable children in comparison counties who did not. To control for case mix and ensure equitable demonstration and comparison groups, the outcomes analysis uses propensity scores as a mechanism to adjust baseline differences between intervention and non-intervention children in the demonstration and comparison counties and uses the Complex Samples module in SPSS to adjust for clustering of families within counties (see Section 3.5).

3.1.3 FTM Practice Manual

To further the evidence base for Ohio's Family Team Meeting model, county and state representatives volunteered to collaboratively write a ProtectOHIO FTM Practice Manual in 2010. With the evaluation team guiding the group in terms of conceptualizing a research-based practice, the volunteers developed core components, fidelity measures, and detailed guidelines related to the following elements:

- ProtectOHIO FTM values and principles
- Facilitator qualifications, training, roles, and duties
- Caseworker training, roles, and duties
- FTM participants
- Referral processes and timeliness
- Preparing parents, service providers, and children for FTMs
- Scheduling FTMs
- Agendas
- Critical Event Meetings
- Administrative Support

- Data Collection

Over the course of a six-month period, representatives from the practice manual workgroup drafted components of the manual and held a series of weekly to bi-weekly web-based conference calls to review sections, offer feedback, and edit the document together through screen sharing programs. Draft sections were also shared with the larger facilitator workgroup to ensure that the practice components were being developed in a manner that was feasible for all agencies.

3.1.4 Description of the ProtectOHIO FTM Model

The purpose of FTM is stated in the ProtectOHIO FTM Practice Manual[26]:

> Family Team Meetings are a collaborative activity, held for the purpose of supporting and educating parents, sharing information, and jointly making decisions, with the goal of empowering and strengthening families while keeping children safe and planning for their ongoing stability, care and protection. Family Team Meetings provide an opportunity for the parents, family, family supports, community service providers, and natural supports to be involved in the building of partnerships to increase the likelihood of having a realistic, achievable plan that will lead to better and more lasting outcomes for their children.

Core components of the FTM intervention are:

- All children in cases that are transferred to ongoing services are eligible for FTMs.
- The FTM process includes: arranging the meetings, helping to assure that participants attend and know what to expect, providing some orientation for potential participants, and supporting the family during the meetings.
- Meetings include at least these components: agenda, introduction, information-sharing, planning, and decision process.
- The initial FTM is held at the point of transfer to ongoing services: This meeting is held within 30 days of the transfer of a case from assessment/investigation to ongoing status, for the purpose of initial planning.
- FTMs are held at least quarterly (at least every 90 days) throughout the life of the case to share information, discuss status, review progress, and make any necessary joint decisions.
- Additional FTMs should be considered at any critical points or combination of critical events in the life of the case, in an effort to keep the case moving forward and have the most beneficial impact on the long-term resolution of the case. These meetings are not mandatory but are an opportunity to address issues and engage families at pivotal points. Examples of appropriate times for FTM: a family request for a meeting; an emergency removal; the child being considered for removal; a placement change or a legal status change; or an upcoming court hearing.

[26] ProtectOHIO Consortium FTM Workgroup, 2011

- For an effective FTM, participants at the table should include:
  - ✓ Parents
  - ✓ Relatives
  - ✓ Substitute caregivers and other service providers
  - ✓ PCSA staff member (caseworker, supervisor)
  - ✓ Additional supportive parties
  - ✓ Independent trained facilitator

  The model requires that at least one parent or primary caregiver, at least one caseworker or other PCSA staff, and at least one other type of person (not including the facilitator) attend the meeting).

- Fostering family engagement in the FTM and assuring facilitator-caseworker collaboration in conducting the FTM are important aspects of the process.
- All FTMs are led by a trained and independent facilitator (i.e., someone who does not have direct line responsibility for the case).
- All children in cases that are transferred to ongoing services are eligible for FTMs. Data will be gathered on each meeting held. A few counties do not have enough facilitator capacity to serve the entire eligible population; at the point of transfer to ongoing services, these counties systematically sample which cases will be targeted for FTM using a set ratio (for example, every fourth case).

3.1.5 FTM Workgroup

The core components of the FTM intervention, outlined above, have been discussed and refined during quarterly FTM facilitator workgroup meetings. The FTM facilitator workgroup was initially established by the ProtectOHIO Consortium during Ohio's second waiver period as a means for facilitators to come together to clarify aspects of the practice model, review evaluation and data issues, and discuss other implementation strategies. With the start of a third waiver period and a renewed effort to further refine the practice model, the workgroup initially focused on reviewing draft sections of the ProtectOHIO FTM Practice Manual, and quarterly meetings were primarily used as a forum for individuals to offer county-specific feedback and suggested revisions to the manual. Over the course of the waiver, the group continued to meet quarterly to share on-the-ground experiences and to discuss challenges that emerged relative to policy, practice, and data collection. The workgroup consists of FTM facilitators and administrators from county PCSAs, ODJFS and SACWIS staff, and members of the evaluation team.

At least one member of the evaluation team participated in all quarterly workgroup meetings over the course of the third waiver, which were alternately held in-person in Columbus and via teleconference to eliminate travel burden for county staff. The evaluation team regularly provided evaluation activity updates and used workgroup interactions as an opportunity to share formative evaluation feedback to inform practice improvements.

Over the course of the waiver, the quarterly workgroup has provided facilitators an opportunity to:

- Discuss how to consistently and safely hold FTMs in cases of domestic violence.
- Review and revise the FTM logic model.
- Discuss strategies to increase family engagement.
- Review family meeting literature and emerging and promising family meeting interventions.
- Discuss strategies to increase fidelity to the model.

3.1.5.1 FTM High Fidelity Subcommittee

In 2014, the FTM workgroup formed a short-term sub-workgroup: the high fidelity subcommittee. This subcommittee came together in part because of the findings from the Interim Evaluation report—that cases that receive high-fidelity FTM may be more likely to be associated with positive outcomes than cases that receive low-fidelity FTM or do not receive FTM at all. "High-fidelity" cases had meetings that were both on time **and** included the minimum mix of attendees at the table.

The high fidelity subcommittee distributed a survey in an attempt to identify strategies that may be associated with high fidelity levels. Although no single specific intervention was found to be closely tied to high fidelity levels, the subcommittee identified several promising strategies and made the following recommendations for best FTM practice:

- Early notifications for initial meetings; as early in the 30-day window as possible.
- Scheduling meetings earlier in the 90-day window to allow for rescheduling time.
- Direct staff involvement in process.
    - Oversight of invitees.
    - Contact with/reminder of meeting to attendees.
- Discussions with parents at FTMs.
    - Review of invitees; request parental input.
    - Future meeting scheduling (including a reminder on the FTM form, a card, etc.).
- Incentive programs (prizes, contests, etc.).

3.1.6 Evaluation Design

While various forms of FTM are in use internationally, questions remain regarding their effectiveness. To date, the evaluation of FTM models has been minimal. Review of the limited research on outcomes has shown positive or neutral effects, though many of the studies suffer from small sample sizes or a lack of adequate comparison groups.[27,28,29] Pennell, Edwards, and Burford (2010) did find that expedited family team meetings in Washington, D.C. significantly increased the likelihood that children would be placed in kin foster homes, have family-group-type permanency goals, exit care faster, and be discharged to

[27] Berzin, 2006

[28] Crampton, 2007

[29] Sundell & Vinnerljung, 2004

family or relatives.[30] However, more evidence has emerged for Family Group Decision Making (FGDM) than for Family Team Meetings; currently, FGDM is the only child welfare family meeting model listed in The California Evidence-Based Clearinghouse for Child Welfare.[31]

Unlike some of the family meeting studies that are limited by sample size or design, the evaluation of FTM practice under the ProtectOHIO Waiver benefits from a large sample size and the use of comparison groups and propensity score matching in the research design.

Six research questions guide the evaluation of FTM under the ProtectOHIO Waiver:

1. How is FTM implemented across the demonstration counties?
2. How does practice in demonstration counties compare to practice in comparison counties?
3. What occurred across demonstration counties in regards to the volume and nature of FTM activity?
4. What level of fidelity to the ProtectOHIO model is achieved in demonstration counties?
5. Do children and families receiving FTM in demonstration sites experience different outcomes than children and families with similar characteristics in comparison counties?
6. Do demonstration children and families receiving high-fidelity FTM experience different outcomes than children and families with similar characteristics in comparison counties?

The logic model that guides FTM practice and evaluation is presented in Table 3.1. Created in consultation with demonstration county staff at the beginning of the second waiver (spring 2005), it was modified slightly at the November 2010 facilitators' workgroup and reviewed again at subsequent FTM workgroup and ProtectOHIO Consortium meetings.

The logic model illustrates the demonstration counties' belief that families that participate in the FTM intervention, which is characterized by frequent meetings that include a wide range of people, will be linked to more appropriate and timely services, leading to better child outcomes in terms of reduced foster care placements and improvement in permanency.

The target population of the FTM intervention is all cases that transfer to ongoing services with a case plan goal of reunification or maintain-in-home. Twelve counties target all eligible cases for FTM, and four counties utilize a sampling process to select eligible cases for FTM.[32] Each county that samples does so due to capacity issues; for these counties, serving all cases that transfer to ongoing services would simply not be viable. While the sampling process differs somewhat across the four counties, each county has a process for systematically selecting cases. In the event that particular cases are occasionally

[30] Pennell, Edwards, & Burford, 2010

[31] The California Evidence-Based Clearinghouse, 2015

[32] Three counties have changed their sampling status since the onset of the third waiver. In fall 2010 (coinciding with the beginning of the third waiver), one county that had been previously serving all cases began sampling. One county that had previously been sampling for FTM began serving their entire target population in March 2011; one additional county switched from sampling to serving their entire population in September 2012. In general, counties have stopped sampling and have begun serving the entire eligible population once they have developed enough staff capacity to schedule and hold the needed meetings.

selected to receive FTM, the use of propensity scores as a weighted covariate or for matching in the outcome analyses is used as a mechanism to adjust for selection bias based on the background covariates chosen.

As the Alternative Response (AR) initiative rolled out across Ohio over the course of the waiver (see Chapter 2 for additional information), counties had to decide whether AR cases that need ongoing services should be part of the target population for the FTM intervention. Ten of the twelve counties that do not sample for FTM do extend FTMs to AR cases that transfer to ongoing services. Of the four counties that sample for FTM, one extends FTM to AR cases; the remaining three counties have not extended FTMs to AR cases and limit their sampling pool to traditional, ongoing cases.

During the most recent site visits, staff in some counties stated that, due to either the newness of AR or the structure of their AR processes, they have not had AR cases that have transferred from intake to ongoing. These AR cases are served wholly within intake or are transferred to traditional ongoing services if they move to an ongoing case.

Table 3.1: ProtectOHIO FTM Logic Model

INPUTS/BACKGROUND VARIABLES	ACTIVITIES	OUTPUTS	OUTCOMES
• The facilitator's training, whether the facilitator is independent (does not have direct line responsibility for the case), and whether the facilitator facilitates full time or has other responsibilities. • Caseworker training and preparation. • Demographics such as the age of children, previous history with CPS, custody and living arrangement at time of initial FTM, etc. OTHER CONSIDERATIONS • Purposes of meetings held. • # of FTMs that result in recommendations for changes to services, placement, or custody. • The facilitator's role in the FTM and how they address their administrative responsibilities. • Facilitator-caseworker preparation for doing FTM together.	For cases with case plan goal of reunification or maintain-in-home: 1. Families have FTMs over the entire period of ongoing services,[33] including at a minimum: • within 30 days of case opening to ongoing services; • at other critical events in the case; and • at least quarterly. 2. FTMs are attended by a variety of people: Participants may include the birth parents, primary caregiver and other family members, foster parent (if child goes to placement), support people, and professionals. 3. Facilitator responsibilities include: arrange meetings, help assure that participants attend and know what to expect (provide some orientation for potential participants), and support the family in the meetings and in preparing for them. 4. FTM process includes: agenda, introduction, information-sharing, planning, and decision process. Activities 1 & 2 will be measured at the case level. Activities 3 & 4 will be measured at the county level.	• Families are linked to more appropriate and timely services. • Families build stronger family relationships, are empowered and motivated. • Greater use of natural supports • Better case decision-making; more clarity in case plans. • More consistent agency practice in deciding whether to place.	1. Shorter time case is open (to ongoing): • # of days sampled cases are open to PCSA, between Family Assessment Approval Date and case closure. 2. Avoiding initial placements: • % of sampled children that have any placement after Family Assessment Approval Date. 3. Shorter time in placement: • # of days in placement. 4. Of children who are placed, more children are placed with kin: • For sampled children with placement, the % that experience kin as their primary placement type. 5. Less time to permanency: • The average time between initial placement and reunification, guardianship, adoption, or legal custody to kin. 6. Increase in exits to permanency: • Of children who are exiting out-of-home care, # who end up in guardianship, adoption, legal custody of kin, or are reunified. 7. Less re-entry to substitute care: • # of children exiting placement who re-enter placement within a year of case closure. 8. Less maltreatment subsequent to Family Assessment: • % of cases with additional indicated/substantiated CAN reports any time after the sampled case's Family Assessment.

[33] Counties would stop doing FTM with the family when the case plan goal changes from reunification or maintain in home to something else, and when child moves to permanent custody, PPLA, or legal custody to kin.

3.1.7 Data Collection Methods and Analytic Approach

As previously mentioned, the evaluation team pursued three major analyses of the ProtectOHIO FTM intervention: an implementation analysis, a fidelity analysis, and an outcomes analysis. These analyses address the five research questions that guide the FTM study. The implementation analysis is presented in Sections 3.2 through 3.4. The fidelity and outcomes analyses are presented in Sections 3.5 and 3.6. Here, we discuss the data collection methods and the analytic approach used for the implementation and fidelity analyses.

3.1.7.1 Data Collection Methods

Data collection for the FTM intervention was complex and multi-dimensional. The six types of data collection methods utilized in the demonstration and comparison sites are outlined below; three were used to obtain information at the county level, one was used to obtain data at the facilitator or caseworker level, and two were used to obtain data at the individual child or case level. The primary data collection method used in the comparison counties depended on whether the county was using some type of FTM-like practice. Administrative SACWIS data was provided by ODJFS, supplying case- and child-level data for demonstration and comparison counties.

- **Site visits**: In fall 2012, site visits were conducted in each of the then-17 demonstration counties and in four comparison counties that were identified as having a robust FTM-like practice during the second waiver. During the fall 2014 site visits were conducted in 15 demonstration counties and 6 comparison counties. One site visit was cancelled due to weather, and the county alternatively participated in telephone interviews. As discussed in Chapter 2, Highland County received a site visit in 2015 for the purpose of exit interviews, but was no longer a demonstration county at that time.

  The site visits included interviews with directors, managers, supervisors, workers, and facilitators about their perceptions of FTM and its operation; they also included focus groups of caseworkers involved in FTM (see "Focus groups," below).

  Prior to the 2014 site visits, the evaluation team administered a brief online survey designed to streamline the site visit process and enhance the richness of the information gathered during the visits. The survey elicited basic FTM intervention-specific details. Additionally, the team used the survey results to confirm which comparison counties had practices similar to either of the FTM or Kinship Supports interventions in order to finalize which comparison counties would receive site visits and which would receive phone interviews. The survey was completed by all 16 demonstration counties and by 14 out of 16 comparison counties.

- **Telephone interviews**: Telephone interviews were conducted in 2012 with 13 comparison counties.[34] In 2014, telephone interviews were conducted with 10 comparison counties and 1 demonstration county.[35] Interview protocols were used to document comparison county

[34] The remaining four comparison counties were interviewed during site visits, as previously described.

[35] As described previously, one demonstration county site visit was cancelled due to inclement weather, and interviews were conducted via phone.

policies, practices, strengths and barriers, and key components of the family teaming models used, if any. The primarily open-ended questions focused on such topics as the facilitators' training and roles, the caseworkers' role, the meeting process, and parent and community involvement. The evaluation team collected information from key staff in each county.

- **Focus groups**: During the 2012 and 2014 site visits, the evaluation team conducted focus groups of caseworkers to gather their perceptions of FTM. Administrators in each demonstration county invited caseworkers (intake and ongoing) to voluntarily participate in these groups. Participation in individual counties ranged from three to nine caseworkers. Focus group participants responded to open-ended questions about the FTM training they received, the caseworker's role in FTM, aspects of FTM that have been difficult to implement, and overall strengths and challenges of the FTM intervention. The caseworkers' perspectives may or may not be representative of the experiences of all caseworkers involved in FTM.

  In the summer of 2014, the evaluation team also conducted focus groups with parents involved in FTM within six demonstration counties. One parent focus group was conducted in each site, with six to eight parents per focus group. To gather information about parents' experiences with FTM from case-start to case-closure, parents whose cases had recently closed were invited to participate in the focus groups. Information gathered included the level of family involvement in intervention activities, the extent to which services were provided as intended by the intervention model and parents' positive and negative experiences with the FTM intervention.

- **Surveys**: In addition to the pre-site visit survey described above, information was gathered through two separate web-based surveys on FTM practice:
  - **Facilitator Survey**: A survey of FTM facilitators was administered in summer 2011, following pilot trainings on the newly developed ProtectOHIO FTM Practice Manual. Using defined-response and open-ended questions, the survey explored perceptions of the training, experience levels of the facilitators, and challenges they face in the job. It was fielded to all staff identified as ongoing facilitators who attended the training or who were listed in PODS as facilitating meetings. Of the 45 facilitators identified, 36 completed the survey (80% response rate). The survey was anonymous with the exception of county identification; at least one response was received from each of the then-17 demonstration counties.
  - **Facilitator and Caseworker Survey**: A survey of FTM facilitators and caseworkers who participate in FTM was administered in spring 2013. It explored the ways in which respondents prepare for FTM and their views on its effectiveness of FTM. The survey was completed by 32 facilitators and 329 caseworkers, representing all of the then-17 demonstration counties. Selected questions were only asked of caseworkers who indicated they had participated in FTMs in the last month; 220 caseworkers responded to those questions. The evaluation team does not have access to data on the precise number of caseworkers who participate in FTM across the ProtectOHIO demonstration counties. However, based on the estimates provided by the counties, we calculated that eight counties had response rates that ranged from 73% to 100%, and six counties had

response rates between 22% and 62%; three counties had response rates that were unknown. The survey responses may or may not have been representative of the experiences of all caseworkers involved in FTM. Some questions appeared to be susceptible to social desirability bias (i.e., caseworkers may have stated that they did something that they thought they should do [such as prepare the family], regardless of whether or not they actually did it), but this problem was minimized by the ability to triangulate the data with facilitators' responses, and the use of a mix of questions that asked caseworkers both what they do and what they believe (see Appendix C for the survey protocols).

- **ProtectOHIO Data System (PODS)**: PODS was developed by HSRI specifically for the purpose of gathering individual-level information on FTM that was not available in SACWIS at the start of the third waiver. Following each meeting, the facilitator entered identifying information on each child involved with the meeting and their custody status and living arrangement. The remaining data items (information on who attended the FTM, its purpose and outcomes, and the supports or accommodations provided to families) were entered once for the entire family. Data collection in PODS commenced in early 2010; however, the database was modified after initial analyses suggested that some data elements could be coded differently and entered once for each family's meeting rather than for each child in that meeting. The more specific codes and elements were put in place in February 2011. Evaluation team staff wrote and distributed a manual and provided webinars to train counties on the proper use of the database. They also provided technical assistance to clarify definitions of the data elements. However, during the course of the third waiver period, county representatives formally requested that a module be built in SACWIS to collect these case-level data elements. The evaluation team worked with SACWIS representatives to ensure that the module was built in a way that supported continuous, quality data for the evaluation team, and six counties volunteered to pilot data-entry in SACWIS. After a six-month period of testing, all counties formally ceased FTM data-entry into PODS and transitioned to entering all FTM data into SACWIS on April 15, 2013. Appendix D illustrates the exact data elements collected for each meeting.
- **SACWIS**: In addition to the FTM data, administrative SACWIS data was provided by ODJFS for each of the demonstration and comparison counties. This data set provided information on case opening and closing dates, reports of abuse or neglect, placement information, placement exit or permanency information, risk and family assessments information, and demographics.

In addition to the discrete data collection methods described above, the evaluation team had ongoing opportunities to interact with demonstration county managers, supervisors and facilitators, especially through facilitators' quarterly meetings and Consortium meetings. These interactions provided valuable feedback and insight on implementation challenges and successes.

3.1.7.2 Analytic Approach

The implementation analysis presented in Sections 3.2 through 3.4 describes similarities and differences between county-level practice in the demonstration and comparison counties. It also provides some basic data on the volume and nature of FTM activity that occurred in the demonstration counties.

- Analysis of the policies and perceptions of FTM in the demonstration counties brings together qualitative data, such as those collected through surveys, focus groups and site visit interviews, collected between 2011 and 2015.
- Analysis of the policies and practices in the comparison counties uses qualitative interview data collected in 2012 and 2014.

For both the demonstration and comparison counties, the evaluation team used Dedoose, a web-based qualitative analysis software, to code interview and focus group data (with the exception of parent focus groups) for themes or units of meaning and sub-themes. Coding was done primarily by one evaluator but was systematically and thoroughly discussed with the evaluation team. Participant focus group data were coded by two evaluators and by hand in order to enable coder familiarity to the data. Hand coding was appropriate in this instance due to the relatively smaller number of focus group participants and subsequent data.

The evaluation team consolidated all interview and focus group data at the county level by assigning to each county categorical thematic codes for all inputs, processes, activities, and outputs that were examined. The team searched for correlations among the different variables and for differences between demonstration and comparison sites, indicating practice differences and nuances resulting from adoption of the ProtectOHIO FTM model. Data from the facilitator and caseworker surveys were entered into Excel and analyzed using a combination of Excel and SPSS to run frequencies and cross-tabulations. Open-ended responses to the surveys were coded for themes by hand.

The analysis of the volume and nature of FTMs that occurred in the demonstration counties provides an overview of FTM activity across the 16 demonstration counties. The analysis of fidelity to the FTM model explores how well the demonstration counties adhered to the ProtectOHIO FTM intervention model. Both analyses use case-level FTM data on meetings held between February 16, 2011 and March 31, 2015[36] In addition to the FTM-specific information, other critical measures were gathered from SACWIS, including case opening and closing dates, placement information, and demographics such as age and race.

The evaluation team conducted analyses on a subset of cases that met a number of conditions; these conditions were designed to limit analysis to those cases that could be verified as belonging to the study's target population.[37] The cases could be closed or still open to the PCSA with ongoing

[36] HSRI made changes to some data elements in PODS in February 2011, reflecting changes made per the FTM Practice Manual written by facilitators at the beginning of the third waiver. By limiting the study population to cases with initial FTMs on or after Feb. 16, 2011, the study focuses on those cases that began FTM after implementation of the practice manual. It also takes advantage of the improved data collection and capability of the updated PODS, including more specific codes and elements as well as trainings on the use of PODS.

[37] These conditions include cases that had an intake on or after Oct. 1, 2010 (when the third waiver began), transferred to ongoing services between Jan. 1, 2011 and Feb. 1, 2015, and had an initial FTM within a chronologically appropriate case

involvement. The team ran a variety of descriptive statistics, frequencies, measures of central tendency, and cross-tabulations to highlight accomplishments across all demonstration counties and the important variations in practice between counties.

To complete the analysis of the intervention, the FTM data were thoroughly cleaned to minimize data entry errors. Various files were created dependent on the unit of analysis desired.

It is important to note that the fidelity analyses are conducted at the family- (or case-) level because FTM is a family-level intervention; meetings generally address all children in the case and discuss services that may impact the entire family regardless of how many children are involved (e.g., treatment services for a parent). When we look at the timeliness of meetings or whether key people attended a specific FTM—common elements across all children involved in a given meeting—the unit of analysis is the family meeting. In order to complete the analysis of the intervention's effects on placement-related outcomes, family-level data (i.e., the level of FTM fidelity for the case) were applied to each child in the family.

Sections 3.5 and 3.6 provide more detail regarding the analytic methods used in the fidelity and outcomes analyses.

3.1.8 Organization of the Chapter

The following sections of this chapter address the core research questions concerning FTM:

Section 3.2: FTM Intervention in Demonstration Counties and Family Meeting Practices in Comparison Counties

- How is FTM implemented in demonstration counties?
- How does practices in demonstration counties differ from practice in comparison counties?

Section 3.3: Volume and Nature of FTM Activity That Occurred in Practice

- What occurred across demonstration counties in regards to the volume and nature of FTM activity?

Section 3.4: Fidelity to the ProtectOHIO FTM Model

- What level of fidelity to the ProtectOHIO model is achieved in demonstration counties?

Section 3.5: Child- and Case-Level Outcomes: Demonstration versus Comparison Counties

- Do children and families receiving FTM in demonstration sites experience different outcomes than children with similar characteristics in comparison sites?
- Do demonstration children and families receiving high-fidelity FTM experience different outcomes than children with similar characteristics in comparison sites?

episode found in SACWIS. The evaluation team used data from the first case episode that occurred on or after Oct. 1, 2010 and excluded subsequent case episodes and any FTMs that fell within a subsequent case episode.

Section 3.6: Summary and Conclusions

3.2 FTM Intervention in Demonstration Counties and Family Meeting Practices in Comparison Counties

This section presents qualitative data, collected over the course of the waiver, about FTM activity that occurred in demonstration counties. Where applicable and informative, it includes corresponding qualitative data collected in comparison counties. FTM policies and practices are explored and described, with particular attention to the qualitative data related to the core elements of the model. As these various elements are explained and expounded on, evolution that has occurred over the course of the third waiver may also be noted.

3.2.1 Core Elements of the ProtectOHIO FTM Model

This section describes the demonstration counties' approach to implementing the core components of the ProtectOHIO FTM intervention and the effort the PCSAs put into organizational aspects that support the core elements—such as hiring and training facilitators, training caseworkers, communication between facilitators and caseworkers, and monitoring the intervention. This section also documents the basic family meeting practices, which parallel the core components of the ProtectOHIO FTM model, in comparison counties. Shifts that occurred related to the core elements of the model during the third waiver are also catalogued throughout the section.

3.2.1.1 Target Population

The ProtectOHIO manual indicates that all children in cases that transfer to ongoing services are eligible for FTMs.[38] Four counties, with approved procedures, sample a proportion of eligible cases; the remaining twelve counties conduct FTMs for essentially all eligible cases. One county that now serves all eligible cases previously served a subset of cases—historically 25% to 50% of eligible cases—due to staff capacity; based on a growing commitment to the FTM process, the agency hired an additional facilitator to expand FTMs to all families in late 2012, midway through the waiver.

3.2.1.2 Neutral Facilitation

As previously explained, the ProtectOHIO demonstration counties began implementing FTM as a common intervention during the second waiver, with some counties experimenting with various forms of family meetings as early as the first waiver. While there are over 50 types of family-centered meeting models, only some of which require a neutral facilitator,[39] neutral facilitation is considered a specific and efficacious mechanism for fostering family engagement.[40] Ohio has incorporated and created the independent facilitator position to organize, prepare for, and facilitate Family Team Meetings. Not only is this considered a core element of the model, but parents involved with FTM recognize its impact; parents in all six counties who had attended FTMs and participated in the 2014 focus groups indicated

[38] ProtectOHIO Consortium FTM Workgroup, 2011

[39] The Annie E. Casey Foundation, n.d.

[40] Child Welfare Information Gateway, 2010, Family Engagement

that the neutral facilitator was one of the most valuable aspects of the FTM process, alternately serving as a preparer, peacemaker, and translator of agency language and expectations.

Number of Facilitators: All 16 demonstration counties maintain at least one neutral facilitator: 14 counties directly employ facilitators while 2 counties contract with outside facilitators. In terms of the number of FTM facilitators within demonstration counties, 9 of the 16 counties have a single facilitator in their agency—a number that has remained consistent over the course of the third waiver (in both 2012 and 2014, 9 counties reported employing one facilitator). Counties may have additional trained backup staff who can step in as an alternate facilitator if the primary facilitator is not available; these backup staff may be supervisors, caseworkers, or others. Two counties now have between seven and ten facilitators. Whereas the maximum number of facilitators in any one county was six at the start of the third waiver, this number has increased to ten. In some counties, it is challenging to capture the number of ProtectOHIO facilitators, as facilitators may be trained on facilitating both ProtectOHIO FTMs and other non-ProtectOHIO meetings, such as case planning meetings.

Overall, the number of facilitators in a county remains largely a function of its size; larger counties have more facilitators due to the number of eligible open cases. There may be both benefits and drawbacks to having fewer facilitators. For example, having fewer facilitators in a county can promote the consistency of the intervention delivery, but it may also limit the availability of peer learning opportunities (e.g., observing other facilitators) and promote a sense of isolation among facilitators. Facilitators also indicated during 2014 site visits that employing fewer facilitators can limit the availability of meeting times and the ability to accommodate family schedules.

While utilizing a neutral facilitator is a core component of the ProtectOHIO FTM model, it has increasingly become a standard component of comparison county practice. This move toward neutral facilitation is not unexpected, as neutral facilitators are prescribed in several family meeting models. As of 2014, 10 comparison counties utilized a neutral facilitator to lead at least some of their meetings with families. However, while comparison counties may technically utilize neutral facilitators, these facilitators may be supervisors, caseworkers from another unit, or caseworkers from the same unit who are not carrying that specific case. By contrast, demonstration county facilitators are more likely to only occupy non-case carrying roles. In one comparison county, for example, the Independent Living Coordinator also serves as the meeting facilitator; in another county, a therapist facilitates meetings. Additionally, while comparison counties may utilize neutral facilitators, they remain less likely to conduct meetings otherwise in accordance with the ProtectOHIO meeting model—that is, on an ongoing basis for all open cases and involving a range of supports.

Demonstration County Support for Facilitators: As noted above, the number of facilitators within a demonstration county may enhance or limit opportunities for peer-to-peer support. However, Table 3.2 demonstrates that counties may provide other types of administrative supports for facilitators, such as flexible hours, mileage reimbursement, and compensatory time or overtime pay. All counties provide at least one of these supports, but 9 of the 16 demonstration counties are able to provide all three. The number of counties that provide mileage reimbursement increased from 2012 to 2014; while this may be a result of changing administrative policy, it may also reflect the evolution of the intervention and increased agency value placed on FTMs being held in family homes or in off-site neutral locations.

It's important to note that compensatory time or overtime pay is not applicable for those counties that employ part-time or contract facilitators; these facilitators simply bill for the number of hours provided and, per their contracts, hold flexible hours. Additionally, facilitators in some counties have access to agency vehicles; thus, mileage reimbursement may not be needed.

Table 3.2: Agency Supports for Facilitators

	2012 Number of counties (n=17)	2014 Number of counties (n=16)
Flexible hours	16	16
Mileage reimbursement	12	15
Compensatory time or overtime pay[41]	11	10
All three supports	9	9

3.2.1.3 Training in Demonstration Counties

Across the literature, both pre-implementation and post-implementation training is considered an important element and a necessary precursor to efficacious practice; Fixsen, Naoom, Blase, Friedman, and Wallace (2005) refer to this as *preservice* and *in-service training*.[42] Quality training of all staff involved in the intervention, such as facilitators and caseworkers, is described below.

Facilitator Training: At the start of the third waiver period—and leading up to it—the ProtectOHIO Consortium planned several trainings focused on meeting facilitation and family meeting models. These trainings were not specific to the ProtectOHIO FTM model and, in some cases, information was provided about meeting models that are dissimilar to the ProtectOHIO FTM model. Once the FTM manual was finalized, more counties solidified their practice around FTMs, and FTM facilitators utilized the practice manual to guide their work. The manual also served as a tool for facilitators to train caseworkers.

Recognizing the need for a formalized mandatory training around the tightened ProtectOHIO FTM model, the Ohio Child Welfare Training Program (OCWTP) developed a two-day training based on the practice manual. This training was well attended. The 2011 sessions reached more facilitators and demonstration counties than any previous training event with a consistent message on facilitation approach and the ProtectOHIO FTM model: 47 staff representing all 17 demonstration counties attended. In 2013, 25 facilitators and supervisors from 10 counties attended the training sessions. Additionally, all counties agreed that following the completion of the mandatory training events, facilitators in each county would develop internal trainings based on the material covered for caseworkers and other agency staff.

While the training content underscored previous training in which facilitators had been involved, participants noted development in their knowledge and skills as facilitators as a result of the initial 2011

[41] Compensatory or overtime pay may not be applicable in counties that employ part-time facilitators or contract facilitators

[42] Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005

OCWTP training. In a survey conducted by the evaluation team, at least half of the 36 respondents recognized improvement in:

- Finding common areas of agreement that can be used to develop an appropriate plan.
- Maintaining their impartiality in the process.
- Making sure all participants feel heard and understood.
- Resolving conflict between participants.
- Identifying family strengths and the problems that need to be resolved.
- Preparing for and facilitating meetings in cases where domestic violence is an issue.
- Establishing trust with meeting participants.
- Managing resistance from caseworkers.

In addition to the OCWTP training, facilitators draw on their previous professional experiences in human services and child welfare to guide their work. And, over the course of the waiver, demonstration county facilitators and caseworkers have engaged in training around cultural competency and diversity. While not specifically related to FTMs, these trainings impact their interactions and ability to successfully engage with diverse families. One county hosted trainings on effectively working with and engaging Amish families, to prevent county staff from unintentionally disrespecting these families during their interactions. Another county held a training on using interpreters to engage with families, a skill utilized during FTMs. Additionally, one county has requirements for all contracted providers to have undergone cultural competency training; these providers may attend FTMs.

Despite this advancement in cultural competency training and strong initial FTM training, a gap exists in terms of ongoing training for existing facilitators and trainings for new facilitators. While the OCWTP trainings have been offered several times over the course of the waiver period (subsequent to the initial two trainings), staff turnover far exceeds opportunities for these formal training events. In May 2015, the FTM workgroup discussed this gap and raised the possibility of having the larger counties with higher capacity open up their internal FTM trainings to smaller counties with new facilitators. Additionally, OCWTP has offered to develop a web-based ProtectOHIO FTM training, similar to a web-based kinship training module that was developed for ProtectOHIO and made available in 2015. It will be used to train new and transitioning workers on the ProtectOHIO model, though in-person trainings will still be offered.

Workgroup as Peer-to-Peer Training and Information Sharing: In addition to informal and formal trainings, the FTM facilitator workgroup may operate as a learning platform. During the 2014 site visits, facilitators were asked about the workgroup's quarterly meetings, including their perceptions of the workgroup and the role it plays in ongoing training or assistance. For many counties, these quarterly meetings are the primary platform for facilitators to share and gain ideas about FTM practice; in this sense, the workgroup functions as an opportunity for ongoing information-sharing.

Overall, facilitators value the collaboration and brainstorming that takes place during the quarterly meetings; this emerged as the most frequently identified strength of the workgroup. The workgroup is especially useful for facilitators in small counties who lack facilitator colleagues with whom to troubleshoot barriers and brainstorm processes and strategies to enhance and streamline practice.

Facilitators noted that they value hearing examples of what other facilitators are doing in other counties. Conversely, because of county variability (in terms of size, number of FTM facilitators, and other characteristics), it is challenging for the workgroup to meet the learning needs of all counties and facilitators, underscoring the necessity of continued focused training.

Caseworker Training: Early on during the course of the third waiver period, it became evident to many counties that caseworkers needed further information on the ProtectOHIO FTM model and their role within it. Like facilitators, caseworkers are heavily involved in the intervention and benefit from model training. While facilitators received training and participate in the ongoing quarterly workgroup meetings, caseworkers may have fewer opportunities to develop their family engagement and FTM skills. In all of the demonstration counties, the FTM facilitators and/or managers offered an initial training of two hours or less to all ongoing workers and supervisors. In 12 counties, the training was extended to intake caseworkers, as they are often involved in the initial Family Team Meeting. Based on facilitator feedback received during 2014 site visits, it seems that new caseworkers continue to receive some sort of FTM training, though the mode and type may vary. For example, new workers may observe FTMs, shadow facilitators, or receive one-on-one training with the facilitators. New workers may also be trained during orientation; at least one county has brought in an external FTM expert to train staff. However, there seems to be a dearth of refresher or follow-up trainings on the model for established workers. And these trainings may be of particular importance given that facilitators note long-term, established workers may be more resistant and less bought into the practice than newer caseworkers.

Some counties do hold ongoing trainings and have developed a learning culture around FTM; one county, in particular, has a heavy emphasis on training and has created training games, including an interactive *Family Feud*-style game about FTMs. Another holds specific policy trainings to underscore caseworker roles and responsibilities related to FTM. But other counties indicated that there are few or no trainings for established workers or that established workers simply attend trainings when new workers are hired and on-boarded.

In caseworker focus groups conducted by the evaluation team during the fall 2012 site visits, we talked with caseworkers whose experience with the agency ranged from a few months to many years. Caseworkers recalled a long list of topics that were covered in the FTM training, such as FTM procedures and processes, family engagement, caseworker role, facilitator role, who should be invited, meeting timeframes, and an overview of the waiver. When asked what has proven to be helpful from the training as they participated in FTMs, caseworkers commonly mentioned understanding the process of an FTM and what to expect in meetings (cited in 5 counties), learning how to engage families (cited in 4 counties), and observing an FTM (cited in 4 counties). The latter continues to be perceived as helpful by caseworkers: In 2014, caseworkers in five counties indicated that the most helpful or useful training in which they've participated is observing FTMs—either when they were new to casework or as follow-up training. Observing FTMs may be accompanied by an opportunity to process the experience with the FTM facilitator and/or the ongoing worker, which seems to be especially helpful for new staff attempting to conceptualize the practice. FTM facilitators in one county conduct mock FTMs during staff meetings to provide an opportunity for observation and real-time practice model training. Staff in one county mentioned that allowing new workers and interns to observe meetings is not only beneficial for those staff but also for established staff; newer staff may bring a fresh perspective, insightful ideas, and

important questions that can rejuvenate the practice. Apart from valuing an opportunity to observe FTMs, caseworkers also mentioned that core or foundation training on family engagement skills is important for their successful FTM practice.

In 2014, caseworkers in at least five counties could not recall specific trainings or pinpoint a most valuable training component; in some cases, these caseworkers had been with their agency since the start of FTMs, prior to established FTM training. There may be some disconnect between caseworker experience of training and facilitator experience of caseworker training. While it could be that the caseworkers in the focus groups did not attend the trainings provided, facilitators tended to report more extensive training opportunities for caseworkers than did caseworkers. In summary, the caseworker training that has occurred during the third waiver appears to have been minimal following initial trainings.

3.2.1.4 Communication between the FTM Facilitator and Caseworker

As articulated in the FTM Practice Manual, the demonstration counties believe that caseworkers and facilitators should communicate prior to an FTM. Specifically, the practice manual notes that caseworkers should share information about the family and case situation with the facilitator.

In a 2013 survey of caseworkers and facilitators, respondents reported on the frequency with which caseworkers and facilitators, prior the first FTM, share the six types of information identified in the practice manual as important to communicate. As shown in Table 3.3, more than three-quarters of respondents noted they always or usually share information on potential sources of conflict and safety, basic family information, and family history and recent involvement with the PCSA.[43] Several respondents noted that county policy determines the other three types of information—how meeting decisions will be shared with third parties, who will take the lead and clarify roles, and who will document meetings and enter information into SACWIS—so a conversation to discuss these prior to an FTM is usually not needed.

Table 3.3: Type of Information Shared Between Caseworker and Facilitator Prior to Initial FTM

	Always or Usually (n=361)
Potential Sources of Conflict/Safety Issues	83% (298)
Basic Family Information	77% (277)
Family History, Recent Involvement	76% (273)
How Meeting Decisions Will be Shared With Third Parties	50% (179)
Who Will Take Lead/Clarify Roles	45% (161)
Who Will Document Meeting, Enter Info in SACWIS	44% (158)

Some facilitators believe they can better remain neutral if the information they receive about a family is limited to potential safety issues that may be present at the meeting or possible points of tension. Others like to have more history and information on the family's child welfare involvement. Some

[43] The pattern of responses was similar when facilitators' responses and caseworkers' responses were analyzed separately.

counties may have more formalized methods of communication, such as the facilitator and caseworker regularly meeting just prior to the FTM, while other counties may have less formal means of communicating.

In a 2013 survey, for example, at least one facilitator in 13 demonstration counties reported that they usually or always participate in some sort of informal information-sharing with the caseworker prior to an FTM. Additionally, 15% (55) of caseworkers and facilitators indicated that they held a formal meeting prior to the FTM to share family information; 35% (128) share an email update rather than hold an in-person discussion; and 4% (14) noted that, in their county, the caseworker completed an FTM referral form that contains relevant information for the facilitator. Lastly, 61% (221) of respondents mentioned that facilitators may familiarize themselves with the case by reviewing case notes in SACWIS prior to the FTM.

These differences in communications between caseworkers and facilitators may be due to county culture or based on county size; in small counties, for instance, meetings or informal conversations between the facilitator and the caseworkers may be more feasible than in large counties with multiple units and many caseworkers.

3.2.1.5 Critical Event FTMs

Beyond holding initial and 90 day FTMs—a core element of FTM fidelity—the FTM manual indicates that additional FTMs should be considered at any critical points or combination of critical events in the life of the case, in an effort to keep the case moving forward and have the most beneficial impact on its long-term resolution. These meetings are not mandatory but are an opportunity to address issues and engage families at pivotal points. Examples of appropriate times for FTM: a family request for a meeting; an emergency removal; the child being considered for removal; a placement change or a legal status change; or an upcoming court hearing.

> *"The critical event FTM could be a game changer for the family."*
> *– FTM Facilitator*

During the 2014 site visits, the evaluation team gathered data from counties on their current critical event FTM practices. At least 10 demonstration counties indicated they had taken steps to incorporate critical event FTMs into practice. The FTM facilitator in one county said, "The critical event FTM could be a game changer for the family". Within these counties, the steps taken varied: In two counties, FTM invitation letters for families describe critical event FTMs and invite families to request those meetings if they feel one is needed. In an additional two counties, facilitators work with caseworkers to ensure that critical event FTMs are scheduled. Facilitators may meet with caseworkers regularly to go over cases or facilitators may attend unit meetings as a platform to stress the importance of critical event FTMs. Facilitators noted that critical event FTMs ensure the worker does not have to make decisions alone or in isolation, that these meetings can help avoid placement disruption, and that they can result in family-driven plans. At least two counties do not hold critical event FTMs because there is an alternate family meeting— such as a crisis response meeting or Team Decision Making meeting—held in the event of placement disruption or other critical events. And two other counties generally do not hold or emphasize critical event FTMs, though an alternative meeting is not held.

Facilitators in five counties, including the two counties where efforts are not made to conduct critical event meetings, indicated that caseworker buy-in for critical event meetings remains low. Caseworkers may just attend to the critical event themselves and not notify the facilitator that it has occurred. Staff in one county said, "Workers just want to take action and not hold a meeting." Beyond this, one county indicated that supervisors also lack buy-in to critical event FTMs, while another county stated that families themselves are not bought-in and do not want to attend them. Other challenges include scheduling and capacity: two counties indicated that they do not have the facilitator capacity to hold additional FTMs and that scheduling is a primary barrier to critical event FTM.

In those counties that have worked to incorporate critical event FTMs, the meeting timing can vary. For example, in one county where scheduling is a challenge, the facilitator tries to schedule critical event FTMs within 30 days of the critical event, whereas in another county where scheduling is not necessarily a challenge, meetings are held within 48 hours of the critical event. While not necessarily critical event FTMs, staff in at least two counties indicated that FTMs may be scheduled sooner than 90 days if the supervisor or worker believes there is insufficient movement on the case. For example, the supervisor might request during an FTM that the following FTM be at 30 or 60 days rather than the standard 90-day benchmark.

3.2.2 Core Elements of Comparison County's Family Meeting Models

As the evidence base for family meetings has developed and additional effective meeting models have emerged, it might be expected that comparison counties would increasingly adopt practices similar to ProtectOHIO FTM. At the end of the second waiver, only one comparison county employed a family meeting practice very similar to ProtectOHIO FTMs—with meetings led by a neutral facilitator, including a range of attendees, and held on an ongoing basis over the life of the case for all cases that transfer to ongoing services. And, according to 2014 site visit data, only one additional comparison county as of the end of the third waiver held meetings that met this criteria. However, while only these two counties can be considered comparable to demonstration counties in practice, the number of comparison counties holding *some* sort of meetings with families may have increased. In a 2014 survey of comparison counties administered prior to site visits, administrators in nine counties indicated that their agencies were conducting some sort of family meetings. These counties identified the following practices: Family Unity Meetings, Case Transfer Meetings, Wraparound Meetings, Family Team Meetings, Treatment Team Meetings, Family Meetings, and Family Group Conferencing. Additional data gathered during 2014 site visits illuminated the nuances of these practices, highlighted in Table 3.4.

Table 3.4: Family Meetings in Comparison Counties		
	2012 (n=17)	**2014 (n=16)**
Family meeting model very similar to ProtectOHIO model	2	2
Family meetings targeted to cases in custody or at risk of placement, rather than all cases in ongoing services; may have an independent facilitator	4	0
Regularly held family meetings managed by caseworker or line supervisor; no independent facilitator	5	6
Family meetings on case-by-case basis; may or may not have an independent facilitator	6	6
Family Meetings are currently being explored; model is not yet solidified	0	1
No Family Meeting Model outside of Semi-Annual Reviews (SARs)	NA	1

As demonstrated, the majority of comparison counties hold some sort of family meeting that aligns with one or more of the FTM core components. Six of the sixteen hold regular family meetings over the life of the case, but these are facilitated by a non-neutral party, such as the caseworker, line supervisor, or, in one county, therapists. In six additional counties, family meetings are held on a case-by-case basis rather than over the life of the case; these meetings may or may not be supervised by a neutral party and may only be offered in the occurrence of specific critical events or at the caseworker's discretion. Staff in one county noted during a 2014 site visit that the county was considering adopting a family meeting model but had yet to conduct any meetings. And in one county, no family meetings are held outside of semi-annual reviews (SARs); these reviews are conducted by the caseworker.

Six comparison counties hold some sort of family meeting, besides SARs or 90-day reviews, with a neutral party facilitating; these neutral facilitators may be non-case carrying caseworkers or permanency unit leaders. While a neutral facilitator is present, however, the family meeting practice in these counties differs from the ProtectOHIO model in that only a subset of families that transfer to ongoing services receive these meetings, and the meetings may not be held on an ongoing basis throughout the life of the case. In this way, these counties differ even from those ProtectOHIO demonstration counties that serve a subset of cases.

In 12 comparison counties, some sort of meeting is held that involves a range of attendees, including the caseworker, the family, and service providers; in some of these counties, meetings also include additional family supports. Again though, practice differs from the ProtectOHIO model in that these meetings may not be neutrally facilitated, may not be available for all families with cases that transfer to ongoing services, and may not be held for the duration of the case. One comparison county conducts Family Group Decision Making meetings for some cases; these are primarily held for Alternative Response cases and are not necessarily conducted over the life of the case.

3.2.3 Peripheral Elements of the ProtectOHIO FTM Model

While the previous sections focused on core elements of the FTM model and data related to those core elements, this section presents data associated with supplemental elements that are instrumental in enhancing practice as well as some county staffing roles or structures related to FTM. As in the preceding sections, comparison county data is provided when applicable or illuminating.

3.2.3.1 FTM and Alternative Response

The completion of the state-wide adoption of Alternative/Differential Response across Ohio occurred during the third phase of Ohio's waiver, reflecting the national move toward distinguishing pathways for low-risk and high-risk cases.[44] In 2014, all ProtectOHIO demonstration counties had implemented AR; however, only 10 counties extend FTMs to Alternative Response cases that transfer to ongoing services. Staff in some counties stated that, due to either the newness of Alternative Response or the structure of their AR processes, they have not had AR cases that have transferred from intake to ongoing and thus have not considered utilizing FTMs for these cases. These AR cases are served wholly within intake or are transferred to traditional ongoing services if they move to an ongoing case.

For those AR cases that do receive FTMs, the model holds some dissimilarities to FTMs for traditional, ongoing cases. Some of the agenda elements, such as case planning and discussion of risk statements, may not be applicable for AR cases. The conversation may center more on the safety plan rather than a case plan. Staff in one county indicated that the conversation at AR FTMs is less about services and more about attendees' goals related to preventive measures.

3.2.3.2 Facilitator Roles

While the FTM practice model and manual indicate some of the important roles that both facilitators and caseworkers play in the implementation of FTMs, it is clear that these roles are not rigid. This variance underscores the flexibility of the practice outside of its core components. While some roles of the caseworker and facilitator are consistent across counties, others vary to best meet county culture and needs.

One of the most commonly cited roles of the facilitator (apart from generally facilitating the meeting) is to take a lead role in the process of scheduling the initial FTM and/or inviting attendees to the initial and 90-day FTMs; this was cited in 10 counties. The facilitator may send invitation letters and/or call meeting attendees, depending on the county.

Another common role of the facilitator is to document the meeting by taking notes during the FTM. In at least 10 counties the facilitator completes notes and disseminates them to all parties present at the FTM and, in some counties, to providers or support people who could not attend.

In at least five counties, facilitators believe one of their roles during the meeting, beyond being a neutral party, is to engage and welcome the family and to ensure the family feels comfortable. As part of this

[44] Kaplan & Merkel-Holguin, 2008

role, facilitators may discuss the purpose of the meeting, explain what FTMs are, define meeting guidelines and rules, and facilitate attendee introductions.

In addition to these various roles, facilitators in one county indicated that their role is to hold both sides (the agency and the family) accountable; facilitators in another county indicated their role is sometimes to gently confront the family. In at least three counties, the facilitator drives the discussion about family strengths during the FTM; however, it is more common for the caseworker to facilitate that conversation (caseworkers maintain this role in at least four counties).

3.2.3.3 Caseworker Roles

Over the course of the waiver, the evaluation team has collected information about caseworkers' roles in the FTM process. Caseworkers may have roles and responsibilities prior to the meeting, such as gathering materials or preparing the family, as well as during or following the meeting. In 2014, facilitators noted that the caseworker should or does take on a lead role in attendee notification, scheduling, and preparation—such as issuing invitations, contacting new service providers prior to 90-day FTMs, coordinating the FTM with the family's schedule, and ensuring meeting attendees understand the purpose of the meeting and the meeting agenda. This is consistent with the caseworker experience in both 2014 and 2012. In 2012, for example, over three-quarters of caseworkers (78%, or 256 of 329 respondents) agreed or strongly agreed with the statement "I am encouraged by my agency to spend time gathering or preparing needed information about the family for FTMs." Prior to scheduling and preparing families, caseworkers in at least four counties complete an FTM referral document, which notifies the facilitator to schedule the FTM.

Caseworker roles have remained consistent as the waiver has progressed; site visit data collected in 2014 demonstrates that caseworkers continue to fill roles identified in 2012. However, roles may fluctuate depending on who is in attendance at any specific FTM. For example, the caseworker may defer to the parent, kinship caregiver, or child to share their own progress or updates, though the caseworker may fill that role if those parties are absent. In this way, the caseworker's role is not just fluid across counties but, to some extent, from meeting to meeting within the same county. The facilitator also plays a role in determining what the caseworker will be responsible for during the meeting.

Primary roles occupied by caseworkers are shown in Table 3.5. Counties have continued to expand the roles that caseworkers are playing in the delivery of the intervention, as reflected by an increase in the number of counties that cite particular duties.

Table 3.5: Primary Caseworker Roles		
	Number of Counties Citing as Caseworker Role	
	2012	2014
Present family history, background information, reasons for involvement	5	7
Present concerns or risks	4	9
Present case update or share progress made	4	6
Help identify strengths	3	6
Help create the case plan or action steps	3	9
Support the family or answer their questions	3	3
Identify the services that should be put into place or be part of the general guiding conversation around services	1	6

In 2014, several additional caseworker roles were noted that had not necessarily emerged earlier in the waiver:

- Hold providers accountable to stay on point
- Develop a family tree and update it during each FTM
- Hold parents accountable

However, the number of counties reporting these roles was low; each was identified in only one demonstration county. The most common role that caseworkers play, which was cited in 9 counties, may be presenting the agency's concerns about safety and risks during the FTM. Facilitators, when asked about caseworkers roles during 2014 site visits, agreed. Facilitators noted that this role is likely not filled by the facilitator, as they typically do not have the historical information necessary to address past harm; filling this role may also violate their neutrality in the eyes of the parent(s).

Caseworker Buy-In: The roles that caseworkers fill—and certainly the training they receive—may be related to their buy-in and engagement. While it's clear that facilitators are invested in the practice and see a strong benefit to both the county and the family, buy-in may vary more among caseworkers. This could be because caseworkers are not as intimately involved in the process as facilitators; FTMs are tertiary to their primary roles; or they may have been accustomed to practice-as-usual before the implementation of FTMs. However, facilitators and supervisors in the majority of demonstration counties (14 counties) indicated that caseworkers are generally on board and bought into the FTM model.

Yet, staff across all counties discussed challenges related to caseworker engagement in the model, particularly among more seasoned caseworkers. Some challenges include caseworkers expressing resistance to holding critical event FTMs and lack of caseworker interest in increasing attendee fidelity. In at least two counties, more established caseworkers may be less likely to be bought into the model than new workers who were on-boarded after the implementation of FTM. In at least one of these counties, established workers contradict facilitators and supervisors by telling newer caseworkers that FTMs are optional. In at least two counties, FTM facilitators indicate that engaging caseworkers in the

FTM process is challenging because of caseworker busyness and workers may see FTMs as an extra, burdensome step in the case planning process. In one county, facilitators indicated that "caseworkers pencil FTMs in," and do not necessarily view them as a firm commitment. In at least two counties, limited buy-in extends beyond caseworkers to managers. For example, in one county, managers may tell supervisors that their attendance at FTMs is optional, though it is the confirmed practice in that county for supervisors to attend all FTMs. To address resistance to the FTM model, one agency has moved toward disciplining workers who do not schedule FTMs, and is beginning to incorporate FTM fidelity components into employee reviews.

Overall, caseworkers express support for the FTM process. In 2012, over 80% of caseworkers indicated that FTMs were always or usually are a useful way to decide case plan goals (83%) and review case plan progress (84%). And in 2014, some unintended consequences as a result of this increased buy-in were noted for the first time through site visit interviews: In some counties, facilitators indicated that caseworkers are so engaged in the FTM process that they request more FTMs than the facilitator has the time or capacity to facilitate. Facilitators expressed concerns that new workers may over-rely on FTM, in that they appear to lack confidence in their own skills and want to call a meeting "any time a decision about the case needs to be made". In another county, workers may want all of their meetings (even non-ProtectOHIO meetings) facilitated, and even indicated they may "sneak" what would normally be non-facilitated meetings in for a ProtectOHIO FTM. In another county, the facilitator reported that caseworkers regularly check in with the facilitator outside the meetings, sometimes to simply ask for a neutral perspective when a critical event has occurred or a decision needs to be made. This reliance on facilitators and FTM highlights its usefulness and caseworkers' increasing acceptance of the practice as well as an increased trust in facilitated meetings to address challenging family issues.

Overall, facilitators see caseworker buy-in as vital to the success of FTM, indicating that meetings are more family-oriented when caseworkers are bought-in. Facilitators also hold that FTMs can be valuable not just to families but also to caseworkers. Workers may feel more supported and structured around case work and view the FTM as an opportunity to build rapport with the family.

3.2.3.4 Case Plans and Services

The ProtectOHIO FTM manual indicates that a fundamental tenant of family-driven, strengths-based practice holds that various perspectives are considered in case planning. At its core, each FTM has a review of the family plan or case plan regarding progress of goals and objectives. [45] Case planning is an important prerequisite to linking families with necessary services, another element of FTM. When surveyed in 2013, 76% of caseworkers thought that FTMs always or usually resulted in families being referred to services that are likely to work for them. In 2014, parents who participated in focus groups agreed that setting goals for case plan services is an important element of FTMs. In fact, FTMs may allow parents to set goals for themselves in addition to learning about the goals and case plan services the caseworker would like for them. Parents who had been involved in FTMs also indicated that the FTMs are a platform to prove to themselves that they could successfully meet the case plan goals. And because parents become accustomed to the FTM facilitator or the caseworker asking about their progress during the regularly held FTMs, parent felt inspired to move toward completing the case plan goals.

In the majority of ProtectOHIO demonstration counties (12 counties), staff indicated that the initial FTM serves as the platform for case plan development. Within these counties, workers may come to the initial FTM with a case plan started in SACWIS and with initial goals or services in mind for the family, but the initial FTM is viewed as an opportunity for families to be involved and offer their voice in case planning. In fact, staff in one county said that nothing should appear on the case plan that was not discussed during the FTM; this sentiment may be shared by other counties, as well. In counties where the case plan is developed during the initial FTM, staff may project SACWIS onto a screen or write the case plan goals and services on a whiteboard, so that parents are both verbally and visually involved in the development.

In 2014, at least two counties also prepared parents for the process of case planning prior to the FTM. Staff in these counties may hold a meeting with parents or call them to ensure they understand the type of case plan that will be developed (custody, protective supervision, voluntary), what will happen at the initial FTM, and the services available to families. This can allow families to consider the services or providers they may want to request during the case plan development component of the initial FTM. Staff in at least one county noted that they wished parents were prepared in advance of the FTM because hearing the entire case plan and service goals at the FTM can be overwhelming. Additionally, some counties provide parents with a list of all services or service providers so that they can independently request services that they may not have otherwise known were available.

The counties that actively involve the parents or family in the development of the case plan indicated multiple benefits of involving parents. For example, this method facilitates family engagement, involvement, and the parent voice in the case plan. Parents or family are able to share the barriers they anticipate to successfully completing the case plan or following through with services, and all those in attendance at the FTM can help troubleshoot these barriers. Additionally, this method allows the agency to be transparent about the case plan goals and the expectations for parents so that parents are

[45] ProtectOHIO Consortium FTM Workgroup, 2011

not surprised at court when the case plan is presented. An FTM facilitator in at least one county noted that FTMs enhance both parent buy-in and caseworker buy-in; as the parent and caseworker are each able to discuss their concerns and suggestions, each party will understand the other's perspective.

When the case plan is created during the FTM, the parents provide input on services and are able to request specific or alternative providers, based on preference or insurance coverage. They are also able to state if they feel there are too many services at one time. This creates an atmosphere of successful service delivery and ensures services are aligned with the parent's values and schedule. At least one county noted that in-home services can also be set up during the FTM if the parent identifies transportation as a barrier.

During the 2014 focus groups with parents, the evaluation team queried parents about their experience of the most helpful aspects of FTM. One area that parents note is FTM as a mechanism for discussion and procuring needed services. Parents expressed appreciation for learning about the array of services available to them during FTMs and finding services for their children. Parents in one county expressed surprise that therapy would be provided for their children—a service the parent wanted for the child but had been unable to afford or procure prior to agency involvement and the FTM.

While the majority of ProtectOHIO counties utilize the initial FTM as the launching pad for case plan development, staff in one county indicated that within their agency, the case plan is wholly created prior to the FTM and then just discussed with the family during the FTM. This staff member said, "It isn't the goal to do the case plan at the FTM." And in one additional county, the regular practice is to garner parent input on the case plan during the FTM and partner with them to create it; however, case plans for families involved in family drug court are standardized (per the court) and there's sometimes less opportunity for flexibility or parent input. In the remaining two demonstration counties, practice may vary around case plan development and FTMs; processes are not necessarily solidified.

These recent findings are consistent with findings from the Interim Evaluation Report, wherein only a few counties noted that they hold the initial FTM once the case plan is written. While uncommon, this practice may inhibit family engagement and joint-decision making.

Comparison Counties: Like demonstration counties, comparison counties vary in terms of the process and timing of case plan development. Counties that conduct family meetings were asked about their case planning processes and the extent to which family meetings are used as a forum for case plan development. In four of these comparison counties, the family meeting is utilized to brainstorm about case plan services and goals, then the worker may finalize the plan following the meeting. In these instances, the worker may come to the family meeting with a skeleton plan, but the family meeting serves as the platform for case planning. In one county where workers create the plan in collaboration with the family during the meeting, staff noted that this intervention builds consensus and involves the family. However, delaying case plan development until the family meeting may present challenges to the worker when trying to meet agency or court deadlines.

In terms of challenges encountered, staff in two counties noted that there are not challenges to creating the plan with families during meetings, but the SACWIS case planning module itself presents challenges and is not user friendly. In one county, the case plan is developed in advance of the family meeting, and then signed during the meeting; staff noted that this often results in case plan amendments once the

meeting occurs and family input is solicited, and this was perceived as a barrier. In another county, the case plan is discussed during the case transfer meeting, which is not that agency's family meeting. This agency is working toward adding a family meeting within 30 days of the case transferring to ongoing services, which will be utilized as a case planning meeting. In this county, staff noted that tension between the family and agency is high at the initial transfer meeting, so it may not be an ideal time to discuss the case plan or solicit family feedback on services.

In two comparison counties, family meetings are *not* used as a platform for case plan development. In one county, the case plan is typically created by the caseworker after the meeting occurs; in the other county, the case plan is created individually between the caseworker and family, outside of the family meeting practice.

3.2.4 Engaging and Involving Families and Partners in FTMs

The FTM manual indicates that fostering family engagement is a significant feature of FTMs; not only do facilitators and caseworkers utilize strategies to enhance family engagement during FTMs, but FTMs themselves are a mechanism of engaging families in the case planning process. Additionally, FTMs are meant to be a collaborative approach for supporting and educating parents, sharing information, and jointly making decisions. These engagement and involvement approaches are highlighted in the following subsections.

3.2.4.1 Notifying, Reminding and Preparing Families for FTMs

Having a variety of attendees at family meetings is a high priority of the FTM intervention. For an effective FTM, a wide range of people should participate, including support persons. The minimum attendee mix includes at least one parent or primary caregiver, at least one caseworker or other PCSA staff, and at least one other type of person (not including the facilitator).[46] In some studies, family meetings that involve a range of community supports and extended family, as well as parents, are associated with positive outcomes for families.[47]

Family attendance is believed to be crucial to the success of FTM. As the logic model illustrates (see Table 3.1), demonstration counties believe that by engaging them in FTMs, families will understand their case plan and be more motivated to follow through with it, use natural supports to a greater extent, and be linked to more appropriate and timely services. While parent attendance (as well as the attendance of extended family and, when appropriate, children or youth) is key to the meetings being truly collaborative and family-focused, parent attendance remains a challenge. To overcome this challenge, counties employ various means of notifying parents of and reminding them of meetings. During 2014 site visits, facilitators identified the following strategies for notifying and reminding parents:

- Parents receive follow-up and reminder calls from caseworkers or interns (cited in 3 counties).
- Invitation or reminder letters are mailed to parents (cited in 10 counties).

[46] ProtectOHIO Consortium FTM Workgroup, 2011

[47] Pennell, Edwards, & Burford, 2010

- Caseworkers remind parents of FTMs as meetings approach, either at the agency or during a home visit (cited in 5 counties).
- Parents are informed of meetings and prepared for them over the phone (cited in 4 counties).
- In addition to agency staff, service providers may remind parents of meetings (cited in 1 county).
- The family is given a brochure about the meeting process and case planning (cited in 1 county).

These strategies remain consistent with those identified through a survey of facilitators and caseworkers in 2013. Based on survey responses, caseworkers appear to explain the FTM process to families more often than facilitators, perhaps because facilitators may not have much contact with families outside of the FTM.

Table 3.6: How Facilitators and Caseworkers Explain the FTM Process to Families Prior to Initial FTM

	Always or Usually In Person	Always or Usually By Phone	Always or Usually Distribute Brochure/ Letter
Caseworkers (n=329)	75% (248)	44% (145)	26% (86)
Facilitators (n=32)	50% (16)	34% (11)	28% (9)

As shown in Table 3.6, FTM is most commonly explained to the family in person: 75% of caseworkers and 50% of facilitators always or usually explain the FTM process in person. As caseworkers are preparing families—whether in person or otherwise—caseworkers share particular types of information with families, namely those listed in Table 3.7.

Table 3.7: Type of Information Caseworkers Share With Families Prior to Initial FTM

	Always or Usually (n=329)
Importance of the Family's Involvement and Input	95% (313)
Importance of Attending	93% (310)
Issues Likely to Be Addressed	92% (303)
That Concerns Will Be Discussed Openly, Honestly, and with Confidentiality	88% (293)
Importance of Inviting Supportive People	85% (278)
Who the Family's Supportive People Might Be	82% (268)
Which Service Providers to Invite	80% (264)
Alerting Parents that Past/Present PCSA Case May Be Discussed	70% (230)
How to Contact the Facilitator for Future Questions about FTM	55% (181)
Whether the FTM Counts as the Required Case Review	46% (150)

As noted, 93% to 95% of respondents mentioned that caseworkers always or usually emphasize the importance of family attendance, involvement, and voice—perhaps because family participation has remained a consistent challenge across demonstration counties.

3.2.4.2 Engaging Families in the Meeting Discussion and Facilitating Family Voice

As noted above, counties emphasize notifying, reminding, and preparing families for FTMs. Once families are in attendance, facilitators and caseworkers engage them in the meeting process and facilitate family voice and participation. Throughout the meeting, facilitators may check in with parents to ensure they've had a chance to speak. Some counties seek to emphasize respect for the family's perspective by asking parents to share their perspectives on the case before professionals do. In one county, when family members arrive at the FTM, they are invited to sit at the meeting table before professionals to decrease unease. In at least one county, staff also ensure that parent support people are actively invited to participate, noting, "We try to make sure that folks aren't here as a spectator. You're here as a participant, and anyone who comes in the room should be getting a chance to participate in the meetings."

> *"We try to make sure that folks aren't here as a spectator. You're here as a participant, and anyone who comes in the room should be getting a chance to participate in the meetings."*
>
> *– FTM Facilitator*

In 12 counties, staff explicitly noted that discussing parent and family strengths is a key element of family engagement; in one county, a facilitator noted that parents often appear visibly more relaxed after this component of the FTM. Additionally, facilitators prevent professionals—particularly supervisors, Guardians ad litem (GALs) and attorneys—from dominating the meeting and preventing the parents or family from having an opportunity to respond. Facilitators may also remind all parties of the meeting rules, to underscore that all participants are invited to speak. One county allows only a certain number of Children Services representatives to attend—both to prevent the meeting from being intimidating for parents and to prevent a lopsided ratio of professionals to non-professionals.

Similarly, counties also focus on using accessible language and ensuring that parents understand agency language and acronyms and what is expected of them. At least five counties explicitly noted that they display FTM notes on a whiteboard or screen so that parents and all participants can read them. This also encourages the agency to utilize strengths-based language, especially if parents will be reading notes directly from SACWIS during the meeting. Likewise, in at least one county, nothing can be added to the meeting notes after the FTM, to ensure the parent is aware of everything in the notes.

In one county, when meetings are held for families who have had children removed from their homes, it is regular practice to ask the biological parents questions about their children—such as the child's favorite foods or favorite blanket—to underscore that parents are the experts on their children. In two counties, the facilitator will pause the meeting and allow parents to take a break or speak to a provider if the meeting is tense or the parent asks for a pause.

In addition to facilitating family engagement during the meeting, counties may also offer to hold meetings at neutral locations or in family homes. During 2014 focus groups with parents in six demonstration counties, at least one parent in each county reported they had FTMs at locations other than the child welfare agency.

As was the case in the 2012 evaluation study, transportation and childcare remain barriers to family attendance. Flexible meeting locations and meeting times may help to increase parent attendance. In 2014, caseworkers in three counties indicated that their agency assists with parent transportation to FTMs (by providing public transit passes or arranging for staff to pick up parents). At least one county provides day care during the FTM. And at least five counties regularly offer flexible meeting locations (including parent homes), encourage parents or providers to join by phone if they cannot join in person, and diligently schedule FTMs around parent availability.

In addition to eliminating barriers to parent attendance, caseworkers also indicated that a strength of the model is making parents comfortable during FTMs. Counties may do this by providing refreshments for families (1 county) and by providing name tags so that parents are clear on who the attendees are (1 county). In one county, staff noted that finding funding to provide snacks or refreshments to enhance family comfort and buy-in is a challenge.

Comparison Counties: Staff in comparison counties noted similar practices for enhancing family engagement during family meetings. Methods cited in more than one county include:

- Facilitator ensures jargon and acronyms are not being used and that families understand what's being said and decided (cited in 3 counties).
- Identify parent strengths, progress, and achievement (cited in 4 counties).
- Chat with families before meetings and take breaks during meetings (cited in 2 counties).
- Asking the family direct questions or allowing them to respond to any concerns cited (cited in 3 counties).
- Utilize technology strategically, such as:
    - Type and display project notes during the meeting to enhance transparency and trust (cited in 2 counties); or
    - Not typing or utilizing a computer during the meeting as it might function as a "physical divide" or barrier to engagement (cited in 3 counties).

Comparison counties were asked about the core components of their family meeting model; four counties noted that meetings are family-driven, family-directed, and that the family engagement component is essential. Methods they employed to engage the family included inviting the family to speak first, providing refreshments, ensuring that someone sits next to the parent during the meeting, and maintaining a sense of humor and an informal environment. Counties also noted that highlighting and discussing family strengths is important, as is establishing goals and communicating with parents about the process of reunification.

3.2.4.3 When Parents Do Not Show Up for a Scheduled FTM

Parent attendance continues to be challenge; in 2014, caseworkers cited this as the main barrier to successful FTMs. However, demonstration counties continue to shift their practices to better accommodate families. In 2012, for example, if a family did not show up for its scheduled FTM, seven counties stated that they would try to reschedule the meeting; in 2014, nine counties indicated that they will reschedule an FTM to accommodate parents. At least two counties attempt to reschedule or, if

multiple agency staff and service providers are already scheduled to attend, will hold an unofficial FTM with the professionals and call an additional, formal FTM when the parent *is* able to attend. If parents do not show up, six counties stated that they will call the family to see if they can join by phone. These methods appear to demonstrate a much more active approach than was found in previous years. In the Final Evaluation Report of the second waiver, for example, the evaluation team noted that 16 of the 17 demonstration counties proceeded with the meeting if the family failed to show up. In 2014, while all 15 counties indicated that ultimately they might proceed with at least some FTMs without the parents present, several staff expressed concern about the strength or "outcomes" of the meetings without family voice.

However, variation exists across demonstration counties in this regard. In one county, the caseworkers and facilitator had different interpretations of agency policy around holding meetings without parents; in another they hold meetings without parents only infrequently; and in yet another the practice of holding meetings without parents varies by facilitator. In one county, facilitators will not hold FTMs on voluntary cases without the family, but they do proceed with FTMs for traditional cases without parent attendance. And in another county, staff will hold FTMs without parents but only if another family member is present. A staff member in another county noted that the county does hold FTMs with just agency staff present and indicated, "I consider it an FTM because we're discussing the case plan and progress." In at least one county, the meeting proceeds with any combination of attendees.

Staff in 6 of the 16 demonstration counties indicated that they hold FTMs without parents because the agency is constrained by the 90-day FTM fidelity timeline, court dates, or 90-day service review timelines. Staff in several counties noted they attempt to schedule the FTMs around the 80-day mark to allow flexibility in rescheduling and to increase the chances that parents will be involved.

Staff in one county mentioned they proceed with the FTMs because kin caregivers and professionals are present; in one county, caseworkers expressed ambivalence about this scenario, feeling the importance of having the parent present but perceiving it as disrespectful to professionals and providers to not hold the meeting when those individuals made an effort to be there.

Comparison Counties: Comparison counties who hold family meetings are mixed in their policies regarding holding meetings without family members present. Five counties might hold family meetings even if parents don't show, especially if the meetings are scheduled close to mandatory timeframes or benchmarks, such as case plan completion, or if providers are present. Some of these counties might reschedule if there's time. Staff in one county noted that workers are usually in contact with parents and know if they'll able to attend. Three counties noted that they generally will not or rarely do hold their family meeting if the family does not attend.

3.2.4.4 Involving Fathers and Paternal Relatives in FTM

As the waiver has progressed, demonstration counties in Ohio have made an increasing effort to incorporate fathers and paternal relatives in case planning processes. At least 10 demonstration counties have participated in the Ohio County Fatherhood Initiative, which emphasizes raising awareness of the importance of father involvement for children and making family-serving agencies

more father-inclusive,[48] and the strides made to involve fathers and paternal relatives in FTMs may be an offshoot of this involvement. One facilitator noted, "Workers used to say 'Dad has never been a part of the case,' and that would be the end of the conversation, but that's no longer enough." This sentiment was shared by staff in other demonstration counties; indeed, all demonstration counties indicated that they regularly notify fathers of FTMs and invite fathers and/or paternal relatives to FTMs. Similarly, if agencies have contact information for paternal relatives, they will invite those relatives to attend the FTM, or, if the father is attending, they will remind him that he can bring his own support people. Agency staff may explain to the mother why it is important for the father to attend even if the parents' relationship is contentious.

