

Final Report
Appendices

RBA Pilot Project Study of Selected Human Services Programs (P.A. 09-166)

January 15, 2010

Legislative Program Review
& Investigations Committee

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a bipartisan statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the Senate, the Senate minority leader, the speaker of the house, and the House minority leader each appoint three members.

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List of Appendices

- A-1 Relevant Portions of Public Act 09-166
- B-1 Study Background and Methods
- C-1 Population Level Accountability – Key Indicators
- D-1 System Level Accountability – Key Child Welfare System Performance Measures
- E-1 DCF Family Preservation and Supports Overview
- F-1 RBA Program Performance Profiles
- Intensive Family Preservation (IFP): p. F-1
 - Parent Aide: p. F-15
 - Supportive Housing for Families (SHF): p. F-27
 - Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) – to be added
 - Flexible Funding (Flex Funds) – to be added
- G-1 Agency Profile: Department of Children and Families
- H-1 Summary of RBA Efforts in Connecticut, prepared by The Charter Oak Group, LLC (Dec. 2009)

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Appendix A: Relevant Sections of Public Act 09-166



House Bill No. 6476

Public Act No. 09-166

***AN ACT CONCERNING A PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE
PILOT PROGRAM UTILIZING RESULTS-BASED ACCOUNTABILITY.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) The Legislative Program Review and Investigations Committee shall implement a pilot program to assess selected human services programs utilizing the principles of results-based accountability. The committee shall select the programs to be assessed under the pilot program after consultation with (1) the human services subcommittee of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, and (2) the joint standing committee of the General Assembly having cognizance of matters relating to human services. For purposes of this section, results-based accountability means the method of planning, budgeting and performance measurement for state programs that focuses on the quality of life results the state desires for its citizens and that identifies program performance measures and indicators of the progress the state makes in achieving such quality of life results in addition to the programs and partners that make a significant contribution to such quality of life results.

(b) The agency or other entity that administers a human services program selected pursuant to subsection (a) of this section shall cooperate with the Legislative Program Review and Investigations Committee in carrying out its assessment of the program and shall provide the committee with such information, books, records and documents as the committee may require for such assessment.

(c) The Legislative Program Review and Investigations Committee shall report, in accordance with section 11-4a of the general statutes, on the pilot program to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies by January 15, 2010. Such report shall include (1) information on the committee's assessments pursuant to this section, including any recommendations for program modifications or terminations, and (2) an evaluation of the pilot program, including any recommendations for its continuation, expansion or modification.

Appendix B: Study Background and Methods

Results-Based Accountability

Under P.A. 09-166, Results-Based Accountability is defined as a method for planning, budgeting, and measuring performance of state programs that focuses on the quality of life results Connecticut desires for its citizens. The first step of the RBA approach is to identify what quality of life results are desired in the form of a broad goal, called a results statement. In addition, data called “indicators,” which show how close or far the desired results are from being achieved, are selected and tracked over time, to see whether progress is being made toward the results statement. This part of RBA is termed “Population Accountability.”

The second step of RBA is “Program Accountability,” which examines some or all of the programs identified as making significant contributions to the results statement. This is accomplished by examining each program’s performance measures through answering the questions:

- 1) What did we do? (i.e., program outputs in terms of quantity)
- 2) How well did we do it? (i.e., program outputs in terms of quality) and
- 3) Is anyone better off? (i.e., program outcomes in terms of results for clients)

Further differentiating itself from other study approaches, RBA calls for data about programs to be presented in charts, with trends and baselines identified, whenever possible.

RBA in Connecticut. The work of the program review committee always seeks to answer the first two program performance questions, and many studies additionally address the third, and most difficult, outcome evaluation question. However, no prior PRI study has been executed – from study development through the reporting of findings and recommendations for improvement – purposefully using an RBA approach. This report, unlike traditional PRI final reports, is organized according to the RBA approach and looks different from other committee work.

The Appropriations Committee has been using an RBA approach within selected areas of the legislature’s budget process since 2005. The committee’s RBA work has been carried out mainly by its RBA subcommittee with assistance from The Charter Oak Group, LLC, a private consulting firm, and Mark Friedman, the developer of RBA who is an international consultant to government and nonprofit organizations. Over the last two years, the legislature’s nonpartisan Office of Fiscal Analysis has also taken on substantial RBA tasks and three staff were hired specifically for that purpose.

The committee is working to incorporate RBA as a tool for determining whether the public is better off because of state expenditures made in selected areas and where future appropriations may have the most positive impact. Its efforts began with two pilot projects – the Long Island Sound and the state early childhood system overseen by the Early Childhood Education Cabinet. The committee’s RBA approach has grown to encompass programs in nearly

all state agencies, as the summary prepared by The Charter Oak Group, LLC and included in Appendix H describes.

Study Topic Selection

To assist the program review committee and other legislators in choosing the topic for the RBA pilot project, PRI staff undertook a three-pronged review of the human services area of Connecticut state government. This included: 1) examination of human services department budgets, program websites, and reports; 2) review of publications on human services issues by state and national research and advocacy organizations and experts; and 3) conversations with a number of nonpartisan Connecticut legislative staff and representatives of major stakeholder groups. PRI staff used that information to formulate several topic options, which were researched further. Committee staff then ranked the topics according to several criteria:

- clearly fits within an RBA framework (i.e., defined program with clear inputs and outcomes);
- not otherwise under review or undergoing restructuring;
- under state legislative control;
- significant in terms of resources and/or clients;
- data are available or collectible by PRI staff; and
- scope is within PRI capacity, given allocated staffing and project timeframe.

The proposed topic options were presented in an RBA format – including population and program level background information – with ranking information to the legislators responsible for topic selection under the public act. The legislators reviewed the proposals and unanimously agreed that Family Preservation and Support programs carried out by the Department of Children and Families would be the best topic for the purposes of the pilot project study.

Study Research Methods

Given the staff resource (two PRI analysts) and time constraints (about six months) of the PRI pilot project, only a limited number of DCF Family Preservation and Support programs could be examined in detail. Our main study objective became evaluating five programs within the FPS program area using a Results-Based Accountability framework.

Selection of the five focus programs was driven by size of client population and costs, as well as legislator interest. Due to legislative interest in child welfare prevention-oriented activities, priority was given to these programs with an emphasis on preservation rather than reunification.

Intensive Family Preservation, Parent Aide, and SHF were chosen because they are the core and the most costly family preservation and supports programs. IICAPS was selected to represent an FPS program with a behavioral health emphasis, particularly since it experienced strong growth in recent years. Finally, legislators were highly interested in continuing close examination of Flexible Funding, based on concerns raised during recent budget hearing processes. It is important to note Flexible Funding serves DCF children and families beyond

those involved in Family Preservation and Support programs. While not a discrete FPS program, Flexible Funding is considered a crucial tool for helping at-risk families meet their children's needs and stay together in the community.

Primary data sources. We interviewed staff and managers at the Department of Children and Families' central office to understand how the programs are funded and monitored. We also reviewed relevant program documents and data maintained by the agency. To learn how the programs are carried out, we interviewed groups of managers at five Department of Children and Families area offices and held a focus group with representatives of contracted FPS program providers. To further learn about department strengths and weaknesses, we spoke with staff from the Office of the Court Monitor for the *Juan F.* consent decree.

We did not visit contracted provider sites to obtain program data, but instead relied on the data given to us by the department's central office and through web-based survey responses. We administered two web-based surveys: one for area offices we did not visit, and the other for contracted providers of the IFP, PA, and IICAPS programs. (SHF, with only one contracted provider whose staff was interviewed multiple times, did not require a survey while a survey of the hundreds of Flex Fund providers was not feasible in the study timeframe.) The bulk of our data gathering work was conducted from July through December 2009.

Document review and interviews. To learn how the five focus programs are funded and monitored, we interviewed DCF staff responsible for managing and overseeing them and reviewed relevant agency documents and data. Specifically, we met with managers and program staff in the Bureaus of Child Welfare Services and Behavioral Health & Medicine to understand the programs, program management, and the paths families take to and within DCF involvement; managers and staff from the Bureau of Finance, Contract Management division to learn about how the programs' contracts are developed and monitored; and managers from various divisions of the Bureau of Continuous Quality Improvement to gather information on how the department implements quality assurance and improvement for its own staff and its contracted providers. In addition, we analyzed program expenditure data and, to the extent it was available, program implementation data given to us by the department.

To understand how the programs are carried out by locally, we visited five DCF area offices, each representing a DCF region and including urban and non urban areas. There, we spoke with the area office director as well as various members of the office's management team with FPS program responsibilities. In a few offices, regional management staff also chose to participate in group interviews. During these interviews, we discussed area office characteristics, management of the focus program providers, and strengths and challenges of the focus programs.

To gather information on provider program delivery and DCF oversight, we held a focus group, arranged with the assistance of the Connecticut Community Providers Association (CCPA), with a sample of private provider agencies in early November 2009. We also administered several surveys to FPS providers, as described more fully below.

To learn about research on: the effectiveness of various FPS program and services; what are considered good indicators of child safety, health, and overall well-being; and causes and effects related to those indicators, we reviewed the relevant literature with the assistance of the General Assembly's Office of Legislative Research. We also contacted experts in the field to verify the research findings and our understanding of them, including staff from the National Conference of State Legislatures and the Connecticut Departments of Education and Public Health, as well as researchers from Boston College, the Washington State Institute for Public Policy, and the University of Michigan.