FTM facilitators may advocate for paternal involvement, asking the caseworker during each FTM if any progress has been made in contacting the father. Similarly, facilitators and caseworkers may ask the mother and maternal relatives at each meeting if they have information about the father's location or contact information. When fathers do attend FTMs, agencies may "praise him" and emphasize his attendance as a strength. Agencies face challenges as they try to involve fathers in FTMs, namely if fathers are unreachable or incarcerated; however, as noted in the following section, agencies do have practices and policies in place to involve parents who are incarcerated.

3.2.4.5 Involving Incarcerated Parents in FTMs

When asked about their methods of inviting and involving fathers in FTMs, staff in many counties explained their methods of involving incarcerated parents—fathers in particular. This may be an important element of family engagement, as children whose fathers are incarcerated are four times more likely to face contact with the child welfare system than the general child population.[49] Involving incarcerated parents is therefore necessary, considering that it may not be uncommon for families eligible to participate in FTMs to have one parent incarcerated.

Counties have varying philosophies around involving parents who are incarcerated. Some do not prioritize their involvement. For example, staff in one county indicated they do not involve incarcerated parents in any capacity. And staff in another county reported that the onus is on the incarcerated parent to write a letter to the caseworker, asking to be involved. In another county, caseworkers focus on engaging extended family members who can attend the meeting and support the family rather than focusing on parents who are incarcerated.

Other counties seek to involve incarcerated parents in various ways. Counties may send them FTM invitations or notification letters as well as meeting summaries. Parents may be encouraged to write letters to be shared during the FTM. In two counties, incarcerated parents are provided with questionnaires or surveys prior to the FTM to gather their input on the case and to share their expectations. The questionnaire feedback is then presented during the FTM. In one county, the caseworker hand-delivers the questionnaire (assuming the parent is in a county jail) and picks it up to

[48] Ohio Commission on Fatherhood, n.d.

[49] Christian, 2009

increase the chances of the parent completing it. In another county, staff meet with parents who are incarcerated in the county jail prior to the FTM to gather their input face-to-face.

During FTMs, parents who are incarcerated may be able to participate by phone, though this may depend on the incarceration site; federal prisons, for example, may be stricter than local jails. In fact, parents in county jails have sometimes attended FTMs, escorted by law enforcement personnel. Conversely, in three counties, FTMs have been held at justice centers or county jails.

For parents incarcerated out of the county or who are in prison, there are additional barriers to involvement. For instance, workers can't travel to other counties or to prisons to meet with parents, prepare them for the FTM, or gather their input. And staff in one county indicated that an additional barrier to involving parents who are incarcerated is a long, bureaucratic process for procuring written letters from those parents.

Comparison Counties: Some comparison counties have implemented processes for involving incarcerated parents in family meetings. Four comparison counties noted specific efforts in this regard:

- In one county, family meetings have been conducted at the county jail.
- In the other three counties, caseworkers will reach out to parents who are incarcerated and, if possible, visit them to collect their input on the case or will correspond with the parent's caseworker.
- Staff in one county mentioned that parents might send a letter to be read during the family meeting or might speak with the caseworker to convey their perspective. Although parents are invited to participate by phone, parents who are incarcerated may not be able to join by phone at the specified meeting time.

3.2.4.6 Engaging Families in the Meeting Discussion

One important aspect of family engagement is the neutral facilitator; in 2014, parents who participated in focus groups felt that neutral facilitators were a helpful aspect of FTM and differentiated FTM from other meetings they may have experienced with child welfare. Parents found the facilitator to be an important resource who helped them prepare by explaining what the FTM was, and parents felt that the facilitator had their best interest at heart and was truthful. The facilitator was also a positive voice in the meetings, played a peacemaker role, and was able to translate information provided at meetings when parents didn't understand.

The meeting itself can pose challenges for caseworkers and facilitators when it comes to engaging families. When asked what they do to encourage productive family engagement during the FTM, caseworkers and facilitators stated that they commonly:

- Encourage families to give their input by asking what they feel they need to work on, what support they need, what progress they've made; and encourage the family to speak first.
- Identify family strengths.
- Explain the FTM process or purpose at the beginning of the meeting.
- Check that the family understands what's being said; provide interpreters.

- Skillfully facilitate: enforce ground rules, redirect to keep the meeting on track, create a non-judgmental atmosphere, encourage open and honest discussion, hold all participants accountable.

Case planning during the FTM may be another mechanism of engaging families in the discussion and decision-making. Staff in one county noted, "If the case plan were to be created before the meeting and presented at the meeting, it feels like the meeting is fake. The meeting process is a farce if the case plan was already done. Parents would feel like their input didn't matter. Probably parents would stop coming to FTMs."

Staff also noted multiple ways that they facilitate and seek family engagement during the FTM:

- Facilitator may check in with families about their feelings and ideas, even if the worker is firm about what services they want for the families.
- Workers encourage family to view the case plan as a map rather than a checklist.
- Workers ask parents if they agree about each component of the case plan. Conversely, for court-involved cases, workers let parents know that if they ultimately disagree with the case plan services, they can share their reasoning at a court hearing.

Caseworkers were asked about their thoughts on how engaging parents through FTMs is valuable for families. Caseworkers in nine counties indicated that the value of FTM for families is that the meetings provide transparency and clarity for the family. These meetings elucidate the agency's expectations. Workers indicated that FTMs ensure that parents understand what they need to do, step by step, to achieve reunification. Similarly, workers indicated that this transparency is underscored by the collaboration that occurs during FTMs when the facilitator, caseworker, supervisor, service providers, and family are present.

Additionally, caseworkers also believe that FTMs highlight and showcase the parent voice. Caseworkers in seven counties noted that the value of FTMs is that they are an empowering environment for families and that they are led by families. Parents are involved in the decision-making at FTMs, and they get to share their perspective on their kids, which may not occur at other meetings.

Caseworkers also noted barriers related to engaging families during the meetings. Even though parents may attend FTMs, caseworkers in two counties emphasized that attendance is not synonymous with engagement—families may think of FTMs as "a hoop to jump through." Staff in one county noted that while allowing for flexible attendance (i.e., by phone), is positive, caseworkers experience parents as less engaged when they are on the phone rather than in the room. Involving incarcerated parents remains an explicitly stated challenge in one county. Other barriers related to family engagement include:

- The use of language and jargon that's not understood by families (cited in 1 county).
- A cold or uncomfortable meeting space (cited in 1 county).
- Parents may be less likely to view the facilitator as neutral when the meeting is at the agency and/or may believe the FTM is a legal hearing (cited in 1 county).

Family Communication: Another way in which families remain engaged in FTMs is through internal family conversation. As noted in the evaluation team's 2014 focus groups, parents focused on FTMs as a platform to communicate with their partner or ex-partner. The FTM may be one of the few opportunities for a custodial and non-custodial parent to discuss the child and their mutual goals for the child or their family, especially if visitation is not occurring. Additionally, conducting these interactions with a mediator, or neutral facilitator, present, may make parents feel safer. Caseworkers in three counties underscored the parent perspective, observing that FTMs bring family members together and allow increased family communication.

3.2.4.7 FTM Fidelity Incentives

Given the emphasis on involving families in FTMs, three demonstration counties have instituted internal incentives to bolster fidelity to the FTM model. Incentive programs were a recommendation of the High Fidelity Subcommittee that met in 2014 (see Section 3.1.5.1 FTM High Fidelity Subcommittee). As such, during 2014 site visits, the evaluation team explored county use of staff incentives to increase FTM meeting fidelity.

Toward the end of the waiver period, most demonstration counties were not providing formal incentives to staff or units for reaching FTM fidelity goals. One county reported that workers get "a lot of praise" for reaching fidelity goals, but there are no tangible incentives or rewards provided; in two counties, workers are disincentivized for patterns of low FTM attendee fidelity. In these counties meeting fidelity is tracked by the facilitator, and workers with consistently low-fidelity meetings may be chastised, and meeting fidelity may be a factor during the caseworker's performance review.

In counties where incentives are provided, incentives are supplied either to the unit with the highest fidelity over the course of the month or to the supervisor of the unit with the highest fidelity. Incentives include an opportunity to dress casually and/or pizza provided for the unit.

3.2.4.8 FTMs and Culture

Given the broad target population for FTMs, understanding and accommodating family culture is an important element to engaging families. During the 2014 site visits, the evaluation team explored how counties accommodate family culture and racial, ethnic, or religious identity during FTMs. Demonstration counties noted that FTMs have been held with families who identify with an array of racial, ethnic, cultural, or religious groups.

FTM facilitators described FTMs as a natural platform to respect and incorporate the unique beliefs, strengths, rules, or ways of handling challenges that families have. For example, staff highlighted the role that support people play in supporting a family's culture and ensuring that families are able to invite individuals they view as supportive and, potentially, culturally or racially aligned with the family. This may prevent, for example, an African American parent being the only person of color in a room of white professionals. One staff person noted that before the implementation of FTM, there was not a vehicle for parents to bring in representatives from their respective communities. Staff noted that seeing who parents invite to FTMs and hearing from those people helps Children Services staff to really understand family culture and dynamics. Additionally, FTM facilitators and caseworkers have learned that engaging

with families through FTMs may require engaging with their communities—for example, working with bishops and elders when working with Amish families.

Another way that FTMs can be made culturally relevant is by holding meetings in family identified-locations, such as a parent's home, the family's church, or in a community center. During FTMs, families can identify what is important to them and their family; they can also express their preference on providers and procure culturally specific services. Subsequently, these culturally specific providers may attend 90-day FTMs, which enhances support for family culture.

Facilitators, caseworkers, and supervisors involved in FTMs have engaged in training and other efforts to understand how family culture may impact the meeting and how to remain cognizant and respectful of the family's beliefs or traditions. Staff have learned, for example, to ask families during the FTM about whether or not they observe religious holidays or if they have preferences about the child's hair being cut, which may be particularly important to Amish families. Another way that staff strive to respect family culture is by not assuming that parents or all FTM attendees are literate; until staff know that all attendees are able to read, staff will read everything aloud that is shared during an FTM. In many counties, translators or interpreters are present at FTMs when necessary; staff have been trained to engage with and direct communication toward the family rather than speak to the translators. In one county, caseworkers noted that the FTM model is successful with families for whom English is not a first language. Staff also understand that cultural gender roles may emerge during an FTM, such as males leading the conversation; similarly, FTM facilitators will ask meeting attendees how they want to be addressed rather than defaulting to first names, which may be perceived as disrespectful. Staff may also try to understand that family tardiness to the FTM is not a sign of disrespect or disengagement, and they also work to respect family decisions around childhood vaccinations. FTM facilitators may also challenge caseworkers' perceptions of families as resistant, noting that perceived resistance may actually be a cultural belief in self-sufficiency and family networks.

3.2.4.9 Involving Natural Supports

In addition to involving and engaging parents and attending to family culture, FTMs include natural supports or supportive parties to ensure that parents feel supported and comfortable.[50] The attendance of supportive parties, particularly non-professionals, may distinguish family meetings from other Children Services meetings parents may experience.

One way in which FTM is expected to lead to positive safety and permanency outcomes is by increasing the family's reliance on their natural support system (i.e., relatives, friends, neighbors, church, etc.). Counties generally acknowledge that they encourage friends and family members to participate in FTM: in 2012, over 80% of caseworkers noted that they always or usually discuss with families the importance of inviting supportive people and who the family's supportive people may be. In 2014, as the evaluation team explored the involvement of family supports in demonstration counties, it emerged that some counties take a broad approach to who they consider support people. These counties may consider both non-professionals and professional providers (such as a parent's therapist) to be support people. Staff in one such county noted, "Anyone can be a support person if the parent views them that way." Other

[50] ProtectOHIO Consortium FTM Workgroup, 2011

counties take a narrower approach to the support role, only considering non-professional persons, such as relatives, significant others, and fictive kin, as support people. One such county indicated that professionals may view particular providers as supportive, but the parent may not. Given these differences, demonstration counties identified a diverse list of individuals who might be considered support people during an FTM, including:

- Relatives and family members (particularly, the parent's parents)
- Significant others
- Friends
- Neighbors
- Religious leaders
- Parent aid
- Kinship caregiver
- Therapists or counselors
- AA sponsor
- Recovery coach
- Foster parent
- GAL
- Parent's attorney
- Foster parent
- Teacher

While support people are present to provide support to the parents, counties expounded on what they view as the support person's role. For example, support people may:

- Encourage parents to "keep up the good work."
- Help parents take ownership.
- Help parents process the events of the meeting after the meetings.
- Provide clarification.
- Comment on barriers that parents may face.
- Comment on parent strengths.

One county noted that professional support people may take on a different role than non-professional support people, noting that professional support people may "call the family out" and encourage transparency. Another county indicated that, "Sometimes hearing it from a support person means more than hearing it from someone that works at the agency."

While support people play an important role, county representatives noted particular challenges related to the involvement of supportive parties. For example, staff in two counties noted that support person attendance may be stronger at the initial FTM meetings and then decrease at 90-day meetings. One county indicated that sometimes parent-invited support persons may "make excuses" for why the

parent was unable to complete action plan steps, rather than holding the parent accountable]; caseworkers in one county indicated that parent-identified support people may be "enabling or sabotaging." Similarly, the parent may view the party as supportive though they actually may inhibit the parent from achieving reunification or meeting case plan goals. Staff in one county noted that if support people attend who are "part of the problem" (for example, a significant other who has been violent), the FTM serves as a platform to procure services or resources to assist that support person in addition to the parent. Two counties have experienced challenges when parents invite their attorneys as support people and the agency was not notified in advance; in these cases, the agency needed to have its attorney present and had to reschedule the FTM. One county has taken responsibility for inviting all attorneys on the case to the FTM to mitigate this issue.

Because parent supports are identified as important attendees, counties may utilize a wide range of activities for encouraging participation by family supports. In 2012, FTM facilitators noted the following strategies:

- The agency offers help with transportation (e.g., bus/taxi fare, rides) (cited in 6 counties).
- Support people can participate in the meeting by phone (cited in 5 counties).
- Facilitators call the parents and let them know they can invite supports (cited in 4 counties).
- The extended family can send a letter or written statement if they cannot attend, or just talk with the caseworker (cited in 4 counties).
- Facilitators directly prepare the family supports prior to coming to the meeting (cited in 2 counties).
- The extended family's schedule is taken into account when scheduling FTMs (cited in 2 counties).
- The agency helps with child care (cited in 1 county).
- Caseworkers call the extended family (cited in 1 county).

3.2.4.10 Involving Service Providers

As the FTM manual notes, FTMs are an opportunity for collaboration among parents, family, Children Services and community service providers.[51] In 2012, the evaluation team asked facilitators how service providers are identified and how they are encouraged to attend FTMs. In two counties, staff specifically noted that the family is asked whether there are service providers that they would like to invite (e.g., that they have worked with in the past that they trust). In 13 counties, caseworkers are responsible for identifying which providers should be invited, while in 2 counties the facilitator is primarily responsible for identifying the people who should be involved.[52] As a matter of policy, counties commonly invite GALs and Court Appointed Special Advocates, probation officers, other court representatives or attorneys, mental health providers, developmental disability services case managers, and Help Me Grow (early intervention) providers.

[51] ProtectOHIO Consortium FTM Workgroup, 2011

[52] In two counties it was unclear who was primarily responsible for identifying service providers.

Many of the same practices used to encourage the participation of family supports are used to reach out to service providers. During the second waiver, some counties made efforts to provide training to community agencies or the courts in the FTM approach; the only mention of this type of provider-level effort during this waiver was by one county that put an article in the foster parent newsletter to explain the importance of their participation. It may be that relationships with service providers are solidified at this point in the waiver.

As with other attendees, some counties allow for providers to participate in meetings by phone rather than in person. In 14 counties, providers can participate by phone. At least five counties explicitly stated that providers are invited to participate by phone if unable to participate in person. Two such counties noted that mental health professionals, such as counselors and therapists, may be more likely to join by phone or teleconference than in person, perhaps due to billable hours. One of these counties noted that FTMs may be scheduled during a therapy session and both the parent and therapist will join the FTM by phone during their session. One county emphasizes the in-person attendance of mental health professionals; consequently, the agency pays for the multi-systemic therapy mental health providers to attend the FTMs. Providers are also able to provide written statements that the caseworker can read or present during the FTM in the provider's absence.

Comparison Counties: Five comparison counties allow providers to join the family meeting by phone.

3.2.4.11 Involving Children in FTMs

As in 2012, the decision to include children or teenagers in FTMs is left up to each county on a case-by-case basis. The FTM manual indicates, "Sometimes it is appropriate to have children/youth attend FTMs. An important aspect of the caseworker's role is to help make the determination of whether the child should attend based on their development (i.e., level of maturity and functioning), the nature of the case issues, and input from parents and other service providers." Given this flexibility, counties indicated various practices and policies related to including children and youth in FTMs:

- Adolescents age 12 and up are generally invited to FTMs.
- Teenagers are invited to FTMs.
- Young children are not invited to FTMs.
- Children school-age or older are invited to FTMs.
- Facilitator will consult with worker, parent and supervisor prior to the meeting to see if the child should be in the whole meeting.
- Children are usually invited.

Comparison Counties: When asked how they ensure the child's perspective is heard and incorporated into family meetings, comparison counties cited a variety of practices and policies. Similar to demonstration counties, county guidelines around which youth should be invited to family meetings differ, ranging from children over the age of 6 to children over the age of 15. Again, similar to demonstration counties, staff in comparison counties indicated that child involvement in a family meeting may be decided on a case-by-case basis, depending not only on the child's age but also on the particulars of the case and the child's cognitive ability.

3.2.5 FTMs and Kinship Caregivers: Intersection of the Strategies

During the 2014 site visits to ProtectOHIO demonstration counties, the evaluation team explored the intersection between the two current ProtectOHIO strategies: Family Team Meetings and Kinship Supports. Staff noted an intersection between the value base and philosophy of the two strategies; both accentuate family engagement and involvement and are underscored by an emphasis on least restrictive placements. And, the site visit interviews revealed that when the strategies do intersect, this primarily occurs within family team meetings.

While there may be regular and informal dialogue and interaction between the FTM facilitator and the designated kinship staff outside of FTMs in small counties, the majority of interaction across the counties occurs before, during, and after FTMs. Additionally, in some counties, one supervisor oversees both the FTM facilitator and designated kinship staff or these staff work in close proximity to one another, creating natural opportunities for dialogue about ProtectOHIO cases. In only one county, staff indicated that there is no regular, ongoing collaboration between designated kinship staff and the FTM facilitator. In two demonstration counties, the FTM facilitator and kinship coordinator staff roles are wrapped into one position, giving these staff opportunity to serve their kinship cases during the FTMs. In these counties, these staff are careful to be impartial when working with families in both of these capacities. This dual role may mean that the staff have timely contact with kinship caregivers during or following FTMs. Additionally, in one county, a designated kinship staff person is trained as a backup FTM facilitator.

The basic interaction between the strategies occurs at the level of FTM attendance. In 12 counties, staff indicated that designated kinship staff is invited to FTMs for kinship cases. One FTM facilitator indicated that s/he consults with the kinship staff member's schedule when scheduling the FTM to ensure the staff member can attend. Staff in only two counties that invite kinship staff to the FTMs indicated that the staff member may be often unable to come to the FTM due to scheduling or the staff member only attends FTMs for specific cases in which it is deemed necessary or helpful. In these counties, the designated kinship staff may attempt to provide updates, feedback, or input prior to the FTM.

It is common practice that kinship caregivers are invited to and attend FTMs, sometimes as a support person at the request of the parents and other times invited by the agency. Staff in one county noted that kinship caregivers are more likely to attend FTMs than biological parents. During the FTMs, the designated kinship staff member serves as a support or advocate for the caregiver. This could mean ensuring that the caregiver gets to share his or her perspective, asking them if they understand what is shared during the FTM, and debriefing with them after the FTM. Staff in one county said that this makes caregivers feel valued and less alone in the case planning process. During the FTMs, kin may discuss how the child is doing and what services they believe the child needs. Staff in one county said, "Having them at the table gives them a voice, and recognition that they are a valuable member of the process of finding permanency for the child." Kinship caregivers are also able to share what they see as family or parent strengths and their concerns about the biological parents or children.

As noted by interviewees in one county, the FTM is also a place to work out familial tension. The FTM facilitator and designated kinship staff person may meet ahead of the FTM to brainstorm ways to mitigate or address relational tension between caregivers and biological parents. Counties may also

address family visit issues or logistics during the FTMs; for example, if parents are moving toward visitation under the caregiver's supervision, agency staff can ensure that both parties understand the rules and expectations about visits.

Staff in five counties indicated that designated kinship staff can call an FTM or that the caregiver may request an FTM through the kinship staff member. And, in one county, kinship staff indicated that they call critical event FTMs to avoid the disruption of a kinship placement.

Additionally, some counties use the FTM as a platform to meet the kinship caregiver's needs. Staff in seven counties said they identify needed supports and services for kinship caregivers during initial FTMs and follow up with kin about service needs during 90-day FTMs. Kinship staff may help kin understand what they're eligible for during the FTMs. While the Kinship staff and caregiver interact outside of the FTM, the FTM may be the first time they are meeting. In fact, staff in one county said the kinship home study is often scheduled during the initial FTM and that the 90-day FTM serves as an opportunity for interaction between the kinship staff and the caregiver. And in one county, if the kinship staff member cannot attend the FTM, the FTM facilitator indicated s/he emails the kinship staff following the FTM to indicate any services the caregiver might need. In one county, the Family Resource Scale—a Kinship Supports intervention data collection tool—is sometimes completed during the FTM.

The FTMs may also be a platform for discussing potential kinship caregivers if the child is in a temporary placement or in foster care. Discussion about kin may happen during FTMs, and tools, such as genograms or family trees, may be completed or discussed at these meetings. Staff in one county said the FTM is where they really push the parents to identify kin, helping parents understand the importance of locating kin. In addition, the FTM may be a platform where parents buy in to the idea of a kinship caregiver, once they are engaged in the case planning process.

3.2.6 Barriers and Strengths of the ProtectOHIO FTM Model

As is expected with the implementation of any intervention, barriers remain across demonstration counties. Some of these are agency-centered while others are community or family-centered. In at least three counties, transportation for parents to FTMs has been an ongoing challenge throughout the duration of the waiver. In those counties that try to engage parents in FTMs by phone—either to remind parents of FTMs or to call when parents do not attend at the scheduled meeting time—staff have indicated that parent phones may be deactivated or not working. Additionally, county staff say that FTM attendance and successful engagement may be especially challenging for parents who are actively abusing substances. When parents do attend FTMs, facilitating true family engagement remains difficult. Staff also find it challenging to navigate animosity between parents and to schedule meetings during times that accommodate families.

Caseworkers expounded on some of the organizational or logistical challenges related to FTM. Barriers related to scheduling emerged in four counties, including challenges related to accommodating parent and caseworker schedules. Additionally, two counties noted that facilitators struggle to meet meeting demand. Separately, caseworkers in one county noted there was a lack of meeting space within the Children Services agency, limiting the number of meetings that could be scheduled at a given time. However, this county has since secured a building in a community setting that can be used to hold FTMs.

In addition to the challenges noted above, challenges related to model fidelity also arose. The most frequently cited challenge is about meeting attendance; caseworkers in 9 counties specifically noted that involving parents and/or service providers is challenging, and that meetings are less successful without parents present. Caseworkers also indicated that it's challenging to update parents and service providers following the FTM if they weren't in attendance. And despite the fact that caseworker buy-in to the model has generally increased, it remains a barrier to some extent across most counties, particularly with seasoned caseworkers who may view the process as burdensome and something "extra" that's not integral to their day-to-day casework practice.

While counties continue to experience and overcome barriers to efficacious Family Team Meeting practices and processes, facilitators noted significant successes experienced over the course of the waiver. For example, four counties have experienced success related to family participation in person and by phone, and these counties indicated that families feel positively about FTMs. Another success experienced in two counties is that practice has become more flexible, in that neutral meeting locations and more flexible meeting times are now available to accommodate families. Other facilitating factors that have strengthened and underscored the intervention include increased service provider attendance, enhanced agency buy-in, and supporting kin caregivers during FTMs.

Caseworkers across the 16 demonstration counties also identified numerous successes that they have experienced related to FTMs. The most frequently cited strength or positive aspect of FTM is that the practice is an opportunity for collaboration and "getting everyone on the same page"; caseworkers in 12 counties reiterated this aspect of FTM. This was mentioned as a core component of family meetings in one comparison county. Furthermore, caseworkers noted that transparency is often fostered during FTMs; parents may be more transparent about their experiences—such as drug use—in FTMs than in other meetings or interactions with the agency. This is particularly important at the beginning of the case, when case plans are developed. FTMs allow parents to share their concerns and to be involved in the case planning process from the very beginning.

Another cited strength is the transfer of knowledge that occurs between the intake worker and the ongoing worker during the initial FTM. Staff also view the FTM as an opportunity for the ongoing worker to initially meet and engage with the family.

Finally, the strengths-based approach that's inherent in the FTM model is also viewed as positive by caseworkers; caseworkers in six counties mentioned that the opportunity to discuss and focus on parent and family strengths is an important success of the model.

3.2.7 Summary of FTM Practice

During the third waiver period, counties have continued to solidify their fidelity to and emphasis on the Family Team Meeting model. For example, the number of facilitators has increased. (Whereas the maximum number of facilitators in any one county was 6 at the start of the third waiver, this number has increased to 10.) This increase may reflect practice or cultural shifts that underscore a growing value placed on FTM, or, perhaps, the expansion of FTM to Alternative Response. The latter is supported with information from the 2014 site visits, during which staff indicated that at least 10 demonstration counties extend FTMs to Alternative Response cases that transfer to ongoing services. This expansion is

in itself indicative of the advancement of FTM practice in demonstration counties, as well as the continued integration and synthesis of FTM with other county processes and initiatives.

Counties have increasingly focused on family engagement, as evidenced by efforts to attend to family cultural dynamics and to involve fathers and incarcerated parents in FTMs. Conversely, there continue to be challenges to the intervention, some of which have remained consistent across counties for the duration of the waiver. One of the primarily challenges is parent meeting attendance, noted as a barrier in multiple years and by multiple staff involved in the intervention. This challenge is not unique to Ohio; child welfare agencies nationally continue to struggle with implementing effective strategies for engaging parents.[53] And despite this challenge, counties continue to evolve their FTM practice to best serve families; fewer counties routinely hold meetings without parents in attendance, and 10 counties have made a focused effort to hold FTMs in the event of critical issues or placement decisions.

Additionally, during the third waiver period, the demonstration counties have undertaken several activities to promote more consistent and informed practice, including writing a practice manual and training curriculum. Facilitators from all demonstration counties were trained using this curriculum. Using materials and ideas from the training, nearly all counties also presented a limited amount of in-house training to their caseworkers. Caseworkers in surveys and focus groups could clearly articulate their role in FTM and were generally quite positive about its benefits. Many facilitators actively participate in the ProtectOHIO facilitator workgroup which meets quarterly—though this is one of the relatively few internal activities that counties report using to monitor and improve the quality of their FTM practice. However, counties do report ongoing cultural competency training that may enhance their efforts to engage Ohio's diverse families in FTMs.

While there is consistency in family meeting practices in demonstration counties, it is likely that comparison counties have individually adopted the family meeting model that best fits their agency's culture, goals, and capacity. These family meeting practices remain varied in availability, facilitation, and rigor. By contrast, demonstration counties are substantially more likely to have a family meeting practice that is targeted to all ongoing cases, is provided throughout the life of a case, and is facilitated by a specially trained, neutral party.

3.3 Volume and Nature of FTM Activity That Occurred in Practice

This section provides an overview of FTM activity during Ohio's third waiver period. Using primarily quantitative data collected about each meeting, it highlights the characteristics of FTM across the 16 demonstration counties. It also describes the nature and volume of the meetings held, including the number of FTMs and families in the study population, the living arrangements and custody status of their children at the onset of FTM, the number and types of meetings held, the number and types of attendees at the meetings, accommodations offered to families to make it easier for them to attend, and recommendations that result from the FTMs.

[53] Casey Family Programs, 2012

3.3.1 FTM Study Population

The FTM study population includes cases that transferred to ongoing services and for which an initial FTM was held between Feb. 16, 2011[54] and March 31, 2015. As previously noted, analyses were conducted on a subset of cases that met the following criteria: the case had an intake on or after Oct. 1, 2010 (when the third waiver began) and the case transferred to ongoing services on or between Jan. 1, 2011 and Feb. 1, 2015. All Volume & Nature and Fidelity analyses examine the initial case episode that met these specifications as well as the FTMs that fell within the selected case episode. Outcome analyses also focus on the initial case episode; when necessary, they also include information from subsequent case episodes (e.g., analyses focused on recurrence, etc.).

Table 3.8 provides information about the number of families, children, and FTMs included in the FTM study population. Per county, the number of families served ranged from 62 to 1,776; the number of children served ranged from 126 to 3,191; and the number of meetings held ranged from 175 to 6,697. County population size is the main contributor to the range in the number of families served, though capacity in terms of the number of facilitators doing ProtectOHIO FTMs also plays a role.

Table 3.8: Number of Families, Children, and Meetings Held

Total Number of Families	7,541
Total Number of Children	15,234
Total Number of FTMs	24,518

3.3.2 Common Living Arrangements and Custody Status of Children at Initial FTMs

To better describe who the FTM intervention is serving, Table 3.9 presents the common types of living arrangements and custody statuses of children at the time the initial FTM was held for their case. Over half of the children (57%) were living with their parents and in the custody of their parents. Twenty-six percent of children were living with kin, with parents most often holding custody of those children. Interestingly, compared to what was reported in the Interim Evaluation Report, which was completed as the Kinship Supports intervention was just being implemented, the proportion of children living with kin at their initial FTM has increased (from 22% to 26%), and the proportion of children living with parents and in the custody of parents has decreased (from 63% to 57%). In fact, when years 2013 and 2014 are examined on their own (after implementation of the kinship intervention), the proportion of children living with kin increases even more: to 30%. Overall, when examined together, we find that 83% of children were living with parents or kin at the time of their initial FTM. These numbers highlight demonstration counties' efforts to reduce placement utilization and favor working with families to prevent the need for removal, and to place with kin when removal becomes necessary.

[54] The data element changes in PODS were made on Feb. 16, 2011.

Table 3.9: Living Arrangements and Custody Status of Children at Initial FTMs		
		Number and Percent of Children (n=15,234)
Live with Parents, Custody of Parents		8,686 (57%)
Live in Substitute Care, Custody of PCSA/Court		2,225 (15%)
Live with Kin	Custody of Parents	1,897 (13%)
	Custody of Kin	1,059 (7%)
	Custody of PCSA/Court	927 (6%)
All Other*		440 (3%)

*Other custody arrangements include law enforcement removal and youth who have recently turned 18; other living arrangements include shelter care, hospital, and detention center, among others.

3.3.3 Distribution of FTMs per Case

Families ranged from receiving 1 to 20 FTMs over the course of the study period. The average number of FTMs per family is 3 with a standard deviation of 2.7, and the median is 2.[55] Depending on when during the study period a family began receiving FTM, the number of meetings a family received may vary. However, when examining closed cases only (n=6,082), the figures remain similar—the average number of FTMs per family is 3 with a standard deviation of 2.4, and the median is 2. Overall, the majority of families both received and were eligible for three or fewer FTMs.

Table 3.10 presents the distribution of FTMs held per family. These figures include all cases in the study group, meaning FTMs may still be ongoing for a family's case if the case had not closed by the end of the study period.

[55] The median is a measure of central tendency representing the middle value for an ordered set of values. It is less sensitive to outliers than the mean.

Table 3.10: Distribution of FTMs Held Per Family	
Total Number of FTMs	**Number of Families With Given Number of FTMs (n=7,541 families)**
1 FTM	2,130 (28%)
2 FTMs	1,679 (22%)
3 FTMs	1,232 (16%)
4 FTMs	803 (10%)
5 FTMs	542 (7%)
6 FTMs	345 (5%)
7 FTMs	239 (3%)
8 FTMs	173 (2%)
9 FTMs	131 (2%)
10 FTMs	99 (1%)
11+ FTMs	168 (2%)

3.3.4 The Purpose of FTMs

The ProtectOHIO model calls for FTMs to be held for a variety of reasons: the initial FTM should be held at the point the case transfers to ongoing services, for the purpose of initial planning; FTMs should be held at least quarterly throughout the life of a case; and additional FTMs should be considered at any critical points in the case, including at case closure.[56] Table 3.11 shows the primary purpose of the FTMs held. Not surprisingly, the majority were held for the purposes of 90-day meetings, followed by initial planning meetings.

[56] Other critical events that could trigger the need for a meeting include: emergency removals, a custody or placement change under consideration, a new CAN report on an existing case, preparation for court hearings, or other reasons such as a safety planning meeting or when the family requests to hold one.

Table 3.11: Purpose of FTMs Held	
Meeting Purpose	**Number of Meetings (n=24,518 FTMs)**
90-Day Meeting	15,776 (64%)
Initial Planning Meeting	6,445 (26%)
Crisis/Critical Event Meeting	1,525 (6%)
Case Closure Meeting	772 (3%)

In many cases there may be more than one meeting purpose, yet facilitators were asked to prioritize and select one primary purpose that best fits each meeting. It's important to note that there is some degree of variability in the way that facilitators classify meetings. For example: a family's initial FTM may be focused on a crisis or a critical event that has occurred, and the facilitator may not classify it as an "Initial Planning Meeting" even when case planning occurs. Similarly, an FTM may be held because the case is expected to close, but the FTM may also be focused on planning for a change in custody or living situation—which would be classified as a critical event and selected as the meeting's primary purpose by facilitators.

When only closed cases are examined (n=6,082 families), we find that 10% of families received an FTM within 10 days of their case closing, and 26% of families had their last FTM within 30 days of their case closing, meaning more families actually received FTMs near case closures than was reported via the meeting purpose that's recorded after each FTM. However, during site visit interviews, facilitators in some counties noted that the ability to hold case closure FTMs may depend on the caseworker involved in the case, as it is up to workers to notify facilitators when a case closure is imminent. Alternatively, facilitators who are able to schedule case closure FTMs noted that they are useful to ensure appropriate services are in place and that services won't be disrupted once the case closes.

The ProtectOHIO Practice Manual notes that holding critical event meetings is a core component of FTM practice; yet, as the table above indicates, only 6% of meetings held were identified as crisis or critical event meetings. Perhaps the need for critical event meetings may be prevented through holding regular FTMs; however, further exploration would be needed to support this theory. As noted in Section 3.2.1.5 through site visit interviews with facilitators and supervisors, the evaluation team learned that 10 counties have taken steps to hold critical event meetings, while the remaining counties either haven't been as proactive at implementing processes to ensure critical event meetings occur or use other types of meetings to address crises situations. Additionally, facilitators in five counties indicated that caseworker buy-in to critical event meetings remains low, and that caseworkers often work to address crisis situations on their own, outside of FTMs, and facilitators may not even know that a critical event has occurred until a subsequent 90-day FTM. Overall, the range of the proportion of critical event meetings held varies across counties. In seven counties, between 10% and 15% of FTMs were held for the purpose of addressing a crisis or critical event; in five counties, the range was between 5% and 10%; and in the remaining four counties, fewer than 5%.

3.3.5 FTM Attendees

An integral part of the FTM model is the concept of engaging the family, natural family supports, and community providers in case planning and decision making. FTMs may include a wide variety of participants—including anyone the family or the worker determines would be helpful in making decisions about the child's future. As the demonstration counties have stipulated in the FTM Practice Manual, they believe that enabling parents to invite extended family members and friends gives parents a sense that their view is respected. The goal is to have a good mix of participants and enough people in the room to engage in meaningful discussions.

Overall, the average (and the median) number of meeting attendees—not including the facilitator—is four. Counties ranged from having a median of three to seven attendees at FTMs. Table 3.12 demonstrates the total number of meetings that included at least one representative of the following categories: parents, kinship caregivers, relatives, parent supports,[57] child supports,[58] reviewed children, service providers,[59] and PCSA staff.

Table 3.12: Types of Attendees at FTMs

Attendee Type	Number of FTMs With at Least One Participant of This Type Present (n=24,518)
PCSA Staff	24,456 (100%)
Parent	15,856 (65%)
Service Provider	6,074 (25%)
Child Support	4,776 (20%)
Reviewed Child	4,536 (19%)
Kinship Caregiver	1,759 (19%)
Relative	3,616 (15%)
Parent Support	1,999 (8%)

PCSA staff were the most common participants, in attendance at nearly all meetings, while parents were in attendance at approximately two-thirds of meetings (65%). Participants identified as "Parent Supports" were in attendance at only 8% of meetings; however, kinship caregivers and relatives were in attendance at 19% and 15% of meetings, respectively. It's worth noting that meeting participants may fall into several categories; a relative may participate in a meeting to support the child or a parent, or both. It is up to the facilitator to determine which category a meeting participant best fits.

Although counties have taken an increasingly active approach to encouraging parental attendance over the course of the waiver period, the rate of parental attendance at meetings has remained relatively

[57] The FTM manual defines "Parent supports" as: advocates/mentors/friends/neighbors. Additionally, facilitators may categories as a parent support if they determine the attendee is there for the purpose of supporting a parent and does not fit into a different, more appropriate category. For the purposes of this report, the evaluation team also includes clergy, attorneys, and tribal representatives in the parent support category.

[58] Child supports include: GALs, CASAs, mentors, friends, coaches, and anyone else a facilitator determines is there for the purpose of supporting a child and does not fit into a different, more appropriate category.

[59] Service providers include staff from mental health agencies, health providers, group home providers, AOD providers, etc.

stable since 2011 (68% in 2011 and 67% in 2014). As previously noted, the majority of counties attempt to reschedule FTMs if a parent cannot attend; however, some counties hold FTMs without parents if service providers or other meeting participants have shown up for a scheduled FTM. Overall, although parents' participation in FTMs is a core component of the model, securing their attendance has been consistently cited as one of the main barriers to FTMs across the years. However, challenges related to engaging parents is not unique to FTM; it's a challenge faced nationally by child welfare service providers.

3.3.6 Meeting Location and Accommodations to Encourage Parent Attendance

The FTM Practice Manual emphasizes that the PCSA should do anything reasonably possible to assure that parents come to meetings. Strategies to encourage parent attendance vary across counties. This section summarizes the meeting-level data available on three components that facilitators and PCSA staff identified as factoring in to parent attendance: where meetings were held, whether transportation was provided, and whether childcare was provided.[60]

Meeting Location: Near the end of the second waiver, facilitators identified the meeting location as a key factor affecting family attendance at meetings; however, the vast majority of meetings (92%) were held at agency settings. Only 6% of meetings were held at parents' or caregivers' homes, and 1% were held off-site at a neutral location. Yet as with other components of the intervention, meeting locations vary across counties. Three counties held a higher proportion of FTMs in parents' homes (38%, 14%, and 10%, respectively) and a lower proportion in the agency (53%, 83%, and 88%, respectively). Facilitators also identified barriers to holding meetings outside of the agency, including the time needed for multiple PCSA staff to travel to the meeting and the risks involved in holding meetings in less secure settings.

Transportation Assistance: Another strategy to promote parental attendance at FTMs is to assist parents and/or support people with transportation by providing rides, bus or taxi fare, or gas vouchers. The majority of counties state that they offer families help with transportation to meetings. However, families only appear to have used transportation assistance for 5% of all meetings. Again, the proportion of meetings held for which transportation was provided varied across counties, ranging from 0% to 15% of total FTMs held. In some cases, a facilitator may have been unaware that transportation assistance was provided and thus recorded it inaccurately.

Childcare Assistance: Providing childcare while holding FTMs is another strategy to encourage parental attendance at meetings, yet childcare was provided for only a very small proportion of overall meetings (2%). Ten counties provided childcare for 1% or fewer of their meetings, while the remaining six counties provided slightly more childcare—for 2% to 6% of their total meetings held.

Although we cannot definitively say whether these strategies increase the rate of parent attendance, there may be a positive association between consistently providing transportation and higher parental attendance rates. Across all counties, parents or primary caregivers attended 65% of total meetings held. However, when we examine parental attendance within the county that provided the most transportation overall, parental attendance increases to 74%. This positive association was not evident

[60] Facilitators identified these strategies to encourage parental attendance at the September 2009 facilitator retreat.

when examining the counties that provided childcare the most frequently and held the most meetings outside of the agency, indicating that increasing transportation assistance could lead to increased parental attendance.

3.3.7 Facilitator Type

A core component of the ProtectOHIO FTM model is that meetings are led by an independent facilitator, meaning the facilitator does not have direct line responsibility for the case. All 16 demonstration counties have one or more independent facilitators. While larger counties may have multiple full-time facilitators, many smaller counties have only one. In all counties, backup facilitators are used if a primary facilitator needs to miss a meeting. Backup facilitators may include caseworkers or supervisors, though it is unknown at the meeting level whether backup facilitators have direct line responsibility for the case. Nearly all FTMs are facilitated by facilitators (97%); the remaining meetings were led by supervisors or other people, indicating that backups are rarely used.

3.3.8 Meeting Outcomes

Each meeting may result in several immediate outcomes or decisions. Unlike for the meeting purpose, facilitators record each outcome that occurred as a result of the FTM, so the categories below are not mutually exclusive. Common meeting outcomes included:

- Identifying new or needed change in a service for a parent or child (28% of meetings).
- Identifying support people (20% of meetings).
- Developing or signing off on a case plan (20% of meetings).
- A recommended change in custody (17% of meetings).
- Preparation for a court hearing (8% of meetings).
- A recommended change in visitation time or supervision level (7% of meetings).
- A recommended change in living arrangement (6% of meetings).

The most common meeting outcome was an identification of a new or needed change in a service for a parent or child. During the 2014 site visits, 10 out of 15 counties cited drug and alcohol–related services as common services identified for parents. This underscores contextual information gathered from agency managers and directors who indicated that drug abuse, primarily opiate addiction, remains a pressing and growing problem in Ohio's counties. Additionally, 11 out of 15 demonstration counties indicated mental health services/counseling as a common service for parents. Other services commonly identified for parents include: financial, housing, transportation, employment (in 6 counties), and parenting, respite, and childcare (in 5 counties). When asked what services were commonly identified for children during FTMs, responses were even more varied. Similar to parental services, mental health services including trauma assessments emerged as the most common service for children (in 11 counties). Other services frequently mentioned by facilitators and supervisors across counties include: medical or developmental services (5 counties) and education-related services (2 counties).

Interestingly, although several meeting outcomes may be recorded for a single meeting, 46% of meetings did not result in any outcome other than an update on the family situation. However, it may be that more particular outcomes were not identified if cases were already working toward a resolution and recommendations were not needed.

3.3.9 Summary of the Volume and Nature of FTMs Held

The 16 demonstration counties provided over 24,000 FTMs to more than 7,000 families and 15,000 children. The majority of children were living with their parents or kin caregivers at the time of their initial FTM, indicating that demonstration counties are committed to finding alternatives to foster care and working with families when children can remain safely in their homes. Additionally, since the implementation of the kinship intervention in 2012, the proportion of children living with kin at their initial FTMs has increased, demonstrating commitment to this newer intervention that all counties agreed to implement as a part of Ohio's third waiver demonstration.

Overall, the majority of families received and were eligible for three or fewer FTMs. Parents or primary caregivers, considered the most important meeting participants, were in attendance for 65% of meetings held. The large majority of FTMs held were facilitated by trained, neutral facilitators and conducted for the purpose of 90-day case reviews. Although FTMs often resulted in multiple meeting outcomes, the most common outcomes recorded were identification of services for parents or children, identification of family supports, and development of case plan goals.

3.4 Fidelity to the ProtectOHIO FTM Model

This section of the report explores the extent to which the demonstration counties have adhered to the ProtectOHIO FTM intervention model, also known as fidelity. It addresses the research question, "What level of fidelity to the ProtectOHIO model is achieved in demonstration counties?" Using case-level quantitative data, it examines variations among the demonstration counties in the degree to which they implement key components of the FTM model, as defined in the ProtectOHIO FTM Practice Manual. It also explores the level of fidelity each case received.

3.4.1 Extent to Which the FTM Intervention Reached Eligible Families

As stated in the ProtectOHIO FTM Practice Manual, all cases that transfer to ongoing services are eligible for FTM; however, a small subset of counties sample for FTM due to capacity issues. Overall, during the FTM study time period, 10,135 cases[61] transferred to ongoing services and were eligible for FTM; 89% received FTM, with individual counties serving between 63% and 100% of eligible cases.[62] In eight counties the penetration rate was 90% or higher, while the other eight counties served between 63% and 87% of eligible cases.

[61] The penetration analysis includes all cases with intakes on or after Oct. 1, 2010 that transferred to ongoing services, regardless of initial FTM date. All other FTM analyses include only those cases with initial FTMs from Feb. 16, 2011 through Mar. 31, 2015.

[62] To determine the penetration rate in counties that sample FTM cases, the evaluation team calculated the total number of cases receiving FTM out of the total number expected to receive FTM based on each county's sampling rate.

While there is no definitive answer as to why families may not have received FTM, facilitators have noted that, in some cases, criminal charges may slow the FTM process while in other instances families may simply refuse to participate in the FTM process. Another aspect that may impact the likelihood of families receiving FTM is the Alternative Response (AR) initiative that has rolled out across Ohio during this waiver period. While most counties that sample for FTM don't hold FTMs for AR cases (again, due to capacity issues), 10 out of 11 non-sampling counties indicated they *do* provide FTM for AR cases. However, when the penetration rate is examined in only these 10 counties, almost half of the non-served families were screened in and transferred to ongoing services as AR cases (40%). This indicates that though the intention may be for AR cases to receive FTM, some counties may have yet to solidify their processes to ensure this takes place. Or it could be that some counties, or some staff within counties, either don't believe AR cases should be receiving FTM, or there is confusion regarding the actual policy. In fact, in 2012 site visit interviews it became evident that there *was* confusion both within and across counties as to whether AR cases were eligible for FTM; however, by the 2014 interviews staff were able to definitively answer whether they thought AR cases were eligible for FTM or not. Surprisingly, the proportion of AR cases, among those not served, has increased each year of the waiver. This is most likely due to the increased number of ProtectOHIO counties implementing AR and not to changes in practice or policy. Further county-level analyses and discussions with facilitators may shed light on FTM practice for AR cases. This aside, the demonstration counties served nearly 90% of eligible cases, clearly indicating the intervention has considerable reach.

3.4.2 Measures of ProtectOHIO FTM Fidelity

The evaluation team explored three specific components of the ProtectOHIO FTM model:

1. Initial FTM within 35 days of case opening.
2. Subsequent FTMs held at least quarterly.
3. Range of FTM participants: at minimum, one parent or primary caregiver, one PCSA staff, and one other type of person.

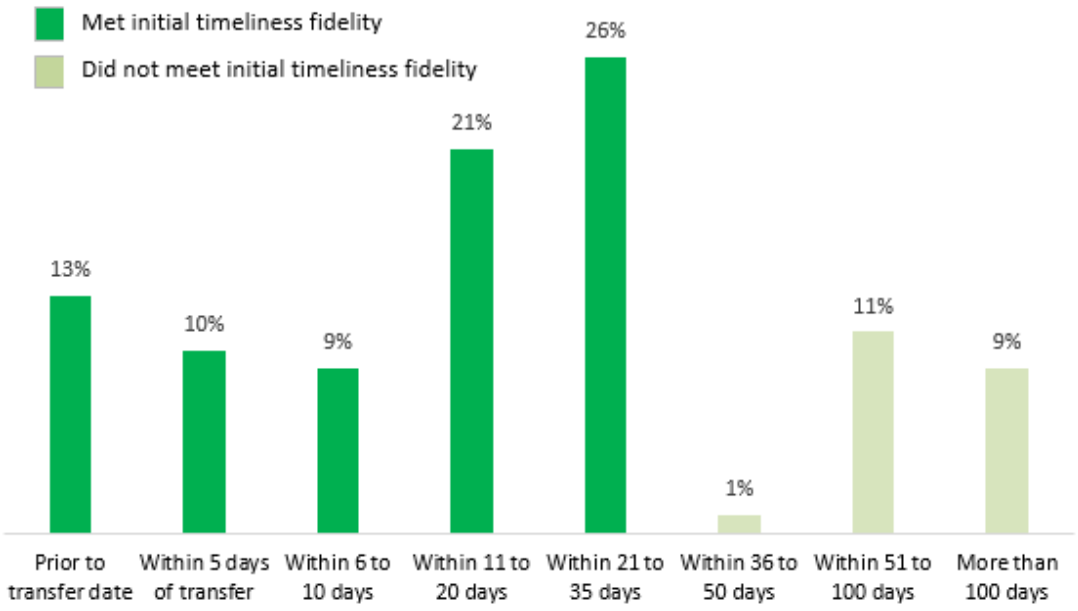
3.4.2.1 Timeliness of Initial FTMs

When families are engaged soon after a case opens, they can provide input into the development of goals that will guide both the family and agency. Demonstration counties believe that the initial FTM should be held as soon as possible, in order to engage families early and create a clear case plan that links them to timely services and other natural supports, ultimately leading to more positive child outcomes (see logic model, Table 3.1). The evaluation team examined the number of FTMs that were held prior to or within 35 days of the transfer of the case from assessment/investigation status to ongoing status.[63]

[63] Strictly speaking, the model calls for initial FTMs to be held within 30 days of the decision to transfer the case to ongoing services (i.e., family assessment approval date). For simplicity, and to allow some flexibility for holidays, sick days, etc., the evaluation team chose to use 35 days as the measure.

Overall, the large majority of families (79%) received their initial FTM within 35 days of the case transfer date—a rate that appeared to remain relatively stable over the course of the waiver period. The average number of days from the case transfer date to the initial FTM is 35 (with a standard deviation of 76 days), and the median number of days is 19. Figure 3.1 displays the variation within the days from transfer to initial FTM. Interestingly, very few cases (1%) held their initial meeting shortly after the formal fidelity marker (35 days after a case transfers to ongoing services). Instead, of the cases that did not meet initial meeting timeliness fidelity, the majority held their FTMs more than 50 days after the case transfer.

Figure 3.1: Time Periods for Initial FTMs (n=7,541 families)



In general, counties were successful in holding initial meetings on time. Five counties held 90% or more of their meetings on time, six counties held 80% to 89% of their meetings on time, and only one county held fewer than half of their initial meetings on time. Overall, counties ranged from holding 44% to 99% of initial meetings on time.

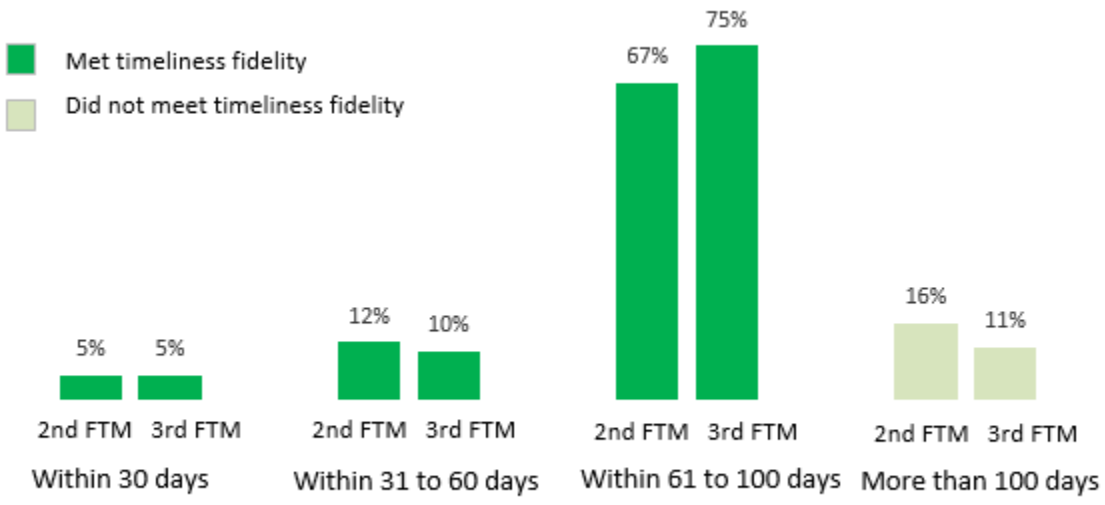
3.4.2.2 Timeliness of Subsequent FTMs

The ProtectOHIO FTM model contends that holding regular meetings throughout the life of the case helps to address issues proactively and to hold all parties accountable to the action steps agreed upon, thus moving the case to a timely resolution. Meetings may be called when a critical event occurs—for example, a court hearing or a new CAN (Child Abuse/Neglect) report on an existing case. If a meeting is not held for some other reason, the ProtectOHIO model calls for meetings to be held at least quarterly (at least every 90 days) throughout the life of the case, or for as long as the case plan goal is

reunification or maintain-in-home. Strictly speaking, quarterly would be 90 days; when translated to months, three months could be as many as 93 days. For simplicity and to account for holidays—and to employ the same measures used in both the Second Waiver Final Evaluation Report (2010) and Ohio's third waiver Interim Evaluation Report (2013)—the evaluation team determined that meetings would be considered on time if they were held within 100 days of the previous FTM.

Overall, the majority of subsequent meetings were held on time. As shown in Figure 3.2, which displays the variation in the number of days to subsequent FTMs, 84% of second FTMs and 90% of third FTMs occurred on time. The majority of subsequent meetings were held near the mandatory quarterly meeting target (within 61 to 100 days of the previous FTM). On average, the number of days between the first and second FTM is 89, and the average number of days between the second and third FTM is 86.[64] Considering that many counties merge FTMs with state required 90-day case reviews, this finding makes sense. In fact, more than half of subsequent meetings (58%) were held for the purpose of a merged 90-day FTM/case review, and another 28% were held for the purpose of non-merged 90-day FTMs. The remaining subsequent FTMs were held for the purpose of addressing a crisis or critical event (13%) and for continued case planning (1%).

Figure 3.2: Time Periods for Subsequent FTMs (n=5,411 families who received a second FTM + 3,732 families who received a third FTM)



We also measured the proportion of meetings that occurred on time out of the total number of meetings that were *expected* to occur. This ensures that timeliness fidelity figures are not inflated, due to meetings not occurring when they were in fact due (i.e., without taking this into account, *not* holding a meeting instead of holding one late would improve the overall fidelity score). When you take into account meetings that should have occurred, we still find that meetings were generally held, and were

[64] The median number of days between the first and second FTM, and also between the second and third FTM is 84.

generally held on time. Cases were determined to be eligible for a subsequent FTM if 90 days had passed since the previous FTM, and the case was still open.[65] Taken together, 75% of subsequent FTMs were not only held, but were held on time (7,686 out of 10,249 instances where a subsequent FTM was expected). Nine counties held 80% or more of their expected subsequent meetings on time; three counties held between 60% and 79% of their expected subsequent meetings on time; and the remaining counties held less than 60% of their expected subsequent meetings on time.

3.4.2.3 Mix of Meeting Attendees

Having a wide range of meeting attendees around the table makes the FTM valuable because it allows various perspectives to be considered in case planning and decision making and it allows attendees to work together to support the family in accomplishing its goals. Facilitators and caseworkers frequently comment that having key parties together in one room allows for better communication and avoids triangulation, as everyone hears what is said by the others present. The ProtectOHIO model requires at least one parent or primary caregiver, at least one caseworker or other PCSA staff, and at least one other type of person[66] (not including the facilitator) to attend the meeting.

Overall, just over half of initial meetings met attendee fidelity (53%), while just under half of subsequent meetings met attendee fidelity (46% of second FTMs; 48% of third FTMs).[67] Because caseworkers or other PCSA staff were present for nearly 100% of meetings held, FTMs that did not meet attendee fidelity usually were missing a parent or the "other" third attendee type—or in some cases, both. Figure 3.3 illustrates the proportion of initial, second, and third FTMs that:

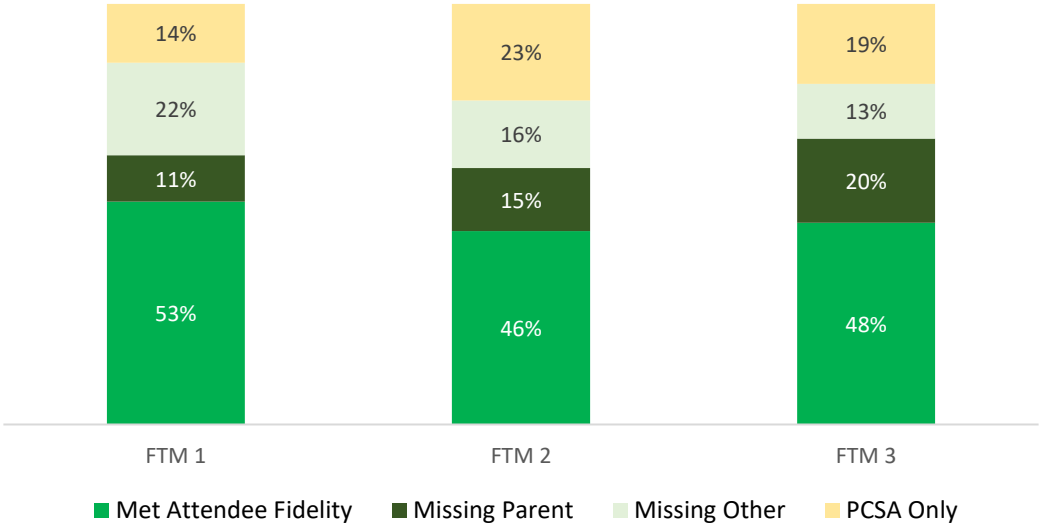
- Met attendee fidelity,
- Included a parent or primary caregiver and PCSA staff, but were **missing the "other"** attendee type,
- Included PCSA staff and an "other" attendee, but were **missing a parent or primary caregiver**; and
- Included agency staff only.

[65] When the total case lengths of all cases that received FTM were examined, we found that over 70% of cases were eligible for three or fewer FTMs. Given that the majority of cases were both eligible for and held three or fewer FTMs during their case episode, and to use the same measure used in the Interim Evaluation report, the evaluation team chose to measure fidelity to the timeliness of subsequent FTMs using the second and third meeting for each case (including the second or third meeting a case should have had).

[66] Other types could include, but were not limited to, relatives, CASAs, service providers, parent supports, etc.

[67] To remain consistent with the fidelity measurements on the timeliness of meetings, the evaluation team measured FTM participant fidelity on the first three meetings of each case.

Figure 3.3: Proportion of FTMs That Met Attendee Fidelity and FTMs That Were Missing Attendee Types (n=16,684 FTMs)



Overall, counties appear to be slightly more successful at achieving attendee fidelity at initial meetings than at subsequent meetings. Interestingly, this pattern did not emerge across every county, though the majority of counties saw a larger proportion of initial meetings reach attendee fidelity than subsequent meetings (12 counties). Across all counties, there appeared to be a moderate jump in the number of FTMs meeting attendee fidelity in 2014. Fifty-two percent of FTMs met attendee fidelity in years 2011, 2012, and 2013 (each); in 2014, this figure jumped to 56%. This corresponds with the implementation of the high fidelity subcommittee, and a general increased enthusiasm for improving fidelity to the FTM model, which arose after findings from the Interim Evaluation Report were shared directly with facilitators, and which noted that high-fidelity FTMs may be associated with positive outcomes.

It's noteworthy that a substantial portion of meetings held actually included PCSA staff only (18% when all meetings are examined). Similar findings were first noted in the Interim Evaluation Report and was discussed by facilitators at subsequent quarterly workgroup meetings and during site visit interviews. While some facilitators felt that without parents present, "It's not really a family team meeting," others felt that holding meetings even when only PCSA staff are present is useful, as it holds caseworkers accountable and can move stagnant cases forward. Additionally, caseworkers, supervisors, and other PCSA staff including kinship staff are all included in the PCSA attendee type; thus, various perspectives may be heard in these meetings—potentially even parents' perspectives, as some counties attempt to attain parent's perspectives through written notes or prior conversations when they are unable to attend a meeting.

During Consortium and workgroup meetings, both supervisors and facilitators have noted that parents appear to show up more often for initial FTMs, and that securing parental attendance for subsequent FTMs is more difficult. Indeed, parents attended approximately 15% more initial meetings than subsequent meetings. Conversely, the "other" type of attendee participated in more third FTMs than first or second FTMs. Perhaps early on in the case, parents are not yet linked to service providers, who

go on to participate in meetings later, when they are involved in the case. Yet, relatives and other family support people are also included in this "other" attendee type, and this theory would not apply for these individuals. When the "other" type of attendee is broken down into two separate categories— service providers and family supports— family supports were found to attend a far greater proportion of meetings than service providers. Figure 3.4 illustrates the proportion of initial, second, and third FTMs that included a parent and "other" attendee type, while Figure 3.5 breaks down the "other" attendee type, by illustrating the proportion of FTMs that included a service provider and family support.[68] Because some meetings may include *both* family supports and service providers, the combined family support and service provider percentages in Figure 3.5 do not total the percentages seen in Figure 3.4.

Figure 3.4: Proportion of FTMs with Parents and 'Other' Attendees Present (n=16,684 FTMs)

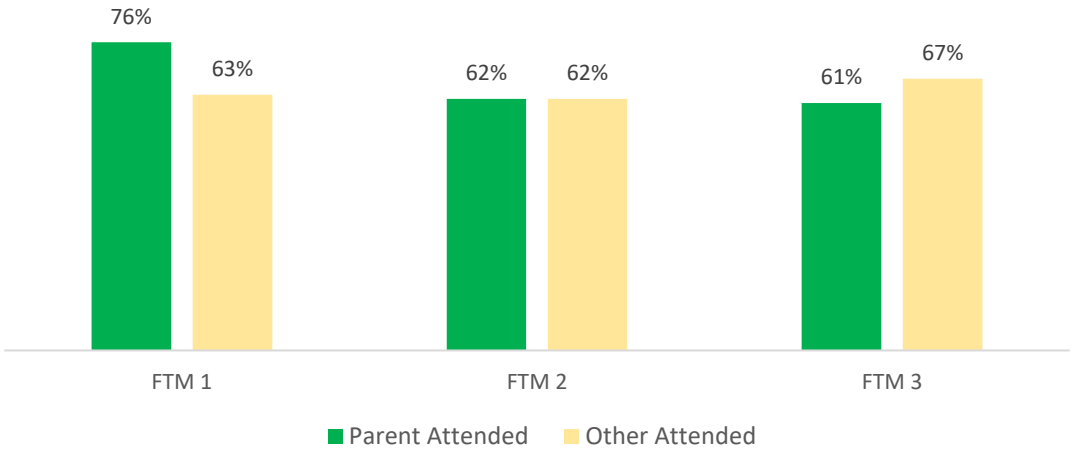
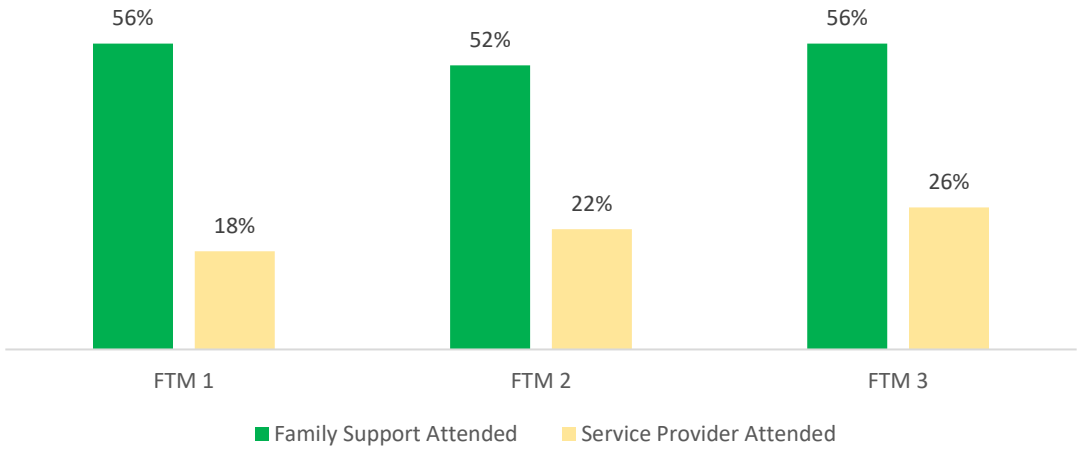


Figure 3.5: Proportion of FTMs with Family Supports and Service Providers Present (n=16,684 FTMs)



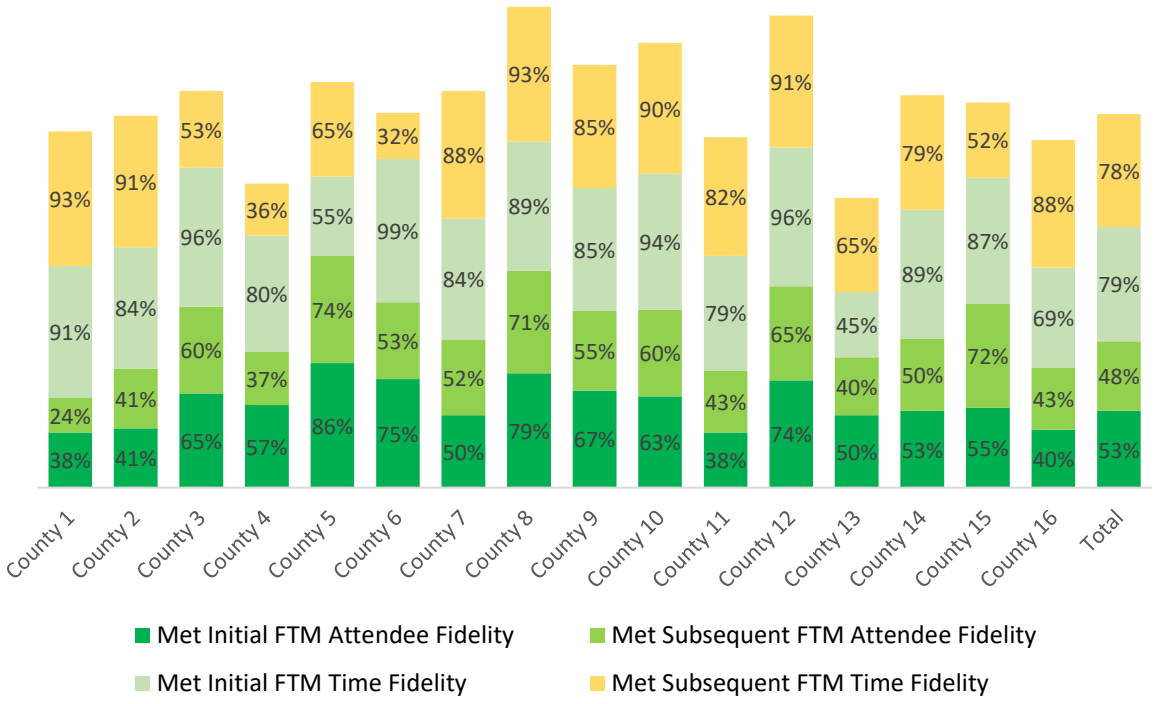
[68] For the purpose of this analysis, family support is categorized as parent support/child support/kinship caregiver.

As seen in the preceding figures, parents attend more initial meetings than subsequent meetings, while the proportion of "other" category types actually increases at the third meeting. When the "other" category type is broken down into family supports and service providers, we see that across all meetings, family supports are present more often than service providers. While family support participation remains relatively stable over the course of the first three meetings, service provider participation increases at the second meeting, and again at the third, supporting the theory that as parents are linked to needed services and supports, those providers begin participating in FTMs.

3.4.3 Overall County-Level Fidelity to the FTM Model

Overall, fidelity is quite variable across demonstration counties. Figure 3.6 synthesizes the information presented above and depicts the differences among counties in their overall fidelity to the model. Each county-specific bar illustrates the proportion of meetings held by that county that met the timeliness and attendee fidelity model components. Because differences were found between initial and subsequent meetings, these fidelity components are presented separately for each county.

Figure 3.6: Fidelity Components by County

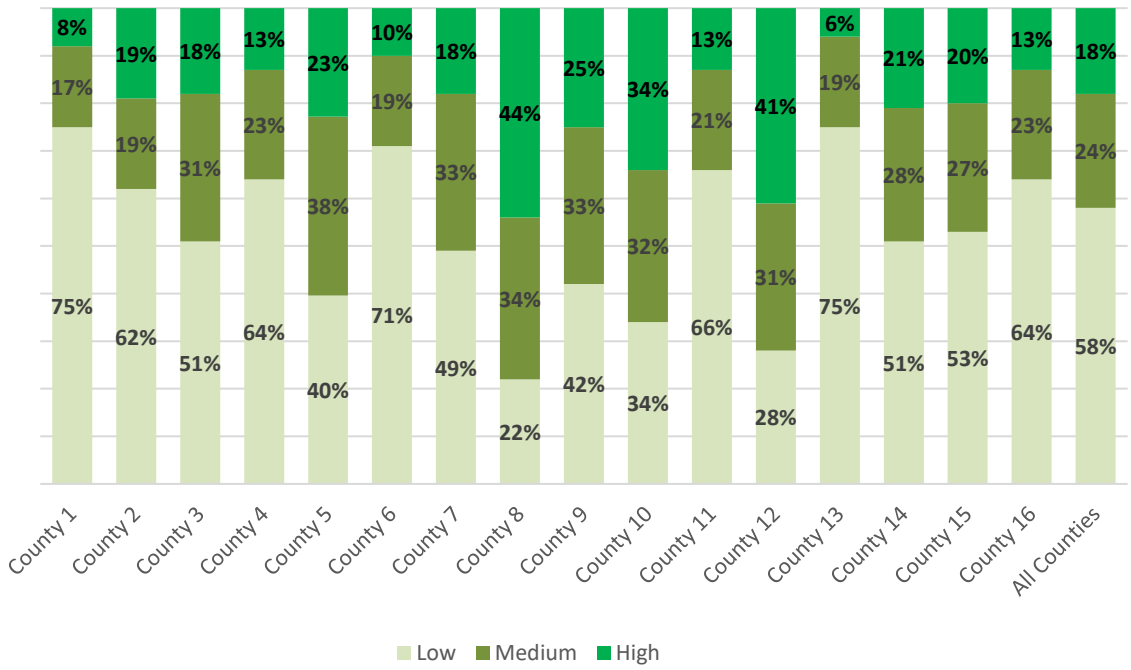


3.4.4 Case-Level Fidelity

To understand the impact of FTM on outcomes for children and families, one must measure the extent to which each case received the intervention as intended. The examination of fidelity at the case-level gives a fuller understanding of how families experienced FTM from case opening to case closure. For this analysis, cases (families) were grouped into three different fidelity levels, based on the degree to which

they received the intervention as intended by the model (see Appendix E for a description of how these calculations were made). Figure 3.7 illustrates the proportion of families who received high, medium, and low fidelity FTM across the demonstration counties.

Figure 3.7: Proportion of Families Receiving High, Medium, and Low Fidelity FTM (n=7,541 families)



As the bar furthest to the right indicates, 18% of families received high-fidelity FTM, 24% of families received medium-fidelity FTM, and 58% of families received low-fidelity FTM. It's worth noting that the threshold for high fidelity was very high: cases had to have had the majority of their meetings both on time *and* include the minimum grouping of attendees; if either the attendee fidelity or the timeliness fidelity component was categorized as "low," the case was automatically classified as a low-fidelity case. Considering that approximately half of the FTM population held only two FTMs, a large portion of cases risked falling into the low-fidelity category. However, strict fidelity measurements are necessary when linking fidelity to outcomes in order to truly understand whether fidelity to the model makes a difference in the success of families receiving FTM.

As with other findings, case-level fidelity varied across counties. High-fidelity cases ranged from 6% to 44% of total cases, medium-fidelity cases ranged from 17% to 38%, and low-fidelity cases ranged for 22% to 75%. In general, families were more likely to have received their meetings on time than they were to have included the minimum grouping of attendees. However, high fidelity cases increased by 4% in 2014 and low fidelity cases decreased by 9%, perhaps reflecting the previously noted concerted effort on the part of demonstration counties to increase fidelity levels, targeting parental and support peoples' attendance in particular. Overall, case-level fidelity scores have remained fairly consistent over the course of the third waiver period.

3.4.5 Summary of Fidelity to the FTM Model

The ProtectOHIO demonstration counties served nearly 90% of cases eligible for FTM, with individual counties serving between 63% and 100% of their targeted families. Surprisingly, among counties that specified that they provide FTMs for AR cases, 40% of cases that were not served were AR, indicating there may be some confusion or varying viewpoints across counties on the practice of FTM in relation to the AR initiative. This aside, the FTM intervention reached the majority of families targeted for FTM.

The majority of families received both their initial meeting and their subsequent meetings on time, though initial meetings were slightly more likely to be held on time. Approximately 80% of initial meetings were held within 35 days of the case transfer date, and approximately 75% of subsequent meetings were held within 100 days of the previous FTM.

Ensuring that a wide range of attendees participate in meetings proved to be more of a challenge for counties. As PCSA staff have noted, initial meetings were more likely to include the minimum grouping of attendees (53% versus 46% and 48% for second and third FTMS, respectively). Nearly all FTMs included PCSA staff; meetings that didn't meet attendee fidelity were usually because *either* a parent or a member from the third, "other," attendee type was not present. However, 18% of meetings included PCSA staff only.

When case-level fidelity was examined, 18% of families were found to have received high-fidelity FTM, 24% of families received medium-fidelity FTM, and 58% of families received low-fidelity FTM. However, it's important to note that the threshold for high-fidelity FTM was very high. Generally speaking, fidelity was quite variable among the counties; yet, there was a slight but noticeable increase in 2014 for both the number of meetings that met attendee fidelity and the number of families that reached the threshold for high fidelity, coinciding with the implementation of the high fidelity subcommittee and the development of more targeted approaches to increase fidelity levels across counties.

In the remainder of this chapter child and case-level outcomes are examined for all children and families that received FTM, and then separately for a subset of children and families that received high-fidelity FTM, to assess the impact of the ProtectOHIO FTM intervention on the success of children and families navigating through child welfare systems across the demonstration counties in Ohio.

3.5 Child and Case-Level Outcomes

A primary goal of the ProtectOHIO evaluation is to understand the impact of the ProtectOHIO FTM model on children and families, within the context of the flexible funding made available by the waiver. Two comparisons are made:

1. Children and families in the demonstration counties who received ProtectOHIO FTM (and had the benefit of the waiver) are compared to similar children and families in the comparison counties (who did not have the waiver).
2. To further isolate the impacts of the FTM intervention, children and families in the demonstration counties who received FTM with high fidelity, as defined in previous sections, are compared to similar children and families in the comparison counties.

The outcomes analysis presented here uses propensity scores to make the groups under study more comparable—that is, to statistically adjust for differences between participants in the demonstration and comparison counties based on a series of background covariates. In this way, the evaluation team could more confidently ascribe outcomes to the effects of FTM rather than to the underlying differences (backgrounds or circumstances) between families in the respective groups.

3.5.1 Data Sources

Two sources of data are used for the FTM outcomes analysis: SACWIS and PODS. The final SACWIS dataset extracted for this analysis contained data beginning with a family assessment transfer date of 1st Jan. 2011 through May 2015 and included demographics, intake, case, family assessment, placement and FTM data. The PODS dataset contained data regarding FTMs that occurred prior to the recent FTM build in SACWIS. PODS information included the dates of families' FTMs, information regarding who participated in the meeting, the county in which the FTM took place, and IDs upon which a match with SACWIS could be established.[69] The two data sources were merged in order to identify families in demonstration counties who had experienced a case episode during which at least one FTM had occurred, together with the appropriate family assessment for the relevant episode.

3.5.1.1 Analytic Methods

Randomized control trials are often considered the gold standard when trying to understand the effects of an intervention on a population. This is because, on average, randomization can serve to eliminate any differences that are observed in the background characteristics, or circumstances, of the groups of participants who receive the intervention and those who do not. Nonetheless, randomization is not always possible due to ethical or practical reasons. Such was the case for this evaluation.[70]

To adjust for differences between groups, the evaluation team chose to use propensity scores. By using propensity scores as a mechanism to statistically balance differences between participants in the intervention and comparison groups, more confidence can be had in the assumption that any differences shown in the outcomes are attributable to the intervention.

In statistical terms, "propensity may be defined as an individual's probability of being treated with the intervention of interest given the complete set of all information about that individual"[71]. The use of propensity scores has the potential to reduce bias in those characteristics that have been chosen to create the propensity score; however, the degree to which outcome differences can be attributed to the intervention is only as strong as the characteristics chosen to establish balance between groups. The selection of characteristics to produce that score is therefore a critical part of the process. The evaluation team sought to identify as many background characteristics as possible upon which to compute the propensity scores; these included demographic characteristics such as race and age, previous contact with Children Services, and previous placement in out-of-home care. The family

[69] As previously mentioned, during this waiver period a module was developed in SACWIS to collect this case-level FTM information. Case-level FTM data from the first half of the waiver period was extracted from PODS, while these same data elements from the second half of the waiver period were extracted from SACWIS.

[70] Further explanation is provided in: Human Services Research Institute, 2011

[71] Nicholas & Gulliford, 2008

assessment was also considered important to use because these assessments contain significant case- and child-level information that is key in the process taken by caseworkers and supervisors to decide whether the case will be transferred to ongoing services.[72]

Except where noted weighted propensity scores via Inverse Probability of Treatment Weights[73]were used as covariates. Weights greater than 10 were trimmed to reduce the influence of outliers. Where samples were weighted, both the weighted and unweighted estimates are provided.

Families and children for these analyses were clustered (nested) within 16 demonstration and 16 comparison counties. Usual statistics assume independence of observations. When nestedness occurs this assumption is violated and Type I errors can occur due to inflated variances—in other words, we may believe there is a statistical difference between groups when in fact there is none. To adjust for this possibility, the evaluation team chose to use the Complex Samples Module within SPSS. This module uses the Taylor series linearization approach to estimate variances from complex samples and so reduce the likelihood of inflated variances and thus increase confidence in the findings from the analyses conducted.

3.5.1.2 Study Population

The FTM outcomes analysis presents the findings for families in the demonstration counties who had a report of abuse or neglect, whose case was transferred to ongoing services on or after Jan. 1, 2011, and for whom at least one FTM was conducted during the case. For families experiencing more than one case episode during the designated time period, the team analyzed the first case episode that transferred to ongoing services during that period.

Table 3.14 displays the characteristics of the families and children from which each subset of data was drawn. Out of the original FTM sample of 7,541 cases, 7,522 matched SACWIS data for the initial analysis.

[72] Appendix F provides more information regarding this process and the variables used.

[73] Harder, Stuart, & Anthony, 2010

Table 3.13: FTM Case and Child Characteristics[74]		
	Percent or Age	
Case Characteristics		
	Demonstration N=7,522	**Comparison N=11,122**
Female Primary Caregivers	93.9%	90.0%
Primary Caregiver: Average Age	31.55	31.99
Minimum Age	13	13
Maximum Age	83	85
Case Type		
Abuse or Neglect[75]	78.6%	74.3%
Family in Need of Services	9.6%	16.2%
Dependency	11.8%	9.5%
Child Characteristics		
	Demonstration N=15,193	**Comparison N=22,669**
Female Children	48.1%	48.8%
Age of Child:		
Age 2 or Younger	45.1%	28.7%
Age 3 to 5	17.0%	18.2%
Age 6 to 12	23.2%	32.8%
Age 13 or Older	14.6%	20.3%
Race[76]:		
Black	21.4%	23.7%
White	61.7%	61.1%
Other	9.5%	8.0%
Missing	7.4%	6.6%
Hispanic Ethnicity	5.6%	3.3%

3.5.1.3 Length of Time Case Is in Ongoing Services

For families, often of immediate concern is the length of time they may be expected to be involved with the child welfare system. The length of time a case remains open is equally of concern to the child welfare agency, both in terms of resource utilization and, more important, in terms of the disruption and uncertainty that agency involvement brings to family life. As illustrated in the FTM logic model (Table 3.1), the demonstration counties believe that FTMs will decrease the length of time the case is open because FTMs will ensure better case decision-making, make greater use of natural supports, motivate families, identify more appropriate services, and hold everyone accountable for getting those

[74] Data were limited to those cases with at least an 18-month follow-up period.

[75] Of the Abuse and Neglect reports, 13.4% had a case disposition of Alternative Response.

[76] "Other" includes American Indian, Asian, and Pacific Islander.

services into place. For these analyses, case length was conceptualized as the time from when the case officially transferred to ongoing services to the time the case officially closed.[77]

Analyses were conducted to examine how case length differs between those families in demonstration counties receiving FTM and matched cases from comparison counties. Specifically, the evaluation team chose to use Cox Regression to compare differences in the time to case closure between intervention and comparison cases. This technique allows for the estimation of time to an event while taking into account those cases that are 'censored'—in other words, while taking into account those cases for which case closure had yet to occur.[78] Additional covariate adjustments were made for county size and the timing of each county's implementation of Differential Response because these were also expected to have an impact on the length of the case.[79] Cases were followed for a 24-month period after the family assessment approval date.

Figure 3.8: Length of Case Survival Curves for All Matched Cases and High-Fidelity Matches

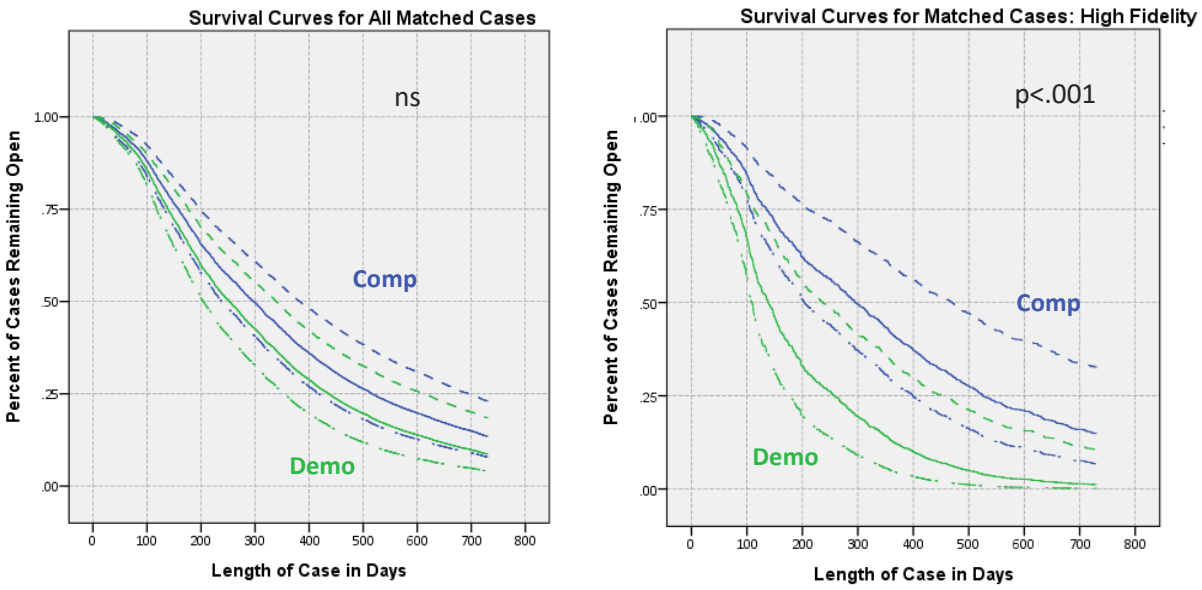


Figure 3.8 presents the results of survival curves for all case-level matches as well as for those cases reaching the threshold for high fidelity. The area under the survival curve represents the proportion of cases that remain open at a particular time point following transfer to ongoing services. The lower, green solid line represents demonstration FTM cases, while the blue line represents matched comparison county cases. The dashed lines represent the confidence intervals around the estimate (green for demonstration counties and blue for comparison counties).

[77] Case length is defined as beginning with the date of the family assessment approval, and ending with the case end effective date.

[78] This allows the statistical model to include cases that are still open at the time the data was pulled from SACWIS and estimate a realistic time to case closure for them.

[79] Full details of the analyses are shown in Appendix F.

No significant differences were found between FTM cases when compared with comparison cases for the larger dataset containing 4,576 FTM cases directly matched with the 4,576 comparison cases; however, significant differences were found between demonstration and comparison counties for the subset of 1,430 high-fidelity matched cases. As shown in the figure, the median length of time for a high fidelity demonstration case to close was approximately 140 days (CI approx. = 110 to 240), while for comparison cases it was approximately 290 (CI approx. = 210 to 460).[80] The figure shows that initially there is little difference between demonstration and comparison counties in the time to a case closing but the difference between the two trajectories increases at time continues.

3.5.1.4 Re-Reports Within 6, 12, and 18 Months of Transfer to Ongoing Services

One of the major concerns for child welfare agencies in general, and particularly for agencies operating under a Title IV-E waiver, is threat to child safety. An immediate indicator of a continuing threat may be estimated by looking at substantiated and/or indicated re-reports after an intervention has occurred.[81] Family Team Meetings are expected to occur within 30 days of transfer to ongoing services and are seen as an opportunity to bring relevant family support members and professionals together to ameliorate threats and provide support. Thus, as another gauge of the success of these meetings, the evaluation team chose to explore differences between intervention and comparison groups in the percentage of cases receiving a substantiated or indicated report of abuse or neglect within 6, 12, and 18 months of the transfer to ongoing services. For the full group of cases, no significant differences were shown between demonstration and comparison counties in the proportion of re-reports after transfer to ongoing; however, re-reports within 18 months after transfer to ongoing services did indicate marginal significance.[82] Cases in demonstration counties were slightly more likely to experience a substantiated or indicated allegation of abuse or neglect than those in comparison counties. There was the suggestion that the odds of a demonstration case experiencing a re-report within an 18-month period was about one and a third greater than the odds of a comparison case experiencing a substantiated or indicated re-report during the same period; it should be noted, however, that no significant differences emerged for cases in the high-fidelity group.

[80] If confidence intervals do not overlap then differences are always significant; however, when confidence intervals do overlap the differences shown may still be significant. Thus, even though the confidence intervals for this analysis overlapped the differences were shown to be significant: Wald Chi-square = 16.91 (1), p <.001; B = -.85, t=-4.11 (31) p <.001.

[81] Because AR cases that remain in the AR track do NOT receive a substantiation, only those AR cases that changed tracks and were then found to be substantiated or indicated were included in this set of analyses.

[82] Chi-square=34.95 Adjusted F (1,31), = 3.86, p = .06: Odds Ratio = 1.33 (CI .98 to 2.07)

Table 3.14: Percentage of Cases Receiving a Substantiated or Indicated Re-report Within 6, 12, and 18 Months of Transfer to Ongoing Services									
	Demonstration N=5,460			Comparison N=7,773			Total N=13,233		
			Weighted			Weighted			Weighted
Re-Report	N	%	%	N	%	%	N	%	%
6 months	412	7.5	7.0	413	5.3	5.3	825	6.2	6.2
12 months	707	12.9	12.2	772	9.9	9.9	1479	11.2	11.1
18 months	948	17.4	16.6	1006	12.9	12.9	1954	14.8	14.8
High Fidelity									
	Demonstration N=852			Comparison N=7,773			Total N=8,625		
			Weighted			Weighted			Weighted
Re-Report	N	%	%	N	%	%	N	%	%
6 months	45	5.3	5.2	413	5.3	5.3	458	5.9	5.3
12 months	79	9.3	9.0	772	9.9	9.9	851	9.8	9.6
18 months	105	12.3	12.1	1006	12.9	12.9	1111	12.8	12.6

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

A second set of analyses, shown in Table 3.15, reflects the proportion of cases experiencing a re-report subsequent to the case closure within 6-, 12- and 18-month timeframes. No significant differences were found between demonstration and comparison cases, suggesting that children within both demonstration and comparison cases were equally as safe after their cases closed out of the child welfare system.

Table 3.15: Percentage of Cases Receiving a Substantiated or Indicated Re-report Within 6, 12, and 18 Months of Case Closure									
	Demonstration N=3,668			Comparison N=5,035			Total N=8,703		
			Weighted			Weighted			Weighted
Re-Report	N	%	%	N	%	%	N	%	%
6 months	193	5.3	5.0	227	4.5	4.5	420	4.8	4.8
12 months	365	10.0	9.7	410	8.1	8.2	775	8.9	9.0
18 months	465	12.7	12.2	536	10.6	10.8	1001	11.5	11.5
High Fidelity									
	Demonstration N=561			Comparison N=5,035			Total N=5,596		
			Weighted			Weighted			Weighted
Re-Report	N	%	%	N	%	%	N	%	%
6 months	34	6.1	6.1	227	4.5	4.5	261	4.7	4.7
12 months	56	10.0	9.3	410	8.1	8.2	466	8.3	8.4
18 months	71	12.7	11.6	536	10.6	10.8	607	10.8	10.9

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

3.5.1.5 Proportion of Children Entering Placement

A further indicator of child safety and a primary goal of both Family Team Meetings and the waiver itself is a reduction in the number of children who are removed from the home through preventative services that can allow children to remain there safely. If a family can be supported to keep the child safely within the home, the trauma of removal for both child and parent is avoided and secure attachment between parent and child may be more easily maintained or improved. The next set of analyses examine the rate of children's removal to out-of-home care. The first examines removal at any time within the case episode; the second examines the rate of removal at any time after the family assessment but within the case episode. No significant differences were found between demonstration and comparison counties in the likelihood of removal within a case, this was regardless of demonstration counties' level of fidelity to the FTM model or whether the child was removed prior to the family assessment or after the family assessment. As shown in Table 3.16, the proportions of children placed in out-of-home care were very similar between the groups.

Table 3.16: Percentage of Children Entering Out-of-Home Care Within the Case Episode

	Demonstration N=15,193			Comparison N=22,669			Total N=37,862		
			Weighted			Weighted			Weighted
Removal Within Case Episode	N	%	%	N	%	%	N	%	%
Post Case Open	4,626	30.4	30.1	6,619	29.2	31.0	11,245	29.7	30.5
Post Transfer to Ongoing	1,936	12.7	12.9	1,925	8.5	8.9	3,861	10.2	10.9
High Fidelity									
	Demonstration N=2,553			**Comparison N=22,669**			**Total N=25,222**		
			Weighted			Weighted			Weighted
Removal Within Case Episode	N	%	%	N	%	%	N	%	%
Post Case Open	728	28.5	28.6	6,619	29.2	29.2	7,347	29.3	28.9
Post Transfer to Ongoing	204	8.0	8.1	1,925	8.5	8.4	2,129	9.9	8.3

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

3.5.1.6 Placement Types

Despite the neglect and abuse a child has suffered, the experience of being removed from a familiar home to one that is unfamiliar is likely to be frightening and potentially traumatic—and all the more so when the adults in that new home are strangers to the child. Therefore, when it is necessary to place a child in out-of-home care, demonstration counties seek to place the child with kin if possible.

It was hypothesized that, for those children entering placement subsequent to the family assessment, the FTM might provide an additional opportunity to explore the possibility of placing a child with kin rather than in stranger foster care or some other alternative. Table 3.17 indicates that the proportions of children shown to have a first placement, last placement, and predominant placement with kin were substantially larger in demonstration counties than in comparison counties. In all cases, the findings

were significant. The results indicated that the odds of a demonstration county child being placed with kin during the initial placement setting or the last placement setting, and of spending more time with a kin member during out-of-home care, were almost three times those of children in comparison counties. This finding held for all children at all levels of fidelity to the FTM model. These findings are consistent with the expectation that the FTM provided child welfare agencies an opportunity to strategize and explore alternative options, such as kin with families, when a child needed to be placed out-of-home.

Table 3.17: Kin Placement for Children Entering Care Subsequent to the Family Assessment

	Demonstration N=1,936			Comparison N=1,925			Total N=3,861		
			Weighted			Weighted			Weighted
With Kin	N	%	%	N	%	%	N	%	%
First Placement[83]	728	37.6	39.5*	422	21.9	22.1*	1150	29.8	32.4
Last Placement[84]	886	45.8	47.3*	440	22.9	23.2*	1326	34.3	37.4
Predominant Placement[85]	791	40.9	42.8*	407	21.1	21.5*	1198	31.0	34.0
High Fidelity 1:1 Matched Cases									
	Demonstration N=204			**Comparison N=204**			**Total N=408**		
With Kin	N	%		N	%		N	%	
First Placement[86]	77	37.7*		36	17.6*		113	27.7	
Last Placement[87]	88	41.1*		38	18.6*		126	30.9	
Predominant Placement[88]	85	39.9*		35	17.2*		120	29.4	

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

3.5.1.7 Exit Types and Timing of Exit Across the Study Period

The following analyses explored differences between demonstration and comparison counties in the exit types to permanency for children during the study period.[89] Table 3.18 shows that there were no significant differences between the type of permanency exit or the proportions of children remaining in care between demonstration and comparison counties regardless of fidelity level.

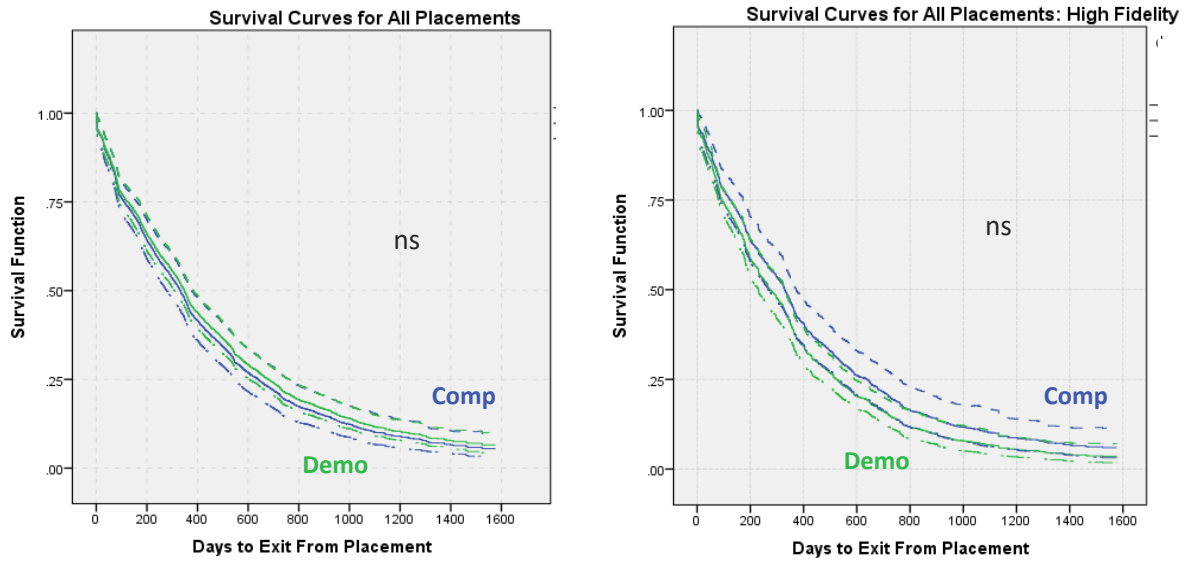
[83] Chi-square = 128.20; Adjusted F (1,31) = 4.30, p <.05; Odds Ratio = 2.29 (CI= 1.00 to 5.24)
[84] Chi-square = 230.99; Adjusted F (1,31) = 6.49, p <.05; Odds Ratio = 2.96 (CI =1.22 to 7.19)
[85] Chi-square = 187.86; Adjusted F (1,31) = 5.42, p <.05; Odds Ratio = 2.73 (CI=1.12 to 6.66)
[86] Chi-square = 20.57; Adjusted F (1,31) = 4.35, p <.05; Odds Ratio = 2.82 (CI= 1.00 to 8.0)
[87] Chi-square = 28.70; Adjusted F (1,31) = 5.65, p <.05; Odds Ratio = 3.31 (CI= 1.15 to 9.52)
[88] Chi-square = 29.51; Adjusted F (1,31) = 6.52, p <.05; Odds Ratio = 3.45 (CI= 1.25 to 9.55)
[89] Children entering placement and whose family assessment approval date was between Jan. 1, 2011 and February 2015.

Table 3.18: Children's Exits From Out-of-Home Care Across Length of Study Period									
	Demonstration (N=4,626)			Comparison (N=6,620)			Total (N=11,245)		
			Weighted			Weighted			Weighted
	N	%	%	N	%	%	N	%	%
Reunification	1,816	39.3	39.6	2,431	36.7	37.3	4,246	37.8	38.4
Custody to Kin	1,158	25.0	24.0	1,772	26.8	26.6	2,930	26.1	25.3
Adoption	256	5.5	5.1	380	5.7	5.8	636	5.7	5.4
Emancipation or Aged Out	88	1.9	2.7	230	3.5	3.1	318	2.8	2.9
Other Exit	36	.08	0.8	26	.04	0.4	62	.06	0.6
Still in Care	1,272	27.5	28.0	1,781	26.9	26.7	3,053	27.1	27.3
High Fidelity									
	Demonstration (N=730)			Comparison (N=6,620)			Total (N=7,350)		
			Weighted			Weighted			Weighted
	N	%	%	N	%	%	N	%	%
Reunification	319	43.7	45.5	2,431	36.7	36.8	2,750	37.4	40.3
Custody to Kin	173	23.7	23.6	1,772	26.8	26.5	1,945	26.5	25.4
Adoption	43	5.9	5.6	380	5.7	5.6	423	5.8	5.6
Emancipation or Aged Out	3	0.4	0.6	230	3.5	3.3	233	3.2	4.6
Other Exit	4	0.5	0.2	26	0.4	0.4	30	0.4	0.3
Still in Care	188	25.8	24.5	1,781	26.39	27.3	1,969	26.8	26.2

***p<.001 **p<.01 *p<.05
Other Exit includes exit to other agency, AWOL, and child death.

A follow-up analysis was conducted using Cox Regression, which takes into account censored cases, In order to estimate whether there were differences in the timing of exit to permanency between the two groups. For the full group median time to exit for both demonstration and comparison was approximately one year (confidence intervals are shown by the dashed lines). No significant differences between groups were found. For the high fidelity group the median time to exit was reduced to slightly less than 300 days; however, the difference between the demonstration group at high fidelity and the comparison group failed to reach significance. Figure 3.9 illustrates the survival curves for this analysis.

Figure 3.9: Timing of Exit across the Study Period



3.5.1.8 Exit Types and Number of Days in Care for Closed Placements Only

An alternative way to consider the proportion of permanency exit-types is to examine closed cases only. Because those children who remain in out-of-home care are not included in this analysis the proportions are different to those shown in section 3.5.1.9 although the raw number of children exiting to each permanency type remains the same.

There were no significant differences between exits to permanency between demonstration and comparison counties regardless of fidelity; however, one can see that descriptively, as shown in Table 3.19, children categorized as high fidelity appear to exit to reunification at a higher rate than children in comparison counties. Nonetheless, because this finding was not significant it should be viewed with caution.

Table 3.19: Children's Exits From Out-of-Home Care Across Length of Study Period									
Closed Placements Only									
	Demonstration (N=3,354)			**Comparison (N=4,838)**			**Total (N=8,192)**		
			Weighted			Weighted			Weighted
	N	%	%	N	%	%	N	%	%
Reunification	1,816	54.1	54.5	2,431	50.2	51.1	4,246	51.8	52.8
Custody to Kin	1,158	34.5	33.4	1,772	36.6	36.2	2,930	35.8	34.8
Adoption	256	7.6	7.4	380	7.9	7.8	636	7.8	7.6
Emancipation or Aged Out	88	2.6	3.6	230	4.8	4.4	318	3.9	4.0
Other Exit	36	1.1	1.1	26	0.5	0.6	62	0.8	0.8
High Fidelity									
	Demonstration (N=542)			**Comparison (N=4,838)**			**Total (N=5,380)**		
			Weighted			Weighted			Weighted
	N	%	%	N	%	%	N	%	%
Reunification	319	58.9	60.2	2,431	50.2	50.8	2,750	51.1	54.4
Custody to Kin	173	31.9	31.3	1,772	36.6	36.4	1,945	36.1	34.4
Adoption	43	8.0	7.4	380	7.9	7.7	423	7.9	7.6
Emancipation or Aged Out	3	0.6	0.8	230	4.8	4.6	233	4.3	3.1
Other Exit	4	0.7	0.3	26	0.5	0.5	30	0.6	0.4

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

Another advantage of this method is that the average time a child spends in out-of-home care can be estimated. Once again no significant differences between groups emerged[90]. On average children in demonstration counties spent 286.25 (se=3.88) days in out-of-home care before exiting to permanency, while children in comparison counties spent an average of 285.45 (se=4.73) days before exiting to permanency, and children considered to have experienced high fidelity FTMs experienced 286.22 (se=20.46) in out-of-home care before exiting to permanency.

3.5.1.9 Re-entry into Out-of-Home Care

Children only exit out-of-home care when the child welfare agency believes the child's home of origin is safe for the child's return or, if this is not possible, when an alternative permanency option has been found. However, despite the agencies' best efforts, some children are found to be at risk after what the agency believes will be a permanent exit from care. These children may have to once again be placed in an alternative home. Therefore, for children who exited placement, allowing for an 18-month follow-up period, the evaluation team explored whether differences could be seen in the proportions of children

[90] All averages shown are adjusted for on the weighted propensity score.

re-entering placement within 6, 12, and 18 months.[91] Table 3.20 shows that demonstration county children re-entered out-of-home care at a lower rate across all follow-up periods—6, 12, and 18 months after a permanency placement. These differences were statistically significant. Note: Due to the very few cases re-entering out-of-home care, this analysis was only performed for the larger group.

Table 3.20: Percentage of Children Entering Out-of-Home Care After the Initial Placement During an 18-Month Follow-Up

	Demonstration N=2,998			Comparison N=4,433			Total N=7,431		
			Weighted			Weighted			Weighted
Re-entry	N	%	%	N	%	%	N	%	%
6-months[92]	45	1.5	1.2**	313	7.5	7.1**	358	4.8	4.2
12-months[93]	112	3.7	3.0**	462	10.4	11.0**	574	7.7	7.0
18-months[94]	148	4.9	3.9**	549	12.4	13.0**	697	9.4	8.5

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

3.5.2 FTM Outcomes Summary

For the FTM outcomes analysis, the evaluation team computed propensity scores at two levels: for case-level analyses and again for child-level analyses. Propensity scores were used to adjust for differences between groups and the Complex Samples module in SPSS was used to account for clustering of cases within counties. Analyses were completed for FTM abuse and neglect, dependency, and family in need of services cases (and children) that transferred to ongoing services triggered by a family assessment occurring after Jan. 1, 2011.

Results indicated some support for FTM as an intervention that may, when delivered with high fidelity, be able to reduce case length. Although there were no significant difference in the length of case after the family assessment was completed when looking at the overall population of demonstration and comparison cases, high fidelity demonstration county cases closed significantly more quickly than matched comparison cases.

No statistical differences were found between demonstration and comparison cases in their experience of a re-report within 6, 12, or 18 months after the first family assessment that triggered transfer to ongoing services, nor within 6, 12, or 18 months of the case closing out from child welfare, indicating that children of families receiving FTM in intervention counties were equally as safe as their counterparts in comparison counties.

Demonstration and comparison children were no more or less likely to enter out-of-home care; however, children in demonstration counties were more likely to be placed with kin than in foster care

[91] Analyses focused on the differences between 'high fidelity' children and comparison children were not possible due to the very small numbers of demonstration children in the high-fidelity category who returned to placement after exiting.

[92] Chi-square = 147.72; Adjusted F = 30.79 (1,31), p <.001; Odds ratio = .17 (CI .05 to .36)

[93] Chi-square = 162.58; Adjusted F = 31.47 (1,31), p <.001; Odds ratio = .27 (CI .16 to 45)

[94] Chi-square = 177.24; Adjusted F = 22.80 (1,31), p <.001; Odds ratio = .29 (CI .17 to .51)

or another type of placement as their first, last, and most predominant placement when placed after the case transferred to ongoing services. Since the first FTM occurs very shortly after transfer or at the time of a critical event, it is likely that FTMs provide a forum for professionals and families to strategize placement options together when children need to be placed out-of-home, increasing the possibility of placing the child with kin and ameliorating the trauma that children might otherwise experience if placed in out-of-home care with a stranger.

There was no evidence to suggest any differences in length of placement between demonstration or comparison counties regardless of level of fidelity and no differences between demonstration and comparison counties in proportions exiting to permanency types.

Of note, however, children in demonstration counties who had exited care and reached permanency were significantly *less* likely to experience another out-of-home placement within 6, 12, and 18 months than were similar children from comparison counties.

In sum, when differences were revealed in support of FTM as a useful intervention, those differences tended to emerge regarding the usefulness of FTM as an intervention to reduce case length, support placement with kin, and to reduce the likelihood of further placements once a county has made a permanency decision for a child that was placed out-of-home.

3.6 Conclusion

The prior evaluation of FTM in Ohio, following the close of the second waiver period, revealed several positive outcomes for children and families in counties that had implemented the intervention, as compared to children and families in similar comparison counties. However, the process study found that, at the time, the initiative was loosely structured and largely left to individual counties to determine their own intervention processes. In addition, it was found that stronger training, supervision, and monitoring components would be beneficial. As a result of these findings, Consortium members established a goal of implementing the FTM intervention in the third waiver period with a more explicitly defined model and incorporating common training for all staff.

Demonstration counties were largely successful in this goal; in the first year of the third waiver period, volunteers from the Consortium and FTM workgroup developed an FTM Practice Manual, outlining core components and providing detailed instructions related to all aspects of the ProtectOHIO FTM model. Shortly after the completion of the manual, the Ohio Child Welfare Training Program developed and provided several two-day trainings on the FTM intervention. Part one of the training included a session on general facilitation skills; facilitators had identified this as a necessary area of focus. The second part of the training focused on implementation of the FTM intervention as defined in the ProtectOHIO FTM Intervention Practice Manual.

In general, buy-in to the intervention has increased since Ohio's second waiver period. There may be more variance in caseworker buy-in than among other PCSA staff, particularly among more seasoned caseworkers who experienced practice before implementation of the model in 2005. In general, however, facilitators and supervisors in the majority of the demonstration counties indicated that caseworkers are on board and bought into the FTM model. And, for the first time since implementation

of the model, site visit interviews in 2014 revealed some unintended consequences that resulted from this increased support, including requests for FTMs that may not be needed and an overreliance on the independent facilitator perspective for case decisions outside of the FTM process. While higher levels of caseworker support may result in overstretched facilitators, it also signifies an increased level of trust and acceptance of the intervention as practice as usual.

In fact, support for FTM as a model resulted in Consortium members requesting that the state build an FTM data collection component into SACWIS, to ensure data collection activities could be continued past the potential end of the waiver demonstration and to ease data-entry burden and enhance report monitoring capabilities. With assistance from the evaluation team (in terms of ensuring that data elements in SACWIS matched data used for the evaluation), SACWIS staff built an FTM module. In 2013, all counties transitioned to data entry in SACWIS.

Also during the third waiver period, implementation of a Kinship Supports intervention began in all 16 demonstration counties. Although there were minimal expectations of overlap for these two waiver strategies, FTMs became a valuable method for supporting kin caregivers. In addition to the initial search for kin that often occurs at a family's first FTM, it is common practice for both kinship staff and caregivers, once identified, to be invited to FTMs. In several counties, kin staff can request an FTM, or a caregiver may request an FTM through a kinship staff member. In fact, in one county it is regular practice for kinship staff to call a critical event FTM to avoid the disruption of a kinship placement. And, when caregivers do attend FTMs, the meetings are often used to identify and follow-up on needed services and supports specifically for the caregiver. The intersection of these two strategies, as evidenced by the use of FTM to support kin, is likely to increase stability of children and families involved with child protective services.

Overall, demonstration counties aimed to target all cases that transferred to ongoing services, with the exception of a handful of counties that sampled for FTM due to capacity issues. Demonstration counties largely succeeded in reaching their targeted populations; nearly 90% of eligible families received FTM. However, there was variance in the extent to which the eligible population was reached in individual demonstration counties (ranging from 63% to 100%).

Fidelity to the model was also examined, and again variance was found among counties. However, across the demonstration counties noteworthy differences in meeting fidelity were found between initial and subsequent FTMs, and between the two primary fidelity components (the timing of meetings and meeting participants). Overall, initial meetings were more likely to have met both the timing and attendee fidelity components than subsequent meetings. And, the timeliness component of the model was far easier for counties to meet successfully than the attendee component, a viewpoint underscored by PCSA staff, who noted that securing parental attendance at FTMs was one of the biggest barriers to successful implementation of the model.

Given the variation in the extent to which the two fidelity components were met across counties, substantial variation existed when case-level fidelity was examined, too. And, because meetings were likely to have met one fidelity component and not the other (i.e., meetings were held on time *or* included the minimum mix of attendees), only a small proportion of families reached the overall threshold for high fidelity for their case (18%).

In late 2013, FTM workgroup members developed a short-term subcommittee tasked with developing strategies to increase fidelity to the model. Although their recommendations were not mandated across counties, they appear to have brought increased attention to the task of increasing fidelity levels: Whereas rates of attendee fidelity and overall case-level fidelity remained stable throughout 2011 through 2013, the respective fidelity component rates increased by 4% each in 2014.

In comparison counties, variation also exists in the implementation of the family meeting models they are utilizing. In a 2014 survey of comparison counties, administrators in nine counties indicated that their agencies were conducting some sort of family meetings, many of them aligning with one or more components of the ProtectOHIO FTM model. The distinguishing factors of the ProtectOHIO model include:

- The intervention is targeted to all open and ongoing cases;
- Meetings are held throughout the duration of a case episode;
- A range of meeting participants are invited; and
- Meetings are led by a trained, neutral facilitator.

In several comparison counties, family meetings are held on as needed basis and they may or may not be neutrally facilitated. And, in some counties that hold meetings with neutral facilitators, those meetings may only be targeted to a sub-population rather than to all open an ongoing cases. Overall, while the majority of comparison counties were implementing one or more elements of the ProtectOHIO FTM model through their own, alternate family meeting strategies, only two comparison counties were identified as having a family meeting model very similar to ProtectOHIO FTM. However, given the small proportion of families that received high-fidelity FTM in demonstration counties, it is possible that families could have had similar family meeting experiences across demonstration and comparison counties. Despite this, several differences in outcomes emerged between demonstration county families that received FTM and their matched counterparts.

While no significant differences in case length were found when comparing all families that received FTM to their matched comparisons, high-fidelity FTM families had significantly shorter case episodes than their matched comparisons. No significant differences were found in the likelihood of placement; however, perhaps unsurprisingly given the emphasis on using the FTM process as a means to support caregivers, demonstration county children who received FTM and experienced an out-of-home placement episode were significantly more likely to be placed with kin during their initial placement setting and their last placement setting, and to spend significantly more time with kin during their out-of-home placement episode than their counterparts in comparison counties. This finding was not limited to the high-fidelity group; it was found when examining all children who received FTM. And while there were no differences between demonstration and comparison counties in the length of time in placement or exit types to permanency, a significant difference was found in the likelihood of re-entry into out-of-home care at 6, 12, and 18 months once a child exited to permanency, again in the larger, overall FTM group, indicating that FTM may assist families in procuring and maintaining truly permanent living arrangements.

Overall, while there was variation among demonstration counties in the extent to which FTM was implemented as intended by the model, positive outcomes emerged. It is evident that, as a result of the training components that were initiated in the current waiver period, the intervention is being implemented much more consistently across counties than it was in the second waiver period. And, although the measured case-level fidelity rates vary substantially across counties, there are many other model components that may impact outcomes (e.g., case plan development as a part of FTM). To further refine the intervention the FTM workgroup is in the process of reviewing the practice manual to determine practice elements that are structured loosely and that could be consolidated to ensure further consistency in FTM practice across counties. Further, a web-based FTM training is in the early stages of development, increasing the likelihood of skilled and trained facilitators facilitating each ProtectOHIO FTM. As Ohio continues to enhance its ProtectOHIO FTM model, the evaluation will continue to examine new research questions, bringing a greater awareness to the particular components of the model that drive positive outcomes, and a further exploration of the intersection between the FTM and Kinship Supports interventions.

Chapter 4. Kinship Supports

4.1 Introduction and Overview

The ProtectOHIO Kinship Supports intervention is a method designed to promote kinship placement as best practice, increasing attention to and support for kinship placements, caregivers, and families. Kin are defined broadly to include relatives and non-relatives who have a biological, familial, community, or cultural connection to the child. The intervention focuses on children in kinship placements who have open cases with the PCSA. Its purpose is to ensure that kinship caregivers have the support they need to meet the child's physical, emotional, financial, and basic needs.

The intervention used during Ohio's third waiver period builds on an initial intervention employed during the second waiver period, when six counties agreed to focus on the use of kinship placements as one of five distinct strategies they could elect. At that time, the aim was simply to increase the use of kinship settings for children in counties that chose to employ the intervention, and, in practice, the intervention was variable and flexible. By contrast, the third waiver period marks an expansion of intervention to all 16 demonstration counties and establishes a well-defined approach, including consolidating the intervention under a designated kinship staff person in each PCSA.

During the third waiver period, the demonstration counties carried out several primary activities to promote consistent and informed practice:

- For a six-month period, beginning in spring 2011, a workgroup of designated kinship staff developed a ProtectOHIO Kinship Supports Practice Manual, detailing all aspects of the third waiver intervention.
- As the Kinship Supports Practice Manual was being developed, HSRI developed a Kinship Component in the ProtectOHIO Data System (PODS), designed to collect case-level intervention data not otherwise available in SACWIS.
- On Oct. 1, 2011, all demonstration counties began formally providing intervention services to all eligible families, and entering data into PODS.
- In February 2012, a new module was built in SACWIS to record placement information related to children for which the agency does not hold custody and who are voluntarily placed (i.e., the Living Arrangement module).
- In 2012-2013, the Ohio Child Welfare Training Program (OCWTP) conducted several two-part trainings for intervention staff; day one included a focus on the general needs of kinship caregivers while day two focused specifically on implementing the intervention per the practice manual. Staff from all 16 counties attended.
- In 2014, initial planning for a web-based training entitled "Implementing the ProtectOHIO Kinship Manual" began. This training is self-directed and includes a course for caseworkers and a companion guide for supervisors. The training modules went live in June 2015.
- In 2015, the ProtectOHIO kinship supports workgroup began discussions about consistently implementing the caregiver support plan element of the intervention, a component that is

currently loosely defined. Additionally, the kinship workgroup has requested to the state that a kinship-specific module be built in SACIWS, which would allow counties to document kinship specific activities.

4.1.1 Background on Kinship Supports

Kinship caregivers are an extremely valuable resource to public child welfare agencies, offering a viable option for placement and permanency that is in the best interest of the child. Child welfare agencies in Ohio and around the country share a common belief that placing a child with kin significantly reduces the amount of trauma that children face by minimizing disruption in their lives, placing them in a familiar setting closer to the family, neighborhood, and culture they know best. The evidence base for these beliefs is growing rapidly, most recently through a number of studies that examine outcomes for children in kinship placements in comparison to a matched set of similar children in non-relative foster placements. This and other work indicate substantial benefits to the use of kinship placement, including that children experience more frequent and consistent contact with birth parents and siblings, greater stability, and remain as safe or safer than children in traditional foster placements.[95] [96] [97] [98]

Nationally, the use of kinship placements has grown substantially in recent years, allowing children at risk of out-of-home foster care to instead be cared for by a kinship caregiver. In Ohio, attention to supporting and promoting kinship placement is evidenced by a continuum of care available to kinship families. This continuum includes the ProtectOHIO Kinship initiative, Kinship Navigator programming, statewide Kinship Permanency Incentive funding, and various additional activities in individual counties. Loosely linking all these efforts is the statewide State Kinship Advisory Council.

As this practice develops and child welfare agencies increasingly utilize kinship placements, agency leaders recognize the need to increase the support available to kinship caregivers. Under the second waiver period of ProtectOHIO and now again under the third waiver, the demonstration counties have chosen to utilize waiver flexibility to pursue a Kinship Supports intervention. In the broadest sense, the waiver enables the demonstration counties to expand and enhance activities to support kinship placements, including location and identification of kin, assessments of home safety and kinship family needs, home visiting, and the purchase and provision of services for children and kinship caregivers.

While the evidence base for kinship care over more restrictive placements has grown, there remains a dearth of evidence about the staffing and practice strategies and interventions designed to support kin. For example, a search of the literature demonstrates that the Kinship Navigator program is the only kinship-oriented intervention listed in the California Evidence-Based Clearinghouse for Child Welfare, though even it remains unrated due to a lack of research evidence demonstrating its effectiveness. Further underscoring the variance in kinship staffing structures and services or supports available to kin, a 2010 Child Welfare Information Gateway factsheet for families identifies an array of services that may or may not be available for kin caregivers by child welfare agencies and encourages kin to ask about what is available in their area; this same document notes that access to services may also vary by

[95] Rubin, et al., 2008

[96] Testa & Slack, 2002

[97] Winokur, Crawford, Longobardi, & Valentine, 2008

[98] Geen, 2003

custody status.[99] The ProtectOHIO Kinship Supports model moves beyond prioritizing kin care to implementing a comprehensive staffing and practice intervention to fully support kin and sustain placements.

4.1.2 Second Waiver Kinship Supports

Six demonstration counties chose to use their waiver flexibility to enhance services and supports for kinship caregivers during the second waiver period of ProtectOHIO. The intervention focused on increasing the use of kinship settings for children who cannot remain in their birth home. It consisted of broadly defined efforts in recruitment, the provision of supportive services, and frequent communication with kinship caregivers.[100] The process evaluation revealed limited differences between the activities in the six kinship counties and those occurring in other counties. Prominent among the findings were the following:

- Kinship counties more often had designated positions to support kinship caregivers, and these designated workers had more responsibilities than designated staff in comparison counties.
- Kinship counties appeared to provide more hard goods and services needed by kinship caregivers to help them care for the children living with them.
- Kinship counties more often offered legal custody to kinship caregivers, giving children permanency and providing caregivers with legal authority to care for the children.
- Caregivers in kinship counties appeared to be more often involved in FTMs, allowing the caregivers to advocate for the child in their care.
- Caregivers in kinship counties who were interviewed reported feeling better-supported by caseworkers than their counterparts interviewed in other counties.

In terms of child-level outcomes, the evaluation team found that:

- Children in the kinship counties were more likely to be in the legal custody of a kinship caregiver at the end of a kinship placement episode and less likely to reunify with a birth parent following such an episode, relative to those in the comparison counties. Based on qualitative findings from interviews with county staff, it appears that the lower likelihood of reunification in the kinship counties could be due to the participating counties' efforts to utilize kinship placements when reunification is not likely.
- Examination of the length of time spent in kinship placement indicates that children's kinship placements were longer in the kinship counties, though this could be due to the higher rate of placements ending in legal custody, a process that is known to take more time due to court procedures.

4.1.3 Kinship Supports Intervention Manual

The second waiver kinship evaluation was clearly exploratory. Although ODJFS offered detailed policy and practice guidance to the county child welfare agencies, each of the six PCSAs tailored its procedures

[99] Child Welfare Information Gateway, 2010. *Kinship caregivers…*

[100] Human Services Research Institute, 2013

and emphasized certain elements according to local needs and norms. The lack of a well-defined intervention common to the six counties made it more difficult to evaluate whether the enhanced Kinship Supports led to better outcomes for children.

Refining this approach was an explicit goal of the third waiver period. To begin the process of gathering solid evidence of the efficacy of the Kinship Supports intervention, the Consortium worked with ODJFS staff and the evaluation team to define the intervention more precisely and to develop a ProtectOHIO Kinship Supports Practice Manual. With the evaluation team guiding the group in terms of conceptualizing a research-based practice, manual workgroup members developed core components, fidelity measures, and guidelines related to the following elements of the model:

- Kinship coordinator duties, competencies and skills.
- Training.
- Specific case management tools, including the Home Assessment Parts I and II and the Family Resource Scale.
- Services and supports.

Representatives finalized the practice manual over a six-month period, with the intent of using the manual to guide counties in consistent implementation of the intervention.

4.1.4 Description of the Third Waiver ProtectOHIO Kinship Supports intervention

The purpose of the kinship intervention is stated in the ProtectOHIO Kinship Supports Practice Manual:

> The mission of the kinship supports intervention is to promote kinship placement as best practice, increasing attention to and support for kinship placements, caregivers, and families…The purpose of the intervention is to ensure that kinship caregivers have the support they need to meet the child's physical, emotional, financial and basic needs.[101]

For the purposes of the ProtectOHIO kinship supports intervention:

- **Kinship caregivers** are defined as relatives and non-relatives who have a connection (biological, familial, community, cultural, etc.) to the child;
- **Kinship placements** consist of a span of time a child lives with kinship caregivers while a case is open to ongoing services; and
- The term **kinship family** is used to describe the kinship caregiver(s), the children in their care, and others that reside in the home during a kinship placement.

Core components of the intervention are:

- The eligible population includes all children with PCSA cases that open to ongoing services at any point during the waiver period, regardless of custody status or supervision orders.

[101] ProtectOHIO Consortium Kinship Workgroup, 2011

- In each demonstration county, a kinship coordinator with knowledge regarding best practices in supporting kin families serves as the expert resource on kinship support practice within the PCSA. The coordinator need not be solely dedicated to kin work; and some kinship coordination functions may be assigned to other PCSA staff as needed.
- PCSA caseworkers work closely with the kinship coordinator. Caseworkers typically conduct many of the activities included in the intervention. The intervention constitutes an enhanced focus on the kinship caregivers' needs for support, and thus the intervention-specific activities will be fully integrated with standard PCSA practices for working with kinship caregivers.
- Two new kin-specific assessment tools and processes are used to ensure that kinship caregivers can support the children in their care, and that services and supports they receive are aligned with their needs. The tools include a kinship home assessment and a kinship caregiver needs assessment, including a validated scale called the Family Resource Scale.
- A support plan is developed in accordance with the home assessment and needs assessment results. This plan has no standard format; it may be incorporated into the case plan or completed as a separate document.
- Home visits with kinship families occur at least monthly and include attention to the needs and concerns of the kinship caregiver as well as the child(ren) and other family members.
- Each county provides caregivers with a PCSA Kinship Handbook, and makes available appropriate training.

4.1.5 Kinship Supports Workgroup

Once the practice manual was complete, the manual workgroup evolved into the intervention quarterly workgroup; this transition occurred in fall 2011. The new group serves as a platform for continued discussion and refinement of the intervention, and it consists of Kinship coordinators or other designated kinship staff from county PCSAs as well as ODJFS and SACWIS staff and members of the evaluation team.

To better support kinship staff in fully implementing the intervention, the workgroup convened via telephone on a monthly basis for the first year of the third waiver period. And it continues to meet on a quarterly basis. The meetings typically include updates from the Consortium, evaluation team, and counties, and participants seek to address any issues that have arisen since the last meeting.

Over the course of the waiver, the quarterly workgroup has provided kinship staff an opportunity to:

- Review the intervention logic model.
- Solidify practice around case management tools, such as appropriate administration of the Family Resource Scale.
- Discuss the inclusion or exclusion of noncustodial parents under the intervention.
- Discuss the services and supports available in their counties for kin, as well as available funding streams for Kinship Supports and services.
- Participate in the creation of an online intervention training.

4.2 Evaluation Design

While placing children with their kin is considered a safer and more secure practice than placement with stranger foster care, questions remain regarding the outcomes of those placements as well as the effectiveness of practices designed to support kin, such as the ProtectOHIO kinship supports intervention.

Six research questions guide this study:

1. How has the intervention been implemented?
2. How do the intervention efforts in the demonstration counties differ from the various kinship support efforts in the comparison counties?
3. What occurred across demonstration counties in regards to the volume and nature of intervention activity?
4. What level of fidelity to the ProtectOHIO kinship supports model is achieved in demonstration counties?
5. Do children receiving the intervention experience different outcomes than children with similar characteristics in comparison counties?
6. Do children receiving the intervention with varying service model types experience different outcomes than children with similar characteristics in comparison counties?

Examining implementation of the intervention in the demonstration counties entails gathering information on a number of topics:

- The extent to which the specific practices as defined in the manual are being followed;
- Internal and external contextual factors that may impact implementation, such as changes in agency structure, interagency relationships, or service array; and
- How the intervention efforts have been integrated into FTM policies and practices (the interplay between the two strategies).

Because the intervention represents an overlay to standard child welfare practice, with special emphasis on identifying and meeting the unique needs of kinship caregivers and their families, it is particularly important to clarify how this intervention is expected to alter outcomes for children who spend some amount of time living with kinship caregivers. The logic model in Table 4.1 shows the inputs, activities, outputs, and expected outcomes for children and families served by the intervention.

The basic argument presented in the logic model is that full implementation of the intervention (designated, trained staff assessing and supporting kinship caregivers) will foster greater collaboration among PCSA staff and greater engagement between staff and kinship families, generating more complete and appropriate provision of services and supports to address kinship family needs, and ultimately leading to improved safety, permanency, and well-being for children.

Table 4.1: ProtectOHIO Kinship Supports Intervention Logic Model			
INPUTS	**ACTIVITIES**	**OUTPUTS**	**OUTCOMES**
• Waiver environment • Kinship coordinators • Staff training • Culture/policy change • Availability of services	• Locate kin • Home assessment • Kin needs assessment • Support planning • Ongoing contact (e.g., home visits) • Kinship coordinator information & training	• Number of kinship caregivers and children served • Communication/collaboration between kinship coordinators and caseworkers • Kinship coordinator relationship to PCSA staff • Amount/range of services provided (compared to needs)	• Decrease out-of-home (non-kin) placement days • Increase permanency • Maintain child safety • Decrease re-entry to care

4.2.1 Data Collection Methods and Analytic Approach

The evaluation team pursued three major analyses of the ProtectOHIO kinship supports intervention: a process analysis, a fidelity analysis, and an outcomes analysis. These analyses address the six research questions that guide the Kinship Supports study, mentioned above. The implementation analysis is presented in Section 4.4. The fidelity and outcomes analyses are included in Sections 4.5 and 4.6. In this section, we present information on the data collection methods and analytic approach used for the implementation and fidelity analyses.

4.2.1.1 Data Collection Methods

Data collection for the intervention was complex and multi-dimensional. Some of the data were collected at the county level and some at the individual level; that is, the information either reflected county policy and procedure or was specific to a single child or caregiver. The primary data collection method used in the comparison counties depended on whether prior data collection indicated the county was implementing services similar to the intervention. Administrative SACWIS data was provided by ODJFS which provided case- and child-level data for both demonstration and comparison counties.

- **Site visits**: In fall 2012, site visits were conducted in each of the then-17 demonstration counties and in 4 comparison counties that were identified as having kinship practices similar to the demonstration counties'. In fall 2014, site visits were conducted in 15 of the now 16 demonstration counties and in 6 comparison counties. One demonstration county site visit was cancelled due to inclement weather, and the agency participated via telephone interviews

instead. The site visits included interviews with directors, managers, supervisors, and kinship coordinators or other designated kinship staff about local kinship practices.

  - Prior to the 2014 site visits, the evaluation team administered a brief online survey designed to streamline the site visit process and enhance the richness of the information gathered during the visits. The results of this pre-site visit survey allowed the evaluation team to confirm which comparison counties had practices similar to either of the strategies in order to finalize which comparison counties would receive site visits and which would receive phone interviews. The survey was completed by all 16 demonstration counties and by 14 out of 16 comparison counties.

- **Telephone interviews**: In 2012, telephone interviews were conducted with 13 comparison counties.[102] In 2014, telephone interviews were conducted with 10 comparison counties and 1 demonstration county.[103] Interview protocols were used to document comparison county policies, practices, strengths and barriers, and key components of their practice with kin caregivers, if applicable. The primarily open-ended questions focused on topics such as designated kinship staff training and roles, services provided for kin caregivers, and county support of the intervention and kin placements in general. The evaluation team collected information from key staff in each county.
- **Focus groups**: In 2014, the evaluation team conducted focus groups with caregivers involved in the Kinship Supports intervention in six demonstration counties. One caregiver focus group was conducted in each site, with an average of five caregivers per focus group.[104] Information gathered during these focus groups included the types of help (such as materials, services, referrals, etc.) caregivers received, ease of access to help, and input on resources that could be provided to ease the burden of caregiving. The evaluation team also conducted interviews with designated kinship staff in those six counties, during which staff were asked the same questions as caregivers. This allowed the evaluation team to gather a full, rich picture of the array of services and supports, as well as the gaps in that array, from both the staff and caregiver's perspective.
- **Survey**: Information was gathered through a survey of kin caregivers across demonstration counties (in addition to the pre-site visit survey described above):
  - **Caregiver Engagement Survey**: In 2013, the evaluation team initiated a kinship caregiver survey that was designed to elicit data on caregiver's experience of the intervention. Evaluators sent the survey packets to all counties in October 2013 and asked kinship staff to begin data collection by November 2013. Caregivers were asked to complete the survey 90 days after the initial home assessment or at case closure if that occurred first. Caregivers answered questions related to the quality of their relationship and communication with designated kinship staff. Data collection ended in March 2015, and

[102] The remaining four comparison counties were interviewed during site visits, as described previously.

[103] As described previously, one demonstration county site visit was cancelled due to inclement weather, and interviews were conducted by phone instead.

[104] In one county, 26 caregivers were involved in the focus group. This county was excluded from the average.

a total of 258 caregiver surveys representing 15 of the 16 demonstration counties were received (see Appendix G for the survey protocol).

- **ProtectOHIO Data System (PODS):** The evaluation team developed a kinship component of PODS to collect case-level data necessary for the evaluation (and not otherwise available in SACWIS). Data is entered for each kinship family served by the intervention, including: SACWIS Person IDs, SACWIS Provider IDs, caregiver demographics[105], home assessments, and Family Resource Scale assessments. In response to changes made in SACWIS for children in voluntary placements, PODS was modified to allow for continued data-entry for these types of families. The team also launched several canned reports, allowing county staff to run a variety of reports on their own data, and conducted three separate web-based trainings for kinship coordinators and data-entry staff on how to use the kinship section of PODS.
- **SACWIS**: In addition to the PODS data, administrative SACWIS data was provided by ODJFS for each of the demonstration and comparison counties. This data set provided information on case opening and closing dates, reports of abuse or neglect, placement information, placement exit or permanency information, risk and family assessments information, service referral/delivery and demographics.

In addition to the discrete data collection methods described above, the evaluation team had ongoing opportunities to interact with demonstration county managers, supervisors and kinship staff, especially through kinship supports quarterly meetings and Consortium meetings. These interactions provided the evaluation team with valuable feedback and insight on implementation challenges and successes.

4.2.1.2 Analytic Approach

The process analysis presented in Section 4.4 describes similarities and differences between county-level practice in the demonstration and comparison sites, and also provides some basic data on the volume and nature of Kinship Supports activity that occurred in the demonstration counties. Analysis of the policies and perceptions of the Kinship Supports intervention in the demonstration counties brings together qualitative data—such as data collected through surveys, focus groups, and site visit interviews, collected between 2011 and 2015. Analyses of the policies and practices in the comparison counties use qualitative interview data collected in 2012 and 2014. For both demonstration and comparison county data, the evaluation team used Dedoose, a web-based qualitative analysis software, to code interview and focus group data (with the exception of participant focus groups) for themes or units of meaning and sub-themes. Coding was done primarily by one evaluator but was systematically and thoroughly discussed with the evaluation team. Caregiver focus group data were coded by two evaluators by hand in order to enable coder familiarity with the data. Hand coding the participant focus group data was appropriate due to the relatively smaller number of focus group participants and subsequent data, whereas site visit data required the online platform to expedite and manage coding and emerging themes.

[105] Some caregiver demographic information is available in SACWIS, though it is not systematically entered. To provide a fulsome description of the characteristics of kinship caregivers served via the kinship supports intervention, ProtectOHIO staff decided to enter this information into PODS.

Evaluators consolidated all interview and focus group data at the county level by assigning each county categorical thematic codes for all inputs, processes, activities and outputs that were examined. Evaluators searched for correlations among the different variables and for differences between demonstration and comparison sites, indicating practice differences and nuances resulting from adoption of the ProtectOHIO Kinship Supports intervention. Data from the caregiver engagement survey were entered into Excel and analyzed using a combination of Excel and SPSS to run frequencies and cross-tabulations.

The analysis of the volume and nature of intervention activity provides an overview of implementation of the intervention across the 16 demonstration counties. The analysis of fidelity to the model explores how well the demonstration counties adhered to the ProtectOHIO Kinship Supports model as intended. Both analyses use case-level kinship data on kinship caregivers and children, including Home Assessment Parts I and II and Family Resource Scale assessments.

The evaluation team conducted analyses on a subset of cases that met a number of conditions designed to limit analysis to those cases that could be verified as belonging to our target population. The cases could be closed or still open to the PCSA with ongoing involvement. A variety of descriptive and inferential statistics were then run to highlight what was accomplished across all demonstration counties and the important variations in practice across the sites.

To complete the analysis of the intervention, SACWIS living arrangement and placement data were merged, which required manipulation of certain data elements, further described below. Finally, various files were created dependent on the unit of analysis desired.

Sections 4.5 and 4.6 provide more detail regarding the analytic methods used in the fidelity and outcomes analyses.

4.2.1.3 SACWIS Living Arrangements

As previously noted, a new module was built in SACWIS in February 2012 to record placement information related to children for whom the agency does not hold custody, and who are voluntarily placed—these placements are referred to as "Living Arrangements." Prior to this build, agency staff could enter non-custody placement information in the Placement module; however, agencies did not consistently enter the data as it was not required and was burdensome for workers to do so. This new Living Arrangement module allows workers to easily enter voluntary placement information, providing the evaluation team with supplemental data from which to conduct analyses. However, with the creation of the new module came a greater awareness of the nuances related to kinship placement data and the limitations associated with our placement outcome analyses.

There are two primary issues related to these limitations: (1) county policies on kinship care, and how those policies impact placement data, and (2) problems associated with the Living Arrangement data itself.

Limitation One: County Policies - Kinship Care and Data Entry: In Ohio, across all counties, staff are mandated to enter placement information in SACWIS when an agency holds custody of a child and places the child in a setting outside of the removal home. These placement settings include foster

homes, residential settings, kinship homes—any type of setting in which custody is held by the agency. However, it is also common for children to be voluntarily placed; in these instances the agency would not take custody, but a parent would consent to a child being moved to an alternate placement setting, oftentimes to a relative or fictive kin caregiver's home, while a parent receives services and works a case plan. And, while the experiences may be similar for children associated with these two types of situations—being uprooted from one's home and placed in another until reunification can safely occur—the data differs depending on whether or not the agency holds custody of the child, as explained below.

While it is mandated that all Placement data be recorded in SACWIS, the extent to which Living Arrangement data is entered varies across counties. In all previous analyses we have excluded non-custody placement data that was entered into the Placement module in order to ensure an even comparison between demonstration and comparison counties (i.e., analyses only included information that was required to be entered by all counties). Because entering data into the SACWIS Placement module was problematic for voluntary cases, it was expected that a great deal of data would be missing. The creation of the Living Arrangement module eased the data-entry process for these types of cases; yet, the completeness of the data still varies across demonstration and comparison counties. Consequently, if we use the Living Arrangement data for placement analyses, we can't ensure an even comparison. But if we exclude Living Arrangement data in favor of using only the placement data, we are knowingly excluding existing data that describes children's experiences when they are placed outside of their primary homes. In either scenario there are limitations.

This issue is especially problematic when examining outcomes specifically focused on kinship, because the large majority of the Living Arrangement data is kinship specific. Furthermore, many counties have policies or particular judges that mandate certain custody arrangements when kinship care is used. For instance, in some counties when a child is removed and placed with kin, the kin are almost always awarded temporary custody until the case is resolved. In other counties, when kinship care is used, the agency typically holds custody of children until reunification or permanency is achieved. In this sense, cases may not differ from one another in any significant factor except for where in SACWIS the information related to these placements/living arrangements is entered. In fact, when ProtectOHIO Consortium members were asked whether they consider living arrangements to be different from placements, they argued that there were no fundamental differences; instead, they indicated that living arrangements are more a function of policy and custody arrangements and are no more or less serious than placements.

In an effort to learn more about counties' policies around kinship care and data entry, the evaluation team surveyed all demonstration and comparison counties to gather information on the existence of policies that may lead an agency to typically take, or not take custody of children when they are placed with kin (signaling where we would expect to find kinship placement data—in the Placement or Living Arrangement data sets) and the extent to which living arrangement data is entered. In this way, we could better assess the extent to which data was missing. For example, if there were few Living Arrangement records for a particular county, and that county's policy is to always take custody of children when they are placed with kin, we would know that data weren't necessarily missing and instead should be found in the Placement data set. On the other hand, if there were little Living Arrangement data for a county that typically awards custody to kin caregivers, we would then need to

examine the extent to which that county enters data into the Living Arrangement module. If they consistently enter Living Arrangement data, it would be likely that this county places relatively few children with kin. If they rarely enter Living Arrangement data, there would be no way of knowing the extent to which kin placements are used. The latter scenario would signify an instance in which data is truly missing.

It is worth noting that the issue of missing placement information related to kinship care is likely not limited to Ohio. As the use of kinship care grows, as it appears to be at a national level, it is especially important to be conscious of the significance of this limitation. There are likely differing policies related to data entry for kinship care from state to state—and from county to county within county-administered states. The distinctions may differ—agencies may differentiate between certified and non-certified, or paid versus volunteer caregivers—but regardless of the distinction, the likelihood increases with the growing use of kinship care that analyses are being completed using incomplete data sets due to varying data-entry policies.

Limitation Two: Inconsistencies between Living Arrangement and Placement Data: To add complexity to the situation, the evaluation team found that the Living Arrangement module was built quite differently than the Placement module. This resulted in several problematic factors for the fidelity and outcome analyses. Although the intent when building the Living Arrangement module was to have comparable Living Arrangement and Placement information, two major inconsistencies between the two data sets exist:

- In the Living Arrangement file, placement setting end reasons (i.e., the reason for a placement move—a caretaker requesting for the child to be moved, for example) are combined with placement discharge reasons (i.e., exit types—legal custody granted to kin caregiver, for example), which results in unknown exit types at the end of a span of time in out-of-home care. This occurs for two reasons: 1) workers are able to select a final end reason that's intended as a setting end reason (e.g., "move from treatment setting"); or 2) end reasons are available to select that simply do not indicate where a child exited to (e.g., "case closure" or "change in legal responsibility"). By contrast, the Placement file differentiates setting end reasons from discharge reasons, and provides exit type information for each record.
- Within the Living Arrangement file, setting end-reasons are end-dated for reasons other than a change in setting, including when there is a change in legal responsibility for a child, or when a case transfers to another caseworker. This results in "false" end-dates and multiple setting records even when children remain in the same home. This is in contrast to the Placement data, where records are associated with placement settings, and are only end-dated when a child moves settings or permanency is achieved.

Placement Outcome Analyses: While the issues presented above are especially problematic for kinship-specific analyses, they also impact overall placement outcome analyses in the sense that, regardless of whether Living Arrangement data is used or excluded, missing data is a factor. After much thought and consideration, the evaluation team determined that, to remain consistent with previous reports so that comparisons can be made—and because the extent to which data are missing prior to the Living Arrangement build is unknown—the overall waiver and FTM outcome analyses would continue to

exclude voluntary placement data. However, because the kinship outcome analyses are focused on only the span of time in which the Living Arrangement data are available (and for which voluntary placement information was likely entered into SACWIS at a higher rate than prior to the build), the kinship analyses would include Living Arrangement data.

Across all analyses, however, information on counties' policies relating to common custody information when kinship care is used (and thus, in which data set we would expect to find the majority of kinship placement information), was used as a variable for propensity score matching, thus controlling to some extent for the varying amount of missing data across counties. In order to include the Living Arrangement information in the kinship outcome analyses, the evaluation team worked to create a combined Placement-Living Arrangement file that accounted for and corrected (to the extent possible) the problematic factors listed above.

4.3 Organization of the Chapter

The following sections of this chapter address the core Kinship Supports research questions:

Section 4.4 Kinship Supports and Kinship Practices in Demonstration and Comparison Counties

- How has the intervention been implemented?
- How have intervention efforts been integrated into Family Team Meeting practices and processes?
- How do the intervention efforts in the demonstration counties differ from the various kinship support efforts in the comparison counties?

Section 4.5: Volume and Nature of Kinship Activity and Fidelity to of Kinship Supports Model

- What occurred across demonstration counties in regards to the volume and nature of Kinship Supports activity?
- What level of fidelity to the ProtectOHIO kinship supports model is achieved in demonstration counties?

Section 4.6: Child- and Case-Level Outcomes: Demonstration versus Comparison Counties

- Do children receiving the kinship supports intervention experience different outcomes than children with similar characteristics in comparison sites?

Section 4.7: Summary and Conclusions

4.4 Kinship Supports and Kinship Practices in Demonstration and Comparison Counties

This section presents qualitative data collected over the course of the waiver with regard to the kinship intervention in ProtectOHIO demonstration counties. Where appropriate, it also presents data collected in comparison counties. Here, we document the implementation of the intervention and its core components, such as staffing structures and the use of such tools as the Family Resource Scale and

Home Assessments Parts I and II. Additionally—given that the mission of the kinship intervention is to promote kinship placement as best practice, increasing attention to and support for kinship placements, caregivers, and families[106]—we present the general work that occurs with kin caregivers and county support provided for kin caregivers.

Throughout this section, we use the term "designated kinship staff" to refer to staff dedicated to the intervention—such as kinship coordinators, kinship support workers, or kinship caseworkers. The practice manual outlines core components of the intervention and specifies specific responsibilities that a "kinship coordinator" must be responsible for. However, while all mandatory kinship coordinator responsibilities are completed by designated kinship staff across the demonstration counties, the term "kinship coordinator" is not used uniformly across all demonstration counties, so we've chosen to use a more generic terminology for this report when describing staff who work.

4.4.1 Kinship Intervention Implementation in Demonstration Counties: Three Models

The kinship intervention is designed to sustain and maintain placements with biological and fictive kin.[107] The intervention includes both prescriptive elements—including specific direct and indirect work with and for kinship families—and considerable flexibility in staffing structures and roles.

These prescriptive elements are defined in the ProtectOHIO Kinship Supports Practice Manual. For example, direct work with kinship families entails:

- Providing direct support to kinship families, either regularly or on an as-needed basis.
- Providing training and support to kinship families.
- Advocating for individual kinship cases and/or in the broader context of influencing and informing policy and practice guidelines.
- Supporting kinship caregivers in fulfilling their roles in connection with child welfare court proceedings.
- Providing kinship caregivers with information regarding the juvenile and family court system and their roles in different types of court proceedings involving children in their care.

Indirect work with kinship families is defined in the Practice Manual as:

- Establishing relationships with community public and private service providers with the intent to educate them regarding the needs of kinship families and to develop capacity and expertise to respond to their needs; and serving as an ongoing liaison between the PCSA and the community.
- Assuring that the county resource guide/list is up-to-date so that it is useful to families and staff.
- Supporting/advising staff on how to locate, assess, and engage kinship caregivers.
- Sharing responsibility for training all workers (intake and ongoing) on how to support kinship caregivers.
- Serving as an expert resource to caseworkers in their work with kinship families, assisting them to find services within and outside the county.

[106] ProtectOHIO Consortium Kinship Workgroup, 2011
[107] Ibid.

- Assuring Family Team Meeting facilitators are knowledgeable regarding the intervention and are able to incorporate and integrate intervention practice into team meetings as necessary and appropriate (i.e., location efforts, visitation, permanency planning, and ongoing support).
- Assuring accurate and complete data collection for the intervention.

4.4.1.1 Kinship Supports Direct Service Staffing Models

While all demonstration counties ensure that both indirect and direct work is occurring, and all have designated kinship staff, counties differ in their kinship models and distribution of kinship-related responsibilities. In all demonstration counties, designated kinship staff consistently complete the indirect components of the intervention; these activities require knowledge of the intervention, data entry expertise, familiarity with community resources, and strategies for supporting both kin caregivers and staff. However, demonstration counties employ three various structures and approaches to completing direct work with kin caregivers. That is, counties may use a two-worker, one-worker, or hybrid approach, as described in Table 4.2.

Table 4.2: Three Approaches to Direct Service with Kin

Kinship Supports Direct Service Model[108]	Model Description	# of Counties (% of Counties)
Two-worker Approach	All kin caregivers are served by a caseworker and a secondary kinship staff. These kinship staff serve the caregiver beyond just completing data collection. From the caregiver's perspective, there are two workers/resources.	6 (37.5%)
One-worker Approach	Kin caregivers are served by caseworkers who may specialize in kinship cases. From the caregiver's perspective, there is one worker/resource.	4 (25%)
Hybrid Approach	Kin caregivers are served by a caseworker; some kin caregivers are also served by designated kinship staff. From the caregiver's perspective, they may have two workers/resources *or* one worker/resource.	6 (37.5%)

Two-Worker Approach: In this approach, implemented in six demonstration counties, all kin caregivers are served by an ongoing caseworker, and there is an additional kinship staff person who provides support to each kinship case. These kinship staff may be part of a unit; the number of these kinship staff varies by county size. These kinship staff serve the caregiver beyond just completing the Family Resource Scale or Home Assessment Parts I and II. For all caregivers in these counties, there are two workers or resources with whom to be in touch. This model may represent the most significant variance from practice-as-usual from the caregiver's perspective.