In developing the study focus, we spoke with legislators, legislative staff from the Office of Legislative Research and Office of Fiscal Analysis, and representatives of various organizations and advocacy groups, including the Connecticut Early Childhood Education Cabinet, Connecticut Voices for Children, and the Connecticut Business and Industry Association. OFA staff also provided us with assistance in developing program and agency expenditure information throughout the study.

To understand RBA and how it is being used in Connecticut, we spoke with: the Charter Oak Group, a consulting firm that has been assisting the legislature, state agencies, and community-based nonprofit organizations with RBA implementation; Office of Fiscal Analysis staff involved in RBA efforts; the RBA developer (Mark Friedman); and staff from the Connecticut Department of Education and the Court Support Services Division of the Judicial Branch. In addition, we attended the September 2009 RBA conference co-sponsored by the Annie E. Casey Foundation and the Charter Oak Group, "Building a Results Culture in Connecticut."

Survey of selected DCF area offices. To gather information on FPS programs from the nine DCF area offices we did not visit, we administered a web-based survey. The survey included questions about program demand (including waitlists), service expectations, monitoring procedures, challenges for effective performance, and recommendations for improvement that were informed by the results of our area office visits. Area offices were surveyed about all the programs except Supportive Housing for Families, as that program had received uniformly positive assessments during the interviews conducted at the other area offices. The surveys were sent in mid-November, and responses were received through the first week of December. We did not pre-test the survey due to time constraints. Nine area offices were surveyed; responses were received from eight for the IFP survey, eight for the Parent Aide survey, seven for the IICAPS survey, and six for the Flexible Funding survey.

Survey of contracted providers. To understand the program implementation by the contracted providers, as well as DCF program management, we administered a web-based survey to providers of the IFP, Parent Aide and IICAPS programs. As with the survey of selected DCF area offices, questions related to program waitlists, service expectations, monitoring, challenges, and recommendations for improvement. The survey was sent in the second week of November and responses were collected through late November. An early version of the survey instrument was pre-tested with one provider; adjustments were made based on that provider's feedback, as well as on what had been learned from the ongoing area office visits. In response to a provider's request, additional comment spaces were added to the IFP and Parent Aide surveys, after the

survey had been distributed. As response rates were less than 100%, provider survey information should not be interpreted as representing the full range of possible provider opinions and experience.

Analysis of program data. To analyze the program data made available by the department, we used several computer programs. For the Parent Aide program, the department kept data on the rates of completion, non-completion by reason, and repeat maltreatment during program services. Each rate for every provider was analyzed using an applet that calculated the Chi-square, to determine whether that provider's rate differed from that of all other providers (together) in a way that was statistically significant ($p < 0.05$). Data entry errors were prevented through double-checking each calculation. Although we are confident in the analysis, we chose not to present the full results for two reasons. First, it is not clear the data included all clients. A manager from the Bureau of Child Welfare noted the data had not been reviewed, at all, within the last several years and stated the data may be unreliable. Further, at the provider focus group, several providers volunteered the data likely is unreliable because they never receive it back from DCF, to check it, and were not careful in data entry and submission because they knew the data was not checked. Second, we did not have time to learn from the providers and area offices whether any significant variations were a result of certain circumstances (e.g., caseload mix) or poor performance.

For the Intensive Family Preservation program, the department since late 2007 has kept client data on characteristics, program experience, and program results. This data was given to us in Excel; it was copied into SPSS for binomial logistic regression to understand which factors could be influencing program completion. Data entry errors from us are unlikely since we did not enter any data; computed variables were double-checked. Each regression tested was run at least twice, to mitigate the chance of mistakes. The analysis is presented in the report, but we did not disclose those providers that had statistically significant results of poor performance holding client characteristics constant. This decision was made because, as with the Parent Aide data, we did not have time to learn from the providers and area offices whether any significant variations were a result of certain exceptional circumstances or poor performance. We note, however, that none of these providers were cited in area office visits as poorly performing.

For the Supportive Housing for Families program, the department worked with the contracted provider agency to obtain performance and client outcome information from the provider's automated data system for state fiscal years 2002 and 2005-2009 (separately). This data was given to us in Excel, which we used to further analyze trends and relationships. Data by sub-contractor was given to us but not used because of the project's time constraints.

For Flexible Funding, the department gave us program expenditure data available for the past three to five fiscal years in Excel spreadsheets. We used that program to further manipulate and analyze program spending by service category (for which there currently are 57 different codes) and by area office. Concerns over the accuracy of flex fund expenditure coding, which the department has begun to address through the new provider credentialing process and additional review by central office fiscal staff, prevented us from presenting findings about expenditure trends by category over time or by office. Time constraints further impeded our

ability to fully review the program data since we received the bulk of the detailed flex fund expenditure information in late November and early December.

For IICAPS, the department gave us copies of year-end and quarterly program evaluation reports prepared by its quality assurance contractor (Yale University IICAPS Services) for the past three fiscal years. These reports contain summary data on client demographics, outcomes, and program model adherence, as well as findings about trends across the network of providers and provider credentialing results. We also received copies of the most recent credentialing report (2009) for each of the current 18 IICAPS provider sites. At our request, Yale developed additional IICAPS program data for the past three fiscal years, by provider and for the overall network, on: client outcomes (e.g., service utilization, child functioning/problem severity, main problem improvement, parent satisfaction) and case characteristics (e.g., numbers of cases served, length of service, discharge status, and service intensity/hours per week). A report containing this information was provided to PRI staff in early December, which limited how much of the data could be reviewed and prepared for inclusion in this report.

Basic information on Medicaid expenditures for IICAPS services from FY 06 through FY 09 was obtained from the Department of Social Services. The DCF fiscal office provided data on the agency's General Fund expenditures for IICAPS since FY 05, as it did for all the other focus programs.

Appendix C

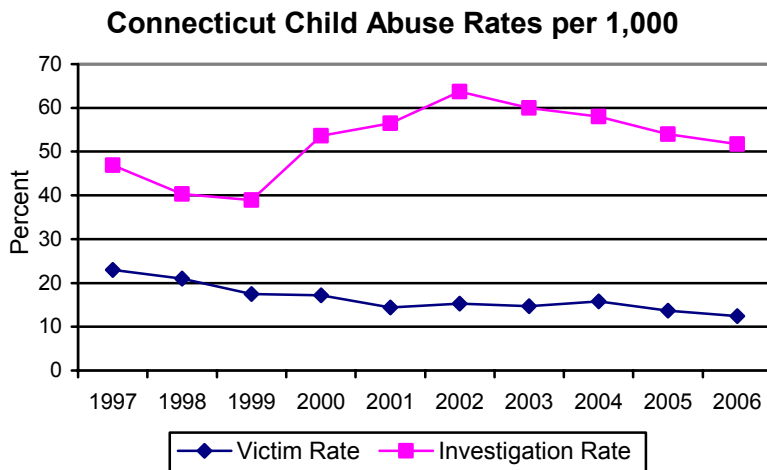
Population Level Accountability: Key Indicators

QUALITY OF LIFE RESULT:

“Connecticut children grow up safe, healthy, and ready to lead successful lives.”

Indicator 1: Connecticut Child Abuse Rates (Safety)

The incidence of child abuse and neglect within a population is a widely used measure of the safety and well-being of children and families. For many federal research and evaluation purposes, child abuse rates are based on numbers of children who are the subject of maltreatment reports received and investigated, or substantiated (confirmed as abuse/neglect victim), by state child protection agencies. Rates often are calculated per 1,000 children under age 18.



Source: Child Welfare League of America, NDAS

Trend: Decline in both rates since 2002 (better)

Story Behind the Baseline: Child abuse and neglect rates are affected by many factors far beyond the control of any single state agency. The economy and social conditions, in particular, have a strong influence on the numbers of alleged maltreatment reports that are made to child welfare agencies. Child abuse reports tend to increase during economic downturns, when families are under more stress and have fewer resources to meet basic needs.

Investigated reports of alleged abuse and neglect can be viewed as a broad indicator of how well public and private efforts at the state level are addressing the needs of at-risk children and families. A recognized high risk factor for child abuse and neglect cases is a history of previous reports, regardless of whether they were substantiated. In general, numbers based on substantiated reports (child victim rates) are considered a more reliable indication of the extent of maltreatment as they: a) represent cases determined to meet set legal and practice criteria; and b) are less influenced by negative events (e.g., publicity about an abused child’s death) that can trigger spikes in reports to protective services agencies.

In Connecticut like the rest of the nation, child abuse rates worsened over time from the 1970s into the early 2000s. (It is unclear whether these changes reflected more abuse and neglect, or heightened awareness and the advent of mandated reporting.) More recent trends suggest that while child abuse and neglect remains a serious problem, rates are on the decline. Connecticut’s investigated abuse rate peaked at 63.7 per 1,000 children in 2003; since then, it has decreased each year, dropping to 51.7 reports per 1,000 children in 2006. Similarly, the rate of children determined to be victims of abuse or neglect reached its lowest level over a recent 10-year period – 12.4 per 1,000 children under age 18 – in 2006. (Child abuse rates validated by the federal government lag the raw data reported by states by two years; DCF does not issue rate information other than validated federal numbers.)