One-Worker Approach: In this approach, implemented in four demonstration counties, kin caregivers are served by caseworkers who, in two counties, specialize in kinship cases and are part of a kinship unit

[108] One county identified here as using the one-worker approach transitioned to a hybrid approach in October 2015, after the conclusion of the third waiver period.

overseen by a kinship coordinator. In these four counties caseworkers serve as the sole caseworker on those cases. In counties where workers specialize in working with kin caregivers, ongoing workers who do not specialize in working with kin caregivers may absorb cases if the unit becomes overloaded. Although the county may have separate kinship home assessors, there is only one worker or resource to contact from the caregiver's perspective. This approach is not practice-as-usual, given that workers may have received additional training in best practices with kin caregivers and there is a designated kinship staff person within the agency who provides indirect service. However, it may be the model most closely aligned with practice-as-usual from the caregiver's perspective. If the caregiver needs support or resources, they contact the ongoing caseworker on the case.

Hybrid Approach: In this approach, implemented in six demonstration counties, kin caregivers are served by a caseworker and some kin caregivers are also served by a designated kinship staff. This kinship staff person may serve kin caregivers on either a case-by-case or as-needed basis, depending on the level of the caregiver's needs or kinship staff capacity. This designated kinship staff person may not reach out to all cases, but may be available as a resource on all cases if kin initiate contact. This model straddles the line between the other two approaches; in essence, sometimes there is a two-worker approach, and sometimes a one-worker approach. Caregivers may have varying experiences of the structure within these counties. It is likely that higher-needs caregivers are in contact with two workers (both a designated kinship staff person and an ongoing caseworker), whereas other caregivers may only be in touch with their ongoing caseworker. From the caregiver's perspective, they may have two workers or resources *or* one worker or resource.

These three approaches, used to capture the intervention direct services practices occurring across demonstration counties, were developed by the evaluation team based on information collected during site visits and during the intervention workgroup meetings. These categories reflect the caregiver's experience of the assistance they receive, which may differ based on the agency's kinship staffing structure. Given the intervention's emphasis on serving kin caregivers and enhancing the system's ability to meet kin's needs and sustain kinship placements, these categories are distinguished by who and how many staff work directly with the caregiver—designated kinship staff, a caseworker, or both, as outlined below. That is, from a caregiver's perspective, are there one or two workers with whom to be in touch and receive support? It appears that this support and communication is significant to kin caregivers, who highlight the services and support they receive in both the caregiver engagement survey, returned by over 200 caregivers over the course of several years, and in focus groups conducted with kin in six demonstration counties in 2014.

It should be noted that during a 2015 kinship supports workgroup quarterly meeting, it became clear that counties implemented the most appropriate direct service model to work with kin in their communities, without necessarily having prior knowledge of the benefits and challenges of the various structures. These choices may have been based on county size, resources, existing staffing structures, county capacity, and readiness rather than a strong ideology around which model is best. Further, most literature on kinship care is focused on types of kinship placements (informal vs. formal) and outcomes for children in the care of kin rather than the benefits of internal staffing structures. And, indeed, demonstration counties had difficulty defining their own models, underscoring the various and fluid ways in which staff interact with kin and divide responsibilities for kin-related work.

One additional factor that complicates the categorization of county practices is whether or not counties retain a Kinship Navigator program. These programs or positions may impact the county's model or structure in some ways; that is, the Kinship Navigator may provide additional services or supports or even double as the designated kinship staff person. Yet though Kinship Navigator programs and staff may shape the way caregivers receive their services or supports, the structures below are described without attention to Kinship Navigator programs, as those programs vary in structure and even in whether or not they are located within the agency. Additional information about Kinship Navigator programs in demonstration counties can be found in Section 4.4.8.4. There are no solidified, agreed-upon definitions of each structural model.

4.4.1.2 Benefits and Challenges of the Approaches

During the 2014 site visits, kinship staff were asked about the benefits and challenges of their agency's approach—whether they implemented the hybrid or two-worker approach (classified together for the purposes of the benefits/challenges analysis) or the one-worker approach. Interestingly, staff described some similar benefits and challenges across both categories.

Benefits of both approaches include staff expertise. In those counties where kinship staff *and* ongoing workers work with caregivers, kinship staff are able to develop expertise and skills and learn about needs and resources specific to kin caregivers as opposed to foster parents. Similarly, in those counties with a one-worker approach, those workers are able to develop their area of specialization while traditional, ongoing workers are able to maintain their area of specialization. In sum, either of these structures may allow workers—whether ongoing workers carrying kinship cases or kinship coordinators/staff—to hone their skills.

Across both approaches, counties report issues related to capacity. In fact, all counties noted that their approach is complicated by worker capacity issues, though these issues may manifest differently. In some counties with the one-worker approach, workers in kinship units may be overwhelmed and cases may be diverted to traditional ongoing workers or units that do not specialize in working with kin. Similarly, kin caregivers may require significant time and attention. Further, some cases may have more than one kinship caregiver for a worker to communicate with and provide resources for.

In counties that always or sometimes use a two-worker approach, the designated kinship staff person may become overwhelmed since he or she may serve all kin caregivers; even if there are more kin caregivers than foster parents, the number of kinship staff may not be commensurate with the number of traditional ongoing workers or foster care staff.

It may be that these capacity challenges reflect the overall workload and resource challenges related to child welfare. One barrier noted specifically by workers in counties with the one-worker approach is that simultaneously supporting bio parents and caregivers has its own set of challenges, particularly when reunification is the goal and caregivers are aiming to gain custody and/or legal, custodial, and visitation issues are raised. Alternatively, in -worker counties where workers specialize in kinship cases, staff have noted that they are better able to connect with caregivers, as they are able to explain that they specialize in kinship care and are able to gain trust quickly.

One barrier distinct to the hybrid and two-worker counties is potential triangulation. Some workers feel kin caregivers may attempt to procure more assistance or support by approaching both their caseworker and kinship staff. Similarly, there may be staff disagreement or miscommunication when multiple staff are working with kin caregivers. There may be times when the kinship support worker might think there are safety risks and doesn't want to place children with the caregiver, but the worker is comfortable with it or vice versa.

It should be noted that while these tensions may pose challenges, they may also enhance collaboration and effective decision-making. In fact, one distinct perceived benefit of these approaches is enhanced support for kin. Counties note that kin have "more than one person to go to if they need something." Although a caregiver's needs may be adequately met by one worker, kin may perceive having two contacts, or a kinship-specific contact, as more supportive. Caregivers may perceive the worker who does not work with bio parents as an advocate and may share things with the kinship worker they wouldn't share with the ongoing worker. One staff person noted, "For instance, when caseworkers can't get a grandma to understand why something she's doing isn't a good idea, it's helpful to have this kinship staff that isn't 'team parent.'" Additionally, designated kinship staff may be able to continue to provide emotional or material support for kin once the case closes.

In the same way that caregivers may feel more supported if they have two agency contacts, counties note that workers may feel more supported when multiple staff are serving the case. This collaboration between workers may ease pressure that the ongoing worker feels to meet the needs of the child, the bio parent(s), and the kin caregiver(s). Staff may also feel that services are expedited when there are two workers and that kinship staff free up time for ongoing workers to work toward reunification and supporting the birth family.

4.4.2 Kinship Practices in Comparison Counties

While there is variability in the manner in which the intervention has been implemented among demonstration counties, there is more consistency in the level of support provided to kin in comparison counties: only four counties have staff dedicated to serving kinship caregivers in some capacity beyond home studies. This may be the most significant difference between kin practices in comparison and demonstration counties. Whereas all demonstration counties, per the intervention, have at least one designated kinship staff person, only 25% of comparison counties in 2014 indicated they had a designated kinship staff person. That is, comparison counties are more likely than demonstration counties to maintain kinship practice-as-usual, in which regular ongoing workers are responsible for serving both bio parents and kin caregivers.

Of those four comparison counties that employ designated kinship staff, three employ one worker. These workers coordinate services and referrals for services for kin. However, one of these counties has a more advanced kinship program in which a kinship coordinator provides support for kin caregivers, produces a monthly newsletter for kin, assists in family search and engagement, facilitates a monthly support group and provides activities for kinship youth. In all of these three counties, kin are certainly served (though perhaps to a limited degree) by the regular ongoing worker and may receive varying degrees of attention from kinship staff. Consequently, these counties are most closely aligned with the

hybrid approach described in Section 4.4.1.1 in terms of approaches employed by demonstration counties.

The remaining comparison county employing kin staff has a unit of seven kinship workers. These workers complete home studies and safety assessments, and they provide services or referrals for services for kin. However, the county does not complete any sort of needs assessment tools to identify services for kin, nor do staff complete support plans for kin—both standard procedures in demonstration counties under the intervention. As in demonstration counties, the unit structure is a function of county size rather than practice with kin caregivers. This county may be most closely aligned with the two-worker approach, though it is unclear if all kin caregivers receive services and support from the kinship unit.

4.4.3 Kinship Supports Target Population

The mission of the kinship supports intervention is to promote kinship placement as best practice, increasing attention to and support for kinship placements, caregivers, and families. The ProtectOHIO Kinship Supports Practice Manual stipulates that, for the purposes of the intervention:

- Kinship caregivers are defined as relatives and non-relatives who have a connection (biological, familial, community, cultural, etc.) to the child;
- Kinship placements consist of a span of time a child lives with kinship caregivers while a case is open to ongoing services; and
- The term kinship family is used to describe the kinship caregiver(s), the children in their care, and others that reside in the home during a kinship placement.
- The ProtectOHIO kinship supports model focuses on all children with PCSA cases that are open to ongoing services in a ProtectOHIO demonstration county, regardless of custody status or supervision orders.[109]

Given these definitions, designated kinship staff in all but one ProtectOHIO county indicated a broad view of the eligible population for the intervention: all kin (biological or fictive) caregivers with open cases regardless of the length of placement. Service may begin during the assessment phase, as this is when a home study may occur. Staff in at least two counties explicitly indicated that designated kinship staff will serve "anybody," including fictive kin, though this may be implied considering the legal definition of kin in Ohio includes fictive kin.

Staff in the one county not serving all kin distinguished that their county serves kinship cases through ProtectOHIO only when the agency holds custody, which is often but not always the case per policy in this county (meaning, this agency generally holds custody of children when they are placed with kin).

Interviewees in at least three counties also indicated that designated kinship staff continue to serve kin caregivers once the case closes and is the caregiver is granted legal custody. For example, in one county, the designated kinship staff may still serve as a "point of contact" to troubleshoot issues with the caregiver; in another county, workers continue to provide whatever emotional or hard goods support

[109] ProtectOHIO Consortium Kinship Workgroup, 2011

they can to the kinship caregiver after the close of the case. Other kinship staff are responsible for conducting the mandatory home studies that kinship caregivers must undergo to be eligible for kinship permanency funds, so, in essence, these staff would serve kin in this manner no matter the existence or status of a case. Additionally, staff in at least one county conduct home studies for families who seek custody privately without agency involvement; in this county, a home study is a court requirement for these private cases.

In 2012, at the time of the Interim Evaluation Report, nine counties that served all kin caregivers required those placements to be long term. Counties defined long term in varying ways, but generally classified it as from 14-30 days. Interestingly, in 2014, as noted above, staff interviewed no longer indicated that placements needed to last a specified number of days for kin caregivers to receive intervention services; this demonstrates a shift toward inclusion and broadened capacity.

4.4.3.1 Serving Noncustodial Parents through the Kinship Supports Intervention

As noted above, while almost all counties serve kin with open cases (and some without) there is less consistency in whether noncustodial parents are considered kinship caregivers and subsequently receive services through the intervention (typically in a scenario where a child is removed from one home and placed with another non-removal parent). Three counties do consider noncustodial parents to be kin for the sake of the intervention whereas twelve counties do not.[110] Classifying noncustodial parents as kinship caregivers could determine the level of hard goods they receive as well as the steps they must complete for the agency to determine their eligibility and safety as a kinship placement.

Within the 12 counties wherein noncustodial parents are not considered kin caregivers and are instead served as biological parents, reasons vary. During the 2014 site visits, some designated kinship staff indicated that noncustodial parents who are granted temporary custody are eligible to receive similar supports and services as kinship caregivers, but these would be provided by the caseworker independently of the intervention, and the parent would not have any contact with a designated kinship worker. Therefore, these staff indicated, there's little reason for the intervention to serve these parents, as they would have access to hard goods and services either way. Staff in at least one county indicated that they do not consider noncustodial parents to be kinship caregivers philosophically; they believe that a kinship caregiver and a biological parent differ in status, and biological parents should not have to go through the same processes to be granted temporary custody as another family member or fictive kin.

In the counties that make this distinction between noncustodial parents and kinship caregivers, home study practices may vary. One agency does not require a comprehensive home study for noncustodial parents and another requires a less strict family assessment instead of a home study.

Within the three counties wherein noncustodial biological parents are considered kinship caregivers, these parents receive intervention services and may interact with designated kinship staff. Staff in at least one of these counties indicated that because Ohio rule designates these parents *as* kin, it follows that the kinship intervention should support them. However, these noncustodial parents are not necessarily treated in the same manner as kinship caregivers. In one of these counties, for example, staff would proceed with completing the home study and fingerprinting the noncustodial parent as if they

[110] Data not available from one demonstration county

were kinship caregivers. However, this same county grants some leniency to noncustodial parents; eligibility (though not safety) standards may be more flexible for noncustodial parents than for other kinship caregivers. For example, whereas kin with a misdemeanor on their record three or fewer years before would be disqualified for placement, noncustodial parents would not be.

In addition to revealing whether they treat noncustodial parents as kinship caregivers, staff discussed the pros and cons of treating noncustodial parents as kin caregivers. Some identified benefits of serving noncustodial kin through the intervention include:

- Noncustodial parents may be required to demonstrate commitment to the placement, and a lack of follow-through with the kinship requirements (home study, etc.) may be a warning sign for the agency that the noncustodial parent is not committed.
- Noncustodial fathers treated as kinship caregivers may have an opportunity they've never had to be with their kids. It may also qualify them for a public attorney and give them opportunity for representation and court filing that they have not had in the past (due to resources) even if they desired to gain custody previously.
- Access to kinship intervention services and supports may be especially important for fathers who are just learning to take care of their children: "When we don't consider dads to be kinship caregivers, they may miss out on services and resources, whereas if they were classified as kinship caregivers, they might receive more services."
- Noncustodial parents can benefit from the emotional support kinship staff can offer.

Identified disadvantages of serving noncustodial parents through the intervention include fewer resources and designated kinship staff time for non-parental kin, as well as potential tension between the custodial and noncustodial parents, especially if the custodial parent views the agency as favoring the noncustodial parent by providing hard goods and services through the intervention. Staff in one county expressed ambivalence about the fairness of providing supports and services for the noncustodial parent that were not provided for the custodial parent. Such supports or services, these staff believe, could have potentially prevented the case opening and supported a struggling custodial parent from facing removal.

4.4.4 Training on the Intervention and Kin Caregiving

As noted elsewhere, the Ohio Child Welfare Training Program (OCWTP) developed and provided several two-part kinship trainings for kinship coordinators beginning in winter 2012-2013. Part I of the training focused on the general needs of kinship caregivers; Part II focused specifically on implementing the intervention according to the practice manual. Both trainings were offered in various regions across the state; each session lasted approximately six hours.

Site visits in 2012 also revealed that, prior to the formal training, kinship staff in 13 of the demonstration counties received an introduction to the intervention from a manager who explained the background of ProtectOHIO and provided an overview of the intervention. Kinship staff in the remaining counties introduced themselves to the intervention, primarily by reviewing the Kinship Supports Practice Manual. In addition, kinship staff in two counties had been heavily involved in the development of the manual,

and the kinship coordinators in another two counties felt well prepared to lead the intervention, as they had been providing kinship services for many years before the intervention started.

The Kinship Supports Practice Manual emphasizes the importance of kinship staff and caseworkers playing complementary roles in the intervention. Because of this, the Consortium recommended that training for caseworkers be provided, and each county agreed to be responsible for assuring that caseworkers were appropriately trained in accordance with the manual and local policy.[111] By the time of the site visits in 2012, caseworkers in only a handful of the demonstration counties had participated in a kinship-related training. In four counties, caseworkers reported participating in the general kinship training through the Regional Training Center, and caseworkers in two counties recalled receiving information and education about kinship at unit or staff meetings.

In addition to this initial rollout training, as new kinship staff join demonstration county PCSAs, they participate in several primary types of training, namely shadowing other staff and familiarizing themselves with the practice manual. Currently, new kinship staff in five demonstration counties shadow existing kinship staff in some way to learn about the kinship intervention. For example, new staff may complete a home assessment with a kinship staff person or the staff person will accompany new kinship staff as they visit kinship households. In one demonstration county, new kinship staff undergo a long period of shadowing before being assigned a caseload of their own. Two counties regularly distribute the Kinship Supports Practice Manual to new kinship staff and staff in another county referenced the manual as a training resource for kinship staff.

Once kinship staff are on-boarded, they may participate in ongoing training opportunities. These opportunities include receiving training from the local or regional training center; this was cited in 4 counties. In another county, designated kinship staff provide one-on-one coaching as needed. Conversely, kinship staff in three counties noted there were no ongoing training opportunities for them. Staff in one county noted there are not very many trainings available through the regional training center, so staff informally receive training through regular interactions with the kinship supervisor.

As a part of caseworkers' annual state-mandated core training, kinship topics are available to staff; however, kinship staff in only one county referred to this as an ongoing training option. Staff in another county noted that this core training is centered on the importance of least restrictive placements with kin rather than specifically on the Kinship Supports intervention or working with kin caregivers. Four demonstration counties train new staff on practices with kin caregivers during the orientation and initiation process for new hires. And two counties invited kinship staff from another county to do an agency-wide training on the kinship model. One kinship staff person noted that she wished all caseworkers in her county could participate in the OCWTP Understanding Kinship Caregivers training to facilitate their understanding of the unique needs and experiences of kin caregivers. This staff noted that caseworkers may expect kin caregivers to understand Children Services, the court process, and how to generally navigate the system even though caregivers may have had no prior involvement with Children Services.

[111] The manual leaves it up to individual counties to decide exactly how to distribute responsibility for the various kinship coordination functions.

As demonstrated above, counties implement and plan their own various kinship-related trainings for staff—both those staff intimately involved in the kinship intervention and other tertiary staff. In addition to these county-specific trainings, an online kinship supports training was completed in 2015 by the OCWTP in collaboration with volunteers from the kinship supports workgroup. This training, entitled "Implementing the ProtectOHIO Kinship Manual" was developed in 2014 and 2015, was piloted in May 2015, and went live on June 30, 2015. It is available across the demonstration counties, is self-directed, and includes a course for caseworkers and a companion guide for supervisors. The online platform mitigates barriers to training for those counties for whom travelling to the regional training center is burdensome. The caseworker course includes eight modules and covers topics that range from an overview of the model to the intervention tools. Participants can stop and resume the self-directed course at any time, and they complete a variety of tasks designed to enhance their knowledge of the intervention. Since this training was rolled out toward the end of the current waiver period, we have yet to examine how counties have integrated it into their training processes.

Comparison Counties: While comparison counties may not have designated kinship staff or kinship programs, they may still engage in trainings related to their kinship practices and to ensure that staff are adept at collaborating with kin. However, comparison counties are less likely than demonstration counties to provide organized kinship trainings. In at least seven comparison counties, there are no additional kinship-related trainings for new staff beyond core caseworker training. Core training may emphasize the importance of least restrictive placements, but may not elaborate on engagement skills or the unique needs of kin caregivers. In at least four comparison counties, there is more extensive training on kin caregiving. These trainings may be centered on searching for kin and supporting kin. In one of these counties, a designated kinship coordinator leads a new worker orientation session on kinship caregiving and values.

Similar to demonstration counties, there may be a dearth of ongoing trainings available for staff. Staff in five comparison counties noted that there are no ongoing kinship training opportunities for staff. In those counties where ongoing trainings are available, they are provided primarily through local regional training centers rather than by Children Services staff. Additionally, these regional center trainings are optional in at least four comparison counties; that is, caseworkers have the option to go through those trainings or to choose trainings in other topic areas. However, supervisors may assign kinship trainings if they perceive it as "deficit."

4.4.5 Workgroup as Peer-to-Peer Training and Information Sharing

In addition to these trainings, the kinship supports workgroup may operate as a learning platform. During 2014 site visits, designated kinship staff were asked about the quarterly workgroup meetings, including their perceptions of the group and the role it plays in ongoing training or assistance. These staff noted that they really value the networking and relationship-building that has come out of the workgroup. Kinship staff mentioned that connections they've formed in the workgroup with other kinship staff across the state have developed beyond the workgroup. Designated kinship workers will reach out to kinship staff in other counties for feedback and input. Staff appreciate knowing that other counties have challenges too, sometimes with similar aspects of the intervention.

Counties also appreciate the information-sharing that occurs during and as a result of the workgroup. Counties may share forms and documents as a result of the workgroup. For example, staff in one county had not previously considered using written support plans independent of the case plan; they learned about this idea during the workgroup meeting and have now implemented these plans. However, staff in some counties may be hesitant to share or may feel "less knowledgeable," which prevents the group from being truly collaborative. Similarly, differences in practices (including court and custody practices that impact placing children with kin) and resources between counties present challenges in keeping workgroup meeting topics relevant for every county. To mitigate this issue, the workgroup facilitators began dividing the in-person quarterly workgroup meetings into two sections in late 2015: the initial meeting time is utilized for all attendees to discuss general intervention issues, and the latter portion of the meeting is utilized for break-out sessions. These break-out or small group sessions are for staff to divide by county size, staffing approach, or another designated category.

During site visits in fall 2012, the evaluation team interviewed kinship coordinators about their involvement in the workgroup. Kinship staff in 13 counties found the workgroup to be helpful for their work with caregivers and/or caseworkers, primarily because of the opportunity to network and share information with kinship coordinators from other counties. One kinship worker found the workgroup to be confusing because implementation of the intervention varies so greatly across the counties. Kinship staff from two other counties felt that the meetings were too long. Kinship staff from one county had yet to participate in the workgroup.

4.4.6 Kinship Supports Case Management Tools

The Kinship Supports Practice Manual includes case management tools designed to assure specific, comprehensive, and concise focus on kinship caregivers and to ensure the safety of children living with kin. After a kinship caregiver is deemed eligible for the intervention, kinship-specific assessment tools and processes are used to ensure that the kinship caregiver can support the child(ren) in their care, and that services and supports they receive are aligned with their needs. These intervention-specific tools, described in this section, include: Kinship Home Assessment Parts I and II, Family Resource Scale, and Written Support Plan.

4.4.6.1 Kinship Home Assessments

The kinship home assessment is designed to assist with identifying the needs of kin and ensuring the safety of the kinship home. Part I of the assessment tool is completed and collected at the time of initial placement regardless of the type of intended placement (temporary or long-term, any custody status) and is meant to cover the minimum information needed to determine whether a placement is appropriate. Part II is completed and collected at the time that a home study is conducted (Parts I and II may be completed at the same time in some cases), and is a kinship-specific supplement to a fuller homestudy process.[112]

Utilizing the Home Assessment Parts I and II: Designated kinship staff in at least nine counties explicitly indicated that they use the Home Assessment Parts I and II to determine the appropriateness or safety

[112] ProtectOHIO Consortium Kinship Workgroup, 2011

of the placement and to determine whether to move forward with the placement. This is consistent with information collected from kinship staff in 2012, at which time designated kinship staff in eight counties noted that they utilized the information gathered in the home assessment to determine the safety of caregiver homes. It is likely that more counties utilize the assessments for these purposes, as they are the express goals of the home assessment documents. Beyond this core use of the home assessment, designated kinship staff in at least four counties utilize the assessment to advise or inform supervisors or the courts about the caregiver and living environment characteristics. For example, in one county, the courts require a specific narrative home study and the home assessments are used to inform it.

In two counties, kinship staff indicated that Part II of the home assessment may guide discussions about whether it will be a long-term or short-term relative placement and to determine the resources the relatives may need to sustain the placement. Staff in at least one county felt that a strength of the home assessment is that it paints a clear picture of the home, eliminating the worker's opinion about what is risky and what is not and ensuring worker bias is mitigated. Alternately, at least one county indicated that Parts I and II are not really utilized beyond a data collection tool.

As noted in a previous section, data collection responsibilities vary. The caseworkers may complete the Home Assessment Parts I and II, or a specific home study worker or assessor or the designated kinship staff may complete them. Alternatively, separate staff may complete the respective parts; for example, Part I could be completed by the intake or ongoing worker and Part II could be completed by the designated kinship staff. These processes vary somewhat depending on the staffing approach or model utilized (one-worker, hybrid, or two-worker). However, designated kinship staff remain likely to complete Part I; this is the case in 10 counties. And kinship staff were even more likely to have responsibility for completing Part II; this was the case in 12 counties. The intake or ongoing worker may complete Part I of the home assessment and then hand it off to designated kinship staff to complete Part II. In one county, a specific home study worker completes both parts. In most counties, the worker who completed Part I of the assessment is also responsible for Part II. And though the parts may be completed at separate points in time or during separate home visits, most counties complete the entire home assessment at the same time, which is an option outlined in the ProtectOHIO Kinship Supports Practice Manual.

Challenges Related to the Home Assessment: During the 2014 site visits, workers expressed some of the challenges they have experienced related to completing Parts I and II of the home assessment:

- In one county, the designated kinship staff person indicated that open communication may be prevented during the home assessment because the worker must maintain confidentiality around the child's behavioral issues, IEPs, etc.
- Staff who complete the home study at the same time as the home assessment may experience challenges that impact both processes. For instance, staff completing the assessment and home study sometimes question whether or not the home is where the caregiver truly lives.
- Staff in other counties expressed general scheduling barriers, as the home study/home assessment timeframe is often dictated by strict court timelines.

- Staff in at least one county find the home assessment redundant when paired with the other data that the county gathers. Similarly, in 2012, Kinship staff in five counties reported that the information gathered through the home assessment was not useful for their work with kinship families, primarily because it duplicated the information already gathered in their agency's standard home assessment procedures.
- In 2014, one designated kinship staff person indicated that the home assessment itself is too formal, that they themselves prefer an informal, conversational approach, and that the assessment is "just more paperwork."

4.4.6.2 Needs Assessment: Family Resource Scale

The Family Resource Scale is a validated questionnaire that is part of the overall kinship needs assessment. The ProtectOHIO Kinship Supports Practice Manual indicates that the Family Resource Scale (FRS) should be completed by the kinship caregiver(s), one per kinship household, once a kinship family is identified or when a child is first placed with that family, and then regularly thereafter, at minimum quarterly. However, if a caregiver needs help in understanding the questions or how to complete the questionnaire, the worker can assist the caregiver in completing the form.[113]

During 2014 site visits, the evaluation team found that initial FRS is most commonly completed during the first home visit, at the home study and/or during the Home Assessment Parts I and II (or any combination of these, as they are often combined). In at least one county, the FRS is done the first time the designated kinship staff or another worker meets with the kinship caregiver, which is likely during the home study though it could also be at the agency. In one other county, the FRS is sometimes completed during a Family Team Meeting.

Staff in seven counties explicitly indicated that the kinship caregiver completes the FRS themselves, though the process by which this occurs varies. For example, in some cases, caregivers complete it while staff are present for the home assessment; at least one county used to leave it with the caregiver to complete and mail back to the agency but has since changed its process and now completes it in the home with the caregiver. In one county, workers use a hybrid approach whereby the staff person asks the caregiver the questions and completes it with them. In another county, practice varies: Staff sometimes give the caregiver the form to complete independently and other times complete it together with the caregiver. In at least one county, the regular practice is for designated kinship staff to complete the FRS independently at the office after completing Part II of the home assessment.

The information gathered from the FRS is used primarily to identify needs and related services and resources. Staff in four counties indicated that they also use the tool to monitor changes in needs over time and to make changes to the case plan as necessary. Staff in at least one county mentioned that the FRS is helpful in ensuring the designated kinship worker or caseworker remains aware of and sensitive to the realities faced by kin caregivers and in ensuring that the county is able to be successful in their supportive roles for the caregiver.

[113] ProtectOHIO Consortium Kinship Workgroup, 2011

Challenges with the Family Resource Scale: In addition to multiple ways in which staff may utilize the FRS, there are ways they may experience the tool as challenging. In some counties, workers identified specific challenges with the tool itself, stating that it is administered too frequently, is not an appropriate tool for homes with multiple adult caregivers (one county), and expressing frustration that SACWIS does not support entry of the FRS (one county). Staff in one county raised the concern that not all questions are appropriate for a Likert scale and stated that some of the questions should be open-ended. Similar to the feedback given about the home assessment, some kinship staff simply feel like everything on the scale would naturally emerge informally in conversation with the kinship caregiver and therefore the tool is unnecessary.

Other challenges relate to the administration of the tool. The most common is that staff feel uncomfortable administering the tool or they perceive that families are resistant or uncomfortable with it. Staff in nine counties expounded on this challenge:

- Staff feel that the tool is culturally insensitive or imposes a narrow, agency-centric view of "need." One designated kinship staff person noted that they felt uncomfortable and insensitive asking about access to dental care when access was obviously lacking.
- Staff believe that it is offensive to ask about time alone and vacation because the socioeconomic status of most caregivers prevents them from access to those privileges.
- Staff believe that if the agency cannot meet an identified need, they should not ask about it. For example, asking about vacation and monetary savings may be perceived as irrelevant because the agency is not going to provide those for the caregiver. There's a sense that these questions may even mislead caregivers into thinking they will be helped with these quality of life components. One designated kinship staff person said, "Unless we can be part of the solution, we shouldn't identify it as a problem." Similarly, with such an emphasis on needs, some staff administering the FRS feel it prevents strengths-based interactions with caregivers.

Staff in at least five counties also reported concerns with the accuracy or validity of the results. Caregivers may be apprehensive about accurately conveying their level of need when they are being evaluated as a potential placement. That is, caregivers are concerned the FRS impacts the decision to place the child with them and, as such, may underreport needs and over report resources. One worker summarized it in this way: "Families don't always trust the agency, so they don't necessarily want to ask for their needs to be met."

4.4.6.3 Written Caregiver Support Plan

After completing the Family Resource Scale, the intervention stipulates that a support plan is to be developed for the caregiver. This can be incorporated into the case plan or completed as a standalone document according to legal protocol or policy with the county. Although the support plan currently has no standard format, the Kinship Supports Practice Manual indicates that it should be: individualized,

based on needs assessment results, and reviewed, monitored, and updated regularly (every 90 days, in conjunction with review of the Needs Assessment).[114]

During the 2014 site visit, staff in 13 counties noted that they were completing some sort of caregiver support plan. Staff in one of the remaining three counties noted they were explicitly planning on implementing a support plan though had not as of 2014, staff in another county noted that capacity has prevented them from implementing a support plan, and information was unavailable during the site visit for the remaining county. Because counties are given autonomy to determine the best way and mechanism of completing the support plan, those 13 counties utilizing support plans for kin caregivers were split with regard to whether they complete a standalone caregiver support plan or simply utilize the existing family case plan as the mechanism for documenting caregiver needs. One county clearly has a support plan in place, but it's unclear if it is incorporated into the case plan or not.

In six counties the case plan doubles as the caregiver support plan. Within these counties, however, the case plan may vary in the level that it addresses caregiver needs. In some counties, the existing case plan does not reflect particular support that the caregiver needs; instead, it generically indicates caregiver needs. In other counties, specific caregiver needs are outlined in the case plan. In counties where the case plan doubles as a support plan, the case plan is often completed during the FTM.

In the six other counties, designated kinship staff develop a separate caregiver support plan apart from the case plan. The specifics of the plan vary; some are informal write-ups of needs while others are written documents that are inputted into the SACWIS activity log and updated during each home visit.

These proportions represent a shift over the course of the waiver; in 2012, only four counties completed a separate support plan document, while 10 counties tracked caregiver goals in the case plan.

Within those six counties that complete a standalone caregiver support plan, staff in five counties involve the kinship caregiver in the development of the plan by letting them know the plan is being created, soliciting their involvement in its development, and/or offering a copy to the caregiver (though at least one county indicated that caregivers do not often want a copy). Staff in one of these counties indicated that caregivers *are* involved in developing the standalone support plan, but may find it overwhelming. In one county, a designated kinship worker indicated that the caregivers are unaware of the support plan and therefore not involved in its creation.

Counties may utilize the Family Resource Scale results to guide and formulate the support plan or the caregiver needs section of the case plan. Designated kinship staff in at least nine counties utilize the FRS to inform the support plan; however the extent to which it's utilized varies by county. While workers in some counties simply "glance at the FRS," workers in other counties indicated the FRS really guides and shapes the support plan.

As of 2014, no comparison counties were completing any sort of needs assessment tools for kin beyond a standard safety assessment, though some counties do complete a support plan for kin. Staff in seven comparison counties indicated that a support plan is created for kin, though the case plan for biological

[114] ProtectOHIO Consortium Kinship Workgroup, 2011

parents doubles as the support plan for kin in six of those counties. That is, only one county employs a standalone written caregiver support plan, though completion of the support plan is voluntary.

Advantages and Disadvantages of the Caregiver Support Plan: The caregiver support plan comes with both strengths and challenges. Staff in one county indicated that the plan is a good reference for the caseworker to see what services and supports are being provided to the kinship caregiver by the designated kinship staff. Counties also experience challenges: caregivers involved in the support plan development may make requests for support that the county cannot meet, or, conversely, caregivers may inaccurately indicate they do not require any support to maintain the placement. Additionally, caregivers may make comparisons between what they and other caregivers are receiving, or as staff in one county noted, between what licensed foster parents receive and what caregivers receive; this can be a challenging conversation for kinship staff to have with the caregiver.

Overall, the caregiver support plan may be the component of the intervention that most directly impacts caregivers: while other intervention tools are designed to measure the safety of homes and caregiver needs, the support plan is more indicative of direct support that caregivers will receive. However, it is perhaps the most loosely structured component in the ProtectOHIO Kinship Supports Practice Manual. This has been discussed throughout the kinship supports workgroup quarterly meetings this past year, and initial planning has begun to consider consolidating this aspect of the intervention, though it's still early in the planning process.

4.4.7 Services for Kin Placements in Demonstration Counties

A primary component of the evaluation of the intervention, as described in the Phase 3 Evaluation Plan, is analysis on case services utilization. This information was not available in the past because not all counties were fully using the case services module, and counties that were utilizing the module had experienced frustrations with its practicality. Enhancements to the services component of SACWIS that were implemented prior to the intervention start date increased the utility of the module.

The services data consists of information about services that are recorded as 'needed, referred, scheduled, or provided' for children and adults served by the PCSAs. Since service referral and provision are core components of the intervention, and all counties were expected to be using the module during this phase of the waiver, an examination of services data was intended to be an integral aspect of the kinship supports analyses. However, through kinship supports workgroup and Consortium meetings it was brought to the evaluators' attention that many agencies were not entering complete case services data into SACWIS and that workers viewed the process as cumbersome, time consuming, and lacking in value.

This topic was discussed both within the Consortium and the workgroup over the course of several months in the late spring through early summer of 2013. In June 2013, the kinship workgroup held a conference call for the purpose of coming to a consensus on a recommendation for the Consortium regarding intervention case services data entry into SACWIS. The group considered four possible options, including adopting one of the various counties' methods for entering case services, modifying SACWIS, and building case services data-entry fields in PODS. Ultimately, however, the group concluded that all demonstration counties should begin entering complete case services data into the existing SACWIS case services module effective Aug. 1, 2013. The group also recommended that the state

provide mandatory trainings on entering case services, including a one-hour instruction session and an additional two hours of hands-on support for county-specific situations for which workers may need technical assistance. On June 11, 2013, the Consortium approved the proposed plan via a conference call meeting. Subsequently, two mandatory trainings on managing case services in SACWIS were held, on July 12, and July 17, 2013; representatives from all demonstration counties attended these trainings.

Although initial feedback related to the trainings was positive, the 2014 site visit interviews revealed that workers found the process of entering case services to be burdensome. Workers across several counties indicated that they often utilize the broader category of "case management" as a catch-all for a range of services they provide, in order to avoid completing time-consuming service reviews for each individual service every 90 days (a mandatory requirement). And it became clear that agencies are not entering services data into SACWIS in the same manner or with equivalent frequency.

To gather information on services qualitatively, the evaluation team asked kinship staff about the services they provide to caregivers. Overall, counties vary in the level of services and resources they're able to provide for kin caregivers. Some counties, for example, are able to provide an array of services, including hard goods, clothing, food vouchers, cash benefits, and daycare. Others remain more limited in what they are able to supply, and they might primarily provide referrals to community services or help kin caregivers complete application(s) for cash assistance or SNAP benefits.

Services and supports may be provided by agencies through several funding streams, including Title IV-E waiver flexible funding, Emergency Services Assistance (ESSA) and or PRC funds. Although all agencies likely provide case management and referrals for kin, kinship staff noted during the 2014 site visits the additional and various types of supports and hard goods their agencies are able to provide for kin caregivers. Examples include:

- Assist caregivers in applying for other JFS services, such as SNAP benefits, TANF, or medical benefits (cited in 9 counties).
- Clothing or clothing vouchers for kids (cited in 9 counties).
- Food or vouchers for food (cited in 8 counties).
- Transportation assistance, such as bus passes or gas cards (cited in 6 counties).
- Furniture, such as beds, cribs, dressers, or car seats (cited in 5 counties).
- Financial or cash assistance (cited in 5 counties).
- Assistance with rent, housing deposits or utilities (cited in 5 counties).

Other services cited by fewer counties include gifts at the holidays (cited in 2 counties), school or extracurricular activity fees (cited in 2 counties), toiletries (cited in 2 counties), and items for infants such as diapers, wipes, and formula (cited in 2 counties).

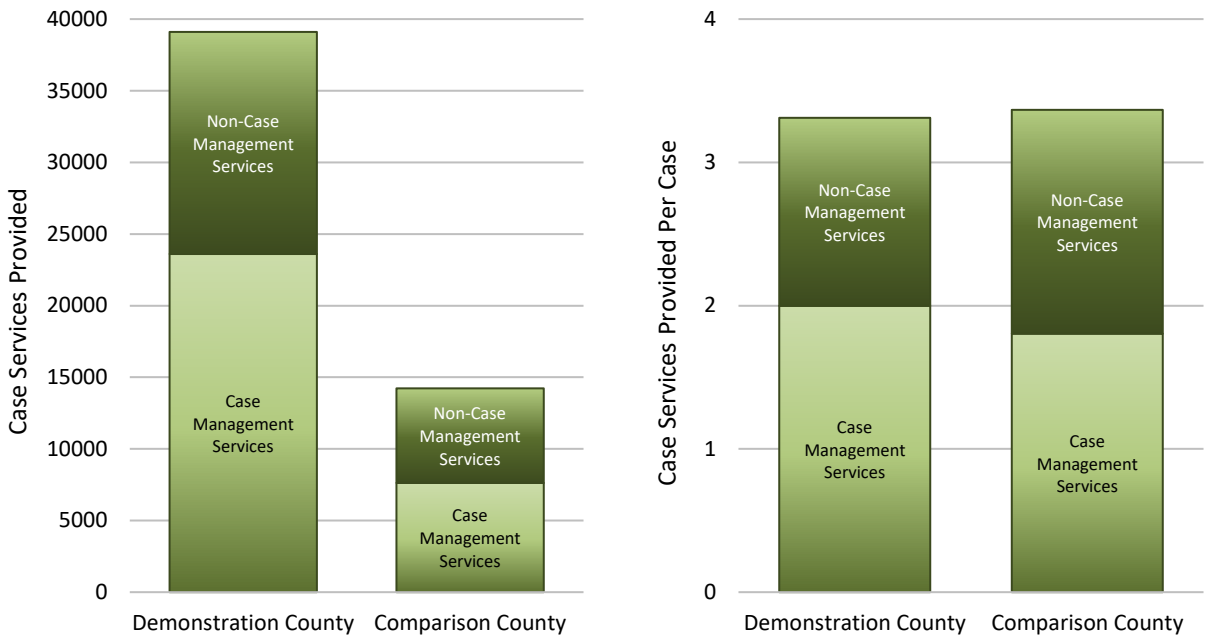
Counties may delimit the services provided. For instance, one county can provide food vouchers for caregivers, but only once a year. Or, in several counties that provide cash assistance, the assistance is provided at the time of initial placement or provided only for blood relatives caring for children. Counties may also experience tension around supplying what the caregivers need to maintain the placement, while also ensuring the placement can be sustained over the long term without agency involvement.

In addition to the qualitative information provided by kinship staff, the evaluation team received SACWIS services data for the purpose of conducting some exploratory analyses. Below, a limited set of case services analyses are presented; however, due to the systematic, between-agency differences in case services data entry, accurate comparisons between demonstration and comparison county groups are challenging. Results from these analyses are limited and should be interpreted cautiously. The analyses cover the time period of August 2013 through July 2015. We report "case management" separately for most analyses since this was the category type used most frequently across both demonstration counties. Other service category types (e.g., "financial support," and "childcare") are grouped together into a separate "non-case management" category. However, because some agency staff indicated that they use the case management category even when providing families with more particular services, the extent to which non-case management services were provided is unknown.

Total Case Services Provided: The first set of analyses examines differences between demonstration and comparison county agencies in their provision of services to any case members (i.e., these analyses are not kinship-specific). As seen in Figure 4.1, demonstration county agencies reported providing significantly more services in general (39,105), compared to comparison county agencies (14,227). The chart on the left side of the figure demonstrates the raw number of services entered into SACWIS. Given the recent focus on case services data in demonstration counties, however, it is likely that demonstration county staff are *entering* more case services data into SACWIS rather than *providing* significantly more services to families. To show a more comparable representation, the chart on the right side of the figure displays the average number of services entered per family, for each family that had at least one service recorded as having been provided (i.e., only those cases for which data has been entered were analyzed).

On average, demonstration and comparison counties recorded just over three services per family. However, the proportion of case management versus other service category types was slightly higher among demonstration counties (approximately 60% case management, 40% other) than in comparison counties (approximately 54% case management, 46% other).

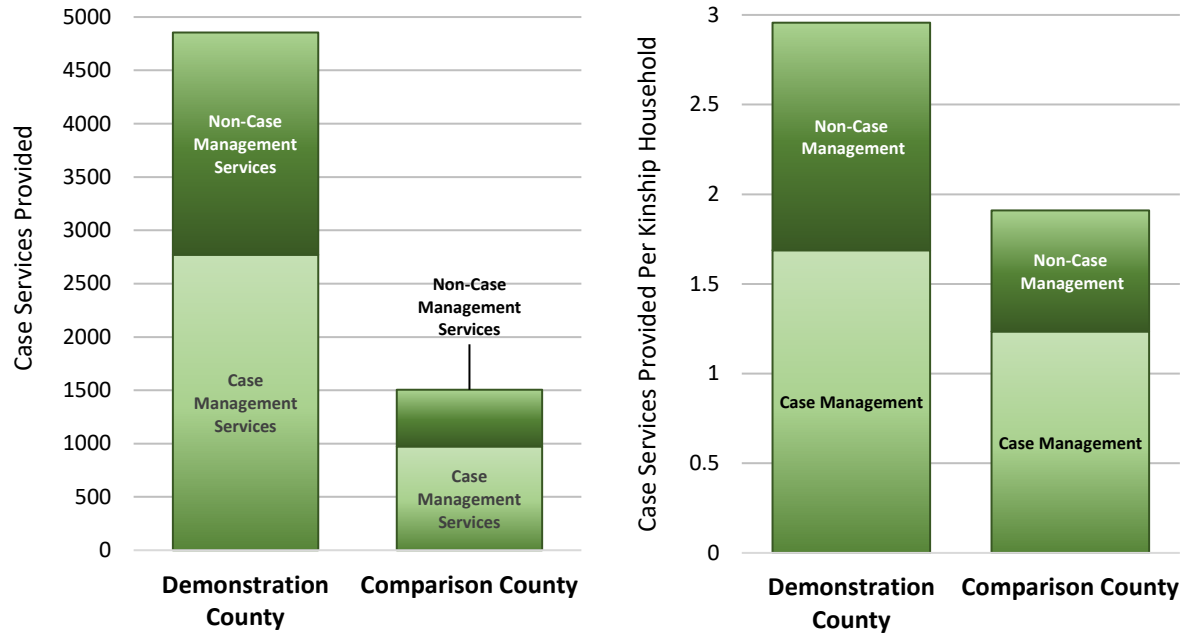
Figure 4.1: Case Services Provided to All Placements – Demonstration & Comparison Counties



Services Provided to Kinship Families: While the figures above are useful in providing a context for understanding the rate at which services are being provided to families on a general level, and the extent to which services are entered into SACWIS across demonstration and comparison counties, the intent of the case services analysis for the intervention is to understand the extent to which services are provided to kinship families. The following analyses focus explicitly on services recorded in SACWIS that were provided to children or kin caregivers during a kinship placement or living arrangement.

Interestingly, with these parameters set, we find that case services data were available for all 16 demonstration counties but only for 11 of the 16 comparison counties. Whereas staff in all 16 comparison counties entered some level of case services data into SACWIS (in the more general case services analyses above), 5 of these counties have no services data specific to kinship households. It follows that either services are not being provided to kinship households in these county agencies or workers are not entering services specific to kinship households, possibly because of the data-entry issues described above.

Figure 4.2: Case Services Provided to Kinship Households – Demonstration & Comparison Counties[115]



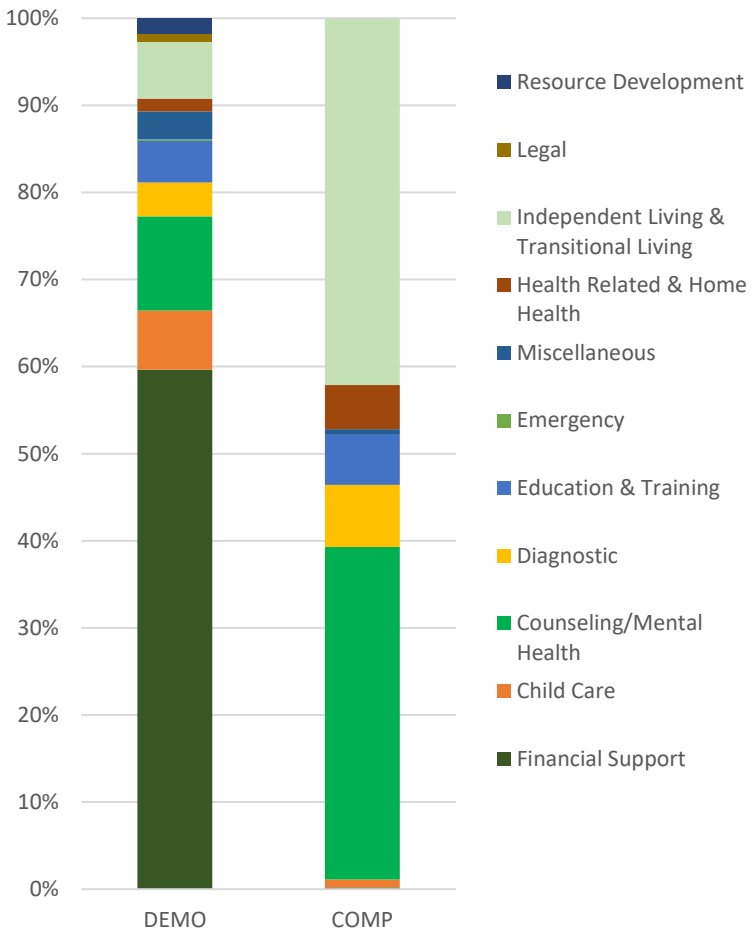
When examining the kinship-specific services data that *were* entered, we find more pronounced differences between demonstration and comparison counties than when we examined case services provided to case members in general. The chart on the left side of Figure 4.2 shows that demonstration county agencies reported over three times as many kinship-specific services as comparison county agencies. And, nearly half of the services recorded in demonstration county agencies were services other than case management, compared to only a quarter in comparison county agencies. However, these findings could again be due to demonstration county agencies' recent focus on entering case services data.

Perhaps more interestingly, the chart on the right side of Figure 4.2 shows the average number of services provided to kinship households. Similar to the more general analysis, this analysis used only those kinship families for whom at least one kinship service was provided (i.e., only those cases for which data has been entered were analyzed). As shown, demonstration county agencies reported providing just under three services per kinship family (m = 2.96, SD = 2.57), while comparison county agencies reported providing just under two services per kinship family (m = 1.91, SD = 2.57); this difference was statistically significant ($p < .001$).

[115] The chart on the left reflects the frequencies of case services provided, as reported by Demonstration and Comparison counties. The chart on the right reflects the number of case services provided per Kinship household, as reported by agencies in Demonstration and Comparison Counties. The portion of Non-Case Management case services provided are shown in dark green.

Types of Non-Case Management Services Provided to Kinship Households in Demonstration and Comparison Counties: To illustrate the types of individual services that are being provided to kin families, Figure 4.3 displays the types and proportions of non-case management services that were recorded as having been provided to kin households among demonstration and comparison county agencies. Interestingly, the types of services most commonly provided vary substantially between demonstration and comparison counties. Among comparison counties, the most common non-case management service was Independent Living/Transitional services, representing 64% of non-case management services; in comparison, Living/Transition services accounted for only 6% of non-case management services in demonstration counties. This could indicate a focus within comparison counties on planning for alternate living situations rather than support for kin placements. Among demonstration counties, Financial Support was the most common non-case management service, accounting for 60% of all non-case management services. By contrast, comparison county agencies recorded providing virtually no financial support to kin families (less than .00% of non-case management services). Although there are limitations to the case services data, it is likely that the increase in financial supports recorded as having been provided to kinship families in demonstration counties are a result of waiver flexibility with IV-E funds.

Figure 4.3: Types of Non-Case Management Case Services Provided by Demonstration and Comparison Counties



4.4.7.1 Child Care for Children in the Care of Kin

As demonstrated in Figure 4.3, childcare is one non-case management service provided in both demonstration and comparison counties; however, as Figure 4.3 underscores, demonstration counties provide child care more often. During the 2014 site visits, the evaluation team learned that half of the demonstration counties are generally able to provide daycare, while only roughly one third of comparison counties are able to do so.

During the 2014 site visits, child care emerged as a service that is often needed or requested by kin caregivers. County staff identified child care as necessary to sustain and maintain placements. In some counties, child care for children in the care of kin emerged as a service gap. If caregivers do not meet the income restrictions for subsidized child care through the Ohio Department of Job and Family Services, counties may be unable to subsidize or absorb the cost. If caregivers do qualify for publicly subsidized child care, they may require other services and supports from the agency to maintain the placement

since their income is likely at 130% of the poverty rate or lower for initial eligibly.[116] Additionally, even if kin qualify, they may still be required to pay a fee or co-pay, though some counties are able to contribute to these co-pays for kin. Conversely, if caregivers do not qualify for publically funded child care through the state (ODJFS), the additional expense of paying for daycare for one or more children may impose a substantial burden and strain on the placement; one interviewee termed this a "big obstacle" for kinship caregivers.

Demonstration counties reported a range of approaches and policies to providing kin caregivers with child care if they do not qualify for subsidized daycare through the ODJFS. In nearly all counties, kin caregivers are expected to apply for child care through ODJFS prior to Children Services contributing to daycare expenses. If kin do not qualify or meet the income restrictions, half the counties are generally able to pay for child care, though provision of child care may be contingent on the caregiver working or going to school or the agency maintaining custody of the child. Staff in one of these counties noted that they provide child care because "it doesn't seem fair" that the kin caregiver would need to adapt their quality of life and (often limited) disposable income to pay for it. In one county, the agency will pay for child care, but staff noted that a lack of child care providers within the county posed a challenge for kinship caregivers. In three demonstration counties, the agency is sometimes able to provide child care on a case-by-case basis or may split the cost with the caregiver. And in five demonstration counties, agencies are generally unable to pay for child care. One of these counties is able to pay for childcare in the short term, until publicly funded child care can be arranged, but cannot contribute over the life of the case. One of these large counties noted that a "majority" of kinship caregivers need assistance with child care.

During the summer of 2014, the evaluation team conducted focus groups with kinship caregivers; two caregivers were from counties who reported being unable to pay for child care for kin caregivers, three were from counties able to contribute to child care, and one was from a county that is able to provide child care on a case-by-case basis. When asked about the services or help that caregivers could use but were not offered, those caregivers in those counties unable to pay for child care or only able to pay for daycare on a case-by-cases basis did not mention day care or child care as a need, though one caregiver mentioned that periodic respite care would be helpful.

Comparison Counties: Comparison counties are less likely to provide child care than demonstration counties; during 2014 site visits, only five comparison counties indicated they are able to provide child care for kin caregivers beyond state-funded child care. Two of these counties noted that they only provide child care on a very limited basis, for a short period of time, or if it may make a difference in the caregiver's ability to maintain the placement. Consequently, only three comparison counties regularly pay for or contribute to child care costs. Inability to provide child care is seen as a barrier in comparison counties.

4.4.7.2 Court Support for Kin Placements and the Kinship Supports Intervention

Because the courts are integral child welfare partners, demonstration counties have put time and energy into educating judges and court representatives about both the importance of least restrictive

[116] Ohio Department of Job and Family Services, n.d.

kinship placements and, more specifically, the ProtectOHIO kinship intervention. Efforts to involve the courts include educating court staff through presentations and collaborative meetings as well as having regular communication or staffings with court staff. In two demonstration counties where the courts are perceived as resistant to kinship placements, child welfare agencies have not had success at engaging the courts in the intervention through education or collaboration. In three demonstration counties, those staff interviewed did not report any specific mechanisms designed to involve the courts, though staff note that the courts in their counties are invested and bought into the intervention and kinship placements. In all, staff in six demonstration counties explicitly indicated that they have strategically involved judges, magistrates, or attorneys in the intervention through formal or informal means.

As noted above, courts and judges vary in their level of support for kinship placements. For example, a new judge in one county is perceived as more supportive of kinship placements than a previous judge. Staff in 11 counties feel that their courts are supportive of and generally value kinship placements; in 1 of these counties, however, the judge is perceived as inconsistent in his custody decisions. In some of those 11 counties, trust exists between the agency and the courts, and the judge values the agency's judgment and trusts that the PCSAs are committed to keeping children safe, even if children are with kin. In another county, the judge's long tenure has allowed him to see kinship placement success; as a result, he is a proponent of least restrictive placements. Alternatively, courts in three counties are not perceived as supportive of kinship placements. Agency staff in two of these counties noted that their judge's mentality tends to be that "the apple doesn't fall far from the tree," and judges are therefore hesitant to place children with relatives or kin. The third county mentioned above has been improving its relationship with the courts after an especially tumultuous relationship in previous years.

Comparison Counties: Among the comparison counties, staff in all 16 counties feel that their courts are supportive of and generally value kinship placements; however, staff in one of these counties indicated that court support has fluctuated over time. Examples of ways in which courts are supportive include: courts will place with kin who do not pass the home study as long as kin is perceived to be safe, courts readily grant legal custody to kin, the judge or magistrate encourages Children Services staff to search for kin, and kin are invited and encouraged to speak in court. Staff in two counties noted that the courts are "too" supportive, preferring to grant custody to kin rather than moving toward reunification or granting custody to relatives who do not request custody nor have the capacity or resources to care for the child(ren). In seven comparison counties, staff have engaged in some sort of conversation, collaboration, or training with court representatives around the importance of kin placements.

4.4.7.3 Kinship Navigator Programs

Kinship navigator programs emerged nationally to provide needed information and referrals for services to grandparents and other relatives raising children.[117] In 2009 through2012, seven ProtectOHIO counties were part of a three-year Kinship Navigator demonstration project; these included Ashtabula, Clark, Crawford, Hardin, Lorain, Portage and Richland. The Kinship Navigator Project differed from the ProtectOHIO kinship model in several ways:

[117] Grandfamilies.org, 2014

- The Kinship Navigator program may be located within a community agency rather than as a part of a Children Services agency.
- Under Kinship Navigator, the kinship family's participation is voluntary.
- Anyone can refer a family to the Kinship Navigator Program.
- Kinship Navigator families can continue to receive formal and informal support as their case is not time-limited.

Although the Kinship Navigator project has ended, five ProtectOHIO counties have continued their Navigator programs; these programs provide support for kin caregivers beyond the support provided through the kinship intervention. One additional county had a Navigator program that ended halfway through the third waiver period, in 2012. The majority of demonstration counties (11) do not have Kinship Navigator programs. Of the five counties with Navigator programs, three are housed within the local counties' Department of Job and Family Services and two are housed externally in the Office of Aging and through the Council on Aging. In one county that houses an internal Kinship Navigator, the Navigator program was previously located within another community organization. Comparatively, three comparison counties have Navigator programs, two of which are internal and one of which is located at a local university. While these programs may allow counties to meet some of the needs of kin caregivers, these programs do not necessarily correlate to the needs assessments or support planning services for caregivers in demonstration counties.

All of these Navigator programs provide support for kinship caregivers with closed cases or kinship caregivers who have not been involved with child welfare. These programs may prevent kinship cases from opening and decrease the number of cases coming into the agency, because caregivers are able to access referrals and supports elsewhere. While it's challenging to measure the benefit of diverting cases from child welfare, one county noted that, as of the day of their 2014 site visit, not a single child served by their Navigator program has come into agency custody. However, Navigator programs may not provide the same hard goods or financial benefits the child-serving agency can provide.

Navigator programs might provide referrals to other community agencies, house a food bank, and organize support groups and holiday parties. In two counties, the Navigator program is able to assist kin caregivers who are seeking custody of the children in their care and are sometimes able to assist kin caregivers seeking custody with legal costs, though program funding was recently decreased.

The level of collaboration between the kinship worker within the agency and the kinship navigator staff vary. In one agency that houses an internal Navigator program, there is significant cohesion between the programs since the kinship coordinator is also the Kinship Navigator. She provides similar supports and services for kin that have placements and informal kin; the funding mechanism simply varies depending on which program the kin is eligible for. In one county, kinship staff noted they may turn to the Navigator program to see if services or supports can be provided through that program; the same county noted that staff regularly communicate with the Kinship Navigator. In another county, some kin staff noted that they have not had communication with the Kinship Navigator.

4.4.7.4 Resource Guides or Handbooks

Along with material resources for kinship caregivers, some demonstration counties have additional resources, at either the county or community level, to support caregivers. In a 2014 pre-site visit survey, staff in 15 out of 16 demonstration counties indicated that their county has some sort of kinship resource guide or handbook available. The Ohio Kinship Resource guide is the most widely used among these counties. It is provided at different points of contact with kin, such as during the home study or home visit, and is also made available to caregivers in one county through the Kinship Navigator program. Six demonstration counties have a county-specific or local kinship resources handbook that is provided during home studies or home visits. Other kinship resources include a local community provider hotline and support groups.

Comparison Counties: Demonstration counties are more likely than comparison counties to utilize and provide resource guides, perhaps as an element or offshoot of the ProtectOHIO kinship intervention and comprehensive approach to serving kin and sustaining kinship placements. In a pre-site visit survey of comparison counties, 10 of the 16 comparison counties, or 63%, indicated that there is a kinship resource guide or handbook available, compared to 94% of demonstration counties.

4.4.8 Diligent Search Activities

In 2014, the evaluation team explored county family search activities and practices, including the ways in which they intersect with the ProtectOHIO strategies. While diligent search is not a direct component of the kinship intervention, these activities support the intervention in that they are geared toward finding suitable kin placements. The diligent search processes varied across counties, including as relates to search methods, staff involved, the stage at which the search is begun, and the length and focus of the search.

Thirteen counties continue to utilize traditional means of search and engagement, such as snowballing conversations with parents and other kin to identify potential kinship caregivers. More than half of the counties—nine—utilize this word-of-mouth information to build genograms and family trees. Some counties, however, have expanded their efforts to include online search programs; staff in five counties indicated they have enrolled in some sort of paid search program such as LexisNexis. Beyond paid subscriptions, counties utilize other online forums, such as general search engines or federal and state sites.

Social media is an emerging platform for diligent search**;** at least four counties use it in some capacity to search for family and potential kinship placements. Staff in one county indicated that social media is solely used to aid in the search for noncustodial parents rather than for extended family or fictive kin. Staff in another county said social media is complicated by the fact that staff have to use their personal account rather than an agency account. Staff in one county indicated that there's a county policy limiting staff access to social media. Additional offline search methods include combing through SACWIS for related parties and utilizing child support databases to search for noncustodial parents.

In 15 counties, the search process begins between screening or intake or within 30 days of removal; some of these counties begin searching before removal, with 1 county indicating that police officers may begin the conversation about potential kinship caregivers at the home. In the remaining county, removal

criteria or custody status may determine when the search begins. Because the searches are likely to begin in intake, intake workers are commonly involved in the search process; in 10 counties, the search is conducted by the intake worker and then continued by the ongoing worker. And in 2 counties, designated kinship staff may also be involved in the search to some capacity.

While all counties begin the search at the start of the case, counties vary in how long or to what extent the search continues. Staff in 12 counties indicated that the search continues in some capacity beyond the identification of an approved kinship caregiver. Only one county indicated the search does not continue in any capacity once a kinship caregiver is identified. Most counties continue a less rigorous search once a kinship caregiver is approved. For example, one county eliminates the more official modes of search and just conducts word-of-mouth searches once the child is placed with kin. Two counties continue searching only for noncustodial parents and cease the search for additional kin or fictive kin. One county moves its search and engagement focus to adults who can support the kinship caregiver by providing respite on the weekends. Six counties conduct a placement-focused continued search, in order to identify an alternative placement or a contingency placement in the case of placement disruption or a non-permanent living arrangement.

Some counties have identified a relationship between the search efforts and the FTM intervention. In this way, these two ProtectOHIO interventions overlap in efforts to emphasize kin placements. In one county, the FTM facilitator is responsible for the continued search, and in four counties, the FTMs are a forum for parents to continue to identify kin and fictive kin. In one county, there is a specific parental document completed at the FTM that informs the search.

4.4.9 Kinship Supports Benefits

During the 2014 site visits, designated kinship staff in all demonstration counties discussed what they saw as the core of the Kinship Supports intervention and what they perceive its value to be for kin caregivers. And in the summer of 2014, kin caregivers in six demonstration counties participated in focus groups, where they elaborated on the benefits and challenges of the support they received. Two major overlapping themes emerged from both staff and caregiver focus groups: emotional and material supports.

- **Emotional Support – Caregiver Perspective:** Caregivers indicated satisfaction with kin coordinators who they viewed as accessible and approachable, supportive and understanding. Caregivers addressed the ease and timeliness of services, and reported that without this relationship, interactions with child welfare seem invasive and that they in turn are hesitant to ask child welfare for services or hard goods due to pride. Caregivers reported that the supportive relationship helped them to feel less alone and isolated, and they linked this emotional support with easing the stress of having children in their home. A caregiver in one county noted, “I could not have survived without the Kinship Program. They are there to help you help the kids. I felt 100% supported.”
- **Emotional Support – Staff Perspective:** Kinship staff agreed that emotional support is a key value of the intervention. In describing what they meant by emotional support, staff mentioned talking on the phone with the caregiver and sending them meaningful items or tokens (such as calendars). Similar to what kinship caregivers in three counties said, staff also indicated that,

under the intervention, with more staff dedicated to kin, caregivers feel they have someone they can talk to and connect with. And, in some counties, they feel like they have one specific person who understands them and their needs, and to whom they can turn. One staff termed this "support just for them." Another worker said, "A lot of the kinship caregivers are surprised about having a coordinator and they appreciate it."

- **Material Support – Caregiver Perspective:** Caregivers indicated that prompt services and supports are important to meet their physical needs and that provision of these supports also allow them to focus on caretaking and maintaining their other professional or personal roles, contributing to the stability of the placement. One caregiver noted that the agency purchased and offered to install smoke detectors in her home; another caregiver indicated that help at the holidays and financial assistance were the most valuable aspects of the services she had received. Caregivers also mentioned that they received help from the agency to pay for childcare, or assistance with negotiations around childcare costs. Other caregivers indicated that kinship staff also provide assistance in understanding and navigating the social services system, including explaining the expectations the agency had for them and helping them apply for public benefits. One caregiver noted, "They've helped me with anything I've ever asked them for—if they can't do it they go out of their way to direct you to agencies that can."
- **Material Support – Staff Perspective:** Designated kinship staff in six counties indicated that a primary benefit of the intervention for caregivers is access to material support. Staff indicated that the model has allowed kinship caregivers access to material services and supports, such as hard goods and, in some cases, financial assistance. Designated kinship staff also mentioned that simply providing referrals to community-based services and increasing kin awareness of available services is an important part of the intervention for caregivers. Kinship staff in at least two counties also indicated that they help kin navigate the child welfare system, including helping them complete benefits applications and serving as an agency liaison by helping them understand agency expectations.

Two additional themes emerged from kinship staff interviews and focus groups:

- **Kinship Supports and FTM:** Kinship staff within two counties indicated that they believe the value of the intervention is that kin caregivers are invited to be more involved in the case, attending Family Team Meetings and sharing their perspective. Staff in one county indicated that through FTM, Children Services hears the kinship caregiver's "side" rather than just the biological parent's side, which is beneficial to the caregiver and to the case overall.
- **Kinship Supports and Family Culture**: When asked about the role of the interventions in attending to family culture, staff noted that a benefit of the intervention is its support for kin caregivers who may be culturally similar to the children in their care. Staff in nine demonstration counties believe that an emphasis on kinship care, as well as the support that kin are able to receive through the intervention, ensures that kids are placed with their extended family or fictive kin and live within their own cultural, ethnic, or racial heritage. One staff member said, "The primary culture is family, so if you can stick with that you can preserve culture." Kinship staff in one county indicated that the FRS is helpful in illuminating family culture, and that the

expected contact between the kinship worker and family during the home assessments, FRS, and support planning allows the worker to really understand the family. In another county, staff said that the national child welfare mentality in years past was to place children in foster care, but now "It doesn't need to be someone with a white picket fence, it just needs to be someone that has a relationship with the kid." The literature underscores this; for example, Harris and Skyles (2008) note that placing African American children—which is the largest group of non-white children represented in Ohio's child welfare system—with kin helps them to maintain "emotional ties to extended family."[118]

Demonstration County Caregiver Engagement Findings: Along with caregiver focus groups, the evaluation team also collected qualitative information from caregivers via a paper survey on their experiences with the intervention. The survey included questions related to the quality of their relationship and communication with their designated kinship staff. In each demonstration county, kinship staff were asked to give each caregiver a survey to complete 90 days after their initial home assessment was completed, or at case closure if that occurred first. Caregivers were incentivized with a gift card drawing to return the completed survey directly to the evaluation team via a self-addressed stamped envelope. Overall, a total of 258 caregiver surveys from 15 demonstration counties were returned between Oct. 1, 2013 and March 31, 2015.

Similar to the sentiments that emerged in caregiver focus groups, the majority of caregivers responded positively to questions, most often indicating agreement or strong agreement to affirmative statements regarding their experience with kinship workers. The means in Table 4.3 show that on a scale of 0-3 point scale— where 0= strongly disagree and 3= strongly agree—, caregivers on average agreed or strongly agreed with all of the statements asked about their kinship worker. The two statements with the highest means (though, as stated above, all were high) illustrate that, as caregivers noted in focus groups, their relationship with designated kinship staff were perceived as important and positive; caregivers indicate they are treated with respect and listened to.

[118] Harris & Skyles, 2008

Table 4.3: Caregiver Engagement Survey Findings	
I feel that my kinship/case worker has……	**Mean** (n=258) 0 = strongly disagree… 3 = strongly agree
Treated me with respect.	2.60
Listened to what I have to say.	2.54
Kept appointments with me.	2.53
Understood my concerns.	2.48
Been straight-forward with me.	2.47
Valued my opinions.	2.47
Recognized my strengths.	2.46
Been committed to helping me.	2.45
Clearly explained my options.	2.41
Made it easier to care for my kin children.	2.39
Followed through with the tasks necessary for addressing my needs.	2.37
Been easy to get in touch with when I have needed something.	2.37
Clearly laid out how to address my needs.	2.36

Caregivers were also given the option to provide open-ended information they wished to share; many caregivers used this opportunity to thank their kinship workers or praise the kinship program, often underscoring viewpoints that emerged in focus groups:

- "[My kinship worker] is a godsend. She has helped me with this child every step of the way, she helps make it easier, and when I need someone to talk to she's always there for me."
- "This is one of the best-created programs for helping families. Kudos to all that are involved in helping families care for children in need. Thank you."
- "I am so grateful for this program! I don't think I could take care of my two grandkids if it wasn't for the kinship program. I am so thankful for your help."

> *"I am so grateful for this program! I don't think I could take care of my two grandkids if it wasn't for the kinship program. I am so thankful for your help."*
>
> *– Kinship Caregiver*

4.4.10 Overall Successes and Challenges of the Kinship Supports Intervention

In its third year of implementation, the kinship intervention has evolved into regular practice in many demonstration counties. Interviewees noted that staff engagement in the kinship intervention has improved over time; caseworkers may employ a more proactive approach with kin caregivers and can better anticipate a caregiver's needs. An increased focus on kinship practice and finding the best possible kinship placement were also high points noted by the staff interviewed. Yet, staff in some counties noted that that their agencies may not be bought into the kinship intervention or kinship placements in general, which may prevent engagement with and investment in kin caregivers. Caseworkers in particular may lack buy-in, or may be generally bought-in to the philosophy of kinship care but practice may not reflect that philosophical commitment. For example, caseworkers may be hesitant to place children with kin caregivers who live far from Children Services because it makes it challenging to serve those kin and children. Or, staff may not support the tenets of the intervention, such as the data collection pieces, though they are generally supportive of kin placements.

Throughout the waiver period, the concept of investment or "bought-in-ness" has continually been discussed in Consortium meetings, with county representatives repeatedly emphasizing the need for this to occur from the top down. PCSA staff of all levels have noted that, while upper-level buy-in doesn't necessarily correspond with caseworker buy-in entirely, the likelihood of an intervention becoming part of an agency's culture is significantly increased when upper management advocates for and promotes the value of an intervention.

In some counties, this seems to have occurred; kinship staff in 11 counties noted that supervisors and administrators support their work simply by emphasizing the importance of keeping kids with relatives and focusing on kinship placements from the start of the case. Managers may even encourage and empower kinship staff to advocate for kin placements themselves, by communicating with other PCSA staff and community partners. Designated kinship staff have also noted they feel supported when administrators give them leeway to creatively serve kin.

Having freedom to think outside the box in terms of serving kin may be especially important in a context where a lack of accessible community resources is one the most notable barriers to providing a strong array of services. This is particularly important for those caregivers who may not qualify for certain benefits because they exceed income restrictions. Additionally, staff in four counties noted that staffing and capacity issues present barriers: High caseloads, few kinship staff, and high turnover are all problematic. Consequently, even when agency staff buy into the importance of kinship care, there may be too few designated kinship staff to successfully support and maintain those placements. Even so, the waiver has resulted in additional kinship staff, and demonstration counties remain more likely than comparison counties to have staff dedicated to serving kin caregivers.

Other kinship staff reported continuous and strong collaboration between caseworkers and kinship staff to support kinship placements. Some have indicated that kin caregivers are receiving more individualized support and services than prior to the intervention; staff can provide assistance to caregivers in ways they couldn't without ProtectOHIO—that is, providing the types of assistance that foster parents would be eligible for under the traditional federal funding stream—such as beds, childcare assistance, and financial support. And, in at least four demonstration counties, caregivers can continue to access supports and resources through Children Services even after their cases are closed,

helping to increase the likelihood of permanency. Finally, a primary benefit noted by staff and caregivers across several agencies is how the intervention helps caregivers to care for their kin children when they otherwise might not have been able to. Demonstration county staff believe that this in turn is helping agencies to improve permanency outcomes for children by preventing entries into foster care.

4.5 Volume and Nature of Kinship Activity and Fidelity to the Kinship Supports Intervention

The following section of the implementation analysis provides an overview of intervention activity during Ohio's third waiver period. Using primarily quantitative data related to the intervention assessment tools, this section highlights the number of assessments that were completed, the timeliness of these assessments, and findings related to changes in caregivers' adequacy of resources over time.

4.5.1 Kinship Study Population

The intervention study population includes children placed in kinship households, including non-custody Living Arrangement kinship households, within a case episode that was opened in a demonstration county PCSA between March 1, 2012 and March 30, 2015 and subsequently transferred to ongoing services. Because multiple children may be placed within the same home and assessments were conducted at the household level, only one placement per kinship household was used for the following sets of analyses. If children were placed at different times within the same household, the first placement date was used to measure the timeliness of assessments completed.