Current Efforts Turn the Curve: Experts point out that child abuse is preventable through effective intervention and education efforts, as well as strong child protective services. According to a recent agency RBA report to the legislature, DCF has been considering ways to enhance its array of primary

Appendix C

Population Level Accountability: Key Indicators

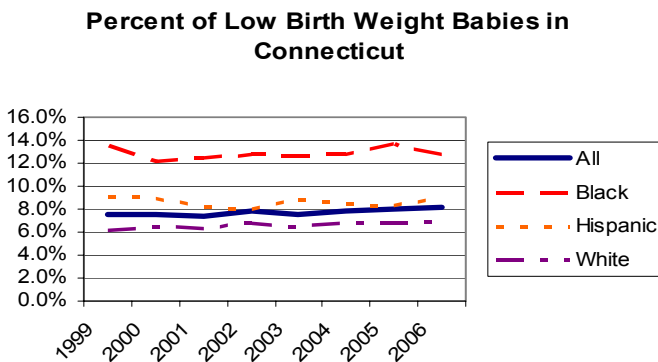
prevention and early intervention services by continuing to shift resources to this relatively small program area. The agency is also planning to undertake a major initiative called Differential Response System (DRS) as a way to decrease its abuse and neglect caseload and better support at-risk families. Implementation of DRS will likely occur on a pilot basis at some point in the upcoming calendar year.

The Commission on Children proposed several strategies for reducing the state’s child abuse rates in its 2009 RBA report. They included: expanding a proven, research-based model of home visitation (“Child First”) that helps the state’s most vulnerable families stay out of the DCF protective services system; increasing fatherhood policies and programs to reduce single-parenting stressors; and increasing research-based interventions that promote family stability and improve family functioning within the community.

Primary prevention of child abuse is the sole mission of the Children’s Trust Fund (CTF), which provides resources for prevention programs that support and strengthen high-risk families. During the past fiscal year, CTF initiated several pilot projects to expand the work of its statewide home visitation program, Nurturing Family Network.

Indicator 2: Low Birth Weight Babies Rate (Health)

Low birth weight is commonly used as measure of maternal and child health, and research has shown low birth weight is associated with a variety of negative health and developmental characteristics. In Connecticut, low birth weight is monitored as an indicator by the Women’s Health Subcommittee of the Medicaid Managed Care Council, the Connecticut Early Childhood Education Cabinet, and the HUSKY insurance program, according to DPH.



Trends: Recently, slight increase overall (worse); Small increases for Whites (worse); Small decline for Hispanics (better)

Story Behind the Baseline: Connecticut’s low birth weight rate (the percent of babies weighing less than about 5.5 pounds) increased to 8.2% in 2006, from a recent low of 7.4% in 2001. The state’s 2006 rate is slightly lower than the U.S. rate (8.4%). However, there are persistent and wide ethnic differences.

Minority population babies had a low birth weight much more often than White infants – double for Black infants, and one-third more for Hispanic babies (1999-2006). These gaps began larger than at present; they have narrowed over time, due to slight increases in the White low birth weight rate. (Over the longer-term – since 1990 – there have been small declines in the rate of low birth weight among Blacks and Hispanics.)

Low birth weight is influenced by a variety of factors, including: mother’s health and behaviors, preconception and prenatal care, multiple gestation, and environment. There is a growing body of research associating low birth weight with later cognitive disabilities, Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, motor difficulties, Type II diabetes, coronary heart disease, stroke, and hypertension. One research project, presented at a national conference and being considered for publication, studied a large group of siblings and found low birth weight has negative effects on adult

Appendix C

Population Level Accountability: Key Indicators

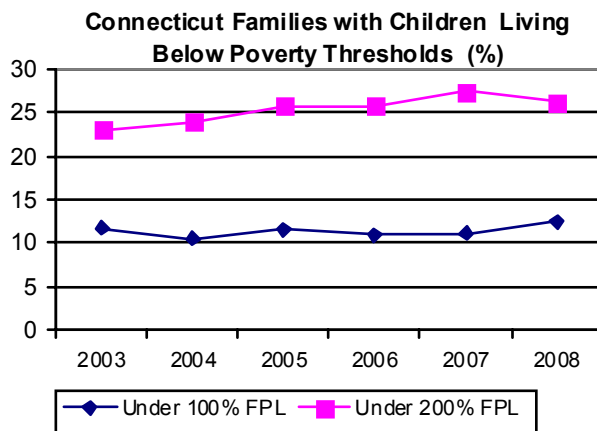
health, education, labor force participation, and earnings.

Low birth weight has immediate fiscal consequences for the state. The Connecticut Public Health Department (DPH) noted, “On average, each low birth weight event among HUSKY A enrollees added \$52,217 in [birth-related] hospitalization charges.”

Current Efforts to Turn the Curve: DPH recognizes that the increasing low birth weight rate and the differences among ethnicities are problems. The department released a report in 2008 that recommends several steps to take to eliminate the disparities, including: improving women’s access to quality care; promoting a certain model of prenatal care; boosting WIC and Medicaid enrollment among women; addressing violence and environment; partnering with the medical community to address low birth weight; increasing activities to promote male involvement; conducting more research regarding the disparities; and launching collaborations with other state agencies. The report also notes two initiatives DPH was beginning to implement: a smoking cessation program for pregnant women at several local health centers and a Sexual Violence Prevention Plan.

Indicator 3: Connecticut Child Poverty Rates (Future Success)

Research shows living in poverty is associated with many negative outcomes for children. A standard definition of poverty is 100% of the Federal Poverty Level (FPL), which currently is an annual income of about \$22,000 for a two-parent, two-child family. The Connecticut Child Poverty and Prevention Council (CPPC) uses the percent of families with children under 18 who fall below the 100% threshold as the state child poverty rate. CPPC also tracks families below 200% FPL rate because Connecticut has a high cost of living and that amount more closely corresponds to the state’s self-sufficiency standard.



Source: CPPC

Trends: Slight fluctuation with recent rise in 100% Federal Poverty Level rate (worse); Increase in 200% FPL rate is greater than accounted for by improved 100% FPL rate (worse)

Story Behind the Baseline: More than one-quarter of all Connecticut families with children under 18 meet the federal definitions of poor (under 100% of FPL) or low-income (under 200% of FPL). Except for 2008, the portion of families with children living in poverty increased every year since 2003; the aggregate change (over 2003-2008) was nearly 20%.

The growth through 2007 in portion of 200% poverty families (4.5 percentage points) appears mostly due to movement of some new Connecticut families into this low-income range (either previously living in the state, or not) – and not to the slight decline in poor category (100% poverty) over the same period (0.7 percentage points). The impact of the current recession is reflected in sharp 1.4% increase in poor (100% poverty) families with children between 2007 and 2008.

Connecticut’s rates of low-income and poor families with children are significantly lower than the national rates, which are 39% and 18%, respectively, at present. However, child poverty varies tremendously across the state. In 2000, seven towns had child poverty rates (100% of FPL) above 23% - including Hartford at 47% - while 38 towns had less than 2%. More than six in ten Latino children and nearly half of Black children are in low-income families, compared to 15% of White children. Most low-

Appendix C

Population Level Accountability: Key Indicators

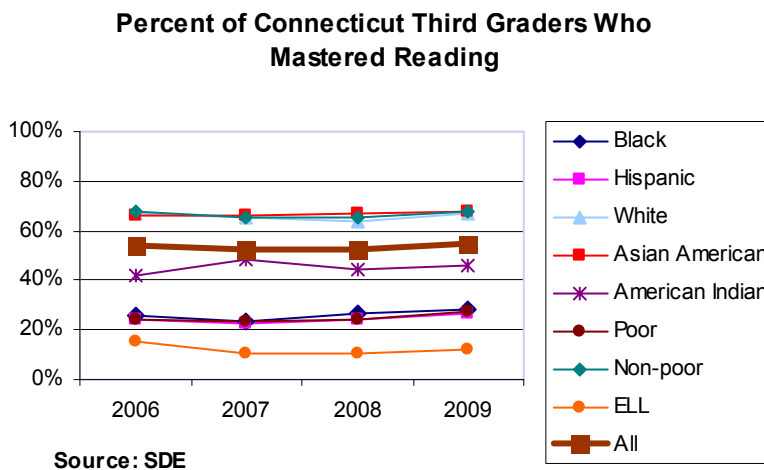
income parents (76%) are working.

There is a strong body of research associating poverty with impaired child development (cognitive, behavioral, social, and emotional) and poor health, both of which have negative effects lasting into adulthood. Child poverty also is associated with unfavorable educational and employment outcomes later in life.

Current Efforts to Turn the Curve: In 2008, the CPPC adopted 12 recommendations to help meet its goal of reducing child poverty by 50% over ten years. The recommendations address income, education, and social safety net matters, as well as family structure and support. The CPPC hired consultants to conduct economic modeling that can show which recommendations would have the greatest effects on reducing child poverty. That analysis was presented to the CPPC in June 2009 and is under review.

Indicator 4: Third Grade Reading (CMT) Proficiency (Future Success)

Connecticut's Early Childhood Cabinet uses the same indicator for its RBA efforts because early student performance is thought to be strongly associated with future educational success. The term "proficiency" refers to meeting at least the state goal level, not the "proficient" level.



Trends: Stable overall (neutral); Small increases across all ethnic groups (better) except whites (worse); Small increase for poor children (better); Small declines for ELLs (worse)

Story Behind the Baseline: Reading performance improved for every student subgroup in 2009, in some cases reversing slight downward trends. However, performance continued to vary dramatically among subgroups: Fewer than 30% of

Black, Hispanic, poor, and English Language Learner students met the state goal, while more than 55% of Asian American, White, and non-poor students were at that level. (A student belongs to several subgroups, based on ethnicity, free lunch receipt as a proxy for family poverty, and whether a student is an English Language Learner.) Overall, 54.6% of Connecticut third-graders are meeting the state's reading goal level.

A student's educational progress and achievement is influenced by many factors. Research has shown strong links between achievement and: the child's prior development; family factors including stress, family physical and learning environment, income, parent occupation, and parent education level; and school factors, most notably teacher quality.