4.5.2 Extent to Which the Intervention Reached Eligible Families

The ProtectOHIO Kinship Supports Practice Manual states that the intervention should focus on all children with PCSA cases that are open to ongoing services in a ProtectOHIO demonstration county, regardless of custody status or supervision orders. The following analysis examines the degree to which the kinship families were reached across counties.

Although all open and ongoing cases are targeted to receive kinship services, the extent to which the eligible population was reached by the intervention was calculated by measuring the number of kinship households served (defined as households for which at least one ProtectOHIO kinship assessment was completed and recorded in PODS) and comparing it to the number of kinship households eligible to receive intervention services (defined as all kinship placements and living arrangements recorded in SACWIS that meet the study population criteria described in Section 4.5.1). This calculation was appropriate given the fact that not all cases ultimately result in a kinship placement.

Overall, during the study period 4,560 kinship households were eligible for intervention services, 60% (2,755) of those households received services, with individual counties serving between 30% and 90% of eligible kinship households. It is unknown why 40% of kinship households did not receive services, though it is not uncommon for a new process to take time before it begins to run smoothly and before all families receive services as the model intends when new interventions are first being implemented. However, when the second half of the study period is compared to the first half, the proportion of families reached increases only slightly (61% and 59%, respectively) with most counties reaching more

or less the same proportion of kinship families in the first and second halves of the study period. Three counties, though, substantially increased the proportion of families reached during the second half (by more than 15%). By contrast, one county substantially decreased the proportion of families reached in the second half (by 47%). This county faced staffing changes mid-data collection; it is likely that both changes in agency staff and issues related to data entry contributed to the reduction of kinship households reached, as seen in the data.

Another potential reason for kinship households to not receive services relates to variation in the ways that "eligible kinship households" can be defined. We previously discussed the varied viewpoints on biological parents being considered kinship caregivers, when a child is removed from one parent household and placed with another. For this particular analysis, however, we excluded biological parents in order to equalize the eligibility determination to an extent. Yet there are other components that may impact a county's decision to serve a kinship household via the intervention. As noted in Section 4.4.3, early on in the implementation of the intervention several counties indicated they had additional criteria for cases to be considered eligible for kinship services, such as minimum placement lengths; this was most often due to capacity issues. When stricter eligibility criteria using varying minimum placement lengths are imposed to examine the proportion of eligible families served, however, we don't see substantial changes in rates served. For instance, when we examine the proportion of eligible families served using only placements that lasted a minimum of seven days, we find that 62% of families were reached (compared to 60% when all kinship families are used). As the minimum placement length increases, so does the proportion of families reached—but not by much: when a minimum placement length of 15 days is used, we find the proportion of families served increases by two percentage points, and when a minimum placement length of 30 days is used, the proportion jumps just one percent point. However, the increase in the proportion of families reached using varying minimum placement lengths varies across counties. In two counties over 10% more families are reached when only placements that last 30 days or longer are examined.

Overall, the proportion of families reached in individual counties likely has many contributing factors, including the type of kinship structure that's been implemented, the number and availability of kinship staff, and the extent to which kinship placements are used in a general sense, which may vary depending on local court policies or particular judges. As the Kinship workgroup continues its effort to consolidate practice across counties, it may be useful for counties to hold further discussions related to county-specific eligibility requirements for ProtectOHIO kinship services and policies related to reaching kinship caregivers.

4.5.3 Measures of Fidelity to the ProtectOHIO Kinship Supports Intervention

Measuring fidelity to the intervention model is useful in determining the degree to which counties adhered to the model among cases that received services. The evaluation team used kinship household-level data to explore three specific components to the model:

1. The completion of the Home Assessment Part I tool.
2. The completion of the Home Assessment Part II tool.
3. The completion of the Family Resource Scale (FRS) tool.

Whereas the analyses above examined the number of families served out of the total number of kinship households recorded in SACWIS, the following analyses examine the extent to which tools were completed out of the total number of households *served*. Households were defined as "served" if at least one of any of the assessment tools were completed (Home Assessment Part I or II, or the FRS) and recorded in PODS.

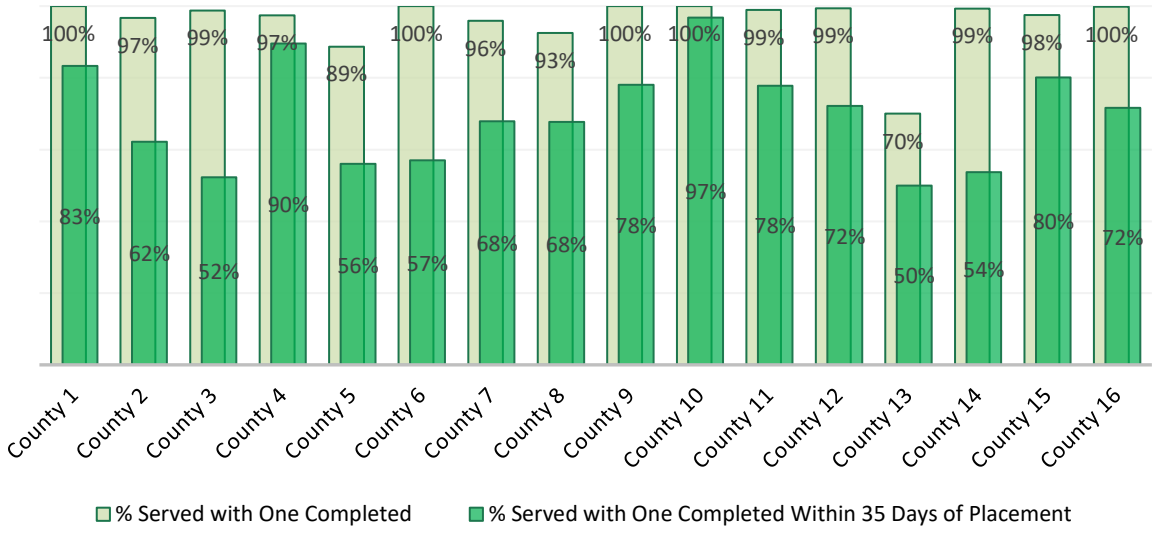
Home Assessment Part I: The kinship home assessment tool was developed by the Kinship workgroup and is used to ensure that the kinship caregivers can support the child in their care, and that services and supports they receive are aligned with their needs. Part I of the assessment is meant to cover the minimum information needed to determine whether a placement is appropriate. It is expected to be completed at the time of the initial placement.

Overall, Part I of the Home Assessment was completed for nearly all kinship households (97%, or 2,976 of 3,065[119] kin homes). Across counties, this rate ranged from 70% to 100%.

Considering that the Home Assessment is designed to assess a caregiver's ability and willingness to provide for children placed in their care, timely completion is key. Overall, a Home Assessment Part I was completed within 35 days of a kinship placement, the formal fidelity marker, for 69% of kin households. Figure 4.4 illustrates the proportion of households that received a Home Assessment Part I (light green) and that received a Home Assessment Part I within 35 days of a child being placed (dark green) across the demonstration counties. Each percentage is calculated out of the total number of households served in that county. The light green bars show the proportion of households that received the Home Assessment, within any timeframe, out of all families served, while the darker green bar shows the proportion of households that received the assessment within 35 days of placement, also out of all families served.

[119] More kin households are included in fidelity analyses than in the penetration analyses for two reasons: 1) Counties had varying viewpoints on whether bio-parent households should be considered kin caregivers and served by the kin intervention, thus because bio-parent households were not targeted by all counties they were excluded from the penetration analyses. By contrast, all data entered into PODS, regardless of caregiver role, were used in the fidelity analyses. 2) One large county implemented the kinship supports intervention in only one of their two regional areas up until Jan. 1, 2015, at which point they began serving all cases. The evaluation team received a supplemental file from this county in order to calculate the penetration rate which included data through 2014. For this county, the fidelity analyses include data past Jan. 1, 2015, whereas the penetration analyses includes data through 2014.

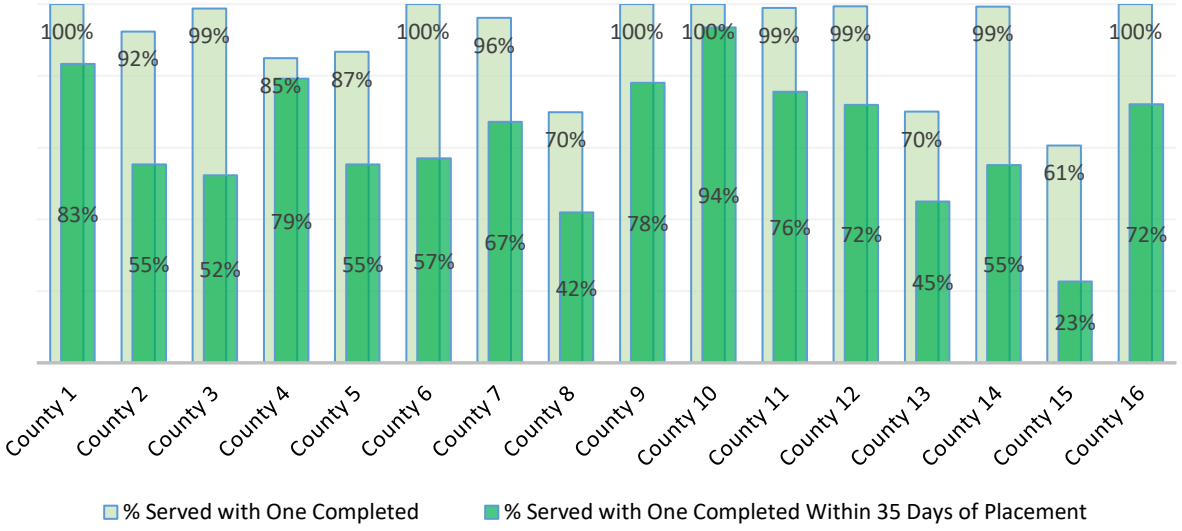
Figure 4.4: Home Assessment I (n=2,862)



It's important to note that because Ohio has a county-administered child welfare system, each county has its own requirements for assessing the safety of homes prior to placements. The Home Assessment Parts I and II were created simply because the homestudy processes varied somewhat across counties, and Kinship workgroup members felt that, to ensure consistency in the implementation of the intervention, a tool should be created for use by all counties. However, some counties use the ProtectOHIO Home Assessment tool in conjunction with their own county-specific homestudy assessments and others use information gathered from their homestudy and complete the ProtectOHIO tool at a later point in time. Given that all counties first and foremost adhere to state and county regulations, the lack of a Home Assessment Part I does not mean a child's safety was compromised.

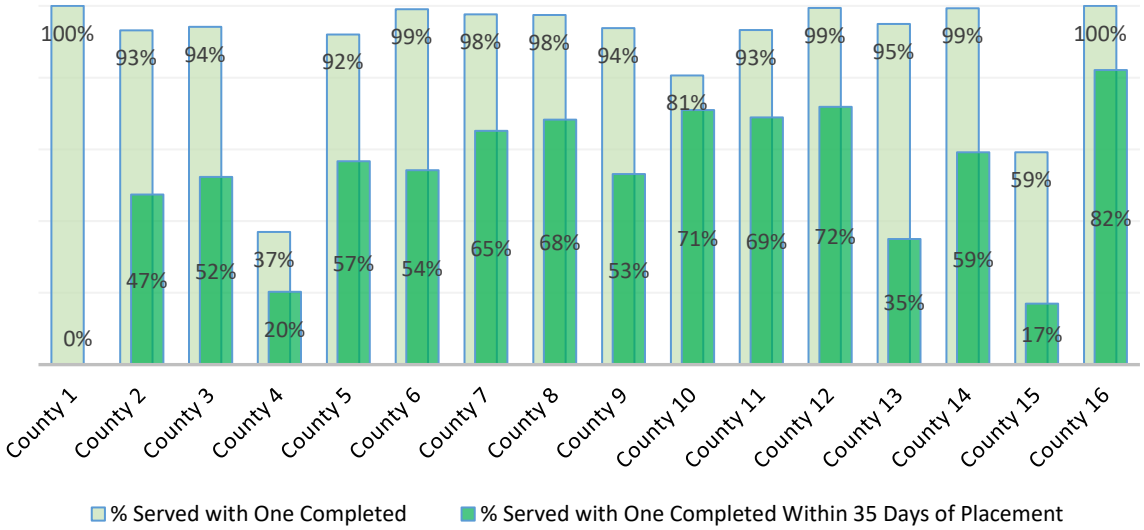
Kinship Home Assessment Part II: Whereas Part I of the Home Assessment primarily focuses on safety, Part II is considered a kinship-specific supplement to the fuller homestudy process. Overall, counties completed Part II less frequently than Part I, though the large majority of kinship households did in fact receive the assessment. Part II was completed for 90% of all kinship households served (2,757 out of 3,065 households); the majority of Part II assessments were completed on the same day as Part I (80%). Overall, a Home Assessment Part II was completed within 35 days of a kinship placement, the formal fidelity marker, for 59% of kin households. Figure 4.5 shows the proportion of kinship households per county that received Part II of the Home Assessment, and the proportion of families that received the assessment within 35 days of placement. Again, all percentages are calculated using the total number of families served.

Figure 4.5: Home Assessment II (n=2,862)



Family Resource Scale: The Family Resource Scale is a needs assessment tool used to assist the kinship worker and the prospective kinship family to accurately identify the services and supports that will be required as well as the family's strengths and resources. It is a validated tool that should initially be completed by the caregiver during Part I of the Home Assessment process and subsequently every 90 days thereafter, throughout the duration of a kinship placement. Overall, 89% of kinship families completed an initial FRS assessment, and 59% of families received one within 35 days of a child being placed. As with the other assessments, the extent to which this tool was used varies across counties. Figure 4.6 illustrates the proportion of families served that received a FRS, and the proportion of families served that received one within 35 days of placement, the formal fidelity marker.

Figure 4.6: Initial Family Resource Scale (n=2,862)



The subsequent-FRS results are intended to be reviewed by the caseworker or kinship staff in order to assist the worker in determining if a change in services is needed. Overall, when examining follow-up assessments that were due, we find that a smaller proportion of families received follow-up assessments than initial assessments.[120] Table 4.4 shows the total number of families eligible for second, third, and fourth follow-up assessments, the proportion of families that received one (within any timeframe), and the proportion of families that received one within 100 days of the prior FRS assessment, a marker of the formal fidelity analyses. This table shows that the frequency of FRS completion decreases over time.

Compared to initial FRS assessments (administered to 89% of kinship families), subsequent assessments were administered less often: 56% of eligible families received a second assessment, 43% of eligible families received a third assessment, and 35% of eligible families received a fourth assessment. This decline over time may be the result of several factors; during 2014 site visits, some designated kinship staff noted that they feel the FRS is administered too frequently and that they experience discomfort administering it. It may be that the initial FRS is the most likely to be administered as it allows workers to familiarize themselves with the family and determine needs, but, as workers feel confident that caregiver and child needs are being met, they may be less likely to administer it. Additionally, since the initial FRS is administered during Part I of the Home Assessment, administration may feel less burdensome to staff than subsequent assessments.

Similar to other assessment findings, the rate at which follow-up FRS assessments were completed varied across counties. Two counties stood out in terms of their completion rate (within any timeframe) and their rate for completing follow-up assessments in a timely manner (near or over 75% of the time). Further discussion among demonstration counties may be helpful in improving processes for completing follow-up FRS assessments.

Table 4.4: Follow-Up Family Resource Scale Assessments

	# that Should Have Received a Follow-up FRS	% of Eligible Households that Received a Follow-up FRS	% of Eligible Households that Received a Follow-up FRS on Time
Second FRS	2,430	56%	37%
Third FRS	1,583	43%	33%
Fourth FRS	950	35%	26%

4.5.4 FRS Results: Changes in Caregivers' Adequacy of Resources Over Time

To explore the change over time in the extent to which kinship households needs were met, the evaluation team examined changes in kinship caregivers' responses to the 31 Family Resource Scale items over the first three FRS assessments. Information regarding each household's access to resources, covering needs ranging from basic (e.g., stable housing) to dispensable (e.g., travel/vacation), were assessed on a 5-point scale. At each of the three assessment points, kinship caregivers (n=1,122) were

[120] Households were considered eligible for follow-up assessments only if the duration of the placement exceeded the timeframe within which an additional FRS should have been administered. In other words, only placements that should have received additional FRSs were included in these analyses.

asked to describe how well access to each resource had been met on a regular basis (1 = Not at all, 2 = Seldom, 3 = Sometimes, 4 = Usually, 5 = Always).

Analyses of Covariance (ANCOVA) were run to provide a descriptive glimpse into how the average household fared with regard to access to resources identified in the FRS. These models examined the significance of mean-level changes between assessments, accounting for when the assessments started. Adjusted means for each resource at each assessment point, as well as test statistics for the significance of change between the assessment points, are shown in Table 4.5 on the following page.

Table 4.5: Family Resource Scale Findings

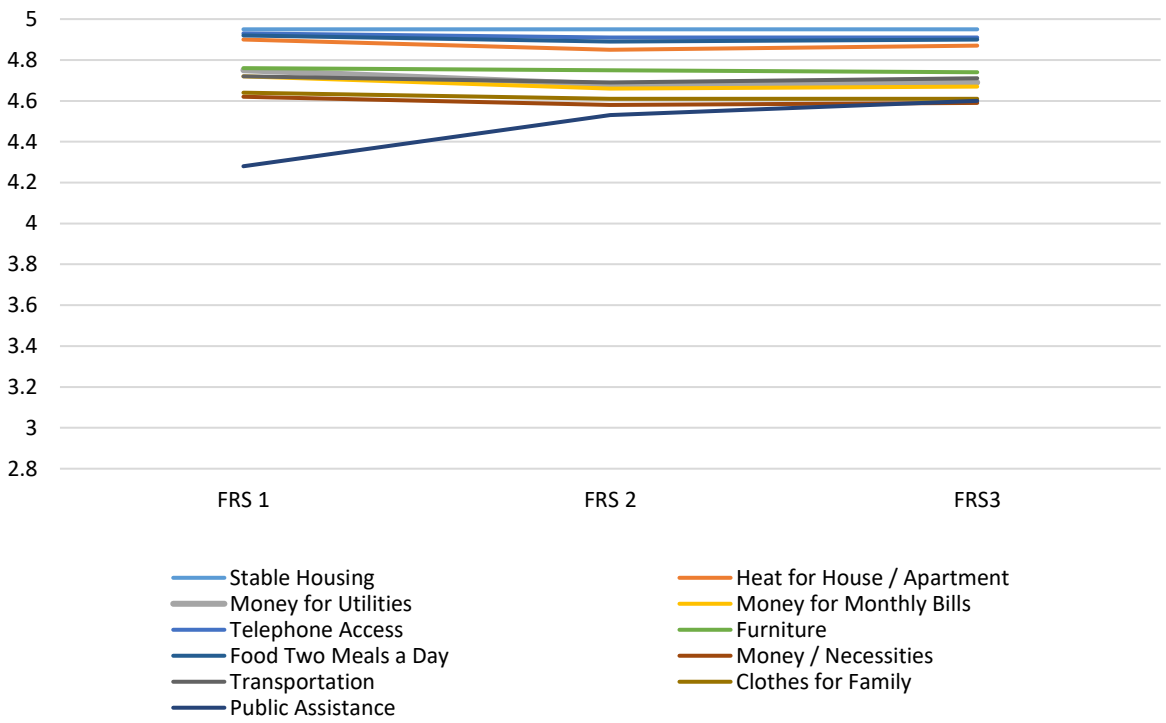
	FRS 1			FRS 2			FRS 3					Direct.
Family Resource	*n*	*mean*	*SD*	*n*	*mean*	*SD*	*n*	*mean*	*SD*	*F*	*Sig*	of Chg.
Basic Household Resources												
Stable Housing	1115	4.95	0.30	1117	4.95	0.30	1120	4.95	0.30	.01	ns	
Heat for House / Apartment	**1117**	**4.90**	**0.40**	**1117**	**4.85**	**0.40**	**1115**	**4.87**	**0.40**	**4.10**	*	↓
Money for Utilities	**1115**	**4.75**	**0.60**	**1117**	**4.68**	**0.60**	**1119**	**4.69**	**0.60**	**3.84**	*	↓
Money for Monthly Bills	**1115**	**4.72**	**0.60**	**1119**	**4.66**	**0.60**	**1121**	**4.67**	**0.60**	**3.43**	*	↓
Telephone Access	1114	4.93	0.37	1117	4.91	0.37	1120	4.91	0.37	1.06	ns	
Furniture	1116	4.76	0.67	1117	4.75	0.67	1119	4.74	0.67	.36	ns	
Food Two Meals a Day	1117	4.92	0.37	1119	4.89	0.37	1120	4.90	0.37	2.95	ł	
Money / Necessities	1116	4.62	0.70	1118	4.58	0.70	1120	4.59	0.70	.83	ns	
Transportation	1110	4.72	0.70	1109	4.69	0.70	1103	4.71	0.70	.88	ns	
Clothes for Family	1115	4.64	0.70	1116	4.61	0.70	1121	4.61	0.70	.82	ns	
Public Assistance	**804**	**4.28**	**1.19**	**944**	**4.53**	**1.20**	**990**	**4.60**	**1.20**	**17.23**	***	↑
Occupational / Financial Resources												
Good Job Self or Spouse	897	4.63	0.90	909	4.59	0.90	912	4.63	0.91	.59	ns	
Money / Supplies for Children	1008	4.53	0.76	1070	4.51	0.75	1088	4.55	0.76	.51	ns	
Childcare While at Work	**479**	**4.36**	**1.09**	**596**	**4.45**	**1.10**	**602**	**4.53**	**1.10**	**3.08**	*	↑
Health Resources												
Medical Insurance Child	**904**	**4.73**	**0.78**	**1035**	**4.79**	**0.80**	**1063**	**4.83**	**0.78**	**3.70**	*	↑
Medical Insurance Self / Spouse	1089	4.58	1.06	1090	4.62	1.06	1099	4.67	1.06	1.98	ns	
Dental Care Self / Spouse	1071	4.45	1.18	1080	4.51	1.18	1087	4.56	1.19	2.17	ns	
Dental Care Child	886	4.74	0.80	991	4.76	0.82	1017	4.81	0.80	2.13	ns	
Nonessential Resources												
Time for Sleep / Rest	1118	4.41	0.84	1118	4.35	0.84	1120	4.33	0.84	2.39	ł	
Alone Time	1114	4.04	1.17	1117	3.95	1.14	1120	3.95	1.14	2.25	ns	
Family Time	**1110**	**4.68**	**0.63**	**1113**	**4.61**	**0.63**	**1120**	**4.64**	**0.64**	**3.30**	*	↓
Time with Children	997	4.70	0.60	1063	4.67	0.62	1082	4.70	0.59	.69	ns	
Time with Spouse	807	4.37	0.99	831	4.30	1.01	843	4.31	0.99	1.21	ns	
Someone to Talk to	1113	4.61	0.73	1113	4.58	0.73	1112	4.57	0.73	1.046	ns	
Time to Socialize	**1110**	**4.14**	**1.10**	**1104**	**4.01**	**1.10**	**1117**	**4.03**	**1.10**	**4.57**	**	↓
Time to Keep in Shape	978	4.06	1.16	979	3.95	1.16	978	3.96	1.16	2.90	ł	
Toys for Children	933	4.59	0.76	1031	4.59	0.77	1056	4.62	0.78	.45	ns	
Money for Self	1115	3.97	1.14	1117	3.90	1.14	1118	3.89	1.14	1.40	ns	
Money to Save	1102	3.20	1.43	1100	3.17	1.43	1110	3.18	1.43	.13	ns	
Travel / Vacation	1080	3.00	1.45	1075	2.99	1.44	1081	3.00	1.45	.01	ns	
Babysitting	680	4.29	1.17	801	4.24	1.16	805	4.33	1.16	1.14	ns	

Note. Mean levels reported are based upon a 5-point scale describing how well each need is met (1 'Not at all', 2 'Seldom', 3 'Sometimes', 4 'Usually', 5 'Always'). Sample sizes for each item do not reflect the overall sample size (N=1122), as cases for which a response indicated 'does not apply' were excluded from analyses. Means and Standard Deviations Reported above are adjusted for the time at which the first FRS was administered. ł $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$.

Basic Household Resources: In general, kinship households' access to the most basic household resources (e.g., stable housing and food) were indicated as being "always" met. Furthermore, the degree to which these needs were met was somewhat stable across the three assessment points. However, there were a few notable exceptions. Specifically, access to public assistance (represented by the dark blue line in Figure 4.7) was, on average, indicated at the first assessment point as being closer to "usually" met. However, the averages at the three assessment points were significantly different ($F(2, 2734) = 17.227$, $p < .001$). Results from a post-hoc analysis suggest that the degree to which this need was met increased significantly between the first and second FRS assessments. Information collected during 2014 focus groups with kinship staff may provide insight into this increase: Staff assist kin caregivers with navigating the benefits system and understanding the benefits available to them, and staff may assist kin with completing benefits applications, perhaps leading to caregivers receiving benefits by the second FRS. It is likely that kinship staff contributed to the significant increase seen in access to public assistance.

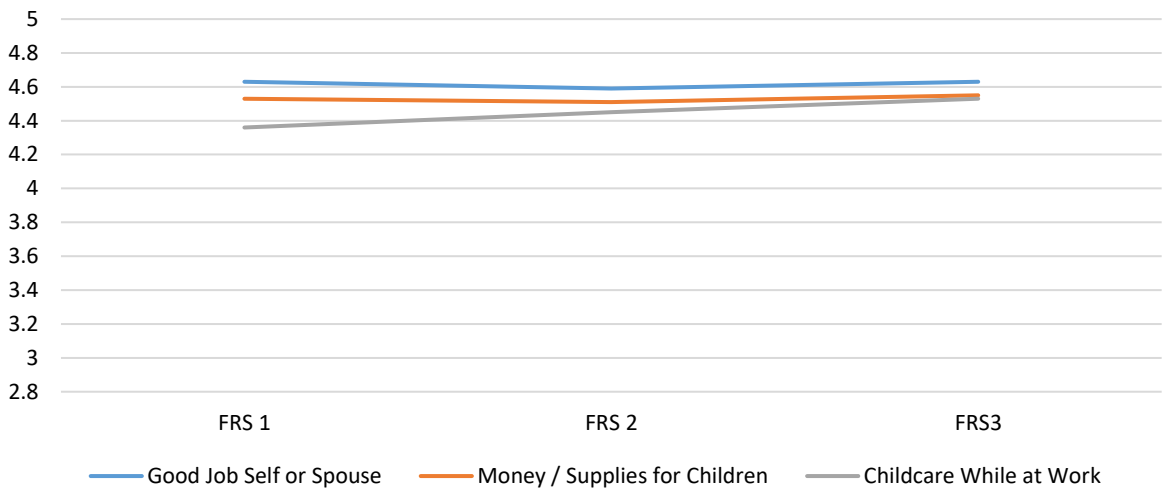
While the extent to which they were met remained fairly high, access to three basic household resources (i.e., heat for the home, money for utilities, and money for bills) decreased significantly between the first and second assessment points. This is unsurprising in that, when additional children enter a household, access to these resources is likely to decrease (utility bills naturally rise with the addition of new members to a household). During 2014 site visits, the evaluation team learned that five demonstration counties are able to help kin caregivers with rent, housing deposits, or utilities; however, the extent to which agencies are able to provide assistance varies. And though there was a significant decrease in access to these items, the change was not substantial. Namely, for each item that decreased, the mean rating was between a 4 (usually) and a 5 (always) at both the initial and third assessment.

Figure 4.7: Mean-Level Changes in Basic Household Resources



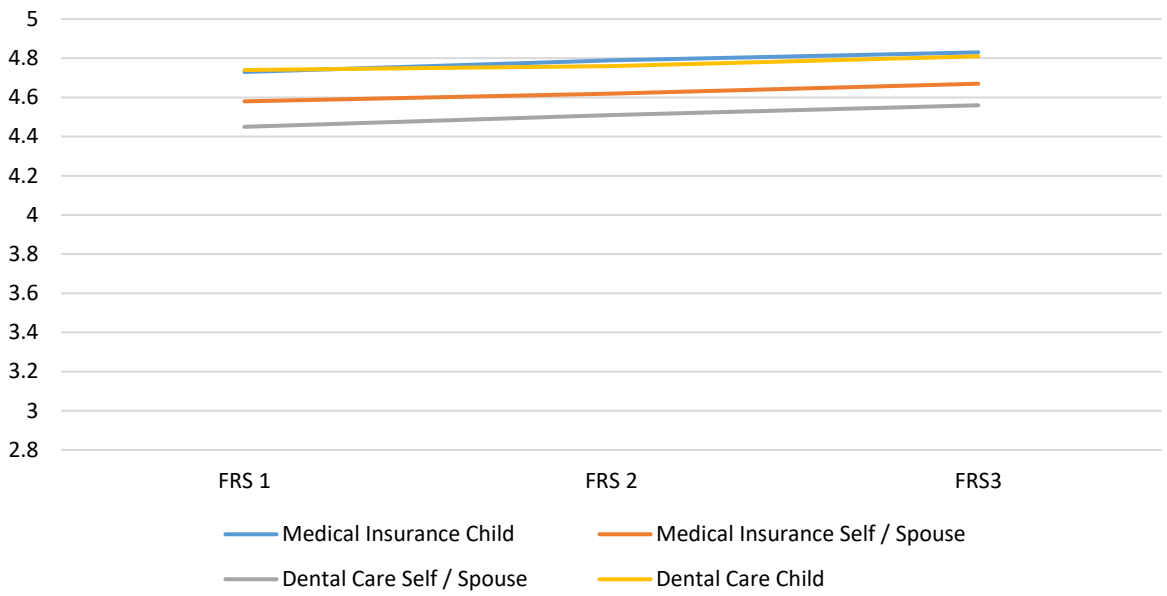
Occupational and Financial Resources: In general, kinship households' access to a variety of occupational resources was indicated as being met halfway on the scale between "usually" and "always." Kinship caregivers consistently reported having access to a good job and money and supplies for the children they cared for (values on both of these items exceeded 4.5 at all three assessment points). While kinship caregivers, on average, reported only usually (as opposed to "always") having access to child care while at work (represented by the grey line in Figure 4.8) at the first assessment point, this value increased over the next two assessment points ($F(2,1673) = 3.08$. $p < .05$). Post-hoc comparisons revealed that the significance of these increases occurred between the second and third FRS assessment. This increase in access to child care was also supported by qualitative information collected during the 2014 site visits. It could indicate that kin caregivers applied for and qualified for subsidized public child care through the Ohio Department of Job and Family Services and these benefits began between the second or third assessment. In multiple counties, caregivers are required to initially apply for public child care if they require day care for those children placed with them. For caregivers who do not qualify, though, eight demonstration counties are able to pay for child care through Children Services; because these kin may be required to first apply for public daycare prior to Children Services contributing to daycare, access might increase during subsequent FRS assessments. It should be noted that the income restrictions to qualify for public daycare are strict, so it is likely that those kin who do qualify for public daycare might not report access to a good job and money.

Figure 4.8: Mean-Level Changes in Occupational/Financial Resources



Health Resources: In general, kinship households' access to health resources, comprising both medical and dental care, were indicated as being well met. In fact, the extent to which these needs were met tended to fall in the "always" category. Furthermore, descriptive increases in kinship household access to health resources over the first three FRS assessments were observed (Figure 3), suggesting modest improvement in the extent to which kinship households' health-related needs were being met. However, only access to medical insurance for the child (represented by the blue line in Figure 4.9) increased significantly ($F(2,2998) = 3.70$, $p < .05$). Post-hoc analyses suggest that while increases from the first FRS assessment and the third FRS assessment were significant, the incremental changes (i.e., differences between FRS 1 and FRS 2, and from FRS 2 to FRS 3) were not. This suggests that increases in kinship caregivers' access to medical insurance for the children in their care was gradual.

Figure 4.9: Mean-Level Changes in Health Resources

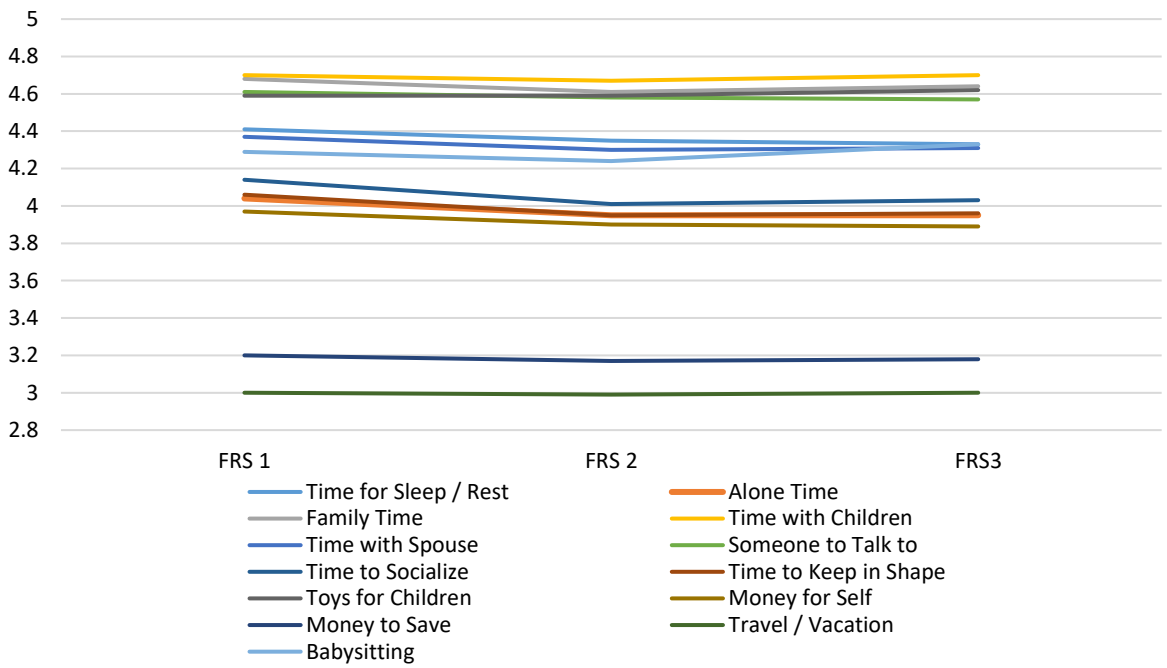


Nonessential Resources: Kinship households' access to nonessential resources, such as social and leisure activities, was generally average, though it varied across items (Figure 4.10). Kinship caregivers generally indicated that they "usually" or "always" had time with their children, their spouse, and their families.

Similar patterns were observed when it came to other resources specifically for the caregiver (e.g., having time to keep in shape and money for one's self). Kinship caregivers reported being able to save money and to travel or vacation only sometimes, and access to these less basic resources was stable over the three assessment points. Having alone time was viewed by caregivers as being met less often, and declined over the first three FRS assessment points ($F(2,3327) = 4.57$, $p < .01$). This is unsurprising in that as more children enter the home, the likelihood of having time to oneself decreases.

In general, the services and supports provided to caregivers from kinship staff are not intended to increase the adequacy of leisure resources. However, some services provided by kinship staff may have indirectly impacted the stability of these items—for example, supports to ensure access to public assistance, childcare, and medical insurance for the child may have increased the caregiver's ability to maintain stable access to other, more nonessential resources.

Figure 4.10: Mean-Level Changes in Social/Leisure Resources



4.5.5 Summary of the Volume and Nature of Kinship Activity and Fidelity to the Kinship Supports Intervention

The ProtectOHIO demonstration counties served over 2,700 kinship households, reaching approximately 60% of all eligible kinship families. The Home Assessment Parts I and II, which are used to ensure that caregivers can support the child in their care, were completed for nearly every kinship household served (97% and 90%, respectively). The FRS, an assessment used to identify needed services and caregiver strengths, was also completed for the majority of kinship households served (89%).

The model calls for all three assessments to be completed when a child is placed, or at the time a home study is completed prior to placement; assessments are deemed 'on time' if they are completed within 35 days of placement (the former fidelity marker). While the large majority of families received each of the three assessments (within any timeframe), a smaller proportion of families received them in a timely manner: 69% of kinship households received Part I of the Home Assessment within 35 days of placement, and 59% of kinship households received both Part II and an FRS assessment within 35 days of placement. Because household needs evolve over time, the intervention model calls for the FRS to be completed every 90 days. However, far fewer families received follow-up assessments: 56% of eligible families received a second assessment, 43% of eligible families received a third assessment, and 35% of families received a fourth assessment.

When the results of the FRS assessments are examined for kinship families that did receive assessments, the results are encouraging. Kinship households' access to the most basic household resources was most often indicated as being "always" met. Furthermore, the degree to which these basic needs were met was somewhat stable across the three assessment points. There were some slight significant

decreases—all of which would be naturally expected as additional children enter the home (e.g., money for utilities/bills); however, although decrease in access to these items was statistically significant, the change was not substantial. Access to certain other resources that kinship staff can assist with increased significantly (e.g., access to public assistance, daycare, and medical insurance for the child in care). Overall, kinship caregivers that received follow-up assessments were largely able to maintain or increase access to the vast majority of resources necessary to maintain life quality.

4.6 Kinship Outcomes

A primary set of analyses examined differences between demonstration and comparison counties in the extent to which kinship care was used. Specifically, these analyses assessed the following questions:

- Are demonstration counties more likely to place children with kin than comparison counties?
- Are children in demonstration counties more likely to experience their initial placement with kin?
- Do children in demonstration counties experience a greater proportion of their days in placement with kin?

In addition, two sets of outcomes analyses were conducted, comparing:

1. Outcomes between children placed with kin and served by the intervention in demonstration counties and children placed in foster care in comparison counties, and
2. Outcomes between children placed with kin and served by the intervention in demonstration counties and children placed with kin in comparison counties.

For both sets of analyses the following research questions were assessed:

- Do children served by the intervention
    - Spend less time in out-of-home care?
    - Experience more stable placements?
    - Have lower rates of re-entry into out-of-home care?
    - Have a lower likelihood of substantiated and indicated re-reports of abuse and neglect?

4.6.1 Method

To examine the causal effect an intervention has on a population, extraneous variables that may in some way be linked to the studied outcome should be controlled. To do this, researchers might utilize experimental designs (e.g., a randomized control trial) as they allow for methodological control, through random assignment. Experimental control potentially eliminates background differences between demonstration and comparison groups, so that any difference observed between the two groups may be attributed to receipt of the intervention; however, experimental control through random assignment

is not always possible due to ethical or practical reasons. Therefore, an alternative method that allowed for an approximation of experimental control was used in the evaluation of the kinship intervention.[121]

To account for differences between demonstration and comparison groups, the evaluation team used propensity scores. Propensity scores allow researchers to approximate balance *statistically*. With balance achieved between participants in the intervention and comparison groups, the interpretation that between-group difference in outcomes is attributable to the intervention may be understood with more confidence.

It is important to note, however, that the strength of this inference depends on the characteristics selected to establish balance between groups. The identification and selection of a robust set of characteristics to produce the propensity score is therefore crucial. To reach this goal, the evaluation team identified as many background characteristics as possible upon which to compute the propensity scores. Characteristics that were selected included demographic characteristics such as race and age, previous contact with children's services, and previous placement in out-of-home care. Variables from the family assessment were also considered important to use because they include case- and child-level information used by caseworkers and supervisors to decide whether the case would be transferred to ongoing services.[122] Using these characteristics, propensity scores were calculated, weighted via Inverse Probability of Treatment Weights[123], trimming weights greater than 10 to reduce the influence of outliers and then used as covariates in our analyses.

4.6.1.1 Sample

The study sample consists of children in cases that were open to ongoing child welfare services and who entered out-of-home care between March 1, 2012 and April 31, 2015. The first set of outcome analyses examines the extent to which kinship care was used in demonstration versus comparison counties. For these analyses data on all children within this time period were used.[124] This includes data for 11,948 children (6,215 children in demonstration counties and 5,733 matched children in comparison counties).

The remaining analyses compare outcomes for children who received the intervention within demonstration counties with two separate comparison groups: 1) matched children in non-relative foster care in comparison counties, and 2) matched children also in kinship care in comparison counties. Both kinship groups (kinship-intervention and kinship-comparison) consist of children placed into unlicensed but approved kinship homes, whose placements were facilitated by the child welfare agency. The foster care comparison group consisted of children placed into licensed non-relative foster homes. Sample n's for each group include:

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[121] Further explanation is provided in: Evaluation of Ohio's Title IV-E waiver, ProtectOHIO: Phase 3 Evaluation Plan. Tualatin, OR: HSRI, June 2011.

[122] Appendix H provides more information regarding this process and the variables used.

[123] Harder, V.S., Stuart, E.A & Anthony, J.C. (2010). Propensity score techniques and the assessment of measured covariate balance to test causal associations in psychological research. Psychological Methods, 15(3), 234-49. doi: 10.1037/a0019623.

[124] One metro county implemented the kinship supports intervention in one region only. For this county, data from only this region was used for this set of analyses.

- **Intervention Sample:** The intervention group consisted of 2,600 children placed into kinship care whose families received the intervention in one of the 16 intervention child welfare agencies. For analyses using only closed placements (i.e., placements that had ended), data on 1,838 children were used.
- **Foster Care Comparison Sample:** The foster care comparison group consisted of 2,365 children placed into non-relative foster care in one of the 16 comparison child welfare agencies. For analyses using only closed placements, data on 1,373 children were use.
- **Kinship Comparison Sample:** The kinship comparison group consisted of 3,750 children placed into kinship care in one of 16 comparison child welfare agencies. For analyses using only closed placements, data on 2,641 children were use.

Children were included in these subsamples only if they met the following criteria:[125]

- The majority (at least 90%) of their total out-of-home days were spent in either kinship (the intervention group) or foster care/kinship (the comparison group, depending on the comparison being made).[126]
- Their last placement was in the specified placement type (i.e., either kinship or foster care).

4.6.2 Results

4.6.2.1 Demonstration and Comparison Counties' Use of Kinship Placement

The mission of the Kinship Supports intervention is to promote kinship placement as best practice, increasing attention to and support for kinship placements, caregivers, and families. Over the course of the third waiver period the demonstration county agencies have undertaken a wide range of activities designed to increase the use of kin care, including expanding methods to locate, interact with, and support kin, as well as internal processes designed to support the agency's ability to use kin as placement options, such as the creation of kinship units or designated kinship positions. As such, it is expected that demonstration county agencies would have the resources and motivation to use kin care more extensively than comparison county agencies.

To understand the extent to which kinship care is used as a placement setting, the evaluation team examined the likelihood of children in demonstration versus comparison counties being placed initially and predominantly with kin. These analyses were complimented by mean-level analyses which examined differences between children in demonstration and comparison counties in the proportion of out-of-home care days placed with kin.

[125] These criteria were adapted from Winokur, Crawford, Longobardi, & Valentine, 2008

[126] To be in the intervention group, the kinship family had to have been *served* by the kinship supports intervention, as indicated by at least one ProtectOHIO kinship supports assessment completed and recorded in PODS, related to the specified kinship placement.

Likelihood of Initial Placements with Kin: A logistic regression model[127] was used to test the hypothesis that children served by demonstration counties were more likely to be placed initially with kin. ProtectOHIO Consortium members had hypothesized that, as a result of implementation of the intervention and a greater focus on kin care in the third waiver period, demonstration counties would be more likely to avoid temporary emergency placements and instead utilize kinship care as an initial placement if the child needed to be removed from the home. Results suggest that county type was a significant predictor[128]; children in demonstration counties were more likely to be initially placed with kin (54%) than children in comparison counties (51%). The odds of being placed initially with kin increased by almost 13%, when children were served by the demonstration county agencies (Odds Ratio = 1.128).

Likelihood of Placement Predominantly with Kin: A similar modeling strategy was used to examine differences between county types in the likelihood of being placed predominantly with kin. Because children may experience more than one placement type within a placement episode, the evaluation team classified "placement predominantly with kin" as children who spent a minimum of 90% of their placement days in kin care. Results suggest that county type was a significant predictor of the likelihood of being placed predominantly with kin.[129] Children in demonstration counties were more likely (53%) to be placed predominantly with kin than children in comparison counties (50%). The odds of being placed predominantly with kin were increased by almost 13%, when children were served by demonstration county agencies (Odds Ratio = 1.126).

Table 4.6: Differences in Likelihood of Kinship Placement

	B	S.E.	Wald χ^2	Df	p	Odds Ratio
Model Predicting Kinship as an Initial Placement						
Weighted Propensity	-.034	.029	1.423	1	.233	.967
County Type[130]	**.121**	**.037**	**10.775**	**1**	**.001**	**1.128**
Constant	.090	.039	5.270	1	.022	1.094
Model Predicting Kinship as a Predominant Placement						
Weighted Propensity	.067	.029	5.444	1	.020	1.069
County Type[131]	**.119**	**.037**	**10.462**	**1**	**.001**	**1.126**
Constant	-.064	.039	2.668	1	.102	.938

Proportion of Out-of-Home Time with Kin: Differences between children served by demonstration and comparison counties in the proportion of days placed with kin versus other out-of-home days were

[127] Model used county type (Demonstration or Comparison) and a weighted propensity score as covariates predicting Kin placement (placed with kin or not).

[128] (Wald $\chi^2(1) = 10.775$. $p < .01$)

[129] (Wald $\chi^2(1) = 10.46$, $p < .01$)

[130] In these analyses, demonstration county was coded 1.

[131] In these analyses, demonstration county was coded 1.

examined using Analysis of Covariance (ANCOVA).[132] In each of these analyses, a weighted propensity score was used as a covariate to adjust for differences between demonstration and comparison groups.

Significant differences were found between children served by demonstration and comparison county agencies in the number of days placed with kin[133] as well as the proportion of days placed with kin[134]. On average, although children served by demonstration counties spent fewer days placed with kin (141 days) than children served by comparison counties (151 days), demonstration county children spent a greater proportion of their out-of-home care time placed with kin (60%) compared to comparison county children (57%).

Table 4.7: Mean Differences In Number and Percentage of Days Placed With Kin

	Days Placed With Kin		Percent of Days Placed with Kin	
	Mean[135]	SD	Mean	SD
Demonstration	141.14	176.63	.60	.46
Comparison	151.20	176.58	.57	.47

Kinship Care Usage Summary: Although the data suggest that both demonstration and comparison counties use kinship as a placement option at moderate rates, results from these analyses indicate that children in demonstration counties were more likely to be placed initially with kin and to spend the majority of their placement days with kin. Further, while children in demonstration counties spent fewer days in placement overall compared to children in comparison counties, a significantly greater proportion of those placement days were with kin.

4.6.2.2 Outcomes Analyses - Kinship Placement Intervention vs Foster Placement Comparison

The following analyses were used to test the hypothesis that children placed in kinship care and served by the intervention would experience greater safety, stability, and permanency compared to similar children placed in foster care in comparison counties.

Substantiated and Indicated Re-Reports During and After Placement: Child safety was assessed by examining the number of substantiated and indicated re-reports of abuse or neglect, during and after placement in out-of-home care. Differences in the prevalence of re-reports between children placed with kin and served by the intervention in demonstration counties and children placed in foster care in comparison counties were examined using logistic regression. For analyses examining re-reports during a child's placement, all children in the sample were used. For the analyses examining re-reports after a child's exit from an initial placement episode, only data on children whose first placement episode had ended were used.

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[132] For these analyses, only closed placements were used (5,733 comparison children and 6,215 demonstration children).

[133] $F(1,11795) = 9.55$, $p < .01$

[134] $F(1,11795) = 12.68$, $p < .001$

[135] Means and Standard Deviations are adjusted by a weighted propensity score.

- **Re-Reports During Placement:** The rates of re-reports of substantiated abuse or neglect during out-of-home placement were very low for both groups. In addition, only slight differences were found between these groups in in this regard. Descriptively, children served by the intervention and placed in the care of kin were slightly less likely (2.5%) than children placed in foster care (3.2%) to experience abuse or neglect while in placement. However, results from logistic regression suggest that these differences were not significant.
- **Re-Reports After End of Placement:** The rates of substantiated or indicated re-reports of abuse or neglect after the end of placement were also very low for both groups. However, significant differences were found between the two groups in the likelihood of substantiated or indicated re-reports of abuse and neglect within six, twelve, and eighteen months after the end of placement. Specifically, children served by the intervention and placed with kin in demonstration counties were less likely than children placed in foster care in comparison counties to experience abuse or neglect within six months (1.8% vs. 3.4%), twelve months (3.4% vs. 5.3%), and eighteen months (4.2% vs. 6.3%) of the end of out-of-home placement. Adjusting for placement begin date, and the weighted propensity score, the placement type significantly predicted the likelihood of re-reports of abuse and neglect within six months[136] of placement end, within twelve months[137] of placement end, and within eighteen months[138] of placement end. Children placed in foster care were more likely to experience abuse or neglect after reaching permanency than children placed with kin within six months[139], within twelve months[140], and within eighteen months[141].

Placement Stability: Differences in placement stability seen in children placed with kin and served by the intervention in demonstration counties versus children placed in foster care in comparison counties were examined using ANCOVA[142]. Overall, children placed with kin in demonstration counties experienced greater placement stability than children placed in foster care in comparison counties. Among the demonstration county kin group, 85% experienced no movement during their first placement episode. By contrast, 73% of children in the foster care comparison group experienced no movement during their first placement episode.

Average mean-level differences between demonstration and comparison counties in number of placement moves were significant ($F(1, 3208) = 109.78$, $p < .001$). On average, children who received the intervention experienced fewer placement moves ($m = .17$, $SD = .43$) than matched children placed in foster care in comparison counties ($m = .39$, $SD = .74$).

Time in Placement: A Cox Proportional-Hazards model examined differences in time spent in placement comparing children placed with kin in and served by the intervention in demonstration counties and

[136] (Wald $\chi^2 = 6.70$, $p < .01$)
[137] (Wald $\chi^2 = 5.94$, $p < .05$)
[138] (Wald $\chi^2 = 4.90$, $p < .05$)
[139] Odds ratio = 1.81, p < .01.
[140] Odds ratio = 1.54, p < .05.
[141] Odds ratio = 1.43, p < .05.
[142] Only closed placement episodes were used in this analysis. Model covariates included a weighted propensity score.

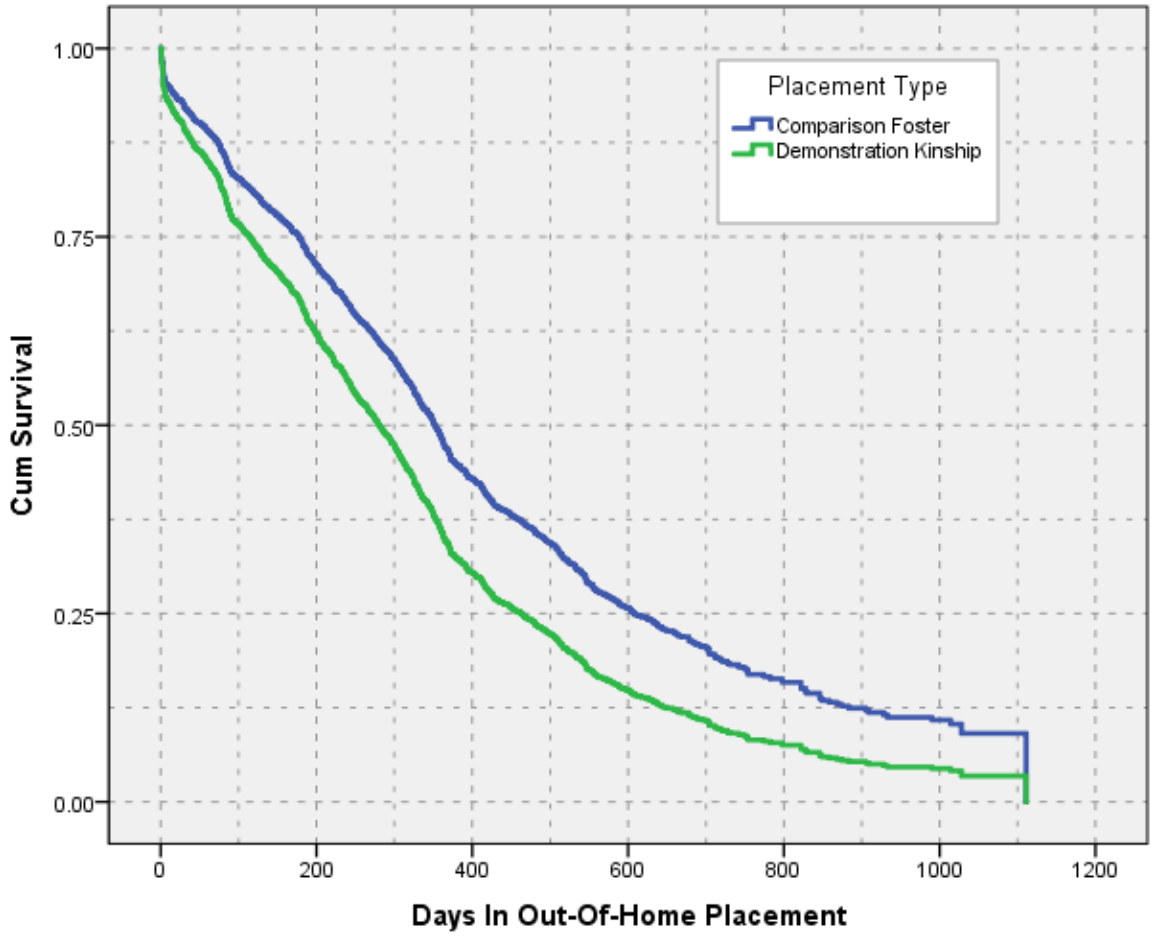
children placed in foster care in comparison counties. A likelihood ratio test indicated that placement type, the variable of interest, significantly predicted time in placement.[143] As shown in Figure 4.11, similar survival paths occur over the first 100 to 125 days. That is, children in each group are exiting placement at similar rates during this time frame. However, from that point forward the paths diverge, indicating that children placed with kin and served by the intervention discharged from placement more quickly than children placed in foster care in comparison counties. The adjusted median time in out-of-home placement was approximately 280 days among children placed with kin in demonstration counties and approximately 350 days for children placed in foster care in comparison counties. Table 4.8 provides the statistics for this model.

Table 4.8: Differences Between Kinship Supports and Comparison Foster Care in Time Spent Out-Of-Home

	df	***X^2***	***P***
Overall Model	**3**	**153.00**	<.001
Model Predictors	***df***	***Wald***	***p***
Weighted Propensity	1	.65	>.05
Placement Begin Date	1	72.64	<.001
Placement Type	1	85.14	<.001
Number of Events: 3211	Total Cases: 4965		Censored: 35.3%

[143] ($\chi^2(1) = 85.14$ $p < .001$), accounting for the effect of the placement begin date ($\chi^2(1) = 72.64$ $p < .001$) and the weighted propensity score ($\chi^2(1) = .65$ $p > .05$).

Figure 4.11: Kinship Versus Foster Care - Differences in Length of Placement



Re-Entry into Out-of-Home Care: Logistic regression models[144] were used to test the hypotheses that children placed with kin and served by the intervention in demonstration counties would be less likely to re-enter out-of-home care within six and within twelve months of discharge from their first placement episode than children placed in foster care in comparison counties. For these analyses, a weighted propensity score was used as a covariate, and only children who had been discharged from initial placements were included.

- **Re-Entry within 6 months:** Results from this analysis suggest placement type was a significant predictor of the likelihood of re-entering care within six months[145], and that the odds of re-entry into care were nearly three times greater for children placed into foster care within comparison counties than for children placed with kin in demonstration counties.[146]

[144] Model used county type (Demonstration or Comparison) and a weighted propensity score as covariates predicting the occurrence or non-occurrence of re-entry.

[145] (Wald $\chi^2(1) = 22.07$, $p < .01$)

[146] Odds ratio = 2.85, $p < .01$.

- **Re-Entry within 12 months:** Results from this analysis suggest placement type was also a significant predictor of the likelihood of re-entering care within twelve months[147], and that the odds of re-entry into care were three times greater for children placed in foster care in comparison counties than children placed with kin in demonstration counties.[148]

Kinship Care versus Foster Care Summary: Overall, children placed with kin and served by the intervention experienced more favorable outcomes than children placed in foster care in comparison counties in the following ways:

- While there were no significant differences found in the rate of substantiated or indicated abuse or neglect allegations while children were in care, children placed with kin and served by the intervention in demonstration counties were significantly less likely to experience abuse or neglect after exiting care than children exiting foster care in comparison counties.
- Children placed with kin and served by the intervention in demonstration counties experienced greater placement stability (significantly fewer placement moves) than children placed in foster care in comparison counties.
- Children placed with kin and served by the intervention in demonstration counties exited care in significantly fewer days than children placed in foster care in comparison counties.
- Children placed with kin and served by the intervention in demonstration counties were significantly less likely to re-enter out-of-home care after exiting an initial placement than children placed in foster care in comparison counties.

4.6.3 Outcomes Analyses - Kinship Placement Intervention vs Kinship Placement Comparisons

The activities undertaken as a part of the intervention were expected to lead to greater engagement between staff and families, and generate more complete and appropriate provision of services for kinship families. Overall, it was expected that intervention services in demonstration counties would increase the likelihood of positive outcomes for children placed in kin care and receiving intervention services. The following set of analyses examine outcomes of children placed with kin and served by the intervention in demonstration counties compared to children placed with kin in comparison counties. While we did not expect outcome differences between these groups to be as substantial as the kin versus foster care comparisons, it was expected that children served by the intervention in demonstration counties would experience more favorable outcomes than children placed with kin in comparison counties.

Substantiated and Indicated Re-Reports During and After Placement: Differences in the prevalence of re-reports between children placed with kin and served by the intervention in demonstration counties and children placed with kin in comparison counties were examined using logistic regression. For analyses examining re-reports during a child's placement, all placements in the sample were used. For the analyses examining re-reports after a child's exit from an initial placement episode, only data on children whose first placement episode had ended were used.

[147] (Wald $\chi^2(1) = 11.22$, $p < .01$)

[148] Odds ratio = 3.09, $p < .01$.

- **Re-Reports During Placement**: The rates of substantiated and indicated re-reports of abuse or neglect during a kin placement were very low in both in demonstration and comparison counties (2.5% in demonstration counties, 2.1% in comparison counties). Differences in the likelihood of substantiated/indicated re-reports of abuse and neglect during a placement were not significant.
- **Re-Reports After Placement Discharge**: The rates of re-reports of abuse or neglect after discharge from placement among children placed with kin, both in demonstration and comparison counties, were similarly low. No significant differences were found between the demonstration and comparison county groups in the likelihood of experiencing abuse or neglect within six months (1.8% and 1.7%, respectively), twelve months (3.4% and 2.7%, respectively), and eighteen months (4.2% and 3.1%, respectively) of placement end.

Placement Stability: Differences in placement stability between children placed with kin and served by the intervention in demonstration counties and children placed with kin in comparison counties were examined using ANCOVA[149]. Overall, children served by the intervention experienced greater placement stability than children placed with kin in comparison counties. Among children served by the intervention, 85.3% experienced no placement moves during their first placement episode. By comparison, 78.2% of children placed with kin in comparison counties experienced no placement moves during their first placement episode.

The average difference in the number of placement moves experienced during a first placement episode between children placed with kin in demonstration and comparison counties was significant.[150] On average[151], children served by the intervention in demonstration counties experienced fewer placement moves (*m* = .16, *SD* = .51) than children placed with kin in comparison counties (*m* = .27, *SD* = .51).

Time in Placement: A Cox Proportional-Hazards model examined differences in time spent in placement, comparing children placed with kin and served by the intervention in demonstration counties with children placed with kin in comparison counties. This model examined treatment type (kinship intervention or kinship comparison) as a predictor of "survival" (which, as used in this context reflects a child still being in placement), adjusting for when the placement began and weighted propensity scores.[152]

As shown in Figure 4.13, discharge from placement occurred more quickly among children placed with kin in demonstration counties compared to children placed with kin in comparison counties. The

[149] Again, only closed placement episodes were used in this analysis.

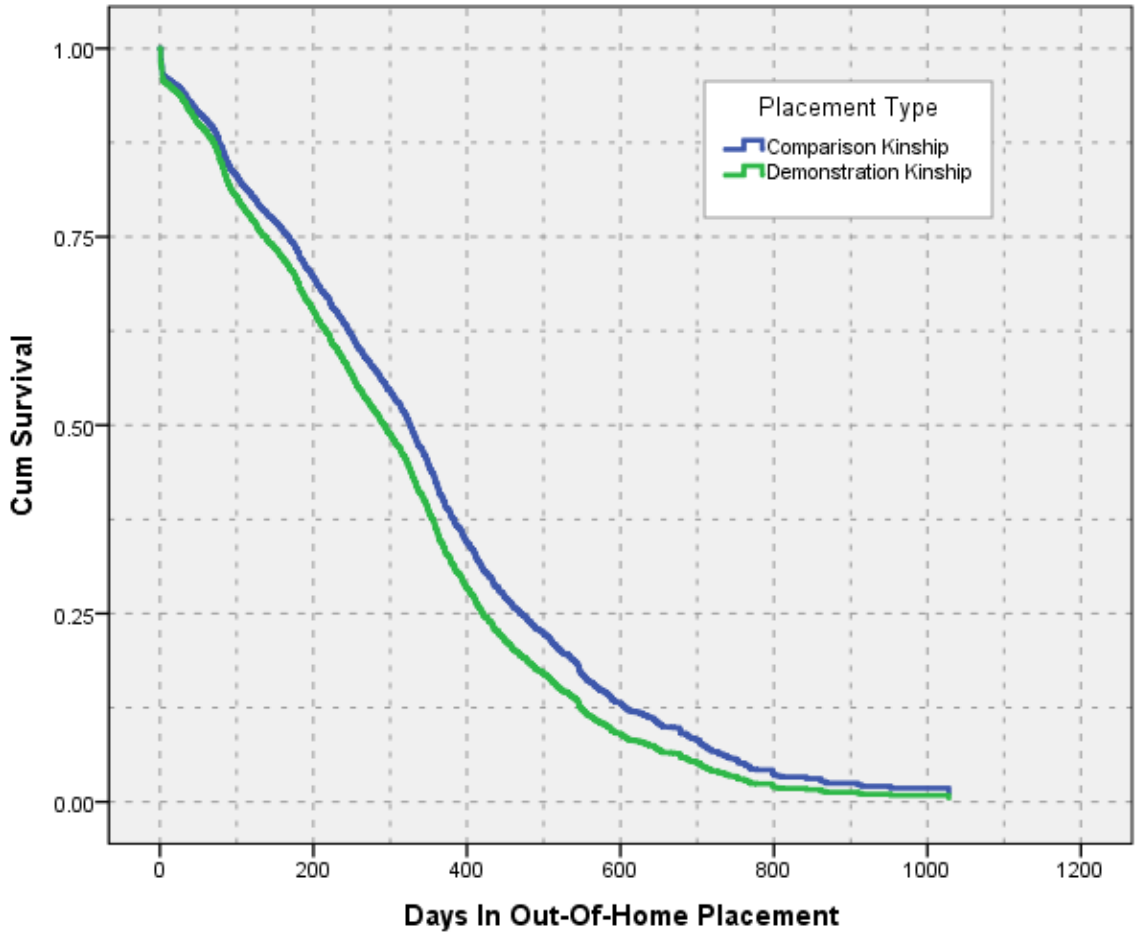
[150] ($F(1, 4476) = 43.59$, $p < .001$)

[151] Means and Standard Deviations reported are adjusted for propensity scores.

[152] A likelihood ratio test indicated that the combination of treatment type, begin date, and weighted propensity score predicted time spent in placement ($\chi^2(3) = 52.31$ $p < .001$). Moreover, treatment type, the variable of interest, predicted time in placement (Wald $\chi^2(1) = 27.92$ $p < .001$), accounting for the effect of placement begin date (Wald $\chi^2(1) = 20.00$ $p < .001$) and the propensity score (Wald $\chi^2(1) = 2.01$ $p > .05$).

adjusted median time in out-of-home placement was 290 days[153] among children served by the intervention and 325 days for children placed with kin in comparison counties.

Figure 4.13: Kinship Supports Versus Comparison Kinship - Differences in Length of Placement



Re-Entry into out-of-home Care: Logistic regression models[154] were used to test the hypothesis that children placed with kin and served by the intervention in demonstration counties would be less likely to re-enter out-of-home care both within six and within twelve months of the end of their first placement episode than children placed with kin in comparison counties. For both sets of analyses, a weighted propensity score was used as a covariate, and only children that had been discharged from initial placement episodes were used.

[153] Although the demonstration subpopulation for this set of analyses is equivalent to the subpopulation used in the kinship versus foster care analyses reported earlier, the reported medians differ due to the use of propensity scores that were generated separately for each population (i.e., demonstration kinship with comparison foster, and demonstration kinship with comparison kinship.)

[154] Model used treatment type (Demonstration Kin or Comparison Kin) and a weighted propensity score as covariates predicting the occurrence or non-occurrence of re-entry.

- **Re-entry within 6 months.** No significant differences were found in the likelihood of re-entry into out-of-home care within six months between the two groups,[155] suggesting that children placed with kin in comparison counties were neither more nor less likely to re-enter out-of-home care within six months of the end of their first placement episode than children placed with kin in demonstration counties.
- **Re-entry within 12 months.** Similarly, no significant differences in the likelihood of re-entry within 12 months were found,[156] suggesting that children placed with kin in comparison counties were neither more nor less likely to re-enter out-of-home care within 12 months of the end of their first placement episode than children placed with kin in demonstration counties.

Kinship Supports Demonstration versus Kinship Comparison Summary: The intervention appears to have positively impacted outcomes for children. While the differences in outcomes between children placed with kin and served by the intervention in demonstration counties and children placed with kin in comparison counties weren't quite as substantial as the differences found when comparing to foster care placements, children placed with kin served by the intervention fared equally as well or better than children placed with kin in comparison counties:

- No significant differences were found between the two groups in the rates of substantiated or indicated abuse or neglect reports during or after a kinship placement had occurred.
- Children served by the intervention experienced greater placement stability (significantly fewer placement moves) than children placed with kin in comparison counties.
- Children served by the intervention spent significantly fewer days in out- of-home care than children placed with kin in comparison counties.
- No significant differences were found between the two groups in the rate of re-entry into out-of-home care at six or twelve months.

4.6.4 Kinship Implementation Models

Previously, we described three direct service models that demonstration counties have implemented. The two-worker approach represents the most significant variance from practice-as-usual, from a caregiver's perspective, while the one-worker model is the most closely aligned with practice-as-usual. In order to investigate possible driving factors of the differences found between outcomes for children placed with kin in demonstration and comparison counties, the evaluation team isolated counties implementing the one- and two-worker models to test the hypothesis that children served by a two-worker model may be driving the positive outcomes found between children receiving intervention services and children placed with kin in comparison counties. Analyses were re-run on the two outcome variables where significant differences were found between the two groups.[157]

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[155] (Wald $\chi^2(1) = .000$, Odds ratio = 1.15, $p > .05$)

[156] Wald $\chi^2(1) = .000$, Odds ratio = .99, ns

[157] Previously we described four counties as having implemented a one-worker model; however, these categorizations were made without attention to Kinship Navigator programs (given the wide variation of Kinship Navigator programs within Ohio). Within one of these counties, though, a Kinship Navigator program is located within the PCSA, meaning caregivers may have access to a secondary kinship worker in addition to their ongoing caseworker. Therefore, because these caregivers may

Placement Stability: Implementation type appeared to be a driving factor in differences found in placement stability between children served by the intervention and children placed with kin in comparison counties. Mean-level differences between children who received intervention services and children placed with kin in comparison counties were slightly more pronounced when only demonstration children served by a county utilizing the two-worker approach were included in the analysis. Kin-placed children who were served by a two-worker model experienced significantly fewer placement moves (m = .15, *SD* = .53) than children placed with kin in comparison counties (m = .27, *SD* = .51); $F(1, 3411) = 28.22$, $p < .001$).

By contrast, placement stability differences between children served by a demonstration county utilizing the one-worker model and children placed with kin in comparison counties were not significant. Although kin-placed children who were served by a one-worker model experienced fewer placement moves (m = .19, *SD* = .53) than children placed with kin in comparison counties (m = .27, *SD* = .51), this difference was not significant ($F(1, 3096) = 3.27$, $p > .05$).

Time in Placement: Implementation type did not appear to be driving factor in the differences found in placement length between children served by the intervention and children placed with kin in comparison counties. Regardless of whether counties used the two-worker or one-worker model, children in demonstration counties spent significantly less time in out-of-home placement than kin-placed children served by comparison counties.

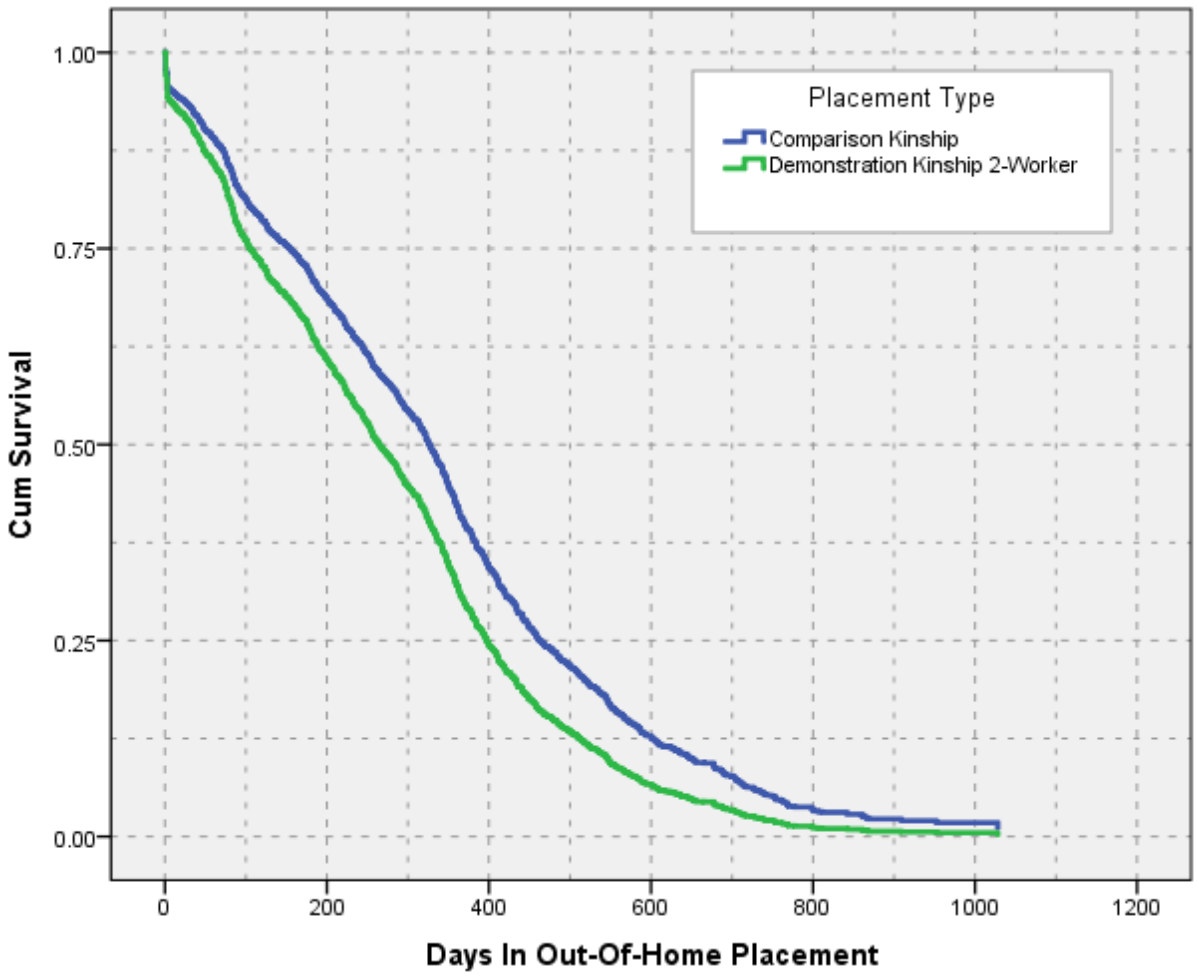
- Two-worker model: Using the same analysis intervention as before, results indicated that discharge from placement occurred significantly more quickly among children placed with kin in demonstration counties implementing a two-worker model compared to children placed with kin in comparison counties (see Figure 4.16). Table 4.11 provides the model statistics. The adjusted median time in out-of-home placement was 265 days among children placed with kin in demonstration counties utilizing a two-worker approach and 325 days for children place with kin in comparison counties.

Table 4.11: Differences Between Two-Worker Kinship Supports and Comparison Kinship in Time Spent Out-Of-Home

Overall Model	***df***	X^2	***P***
	3	**59.89**	<.001
Model Predictors	***df***	***Wald***	***p***
Weighted Propensity	1	8.44	<.01
Placement Begin Date	1	3.07	>.05
Placement Type	1	44.47	<.001
Number of Events: 3414	Total Cases: 4779		Censored: 28.6%

experience services that resemble a hybrid or two-worker model, this county was excluded from the one-worker model grouping for this analysis.

Figure 4.15: Two-Worker Kinship Supports Vs Comparison Kinship - Differences in Length of Placement

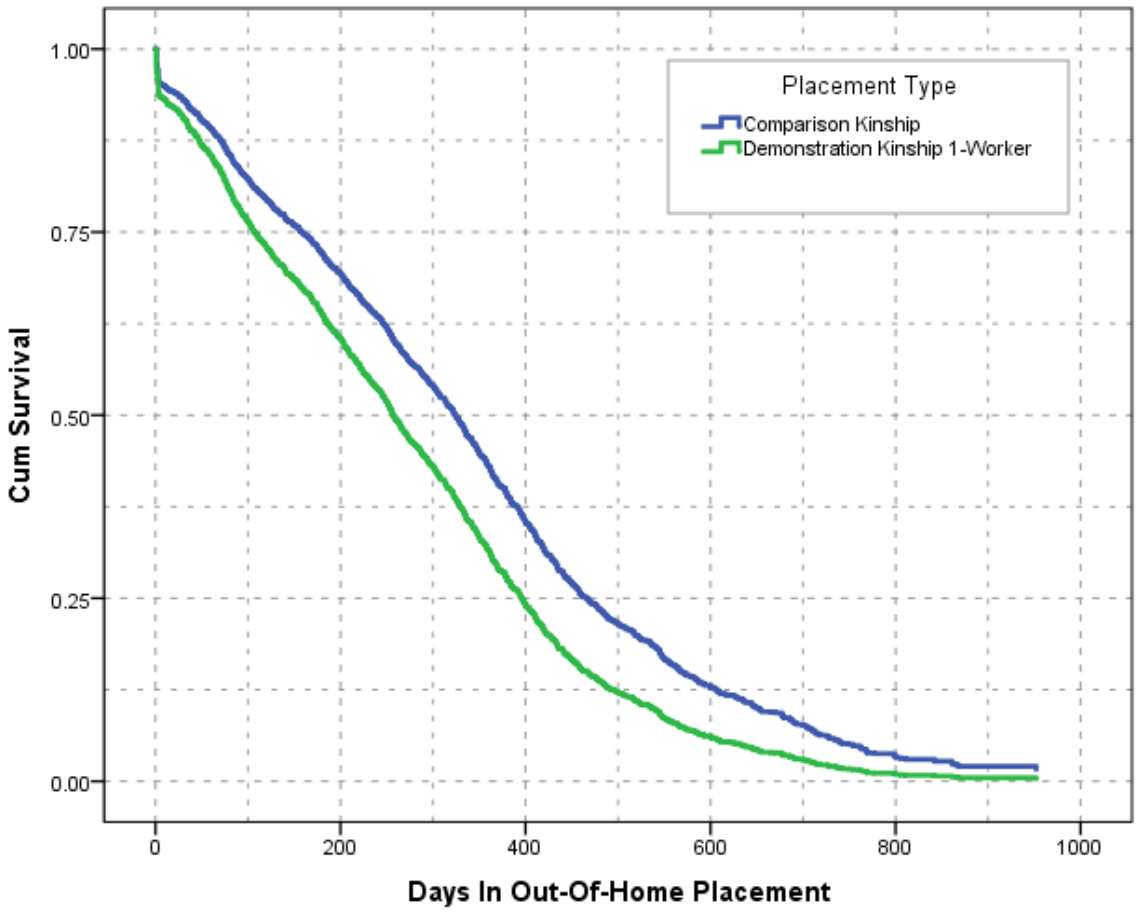


- **One-worker Model:** Results indicated discharge from placement also occurred more quickly among children placed with kin in demonstration counties implementing a one-worker model compared to children placed with kin in comparison counties (see Figure 4.17). Table 4.12 provides the model statistics. The adjusted median time in out-of-home placement was 264 days among children placed with kin in demonstration counties utilizing a one-worker approach and 325 days for children placed with kin in comparison counties.

Table 4.12: Differences Between One-Worker Kinship Supports and Comparison Kinship in Time Spent Out-Of-Home

Overall Model	***df***	X^2	***P***
	3	**53.82**	<.001
Model Predictors	***df***	***Wald***	***p***
Weighted Propensity	1	.42	>.05
Placement Begin Date	1	7.03	<.01
Placement Type	1	17.58	<.001
Number of Events: 3099	Total Cases: 4359		Censored: 28.9%

Figure 4.16: One-Worker Kinship Supports Vs Comparison Kinship - Differences in Length of Placement



4.6.5 Kinship Outcome Summary

Demonstration county agencies were successful in utilizing kin care as a placement option. As Consortium members suspected, demonstration PCSAs were significantly more likely to utilize kinship care as an initial placement option, avoiding the trauma often associated with temporary emergency foster care placements. Further, children in demonstration county agencies were more likely to spend the majority of their placement days with kin. And, while demonstration county children spent fewer days in out-of-home care overall, a significantly greater proportion of those placement days were spent with kin.

When outcomes for children who were placed with kin and received intervention services were compared to outcomes for children placed in foster care in comparison counties, several positive findings emerged, including:

- Children who had exited kin care in demonstration counties were significantly less likely to experience subsequent abuse or neglect than children exiting foster care in comparison counties.

- Children placed with kin in demonstration counties experienced significantly fewer placement moves than children placed in foster care in comparison counties.
- Children placed with kin in demonstration counties spent significantly fewer days in out-of-home care than children placed in foster care in comparison counties.
- Children placed with kin in demonstration counties were significantly less likely to re-enter out-of-home care than children placed in foster care in comparison counties.

Further, when outcomes for children who received intervention services were compared to outcomes for children placed with kin in comparison counties, positive and neutral findings emerged:

- No significant differences were found between the two groups in the rates of substantiated or indicated abuse or neglect reports during or after a kinship placement had occurred.
- Children placed with kin and served by the intervention experienced significantly fewer placement moves than children placed with kin in comparison counties.
- Children placed with kin and served by the intervention spent significantly fewer days in out-of-home care than children placed with kin in comparison counties.
- No significant differences were found between the two groups in the rate of re-entry into out-of-home care.

Finally, the direct service model type appeared to be a driving factor in the differences seen in placement stability between children served by the intervention and children placed with kin in comparison counties. When children served by a two-worker model were isolated and compared to children placed with kin in comparison counties, the difference in the number of placement moves became slightly more pronounced. By contrast, when children served by a one-worker model were isolated and compared to children placed with kin in comparison counties, the difference in the number placement moves was no longer significant.

In sum, demonstration county agencies were more likely to use kinship care, and to use it more extensively than comparison counties. And, kinship care appeared to produce better outcomes than foster care in terms of safety, stability, and permanency. The ProtectOHIO Kinship Supports intervention also appeared to benefit children; children receiving intervention services experienced fewer placement moves and fewer days in out-of-home care than children placed with kin in comparison counties.

4.7 Conclusion

Ohio's third waiver period Kinship Supports intervention builds on an initial intervention employed during the second waiver period, when six counties agreed to focus on the use of kinship placements. The second waiver period evaluation found that across the demonstration counties kinship practice was variable and flexible, and while some positive findings emerged, limited large-scale differences were found between those counties implementing the intervention and those that were not. However, child welfare agencies participating in the waiver share a common belief that when placement becomes necessary, kinship care is in the best interest of the child. Consequently, Consortium members sought to establish a well-defined approach and expand intervention use to all 16 demonstration county agencies.

Consortium members were successful in their efforts. Early on in the waiver period, a workgroup of designated kinship staff developed a ProtectOHIO Kinship Supports Intervention Practice Manual, detailing core components, fidelity measures, and guidelines related to the following aspects of the model:

- Kinship staff duties, competencies, and skills
- Training
- Case management tools
- Services and supports

And, as the practice manual was being developed, the evaluation team developed a kinship module in the ProtectOHIO Data System, designed to collect case-level intervention data not otherwise available in SACWIS. Upon completion of the manual and data system in October 2011, the intervention was formally implemented across all demonstration agencies.

Shortly after implementation of the intervention, the Ohio Child Welfare Training Program worked with volunteers from the kinship manual workgroup to develop and conduct several two-part trainings that would be required of all intervention staff. Part one of the training included a focus on the general needs of kinship caregivers while part two focused specifically on implementation of the intervention per the practice manual; staff from all 16 demonstration counties participated. The development of the practice manual combined with common training for all staff allowed for a more comprehensive and systematic implementation of kinship practices than were seen in the second waiver period. Furthermore, a workgroup of intervention staff was established upon completion of the manual, which meets quarterly and serves as a platform for continued discussion and refinement of the intervention.

While the intervention is clearly more comprehensive in the third waiver period compared to the second, variation in implementation of the model remains across the demonstration counties. While all demonstration counties have a designated kinship expert and have ensured that all direct and indirect components of the model are occurring, three primary structures have been employed: a two-worker model, a one-worker model, and a hybrid approach.

Two-Worker Model: In this model, implemented by six demonstration counties, all kin caregivers have a kinship specific staff member that provides ongoing support in addition to the ongoing caseworker assigned to the case. The ongoing caseworker follows the traditional child welfare model of working a reunification plan with the biological parents, and also supporting the kin caregiver to the extent that he or she can, while the primary responsibility of the designated kinship staff is to support the caregiver. This model represents the most significant variance from practice as usual.

One-Worker Model: In this model, implemented by four demonstration counties, ongoing caseworkers assigned to the case are the primary source of support for both biological parents and kin caregivers. This approach is not practice as usual, because the agency has a kinship expert and caseworkers may be trained on the intervention; however it is the model most closely aligned with practice as usual.

Hybrid Approach: In this approach, implemented in six demonstration counties, designated kinship staff may act as an additional, kinship specific resource for caregivers on a case-by-case or as-needed basis, depending on staff capacity or the level of caregiver need. In these counties, caregivers may have

varying experiences of the model; depending on the caregiver there may or may not be a secondary staff member beyond the ongoing caseworker to provide kinship-specific support.

These categorizations were developed by the evaluation team in an attempt to elucidate the intervention models that have emerged across the demonstration counties. However, the model descriptions are not concrete, and individual PCSA staff may identify their county as implementing a model other than the one the evaluation team classified the agency as implementing. For instance, during a recent workgroup meeting, staff in a two-worker model county noted that sometimes caregivers refuse or don't need intervention services. In this sense, the primary contact for some caregivers may be the ongoing worker on the case – a practice more closely aligned with a one-worker or hybrid model because the caregiver chooses not to interact with two contacts. The evaluation team attempted to classify county models by categorizing counties based on the experience the majority of caregivers in the county would have; although some caregivers may not accept intervention services, counties were classified as utilizing a two-worker approach if each caregiver had a designated kinship staff member providing – or attempting to provide – ongoing support throughout the duration of their kinship placement.

Although three different models have emerged, there appears to be a much greater emphasis on kinship care overall in demonstration counties than in comparison counties. Whereas all demonstration counties have, at a minimum, a designated kinship expert, only a quarter of comparison counties indicated they have staff dedicated to serving kin in some capacity beyond home studies. This may be the most significant difference between demonstration and comparison counties, and a likely factor in the differences found in kinship-specific case services utilization and outcomes for children and families seen between demonstration and comparison counties.

Since service referral and provision are core components of the intervention, the evaluation team analyzed case service utilization between demonstration and comparison counties. However, the services data in SACWIS has several limitations and results should be interpreted cautiously. Nonetheless, several interesting findings emerged.

Demonstration county agencies reported providing significantly more services in general than comparison counties. However, during the third waiver period demonstration county staff received training and were encouraged to enter case services data; meaning it is likely that demonstration county staff *entered* more services data rather than provided significantly more services. In fact, when only those cases for which data had been entered were analyzed, the average number of services provided to families were equivalent between demonstration and comparison counties. However, when this analysis was limited to services provided to *kinship families*, demonstration county staff reported providing significantly more services per kinship family than comparison counties. Furthermore, while all 16 comparison counties entered some level of case services data into SACWIS, 5 of these counties have no services data specific to kinship households. And, interestingly, the types of services most commonly provided vary substantially between demonstration and comparison counties. Among comparison counties, the most common non-case management service provided to kin families was Independent Living/Transitional services, possibly indicating a focus on planning for alternate living situations rather than supporting kin. By contrast, the most common non-case management service provided to kin families in demonstration counties was Financial Support, likely a result of IV-E waiver flexibility.

Having a combination of designated kinship staff and waiver flexibility to provide needed services and supports is at the core of the intervention. In fact, when kinship staff and caregivers were asked what the primary benefits of the intervention were, material and emotional support emerged from both groups. Caregivers indicated that prompt services and supports are important to meet their physical needs and contribute to the stability of placements; staff indicated that waiver flexibility allows them to provide hard goods and financial supports. Caregivers also noted that the emotional support they receive from kinship staff is a key value of the intervention, and that without that relationship they may be hesitant to ask Children Services for services or hard goods due to pride.

Overall, the intervention has evolved into regular practice in many demonstration counties. Yet, staff in some counties noted their agencies – or some staff within their agencies – may not be bought into the intervention or kinship placements in general. This variance in level of support for the intervention may have impacted the extent to which the eligible population was reached. Overall, across the demonstration counties, 60% of eligible kinship families were served by the intervention, with individual counties serving between 30% and 90% of eligible kinship families.

Variation also existed in the extent to which intervention assessments were completed. A fidelity analysis examined three specific components of the model:

- The Home Assessment Part I - intended to collect minimum information needed to determine whether a placement is appropriate,
- The Home Assessment Part II – a kinship specific supplement to the fuller homestudy process, and,
- The Family Resource Scale (FRS) – an assessment designed to assist the worker and family to identify family strengths and needed services and supports.

Overall, 69% of kinship households received part I of the home assessment within 35 days of placement, 59% of kinship households received part II within 35 days of placement, and 59% of families received an initial FRS within 35 days of placement – the formal fidelity markers. The FRS is also intended to be completed quarterly, in order for the worker to determine if a change in services is needed. However, the fidelity analyses found that follow-up assessments were administered far less frequently and were often not completed within the specified timeframe (56% of eligible kin families received a second assessment, 43% of eligible families received a third assessment, and 35% of eligible families received a fourth assessment – a smaller proportion of these families received them on a quarterly basis).

However, when the data that was collected was examined, positive findings emerged. Overall, kinship families' need for basic family resources was most often indicated as being "always" met. There were some slight significant decreases in access – all of which would be naturally expected as additional children enter the home (e.g., money for utilities/bills); however access to other resources that kinship staff can assist with increased significantly (e.g., access to public assistance, daycare, and medical insurance for the child in care). These findings support the case services analyses and underscore what was heard from caregivers and staff – that intervention services assist caregivers to access needed resources to maintain stable and secure placement options.

Qualitatively, the demonstration agencies appear to have successfully implemented the intervention in Ohio's third waiver period. However, an outcome analysis was conducted to examine the impact of the intervention on children served in terms of safety, stability and permanency measures. Overall, positive findings emerged.

Demonstration agencies were largely successful in their goal of utilizing kinship care as a placement setting Demonstration county children were significantly more likely to be placed with kin, were significantly more likely to experience an initial placement with kin (i.e., avoid temporary emergency placements), and spent a significantly greater proportion of their placement days with kin than comparison county children.

Because kin care was used more extensively in demonstration counties than in comparison counties, the evaluation examined outcomes for children placed with kin and served by the intervention compared to outcomes for children placed in foster care in comparison counties. This was necessary to ensure that kin care is indeed a safe and appropriate placement option. Again, positive findings emerged, demonstrating the benefits of kin care over foster care:

- Children who had exited kin care were significantly less likely to experience subsequent abuse or neglect,
- Children placed with kin experienced significantly fewer placement moves,
- Children placed with kin spent significantly fewer days in out-of-home care,
- Children placed with kin were significantly less likely to re-enter out-of-home care.

While comparing kinship care to foster care is necessary and furthers the evidence base for kinship care as best practice, in order to assess the impact of the intervention specifically, outcomes for children who were placed with kin and received intervention services were compared to outcomes for children placed with kin in comparison counties. Interestingly, while there were no significant differences in certain outcome variables (re-reports and re-entry into care), significant positive findings emerged for other outcome variables, in favor of children that received intervention services over those that did not:

- Children served by the intervention experienced significantly fewer placement moves, and
- Children served by the intervention spent significantly fewer days in out-of-home care.

These findings are particularly interesting because, while the intervention is intended to *indirectly* impact a variety of outcome measures, the intervention components identified as most valuable by both caregivers and kinship staff – material and emotional support – are most likely to *directly* impact placement stability. Both staff and kin caregivers who were interviewed cited the benefits of these intervention components in terms of assisting caregivers in maintaining stable and healthy home environments. And, because a large proportion of children who "exit" placement actually remain with their kinship caregivers who are awarded custody, the intervention services may decrease placement lengths by helping caregivers to access services and supports to reach permanency sooner. While we didn't see significant differences in relation to recurrence or re-entry into out-of-home care, these are outcome measures the intervention is less likely to directly impact.

Finally, to begin exploring whether counties' direct service model type, that of a one- or two-worker model, was driving the positive outcomes seen between children receiving intervention services and children placed with kin in comparison counties, further analyses were conducted isolating those two groups. The results suggested that while model type didn't appear to be driving the shorter placement lengths seen in children receiving intervention services, there did appear to be an association between model type and placement stability. When children receiving intervention services under a two-worker model (the model type most different from practice-as-usual) were compared to children placed with kin in comparison counties, the difference in number of placement moves was more prominent. By contrast, when children served by a one-worker model (the model type closest to practice-as-usual) were compared to children placed with kin in comparison counties, the difference in the number of placement moves was no longer significant.

Overall, in Ohio's third waiver period, demonstration agencies have established a intervention that appears to be largely successful. While there was variation in implementation of the intervention and the extent to which the eligible population was reached, a substantial number of positive outcomes emerged. Demonstration PCSAs are utilizing kin care to a greater extent than their comparison counterparts, and these children in kinship care experience better outcomes than children placed in foster care. Furthermore, they have demonstrated evidence that suggests that the intervention itself leads to improved permanency and stability outcomes.

Chapter 5. Fiscal Analysis

5.1 Introduction

The fiscal study addresses the question of whether the third waiver will have the hypothesized effect on child welfare expenditure patterns, relative to the period prior to the third waiver. The first section recaps the fiscal stimulus embedded in the ProtectOHIO waiver and its expected impact. This section includes a history of waiver funding and savings since calendar year 1998. Next, we describe the data collected by the evaluation team and issues that arose in interpreting the data. The third section describes changes in foster care board and maintenance expenditures and related data. Then, we report on the analysis of how much flexible funding demonstration counties had during the third waiver and the extent to which those funds were spent on child welfare purposes other than foster care board and maintenance. The comparison we use is 2010,[158] the year prior to the start of the third waiver period.

5.2 Waiver Stimulus

The fiscal stimulus embedded in the ProtectOHIO waiver was anticipated to reduce foster care expenditures in demonstration counties by allowing county administrators more freedom to invest in services other than foster care. Prior to the waiver's beginning on October 1, 1997, ODJFS acted as the "pass through" for federal Title IV-E reimbursement to counties. Counties claimed Title IV-E foster care board and maintenance expenditures to the state, the state made those claims to the Children's Bureau and "passed through" federal revenue according to the reimbursement percentages set by the Children's Bureau. Starting on October 1, 1997, counties participating in the Ohio waiver gave up these guaranteed, unlimited, fee-for-service federal contributions to foster care board and maintenance costs for certain children in exchange for a fixed amount of money that could be used for all child welfare services for any child. The fixed amount of money was intended to be the same amount as the county would have received under normal Title IV-E reimbursement rules in the absence of the waiver. The amount was based on each county's historical foster care expenditures, adjusted each year in accordance with changes in foster care utilization and unit costs of a group of cost-neutrality control counties not participating in the waiver. Title IV-E administrative claims were not, and have not been a part of the ProtectOHIO waiver.

The Ohio waiver addressed the prevailing belief that restricting the use of Title IV-E funding to foster care board and maintenance 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 would be able to retain this federal Title IV-E funding for other child welfare purposes. As a result, it was hypothesized that administrators in demonstration counties would take more action to reduce foster care expenditures in ways that were favorable to children, families, and communities, relative to actions taken by comparison counties.

[158] Our team also tested using the average of 2009 and 2010 as the comparison baseline. Although the absolute percent changes varied slightly, the pattern of change across all measures remained same with this alternative baseline. To be consistent with the second waiver report (2004 vs 2005-2008), we used 2010 year alone as the comparison for the third waiver analysis.

The Ohio waiver also made the amount of Title IV-E revenue more predictable. Rather than fluctuating with the number of children in placement or the number of high-cost placements, the waiver payment grew or shrunk by a relatively small amount from year to year. Revenue in the second and third waiver periods became even more predictable when annual Title IV-E eligibility rates were removed from the calculation of each county's waiver payment.

The Ohio waiver did expose county administrators to new risks. At a minimum, county administrators risked that the fixed 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 at the same rate as the control counties during the waiver period, 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 structure of the waiver stimulus has been the same since the beginning of the waiver. The essential feature of the payment methodology is that a county's Title IV-E foster care payment in a given year is based on the prior year's payment, adjusted by the change in placement day usage and unit costs generated by a group of control counties.[159] Thus the two components of foster care expenditures – days and unit costs – are allowed to vary independently.

The base amount for the original set of demonstration counties traces back to the county's own historical foster care expenditures and care day utilization from July 1, 1996-June, 30 1997, now almost 20 years ago. At the beginning of the second year of the first waiver and for each year after that, ODJFS applied estimates of changes in control county unit cost and placement days to the previous year's budget to derive the new year's budget. In the first waiver period, this budget was then adjusted by the actual percent of children who were Title IV-E eligible in that year. ODJFS then reconciled those payments once actual control county data was available.[160]

Figure 5.1 shows the total amount of federal revenue paid through the waiver to the original fourteen demonstration counties over the last seventeen years. During the first waiver period, particularly in the first years, control counties had high rates of placement day growth, generating a total amount of revenue that reached $61 million in 2003. During the second waiver period (2005-2009), placement day utilization of the aggregated group of control counties shrunk, causing demonstration county's waiver payments to go down relative to the prior years.[161] Waiver revenue declined modestly in almost every year between 2004 and 2011. Since 2011, the start of the third waiver, there has been a gradual increase in demonstration county waiver payments again[162]. These trends in growth and reduction of foster care board and maintenance expenditures among control counties reflected trends in the use of

[159] The control counties are a different group from the comparison counties used for the evaluation, though some counties are in both groups.

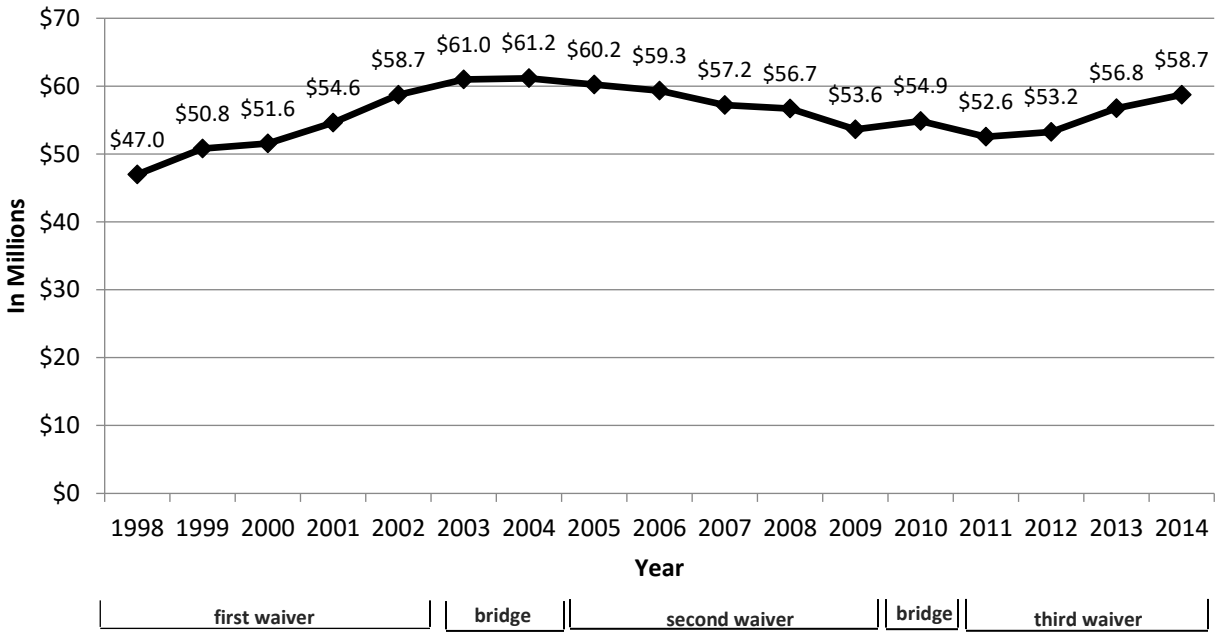
[160] While ODFJS sought to avoid overestimating waiver revenue, in some years, after this reconciliation, demonstration counties received less than was originally estimated.

[161] Waiver payments went down in each of the four fiscal years during the second waiver period, by 1.9% in FFY 2005, 0.5% in FFY 2006, 4.66% in FFY 2007 and 0.25% in FFY 2008.

[162] Waiver payment went up in each of the past three fiscal years during the third waiver period, by 1.3% in FFY 2012, 6.6% in FFY2013 and 3.5% in FFY2014.

foster care taking place across Ohio. From a cost-neutrality point of view, these fluctuations were "fair" in the sense that they represented what would have happened in the absence of flexible funding.

Figure 5.1: Title IV-E Waiver Payments, 1998-2014



During the third waiver period, most demonstration counties continued to receive more waiver revenue than they would have under normal reimbursement rules. Table 5.1 shows, starting in 2004, the results of comparing the amount of waiver revenue received in a year to the estimated amount of Title IV-E reimbursement the county would have received, based on actual foster care expenditures in that same year. (This calculation is discussed in detail in Section 5.4.) If a county received more waiver revenue that the federal share of foster care expenditures would have been, the county had waiver savings to reinvest. As shown in Table 5.1, six counties had savings to reinvest in all eleven years (2004-2014). Hamilton County also had savings to reinvest in the seven most recent years.[163] Three counties had savings in at least 6 of the 10 years. A minority of the demonstration counties (four) had savings in five or fewer years. It is worth noting that 10 out 14 original demonstration counties had savings to reinvest in all four consecutive years (2011-2014) during the third waiver period (Belmont, Clark, Crawford, Franklin, Hamilton, Lorain, Muskingum, Portage, Richland, and Stark).

[163] Hamilton County's savings could only be calculated for the 7 most recent years because of missing data in 2004-2007.

Table 5.1: Years with Waiver Savings, 2004-2014	
Counties with savings **in all 11 years**	Belmont Clark Crawford Hamilton[164] Lorain Portage Richland
Counties with savings **in 6-10 years**	Medina Muskingham Stark
Counties with savings **in 5 or fewer years**	Ashtabula Fairfield Franklin Greene

Even though the majority of demonstration counties have been "stimulated" for thirteen years prior to the start of the third waiver, we would expect the fiscal stimulus of the waiver to continue to operate and, if effective, give rise to distinctions between demonstration and comparison counties. For example, county administrators and staff who reduced the use of foster care during the second waiver period may find themselves facing rising placements due to new challenges in their community. In theory, a demonstration county, facing a fixed budget for foster care, would work harder to find alternatives to placement than a comparison county, where there would be fewer concerns about covering 100% of foster care costs above a certain amount. Thus, the original waiver hypothesis still applies: counties receiving waiver funds can be expected to reduce foster care expenditures more than comparison counties, or at least not increase expenditures as much.

5.3 Methodology

As in prior waiver periods, the evaluation team used county budget documents, clarified through interviews with county officials, to compile annual county-level aggregate expenditure data for child welfare services from demonstration and comparison counties. Since the last evaluation report, the evaluation team collected fiscal data from 2010 through 2014 for a total of 31 counties: 15 demonstration counties (14 original and one 2005 county) and 16 comparison counties (13 original and three 2005 counties).[165]

The data presented are best estimations of program costs for each county rather than an exact accounting of expenditures. Two reasons lie behind this lack of precision: first, counties differed widely

[164] Ibid

[165] Counties that joined in 2005 that are included are Coshocton (demonstration) and Guernsey, Morrow and Perry (comparison). Three other 2005 counties are not included: Highland and Hardin (demonstration) and Hocking (comparison). Highland dropped out of the waiver in 2013 due to rising foster care costs. Hardin was unable to provide data for the evaluation. Hocking withdrew as a comparison county due to a merger with another county.

in their ability to track expenditures by program type. For example, some line items as reported by the county contained expenditures that spanned multiple expenditure categories. Resolving such difficulties sometimes required estimations, and some counties were better able to resolve certain difficulties than others. Second, counties' ability to interpret expenditure trends also varied significantly. Some counties had difficulties interpreting their own historical data, and many had not previously viewed expenditure information in a summarized format designed to show trends over time. Not all counties were able to explain their expenditure trends.

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

- Paid placement days;
- Average daily cost of foster care placement (total foster care expenditures divided by paid placement days[166]);
- Total foster care expenditures;
- All other child welfare expenditures; and
- Foster Care expenditures as a percent of all child welfare expenditures.

For each dependent variable listed above, we present the change in the indicator in the third waiver period by comparing 2010 (the year prior to the third waiver) to the average of four years of the third waiver – 2011, 2012, 2013 and 2014. The fiscal data we collected is typical repeated measures data with: (1) individual counties as subjects that were assigned to comparison and demonstration groups and (2) five dependent measures cited above which were each repeatedly measured at five time points (2010-2014). The team chose a commonly used statistical procedure -- SAS Proc Mixed -- for the analysis of this time series. This procedure offers repeated measures analyses that account for within-county covariability, accommodate any type of covariance structure, and allow the full range of variation in each time series to be examined simultaneously. In this case, the between-county effect is the comparison/demonstration group status that remains constant within each county over the five points of the time series, whereas the within-county effects are the individual waiver years and the interaction of each individual year and group status. A statistically significant effect in the Proc Mixed model would indicate that the underlying pattern of change in that particular measure was different between the demonstration and comparison groups due to the implementation of the waiver.

5.4 Foster Care Expenditures

If counties were to reduce foster care expenditures, they would have to reduce the number of paid placement days, reduce the average daily cost of care, or both. This section presents data on trends in paid placement days, unit costs, and foster care expenditures. In addition, to analyze the pattern of foster care expenditures relative to child welfare spending generally, the section also shows data on trends in all other non-foster care expenditures and foster care as percent of all child welfare expenditures.

[166] The average daily cost summarizes the daily cost of care based on the cost of each unit (level of care) and the amount of each unit provided. While we arrive at this cost by dividing all days into all foster care expenditures, we would arrive at the same figure if we were able to differentiate days by level of care and multiplied those days by the unit costs for each level.

5.4.1 Paid Placement Days

Table 5.2 shows counts of paid placement days provided from 2010 through 2014. The column "Average Change" shows the percent change between 2010 and the average of the subsequent four years (2011-2014). For example, Belmont reduced paid placement days by 14% over the four years of the third waiver on average relative to 2010. Across all counties, we see a very similar picture of the pattern of changes between demonstration counties and comparison counties. A total of 15 counties (about half of the counties) had an average decrease in paid placement days, and they are about equally distributed between the demonstration and comparison groups (7 demonstration counties and 8 comparison counties). The two groups can be found at both ends of the distribution, and similar numbers of counties show placement day growth and decline. The difference in the distribution of average annual changes in paid placement days between the demonstration group and comparison group was not statistically significant when measured by Proc Mixed model. In other word, the demonstration status was not sufficient to explain the variation in annual counts of paid placement days.

Because the waiver stimulus has been operating for 17 years, it is important to consider the possibility that, for some counties that were particularly successful in reducing placement utilization in the early years of ProtectOHIO, further placement day reductions were not possible. Going into 2014, a few counties had already dramatically reduced placement days since 1998. These were Richland (demo), Lorain (demo) and Miami (comp). In each of these counties, in 2009 - one year prior to the start of the third waiver period - placement days were one-third of what they had been in 1998. This common experience of dramatically reducing placement utilization was not continued in the third waiver. In Richland and Miami counties, placement days have modestly decreased, whereas in Lorain County, placement days have increased in the first three years of the third waiver period. Still, in Lorain County, placement day utilization in 2012 was half of what it was in 1998, and in 2014, the placement day utilization dropped sharply to the level seen in 2009. The experience of these counties suggests that some reductions may continue to be possible for some counties, with expected fluctuations from year to year.

Table 5.2: Paid Foster Care Placement Days Recorded in SACWIS, 2010-2014						
	2010	**2011**	**2012**	**2013**	**2014**	**Average Change**
Demonstration Counties						
Ashtabula	31,611	31,667	31,960	38,270	42,552	14%
Belmont	14,015	13,744	11,240	10,904	12,072	(14%)
Clark	47,545	40,462	38,160	39,644	41,181	(16%)
Coshocton	6,225	7,823	8,636	7,969	7,076	27%
Crawford	11,873	12,629	12,295	18,242	20,609	34%
Fairfield	27,566	35,355	38,524	34,691	33,145	29%
Franklin	612,351	605,387	574,732	578,761	587,297	(4%)
Greene	41,022	32,231	28,455	29,697	33,821	(24%)
Hamilton	354,319	377,381	388,729	373,299	344,811	5%
Lorain	33,500	34,618	39,051	41,729	37,730	14%
Medina	8,763	14,255	13,200	9,719	9,378	33%
Muskingum	21,338	25,464	18,398	16,107	22,480	(3%)
Portage	36,304	34,527	25,947	29,230	31,981	(16%)
Richland	16,356	14,401	18,427	18,921	21,623	12%
Stark	128,641	139,098	123,115	112,505	117,521	(4%)
Comparison Counties						
Allen	33,182	35,066	29,091	21,200	26,848	(15%)
Butler	119,767	114,528	128,935	155,005	152,780	15%
Clermont	81,249	78,810	83,990	85,583	84,561	2%
Columbiana	27,587	28,702	22,984	24,089	23,948	(10%)
Guernsey	18,512	19,457	16,182	14,975	11,673	(16%)
Hancock	16,225	15,028	19,147	15,348	11,003	(7%)
Mahoning	69,135	66,648	65,375	63,662	59,235	(8%)
Miami	14,390	14,870	18,553	15,967	13,988	10%
Montgomery	279,818	263,613	249,877	266,768	266,283	(6%)
Morrow	3,457	3,517	5,567	6,465	9,348	80%
Perry	12,175	12,914	11,141	19,372	17,798	26%
Scioto	19,951	25,857	21,262	28,208	27,197	28%
Summit	195,947	171,430	150,164	149,415	141,520	(22%)
Trumbull	60,890	58,275	54,888	52,522	61,981	(7%)
Warren	21,068	27,844	32,810	33,019	27,227	43%
Wood	15,103	15,267	15,980	16,210	15,105	4%

Source: SACWIS

5.4.2 Unit Costs

Table 5.3 shows annual average daily cost of foster care placement (unit cost) from 2010 to 2014. In the column "Average Change" it also shows the percent change between 2010 and the average of the subsequent four years (2011-2014). The average daily cost of foster care placement is calculated by dividing the number of paid days by foster care expenditures. This cost summarizes the daily cost of care based on the cost of each unit (level of care) and the amount of each unit provided. While we arrive at this cost by dividing all days by all expenditures, we would arrive at the same figure if we were able to differentiate days by level of care and multiplied those days by the unit costs for each level. The average daily cost of placement can change as unit costs for each level change, and as share of days provided at each level changes. For example, if fewer low-cost units are provided (say, regular foster care) and the same number of high-cost units are provided, the average daily cost of care will go up.

Across the four years of the third waiver period, about one third of the counties (ten counties) had an average annual decrease in unit costs; five of these counties were demonstration counties and five were comparison counties. Twenty one counties had an average increase in unit costs. Three of those counties (Belmont, Stark; Demonstration, Scioto; Comparison) had an average increase of under 4%. For example, unit costs in Belmont grew an average of 3% per year from 2011 to 2014. But the remaining counties saw average increases of 4% or higher. It should be noted that over the course of the same four years, average annual inflation[167] was 1.9%. The difference in the distribution of average annual changes in unit costs between the demonstration group and comparison group was not statistically significant when measured by Proc Mixed model. In other words, the demonstration status was not sufficient to explain the variation in average daily costs of foster care placement.

[167] Annual inflation rates were derived from http://www.bls.gov/cpi/cpid1511.pdf

Table 5.3: Annual Average Daily Cost of Foster Care Placement (in Thousands of Dollars), 2010-2014						
	2010	**2011**	**2012**	**2013**	**2014**	**Average Change**
Demonstration Counties						
Ashtabula	$83	$85	$72	$66	$71	(11%)
Belmont	$38	$38	$50	$40	$31	3%
Clark	$78	$80	$80	$88	$91	9%
Coshocton	$53	$52	$49	$62	$63	7%
Crawford	$92	$67	$79	$75	$74	(20%)
Fairfield	$43	$38	$46	$54	$57	15%
Franklin	$81	$82	$92	$80	$82	4%
Greene	$92	$72	$79	$85	$87	(12%)
Hamilton	$90	$92	$98	$101	$105	11%
Lorain	$64	$65	$66	$71	$71	6%
Medina	$95	$86	$81	$102	$100	(2%)
Muskingum	$94	$83	$119	$135	$105	17%
Portage	$102	$115	$97	$80	$87	(8%)
Richland	$34	$32	$33	$38	$43	6%
Stark	$61	$59	$61	$62	$65	0%
Comparison Counties						
Allen	$46	$43	$49	$57	$52	9%
Butler	$72	$65	$65	$63	$75	(6%)
Clermont	$62	$63	$53	$56	$60	(7%)
Columbiana	$54	$57	$82	$99	$101	57%
Guernsey	$41	$45	$51	$58	$68	34%
Hancock	$65	$66	$67	$70	$68	4%
Mahoning	$96	$84	$78	$69	$57	(25%)
Miami	$98	$100	$85	$98	$95	(4%)
Montgomery	$58	$53	$53	$62	$75	5%
Morrow	$107	$74	$66	$109	$117	(14%)
Perry	$30	$29	$33	$51	$58	44%
Scioto	$44	$41	$46	$46	$45	1%
Summit	$76	$83	$82	$85	$95	14%
Trumbull	$81	$86	$98	$89	$81	9%
Warren	$57	$52	$51	$66	$75	7%
Wood	$95	$103	$97	$94	$132	12%

5.4.3 Foster Care Board and Maintenance Expenditures

The previous two sections showed trends in the two components of foster care expenditures – paid placement days and unit costs. In this section, the product of the two components, which is total expenditures on foster care board and maintenance expenditures, is presented.

Table 5.4 shows annual foster care board and maintenance expenditures from 2010 to 2014. In the column "Average Change" it also shows the percent change between 2010 and the average of the subsequent four years (2011-2014). For example, in Coshocton County, foster care board and maintenance costs in 2011-2014 were 34% percent higher on average than in 2010. During the third waiver period, 12 counties had an average decrease in foster care board and maintenance expenditures. Six were demonstration counties and six were comparison counties. Of the 19 counties with an average growth in foster care expenditures, nine were demonstration counties and ten were comparison counties. The balanced distribution between demonstration and comparison groups are consistent with the pictures we saw in previous two analysis on paid placement days and unit cost. The difference in the distribution of average annual changes in foster care board and maintenance expenditures between the demonstration group and comparison group was not statistically significant when measured by Proc Mixed model. In other words, the demonstration status was not sufficient to explain the variation in foster care expenditures.

In a separate analysis, the evaluation team also examined foster care expenditure trends in the seventeen years since the waiver began in 1997. Using 17 years of the CPI-U, each county's 1997 foster care expenditures were projected for 17 years, through 2014. This formed a baseline for comparison to actual expenditures in each year. In eight counties (five demonstration -Belmont, Clark, Lorain, Portage, Richland - and three comparison – Allen, Butler, Wood), foster care expenditures were below adjusted 1997 expenditures in at least 12 out of 17 years. In two counties (Butler, comp; Wood, comp), foster care expenditures were below 1998 levels in all seventeen years.

Table 5.4: Foster Care Board and Maintenance Expenditures (in Thousands of Dollars), 2010-2014						
	2010	**2011**	**2012**	**2013**	**2014**	**Average Change**
Demonstration Counties						
Ashtabula	$2,611	$2,703	$2,291	$2,527	$3,015	1%
Belmont	$537	$517	$566	$431	$371	(12%)
Clark	$3,685	$3,245	$3,055	$3,492	$3,742	(8%)
Coshocton	$329	$406	$422	$497	$445	34%
Crawford	$1,095	$848	$977	$1,375	$1,532	8%
Fairfield	$1,180	$1,358	$1,789	$1,880	$1,902	47%
Franklin	$49,413	$49,499	$53,028	$46,582	$47,940	(0%)
Greene	$3,772	$2,316	$2,260	$2,513	$2,940	(34%)
Hamilton	$31,811	$34,781	$38,145	$37,862	$36,265	16%
Lorain	$2,148	$2,250	$2,584	$2,964	$2,670	22%
Medina	$829	$1,226	$1,066	$995	$937	27%
Muskingum	$2,014	$2,117	$2,191	$2,182	$2,354	10%
Portage	$3,718	$3,967	$2,516	$2,342	$2,777	(22%)
Richland	$559	$456	$608	$721	$923	21%
Stark	$7,908	$8,239	$7,501	$6,951	$7,656	(4%)
Comparison Counties						
Allen	$1,524	$1,500	$1,411	$1,205	$1,399	(10%)
Butler	$8,593	$7,409	$8,432	$9,789	$11,484	8%
Clermont	$5,062	$4,955	$4,415	$4,812	$5,110	(5%)
Columbiana	$1,490	$1,646	$1,884	$2,396	$2,427	40%
Guernsey	$766	$882	$821	$863	$799	10%
Hancock	$1,054	$987	$1,282	$1,077	$747	(3%)
Mahoning	$6,608	$5,574	$5,109	$4,421	$3,353	(30%)
Miami	$1,410	$1,482	$1,580	$1,565	$1,328	6%
Montgomery	$16,143	$13,863	$13,279	$16,557	$19,847	(2%)
Morrow	$369	$261	$365	$707	$1,098	65%
Perry	$362	$377	$371	$989	$1,026	91%
Scioto	$879	$1,058	$968	$1,296	$1,225	29%
Summit	$14,828	$14,225	$12,372	$12,744	$13,502	(11%)
Trumbull	$4,929	$5,023	$5,356	$4,659	$5,015	2%
Warren	$1,206	$1,458	$1,658	$2,185	$2,037	52%
Wood	$1,438	$1,577	$1,550	$1,516	$1,989	15%

5.4.4 All Other Child Welfare Expenditures

Table 5.5 shows five years of all other child welfare expenditures. As in previous tables, the column "Average Change" shows the percent change between 2010 and the average of the subsequent four years (2011-2014).

About half of the counties – nine demonstration and seven comparison counties -- reduced non-foster care spending during the third waiver period. These findings are consistent with what many counties reported about challenges on the service and revenue side (chapter 2). The remaining 16 out of 31 counties had successfully increased their spending on non-foster care services. Notably, all four counties (Belmont, Coshocton, Fairfield, and Muskingum) that had the greatest increase in (or, if you prefer, had double-digit increases in) non-foster expenditures were demonstration counties. The difference in the distribution of average annual changes in all other non-foster care expenditures between the demonstration group and comparison group was not statistically significant when measured by Proc Mixed model. In other word, the demonstration status was not sufficient to explain the variation in non-foster care expenditures.

Table 5.5: Annual All Other Child Welfare Expenditures (in Thousands of Dollars), 2010-2014						
	2010	**2011**	**2012**	**2013**	**2014**	**Average Change**
Demonstration Counties						
Ashtabula	$4,830	$5,038	$4,688	$3,890	$3,513	(11%)
Belmont	$2,048	$2,358	$2,245	$2,466	$2,574	18%
Clark	$6,643	$6,463	$7,430	$7,153	$5,509	(0%)
Coshocton	$1,155	$1,252	$1,459	$1,481	$1,454	22%
Crawford	$1,310	$1,271	$1,011	$1,021	$1,099	(16%)
Fairfield	$7,742	$8,880	$9,910	$9,749	$9,941	24%
Franklin	$116,319	$118,177	$115,138	$124,739	$132,603	5%
Greene	$5,210	$5,244	$4,755	$4,985	$5,779	(0%)
Hamilton	$35,465	$32,062	$34,205	$30,375	$33,738	(8%)
Lorain	$14,821	$14,548	$13,256	$12,539	$12,279	(11%)
Medina	$2,700	$2,346	$2,243	$2,284	$2,580	(12%)
Muskingum	$3,466	$3,870	$4,202	$4,528	$4,840	26%
Portage	$3,782	$2,973	$3,403	$4,081	$4,060	(4%)
Richland	$7,907	$8,366	$9,232	$8,113	$8,179	7%
Stark	$16,215	$16,246	$15,165	$15,982	$15,867	(2%)
Comparison Counties						
Allen	$4,291	$4,572	$4,332	$4,644	$4,595	6%
Butler	$16,948	$16,797	$16,725	$15,216	$15,561	(5%)
Clermont	$3,883	$4,296	$3,883	$4,309	$4,231	8%
Columbiana	$2,082	$1,925	$2,014	$2,083	$2,233	(1%)
Guernsey	$2,260	$2,059	$2,012	$2,042	$2,138	(9%)
Hancock	$1,290	$1,338	$1,269	$1,428	$1,367	5%
Mahoning	$9,097	$8,536	$8,067	$7,461	$7,927	(12%)
Miami	$1,813	$1,746	$1,911	$1,870	$1,868	2%
Montgomery	$32,196	$31,128	$30,986	$32,357	$33,035	(1%)
Morrow	$949	$879	$910	$1,015	$1,059	2%
Perry	$1,291	$1,293	$1,229	$1,380	$1,375	2%
Scioto	$1,801	$1,792	$1,753	$1,745	$1,512	(6%)
Summit	$35,543	$32,885	$31,743	$31,693	$33,535	(9%)
Trumbull	$10,129	$9,819	$10,548	$10,583	$10,280	2%
Warren	$2,464	$2,397	$2,586	$2,570	$2,703	4%
Wood	$1,874	$1,884	$2,065	$2,066	$1,929	6%

5.4.5 Foster Care as a Proportion of Total Child Welfare Spending

The proportion of foster care board and maintenance expenditures relative to all child welfare expenditures is calculated by dividing foster care expenditures by the combination of foster care expenditures with all other non-foster care expenditures. This proportion could change in a few different ways including: (1) changes in all other child welfare expenditures, or (2) changes in foster care expenditures, or (3) some combination of the two.

Table 5.6 shows what percent foster care board and maintenance expenditures were of all child welfare expenditures from 2010-2014. In the column "Average Change" it also shows the percent change between 2010 and the average of the subsequent four years (2011-2014). For example, in 2010, the year prior to the third waiver, Greene County's foster care board and maintenance expenditures accounted for 42% of total child welfare expenditures. In 2014, Greene's foster care expenditures dropped and accounted for 34% of all child welfare expenditures. Across four years of the third waiver period, we saw an average of 23% change in hypothesized direction compared to 2010. There were about half of the counties (7 demonstration counties and 7 comparison counties) that decreased their annual foster care expenditures as a share of total child welfare expenditures during the third waiver period, among which, two demonstration counties (Belmont and Greene) had the largest decrease. One comparison county (Perry) had the largest increase in foster care expenditures as a share of all child welfare expenditures. The difference in the distribution of average annual changes for this measure between the demonstration group and comparison group was not statistically significant when measured by Proc Mixed model. In other word, the demonstration status was not sufficient to explain the variation in foster care as a portion of total child welfare spending.

Table 5.6: Annual Foster Care Board and Maintenance Expenditures as Percent of All Child Welfare Expenditures, 2010-2014						
	2010	**2011**	**2012**	**2013**	**2014**	**Average Change**
Demonstration Counties						
Ashtabula	35%	35%	33%	39%	46%	9%
Belmont	21%	18%	20%	15%	13%	(21%)
Clark	36%	33%	29%	33%	40%	(5%)
Coshocton	22%	24%	22%	25%	23%	8%
Crawford	46%	40%	49%	57%	58%	12%
Fairfield	13%	13%	15%	16%	16%	15%
Franklin	30%	30%	32%	27%	27%	(4%)
Greene	42%	31%	32%	34%	34%	(23%)
Hamilton	47%	52%	53%	55%	52%	12%
Lorain	13%	13%	16%	19%	18%	32%
Medina	23%	34%	32%	30%	27%	31%
Muskingum	37%	35%	34%	33%	33%	(8%)
Portage	50%	57%	43%	36%	41%	(11%)
Richland	7%	5%	6%	8%	10%	12%
Stark	33%	34%	33%	30%	33%	(1%)
Comparison Counties						
Allen	26%	25%	25%	21%	23%	(11%)
Butler	34%	31%	34%	39%	42%	8%
Clermont	57%	54%	53%	53%	55%	(5%)
Columbiana	42%	46%	48%	53%	52%	20%
Guernsey	25%	30%	29%	30%	27%	14%
Hancock	45%	42%	50%	43%	35%	(5%)
Mahoning	42%	40%	39%	37%	30%	(14%)
Miami	44%	46%	45%	46%	42%	2%
Montgomery	33%	31%	30%	34%	38%	(1%)
Morrow	28%	23%	29%	41%	51%	28%
Perry	22%	23%	23%	42%	43%	49%
Scioto	33%	37%	36%	43%	45%	22%
Summit	29%	30%	28%	29%	29%	(2%)
Trumbull	33%	34%	34%	31%	33%	(0%)
Warren	33%	38%	39%	46%	43%	26%
Wood	43%	46%	43%	42%	51%	5%

5.5 Waiver Revenue and Spending

To estimate the amount of additional revenue each demonstration county received to spend on services other than foster care board and maintenance, the evaluation team estimated the amount of Title IV-E reimbursement a county would have received for foster care expenditures from 2011-2014. This amount was compared to the actual waiver award to determine how much was left over for flexible spending after paying what would have been the federal share of foster care board and maintenance.

Table 5.7 shows these waiver revenue calculations for all demonstration counties. Franklin and Portage provided their own estimates of waiver reimbursement; for all other demonstration counties, the evaluation team estimated what the county would have received in absence of the waiver by multiplying total foster care expenditures by the county's average annual Title IV-E eligibility rate and the federal Title IV-E participation rate. According to these calculations, four counties received less under the waiver than the estimate of Title IV-E reimbursement, but not significantly less (differences were between $165,000 for Greene and $626,000 for Fairfield). Eleven counties received more revenue under the waiver. Thus, during the third waiver period, 11 counties can be said to have had flexible waiver revenue to reinvest. Taken together, these eleven demonstration counties had an additional $50.5 million to spend on non-foster care services over the four years of the third waiver.

Table 5.7: Estimates of ProtectOHIO Revenue Available for Flexible Spending (in Thousands of Dollars), 2011-2014

Demonstration Counties	ProtectOHIO Revenue Received	Estimated IV-E Foster Care B&M Reimbursement in Absence of Waiver	Flexible Spending: Total ProtectOHIO Revenue Available for Non-Foster Care Services
Ashtabula	$3,135	$3,459	($324)
Belmont	$2,496	$598	$1,898
Clark	$10,659	$7,276	$3,383
Coshocton	$553	$880	($327)
Crawford	$2,981	$1,923	$1,058
Fairfield	$1,709	$2,335	($626)
Franklin*	$82,366	$71,253	$11,113
Greene	$4,160	$4,325	($165)
Hamilton	$61,479	$52,728	$8,751
Lorain	$10,046	$5,057	$4,989
Medina	$1,413	$1,321	$92
Muskingum	$5,065	$3,557	$1,508
Portage*	$7,592	$3,754	$3,838
Richland	$5,472	$1,349	$4,123
Stark	$22,689	$11,483	$11,206
Total	$221,815	$171,298	$51,959[168]

** Franklin and Portage provided their own estimates of expenditures eligible for foster care board and maintenance reimbursement.

[168] Note that this total excludes the estimated foregone federal in Ashtabula, Coshocton, Fairfield and Greene counties, totaling $1.422 million.

However, to say that these dollars represented "additional" revenue for reinvestment does not take into account the fact that for most of these counties, this revenue was used to continue to fund investments made in prior years on services and operations that are now part of the county's base budget. To address the question of continued reinvestment of waiver savings in non-foster care activities, the evaluation team examined whether each county's flexible revenue pool continued to grow during the third waiver period. As shown in Table 5.7, eleven demonstration counties had available waiver revenue during the third waiver period. Among these eleven counties, five counties (Clark, Crawford, Franklin, Muskingum, and Portage) had more flexible revenue in four consecutive years between 2011 and 2014 than they had in 2010.[169]

For these five counties, Table 5.8 compares the additional waiver revenue available to changes in all other child welfare expenditures in those same years. A total of $17.2 million in additional waiver revenue was available to these counties during the third waiver period. For example, Clark County had $543,000 in additional waiver revenue to spend during the third waiver period, over and above the waiver savings it was already reinvesting as of 2010. During that same period, Clark County's other child welfare expenditures decreased slightly, so all of the additional waiver revenue was not reinvested in expenditures other than foster care. By contrast, Muskingum county had a similar amount of additional waiver revenue ($568,000) to spend during the 4 year period between 2011 and 2014 (relative to 2010), and at the same time, their other child welfare expenditures grew by $3.576 million. All of the additional waiver revenue was reinvested in non-foster care services and an additional $3 million was used to supplement the waiver revenues to fund non-foster care activities. In Crawford County, a total of $458,000 new waiver dollars was available, but Crawford County reduced all other child welfare expenditures by almost double that amount, so the new flexible dollars went to offset other county expenditures. Overall, two of the counties (Franklin and Muskingum) with additional waiver dollars relative to 2010 reinvested all of their additional flexible revenue in non-foster care activities and three did not (Clark, Crawford, Portage).

Table 5.8.: Comparison of Additional Waiver Revenue and Changes in All Other Expenditures, 2011 to 2014, Relative to 2010

Demonstration County	Additional Waiver Revenue	Changes in All Other Expenditures	Difference (Additional Investment)
Clark	$543,000	($17,000)	$0
Crawford	$458,000	($838,280)	$0
Franklin	$12,709,000	$25,381,000	$12,672,000
Muskingum	$568,000	$3,576,000	$3,008,000
Portage	$2,906,564	($611,000)	$0
Total	**$17,184,564**	**$27,490,720**	

[169] One county (Medina) experienced flexible revenue increase for three out of four consecutive years (but not the last year) relative to 2010, and the remaining five counties (Belmont, Hamilton, Lorain, Richland, Stark) had less flexible revenue in two or more of the four years of the third waiver, relative to 2010.

5.6 Discussion

The fiscal analysis of the first waiver period (October 1, 1997-September 30, 2002) was published in 2003[170]; the report provided evidence that foster care utilization, unit costs and therefore expenditures in the demonstration county group during the five years of the first waiver did not appear to be different from foster care utilization and unit costs in the comparison county group during the same time period. The fiscal analysis of the first four years of the second waiver period was published in 2010[171]. This report found that presence of the waiver was associated with a reduction in the proportion of child welfare expenditures spent on foster care board and maintenance. This reduction was caused by a combination of reductions in foster care board and maintenance and increases in spending on other child welfare services, such as expansion in county staff and programs and family and community-based services. These increases were funded in part by waiver revenue. As a result, demonstration counties did increase the variation in services supported by Title IV-E funds beyond foster care board and maintenance. Given the variety of operating environments for both demonstration and comparison counties, it was an important finding that the waiver stimulus distinguished the groups in this way during the second waiver period.

During the third waiver period, while the differences in the distribution of average annual changes in all five measures were in the hypothesized direction by the theory of the waiver (which is among waiver counties, more changes that shifted expenditures from foster care to other types of child welfare expenditures would take place), the models did not reveal any statistically significant distinctions in those changes between the demonstration and comparison counties over the four years.

It's important to note that the context in which the waiver demonstration has been implemented has evolved greatly over the past 18 years. As Chapter 2 described, the social and economic environment has changed over time and varies across the state. Consortium members have noted that local environments can largely influences removal rates, which in turn impact foster care expenditures. The heroine and opiate epidemic seen in areas across Ohio have necessitated an increase in child removals in some counties, in other counties local judges prefer foster care over placement with kin or mandate that the PCSA take custody of children when they are placed with kin. One Consortium member commented on a general shift seen in the types of child welfare cases opened in her county; whereas 18 years ago cases were primarily opened due to parental issues (i.e., child abuse and neglect), they now offer assistance to families due to *child* behavior issues, causing an uptick in their placement day numbers overall. In this sense, while waiver flexibility is expected to lead to a decrease in foster care utilization, local environments often play a large role in this equation. Furthermore, Consortium members have expressed their belief that counties not involved in Ohio's waiver have taken note of the ProtectOHIO programs and successes; over time, staff have moved from county to county and brought with them lessons learned. Consequently, it is possible that the shift to non-significant cost study findings found in Ohio's third waiver period could be due to non-ProtectOHIO counties "catching up" and improving the child welfare service delivery system overall.

[170] Human Services Research Institute, 2003

[171] Human Services Research Institute, 2010

Chapter 6. Overall Waiver Impact: Placement Outcomes Study

6.1 Introduction

This chapter examines the effects of the Ohio Title IV-E Waiver Demonstration on placement outcomes for children placed in out-of-home care during the third waiver period, including all children entering care during calendar years 2011 through 2014. As noted previously, for children who do enter placement, the intent of the waiver is to decrease the length of stay in care, increase the number of children reunited with their families or placed in other permanent situations, and decrease the number of placements experienced by children. While Chapters 3 and 4 offer outcome findings for children and families who received the FTM and Kinship Supports interventions specifically, this chapter focuses primarily on the waiver impact overall.

The analyses estimate the waiver effect on the likelihood and timing of an exit to permanency within 12 and 24 months. Permanency is defined to include reunification, custody or guardianship to a relative or third party, and finalized adoption. The analyses also estimate the waiver effect on the likelihood and timing of an exit to reunification specifically. Then, for those who exit within 12 months, the analyses estimate the likelihood and time to re-entry into care within the 12 months after exit, to better understand the extent to which permanency succeeded.

In addition, the placement outcomes analyses (POA) explore out-of-home placement disruption among children who entered care during 2011 through 2014. The analyses seek to understand whether being in a demonstration county decreases placement disruption, under the hypothesis that demonstration counties have a wider range of placement options and prevention options to choose from at the time of initial placement in out-of-home care. We examine early disruption—having more than two moves within the first month of care. In addition, for each entry cohort year (2011, 2012, 2013, 2014), we present a global measure of placement stability based on the federal definition, assessing the number of moves per 1,000 days in care during the year for the demonstration and comparison counties.

The POA test three main hypotheses regarding the third waiver period. We hypothesized the following:

- ***Reduction in Placement Duration:*** For children entering agency custody and placement, children in demonstration counties will spend less time in care compared to children in comparison counties.
- ***Increase in Permanency Without Re-entry:*** For children who are reunified, children in demonstration counties will have a lesser likelihood of re-entering custody and placement, compared to children in comparison counties.
- ***Increase Placement Stability:*** For children entering agency custody and placement, children in demonstration counties will experience more placement stability, with fewer disruptions, than children in comparison counties. More specifically, children in demonstration counties will be less likely to experience early placement disruption (within the first month in care). Moreover, demonstration counties will experience a lower rate of moves per 1,000 days in care each year.

Administrative data from the 16 demonstration and 16 comparison counties were used for the analyses, with data provided by Ohio's Department of Job and Family Services. Like most Title IV-E Waiver demonstrations this is an observational study, as a randomized control trial is not feasible in this situation. Thus, the evaluation team used propensity modeling to improve the balance of the sample between demonstration and comparison counties in order to reduce bias in findings (Section 6.3.1.1). Propensity modeling is used to create propensity scores, which are the probabilities of units (such as a child) being assigned to a particular treatment (such as being in a waiver demonstration county) given a set of observed covariates. Propensity scores are used to reduce selection bias by equating groups based on these observed covariates by techniques such as matching and weighting.

In the placement outcome analyses, a weighting approach was taken. Essentially, by creating propensity weights and including them in outcome analyses, we may better understand whether similar children would have different outcomes served under the waiver (demonstration county) than not served under the waiver (comparison county). Propensity model variables included child and family characteristics as well as service related characteristics (see Table I.2 in Appendix I). A description of the team's approach to propensity modeling may also be found in Appendix I.

The research questions were tested using a series of statistical methods (Section 6.2.4) that include Kaplan Meier survival curves, Cox Proportional Hazards regression, logistic regression, and others. The evaluation team used Cox Proportional Hazards Regression to model the relationship between waiver status (children and families served in demonstration counties versus comparison counties) and permanency outcomes. We controlled for a series of covariates including child and family characteristics and service related characteristics such as removal reason and placement type, in addition to balancing the sample using propensity weights. Since children in the study were clustered within counties and family units, the Taylor Series Linearization method was used to calculate correct variances to account for the dependencies in the data induced by the fact that children within the same county or the same family unit are more similar than children from different counties or family units (Section 6.3.4.5). Each child was followed for 12 months and 24 months from the time of entry. Kaplan-Meier analyses, also adjusted for clustering, were conducted to provide survival curves, stratified by demonstration and comparison county assignment. These methods were also used to assess re-entry after reunification. The evaluation team conducted a logistic regression analysis to model the relationship between waiver status and early placement disruption for children in care at least one month, controlling for child, family, and service related characteristics, and accounting for clustering within counties. SAS 9.3 with the SUDAAN add-on were used to estimate these models. Finally, a global rate of placement disruption was estimated, based on the federal measure, for demonstration and comparison counties for each year from 2011 to 2014. The difference between global rate of placement disruption for demonstration and comparison counties was tested within each year using a *t*-test.

The findings reported in this chapter are summarized below. Findings from these analyses were interpreted as statistically significant if the p-values were $p<.05$ even if the effect size is small. In sum, findings indicate the following:

- Children experience similar exit types in demonstration and comparison counties, when comparing similar children (using propensity weights to balance the groups, and adjusting for

clustering within county). There are no statistically significant differences in the types of exits experienced by children in demonstration and comparison counties.

- Similar children in demonstration and comparison counties exit care to permanency at similar rates, except during the initial time in care. In reviewing a survival curve, it appears that in the first 30 days and especially the first 4 days, comparison children exit to permanency more quickly. After the first 30 days the survival lines begin to merge, indicating similar exit rates for the rest of the two-year period examined. At the end of two years, about four-fifths of children are likely to have exited to permanency.
- After controlling for a series of child, family, agency, and county factors, children in demonstration counties are somewhat less likely to achieve permanency (reunification, custody or guardianship of a relative or third party, and adoption), and less likely to reunify specifically, compared to similar children in comparison counties. However, there are significant interactions between waiver status and several variables in each of the permanency and reunification outcomes examined (within 12 and 24 months). In other words, there are certain subgroups of children who are more likely to exit more quickly to permanency, and more specifically reunify, in demonstration counties:
    - Among children whose predominant placement type is an adoptive home, those in demonstration counties reach permanency more quickly than those in comparison counties;
    - Among children whose predominant placement type is a group home, those in demonstration counties reach permanency more quickly than those in comparison counties.
    - Consistent with prior literature, there are other factors associated with children exiting more quickly to permanency (e.g., being older or Black, unless drug/alcohol use is identified as a risk contributor) or more slowly to permanency (e.g., child development/disability).
- Waiver status alone does not predict re-entry into care after reunification; however, Black children in demonstration counties are more likely than Black children in comparison counties to re-enter care within 12 months. Regardless of waiver status, children predominantly placed in kinship homes are less likely to re-enter care post-reunification than children placed in foster homes. There was an interaction between caregiver substance use issues and the reason for removal in the prediction of re-entry. If the caregiver has a history of drug or alcohol use or the removal was due to child behavior issues, children are more likely to reenter the system overall; but if both were a factor, the effect is somewhat modified downwards.
- The percent of children experiencing early placement disruption is similar in demonstration and comparison counties, each around 2.7%. There is no statistically significant difference between demonstration and comparison counties in the presence of early disruption.
- Children in demonstration and comparison counties experience similar rates of placement disruption, about 4 moves per 1,000 days in care. Placement disruption was defined as the number of moves per 1,000 days in care for each 12-month period, based on the federal measure.

The research questions, methods, and findings are provided in more detail in the remainder of this chapter, followed by a discussion of findings.

6.2 Research Questions and Hypotheses

In the third waiver period, the research questions regarding placement outcomes for children entering the custody and care of the child welfare agency are as follows:

Exit Reasons

1. What proportion of children exit child welfare custody and placement to permanency (reunification, custody or guardianship to relative or third party, or adoption) or other reasons (emancipation, runaway, transfer to another agency, death, and unclassified) and what proportion remain in care in demonstration and comparison counties?
2. Do demonstration and comparison counties differ in the proportion of children experiencing each exit type?

Placement Duration

3. Does waiver status (demonstration vs. comparison counties) predict the likelihood and timing of exit to permanency, after controlling for other factors? Exit to permanency[172] refers to "desirable" exit reasons, including reunification, custody or guardianship to a relative or third party, or adoption.
4. What other factors predict exit to permanency?
5. Does waiver status (demonstration vs. comparison counties) predict the likelihood and timing of exit to reunification, after controlling for other factors?
6. What other factors predict exit to permanency?

Re-entry After Exiting to Reunification

7. Of the children who exit to reunification, what proportion re-enter child welfare custody and placement in demonstration and comparison counties? Is there a significant difference between demonstration and comparison counties in the proportion of children who re-enter after reunification?
8. For children who exit to reunification, does waiver status (demonstration vs. comparison counties) predict the likelihood and timing of re-entry, after controlling for other factors? What factors predict re-entry after reunification?

Placement Stability/Disruption

[172] This analysis focuses on desirable permanent exits, which we define in a manner that is consistent with the federal definition of permanency. According to the federal government, permanency includes: "Reunified with parents or primary caretakers, Living with other relatives, Living with a legal guardian, Legally adopted" (U.S. Department of Health and Human Services, Administration for Children and Families, n.d., p.11).

9. Does waiver status predict the likelihood of early placement disruption? Specifically, for those children remaining in care for at least one month, are children in demonstration counties more likely to experience three placements (two moves)[173] within their first month of care?
10. Of all children who entered care in a 12-month period (each calendar year), what is the rate of placement moves per 1,000 days of out-of-home care?[174] Is there a statistically significant difference between demonstration and comparison counties?

As specified in the overview, we hypothesized that there would be a reduction in placement duration, an increase in exits to permanency, a decrease in re-entries, and a decrease in placement disruption for children in demonstration counties, served under the Title IV-E Waiver, compared to comparison counties (see Section 6.1.1 for detailed hypotheses).

6.3 Methods

6.3.1 Design

The placement outcomes study is designed to test the theory that the Ohio Title IV-E Waiver—which allows flexible funding to support non-placement activities—reduces placement days and improves placement outcomes. The theory of the waiver requires a reduction in placement days to fund the other activities. The placement outcomes analyses looks for waiver effects on placement duration, exit type, re-entry and placement disruption.

Like most Title IV-E Waiver demonstrations, this theory is being tested using a non-experimental design, controlling for other factors that may influence outcomes. At the inception of the Ohio Title IV-E Waiver, comparison counties were selected based on having similar characteristics to demonstration counties (see Chapter 1, Table 1.1). Nonetheless, there are differences between demonstration and comparison counties that could bias findings. To reduce bias, the evaluation team used propensity modeling to improve the balance of the sample between demonstration and comparison counties (described below, Section 6.3.1.1). When testing the hypotheses, multivariate analyses are used to control for child, family, and placement episode-related factors that may be related to outcomes, including any measured differences identified in bivariate analyses comparing demonstration and comparison counties.

Child welfare services, including placement services, are administered by county agencies in Ohio. Consequently, policies may differ between counties. Because children within the same county may have similar experiences due to county-level policies, and their experiences may differ somewhat from children in other counties, there may be clustering of data by county that has the potential to lead to false results. To address this concern, each of the analyses adjusts for clustering within county (see Section 6.3.4.5 for details).

[173] This count includes the first placement even if it lasted only one day, such as an emergency placement.

[174] Based on the federal measure, examines the global rate of placement moves per 1,000 days in care for demonstration vs. comparison counties (i.e., total number of moves across all children per total number of days in foster care multiplied by 1,000).

6.3.1.1 Propensity Weights

Propensity score methods are often used in analyses with non-randomly assigned treatment and control groups in order to adjust for differences between the two groups on observed covariates. For all methods, a propensity score is generated for each observation via a logistic regression model using some set of observed covariates to predict treatment status; the predicted probability of treatment under this model (or, the *propensity* for treatment) is the propensity score. There are various approaches for applying propensity scores to make these adjustments. In the current setting, the effect of most interest is the Average Treatment Effect, which is the effect that the demonstration would have if it were applied to all counties. Harder, et al.[175] recommend using either propensity score weighting via Inverse Probability of Treatment Weights (IPTW) or Subclassification in this scenario. Since IPTW more accurately reduces bias in any test of significance, that method was chosen. Large weights (defined as weights greater than 10) are trimmed to reduce the influence of outliers. The sample is checked for balance on the covariates pre- and post-weighting adjustment in order to determine the effectiveness of the propensity weighting process. If the propensity adjustment improves balance sufficiently, then all estimates and tests use the propensity weights. The team found that propensity weights did in fact improve sample balance, and so, all analyses presented are weighted with the appropriate propensity score weights.

A more detailed description of the team's approach to propensity modeling, along with covariate balance information, may be found in Appendix I.

6.3.2 Sample

The analysis for the final report examines outcomes for children entering custody and placement during calendar years 2011 through 2014 (n=23,219[176]), regardless of whether the child had a placement history prior to the study period. The sample includes children in the 16 demonstration counties (n=14,832) and 16 comparison counties (n=8,387).

Table 6.1 provides the number of children entering each year of the study and their entry status (e.g., first time entry vs. prior entry). For most youth (n=19,781 or 85%[177]), this was the first time they entered custody and placement in Ohio. Other youth (n=2,798, 12%) had a previous placement episode that ended prior to 2011 and returned to care during our study period. In addition, a small proportion of youth (n=640, 3%) entered care prior to the study period, were still in care on 1/1/2011, exited during the study period, and then re-entered care for the first time during the study period 2011 through 2014. The proportion of children by entry status was similar for demonstration and comparison counties (e.g., 85% and 86% first-time entries, respectively).

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[175] Harder, Stuart, & Anthony, 2010

[176] There were 23,235 children who entered care in the demonstration and comparison counties from 2011 through 2014. Seven children were dropped from the analysis file because they could not be classified as CANRPT or FINS/DEP for the propensity weight procedure (due to missing intake information). Another nine children were dropped due to missing age (n=1) or gender (n=8), creating very small "missing" cell sizes that could not be incorporated into analyses; these children were also missing family assessment (FA) information and some intake data. The remaining children (n=23,219) were included in the analyses.

[177] The percentages for entry status are the same whether calculating as weighted or unweighted.

Table 6.1: Entry Cohort by Entry Status When Youth Entered Study Episode (n=23,219)				
Entry Year	**N**	**First-Time Entry**	**Prior Entry: Prior episode ended before 2011**	**Prior Entry: Prior episode ended on or after 1/1/2011**
2011	6,306	4,987	1,128	191
2012	5,602	4,693	675	234
2013	5,796	5,124	535	137
2014	5,515	4,977	460	78
Total	**23,219**	**19,781**	**2,798**	**640**

6.3.2.1 Sample Characteristics

Table 6.2 provides the child and family characteristics for all children in the study, by demonstration and comparison counties, including weighted and unweighted percentages[178]. The table also presents placement episode characteristics, including number of previous episodes in placement, initial and predominant placement types, number of placement settings, and county size. Analysis of all variables is conducted at the child level, based on their first entry into custody and placement during the period 2011 through 2014.

Weighted percentages represent the proportion of children in each group after applying propensity weights used to balance the characteristics of children in demonstration and comparison counties, creating similar groups for comparison purposes. Appendix I provides information about the development of propensity weights and the extent to which the two groups are balanced on these characteristics.

There were no statistically significant differences between demonstration and comparison children on these measured characteristics after applying propensity weights and adjusting for clustering within counties. The following text describes the sample with weighted percentages. Both weighted and unweighted percentages are available in Table 6.2 and are often within 1% of each other but can be up to 4% different.