Current Efforts to Turn the Curve: The Early Childhood Cabinet's RBA report cards note that SDE is aware of the differences in student performance and the need to continue to improve. The department is addressing the achievement gap by focusing on assisting Priority School Districts, requiring new teachers meet a certain standard on a pre-service reading test, and including literacy as a part of district and school improvement plans, among other efforts. The Early Childhood Cabinet has led efforts to improve pre-primary school preparation by: expanding school readiness program capacity in Priority School Districts; improving preschool facilities; moving toward an early childhood education quality monitoring and

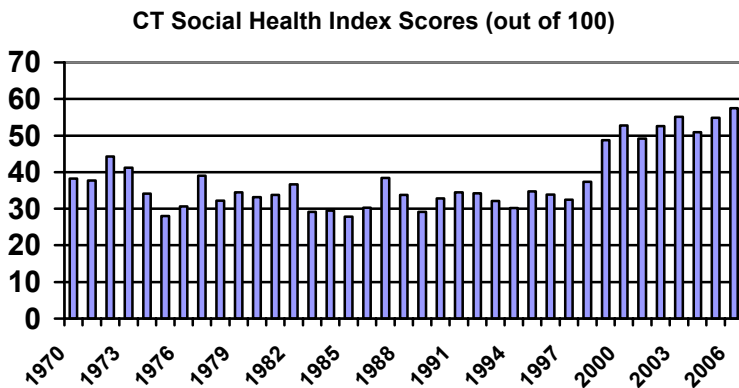
Appendix C

Population Level Accountability: Key Indicators

improvement plan; and developing an effort to understand and improve the early childhood education workforce.

Overall Indicator (Well-Being): Connecticut Social Health Index (SHI)

The Social Health Index is a composite calculation of 11 quality of life indicators designed to represent the well-being of Connecticut residents. A joint effort of the General Assembly, the Commission on Children, and a nonprofit foundation, the SHI was developed in 1994 to monitor state-level performance and track trends in social, economic, and health conditions that impact children, youth, and adults.



Source: The Social State of Connecticut 2008

Trends: Sustained, significant improvement after 1999 (better)

Story Behind the Baseline:

The state's Social Health Index is at its highest level since its beginning data year (1970). Scores consistently have been very close to or above 50 since 1999. In all prior years, the highest value was 44.3 (1972), 11% lower than the 50 mark. The lowest score was 27.8 in 1985, 44% lower than 50.

Despite the substantial increases over prior decades, SHI scores for the 2000s are still far below 100, the best possible value.

Specific areas in need of improvement, as well as areas where progress is being made, can be identified by analyzing the performance of each component indicator of the index. These are: infant mortality; child abuse; youth suicide; high school dropouts; teenage births; unemployment; average weekly wages; no health insurance; violent crime; affordable housing; and income variation.

Since the index began, there have been significant reductions in the areas of infant mortality, teen births, high school dropouts, and unemployment. Average weekly wages also improved, but child abuse, no health insurance, violent crime, and income variation worsened. Youth suicides and affordable housing showed no clear positive or negative longer-term trends. Five-year trends for violent crime and average weekly wages, as well as income variation, reveal declining performance and no health insurance in the short term has not changed.

Current Efforts to Turn the Curve: With the exception of the Commission on Children, neither the legislature nor state agencies appear to be routinely using the SHI to assess areas of problem social performance and develop strategies for addressing them. COC included several proposals in its latest RBA report (March 2009) for addressing the lack of progress in reducing income variation and increasing affordable housing (e.g., maximizing federal stimulus dollars to ensure basic needs are met). To improve the well-being of children, the commission proposed support for strategies that address low birth weight, which has shown an increased prevalence recently.

While not specifically citing Social Health Index findings, several legislative and executive initiatives

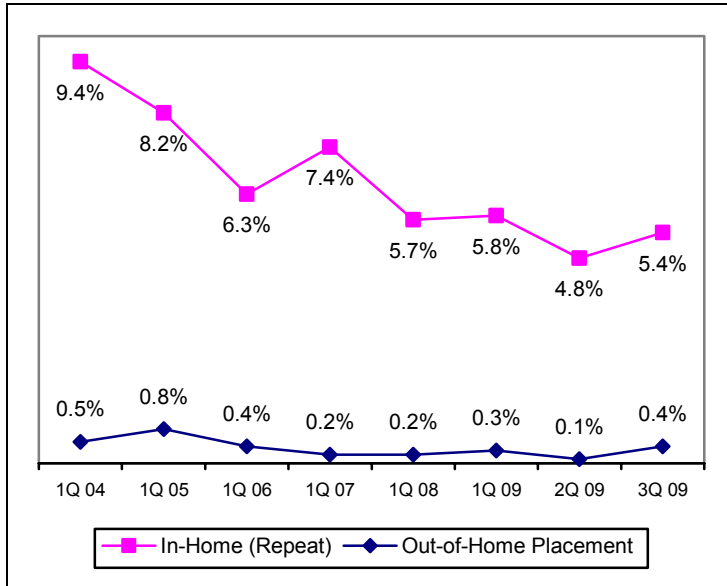
Population Level Accountability: Key Indicators

aimed at improving progress in problems areas highlighted by the index have been undertaken in recent years. These include: the Child Poverty and Prevention Council, which is working on a statewide agenda to reduce the number of children living in poverty in Connecticut by 50 percent over 10 years; and the Early Childhood Education Cabinet, which has set goals and is developing an action plan concerning age-appropriate development, health and school readiness, and academic success for the state's young children (ages birth to nine).

Most recently, a legislative task force on the recession and children was created in June 2009 to review trends in programs and services that support basic needs of children and families (e.g., housing, child care, and employment). The task force, which is bipartisan and broadly representative of stakeholders, also will issue recommendations on appropriate budget and policy actions to streamline services and improve access to programs.

System Level Accountability: Key Child Welfare System Performance Measures

**System Performance Measure 1. Maltreatment Rates: Child Abuse and Neglect Victims
(Percentage of DCF-Involved Children)**



Trend: Significant drop in in-home and decline in out-of-home rates with recent rise in both (better)

Story Behind the Data: Two ways of measuring how well children already involved in protective services are being kept safe by the system are being kept safe by the system are shown in this figure: recurrence of substantiated abuse and neglect among children in DCF in-home cases (repeat maltreatment) and substantiated maltreatment of children who have been placed in out-of-home care.

In-home repeat maltreatment and out-of-home maltreatment rates are two of the 22 *Juan F. Exit Plan Outcome Measures* tracked by the DCF Court Monitor.

Source: DCF Court Monitor

Both rates have been at or below the exit plan compliance targets ($\leq 7\%$ and $\leq 2\%$, respectively) since 2007. DCF has met the maltreatment standard for out-of-home cases for 23 consecutive quarters and for in-home cases for 10 consecutive quarters as of the third quarter of 2009.

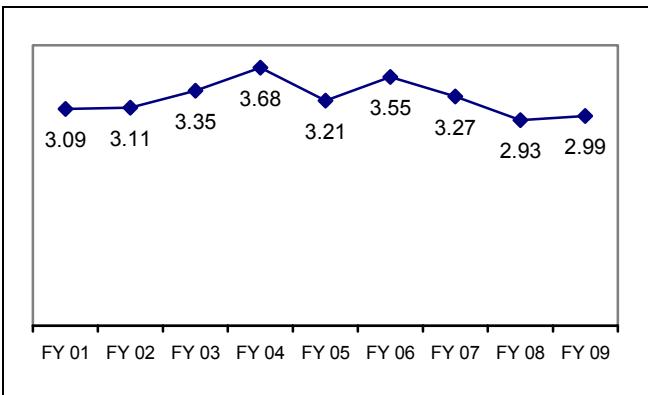
The exit plan repeat maltreatment rate captures recurrence of substantiated abuse or neglect within a six month period for children who remain with their families (in-home cases) while the second rate is reflects substantiated maltreatment by a substitute caregiver any time during the period of out-of-home care. Some states use a broader timeframe for tracking repeat maltreatment and others include indicated and substantiated abuse or neglect reports when calculating rates of recurrence. About two dozen states (not including Connecticut) track whether repeat child abuse victims had received family preservation or family reunifications services previously (e.g., within the prior five years).

Current Actions to Turn the Curve: The overall declines in Connecticut’s repeat and out-of-home maltreatment rates seem to correspond with DCF’s progress in improving its social work practice. This is evidenced by the department’s sustained compliance with the majority of process-related Exit Plan Outcome Measures, particularly those related to investigations, caseloads, and home visits. The department also attributes improvement to agency wide implementation, starting in 2007, of Structured Decision Making (SDM), an evidence-based practice for risk assessment and referral.

The recent drop in performance has been attributed by both the court monitor and the department to the impact of recent large-scale retirements and budget cuts combined with the agency’s ongoing internal reorganization. One of the chief ways the department intends to improve the trend in both maltreatment rates is by ensuring social work staff at all levels in the agency are adhering to the SDM model when making critical case decisions.

System Level Accountability: Key Child Welfare System Performance Measures

**System Performance Measure 2. Entries to Out-of-Home Placement:
Rate Per 1,000 Connecticut Children (All Under Age 18)**



Trend: Progressive reduction after spike in mid-decade; slight recent increase (better)

Story Behind the Data: The rate that children at risk of abuse or neglect are placed in out-of-home care shows how well a state child welfare system is doing at keeping families together, a key child welfare goal that must be balanced with safety.