Child Characteristics: At the time of removal, almost one-third (32%) of children were very young (age 0-2 years) and close to one-third (30%) were age 13 or older. Just over half (53%) were male children. Most of the children were identified as being White (59%) or Black (29%), and 4% were identified as Hispanic ethnicity. Risk contributors included physical, cognitive or social development risk (21%), emotional/behavioral functioning (31%), and child self-protection (68%).

Family Characteristics: Just over half (54%) of the children were removed from "mother only" households and another one-third (33%) from two-parent households. Two-thirds (66%) had one or more siblings in care. Risk contributors for caregivers and other adults in the home include drug/alcohol use (48%), mental health (43%), domestic violence (38%), and parenting practices (59%). Three-quarters

[178] Standard errors and 95% confidence intervals for weighted percentages are available upon request. See Appendix I for information about the propensity weights and the balance of this sample.

(75%) of the children were Title IV-E eligible; IV-E eligibility is used as a proxy for poverty income levels for families.

Placement Episode Characteristics: Most children (85%) had no previous placements, 11% had one prior placement, and 4% had two or more prior placements. Children were most often removed from home for neglect (37%), dependency (30%), child behavior (14%), or physical abuse (13%). The first placement type for over half (55%) of the children was a foster home, another 26% were placed in kinship homes, and the remainder in group homes, residential facilities, or other placements. Almost one-third of the children were in a kinship home for most of their stay in care.

Child Welfare Agency Characteristics: For most children (93%), the placement agency was the child welfare agency, but for others the placement agency was the juvenile courts or another agency (7%). Most of the children (71%) were served by the 15 counties that report they do not have policies leading them to consistently take, or not take, custody of children when they go to kin homes. There were some children (20%) served by the 12 counties with policies leading them to *consistently not take custody* when children go to kin (i.e., they rarely hold custody when children go to kin), and some children (9%) served by the 5 counties with policies leading them to *consistently take custody* when children go to kin. Most children in the study were in placement in a metro county (69%), some in a large county (16%), and a small number of children were in medium (8%) or small (7%) counties.

Table 6.2: Child, Family, Placement Episode, and County Characteristics for Children Entering Custody and Placement CY 2011-2014 (n=23, 219)

	Demonstration Counties			Comparison Counties			Total		
	N	%	Weighted %	N	%	Weighted %	N	%	Weighted %
TOTAL CHILDREN	14,832			8,387			23,219		
CHILD FACTORS									
Child age at removal									
0-2 years	4,295	29.0	30.5	2,932	35.0	33.4	7,227	31.1	32.0
3-5 years	2,098	14.2	14.7	1,309	15.6	15.6	3,407	14.7	15.1
6-12 years	3,503	23.6	23.9	2,056	24.5	24.1	5,559	23.9	24.0
13+ years	4,936	33.3	30.9	2,090	24.9	27.0	7,026	30.3	28.9
Gender									
Male	7,987	53.9	53.8	4,428	52.8	52.6	12,415	53.5	53.2
Female	6,845	46.2	46.2	3,959	47.2	47.5	10,804	46.5	46.8
Race									
White	7,771	52.4	58.3	5,478	65.3	60.7	13,249	57.1	59.5
Black	5,182	34.9	30.1	2,015	24.0	27.6	7,197	31.0	28.9
Other	1,635	11.0	10.1	748	8.9	10.1	2,383	10.3	10.1
Missing	244	1.7	1.5	146	1.7	1.6	390	1.7	1.5
Hispanic ethnicity									
No	12,769	86.1	87.7	7,536	89.9	90.2	20,305	87.5	89.0
Yes	749	5.1	4.4	320	3.8	3.8	1,069	4.6	4.1
Missing	1,314	8.9	7.9	531	6.3	6.0	1,845	8.0	7.0
Child physical/cognitive/social development risk									
No	10,442	70.4	70.8	5,779	68.9	69.4	16,221	69.9	70.1
Yes	3,029	20.4	21.0	1,914	22.8	20.5	4,943	21.3	20.7
Missing	1,361	9.2	8.3	694	8.3	10.2	2,055	8.9	9.2
Child emotional/behavioral functioning									
No	8,254	55.7	57.3	5,118	61.0	61.5	13,372	57.6	59.4
Yes	5,217	35.2	34.5	2,575	30.7	28.4	7,792	33.6	31.4
Missing	1,361	9.2	8.3	694	8.3	10.2	2,055	8.9	9.2
Child self-protection ability is a risk contributor									
No	3,404	23.0	22.7	1,947	23.2	22.4	5,351	23.1	22.5
Yes	10,067	67.9	69.1	5,746	68.5	67.5	15,813	68.1	68.3
Missing	1,361	9.2	8.3	694	8.3	10.2	2,055	8.9	9.2

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Table 6.2, CONTINUED									
	Demonstration Counties			Comparison Counties			Total		
	N	%	Weighted %	N	%	Weighted %	N	%	Weighted %
FAMILY FACTORS									
Family Structure									
Two Parents	4,397	29.7	31.8	2,719	32.4	33.8	7,116	30.7	32.8
Mother only	8,073	54.4	53.7	4,456	53.1	54.0	12,529	54.0	53.9
Father only	659	4.4	4.9	406	4.8	5.1	1,065	4.6	5.0
Other	151	1.0	1.0	82	1.0	0.8	233	1.0	0.9
Missing	1,552	10.5	8.5	724	8.6	6.3	2,276	9.8	7.4
Siblings in care									
Yes	9,447	63.7	64.3	5,588	66.6	66.7	15,035	64.8	65.5
No	5,385	36.3	35.7	2,799	33.4	33.4	8,184	35.3	34.5
Caregiver age at removal									
13-17 years	98	0.6	0.6	41	0.5	0.7	139	0.6	0.6
18-35 years	9,874	66.6	67.4	5,819	69.4	68.5	15,693	67.6	68.0
36-60 years	4,560	30.7	29.9	2,308	27.5	26.3	6,868	29.6	28.1
61+ years	141	1.0	1.0	133	1.6	1.2	274	1.2	1.1
Missing	159	1.1	1.1	86	1.0	3.3	245	1.1	2.2
Caregiver drug/alcohol use									
No	6,894	46.5	45.0	3,589	42.8	40.6	10,483	45.2	42.8
Yes	6,562	44.2	46.7	4,086	48.7	49.0	10,648	45.9	47.9
Missing	1,376	9.3	8.4	712	8.5	10.3	2,088	9.0	9.4
Caregiver mental health									
No	7,890	53.2	50.4	3,708	44.2	44.2	11,598	50.0	47.3
Yes	5,566	37.5	41.3	3,967	47.3	45.5	9,533	41.1	43.4
Missing	1,376	9.3	8.4	712	8.5	10.3	2,088	9.0	9.4
Caregiver domestic violence									
No	7,930	53.5	53.6	4,913	58.6	50.9	12,843	55.3	52.2
Yes	5,526	37.3	38.1	2,762	32.9	38.8	8,288	35.7	38.4
Missing	1,376	9.3	8.4	712	8.5	10.3	2,088	9.0	9.4
Caregiver parenting practices									
No	5,231	35.3	32.8	2,555	30.5	29.6	7,786	33.5	31.2
Yes	8,225	55.5	58.8	5,120	61.1	60.1	13,345	57.5	59.5
Missing	1,376	9.3	8.4	712	8.5	10.3	2,088	9.0	9.4
IV-E Eligibility									
No	3,585	24.2	25.1	1,968	23.5	22.3	5,553	23.9	23.7
Yes	11,111	74.9	73.9	6,278	74.9	76.2	17,389	74.9	75.1
Missing	136	0.9	1.0	141	1.7	1.5	277	1.2	1.2

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Table 6.2, CONTINUED									
	Demonstration Counties			Comparison Counties			Total		
	N	%	Weighted %	N	%	Weighted %	N	%	Weighted %
PLACEMENT EPISODE FACTORS									
Cohort									
2011	4,120	27.8	26.9	2,186	26.1	27.0	6,306	27.2	26.9
2012	3,514	23.7	23.9	2,088	24.9	24.0	5,602	24.1	23.9
2013	3,635	24.5	24.8	2,161	25.8	24.3	5,796	25.0	24.6
2014	3,563	24.0	24.4	1,952	23.3	24.8	5,515	23.8	24.6
Removal reason									
Neglect	5,626	37.9	39.3	2,719	32.4	35.4	8,345	35.9	37.3
Sexual abuse	286	1.9	1.8	138	1.7	1.7	424	1.8	1.8
Physical abuse	1,774	12.0	11.6	964	11.5	13.6	2,738	11.8	12.6
Emotional abuse	56	0.4	0.3	19	0.2	0.2	75	0.3	0.3
Dependency	3,327	22.4	23.4	3,591	42.8	36.6	6,918	29.8	30.0
Child behavior	3,174	21.4	19.0	691	8.2	8.9	3,865	16.7	13.9
Other	589	4.0	4.6	265	3.2	3.6	854	3.7	4.1
Previous placement episodes									
None	12,550	84.6	85.7	7,231	86.2	84.9	19,781	85.2	85.3
One	1,613	10.9	10.4	887	10.6	11.2	2,500	10.8	10.8
Two or more	669	4.5	4.0	269	3.2	3.9	938	4.0	4.0
First placement setting									
Foster home	7,380	49.8	53.4	5,111	60.9	55.8	12,491	53.8	54.6
Kinship home	4,029	27.2	25.8	1,768	21.1	25.5	5,797	25.0	25.7
Group home	554	3.7	3.0	191	2.3	1.7	745	3.2	2.3
Residential	1,461	9.9	9.3	500	6.0	8.4	1,961	8.5	8.8
Other	1,408	9.5	8.6	817	9.7	8.6	2,225	9.6	8.6
Predominant placement									
Foster home	6,613	44.6	47.8	4,855	57.9	50.0	11,468	49.4	48.9
Kinship home	4,822	32.5	30.9	2,073	24.7	32.0	6,895	29.7	31.5
Adoptive home	590	4.0	4.4	436	5.2	4.6	1,026	4.4	4.5
Group home	506	3.4	2.9	324	3.9	3.6	830	3.6	3.2
Residential	2,078	14.0	12.7	600	7.2	8.8	2,678	11.5	10.7
Other	223	1.5	1.3	99	1.2	1.2	322	1.4	1.2
Number of placement settings									
One	7,078	47.7	49.7	4,389	52.3	51.9	11,467	49.4	50.8
Two	4,409	29.7	29.5	2,407	28.7	29.0	6,816	29.4	29.2
Three	1,855	12.5	11.8	879	10.5	10.7	2,734	11.8	11.2
Four or more	1,490	10.1	9.1	712	8.5	8.5	2,202	9.5	8.8
First placement setting one day									
No	14,146	95.4	95.7	7,913	94.4	94.2	22,059	95.0	94.9
Yes	686	4.6	4.3	474	5.7	5.9	1,160	5.0	5.1

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Table 6.2, CONTINUED									
	Demonstration Counties			**Comparison Counties**			**Total**		
	N	%	Weighted %	N	%	Weighted %	N	%	Weighted %
CHILD WELFARE AGENCY FACTORS									
Child Welfare vs. Related Agency									
Child welfare agency	13,018	87.8	90.0	8,113	96.7	95.1	21,131	91.0	92.6
Related agency	1,814	12.2	10.0	274	3.3	4.9	2,088	9.0	7.4
Kinship policy									
May take custody, or not	12,677	85.5	73.9	3,549	42.3	68.2	16,226	69.9	71.0
Consistently not take custody	1,187	8.0	17.4	3,891	46.4	22.7	5,078	21.9	20.1
Consistently take custody	968	6.5	8.8	947	11.3	9.1	1,915	8.3	9.0
County Size									
Metro	11,556	77.9	67.2	5,484	65.4	71.2	17,040	73.4	69.2
Large	1,938	13.1	16.1	1,828	21.8	15.7	3,766	16.2	15.9
Medium	1,031	7.0	8.2	603	7.2	8.3	1,634	7.0	8.3
Small or medium small	307	2.1	8.5	472	5.6	4.9	779	3.4	6.7
Note: Upper and lower confidence intervals and standard errors (SE's) for weighted percentages are available upon request. See Appendix I for information about the weighting process and balance statistics.									

6.3.3 Variables

Data were obtained from Ohio's Statewide Automated Child Welfare Information System (SACWIS), which is maintained by Ohio's Department of Job and Family Services.[179] The SACWIS tracks child and family involvement with the child welfare system, including intakes, child maltreatment, safety, risk, and family assessments, removals from home, legal status changes, placement changes, client services, providers, child and family characteristics, and other pertinent information to manage cases involved in the child welfare system. This includes information about child and family characteristics collected in the family assessments.

6.3.3.1 Outcome Variables

The study examines the following outcome variables: (1) exit type; (2a) time to exit to permanency (reunification, custody or guardianship of a relative or third party, adoption); (2b) time to exit to reunification (specifically); (3) time to re-entry after reunification; (4a) early disruption and (4b) a global measure of placement disruption (the rate of moves per 1,000 days in care across all children).

Exit type was constructed based on information in the discharge reason field and the court termination reason data, and the exit type was recoded into fewer categories: reunification, custody or guardianship of a relative or third party, adoption, and emancipation, and other types. Custody or guardianship of a

[179] Data were provided as of 5/7/2015.

relative includes custody to a kinship caregiver (relative or non-relative), guardianship to a kinship caregiver (relative or non-relative), and custody to third party. "Other" types include exit to other agency, absent without leave, and child death.

The time to exit was calculated for each child as the number of days from the date of removal to the date of discharge. For children exiting to reunification, relative or third party, adoption, emancipation, and other, this calculation represents the time to that type of exit. For children remaining in care, time is calculated as the number of days from the date of removal to the file end-date (the date the data were extracted from the system). The time variable was truncated to 12 months and to 24 months for analyses examining these time periods.

For children who exited to reunification within 12 months, the time to re-entry is calculated as the number of days from the date of discharge to reunification to the subsequent date of removal from home. For children who did not re-enter during the study, the time is calculated as the number of days from the date of discharge to the file end-date.

Early disruption was defined as having three placement settings—two or more moves—within one month of care, for the subset of children in care for at least one month. The placement setting data was adjusted to account for temporary absences that are not considered placements. Following federal guidelines, temporary absences from an ongoing placement (e.g., runaway, hospitalization, respite, trial home visit) were not counted as placement settings as long as the child returned to the same foster home after that absence within a specified timeframe.[180]

The global measure of placement disruption assesses the extent to which children experience placement stability, or disruption, while they are in out-of-home care, controlling for the amount of time spent in care. The measure consists of the number of placement moves per 1,000 placement days for the demonstration counties, and the same for comparison counties. The measure is based on the federal measure for Placement Stability defined for the federal Child and Family Services Review, Round 3,[181] which assesses the rate of placement moves per 1,000 days in care across all children within each state within a 12-month period.

The global measure is unlike the other analyses presented in this chapter in several ways:

- **An entry cohort for each year:** This analysis examines each entry cohort separately (2011, 2012, 2013, and 2014), including all children who entered during that year whether or not they had been in care during another year during the waiver.

[180] To be counted as a temporary absence for the current analysis, children had to return from hospitalization, their own home, or runaway within 30 days. Respite care generally lasted a few days, but was still considered respite up to 7 days for single respite events, and up to 14 days in a small number of cases in which the child spent that time in a home where they had recurring short respite stays.

[181] For more information about the Child and Family Service Review Round 3 and the federal measure for placement stability, visit http://www.acf.hhs.gov/programs/cb/monitoring/child-family-services-reviews/round3 and see the "Combined Federal Register Announcement: Statewide Data Indicators and National Standards Round 3 at http://www.acf.hhs.gov/sites/default/files/cb/combined_fr_document_may_2015.pdf. See also Federal Register (Vol. 79, No. 197), Friday, October 10, 2014/Rules and Regulations, p. 61246, for information on the stability measure.

- **Several exclusions in the population:** This global measure includes all children who enter foster care in a 12-month period, excluding children in foster care less than 8 days and those who enter care at age 18 years or older, consistent with the federal measure.
- **Counts all days and moves across placement episodes:** In other words, if the child entered twice during the same year, the number of days they were in care that year includes the number of days during the first and second placement episodes, up to the end of the year.
- **Calculated across children:** This measure sums data across all children in demonstration counties, and likewise in comparison counties, rather than calculating at the child level.

The numerator for the global measure of placement disruption is the total number of placement moves all the children experience during the 12-month period (not counting the removal as a placement move). The denominator is the total number of days these children were in out-of-home care as of the end of the 12-month period, divided by 1,000. This is mathematically the same as the federal measure:

$$(\frac{moves}{days\ in\ care} * 1{,}000\ ).$$

After calculating the ratio for demonstration counties and for comparison counties, the ratios are used in a ratio test to assess differences between demonstration and comparison counties.

6.3.3.2 Predictor Variables and Covariates

Twenty independent variables were entered into the initial multivariate analyses as potential predictors, including child characteristics, parent and family characteristics constructed at the child level, and placement episode–related factors (see Section 6.4 for findings and Appendix J for more information). These variables are either dichotomous (two categories) or categorical (with three or more categories). Child characteristics include age at removal, gender, race, Hispanic ethnicity, and developmental risk. Developmental risk[182] was included as a proxy for disability, which has been associated with longer duration in care; specifically, physical, cognitive, or social development was identified by the worker as a risk contributor as part of the Family Assessment and recorded in SACWIS.

Parent and family characteristics were entered in the data set at the child level. Family structure describes the adult structure of the home of removal; that is, the child was removed from a home with two parents, mother only, father only, or other. "Other" includes step-parent only, relative, non-relative, and "legally separated," which did not identify which parent was the caregiver. Presence of siblings in foster care indicates whether or not each child in the data set has a sibling in agency placement and care, as identified by having the same case identifier in SACWIS. Caregiver drug or alcohol use indicates that one or more of the caregivers either did or did not have this risk condition as determined in the

[182] Child mental health and self-protection risk were also variables considered for the model, all from the Family Assessment (FA). However, due to missing data and collinearity across FA child variables, the team selected one child variable from the FA, based on prior research.

Family Assessment and recorded in SACWIS.[183] Title IV-E eligibility identified in SACWIS, is used as a proxy for family income at or below poverty level.

Placement episode variables include the cohort (entry year), primary removal reason, number of prior episodes (none, one, two or more), placement setting variables, and agency related variables. Primary removal reason is categorized in eight categories: neglect, physical abuse, sexual abuse, emotional abuse, dependency, child behavior, other, and not available (missing). Placement settings are categorized into six categories: foster home, kinship home (including relative and non-relative kinship placements), adoptive home, group home, residential center, and other. "Other" type of placement includes detention, medical or educational facility, independent living, and other types, which together made up a very small proportion of placement settings. Predominant placement type was calculated by summing the number of days in each type of placement (e.g., the number of days the child was in foster home settings, number of days in kinship placements, etc.) during the placement episode and selecting the type with the longest duration. The number of placement settings was calculated (excluding temporary absences, defined in Section 6.3.3.1) and categorized into four groups: one, two, three, and four or more placements. A variable was created to indicate whether or not the first setting lasted only one day. Agency variables include agency type, kinship policy, and county size. Agency type indicates whether the youth was in a placement episode associated with the main child welfare agency or a related agency (e.g., the juvenile court). Kinship policy indicates whether counties reported having policies that lead them to (1) consistently take custody when children go to kin (usually take custody), (2) consistently do not take custody when children go to kin (rarely hold custody), or (3) counties reported they do not have policies leading them to consistently take or not take custody of children when they go to kin (may take custody, or not). County size was defined using the population size according to the U.S. Census 2013, divided into four categories: metro (more than 200,000), large (100,000 to 200,000), medium (50,000 to 100,000), and small (less than 50,000).

Waiver status indicates that the child is in either a demonstration or a comparison county. This is the primary predictor variable of interest in the current study.

6.3.4 Data Analyses Methods

The evaluation team conducted descriptive and bivariate analyses; survival analyses, including the Kaplan-Meier procedure and Cox proportional hazards models; and logistic regression to test the hypotheses. Propensity weights (Section 6.3.1.1) were included in each analysis to balance the demonstration and comparison groups to reduce bias in findings. The Taylor series linearization method (Section 6.3.4.5) was used to adjust for clustering within county for each set of analyses, to produce clustering adjusted variances. Findings from these analyses were interpreted as statistically significant if the p-values were $p<.05$ even if the effect size is small. Unless specifically noted in the text, propensity weights and Taylor linearization was always used for modeling, estimation and significance testing.

[183] Caregiver mental health, experience of domestic violence, and parenting practices were also variables considered for the model, all from the Family Assessment (FA). However, due to missing data and collinearity across FA caregiver variables, only one caregiver variable from the FA was selected, based on prior research.

6.3.4.1 Descriptive and Bivariate Statistics

Descriptive data are provided to describe the characteristics of the sample, including weighted and unweighted percentages. Descriptive data also describe the proportion of children exiting to reunification, custody or guardianship of a relative or third party, adoption and non-permanency exits (e.g., emancipation, runaway, transfer to another agency, death, and unclassified) and children remaining in care. In addition to describing each group, bivariate statistics (e.g., chi-square) tested whether or not there is a statistically significant difference between groups on each of the variables.

6.3.4.2 Survival Analysis: Kaplan Meier Procedure

Survival analyses (also called event history analyses) were used to model time-to-event data to study placement duration (i.e., time to exit to permanency, time to reunification) and re-entry for entry cohorts during the waiver study period. Specifically, the Kaplan-Meier and Cox Proportional Hazards Regression procedures were conducted using SAS 9.3 with the SUDAAN add-on. The Kaplan-Meier procedure is described here, and the Cox regression is described in Section 6.3.4.3.

The Kaplan-Meier procedure was used to model the time to event (i.e., exit from care; re-entry). The Kaplan-Meier procedure produces estimates of the cumulative proportion of the sample that did not experience the event over time, stratified by demonstration and comparison counties. Cases were "censored" if the event of interest for the analysis had not occurred (e.g., in the time to permanency analyses, if they did not exit care) during the analysis timeframe (e.g., within the 365 day observation period) or if the outcome of interest was no longer an option for some other reason (e.g., the child exited to emancipation, was placed in detention, etc.). In the discussion that follows, we use exit type as the example, but the theory is identical for the re-entry analyses except that the outcome of interest is re-entry rather than exit.

Censoring is an analytic concept that accounts for the fact that for some units (children) we have only partial information about exit time. For example, if the child had not exited care within the study period the child is "censored" at the study period end. We know definitely that the exit time for this child is greater than the observed time but we do not know when and if the specific exit occurred. For children who exited care for reasons other than the outcome of interest, censoring accounts for the fact that even though a form of exit took place, this exit was not the one of interest and hypothetically, if that undesirable exit had not taken place, the child may have had the outcome of interest at a time beyond that which we observed. In both situations, the bottom line is that censoring distinguishes between the information on the outcome of interest that is complete (where it is actually observed) and where the information is incomplete. This enables the model to estimate parameters of interest accounting for the incomplete (censored) information, but not treating it as equivalent to cases where we know a child's exact exit date.

The Kaplan-Meier estimates were graphed to produce the survival curves, including the average estimated proportion of children in each group who experience the event each day for 365 days, and the 95% confidence intervals (lower level and upper level) for these estimates. When the confidence intervals overlap for the distinct groups, there is no evidence of a statistically significant difference, whereas when confidence intervals do not overlap there is evidence of a difference.

The Kaplan-Meier procedure was also used to examine the timing and occurrence of each exit type using a competing risks framework, to determine whether or not the time to exit to permanency was different depending on exit type. In the competing risks analysis, first we model time to exit using the Kaplan-Meier procedure, stratified by exit reason, to ascertain whether or not there is a difference in time to exit for each type. Next, if there is a significant difference between groups, survival analyses would be run separately for each exit type, censoring for children who exit for another reason as well as children still in care after 365 days, as we have discussed earlier.

6.3.4.3 Survival Analysis: Cox Proportional Hazards Regression

The Cox proportional hazards model was used to examine whether or not being in a demonstration county predicts the "hazard," or likelihood, of exiting care to permanency after controlling for as many confounding factors as possible. Likewise, we use this method to examine whether or not being in a demonstration county predicts the hazard (likelihood) of re-entry, among those children who exited to reunification within 12 months.

In survival analysis procedures, "surviving" refers to the time without experiencing the event and "hazard" refers to the likelihood of experiencing the event. (This terminology stems from the medical literature where the event is death, thus not experiencing the event refers to surviving). In the placement duration analyses, "survival" in care is a negative outcome, whereas the "hazard" of exit or reunification is a positive outcome. In the re-entry analysis, "survival" without re-entry is a positive outcome, whereas the "hazard" of re-entry is a negative outcome.

For the Cox models, a series of predictive variables were identified in the literature and entered into the analyses to determine which factors predict permanency outcomes in the current study. A model selection procedure was used to arrive at the final models presented in this report. Since it was computationally impossible to fit a model that included all main effects and all possible two-way interactions, the pool of potential interactions was restricted to interactions with waiver status and a set of other interactions deemed to be of substantive interest based on existing literature. Starting with this pool of potential predictive effects, model selection was performed to obtain a final parsimonious model. Due to clustering in the data, we were restricted to models with 62 or fewer degrees of freedom and even with the smaller pool of interactions, this restriction made it impossible to perform model selection using all effects desired while accounting for clustering correctly. Thus we used a two-step model selection process. First, stepwise model selection was performed ignoring the clustering in an exploratory step to produce a maximal model with less than 62 degrees of freedom, where the selection process was designed to select only the most significant effects. This maximal model is too liberal as the unadjusted significance tests produce p-values that are smaller than they should be. This first step model was then used as the starting point for a rigorous, clustering adjusted model selection procedure, leading to the final parsimonious models presented.

Each model produces hazard ratios and confidence intervals, with p-values, to identify those variables that are significant predictors of the outcome variable and the strength of those relationships. The key variable of interest is the waiver status—whether or not being in a demonstration county predicts the outcome.

6.3.4.4 Logistic Regression

Logistic regression was used to model early disruption of placements, defined as having three or more placement settings (two or more moves) within the first month in care, for those children in care for more than one month.

Logistic regression is a statistical technique that models a categorical outcome variable based on one or more predictor variables. It is used to estimate the empirical values of parameters in a qualitative response model. Logistic regression measures the relationship between the categorical dependent variable and one or more independent variables by estimating probabilities of each outcome category using a mathematical transformation of the probabilities called a logistic function. Logistic regression estimates the odds that the dependent variable is in a particular category. Odds are the ratio of the probability of the outcome being in a specific category to the probability of not being in that category. Although logistic regression may be used to model outcomes that have more than two categories, it is more commonly used to model binary (yes/no) type outcomes.

Coefficients of a logistic regression model cannot be interpreted the same way as in linear regression models. This is because logistic regression coefficients represent the change in the logit for each unit change in the predictor, not the change in the outcome or the probability of the outcome category itself. The usual method of interpretation is to examine the odds ratio. The odds are the ratio of the probability that an event will happen to the probability that the event will not happen; therefore, the odds ratio is the ratio of the odds of an event occurring in one group to the odds of it occurring in another group. The odds ratio can be thought of as a measure of effect size, describing the strength of association or non-independence between two binary data values.

A model selection procedure was used to arrive at the final model presented in this report. Since it was computationally impossible to fit a model that included all main effects and all possible two-way interactions, the pool of potential interactions was restricted to interactions with waiver status and a set of other interactions deemed to be of substantive interest based on existing literature. Initially, a model selection process was performed on only main effects. At the next step, only the significant main effects, their interactions with waiver status, and the interactions deemed to be of substantive interest were included in the model and model selection used to arrive at a parsimonious final model.

6.3.4.5 Taylor Linearization Method (adjusting variances for clustering in all models)

The data used are clustered, that is, they are naturally organized into units such as counties and families. Potentially the data within each cluster are more similar than data from two different clusters. For example, data from units (children, families) within the same county are likely more similar than data from units across counties due to the same county-level policies applying to the units. Because of this, the observation units are no longer independent, resulting in increased variance beyond what would be expected with independent observations. The usual analyses that assume independence of the observations will generally underestimate the true variance and lead to test statistics with inflated Type I errors, or in other words, showing falsely significant results. The variances, and therefore the test statistics, need to be adjusted to reflect the true uncertainty in our estimates and the true significance levels. In general, such adjustment is a fairly complicated procedure owing to the difficulty of estimating accurately the degree of non-independence; there is typically no simple formula that can be applied.

Frequently used adjustment methods include replication techniques, which are more applicable to clustered data arising from complex surveys, and Taylor series linearization techniques, which have been used here.

Taylor series linearization is a mathematical technique used to adjust for clustering in statistical analyses. Taylor series linearization simplifies the statistic in question by linearization of the function on which the statistic is based, approximating the function by a truncated Taylor series expansion. This linearized variable is then substituted into the appropriate variance formula under the specified clustering in the data. The actual formulae and the form of the linearized variable depend on the statistic in question, whether mean, proportion, regression coefficient, or other statistic. This method enables us to get an approximation to the true variance of the statistic being estimated. In practice, Taylor series techniques are widely implemented in standard statistical software.[184] By applying this method to correct for clustering, we are more confident that the statistical tests do not provide false significant results due to underestimating the variance, and thus we are more confident in the findings.

6.3.4.6 Significance Test of Rate of Placement Disruption

The analysis team conducted a significance test to compare the rate of placement disruption (Section 6.2.3.1) in demonstration counties to the rate in comparison counties for each year (2011, 2012, 2013, and 2014). The rates were estimated using a weighted ratio estimator in SUDAAN's Proc Ratio. Then pairwise differences between the aggregate rate in demonstration counties and the aggregate rate in comparison counties within each year (2011, 2012, 2013, and 2014) were tested using a *t*-test. The *t*-test accounted for the clustering within county and the intake category code (child abuse and neglect report vs. FINS or dependency). The previously mentioned Taylor linearization method was used in the variance estimation approach. Propensity weights were used to balance the two groups.

6.4 Findings

6.4.1 Exit Reasons

Table 6.3 contains exit reasons, as of May 7, 2015, for children who entered care in CY 2011 to 2014. Of the 23,219 children who entered care, most children exited to reunification (45% weighted) or to the custody or guardianship of a relative or third party (23%). Other children exited to adoption (6%), through emancipation (3%), or because of other exit reasons (1%). Approximately one-fifth (21.5%) of children remained in care. Exit reasons for each county, along with several other variables by county, are available in Appendix K.

[184] The current study uses SAS with the SUDAAN add-on to run the analyses applying the Taylor series method.

Table 6.3: Exit Type as of May 2015, for Entry Cohorts 2011-2014 (n=23, 219)									
	Demonstration			Comparison			Total		
	N	%	Weighted %	N	%	Weighted %	N	%	Weighted %
Reunification	6,842	46.1%	43.9%	3,363	40.1%	45.3%	10,205	44.0%	44.6%
Custody or Guardianship	3,140	21.2%	23.2%	2,158	25.7%	23.5%	5,298	22.8%	23.4%
Adoption	789	5.3%	5.9%	565	6.7%	5.7%	1,354	5.8%	5.8%
Emancipation[a]	498	3.4%	3.4%	303	3.6%	3.5%	801	3.4%	3.4%
Other[b]	299	2.0%	1.7%	47	0.6%	1.0%	346	1.5%	1.3%
Still in care	3,264	22.0%	22.0%	1,951	23.3%	21.1%	5,215	22.5%	21.5%
Total	**14,832**	**100.0%**	**100.0%**	**8,387**	**100.0%**	**100.0%**	**23,219**	**100.0 %**	**100.0%**

[a] Emancipation includes aged out of system or emancipated.
[b] Other exit includes exit to other agency, AWOL, and child death.

Offering a different perspective on exit status, Table 6.4 provides exit reasons for children who exited within one year after entry and Table 6.5 provides exit reasons for children who exited within two years of entry.[185] Of the 12,849 who exited within one year of entry, 63% of the children were reunified, 31% exited to guardianship or custody of a relative or third party, and 1% were adopted. Another 5% had other outcomes, including emancipation (3%) and other reasons (2%). Of the 16,674 who exited within two years, 59% of the children were reunified, 31% exited to guardianship or custody of a relative or third party, and 4% were adopted. Another 5% had other outcomes, including emancipation (4%) and other reasons (2%).

Table 6.4: Exit Type for Children Exiting Care within 12 Months, for Entry Cohorts 2011-2014 (n=12,849)									
	Demonstration			Comparison			Total		
	N	%	Weighted %	N	%	Weighted %	N	%	Weighted %
Reunification	5,429	65.7%	62.1%	2,690	58.7%	63.9%	8,119	63.2%	63.0%
Custody or Guardianship	2,264	27.4%	30.9%	1,698	37.0%	31.4%	3,962	30.8%	31.2%
Adoption	96	1.2%	1.7%	29	0.6%	0.5%	125	1.0%	1.1%
Emancipation	222	2.7%	2.8%	131	2.9%	2.6%	353	2.7%	2.7%
Other	252	3.0%	2.6%	38	0.8%	1.5%	290	2.3%	2.0%
Total	**8,263**	**100%**	**100.0%**	**4,586**	**100.0%**	**100.0%**	**12,849**	**100.0%**	**100.0%**

[185] Table 6.4 does not account for children who entered care in the second half of 2014, who were still in care May 2015, but who may have exited thereafter within a 12-month timeframe, as we only have observations as late as May 2015. Likewise, Table 6.5 does not account for children who were not observed for the full 24 months and were still in care as of May 2015. Later in the report we use the Kaplan Meier procedure to estimate time to permanency and time to reunification for all children in the entry cohorts, including those children who have not yet been observed for the full 12-month or 24-month period.

Table 6.5: Exit Type for Children Exiting Care within 24 Months, for Entry Cohorts 2011-2014 (n=16,674)									
	Demonstration			**Comparison**			**Total**		
	N	**%**	**Weighted %**	**N**	**%**	**Weighted %**	**N**	**%**	**Weighted %**
Reunification	6,643	61.9%	58.7%	3,284	55.3%	60.0%	9,927	59.5%	59.4%
Custody or Guardianship	2,991	27.9%	30.6%	2,114	35.6%	31.3%	5,105	30.6%	31.0%
Adoption	432	4.0%	4.8%	261	4.4%	3.8%	693	4.2%	4.3%
Emancipation	381	3.5%	3.7%	233	3.9%	3.6%	614	3.7%	3.7%
Other	291	2.7%	2.3%	44	0.7%	1.2%	335	2.0%	1.8%
Total	**10,738**	**100%**	**100.0%**	**5,936**	**100%**	**100.0%**	**16,674**	**100%**	**100%**

The results presented in Tables 6.3 through 6.5 indicate that the weighted proportion of children exiting to each exit type is very similar for children in demonstration and comparison counties, within 1% to 2% of each other for both 12-month and 24-month periods. The difference between demonstration and comparison counties was statistically significant at 12 months, after applying propensity weights to compare similar children and adjusting for clustering within counties (Adjusted Wald F=2.96, p=0.027); however, the effect is so small that the difference may not be practically significant (see Table 6.4). There was no statistically significant difference at 24 months. These results should be interpreted cautiously as they do not account for all children, since children in the later entry cohorts may not have been observed for the full period (e.g., a child enters in fall 2014, can only be observed through the May 2015 file creation date, which is less than a year). Additional analyses are presented in the following sections, examining the likelihood and timing of permanency exits for all children while controlling for other variables that may predict permanency outcomes, according to prior studies. The additional analyses provide estimates for all children, including those who were not observed for the full period.

6.4.2 Placement Duration and Likelihood of Exit

6.4.2.1 Time to Permanency by Waiver Status: Kaplan Meier

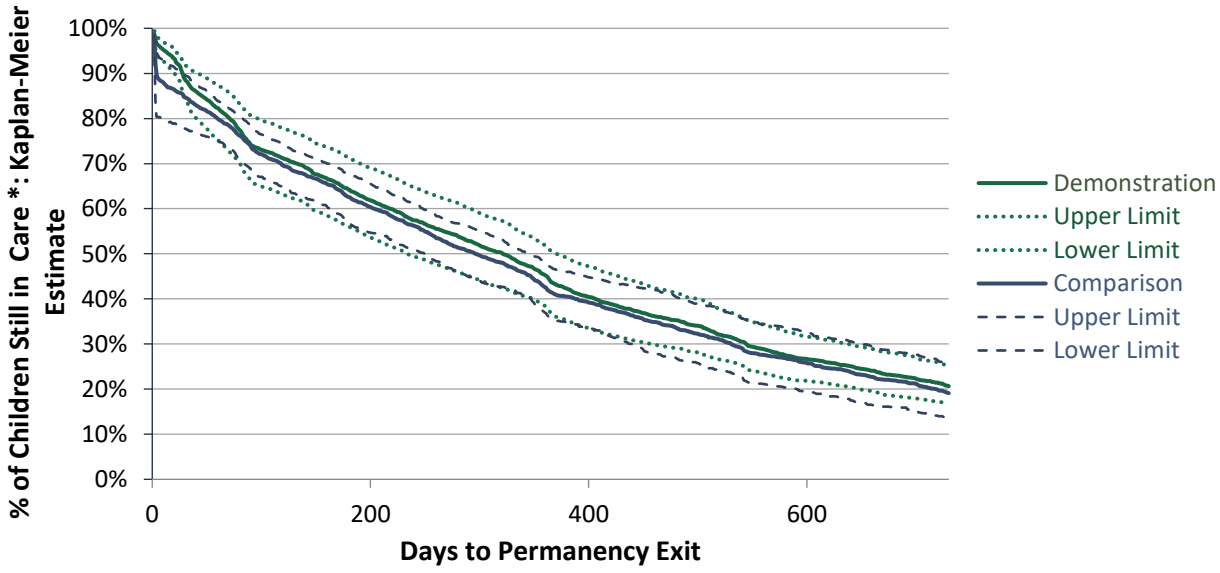
The evaluation team used the Kaplan Meier procedure, applying propensity weights and the Taylor series linearization method, to produce survival curves for demonstration and comparison counties for the time to permanency exit (Figure 6.1). The time to permanency exit was modeled for all children entering care during CY 2011 through 2014. Permanency exit was defined as exits to reunification, custody or guardianship of a relative or third party, or adoption. Cases were censored if they did not exit care during the 24 month observation period, or if they exited for reasons that are not considered desirable permanency placements, including emancipation, absent without leave, and death (see Section 6.3.4.2 for discussion of censoring).

Figure 6.1 provides the time to permanency within 24 months, and Figure 6.2 focuses on the first 60 days to allow closer examination of the same data. During the first 30 days there is a difference between demonstration and comparison counties, as the two lines and confidence intervals are clearly separate.

Most notable, children in comparison counties exit to permanency very quickly within the first four days, with the percent still in care dropping to 90% (Figure 6.2). Thereafter, the demonstration and comparison lines begin to merge. The confidence intervals overlap completely for most of the 24 months. Thus, for most of the 24 months, no statistically significant difference is evident between demonstration and comparison counties on length of time to a permanency exit.

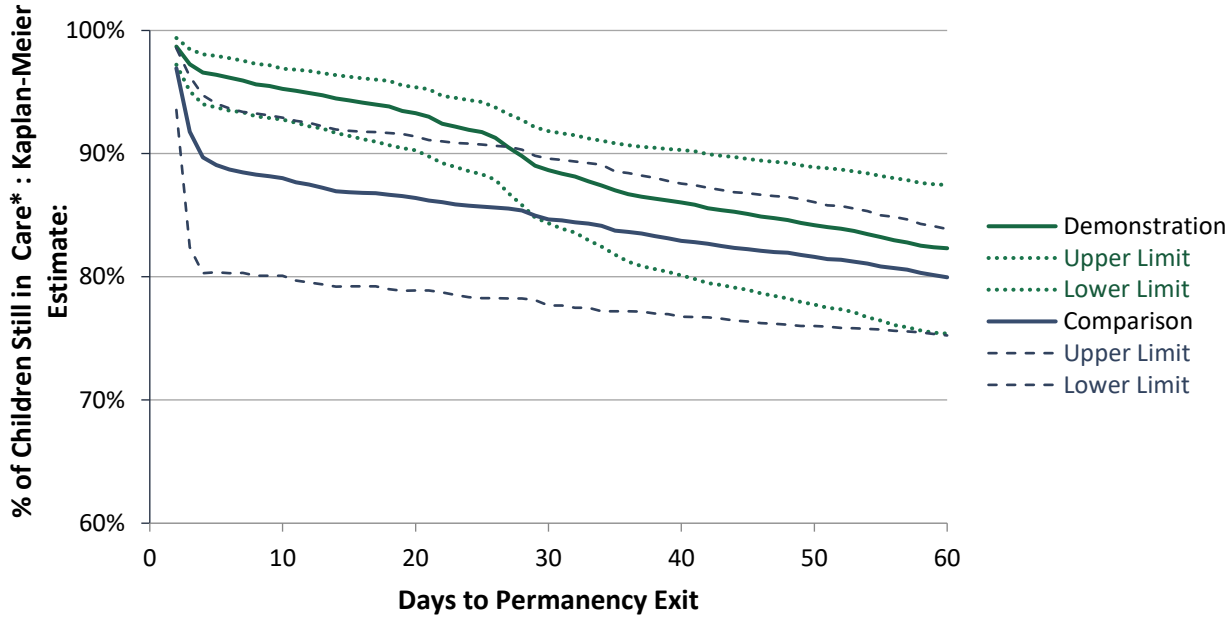
The estimates indicate that at the end of one year, more than half of children (56% in demonstration and 58% in comparison counties) are likely to have exited to permanency.[186] At the end of two years an estimated four-fifths of children (79% in demonstration and 81% in comparison counties) are likely to have exited to permanency and about one-fifth (21% in demonstration and 19% in comparison counties) are likely to either remain in care or, for a small number, exit to emancipation or other reasons (exit to other agency, runaway, death). The 95% confidence intervals for remaining in care or other exit range from 17% to 25% in demonstration counties and 14% to 25% in comparison counties.

Figure 6.1 Time to Permanency by Waiver Status Following Children for 24 Months (730 Days): Children Entering Care 2011 - 2014



[186] These estimates differ slightly from the percentages presented in the descriptive table (Table 6.3) because the Kaplan-Meier procedure takes into account censoring whereas the descriptive proportion does not.

Figure 6.2: Time to Permanency Exit by Waiver Status Following Children for 60 Days: Children Entering Care 2011 – 2014

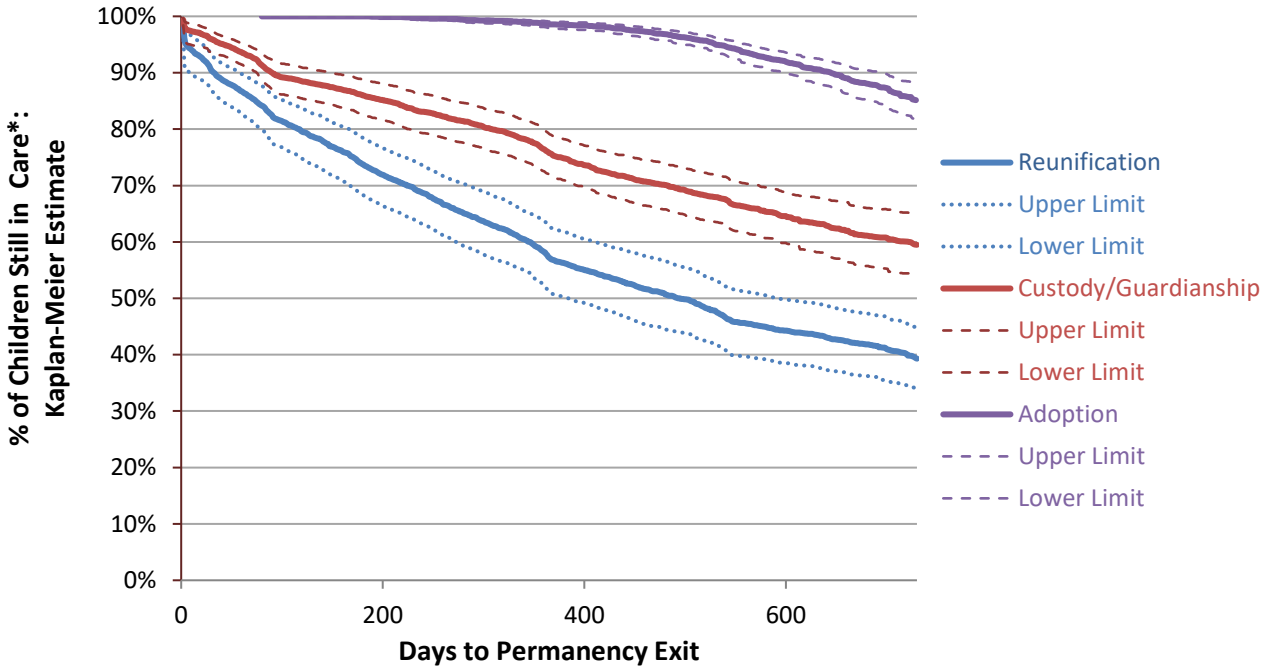


*In Figures 6.1 and 6.2, the percentage of children still in care includes a small number of children who exit to emancipation, runaway, transfer to another agency, death, and other/unclassified.

6.4.2.2 Time to Exit to Permanency by Exit Type: Competing Risks Framework: Kaplan Meier

A competing risks framework was used to examine the time to specific permanency exit types. The POA evaluation team used the Kaplan-Meier procedure, with propensity weights and the Taylor series linearization method, to produce survival curves for each of the three permanent exit types (reunification, custody/guardianship of relative or third party, and adoption) for the time to exit within 24 months (Figure 6.4). Cases were censored on exits to emancipation or "other" exit and on children still in care at the end of the 24 month observation period.

Figure 6.3: Competing Risks – Time to Permanency, Following Children for 24 Months (730 Days), For Children Who Entered Care 2011-2014



*In Figure 6.3 the percentage of children still in care includes a small number of children who exit to emancipation, runaway, transfer to another agency, death, and other/unclassified.

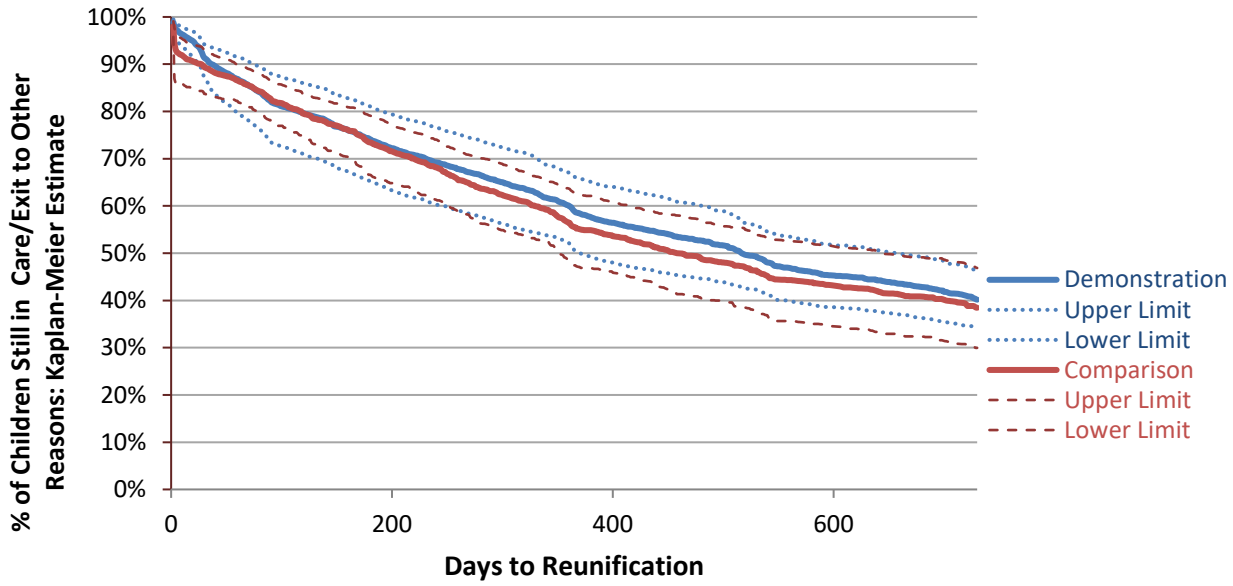
As seen in Figure 6.3, the 95% Confidence Intervals (CIs) for the Kaplan Meier estimates of time to reunification, to custody or guardianship of a relative or third party, and to adoption are well separated throughout the 24 month period. The 95% CIs for adoption were clearly separate. As expected, time to adoption is significantly longer than time to reunification or custody or guardianship, consistent with policies related to adoption. Time to custody or guardianship is also longer than time to reunification. Based on this graph, there is some evidence that there is a difference between these exit types.
A separate analysis of time to reunification was conducted as part of the data analysis plan, due to specific interest in reunification (see Sections 6.4.2.3 and 6.4.2.5) and any subsequent re-entry among children who reunify (Section 6.4.3).

6.4.2.3 Time to Reunification by Waiver Status: Kaplan Meier

The evaluation team also used the Kaplan Meier procedure, applying propensity weights and the Taylor series linearization method, to produce survival curves for demonstration and comparison counties for the time to reunification (Figure 6.4). Time to reunification was modeled for all children entering care during calendar years 2011 through 2014. Cases were censored if they did not exit care during the 24 month observation period, or if they exited for reasons other than reunification (see Section 6.3.4.2 for discussion of censoring).

Figure 6.4 provides the time to reunification within 24 months. Similar to the permanency survival curve, during the first 30 days there is a difference between demonstration and comparison counties, as the two lines and confidence intervals are clearly separate. Most notable, children in comparison counties reunify very quickly within the first four days, with the percentage still in care dropping to 93% in comparison counties compared to 97% in demonstration counties (Figure 6.4). After about 30 days, the demonstration and comparison lines begin to merge (89% vs. 91%). The confidence intervals overlap completely for most of the 24 months. Thus, for most of the 24 months, no statistically significant difference is evident between demonstration and comparison counties on length of time to reunification.

Figure 6.4: Time to Reunification by Waiver Status – Following Children for 24 Months (730 Days), Children Entering Care 2011-2014



The estimates indicate that at the end of two years well over half of children (60% in demonstration and 62% in comparison counties) are likely to have exited to reunification, whereas more than one-third of children (40% in demonstration and 38% in comparison counties) remain in care or exit for reasons other than reunification.

6.4.2.4 Likelihood and Timing of Exit to Permanency: Cox Regression

The model selection procedure described in the Section 6.3.4.3 was used to develop a set of multivariate Cox proportional hazards models testing the hypothesis that children in demonstration counties achieve permanency more quickly than children in comparison counties. The outcome variable was days to permanency, either censored at 12 months (the first model presented in this section, Table 6.6) or at 24 months (the second model presented, Table 6.7); the detailed tables with main effects and interaction terms for these models are presented in Appendix J (Table J.1 and J.3, respectively). The set of potential predictors used in the permanency models is also provided in Appendix J (Tables J.2A and J.2B for 12 months, and Tables J.4A and J.4B for 24 months).

The final Cox proportional hazards models, including selected interactions, were both highly statistically significant, indicating that the explanatory variables chosen do predict the likelihood and timing of reunification within 12 months and within 24 months. The Wald F statistic and the associated Wald Chi Square were computed, as well as the Adjusted Wald F statistic; all three have p-values <.001 for both models. The 12-month model is discussed in detail first, followed by the 24-month model.

Permanency within 12 months: Waiver status is predictive of permanency within 12 months, with children in demonstration counties being less likely to achieve permanency than comparison counties overall; however, there are significant interactions between waiver status and two placement episode factors (previous placement episodes, and predominant placement type), as well as with kinship policy. In particular:

- Children whose predominant placement type was an adoptive home were less likely to achieve permanency within 12 months compared to children in foster homes, but if they were predominantly in an adoptive home in a demonstration county, they were three times more likely to achieve permanency within 12 months than those in a comparison county in an adoptive home. Children in demonstration counties who were predominantly in group home placements were significantly more likely to achieve permanency within 12 months (approximately three times more likely than similar children in comparison counties.
- Children with one previous placement episode were less likely to achieve permanency than children with no previous placement episodes; but, among children with one previous placement episode, if they were in a demonstration county, they were more likely to achieve permanency within 12 months as compared to similar children in a comparison county. Children with two or more previous placement episodes were more likely to achieve permanency; but, among those with two or more previous episodes, if they were in a demonstration county, they were less likely to achieve permanency within 12 months as compared to similar children in a comparison county.

Note that if a covariate appears in an interaction term, the overall test of significance for the main effect for that particular covariate will be missing in Table 6.6 because its effect can no longer be tested separately. Coefficients, p-values, and hazard ratios for all terms in the models are presented in Appendix J in Table J.1 (12 months) including the main effect terms missing in Table 6.6. These main effect terms should be interpreted only in conjunction with the corresponding interaction effects and not as standalone effects. Doing so may lead to misleading and confusing interpretations.

Other significant factors in the model include child age at removal (older children are more likely to achieve permanency by 12 months) and race (Black and other race children are more likely to achieve permanency by 12 months than White children). Children are also more likely to achieve permanency by 12 months if their family structure includes only a mother (vs. two parents), if there are no siblings in care, or if the first placement setting lasts one day. Children are less likely to achieve permanency by 12 months if the child's physical, cognitive, or social development was identified as a risk contributor, if the caregiver has a history of drug or alcohol use, or if the child is IV-E eligible. Children who had more than one placement setting were less likely to achieve permanency by 12 months. Children in the 2014 cohort were significantly less likely to achieve permanency by 12 months, but note that since a large amount of the 2014 data is censored, it is unclear whether this effect is due to that censoring or is a genuine trend.

Table 6.6: Cox Proportional Hazard Model (Final Model) Tests of Null Hypothesis **Predicting Likelihood of Permanency within 12 Months for Children Entering Out-of-Home Care from January 1, 2011 through December 31, 2014 (n=23,219)**							
	df	Wald *F*	*p*	Adj. Wald *F*	*p*	Wald ChiSq	*P*
OVERALL MODEL	**55**	**2861.33**	<0.001**	**369.20**	**0.000**	**157373.16**	**0.000**
CHILD FACTORS							
Age at removal	3	6.81	0.001**	6.59	0.001**	20.44	<0.001**
Race	3	9.25	<0.001**	8.95	<0.001**	27.74	<0.001**
Hispanic ethnicity	2	17.88	<0.001**	17.59	<0.001**	35.76	<0.001**
Developmental risk	2	11.55	<0.001**	11.36	<0.001**	23.10	<0.001**
FAMILY FACTORS							
Family structure	4	10.98	<0.001**	10.45	<0.001**	43.92	<0.001**
Siblings in foster care	1	23.53	<0.001**	23.53	<0.001**	23.53	<0.001**
Caregiver age at removal	4	3.76	0.008*	3.58	0.011*	15.05	0.005**
Caregiver drug/alcohol use	2	7.94	0.001**	7.81	0.001**	15.88	<0.001**
Title IV-E eligibility	2	43.06	<0.001**	42.37	<0.001**	86.12	<0.001**
PLACEMENT EPISODE FACTORS							
Cohort (Entry Year)	3	14.82	<0.001**	14.34	<0.001**	44.45	<0.001**
Removal reason	6	4.57	0.001**	4.20	0.002**	27.40	<0.001**
Previous placement episodes	.	.	.	.	.	.	.
Predominant placement type	.	.	.	.	.	.	.
Number of placement settings	3	270.05	<0.001**	261.33	<0.001**	810.14	<0.001**
First setting one day	1	32.10	<0.001**	32.10	<0.001**	32.10	<0.001**
CHILD WELFARE AGENCY FACTORS							
Kinship policy	.	.	.	.	.	.	.
Waiver status	.	.	.	.	.	.	.
INTERACTIONS							
Waiver status by kinship policy	2	4.63	0.013*	4.56	0.014*	9.26	0.01*
Waiver status by predominant placement type	5	5.59	<0.001**	5.23	0.001**	27.95	<0.001**
Waiver status by previous placement episodes	2	7.35	0.001**	7.23	0.002**	14.70	0.001**
Number of events: 12556.988 (weighted)			Total cases: 23,219		Censored: 54.1% (weighted)		
^*p*<.10 (marginal evidence) *p<.05 **p<.005							

Permanency within 24 months. The model predicting likelihood of permanency at 24 months is very similar to the 12-month model, with significant interactions between waiver status and predominant placement type as well as kinship policy. In addition, there was an interaction between race and

caregiver substance abuse. In the 24-month analysis, there was no longer an interaction between waiver status and previous placement episodes.

Waiver status has a significant main effect on likelihood of permanency by 24 months with children in demonstration counties being less likely to achieve permanency compared to comparison counties; however, there are significant interactions between waiver status and predominant placement type and with kinship policy. In particular:

- Children whose predominant placement type was an adoptive home were less likely to achieve permanency overall, but if they were in an adoptive home in a demonstration county, they were 1.5 times more likely to achieve permanency within 24 months than those in a comparison county in an adoptive home. Although, overall, children placed predominantly in group homes were marginally less likely to achieve permanency in 24 months, children in demonstration counties who were predominantly in group home placements were significantly more likely to achieve permanency within 24 months (approximately 2.5 times more likely) than similar children in group homes in comparison counties. These are in line with the 12-month results.

Other significant factors in the model include child age at removal, developmental risk, family structure, siblings in care, IV-E eligibility, several placement related variables, and an interaction between race and caregiver drug or alcohol use. Children are more likely to achieve permanency within 24 months if they are older (age 13+ vs. 0-2 years), if they have no siblings in care, or if the first placement setting is of one day. Children are marginally more likely to achieve permanency by 24 months if their family structure includes only a mother. Children are less likely to achieve permanency by 24 months if child development is identified as a risk contributor or if the child is IV-E eligible. Children in the 2014 cohort, children who were removed for dependency reasons, and children who had more than one placement setting were less likely to achieve permanency by 24 months. Again, these are in line with the 12-month findings.

Overall, all races are more likely to achieve permanency by 24 months than Whites, and children are less likely to achieve permanency by 24 months if caregiver substance use is a factor. However, if caregiver substance abuse is a factor, all races are less likely to achieve permanency by 24 months when compared to White children for whom caregiver substance abuse is a factor.

Table 6.7: Cox Proportional Hazard Model (Final Model) Tests of Null Hypothesis							
Predicting Likelihood of Permanency within 24 Months for Children Entering Out-of-Home Care from January 1, 2011 through December 31, 2014 (n=23,219)							
	df	Wald *F*	*p*	Adj. Wald *F*	*p*	Wald ChiSq	*P*
OVERALL MODEL	**59**	**2634.43**	**<0.001****	**169.96**	**<0.001****	**155431.63**	**<0.001****
CHILD FACTORS							
Age at removal	3	3.20	0.029*	3.10	0.033*	9.61	0.022*
Race	.	.	.	.	.	.	.
Hispanic ethnicity	2	22.77	<0.001**	22.40	<0.001**	45.54	<0.001**
Developmental risk	2	17.66	<0.001**	17.37	<0.001**	35.32	<0.001**
FAMILY FACTORS							
Family structure	4	6.81	<0.001**	6.48	<0.001**	27.25	<0.001**
Siblings in foster care	1	36.47	<0.001**	36.47	<0.001**	36.47	<0.001**
Caregiver age at removal	4	6.57	<0.001**	6.25	<0.001**	26.28	<0.001**
Caregiver drug/alcohol use	.	.	.	.	.	.	.
Title IV-E eligibility	2	36.83	<0.001**	36.23	<0.001**	73.66	<0.001**
PLACEMENT EPISODE FACTORS							
Cohort (Entry Year)	3	14.62	<0.001**	14.15	<0.001**	43.87	<0.001**
Removal reason	6	5.95	<0.001**	5.47	<0.001**	35.68	<0.001**
Previous placement episodes	2	3.67	0.031*	3.61	0.033*	7.34	0.026*
Predominant placement type	.	.	.	.	.	.	.
Number of placement settings	3	371.35	<0.001**	359.37	<0.001**	1114.06	<0.001**
First setting one day	1	28.09	<0.001**	28.09	<0.001**	28.09	<0.001**
CHILD WELFARE AGENCY FACTORS							
Kinship policy	.	.	.	.	.	.	.
Waiver status	.	.	.	.	.	.	.
INTERACTION TERMS							
Waiver status by predominant placement type	5	5.34	<0.001**	4.99	0.001**	26.69	<0.001**
Waiver status by kinship policy	2	5.97	0.004**	5.87	0.005**	11.94	0.003**
Race by caregiver drug/alcohol use	6	7.09	<0.001**	6.51	<0.001**	42.52	<0.001**
Number of events: 16104.818 (weighted)			Total cases: 23,219		Censored: 30.6% (weighted)		
^*p*<.10 (marginal evidence) **p*<.05 ***p*<.005							

6.4.2.5 Likelihood and Timing of Reunification: Cox Regression

The model selection procedure described in the Section 6.3.4.3 was used to develop a second set of multivariate Cox proportional hazards models testing the hypothesis that children in demonstration counties are reunified with caregivers more quickly than children in comparison counties. The outcome variable was days to reunification, either censored at 12 months (the first model presented in this section, Table 6.8) or at 24 months (the second model presented, Table 6.9); the detailed tables with main effects and interaction terms for these models are presented in Appendix J (Table J.5 and J.7, respectively). The same set of potential predictors used in the permanency models was used for the reunification models, provided in Appendix J (Tables J.6A and J.6B for the 12-month reunification main effects model, and Tables J.8A and J.8B for the 24-month reunification main effects model).

The final Cox proportional hazards models, including selected interactions, were both highly statistically significant, indicating that the explanatory variables chosen do predict the likelihood and timing of reunification within 12 months and within 24 months. The Wald F statistic and the associated Wald Chi Square were computed, as well as the Adjusted Wald F statistic; all three have p-values <.001 for both models. The 12-month model is discussed in detail first, followed by the 24-month model.

Reunification within 12 months: Waiver status alone does not predict reunification within 12 months; however, there are significant interactions between waiver status and several placement episode factors (previous placement episodes, predominant placement type, and number of placement settings), as well as with kinship policy. In particular:

- Children in demonstration counties who were predominantly in group home placements were more than twice as likely to achieve reunification as similar children in comparison counties also predominantly in group home placements.
- Children in demonstration counties with exactly three placements were only half as likely to achieve reunification within 12 months, compared to similar children with exactly three placements in comparison counties.
- Finally, children in demonstration counties with two or more previous placement episodes were much less likely to reunify within 12 months, at only about 60% of the rate of such children in comparison counties.

As noted above, if a covariate appears in an interaction term, the overall test of significance for the main effect for that particular covariate will be missing in Table 6.8 because its effect can no longer be tested separately.

Table 6.8: Cox Proportional Hazard Model (Final Model) Tests of Null Hypothesis							
Predicting Likelihood of **Reunification within 12 Months** of Entry for Children Entering Out-of-Home Care from January 1, 2011 through December 31, 2014 (n=23,219)							
	df	Wald *F*	*p*	Adj. Wald *F*	*p*	Wald ChiSq	*P*
OVERALL MODEL	**53**	**2882.00**	**<0.001****	**464.84**	**<0.001****	**152746.12**	**<0.001****
CHILD FACTORS							
Age at removal	3	12.44	<0.001**	12.04	<0.001**	37.32	<0.001**
Race	3	.	.	.	.	.	.
Hispanic ethnicity	2	13.63	<0.001**	13.41	<0.001**	27.26	<0.001**
Developmental risk	2	14.25	<0.001**	14.02	<0.001**	28.51	<0.001**
FAMILY FACTORS							
Family structure	4	11.94	<0.001**	11.37	<0.001**	47.77	<0.001**
Caregiver drug/alcohol use	2	29.22	<0.001**	28.74	<0.001**	58.43	<0.001**
Title IV-E eligibility	2	74.95	<0.001**	73.75	<0.001**	149.91	<0.001**
PLACEMENT EPISODE FACTORS							
Cohort (Entry Year)	3	15.75	<0.001**	15.24	<0.001**	47.24	<0.001**
Previous placement episodes	2	.	.	.	.	.	.
Predominant placement type	5	.	.	.	.	.	.
Number of placement settings	3	.	.	.	.	.	.
First setting one day	1	55.34	<0.001**	55.34	<0.001**	55.34	<0.001**
CHILD WELFARE AGENCY FACTORS							
Kinship policy	2	.	.	.	.	.	.
Waiver status	1	.	.	.	.	.	.
INTERACTION TERMS							
Waiver status by predominant placement type	5	6.61	<0.001**	6.19	<0.001**	33.07	<0.001**
Waiver status by number of placement settings	3	7.07	<0.001**	6.85	<0.001**	21.22	<0.001**
Waiver status by previous placement episodes	2	7.38	0.001**	7.26	0.002*	14.75	0.001*
Waiver status by kinship policy	2	3.80	0.028*	3.74	0.030*	7.59	0.0224*
Race by kinship policy	6	3.37	0.006*	3.10	0.011*	20.25	0.003*
Number of events: 8,305.80 (weighted)			Total cases: 23,219		Censored: 64.2% (weighted)		
^*p*<.10 (marginal evidence) **p*<.05 ***p*<.005							

Other significant factors in the model include child age at removal (older children are more likely to achieve reunification) and race (Black children are more likely to achieve reunification. Children are less likely to achieve reunification if the child's physical, cognitive or social development was identified as a

risk contributor in the family assessment, if the caregiver has a history of drug or alcohol use, or if the child is IV-E eligible. Finally, placement episode factors are highly predictive of likelihood of reunification. Reunification within 12 months becomes less likely with each additional placement: a child with two placements is already half as likely to reunify as a child with one placement. Children with a first placement setting lasting only one day are more likely to reunify more quickly.

Reunification within 24 months: The model predicting likelihood of reunification at 24 months is very similar to the 12-month model, with the addition of three main effect terms (caregiver age at removal, removal reason, and the indicator for child welfare agency vs. related agency). The interactions between waiver status and number of placement settings and between waiver status and previous placement episodes were no longer significant at 24 months, so are not included in this model.

Waiver status does have a significant main effect on likelihood of reunification at 24 months: children in demonstration counties achieve reunification within 24 months at only about two-thirds the rate of comparison county children, but this finding must be interpreted in conjunction with the interaction terms in the model.

Table 6.9: Cox Proportional Hazard Model (Final Model) Tests of Null Hypothesis Predicting Likelihood of **Reunification within 24 Months of Entry** for Children Entering Out-of-Home Care from January 1, 2011 through December 31, 2014 (n=23,219)							
	df	Wald *F*	*p*	Adj. Wald *F*	*p*	Wald ChiSq	*P*
OVERALL MODEL	**56**	**16152.61**	**<0.001****	**1042.10**	**<0.001****	**953003.86**	**<0.001****
CHILD FACTORS							
Age at removal	3	10.70	<0.001**	10.36	<0.001**	32.11	<0.001**
Race	3		.		.		.
Hispanic ethnicity	2	14.53	<0.001**	14.29	<0.001**	29.06	<0.001**
Developmental risk	2	17.30	<0.001**	17.02	<0.001**	34.60	<0.001**
FAMILY FACTORS							
Family structure	4	11.24	<0.001**	10.70	<0.001**	44.97	<0.001**
Caregiver age at removal	4	4.75	0.0021*	4.52	0.003*	18.99	<0.001**
Caregiver drug/alcohol use	2	25.62	<0.001**	25.20	<0.001**	51.24	<0.001**
Title IV-E eligibility	2	61.54	<0.001**	60.55	<0.001**	123.08	<0.001**
PLACEMENT EPISODE FACTORS							
Cohort (Entry Year)	3	21.14	<0.001**	20.46	<0.001**	63.41	<0.001**
Removal reason	6	5.52	<0.001**	5.07	<0.001**	33.09	<0.001**
Previous placement episodes	2	6.17	0.004*	6.07	0.004**	12.34	0.002**
Predominant placement type	5	.	.	.	.	.	.
Number of placement settings	3	729.46	<0.001**	705.93	<0.001**	2188.37	<0.001**
First setting one day	1	34.42	<0.001**	34.42	<0.001**	34.42	<0.001**
CHILD WELFARE AGENCY FACTORS							
Child welfare vs. related agency	1	8.80	0.004**	8.80	0.004**	8.80	0.003**
Kinship policy	2	.	.	.	.	.	.
Waiver status	1	.	.	.	.	.	.
INTERACTION TERMS							
Waiver status by predominant placement type	5	6.26	<0.001**	5.85	<0.001**	31.29	<0.001**
Waiver status by kinship policy	3	6.01	0.004*	5.92	0.005*	12.03	0.002**
Race by kinship policy	6	3.00	0.012**	2.76	0.020**	18.03	0.006*
Number of events: 10,105.40 (weighted)			Total cases: 23,219		Censored: 43.5% (weighted)		
^*p*<.10 (marginal evidence) **p*<.05 ***p*<.005							

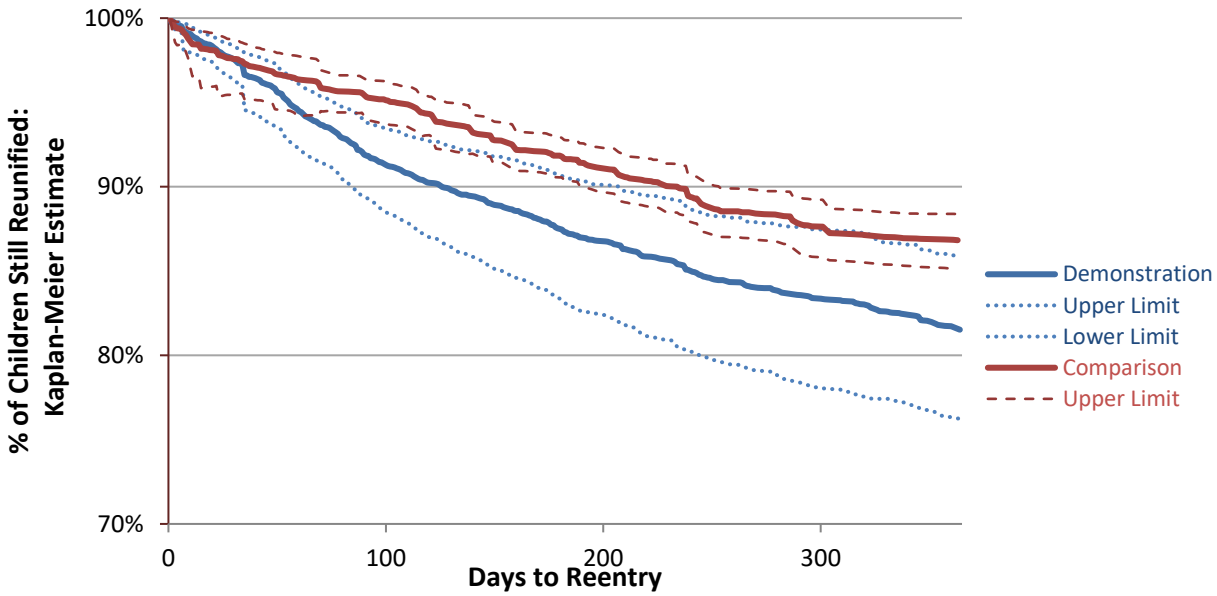
6.4.3 Re-Entry to Placement after Exiting to Reunification

6.4.3.1 Time to Re-Entry by Waiver Status: Kaplan Meier

The evaluation team used the Kaplan Meier procedure, applying propensity weights and the Taylor series linearization method, to produce survival curves for demonstration and comparison counties for time to re-entry for children who exited to reunification within 12 months, of those who entered placement during calendar years 2011 through 2014 (Figure 6.5). Cases were censored if they did not re-enter care during the 12 month observation period.

During the first several months (the first 70 to 80 days) after reunification, children in demonstration and comparison counties follow similar paths. Thereafter, they begin to separate, indicating comparison counties are more likely to remain home, not re-enter. Approximately 82% (CI 76%-86%) of children in demonstration counties remained home and 87% (CI 85%-88%) of children in comparison counties remained home at the end of the year.

Figure 6.5: Time to Reentry by Waiver Status – Following Children for 12 Months, Children Entering Care 2011 - 2014 Who Exited to Reunification within 12 Months



6.4.3.2 Likelihood and Timing of Re-entry after Reunification: Cox Regression

The model selection procedure described in Section 6.3.4.3 was used to develop a set of multivariate Cox proportional hazards models testing the hypothesis that post-reunification, children in demonstration counties reenter the child welfare system slower than children in comparison counties. The outcome variable was days to reentry post-reunification, censored at 12 months (Table 6.10); the detailed table with main effects and interaction terms is presented in Appendix J, Table J.9. For this analysis, we restricted the data to children who were reunified within 12 months. The set of potential predictors used in this model is provided in Appendix J in Tables J.10.A and J.10.B.

The final Cox proportional hazards model, including selected interactions, was highly statistically significant, indicating that the explanatory variables chosen do predict the likelihood and timing of reentry within 12 months post reunification. The Wald F statistic and the associated Wald Chi Square were computed, as well as the Adjusted Wald F statistic; all three have p-values <.001 for both models.

Waiver status alone does not predict re-entry into care after reunification. However, there is a significant interaction between waiver status and race; Black children in demonstration counties are more likely than Black children in comparison counties to re-enter care within 12 months.

There is a significant interaction between caretaker substance use issues and the reason for removal. If the caregiver has a history of drug or alcohol use, or the removal was due to child behavior issues, children are more likely to reenter the system overall, but if both were a factor, the effect is somewhat modified downwards. Children were less likely to reenter the system if physical abuse was a factor overall but if physical abuse was aggravated by caretaker substance use factors, the likelihood of reentry increased by a factor of 1.7.

Children who were predominantly placed in kinship homes are less likely to reenter post reunification.

Table 6.10: Cox Proportional Hazard Model (Interaction Effects) Tests of Null Hypothesis

Predicting Likelihood of Re-Entry within 12 Months of Reunification for Children Entering Out-of-Home Care from January 1, 2011 through December 31, 2014 (n=8,119)

	df	Wald *F*	*p*	Adj. Wald *F*	*p*	Wald ChiSq	*p*
OVERALL MODEL	**33**	**856.29**	**<0.001****	**414.33**	**<0.001****	**28257.60**	**<0.001****
CHILD FACTORS							
Race	.	.	.	.	.	.	.
Hispanic Ethnicity	2	8.08	0.001**	7.95	0.001**	16.17	<0.001**
FAMILY FACTORS							
Caregiver drug/alcohol use	.	.	.	.	.	.	.
PLACEMENT EPISODE FACTORS							
Removal Reason	.	.	.	.	.	.	.
Predominant placement type	4	7.99	<0.001**	7.60	<0.001**	31.95	<0.001**
CHILD WELFARE AGENCY FACTORS							
Waiver Status	.	.	.	.	.	.	.
INTERACTIONS							
Waiver Status* Race	3	83.31	<0.001**	80.63	<0.001**	249.94	<0.001**
Caregiver drug/alcohol use *Removal Reason	12	34.21	<0.001**	28.14	<0.001**	410.47	<0.001**
Number of events: 1559.511(weighted)			Total cases: 8119		Censored: 81.2% (weighted)		
^*p*<.10 (marginal evidence) **p*<.05 ***p*<.005							

6.4.4 Placement Disruption

6.4.4.1 Early Disruption

The model selection procedure described in Section 6.3.4.4 was used to develop a logistic regression model testing the hypothesis that children in demonstration counties are less likely to experience early placement disruption than children in comparison counties. Early disruption, as defined by two or more moves within the first month of care, was tested using a binomial logistic model with the binary outcome variable being 1 if there was early disruption and 0 if there was no early disruption. The model selection procedure was used to develop a parsimonious model predicting early disruption (Table 6.11).

Twenty main effects and thirty eight two way interactions were entered into the selection process. Of these, ten main effects variables were in the final logistic model but no interaction terms were selected into the final model. The main effect of waiver status was not significant; Table 6.12 below shows the percent of early disruption is almost identical between demonstration and comparison counties. Coefficients, p-values, and Odds Ratios for the final main effects model are provided in Appendix J in Table J.11, and the complete set of predictors in the initial main effects model are in Appendix J in Table J.12.A and J.12.B.

The significant main effects in the final model are child age at removal, family structure, caregiver drug or alcohol abuse, cohort, reason for removal, first placement type, first placement setting one day, placement agency, and county size. However, the findings on the significant impact of caregiver substance abuse may be due to the missing data pattern in the data and needs to be interpreted with caution. Children are more likely to experience an early disruption if they are older, removed from a single mother family, entered placement in 2011 (all years after 2011 experienced lower early disruption), have primary removal reason of physical abuse (vs. neglect), or if the first placement type is a group home vs. foster home. Children are less likely to experience an early disruption if the primary removal reason is dependency or child behavior issues, if the placement agency is a related agency (juvenile court or, in Franklin County, another agency: PFSN or NYAP) instead of the child welfare agency, or the county is large, compared to metro. The full test information on these effects is given in Table 6.11 below and in Table J.11 in Appendix J.

Table 6.11: Logistic Model Final Model Main Effects and Interaction Terms: Tests of Null Hypothesis Predicting Likelihood of **Early Disruption** for Children Entering Out-of-Home Care from January 1, 2011 through December 31, 2014 (n=20,449)							
	df	Wald *F*	*p*	Adj. Wald *F*	*p*	Wald ChiSq	*p*
OVERALL MODEL	**29**	**560.26**	**<0.001**	**307.24**	**<0.001**	**16247.59**	**<0.001**
CHILD FACTORS							
Age at removal	3	5.11	0.003**	4.95	0.004**	15.33	0.002**
FAMILY FACTORS							
Family Structure	4	2.87	0.030*	2.74	0.037*	11.50	0.021*
Caregiver drug/alcohol use	2	8.28	0.001**	8.14	0.001**	16.56	<0.001
PLACEMENT EPISODE FACTORS							
Cohort (Entry Year)	3	2.97	0.039*	2.87	0.044*	8.91	0.031*
Removal Reason	6	7.07	<0.001**	6.50	<0.001**	42.41	<0.001**
First placement type	4	34.87	<0.001**	33.19	<0.001**	139.50	<0.001**
First setting one day	1	166.37	<0.001**	166.37	<0.001**	166.37	<0.001**
CHILD WELFARE AGENCY FACTORS							
Child Welfare vs. Related Agency	1	6.16	0.016*	6.16	0.016*	6.16	0.013*
County Size	3	6.68	0.001**	6.46	0.001**	20.04	<0.001
Waiver Status	1	0.69	0.409	0.69	0.409	0.69	0.405
Number of events: 590.40 (weighted)			Total cases: 20,138 (Weighted)				
^*p*<.10 (marginal evidence) *p**<.05 *p***<.005							

Table 6.12 shows the weighted frequencies for early disruption by waiver status. Within the demonstration counties the weighted percent of early disruption cases was 2.69% whereas within the comparison counties the weighted percent of early disruption cases was 2.68%. Since both demonstration and comparison counties have early disruption rates below 3%, in both cases early disruption can be classified as a rare event since any event occurring less than 5% of the time is considered statistically rare.

Table 6.12: Weighted Frequencies of Early Disruption[a] by Waiver Status					
	Demonstration		**Comparison**		**Total**
	N	**%**	**N**	**%**	**N**
No Early Disruption (0 or 1 moves)	9,970.5	97.31%	9,625.8	97.32%	19,596.2
Early disruption (2 or more moves)	275.9	2.69%	265.6	2.68%	541.5
Total	10,246.4	100.0%	9,891.4	100.0%	20,137.7

[a] Early disruption refers to 2 or more moves within 30 days of entry.

6.4.4.2 Rate of Placement Disruption by Year, Based on Federal Measure

Placement disruption was also assessed based on the federal measure, which examines the rate of placement moves per 1,000 days in care within a 12 months period, using an entry cohort (Sections 6.3.3.2 and 6.3.4.6 further describe the measure and analytic method). For each year, the analysis team selected all children entering care that year, whether or not they were included in another analysis year, and calculated total moves per year and total days per year. Next we used a weighted ratio estimator, then tested for pairwise differences between the aggregate rate in demonstration counties and the aggregate rate in comparison counties.

There is no significant difference in the test of ratios between demonstration and comparison county in this global measure of placement disruption for any of the years 2011 to 2014 (Table 6.13). Demonstration and comparison counties have similar rates of placement disruption within a 12 month period, according to this measure.

Table 6.13: Rate of Placement Disruption by Year by Waiver Status, 2011-2014

		Rate of Moves/1000 Days in Care (Weighted)		Statistical test		
Year	N	Demonstration	Comparison	*T value*	*p value*	Result*
2011	5,952	4.3	3.9	0.477	0.63	NS
2012	5,671	4.2	4.6	-0.572	0.57	NS
2013	6,038	4.3	4.4	-0.046	0.96	NS
2014	5,968	4.1	4.1	0.026	0.98	NS

** Indicates significance at p<.05. NS=Not significant. There were no statistically significant differences.*

6.5 Discussion

6.5.1 Summary

The POA analyses tested the three main hypotheses regarding placement outcomes during Ohio's third waiver period. We hypothesized that children in demonstration counties will experience reduced time to permanent placements, increased permanent placement without re-entry, and decreased placement disruption. The analyses examined children who entered care during Calendar Years 2011-2014, following them forward for 12 months or 24 months from the date of entry.

The findings are summarized and discussed for each outcome below. In general, the findings do not provide evidence supporting our hypotheses regarding placement duration, re-entry, and early disruption. However, there are some circumstances in which children in demonstration counties do experience permanency more quickly–when placed predominantly in adoptive homes or group homes, or when the demonstration county has policies that lead to consistent placement decisions (consistently take custody, or consistently not take custody). Also, there were other factors that did predict placement duration, re-entry, and early disruption outcomes, consistent with the literature.

6.5.1.1 Exit Types

Children experience similar exit types in demonstration and comparison counties, when comparing similar children (using propensity weights to balance the groups, and adjusting for clustering within county). There are no statistically significant differences in the types of exits experienced by children in demonstration and comparison counties. The most common exit type was reunification (63%, weighted, of those exiting within 12 months), followed by custody or guardianship of a relative (31%), consistent with prior research and the principles of child welfare practice.

6.5.1.2 Placement Duration

The current study seeks to understand whether or not implementation of a title IV-E Waiver—including a Kinship Supports intervention and family team meetings—will reduce the placement duration for foster children, with more children achieving permanency more quickly. The findings regarding placement duration are complex and must be interpreted carefully.

According to the Kaplan Meier estimates, at the end of one year more than half of children (56% in demonstration and 58% in comparison counties) are likely to have exited to permanency. An estimated four-fifths of children (79% in demonstration and 81% in comparison counties) are likely to exit placement to permanency within 24 months, with about one-fifth (21% in demonstration and 19% in comparison counties) likely to remain in care. When examining time to reunification specifically, the estimates indicate that at the end of two years well over half of children (60% in demonstration and 62% in comparison counties) are likely to have exited to reunification, with more than one third of children (40% in demonstration and 38% in comparison counties) remain in care or exit for reasons other than reunification.

After controlling for a series of child, family, agency, and county factors, children in demonstration counties are less likely to achieve permanency (reunification, custody or guardianship of a relative or third party, and adoption), and less likely to reunify specifically, compared to similar children in comparison counties. However, this finding must be interpreted carefully and in concert with several related findings. First, we found interaction effects that indicate that children in demonstration counties do experience permanency more quickly under some circumstances –when placed predominantly in adoptive homes or group homes, or when the demonstration county has policies that lead to consistent placement decisions (consistently take custody, or consistently not take custody, for children placed with kin). Second, examination of a survival curve shows a difference in the initial period in care, but similar rates thereafter. Comparison children exit to permanency more quickly during the first 30 days, with the most notable difference in the first 4 days (90% still in care in comparison counties vs. 97% in demonstration counties on day 4). After the first 30 days the survival lines begin to merge, indicating similar permanency exit rates for the rest of the two year period examined. Findings were similar for exit to reunification. These findings may point to a positive finding for demonstration counties—it is plausible that the demonstration counties may be preventing placements that would have been very short stays in care, even if they are not reducing time in care for those who enter placement.

Thus, although the findings may be contrary to the hypothesis, these findings must be interpreted carefully. Rather than being detrimental to duration in care, the waiver may prevent some of the short

stays in care and still lead to similar outcomes for children who do come into care. Further exploration of this issue is needed.

In addition to examining the impact of the waiver on placement outcomes, this study identified a number of factors that predicted time to permanency and reunification. These factors are discussed below in the context of prior research.

Factors predicting likelihood of exiting more quickly to permanency or reunification: Consistent with recent literature[187] [188], older children were more likely to exit to permanency placements, and specifically, to reunification more quickly. Unlike some prior studies[189] [190], Black children in this study achieved permanency/reunification more quickly than White children. Like prior studies there were several interactions with race[191] [192]; when the caregiver is identified as having drug/alcohol use as a risk contributor, Black children are more likely to exit more slowly than White children, consistent with these studies. Also, when the county has a kinship policy that leads to consistently not take custody, Black children exit care more slowly to reunification than White children.

Children who do not have siblings in care have a greater likelihood of exiting more quickly to a permanency placement, although this was not true for reunification alone. Interestingly, a prior study[193] found than children with no siblings in placement and children placed with their siblings had a greater likelihood of exiting to reunification than children with siblings who were placed in separate placement settings. Separation of siblings was not examined as a factor in the current study.

Reason for removal was identified in prior literature as a significant predictor of reunification, where children who were neglected had a slower rate of reunification than children removed for physical abuse[194] [195] or sexual abuse[196]. In the current study, the main effects model for reunification within 12 months showed a trend toward neglect having a slower reunification rate than physical abuse, but there was no evidence of this in the final model with interactions.

Factors predicting slower exit to permanency, or reunification: Children with physical, cognitive, or social development identified as a risk contributor were slower to be reunified or otherwise achieve permanency. This variable was used as a proxy for disability, which is also associated with slower reunification in the literature[197] [198] [199]. Children with caregivers with a history of drug or alcohol use

[187] Akin, 2011
[188] Weigensberg, 2009
[189] Ibid
[190] Wells & Guo, 1999
[191] Baumann et al., 2010
[192] Wittenstrom et al., 2015
[193] Akin, 2011
[194] Ibid
[195] Wells & Guo, 1999
[196] Akin, 2011
[197] Ibid
[198] Wells & Guo, 1999
[199] Welch, Jones, & Steward, 2015

were also slower to exit to permanency or reunification, consistent with prior literature[200]. In addition, children who are IV-E eligible or have more placement settings are slower to permanency or reunification.

In the prior study of one Ohio County[201], children removed from a mother only family were reunified more slowly than children removed from two parents. However, in the current study there was no statistically significant relationship between family structure and reunification. On the other hand, there was evidence that children achieve permanency within 12 months more quickly when removed from a mother only family, compared to two parents, and marginal evidence of a relationship between family structure and permanency within 24 months.

Several placement related variables (prior removals, predominant placement setting, number of placement settings) had interactions with waiver status. Having a history of prior removals did not predict timeliness of exit to permanency, but there was an interaction between previous placement episode, waiver status and permanency or reunification within 12 months. This is somewhat consistent with prior research that identified a weak effect of prior removals.[202]

Children with predominant placement in an adoptive home in a demonstration county reach permanency more quickly than children with predominant placement in an adoptive home in a comparison county. Children with predominant placement in a group home in a demonstration county reach permanency, or reunify, more quickly than children with the same predominant placement type in a comparison county. Prior studies have found placement type, and specifically kinship homes, predicts permanency, but findings vary. Some find that children in kinship homes are more likely to exit to permanency more quickly[203] [204], others find the opposite (for example, a multi-state study in which different states had opposite findings[205]), and still others find no difference between permanency outcomes for children placed in kinship versus non-kinship foster homes (Koh & Testa[206], when using propensity score matching to address selection bias). The main effects model in our ProtectOHIO study did indicate that children who spent most of their time placed with kinship families were more likely to exit to permanency within 12 months than children in foster homes, but when interactions were identified in the final model the interaction effects involved adoptive homes and group homes, not kinship families.

Children who experienced only one placement setting while in care had a greater likelihood of timely exit to reunification within 12 months, although not for 24 months, and children were less likely to exit with each additional placement. Similarly, children with early placement stability were more likely to exit to reunification in another study[207].

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[200] Baumann et al., 2010

[201] Wells & Guo, 1999

[202] Akin, 2011

[203] Ibid

[204] Koh, 2008

[205] Ibid

[206] Koh & Testa, 2008

[207] Akin,2011

6.5.1.3 Re-entry after Reunification

We found no statistically significant effect of the waiver on re-entry overall, but Black children in demonstration counties are more likely than Black children in comparison counties to re-enter care within 12 months. This suggests that the title IV-E Waiver did not reduce re-entry.

Other factors did predict re-entry. The literature identifies many variables associated with re-entry, but results vary across studies. For this study, nine of the child, family, and placement episode variables identified in the literature were found to be significant in the initial main effects model, but the final model with interactions includes fewer significant predictors. We found that children predominantly placed in kinship homes are less likely to re-enter care post-reunification than children placed in foster homes; this is consistent with prior literature (for example, Wells & Guo[208]), although we did not find interactions between kinship homes and child characteristics as suggested in the more recent Koh & Testa[209] study. There was an interaction between caregiver substance use issues and the reason for removal (behavior) in the prediction of re-entry. If the caregiver has a history of drug or alcohol use, or the removal was due to child behavior issues, children are more likely to re-enter the system overall but if both were a factor, the effect is somewhat modified downwards. Children were less likely to re-enter the system if physical abuse was a factor overall, but if physical abuse was aggravated by caretaker substance use factors, the likelihood of re-entry increased. Both of these variables (substance use, child behavior removal reason) have been identified as predictors in prior studies[210] [211] [212] [213], but this interaction was unexpected.

6.5.1.4 Placement Disruption

The current study also sought to understand whether or not implementation of a title IV-E Waiver would reduce the placement disruption for foster children. We found no statistically significant difference in the proportion of children who experienced two or more moves (three or more settings) during their first month in care in demonstration counties compared to comparison counties, suggesting the title IV-E Waiver neither increased nor decreased early placement stability. Children in demonstration and comparison counties experience very low, and similar, levels of early placement disruption, each around 2.7%. We also found no difference between demonstration and comparison counties in placement disruption during a 12 month period. Placement disruption was defined as the number of moves per 1,000 days in care for each 12 month period, based on the federal measure. Children in demonstration and comparison counties experienced similar levels of placement disruption, about 4 moves per 1,000 days in care, during each calendar year of the study (2011, 2012, 2013, and 2014).

Multivariate analysis indicated there were a number of factors that predicted a greater likelihood of early disruption: the child being older at removal, being removed from a single mother family (compared to two parents), entering placement in 2011 (subsequent years experienced lower early

[208] Wells & Guo, 1999
[209] Koh & Testa, 2011
[210] Jones & LaLiberte, 2010, review
[211] Shaw, 2006
[212] Shaw & Webster, 2011
[213] Koh & Testa, 2011

disruption), having a removal reason of physical abuse (vs. neglect), and the first placement type is group home (vs. foster home). Children are less likely to experience an early disruption if the primary removal reason is dependency or child behavior issues, if the placement agency was a related agency (e.g., juvenile court) instead of the child welfare agency), or if the county is large, compared to metro.

The finding that older children are at greater risk for early disruption is consistent with prior literature that has identified a link between age and placement disruption[214] [215] [216] [217]. Prior research also shows that children placed in relative homes have lower risk of placement disruption than children in foster homes[218] [219] and group homes[220]. Our study found a relationship between first placement type and early disruption. There was no statistically significant difference between kinship and foster homes, although the odds ratio was in the right direction; it is possible this effect may have become significant in a model that looked beyond 30 days. Also, group homes had a higher risk of placement disruption than foster homes; although we did not compare group homes to kinship homes, it is possible that there would be a difference, consistent with the literature.

The current study found that children are less likely to experience early disruption if the primary removal reason is child behavior issues, compared to neglect. Prior studies have identified a link between child behavior problems and placement disruption[221] [222] [223] [224], but the direction of this relationship is unclear. In a content analysis study, almost half of the children experienced one or more moves before their behavior problems emerged[225]. Taking these findings together, perhaps the children removed due to behavior issues are initially placed in an appropriate environment, a positive finding.

6.5.2 Strengths and Limitations

The current study tests the hypotheses that children in demonstration counties have decreased placement duration and reduced early disruption compared to comparison counties. The study is quasi-experimental, but several steps were taken to reduce the possibility of selection bias in findings. At the beginning of the project an effort was made to select comparison counties that were similar to demonstration counties on a series of variables, including county population size, the percent of county considered rural, the percent of children in the population receiving Aid to Dependent Children (ADC), the percent of child welfare spending coming from local government, child abuse and neglect rates, out-of-home placement rates, and median placement days. Despite these efforts, demonstration and comparison counties differed, so for this analysis, propensity weights were calculated and applied to the

[214] Barth et al., 2007
[215] Connell et al, 2006
[216] James, 2004
[217] Weiner, et al, 2001
[218] Chamberlain et al, 2006
[219] Connell et al., 2006
[220] Ibid
[221] Barth et al, 2007
[222] Chamberlain et al., 2006
[223] Cross et al., 2010
[224] James, 2004
[225] Cross et al., 2013

analyses to balance the two groups to allow comparison of similar children in the demonstration and comparison populations, in order to reduce bias in findings. Also, multivariate models were used to test the relation between waiver status (demonstration vs. comparison counties) and the placement outcomes, controlling for child, family, placement episode and county factors.

Another strength of the study is that it addresses a limitation of prior studies by adjusting for clustering within counties in the analyses, avoiding false findings. Observed children in this study are organized into groups within counties. Because of this, there is naturally occurring dependence among observations (i.e., similarities among children from the same county). Such dependency leads to larger standard errors than would occur if the data were not clustered. Thus, if clustering and dependency are not adjusted for, estimated standard errors will be too small and thus significance levels too large and hence analyses may result in misleading findings, leading one to believe falsely that there are significant effects. In the current study we adjust for this clustering when conducting statistical tests in order to avoid false findings that may occur due to the clustering.

Clustering also occurs within families, as all children in placement from each family are included in the current study. Ideally we would want to adjust the data to address family clusters explicitly to avoid misleading results. However, we do not have the data needed to do this. Viewing the data from the family perspective, 70% of families[226] had only one child in care, not multiple children, so the variance estimates we could produce after adjusting for family level clustering would be unstable. Note that, since families are contained within counties, adjusting for county level clustering does adjust for family level clustering in an approximate and implicit way. If additional data sets in future waiver periods contain more families with multiple children, we may be able to adjust for family level clustering in a more explicit and consistent way.

Another strength of the study was that it tested interactions in the model. Wittenstrom et al.[227] emphasize that simple main effects models cannot explain racial disparities, and incorporating different combinations of interactions result in a wide range of results, from no significant differences between African American and White children to large differences in likelihood of reunification.

The analyses for this report have several limitations. A limitation of the models presented is that they do not include some theoretically relevant variables, either because the variable is not available for some children in the data set (e.g., parenting skills, attitudes or behaviors) or due to collinearity with other data due to missing portions of the variables obtained from the family assessment (e.g., child mental health, same missing patterns as child development variable).

[226] The majority (70%) of families had one child in care, but because of the presence of larger families in the sample (i.e., all children from a family are included in the sample), about two-thirds (64%) of the individual children had siblings in care.
[227] Wittenstrom, et al., 2015

Chapter 7. Overall Waiver Impact: Trajectory Analysis on Placement and Re-Abuse

7.1 Introduction

Among other objectives, waiver programs are designed to afford county caseworkers the latitude needed to serve children at home with their families. It is viewed that staying with parents, as long as children can be kept safe using in-home services, offers continuity of relationships that benefits children. The waiver creates this context by promoting investments in alternatives to placement.

By their nature, waivers require synergy across levels of the system. Policy makers have to make resources available; caseworkers have to use the services for those clients who stand to benefit. The key is rebalancing the system without increasing population-level safety risks, all things being equal.

In the waiver context, three basic indicators point to whether demonstration counties responded to the waiver stimulus and succeeded in changing placement patterns without increasing safety risks relative to the comparison counties. The indicators are: placement into foster care following a substantiated or indicated report; recurrence of maltreatment in situations where the child was not placed; and, occurrence of maltreatment following the child's return home.

In this chapter, we examine whether waiver counties were able to reduce entry into out-of-home care without increasing safety risks, either prior to placement or after leaving foster care. Similarly to the previous chapter, these analyses examine the impact of the waiver overall, while outcomes for the FTM and Kinship Supports interventions are found in Chapters 3 and 4, respectively. What follows is a description of the study populations and an overview of how we answered the primary evaluation questions.

7.2 Methods

7.2.1 Research Questions

This chapter presents the results from three methodologically similar sub-studies, each of which follows a distinct population of children in the demonstration and comparison counties. The research questions and target population include:

Study population 1: Did the probability of placement following the first substantiated/indicated allegation of maltreatment change in demonstration counties at a rate that was different than the pattern of change observed in the comparison counties? For ease of exposition we refer to this population as *children who were placed.*

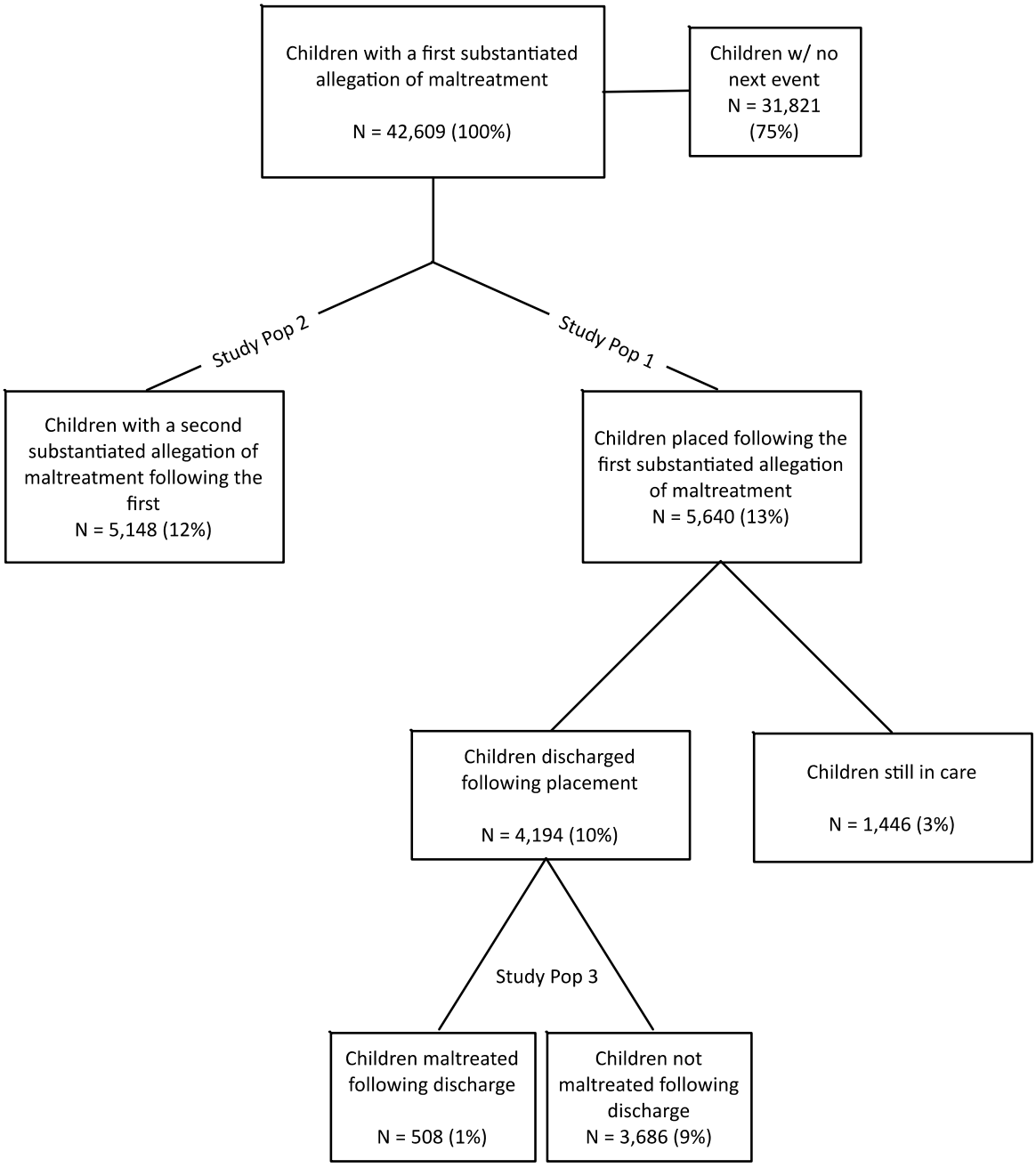
Study population 2: Did the probability of a substantiated abuse report following the first substantiated abuse report (recurrence) change in demonstration counties at a rate that was different than the pattern of change observed in the comparison counties? These children are referred to as having experienced a *recurrent maltreatment* event (i.e., recurrence).

Study population 3: Did the probability of a substantiated maltreatment following discharge from placement (occurrence following discharge) change in demonstration counties at a rate that was different than the pattern of change observed in the comparison counties? These are children who have experienced *post-placement re-abuse.*

The actual distribution of children by sub-study is shown in Figure 7.1. This Figure was created based on the following event streams of children over time: Among children who were substantiated for the first time, children were either placed or stayed at home. Those children who stayed at home either experienced a second substantiation or experienced no next event until censored. Among children who were substantiated and placed after the first substantiation, children were discharged or are still in care until censored. Among children who were discharged, they were either maltreated or not maltreated until censored. Overall, between January of 2011 and May 11 of 2015, there were 42,609 first-time victims of child maltreatment across the demonstration and comparison counties. In order to be consistent with the previous evaluation report,228 only children who were 13 years old or younger when their first investigation occurred are included in this report. Studies 1 and 2 use the whole sample to ascertain whether changes in placement and recurrence rates in the demonstration counties differ from those reported in the comparison counties; study 3 looks at whether the subset of children in the sample who were placed following the substantiated report experienced another substantiated allegation once they were discharged from care.

[228] Comprehensive Final Evaluation Report of the third waiver, November 2013.

Figure 7.1: Study Populations in Relation to the Trajectory Followed



7.2.2 Empirical Strategies

The empirical strategy for all three studies is the same. For studies 1 and 2, we are interested in what happens after the first substantiated report of maltreatment. There are three possibilities: [1] the child is placed following the substantiated maltreatment report; [2] the child is re-abused before a placement takes place; or [3] there is no subsequent contact with the child welfare system following the first substantiated report. Study 1 follows children who are placed; study 2 follows children who are maltreated again. Study 3 follows children who were placed and then discharged from placement.

Each of the underlying questions involves the likelihood that one event will be followed by another as time passes. Questions of this sort are typically answered using some type of event history model. For this piece of the analysis, we adopt a discrete time hazard model, which is more fully explained in Appendix L. Discrete time hazard models offer a number of advantages over other types of event history techniques. In the waiver context, one important advantage has to do with the fact that discrete time models are readily adapted to a multilevel framework. As shown below and discussed in prior chapters, counties within the demonstration and comparison groups differ considerably in size. Practically speaking, this means that counties provide differing amounts of information to the analysis. The multilevel framework takes these differences into account when estimating effect sizes[229]. Again, these issues are covered in greater detail in Appendix L.

7.2.3 Data Description and Summary Statistics

Ohio's SACWIS data contains historical data for children who were reported to child protective services from 2011 through May 11, 2015. For purposes of the evaluation, only children with a first substantiated report between those two dates are included. Children in this group are followed from the date of the first substantiated report through May 11, 2015. Children for whom there is no next event (i.e., no placement or substantiated report) are censored.[230] A child is considered abused when a child report was recorded as substantiated or indicated.

As noted in Figure 1 above, for the placement question (Study Population 1) and the recurrence question (Study Population 2), 42,609 children were included in the analysis. For Study Population 3 there were 4,194 children discharged from foster care and therefore at risk of post-discharge abuse. Table 7.1 shows the number of observations in each study population by year, from 2011 through May 11, 2015.

[229] Effect size refers to the magnitude of the impact observed; for example, analysis may find a statistically significant difference in placement rates, indicating that difference is not due to chance; but the magnitude of the difference observed may be only 1%, a small effect size.

[230] Chapter 6 offers more explanation of censoring.

Table 7.1: Study Sample Size by Year and County Type				
	Frequency		Percent	
Year of Admission and County Type	Study Pop. 1 & 2	Study Pop. 3	Study Pop. 1 & 2	Study Pop. 3
All Counties				
Total	*42,609*	*4194*	*100%*	*100%*
2011	11,696	1326	27%	32%
2012	10,715	1093	25%	26%
2013	9,695	1074	23%	26%
2014	8756	631	21%	15%
As of 5/11/2015	1747	70	4%	2%
Demonstration Counties				
Total	*25,488*	*2243*	*100%*	*100%*
2011	7,094	757	28%	34%
2012	6,225	585	24%	26%
2013	5,712	555	22%	25%
2014	5,375	319	21%	14%
As of 5/11/2015	1,082	27	4%	1%
Comparison Counties				
Total	*17,121*	*1951*	*100%*	*100%*
2011	4,602	569	27%	29%
2012	4,490	508	26%	26%
2013	3,983	519	23%	27%
2014	3,381	312	20%	16%
As of 5/11/2015	665	43	4%	2%

Table 7.2 presents basic demographic data on children from the demonstration and comparison counties. By and large, children in the base population (25,488 in demonstration counties and 17,121 in comparison counties) are similar, with a single exception. The proportion of Black children was larger in the demonstration counties, due to the presence of larger urban counties within the sample of demonstration counties.

With respect to Study population 3, two key differences are evident. Demonstration county children were younger and more likely to be Black. Because children in Study Population 3 represent the sub-set of children who were placed and then discharged, the observed differences are likely tied to differences in the underlying placement and discharge processes.

Table 7.2: Study Sample by County Type, Age, Race, and Gender				
County Type, Age, Race, and Gender	**Number**		**Percent**	
	Study Pop. 1 & 2	Study Pop. 3	Study Pop. 1 & 2	Study Pop. 3
All Children				
Age, total	*42,609*	*4,194*	*100%*	*100%*
Under 1	7,526	1,075	18%	26%
1 to 6	20,451	2,152	48%	51%
7 and above	14,632	967	34%	23%
Race			*100%*	*100%*
Black	12,790	1,435	30%	34%
White	23,838	2,563	56%	61%
Other	5,981	196	14%	5%
Gender			*100%*	*100%*
Male	21,408	2,197	50%	52%
Female	21,201	2,015	50%	48%
Demonstration Counties				
Age	*25,488*	*2,243*	*100%*	*100%*
Under 1	4,611	622	18%	28%
1 to 6	12,281	1,162	48%	52%
7 and above	8,596	459	34%	20%
Race			*100%*	*100%*
Black	8,657	845	34%	38%
White	13,575	1,303	53%	58%
Other	3,256	95	13%	4%
Gender			*100%*	*100%*
Male	12,631	1,162	50%	52%
Female	12,857	1,081	50%	48%
Comparison Counties				
Age	*17,121*	*1,951*	*100%*	*100%*
Under 1	2,915	453	17%	23%
1 to 6	8,170	990	48%	51%
7 and above	6,036	508	35%	26%
Race			*100%*	*100%*
Black	4,133	590	24%	30%
White	10,263	1,260	60%	65%
Other	2,725	101	16%	5%
Gender			*100%*	*100%*
Male	8,570	1,017	50%	52%
Female	8,551	934	50%	48%

7.3 Findings – Descriptive Analysis

Table 7.3 shows the likelihood of placement following the initial substantiated report. From these data, two specific conclusions are most relevant. First, at the aggregate level, the likelihood of placement following the first substantiated report differs only slightly between the two groups of counties. In the demonstration counties the post-placement rate was 12.2 percent; in the comparison counties the comparable figure was 14.7%.

Table 7.3: Likelihood of Placement Following the Initial Substantiated Allegation of Maltreatment

Demonstration Counties			**Comparison Counties**		
County	Number	% Placed	County	Number	% Placed
Total	*25,488*	*12.2%*	*Total*	*17,121*	*14.7%*
10003	636	22%	10001	1243	5%
10006	334	12%	10008	2269	12%
10011	950	6%	10012	1407	16%
10015	190	11%	10014	477	4%
10016	403	20%	10029	308	6%
10022	404	22%	10031	550	8%
10024	7214	13%	10049	855	11%
10028	896	4%	10054	269	5%
10030	5747	13%	10056	3877	7%
10032	344	10%	10058	172	6%
10046	2256	6%	10063	319	40%
10051	283	19%	10072	514	42%
10059	1140	18%	10076	2728	34%
10066	813	15%	10077	607	17%
10069	1429	2%	10082	832	13%
10075	2449	16%	10086	694	3%

Table 7.3 also shows that county-level placement rates vary substantially. For demonstration counties, placement rates range from 2% to 22%, and from 3% to 40% for comparison counties. The variation among counties poses a challenge for the evaluation because counties provide varying amounts of information. In order to take into account the specific nature of county effects, the evaluation team utilized a multilevel model.[231] Details of the model used are found in Appendix L.

If children are not placed following the first substantiated report, they stay with their families. For these children, there is a risk of recurrence.[232] Recurrence is an important evaluation question; if caseworkers assess that children can stay at-home safely, the soundness of their decisions in the aggregate may be

[231] Raudenbush, & Bryk, 2002

[232] Note that children who have a substantiated investigation while in placement are not a part of this analysis.

judged by comparing recurrence rates in the demonstration counties with those in the comparison counties.

Table 7.4 provides the recurrence rates for the demonstration and comparison counties. As seen in Table 7.3, there are again two general findings to highlight. The demonstration / comparison county difference is negligible. 12.4 percent of the children in the demonstration county experienced recurrence whereas 11.5 percent of the comparison counties experienced recurrence.

Table 7.4: Likelihood of Recurrence Following the Initial Substantiated Allegation of Maltreatment

Demonstration Counties			Comparison Counties		
County	Number	% Re-abused	County	Number	% Re-abused
Total	*25,488*	*12.4%*	*Total*	*17,121*	*11.5%*
10003	636	12.6%	10001	1243	15.6%
10006	334	10.5%	10008	2269	11.4%
10011	950	15.5%	10012	1407	8.7%
10015	190	6.8%	10014	477	10.1%
10016	403	10.2%	10029	308	11.0%
10022	404	8.9%	10031	550	13.8%
10024	7214	10.3%	10049	855	8.5%
10028	896	13.1%	10054	269	7.8%
10030	5747	11.4%	10056	3877	13.4%
10032	344	15.7%	10058	172	10.5%
10046	2256	15.3%	10063	319	10.7%
10051	283	4.9%	10072	514	7.2%
10059	1140	17.1%	10076	2728	11.7%
10066	813	15.1%	10077	607	10.0%
10069	1429	20.2%	10082	832	9.5%
10075	2449	12.0%	10086	694	11.2%

The data also show substantial variation among counties. The range of recurrence rates in the demonstration counties was from 5 percent to 20 percent. Among the comparison counties the range was 7 percent to 16 percent.

To complete the initial picture of safety, Table 7.5 presents data on rates of abuse following discharge. Again, the story follows the established narrative: The difference between comparison and demonstration counties is negligible and there is significant variation among the counties within each group (from 3% to 26% for demonstration counties and from 0% to 40% for comparison counties).

Table 7.5: Likelihood of Abuse Following Discharge from Placement					
Demonstration Counties			**Comparison Counties**		
County	Number	% Abused Post-Discharge	County	Number	% Abused Post-Discharge
Total	*2,243*	*13.0%*	*Total*	*1,951*	*11.1%*
10003	102	18.6%	10001	48	12.5%
10006	23	17.4%	10008	216	8.8%
10011	38	2.6%	10012	152	5.9%
10015	10	20.0%	10014	15	33.3%
10016	66	25.8%	10029	15	40.0%
10022	66	4.5%	10031	32	15.6%
10024	702	11.7%	10049	71	12.7%
10028	21	4.8%	10054	6	0.0%
10030	488	13.7%	10056	174	9.2%
10032	22	18.2%	10058	9	0.0%
10046	94	6.4%	10063	113	13.3%
10051	44	6.8%	10072	168	12.5%
10059	181	21.5%	10076	791	11.8%
10066	76	13.2%	10077	68	14.7%
10069	24	25.0%	10082	64	3.1%
10075	286	9.4%	10086	9	11.1%

7.4 Findings – Statistical Model

The descriptive data presented above point to negligible demonstration / comparison county differences, regardless of the outcome. That said, because counties differ in size and population composition, multilevel statistical models were used to study county differences at a deeper level. The specifics of the model used in this study are found in Appendix L. The presentation of the results is in two parts. Below, we present three graphs (Figures 7.2 through7.4) that depict the probability of placement, recurrence and post-placement abuse. The graphs show both demonstration and comparison county differences as well as patterns that relate the likelihood of placement, recurrence, and post-placement abuse with the passage of time. The results depicted in the graphs are adjusted results; that is, the probabilities take into account population composition (e.g., race/ethnicity, gender, and age) and size. The detailed results of the statistical models can be found in Appendix L.

Because the results are comparable across the outcomes, we offer here a single explanation of the findings. For each graph, the x-axis (D1, D2, D3, etc.) refers to a specific interval of time. In the case of placement after the first substantiated maltreatment report, the time between events is divided into one-month intervals. The y-axis shows the likelihood of an event within the corresponding interval. For recurrence and post-discharge maltreatment, time was divided into 3-month intervals.

Figure 7.2: Placement Following the Initial Substantiated Report, Demonstration and Comparison Counties

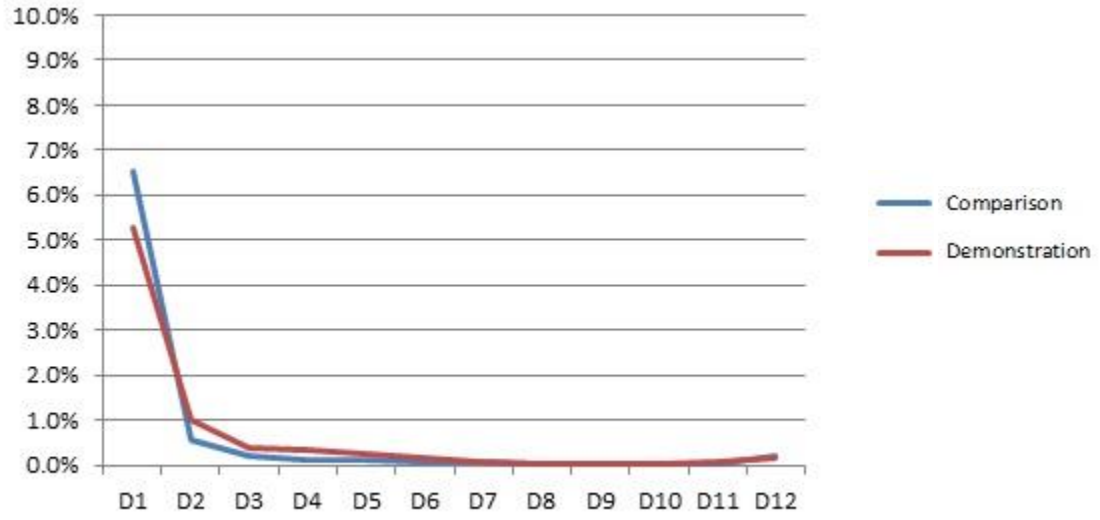
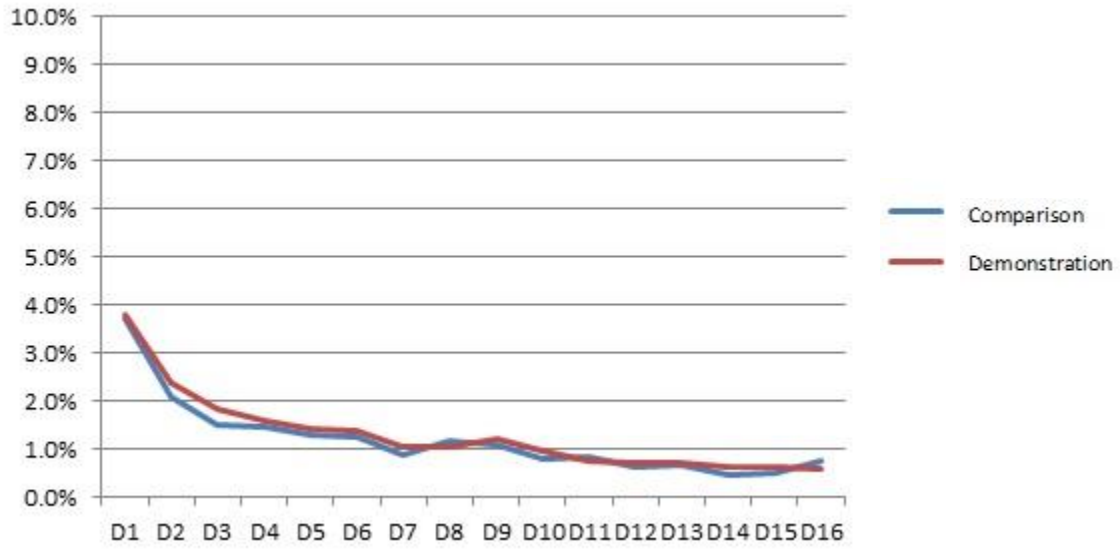


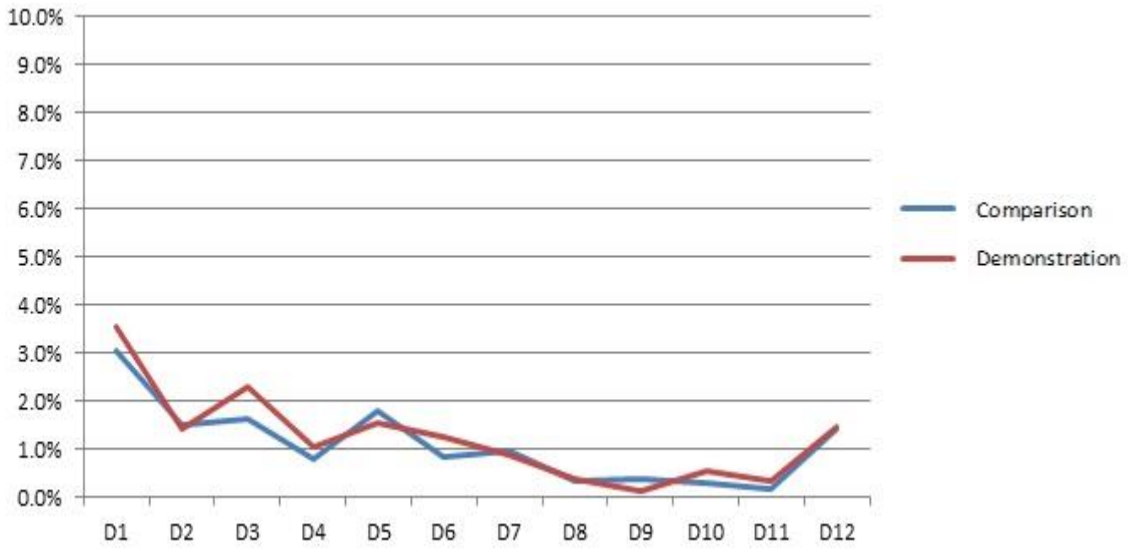
Figure 7.3: Recurrence of Maltreatment Following the Initial Substantiated Report, Demonstration and Comparison Counties



In the case of placement, recurrence, and post-discharge maltreatment, the risk is greatest in the interval immediately following either the first substantiated report or discharge from foster care, respectively. Thereafter, risk declines. For example, placement is unlikely in any given time interval following the initial month. With respect to the other outcomes, the risk following the first interval is lower than during the first interval. Figure 7.2c shows elevated risk in the twelfth interval. This is an artifact of how the data was grouped. Because post-discharge maltreatment depends on a series of preceding events (i.e., maltreatment, placement, and discharge), the time needed to observe the full set

of preceding events reduces the time available to observe post-discharge events. Consequently, all reported (and substantiated) maltreatment in subsequent time periods were grouped into the twelfth interval.

Figure 7.4: Recurrence of Maltreatment Following Discharge From Foster Care, Demonstration and Comparison Counties



The pairs of lines in Figures 7.2 through 7.4 show demonstration/comparison group differences by outcome. As suggested with the descriptive data, there were no statistically significant differences between the two groups of counties, even after controlling for the composition of the county populations and county size.

7.5 Summary

To answer whether the waiver has an impact on placement, recurrence, and post-discharge maltreatment, the evaluation team analyzed the data using a multilevel discrete time hazard model. The multilevel discrete time model was chosen because it provides for a unified statistical approach to the problems of censoring (i.e., children in the sample were still at risk of experiencing one of the outcomes when the data was pulled for the analysis) and the unobserved effect of counties.

The descriptive results show that counties differ in size. Counties also differ with respect to the outcomes. Nevertheless, when the between-county variation is taken into account, we failed to detect an overall waiver effect. Children in the demonstration counties were no more or no less likely to experience placement, recurrence, or post-discharge maltreatment; i.e., they remained equally safe under the waiver as they would have been under usual Ohio child welfare practices (as represented by the comparison counties).

Chapter 8. Conclusion and Discussion

The child welfare waiver demonstration authority provides states with an opportunity to use IV-E funds – traditionally allocated for foster care services – flexibly to explore innovative approaches for services and supports that promote safety, permanency, and well-being for children involved with child protective services. Ohio was one of the first states to implement a waiver demonstration project in 1997. It has operated continuously since then, providing a unique context for understanding the short- and long-term impacts of flexible funding on child welfare agencies. The first waiver period, 1997-2002, allowed participating counties maximum flexibility in how they chose to use the federal funds. While demonstration counties reported many activities and programs undertaken as a result of the waiver, these actions were neither sufficiently large-scale nor sufficiently targeted to bring about a statistically significant change in foster care expenditures or child and family outcomes. Evaluation findings from Ohio's first waiver were consistent with the cross-state waiver demonstration evaluation findings; flexible funding alone tended to result in diffuse and sporadic spending patterns, which were not always sufficient to guarantee cumulative positive outcomes.[233]

The second waiver period featured a major shift in focus – the demonstration counties agreed to target waiver activities to five intervention strategies, with each county required to implement the core intervention, Family Team Meetings (FTM), and at least one of four other interventions. The evaluation identified some key systemic changes that occurred substantially more in demonstration counties than in comparison counties, and also found statistically significant yet modest waiver effects on child outcomes, particularly among children and families who had received the FTM intervention. Also of note, evidence of a shift in PCSA spending patterns emerged during the second waiver period, with demonstration counties making significantly greater reductions in the proportion of child welfare expenditures going to foster care board and maintenance relative to comparison counties.

Given Ohio's success with increasing positive outcomes in the second waiver period compared to the first waiver period by implementing more consistent practice changes across the demonstration counties, the counties decided to narrow the focus of the third waiver period to just two interventions: FTM and Kinship Supports. The major focus of this evaluation therefore was the continued implementation of the FTM and Kinship Support models, examining the evolution and maturation of each model and the effects these interventions had on outcomes for children and families.

The evaluation of ProtectOHIO's third waiver period has resulted in important findings both in terms of implementation as well as outcomes. For both initiatives, counties worked to develop comprehensive manuals to systematize trainings and ensure that implementation could be as consistent as possible across the demonstration, particularly given the diversity among the demonstration counties. That is, demonstration counties vary in size, demographic make-up and they range from large metropolitan counties split into major regions and having, in some agencies, well over 100 caseworkers to small, rural, county agencies with fewer than a dozen workers in total. Further, in order to ease the burden of entering data into multiple data entry systems as was necessary during the first and second waivers, the state worked closely with the evaluation team and a committee made up of county representatives to incorporate an FTM data entry module in SACWIS - this was completed in 2013. And, in 2015, a

[233] Collins, 2005

workgroup of ProtectOHIO kinship staff began planning with SACWIS staff to do the same for the kinship intervention. This will ultimately eliminate the need for a supplemental data system and allow all case-level intervention information to be entered directly into SACWIS, and more importantly, allow counties to more easily self-monitor progress.

The primary focus of the current evaluation was to examine whether Family Team Meetings and Kinship Supports as interventions resulted in the outcomes counties hypothesized; thus, the intervention-specific analyses focused only on families who had specifically been exposed to the intervention in question, and were compared with similar comparison county families and children.

Further analyses that were first conducted during the first and second waiver periods, which focused on understanding whether there was an overall "waiver effect," were replicated during this waiver period: a fiscal analysis which examined changes in spending patterns as a result of flexible funding, and a placement outcome and a trajectory study, which each extended a focus to all children and families regardless of whether the family or child experienced the FTM or Kinship Supports interventions. While some might consider this to be akin to an intent-to-treat approach, it is important to understand that several counties specifically chose to randomly sample cases for inclusion into the FTM intervention (as described in Chapter 3), or to implement the Kinship Supports intervention within specific regions only (Chapter 4). This is different to an intent-to-treat approach in which analyses are conducted on participants based on the initial assignment to treatment regardless of whether the participant actually received treatment. Consequently, the intervention-specific analyses provide information on the impact of FTM and Kinship Supports as interventions, specifically, while the fiscal, trajectory, and placement outcome analyses provide an assessment on the impact of the waiver as a whole.

8.1 General State Context

Ohio faced a variety of contextual challenges over the period of the third waiver. The global recession that began in 2008 and continued through 2012 hit Ohio hard. It caused serious strains on child-serving systems across the state as jobs were lost. Although the average rate of unemployment is now comparable with the national average, some estimates suggest that parts of Ohio that were previously known for manufacturing may not rebound until 2021.[234] Housing prices also plummeted during the waiver period with Ohio having one of the highest rates of bank foreclosures in the nation, causing even more strain on county agencies as part of their funding is based on property value assessment processes. In concert with the economic problems caused by the recession, drug use increased, particularly the use of opiates. And in some parts of the state the increase in usage was dramatic, this causing a surge in the numbers of infants born with symptoms of opiate addiction. As a consequence of what some people referred to as an opiate epidemic, placement rates underwent large increases in some counties (and directly caused one county to leave the waiver), as intergenerational use restricted some counties' abilities to place children with kin. Finally, staff turnover added to the stressors placed on counties as retirement rules within Ohio changed, resulting in the retirement of seasoned agency leaders such as directors and managers in both demonstration and comparison counties. Further, casework staff were lost due to factors such as increased workload and stress. However, while the

[234] Stockdale, 2011

majority of the third waiver was characterized by staff change and decreasing revenues, during 2014 site visit interviews many staff described economic recovery and increased agency stability.

Despite the contextual strains of the past five years, ProtectOHIO has a dedicated group of Consortium members who meet regularly to troubleshoot challenges as they arise and to strategize how to best serve their counties' child welfare families. It is within this context that ProtectOHIO counties put their efforts toward full implementation of the FTM and Kinship Supports interventions as mechanisms to ensure the safety, permanency, and well-being of families involved with child welfare.

The following pages discuss the recent ProtectOHIO findings as they relate to results from earlier phases of ProtectOHIO, as well as how the different sub-studies relate to each other. Strengths and limitations of the evaluation approach are then described, followed by some thoughts about future directions for research.

8.2 Family Team Meetings

Increasingly over the past decade or so child welfare professionals have recognized the importance of engaging families in case-planning, with the philosophy that families are likely to be more bought into decisions made through collaborative processes, and that outcomes may be improved through family involvement. ProtectOHIO counties use Family Team Meetings, held within approximately 30 days of transfer to ongoing services, and thereafter on a quarterly basis, as a way to bring families, and child welfare and community professionals together. A key feature of the approach is that each meeting is hosted by a neutral facilitator.

Demonstration counties first began the implementation of FTMs during the second waiver period; however, one of the major achievements made during the third period has been the more standardized approach to FTM delivery that occurred as a result of the development of a clearly documented practice manual detailing the core features of the model. Trainings developed by the Ohio Child Welfare Training Program (OCWTP) in Ohio, in association with ProtectOHIO representatives, ensured that all facilitators understood the core features of the model and how meetings should be conducted. Nonetheless, despite all efforts to systematize implementation across counties a certain amount of variation is inevitable and even desirable due to differences in local community culture.

One of the challenges to the success of the FTM intervention has been family attendance; to address this some counties have provided FTMs in the home or community, provide transportation assistance for families, or allow for alternative forms of participation (e.g., by phone). When FTM is at its best one of the major advantages is the opportunity to get everyone "on the same page" to identify services that providers and families believe will be helpful, to identify possible kin should placement become necessary, and to keep everyone, families and professionals alike, accountable.

Assessing the results from the second waiver period and comparing these with findings from the current waiver, cumulative evidence now exists for some important positive FTM findings. Analyses conducted at the end of the second waiver period provided evidence that families involved with FTM tended toward shorter case episodes; this was further supported during the interim report for the third waiver period. This same result for this final report of Ohio's third waiver period was only found for the high

fidelity group of families. However, the growing evidence tends to indicate that families involved with the FTM intervention are to some degree experiencing shorter case episodes.

The likelihood of placement for children of these families has shown more mixed evidence over the course of the past two waiver periods, with the second waiver analyses suggesting that children of FTM families were less likely to be placed in out-of-home care and the current analyses suggesting there is no difference in the likelihood of placement. Part of this might be explained by differences in the way analyses were conducted between the second and third waiver periods; the current analyses used propensity scores to more closely identify similar families with whom to compare outcomes and are therefore more targeted.

Consistent with the results from the second waiver period, findings from the third period found that children whose families received FTM, when placed out-of-home, were placed more often with kin. The current analysis further suggests that children whose families received an FTM more often experienced their first placement setting with kin, were more often placed predominantly with kin, and were more often found with kin as the last placement prior to a permanency decision. This is an important finding particularly when combined with other findings that show FTM cases to be no more likely than comparison cases to experience a subsequent substantiated or indicated report within 18 months of the case closing, and when further combined with the finding that demonstration children were significantly less likely to experience re-entry into out-of-home care within the 18 month period following the end of a placement.

While the cumulative evidence from the findings of the second waiver report and the results from the current waiver suggest no differences in the length of placement for children who are in out-of-home care, one would assume that children placed with kin (as is the tendency for demonstration children) may feel less traumatized by the temporary change in home, feel more comfortable living with family members or fictive kin they already know – and depending on the location of the kin home – may even be more likely to remain in the same school and thus maintain contact with the same friends. Of course, the latter postulation is an empirical question but an important one worth exploring given the implication of findings from other research that suggest that higher numbers of school moves for children in foster care are associated with poorer socioemotional development at later stages,[235] and that the number of school moves a foster child experiences is correlated with poorer school outcomes.[236]

8.3 Kinship Supports

The Kinship Supports intervention began in the second waiver period when six counties chose to use their waiver flexibility to implement it as their second waiver intervention. The intervention, however, was substantially less mature than FTM at that point. The major intent of the six counties employing this

[235] Pears, Hyoun, Buchanan, & Fisher, 2015

[236] Ferguson & Wolkow, 2012

intervention was simply to increase their emphasis toward placing children with kin; beyond this emphasis the model was loosely defined. During the third waiver period, with the advent of all ProtectOHIO counties making the decision to embrace this intervention, many advances have been made. Discussions within the ProtectOHIO Consortium led to the formation of a workgroup of kinship staff who developed a practice manual outlining core components, fidelity measures, and guidelines related to staff duties, training, and intervention tools. Upon completion of the manual the OCWTP, together with intervention staff, developed an in-person two-day training session based on the practice manual. This training became a requirement for all intervention staff and was offered several times throughout the waiver period. Because the rate of staff turnover exceeded that of available training opportunities, ensuring that newly hired staff have access to training materials eventually became problematic. To safeguard consistent practice and sustainability of the Kinship Supports model, in 2015 the OCWTP, in partnership with Kinship Supports intervention staff, developed a web-based training covering the required training topics so that newly hired staff could have immediate access to a formal intervention training.

The core emphasis of the kinship program as implemented throughout ProtectOHIO is to place children with kin whenever possible when an out-of-home placement is necessary, and very importantly, to actively provide support to kin caregivers during the child's stay. A standardized assessment tool is used to help assess caregivers' needs; however, support comes in many forms - from a worker simply being available to offer advice, to helping kin with referrals, to arranging for respite or hard goods such as beds for the children. The information gathered from family focus groups found that all of these supports are helpful for families.

However, as described in Chapter 4, counties have varied somewhat in the way they have structured and/or restructured their agencies to accommodate this intervention, with some agencies having a two-worker model – one caseworker who works the case as usual, while another designated kinship staff focuses on supporting the kin caregiver; some have a one-worker model where caseworkers work the case as usual while also supporting the kin caregiver; and other counties offer a hybrid approach where kinship support staff may be available to help caseworkers in their support of kin on an as-needed basis, depending on staff capacity and/or level of need.

Initial findings were very similar to those found during FTM analyses: children who were placed in out-of-home care were more likely in demonstration counties to be placed with kin, more likely to experience their first placement setting with kin, and spent proportionally more time with kin when in out-of-home placement.

Perhaps unsurprisingly, when comparing outcomes for children in the Kinship Supports intervention with those of comparison children placed in foster care, many beneficial results were seen: demonstration children placed with kin received less substantiated or indicated re-reports, more placement stability, less time in out-of-home care, and had a lower likelihood of re-entry into out-of-home care. A second set of analyses was conducted comparing kinship intervention children with comparison county children placed with kin, and though there was less differentiation between the two groups compared to the foster care comparison, two statistically significant differences in outcomes emerged: kinship intervention children continued to show more placement stability and less time in out-of-home care.

There could be several interacting reasons for these mixed findings. For example, it is possible that children in foster care had needs that were of higher intensity; nonetheless, it must be remembered that the methodology – using a weighted propensity score vector as a covariate— balanced many of the family and child risk differences between the two groups. It should also be noted that other research has also found beneficial outcomes for children placed with kin as compared with those placed in foster care. This research has suggested that some of the reasons for the better outcomes seen for children who live with kin rather than in stranger foster care are that the children are more likely to be placed together with their siblings, remain in the same general neighborhood, and have consistent contact with their birth parents.[237]

Although some differences disappeared when contrasting children who were served by the intervention with children placed with kin in comparison counties two differences remained. Intervention children still spent less time in out-of-home care and experienced fewer placement moves than similar children placed with kin in comparison counties. When considering the differences that emerged between children placed with kin who received intervention services and children placed with kin in comparison counties, it is likely that, given the similarity of these children, the active outreach and support provided to kin caregivers by kinship staff in demonstration counties was a major factor in helping caregivers overcome some of the challenges they face in caring for these very vulnerable children. Adding further support to this supposition, when the differences in outcomes were explored between those counties having dedicated staff whose exclusive job was to support kin caregivers, as in the two-worker approach, it was this model that seemed to make the most difference for demonstration families in terms of maintaining placement stability.

8.4 Intersection of and County Support for FTM and Kinship

The intersection of FTM and the Kinship Supports intervention was not explicitly examined quantitatively but qualitative evidence suggests that it is through FTMs that kin placement options are often identified. As the case proceeds FTMs provide a further forum for ensuring that all voices are heard and for keeping all FTM participants accountable. The synergy of these two strategies may be particularly important for children to be maintained in the kin home without disruptions occurring, as kin caregivers are also invited to meetings and it is at these meetings that supports and services are often identified for caregivers. It is also important to note that when placement into out-of-home care is necessary for a child, a kinship placement may not be viable or even the best option in all cases. The FTM also provided the opportunity for these discussions among families and professionals.

In order for the FTM and Kinship Supports strategies to work at their best, attention has to be paid to agency structural changes, and policies and procedures that support workers to effectively accomplish the mission of the interventions. For example, as described in Chapter 2, and very briefly earlier in this chapter, some counties experienced extensive turnover in staff. In order for the interventions to be sustained without program drift it was necessary to have certain mechanisms in place. Both interventions achieved this, first by means of clearly written manuals and secondly by systematized operations for the training of current and new staff.

[237] U.C. Davis Extension Center for Human Services, 2008

In some scenarios, agency structures were changed to support the intervention. As all would probably agree, despite their dedication caseworkers tend to be stretched thin in the time they have to carry out their duties, and asking them to increase their workload to take on new tasks can be met with resistance. Thus, one mechanism that was successfully used to overcome this in the two-worker kinship model was to incentivize the identification and placement of children with kin by dedicating designated kinship staff to support the caseworker with ongoing case management activities, such as home studies and ongoing support for kin caregivers. In fact, prior to the implementation of the kinships intervention, this type of support was available for workers in several counties only when foster care placements were used. Thus, implementation of the kinships intervention allowed agencies to convert positions that previously incentivized foster placements to those that would support the worker if kin care was used.

When examining the core strengths of both the FTM and Kinship Supports strategies, it became evident that two primary components were integral to the success of each of the strategies – both of which were made allowable by the flexibility of the waiver. **Trained non-case worker staff** and the **ability to use funds flexibly** at the case-level emerged as core strengths of both strategies. Neutral facilitators were cited as valuable by both parents and staff in helping cases to move forward toward a successful resolution. Similarly, in counties implementing the hybrid and two-worker kinship models, designated kinship staff were described as invaluable resources; caseworkers indicated that having kin staff available decreased their workloads and allowed them to concentrate primarily on working reunification, while caregivers indicated that their kinship workers contributed to placement stability by providing direct services and supports and offering assistance in accessing community resources when services weren't available directly through the agency. And, in both strategies the ability to use funds flexibly was also cited as a key component in helping families to succeed, as staff were able to provide parents and caregivers with services and supports they might have otherwise been ineligible for. When considering both the core strengths of the strategies and the overlap between them, it is possible that it is not solely the FTM and Kinship strategies individually that are leading to successful outcomes for children and families, but rather the implementation and intersection of these strategies in the context of a flexible IV-E waiver environment.

8.5 The Waiver Effect

8.5.1 Trajectory and Placement Outcomes Analyses

The results of the placement outcomes analyses and the trajectory analyses which examined the overall "waiver effect" without attention to the receipt of particular interventions, indicated fewer differences in outcomes between children in demonstration and comparison counties. Specifically the trajectory analyses found no differences between a child's likelihood of being placed in out-of-home care, no differences in likelihood of maltreatment following the first substantiated or indicated report, and lastly no differences in likelihood of maltreatment following discharge from out-of-home care (although there were variations between counties). In other words these analyses found children in demonstration counties to be equally as safe as those in comparison counties.

The placement outcomes sub-study found no differences in exit types after children exit out-of-home care and no overall differences in timing to the exit of out-of-home care, apart from the first 30 days when comparison county children appear to exit more quickly. However, caution must be emphasized

when interpreting this result; one explanation could be that demonstration counties have reduced some of the short term placements where removal is found to be unnecessary. Interestingly, demonstration children in group homes or those whose predominant placement type was an adoptive home reached permanency more quickly. These analyses also suggested that Black children in demonstration counties were more likely than Black children in comparison counties to re-enter care within 12 months.

Some of these findings may on the surface appear to be contradictory to those found in the FTM and Kinship analyses, but it must be remembered that individual county capacity for providing FTM to all families, despite their eligibility if they transferred to ongoing services, played a role in whether the family received this service. Several counties randomly sampled from their larger pool of cases meaning that the extent to which the eligible population was reached varied across counties. In addition, not all cases were ultimately eligible for the Kinship Supports intervention. In some cases placement was not necessary and in others kinship may not have been a viable option for different reasons. Further, one of the major metro demonstration counties only implemented the kinship intervention in one region of its county for the majority of the study period. Thus in the "waiver effect" analyses some of the results may have been 'diluted' due to the addition of families included in the demonstration group that were deliberately excluded from the intervention(s).

8.5.2 Fiscal Analyses

The other 'waiver effect' analysis which has continued since 1997 is that of the fiscal sub-study. Once again, this analysis showed some differences *among* the counties in the degree to which placement days increased and decreased, and in the proportion of funds spent on foster care board and maintenance and all other child welfare expenditures, but overall between demonstration and comparison counties no differences emerged. It should be noted that once again, the recession and local community contexts likely impacted some of these finding. It should also be noted that although there was no *overall* difference between demonstration and comparison counties in the annual average change in number of placement days, this varied among counties, and in the previous waiver some counties had dramatically reduced placement days. As Bryan Samuels suggested, in his then capacity as Commissioner of the Administration on Children, Youth and Families, and in his comments to Title IV-E demonstration counties at the meeting of demonstration sites in Washington D.C., in 2011; it is possible that some of the legacy sites may now have reduced foster care placement to as low as they are able without compromising safety (paraphrased), and therefore we should place increased emphasis on socio-emotional, behavioral, physical, and educational well-being for these children.

8.6 Strengths and Limitations

A major strength of the evaluation is that Human Services Research Institute has been working (together with Westat and Chapin Hall), with ProtectOHIO counties now since 1997. During this time we have developed a thorough understanding of the nuances existing within and between different counties and how these nuances can impact service delivery and SACWIS data entry patterns. As described previously, counties are locally administered and although the state requires certain data to be entered into SACWIS, any data entered thereafter is at the discretion of counties; this impacts the data that is entered into SACWIS and its reliability for use in analyses. Nonetheless, a wealth of qualitative data was collected during this phase of the waiver in order to contextualize findings from quantitative analyses.

Despite the additions of several new modules in SACWIS some challenges remain for the evaluation team. In a county-administered system although the state requires certain baselines for consistent data entry, other types of data that would be useful for a complete understanding of the families' and children's experiences are discretionary to enter. For example, as described in Chapter 4, counties are only required to enter kin placements into SACWIS when custody is held by the agency; however, many kin placements are voluntary placements, additionally, judges may award temporary custody to caregivers when a child is removed and placed into kin care. As such, whether the agency takes custody or not is often a product of the assumptions and biases of the local courts rather than decisions based on systematic criteria, but unfortunately it also results in some variation in data entry. This variation occurred in both demonstration and comparison counties to one degree or another; however, as far as possible local policies around this issue were accounted for in the analyses undertaken by the evaluation team by the use of propensity scores.[238]

Additionally, because the Kinship Supports intervention relies on active support for kin caregivers by PCSA staff, the evaluation team believed it was necessary to understand the types of services that were offered to these families. The SACWIS team developed an enhanced services module within SACWIS which allowed counties to record whether services for families were needed, referred, scheduled, or provided. Trainings on data entry were given by the state; nonetheless, although demonstration counties required their staff to enter these data, it was not required by the state. Workers indicated that data entry was burdensome[239] and although data entry is likely to have increased within demonstration counties as a result of the trainings, many of the entries by caseworkers fell under the generalized category of Case Management, therefore information regarding differentiation between services types was relatively limited. Burden on caseworkers ensues because they have to complete a time-consuming service review for each individual service every 90 days when services data are entered (a mandatory state requirement). Although the evaluation team augmented the services data extracted from SACWIS with information gathered qualitatively, future efforts should be focused on understanding the types and extent of services provided to these families. A suggestion would be to modify the services module within SACWIS to reduce caseworker burden when entering and reviewing service data.

A final study strength is that propensity scores were used for the intervention-specific and placement outcome studies. These scores allowed for a closer estimate of how differences may occur between families of similar types when served differently by demonstration and comparison counties.

8.7 Future Directions for Research

The FTM intervention in combination with the Kinship Supports intervention have both reached a certain level of maturity within ProtectOHIO counties. Should Ohio receive a waiver extension, several future steps could be considered for future research.

Some of the benefits seen in both FTM and the kinship intervention are shorter case lengths, and in the case of the kinship intervention, shorter placement episodes. We know that services are being provided

[238] Pages 151-154 discuss some of the other challenges with the Living Arrangement Module into which voluntary kin placement information is entered.

[239] Pages 160 through 162 discusses this in more detail.

to both FTM and kinship families and the evidence suggests that these services are resulting in fewer subsequent reports of abuse and neglect as well as fewer re-entries into out-of-home care. Next steps could focus on costs of the programs and exploring whether program costs result in longer-term savings for counties and the local community. For example, some studies have found that costs may be decreased by reducing placement moves: one study found that each time a child's placement was disrupted, around 25 hours of casework was needed to find a new placement.[240] Because both placement with kin and the kinships intervention specifically were associated with increased placement stability, a cost study could examine the extent to which this increased stability results in cost-savings.

Also, increased efforts could be put toward understanding differences in aspects of well-being for children placed with kin and those placed with foster care in demonstration counties. Although the Consortium has decided against expanding upon the well-being pilot, a state-level CANS pilot is currently being conducted and is expected to be completed by the end of 2016. If the CANS assessment is rolled out across the state, this data would likely be available and could be used to explore weather placement with kin compared to foster care impacts well-being measures for youth. Valuable information could also be gathered by conducting individual interviews and perhaps focus groups with adolescent youth, comparing those in kin care in with those in foster care in demonstration counties. It would be particularly important to approach this with extreme caution, and any efforts in this direction would have to undergo extensive ethics board and individual county review.

8.8 Final Thoughts

Over the three phases of ProtectOHIO, the waiver-generated activities have become increasingly consistent and consolidated as the benefits of adopting common strategies has become evident. While the overall waiver analyses in Ohio's third waiver period failed to detect significant differences between demonstration and comparison counties due to waiver flexibility alone, significant differences emerged between children and families that received the FTM and Kinship Support interventions and comparison children and families that did not. The evolution of ProtectOHIO captures the essence of one of the clearest messages that emerged from waiver evaluation findings over the past 18 years: flexible funds are necessary but are not sufficient to achieve significant improvements in child/family outcomes; a clear focus on using those funds for specific placement-prevention and placement-reduction activities is also required. Based on the aforementioned analyses, both of the FTM and Kinship Support interventions, and perhaps particularly in combination, appear to be very promising.

[240] U.C. Davis Extension Center for Human Services, 2008

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