For example, a high incidence of repeat maltreatment combined with low removal rates indicates a need to examine placement criteria and the adequacy of in-home services. In contrast, if out-of-home placement is increasing

Source: DCF

while repeat maltreatment is falling, policies and practice concerning removal for safety reasons should be reassessed. In spite of research, expert opinion, and federal policy that emphasizes avoiding removal whenever possible, there is no established national indicator for out-of-home placement due to child abuse or neglect. Within Connecticut, one of the *Juan F.* Exit Plan Outcome Measures tracks the number of DCF-involved children who are placed in residential care, but rates of entry into all types of out-of-home care have not been regularly calculated and reported.

For its recent strategic planning effort, however, the department developed agency wide information on rate of entry into foster care. Foster care is broadly defined, in accordance with federal convention, to encompass all types of out-of-home placement: family foster homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes. The DCF out-of-home placement rate shown in the figure is calculated using the number of children in placement due to child maltreatment (i.e., removed from home by DCF because of abuse or neglect risk) and the state’s total population under age 18, which were developed by the department from estimates provided by the Connecticut State Data Center.

The department is still refining its method for counting children in placement, as well as total children served, and continued revision of figures on out-of-home placement rates is expected. Based on one methodology, DCF reported to PRI staff that during FY 09, the agency served a total of 57,786 unique children; 8,003 children were served in out-of-home care, so roughly 86 percent were served solely in-home. A second, “point-in-time” method showed of the 21,262 children served by DCF on December 6, 2009, 3,998 children were in placement, meaning approximately 81 percent were served in-home.

Current Actions to Turn the Curve: The downward trend in out-of-home placements is due in large part to the department’s efforts to comply with the 2004 *Juan F.* consent decree exit plan, which gives priority to keeping and treating children in the community. According to DCF, two major factors were: implementation during 2007 of SDM to promote consistent and accurate safety and risk assessments throughout the life of a case; and the significant expansion of community-based, in-home treatment and support services for at-risk children and families since 2002. Growth in in-home services included:

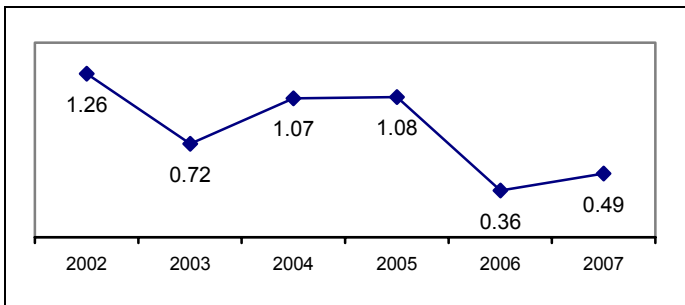
- a nearly 400 percent increase in flexible funding resources for timely, individualized family supports and services between FY 04 and FY 09 (from about \$5 million to \$26.5 million);
- a doubling in funding for community-based behavioral health services, including many new evidence- and research-based in-home clinical treatment programs (from \$32 million in FY 02 to \$69.2 million in FY 09);
- various improvements, including increased hours and types of services, to the agency’s Emergency Mobile Psychiatric Services, a program that helps divert children from intensive in-patient care settings; and

System Level Accountability: Key Child Welfare System Performance Measures

- the introduction of two new programs aimed at facilitating prompt reunification, thereby reducing time children spend in out-of-home care (“Intensive Safety Planning” in early 2007 and “Reconnecting Families” during 2008).

To make continued progress in keeping children safely with their families, the department is planning to: work on better adherence to the SDM model; implement its new treatment plan process and practice model that emphasizes improved working relationships with families; and further develop effective in-home, community-based services that preserve and support vulnerable families.

**System Performance Measure 3. Child Abuse Fatalities:
Rate Per 100,000 Connecticut Children (All Under Age 18)**



Trend: Fluctuating with drops in the two most recent years (better)

Story Behind the Data: Deaths due to abuse or neglect are the ultimate safety measure for at-risk children. If fatalities involving child maltreatment occur at a time when out-of-home placements are low, removal policies and practices should be examined immediately.

Source: NCANDS (Child Maltreatment Annual Reports)

Like most states, Connecticut reports child abuse fatality data to the National Child Abuse and Neglect Data System (NCANDS), which is shown in the figure. It is important to note this federal reporting is voluntary and there are neither standard definitions for child abuse deaths nor established criteria for calculating related fatality rates. Comparisons across states cannot be made. However, Connecticut’s fatality rate and actual numbers of child deaths due to abuse and neglect generally are viewed as low – less than 1 per 100,000 people under 18 in last two years (representing 3 and 4 deaths related to maltreatment, respectively).

The NCANDS figures only include fatalities that came to the attention of the department because either the child was DCF-involved, or abuse and neglect was a suspected cause of death and the agency was asked to conduct an investigation. DCF acknowledges additional child deaths in the state could involve maltreatment but would not be reflected in this reported rate. The Office of the Child Advocate, through its role in the state Child Fatality Review Panel process, reviews reports of unexplained and unexpected deaths for those under age 18, which it receives from the state Office of the Chief Medical Examiner.

At the request of PRI staff, OCA conducted an assessment of all fatalities it reviewed during a recent five-year period (January 1, 2002 through December 31, 2006) to determine the number of cases where child abuse and/or neglect (using DCF definitions) may have been a contributing factor to the child’s death. As the table below indicates, the OCA analysis found a higher number of child deaths in Connecticut involving maltreatment, particularly neglect, than is reported currently through the NCANDS system.

Child Death Reviews Conducted by OCA	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006
Total No. Cases Reviewed	155	157	176	173	141
No. Meeting Abuse Definition	5	10	5	6	3
No. Meeting Neglect Definition	22	17	22	27	6

Current Actions to Turn the Curve: In Connecticut, the many actions being taken to reduce child abuse and neglect

System Level Accountability: Key Child Welfare System Performance Measures

in general (i.e., effective intervention and education efforts, as well as strong child protective service case work; see earlier Key Indicator Child Abuse Rate) are intended to prevent child fatalities. A specific statutory charge of the state Child Fatality Review Panel is to recommend prevention strategies to address trends and patterns of risk for child maltreatment the panel may identify. In addition, the special review unit within DCF is responsible for examining all fatalities and critical incidents involving open protective services cases or those closed within six months to determine ways agency practice and policy can be improved. Until this year, the agency's special review process was carried out with the assistance of experts from the Child Welfare League of America (CWLA). However, as a cost-cutting measure, the CWLA contract for independent analysis of DCF fatality cases was not continued and the department is still formulating a new internal process to replace it.

OCA has been participating in a national effort to improve the quality of the state child abuse and neglect fatality data. One goal is to develop a web-based information system with standardized fatality data from all states that can be used to help target abuse and neglect prevention efforts nationwide.

The child advocate's office, in partnership with DCF, also is involved in a "Safe Sleep Initiative" that is aimed at reducing infant deaths due to sleeping in the same bed as adult caregivers. In recent years, several prevention programs for new mothers with high abuse/neglect risk factors also have been developed by DCF, DOC, DPH and DMHAS to reduce child abuse fatalities. Interagency efforts to address child deaths also include a variety of suicide prevention initiatives sponsored by the DPH Interagency Suicide Prevention Network and by the DCF Youth Suicide Advisory Board in conjunction with DMHAS.

Appendix E: DCF Family Preservation and Supports

Overview

Family Preservation and Supports (FPS) programs administered by the Department of Children and Families were selected as the study topic for the PRI pilot project in accordance with the provisions of P.A. 09-166. Family Preservation and Supports includes all of the agency's programs and services intended to safely keep at-risk families together and reunify those who have been separated by a child's out-of-home placement.

In general, these programs are consistent with accepted child welfare practice and based on research that shows children have the best outcomes when they can remain safely within their families or in the most stable, family-like environment possible. Certain family preservation services have been required by federal law since passage of the 1980 Adoption Assistance and Child Welfare Act.

Given the broad goal, it is not surprising the department's family preservation and support efforts comprise a wide array of programs. An inventory provided to PRI staff by DCF at the beginning of this project lists 20 different categorical programs the agency considers to contribute significantly to the preservation and support of families. In addition to these programs, Flexible Funding (Flex Funds), which the agency uses to meet a wide variety of individualized needs for many types of cases and clients, is an important resource for helping to keep or reunify children with their families. A brief overview of the whole FPS program area including Flex Funds follows, while details on each program are provided below in Table E-1.

FPS program area summary. Some FPS programs are open only to families involved in DCF abuse and neglect (A/N) cases; others can be accessed by any child or family in need of the specific services offered. Families may participate simultaneously in multiple programs that have different but generally complementary purposes (e.g., boost parents' household management skills and improve children's behavioral health).

Half of the 20 programs included in the department's FPS inventory are aimed at helping families with potential or confirmed child maltreatment situations by improving the family's functioning or environment. Despite this shared goal, the administration of the programs is split within DCF: Six of these 10 programs are administered by the department's Bureau of Child Welfare (CW), while the other four are administered by its Bureau of Behavioral Health and Medicine (BH). (An overview of the Department of Children and Families, including its current organization and resources, as well as selected information on major activities, is provided in Appendix G.) Two of the programs are tailored for parents with substance abuse problems.

The other half of the DCF family preservation and support programs primarily assist children with clinical behavioral health issues (mental health and substance abuse problems). These programs are included in the FPS inventory because they attempt to stem children's out-of-home placement (into residential treatment or hospitalization) due to severe behavioral health problems. All of these programs are under the jurisdiction of the agency's behavioral health bureau, except for one that is within the DCF Bureau of Prevention.

FPS Program Details

A summary of each of the 20 categorical FPS programs and department Flexible Funding is provided in Table E-1. The programs and resources vary tremendously in terms of DCF cost and numbers of clients served, as the table indicates:

- The median program *cost to DCF* is approximately \$1.48 million.¹
- In addition to Flexible Funding (\$26.6 million, serving 9,281 families), the Family Preservation and Supports effort with highest cost to DCF is Outpatient Psychiatric Clinics for Children (nearly \$11.8 million, serving 13,837 children).
- Therapeutic Mentoring (\$0.20 million, serving 50 youth) and Substance Abusing Families at Risk (\$0.22 million, number served not provided) are the two lowest-cost programs.
- The median number of client families served per program is 424.

Altogether, Family Preservation and Supports programs, together with flexible funding, account for under nine percent of DCF's annual budget.

Service delivery. All of the agency's Family Preservation and Supports programs are operated by private providers under contracts with the department; DCF does not directly provide any of these services. The provider contracts specify the scope of services required and many include program performance measures. Service scope and measures are developed by the agency staff responsible for the program area, sometimes with input from nonprofit providers and other community-based groups, and assistance from DCF research and administrative support units.

Contracts generally are awarded through competitive (e.g., request-for-proposal) processes for multi-year terms (usually three years). Service areas for DCF contracted providers tend to be regional, matching towns covered by the agency's 14 area offices, but programs can be available statewide, as Table E-1 indicates. For the most part, DCF clients are referred to contracted FPS service providers by area office social workers, based on individualized treatment plans that must be developed and maintained for each case.

Contracted services are managed, however, by central office staff designated at program leads, who perform this function in addition to other, often significant, management duties. For example, the assistant Child Welfare bureau chief is the program lead for one of the core FPS programs (IFP). In addition, all provider payment and other accounting functions are handled by the department's fiscal division. The agency's automated case management system, LINK, is used to enter, review, approve, and track all contracted service expenditures on a client or case level.

¹ Only direct DCF funding for FPS programs and services is included in these figures. Other resources, such as Medicaid payments for certain clinical behavioral health services, (e.g., those provided through IICAPS), which can be significant, are not reflected in these figures.

Program monitoring and evaluation. Program oversight varies across the FPS program area, as Table E-2 indicates. The table summarizes the current status of quality assurance and quality improvement activities DCF carries out for each of its family preservation and support programs.

Overall, a process is in place to compile and review data on provider performance for 13 programs while data collection tools are in development for five others (all in the Child Welfare bureau) and two small pilot programs do not have any procedures for routinely gathering data. A total of 10 programs, nine of which are within the Behavioral Health bureau, have contracted quality assurance or independent evaluation resources. As the table indicates, quality assurance and improvement efforts are strongest for Behavioral Health bureau programs, which includes all five of the evidence-based FPS program models and two of the four programs that are based on research or are best/promising practice.

The Program Review Committee's 2007 report, *DCF Monitoring and Evaluation*, noted major weaknesses in the agency's contract management process. Specifically, the committee found best practices for assuring quality and effective service delivery were not in place:

- data reporting requirements for providers were vague or not specified in contract documents;
- monitoring of contractor performance was haphazard, site visits were rare and communication was weak;
- consequences for poor performance were seldom imposed; and
- follow up and support for contracted providers to address deficiencies was inadequate.

The committee's RBA pilot project showed these problems have not been adequately addressed. Some progress has been made, particularly in terms of better data systems, as noted below. However, recommended improvements contained in the 2007 study require ongoing attention from department managers. DCF still needs to ensure: required outcome data are clearly specified in all contracts; a team approach is taken when working with contractors; data received from providers are analyzed, aggregated, and shared with area office staff and contractors; and providers are held accountable for expected contract outcomes (e.g., withhold payments for unsatisfactory work). Also, it is still appropriate for the department to consider reallocating some central office staff from accounting and other fiscal functions to contractor performance monitoring.

Overall research capacity in the agency is better now than in 2007. The department created the Office of Research and Evaluation (ORE) in 2008 to initiate, facilitate and conduct data analysis, research, and evaluation for the entire agency. Dedicated resources for this purpose still are limited with six professional staff, a director and two support staff currently assigned to ORE. Also, budget constraints have ended several of the agency's outside research and evaluation contracts (e.g., Child Health and Development Institute – Connecticut Center for Effective Practice).

Data systems. In general, effective oversight of program performance requires strong data collection and analysis capacity. Weak computerized information systems and inadequate research and evaluation resources have been an ongoing problem for the agency, as noted in the

2007 PRI report mentioned above. That study showed, program performance measures and data analysis capabilities for contracted services were insufficient, data quality was poor, and web-based access (e.g., for data entry) was lacking.

DCF began to overhaul its contracted program data systems because, according to staff interviewed for this study, major changes clearly were needed to ensure accountability. For example, in past years, the department required its contracted behavioral health programs to submit certain client and service information via its automated Behavioral Health Data System (BHDS); child welfare program providers were required to submit information in varying formats and levels of detail through a number of other mechanisms.

In July 2009, the department started to implement an entirely new provider data system expected to provide higher-quality data more useful for understanding how all contracted programs are performing. The new system, Programs and Services Data Collection & Reporting System (PSDCRS), is being phased in, starting with behavioral health services. Eventually, it will encompass Bureau of Child Welfare programs.

The department's program managers, providers, and research staff working on the new system considered for approximately nine months the measures PSDCRS would include for each behavioral health program. Some of their efforts involved using logic models to understand what could reasonably be expected as program outputs and outcomes, and then devising data items to allow those results to be measured. Extensive training in the new system for contracted program providers was planned and delivered beginning in the spring of 2009.

Initial information produced through the new system became available in late fall 2009. These first reports were limited to client demographics for Behavioral Health bureau programs, including only two under in-depth examination through the program review committee's RBA pilot project (SHF and IICAPS). Therefore, for the purposes of this study, PRI staff drew on provider data obtained and kept by DCF through means other than the new (PSDCRS) or previous (BHDS) automated systems. Also, until the PSDCRS is more fully implemented, the quality of information produced and usefulness of the overall system for the department and providers cannot be assessed.

Table E-1. DCF Family Preservation and Support Programs and Resources (FY 09)

<i>Program and Bureau: Child Welfare – CW Behavioral Health – BH</i>	<i>Description - Duration</i>	<i>Annual Capacity</i>	<i>Service Area</i>	<i>DCF FY 09 Funding* (\$ millions)</i>
FOCUS PROGRAMS AND RESOURCES				
<i>For Families with an Open Abuse/ Neglect Case</i>				
Intensive Family Preservation (IFP) (CW)	In-home intervention services to strengthen family, prevent removal or facilitate immediate reunification; serves higher risk families than Parent Aide - 12 weeks	1,290 families	Statewide	\$5.76
Parent Aide** (CW)	In-home parenting education and supports - 17 wks	1,991 families	Statewide	\$4.25
Supportive Housing for Families (SHF) (BH)	Housing assistance, intensive case management for DCF-involved families to prevent removal, allow reunification, when problem is inadequate housing; housing provided in conjunction with DSS - 2 years	500 families	Statewide	\$7.01
<i>For Any Children/Families with Need for Specific Services Offered (May Have Open Abuse/Neglect Case)</i>				
IHBS***: Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) (BH)	Intensive home-based clinical treatment and supports to improve child and family functioning, reduce need for child institutional psychiatric care, for children at risk of or just discharged from inpatient treatment - 21 weeks	In FY 09, served 1,595 cases	Statewide	\$2.94
Flexible Funds (CW)	Discretionary funds available for broad array of services and supports – duration varies	In FY 09, served 9,281 families	Statewide	\$26.61
OTHER PROGRAMS				
<i>For Families Experiencing Problems (May Also Participate in Child Behavioral Health Services)</i>				
Integrated Family Violence/Family Violence Outreach**** (CW)	Crisis and support services, in-home if possible, to domestic violence victims and their children with open DCF case - 3 months	725 families	In 10/14 area offices	\$0.90
Intensive Safety Planning (ISP) (CW)	Very short term in-home intervention to address safety issues in families with open DCF A/N case to aid reunification - 24 days	456 families	Statewide	\$1.42
IHBS***: Family Based Recovery (FBR) (BH)	Intensive in-home or community based intervention combined with adult SA treatment, for families that include infants and toddlers exposed to parental substance abuse; priority to open DCF cases - 12-18 months	60 families	In 2/14 area offices	\$1.48
Multidisciplinary Team (CW)	Multidisciplinary investigations for physical/sexual abuse cases to help suspected victims of serious A/N and their families – duration varies based on investigation	DCF reports meet demand	Statewide	\$1.15

Table E-1. DCF Family Preservation and Support Programs and Resources (FY 09)

<i>Program and Bureau: Child Welfare – CW Behavioral Health – BH</i>	<i>Description - Duration</i>	<i>Annual Capacity</i>	<i>Service Area</i>	<i>DCF FY 09 Funding* (\$ millions)</i>
Parent Ed & Assessment (PEAS)** (CW)	Home-based parenting education for families with children up to age 8 in open DCF A/N case (family preservation) - 6 months	392 families	In 9/14 area offices	\$0.86
Project SAFE (Joint program with DMHAS) (BH)	Priority access for parent to substance abuse evaluation and outpatient treatment if recommended, in family with open DCF A/N case (family preservation or reunification) – duration varies	More than 150 families	Statewide	\$1.73
Substance Abusing Families at Risk (SAFAR) (BH)	Assessment, prenatal education, case management and referral services for mothers of high risk newborns; includes incarcerated women and pregnant and parenting women substance abusers – duration varies	8 residential beds	In 1/14 area offices	\$0.22
<i>For Children / Families Dealing with Child Behavioral Health Problem (May Have Open Abuse /Neglect Case, and/or Open Juvenile Justice Case)</i>				
Family Support Team (BH)	Home-based therapeutic services for children with a serious emotional disturbance (SED) at risk for out-of-home care, needing reunification, in DCF BH services - 12 months	249 families	In 13/14 area offices	\$7.19
Hartford Youth Project (BH)	Community-based substance abuse education, case management, assessment, referral services for youth with substance abuse problems, mainly Hartford residents - 14 months	100 youths and their families	In 1/14 area offices	\$0.44
IHBS:*** Family Substance Abuse Treatment Service (FSATS) (BH)	Intensive home-based substance abuse treatment services based on family recovery model for Hartford children in detention where there is evidence of parental substance abuse - 9-11 months	100 families	In 7/14 area offices	\$1.06
IHBS: ***Functional Family Therapy (FFT) (BH)	Intensive home-based clinical intervention and supports to stabilize children with SED at risk of out-of-home care, whose families have limited resources - 4 months	396-492 DCF-involved youths; 143-167 youths on parole	Statewide	\$1.86
IHBS: ***Multi-Dimensional Family Therapy (MDFT) (BH)	Intensive home-based clinical interventions for children 11-17 with substance abuse needs at imminent risk of removal/return home from residential care - 21 wks	256 families	Statewide	\$1.58
IHBS:*** Multi-System Therapy – Problem Sexual Behavior (PSB) (BH)	Intensive home-based clinical interventions for youths with problem sexual behavior - 6-8 mo.	14 youths and their families	In 2/14 area offices	\$0.25
Neighborhood Place (Prevention)	After school and summer drop-in outpatient mental health	66 families	In 2/14 area	\$0.25

Table E-1. DCF Family Preservation and Support Programs and Resources (FY 09)

<i>Program and Bureau: Child Welfare – CW Behavioral Health – BH</i>	<i>Description - Duration</i>	<i>Annual Capacity</i>	<i>Service Area</i>	<i>DCF FY 09 Funding* (\$ millions)</i>
<i>Bureau)</i>	services for New Haven children and families – duration varies		offices	
Outpatient Psych. Clinics for Children (<i>BH</i>)	Outpatient mental health services for children with diagnosable condition and their families with emphasis on family, school, and community – duration varies	6,599 DCF clients; 7,238 other	Statewide	\$11.78
Therapeutic Mentoring (<i>BH</i>)	Individualized, interactional activities to promote one-on-one positive relationship between trained mentor and child involved in juvenile justice or court and have mental health problems - 6-9 months	50 youths	In 2/14 area offices	\$0.20
<i>TOTAL DCF FUNDING</i>				\$78.94
<i>% TOTAL DCF FY 09 BUDGET</i>				8.6%

NOTES:

* Represents DCF funding only; other resources, particularly for behavioral health programs that include services funded through KidCare/Connecticut Behavioral Health Partnership (e.g., Medicaid fee-for-service) can be significant; for example, payments for IICAPS services made through the Behavioral Health Partnership are estimated to total millions of dollars annually.

** Parent Aide and PEAS redesigned/to be combined during FY 10 as Family Enrichment Services (FES)

*** IHBS = In-home Behavioral Health Service

**** Family Violence Outreach being phased out and replaced by Integrated Family Violence program

Table E-2. FPS Quality Assurance and Improvement Summary

Program	Data Collection, Evaluation and Quality Assurance (Details Supplied by DCF)	Contracted QA or Independent Evaluation	Evidence or Research on Effectiveness*
Intensive Family Preservation (IFP) (CW)	No independent evaluation. A data collection tool has been developed to track client specific information as well as service delivery information.		
Parent Aide (CW)	The Parent Aide programs have been redesigned using a logic model framework. Contract amendments are in process. No independent evaluation. Data collection tool has been developed to track client and service delivery information.		
Supportive Housing for Families (SHF) (BH)	Program participates in the PSDCRS System and the statewide contractor has an external QA and data system for program monitoring and quality assurance. UCONN has completed several evaluations of the program.	✓	✓ Research-based model
IHBS Intensive In-home Child and Adolescent Psychiatric Services (ICAPS) (BH)	Yale [conducts] training, quality assurance including annual credentialing, quarterly and year end programmatic reporting and maintenance of program database (\$500,000)	✓	✓ Promising practice
Integrated Family Violence/Family Viol. Outreach (CW)	No independent evaluation. The SSA for the domestic violence consultants provides training and consultation to ensure program fidelity [to the “Safe and Together” model]. Data collection tool has been developed to collect client and program information.	(some external training and consultation)	✓ Research-based model
Intensive Safety Planning (ISP) (CW)	No independent evaluation. Data collection tool has been developed to track client and program specific information.		
IHBS: Family Based Recovery (FBR) (BH)	External QA and fidelity management contracted through Yale University. External program evaluation being conducted by UCONN.	✓	✓ Portion evidence-based
Multidisciplinary Team (CW)	Required by [statute] The Village for Children and Families receives [funding] annually to evaluate 5 teams per year. Each team evaluated every 3 years. Evaluates team structure, functioning and best practice standards. GTFJAC oversees work.	✓	✓ Best practice
Parent Ed & Assessment (PEAS)/ Family Enrichment Services (CW)	PEAS/Parent Aide programs redesigned to Family Enrichment Services. Contract amendments in process. No independent evaluation. Data collection tool developed.		
Project SAFE (BH)	Joint Contract with DMHAS includes a contract with Advanced Behavioral Health for program management and data reporting.	✓	
Substance Abusing Families at Risk (SAFAR) (BH)	No data system or evaluation.		

Table E-2. FPS Quality Assurance and Improvement Summary

Program	Data Collection, Evaluation and Quality Assurance (Details Supplied by DCF)	Contracted QA or Independent Evaluation	Evidence or Research on Effectiveness*
Family Support Team (BH)	QA is performed by the DCF Program Lead using data from the BHDS/PSDCRS data systems.		
Hartford Youth Project (BH)	Evaluation completed as part of the federal grant and continuing QA through the DCF administered GAIN program.	✓	
IHBS: Family Substance Abuse Treatment Service (FSATS) (BH)	External QA and evaluation is purchased through a contract with Advanced Behavioral Health which includes consultation by the model developers at the University of Miami.	✓	✓ Based on evidence-based MDFT
IHBS: Functional Family Therapy (FFT) (BH)	Each FFT provider is required to purchase external QA from the FFT Model Developer, FFT, Inc.	✓	✓ Evidence-based
IHBS: Multi-Dimensional Family Therapy (MDFT) (BH)	External QA and evaluation is purchased through a contract with Advanced Behavioral Health which includes consultation by the model developers at the University of Miami.	✓	✓ Evidence-based
IHBS: Multi-System Therapy – Problem Sexual Behavior (PSB) (BH)	Contract with ABH to conduct QA.	✓	✓ Based on evidence-based MST
Neighborhood Place (Prevention)	No independent evaluation. Plans are to bring this into the Prevention Bureau's Positive Youth Development Initiative which does have an independent evaluation.		
Outpatient Psych. Clinics for Children (BH)	QA is performed by the DCF Program Lead using data from the BHDS/PSDCRS data systems.		
Therapeutic Mentoring (BH)	QA is performed by the DCF Program Lead using data from the BHDS/PSDCRS data systems.		

*Determined from available agency documents and information provided by DCF; for the purposes of this study, a checkmark denotes effectiveness of all *or part* of the service model has been documented to *some* extent by empirical research as follows:
 Evidence-based model = scientific studies proven effective; fidelity to model and service outcomes evaluated regularly
 Research-based model and Best/Promising Practice = generally accepted research findings indicate effective; adherence to recommended practices, and service outcomes, at least reviewed and in some cases independently evaluated

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Appendix F

RBA Program Performance Profile

Intensive Family Preservation (IFP)

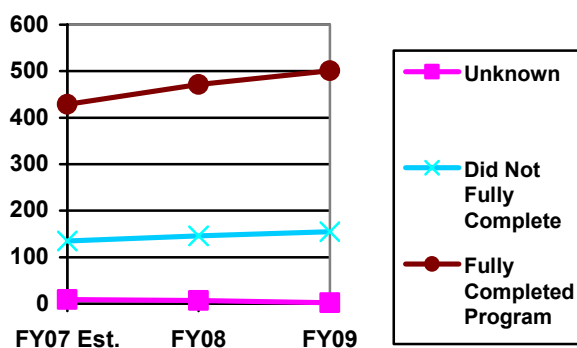
Background	
<i>IFP, which provides in-home visits, is the higher level of the two main services available to families with open child maltreatment cases; it also works to foster reunification.</i>	
Purpose (CW bureau)	Reduce immediate safety threats to prevent child out-of-home placement and promote successful reunification for those children who have already been removed
Target Population	Families with an open DCF abuse / neglect case at high risk of out-of-home placement, just reunified, or with an upcoming reunification
Services	In-home visits to provide: mitigation of safety problems; links to community services (including therapeutic interventions); parenting education; and crisis intervention, over five hours each week (minimum), for up to 12 weeks; contracted provider is on-call 24 hours a day
Partners	<ul style="list-style-type: none"> • 17 contracted providers: One serves clients out of four area offices, one out of three area offices, three out of two area offices, and 12 out of a single area office • Other community agencies that provide services through referrals from IFP workers

I. How Much Did We Do?

IFP's client database indicates more clients were served recently, but it is possible that is due simply to better reporting as providers have gotten used to the new client reporting system (instituted 2006-2007). The reported client information is for substantially fewer clients than the program capacity required by provider contract. Clients who complete the program successfully receive more services – of each type, and altogether – than non-completers.

Performance Measure 1: Clients Served

Client Families Served, By Completion Status



Trend: Small increase in clients served; small increase in stable completion rate

Clients are referred to IFP by the family's DCF social worker. DCF's data indicate 660 DCF families who began IFP services in FY 09 have ended their participation in IFP (in either FY 09 or by Sept. 22 of FY 10). It should be noted that DCF funded between 1,059 (PRI staff count of total slot capacity in provider contracts) and 1,290 (DCF reported) IFP client slots in FY 09. DCF began the IFP client database in 2006-2007.

Source of data: DCF

The FY 09 IFP data covers less than two-thirds of aggregated provider client capacity (62% or 51%, respectively).

Story Behind the Baseline: DCF staff is unsure why there appears to have been more clients served in FY 09; funding and provider expected capacity did not increase and they do not recall a greater demand

Appendix F

RBA Program Performance Profile

Intensive Family Preservation (IFP)

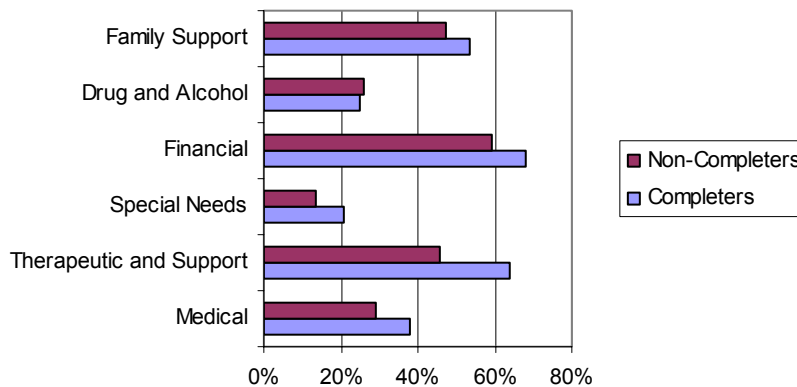
for IFP or shorter program duration compared to FY 08. They speculate the increase may be due to better providing reporting, as the providers became more familiar with the new data system. It does not appear providers are “cherry-picking” the best cases for reporting to DCF, based on data presented in “II. How Well Did We Do It?”. Most providers who responded to the PRI staff survey (nine out of eleven) said their client data in DCF’s system is generally complete. A majority, however, (seven out of eleven) reported they were serving fewer clients than contracted for a variety of reasons, including not receiving enough referrals (three providers), long duration of client services (two), and staff turnover (one). Indeed, PRI staff comparison of clients served as reported to DCF, to client slots, shows ***all but two of the 17 providers reported substantially fewer clients than they were contracted to serve.***

DCF analyzed the IFP client database once, in 2007, but has not dedicated resources to periodic analysis, even of the numbers of clients served. DCF area office staff and providers are not given access to the data so they cannot check accuracy. To improve data quality so that it may be used for program management and improvement:

- ***DCF should allow providers and area offices to view their respective data so: 1) providers may correct data as necessary; and 2) area offices can monitor whether providers are meeting their contracted slot amounts, and if not, understand why***
- ***The IFP program lead (i.e., manager, recommended below) should analyze the client data every six months***

Performance Measure 1a: Types and Amounts of Program Services Received

Types of Services Received by IFP Clients



Source of data: DCF

Trend: More than half of completers receive assistance with family, financial, and/or therapeutic matters; except for substance issues, completers are more likely than non-completers to receive each type of assistance

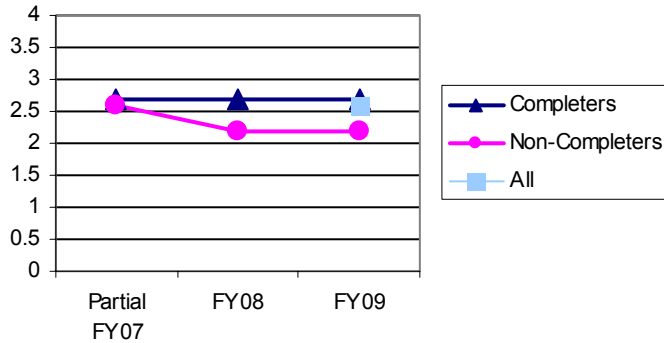
Data shown are from FY 09; the percent receiving services has changed in only a few ways over FY 07 - FY 09: There has been an increase (from 17% to 25%) in completers receiving substance abuse services, and decreases

in non-completers receiving medical assistance (49% to 29%) and family support services (62% to 47%).

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

**Average Number of Service Types
Received Per Client**



Source of data: DCF

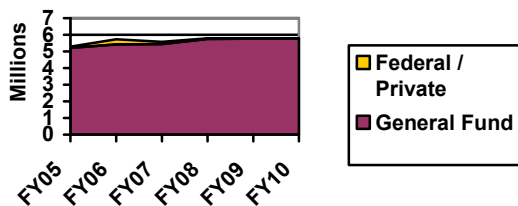
Trend: Average number of service types was stable for program completers (neutral); non-completers' amount of service types dropped somewhat (worse)

Reported IFP clients who began services in FY 09 received, on average, 2.6 types of services. Completers continued to receive 2.7, while non-completers who started IFP in FY 07 received 2.6 but those who began in FY 08 or FY 09 received 2.2.

Story Behind the Baselines: The relationship between whether a client completes IFP and the number of program services received was statistically significant in PRI staff regression analysis, with more services being positively related to completion. However, the meaning of this relationship is unclear. Non-completers could receive fewer service types for a number of reasons (e.g., might be less willing to more fully engage, needs might be less fully understood by IFP workers who are with them for a shorter amount of time, shorter service duration meant less opportunity to offer different services, or fewer services might really be directly related to non-completion).

Performance Measure 2: Expenditures

Expenditures by Source



Source of data: DCF

Trend: Small fluctuations, then flat

Expenditures grew 8% in FY 06, declined slightly in FY 07, and since FY 08 have held at almost \$5.8 million. The General Fund has covered nearly all costs. (Note: The FY 10 amount was projected by DCF in August 2009.)

Story Behind the Baseline: Although theoretically one would examine Performance Measures 1 and 2 together, and therefore conclude that the number of IFP clients served increased

(by 5.4%) and the completion rate remained the same – despite level funding – this analysis cannot be made confidently due to the question of data integrity.

For the FYs 10-11 biennium, DCF requested substantially more IFP funding – an additional \$2.1 million in the first year, and \$2.8 million annually beginning in the second year (raising the total to \$8.6 million in FY 11) – to increase the number of clients that may be served. Neither request was approved by OPM.

Appendix F
RBA Program Performance Profile
Intensive Family Preservation (IFP)

II. How Well Did We Do It?

Client demand is not quickly met in at least six area offices. The program’s completion rate has remained stable, but certain clients are less likely to complete than others. A key aspect of the program, five hours of weekly services are provided by the IFP worker, is not met for a substantial portion of both non-completers (59%) and completers (30%), and has trended worse recently. At the same time, a majority of program completers is staying in program longer than called for by the program’s standards (beyond 12 weeks) – which could be impacting providers’ ability to meet area office demand. A variety of process-oriented IFP requirements is not measured, as this is (or should be) monitored through the biweekly DCF social worker and IFP family worker meetings. Those meetings are helpful in providing case-level management of IFP services, but provider-level performance and costs are not tracked. Providers would like training to be made available to their IFP workers, while area offices would like more Spanish-speaking provider staff, and greater provider staff availability on evenings and weekends.

Performance Measure 3: Meeting Client Demand

a. Frequency of Waitlist for IFP Services

	<i>Area Offices*</i>
Always	Bridgeport Meriden
Most of the time	Hartford New Haven Norwich Waterbury
Sometimes	Manchester Middletown Milford Willimantic
Rarely	Danbury Norwalk-Stamford Torrington

Source: PRI staff interviews and web survey
 *No information was provided by New Britain.

b. Average Length of Time on Waitlist

	<i>Area Offices*</i>
3-6 days	Manchester
1-2 weeks	Waterbury
3-4 weeks	Bridgeport Hartford Milford Willimantic
1-2 months	Meriden Middletown New Haven Norwich
Not applicable: rarely is a waitlist	Danbury Norwalk-Stamford Torrington

Source: PRI staff interviews and web survey
 *No information was provided by New Britain.

Trend: Unknown

Story Behind the Baseline: *The ability to meet demand for the program varies among area offices.*

Six offices always or most of the time have an IFP waitlist, while three rarely have one. The time spent on waitlists can be quite lengthy. Some offices reported prioritizing very high-risk cases. While DCF social workers are waiting for their families to get into IFP, they reported using a variety of methods to try to improve parenting skills and ensure repeat maltreatment is avoided, including employing Flex Funds and more frequently and intensively working with the family. A few area office staff noted they are troubled by the waitlists because IFP was intended to serve high-risk families with urgent needs.

When the client data has been reviewed by providers, to better meet area office demand, DCF should:

- *Examine the numbers of clients served and area office waitlists to shift capacity so demand is*

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

better met in area offices whose clients persistently have long waits for IFP services

It is important to *add waitlist times and SDM risk rating to the client data form* to be certain that the differences in demand are: 1) documented; and 2) not resulting from differences among the area offices in family level of need required for an IFP referral.

Performance Measure 4: Completing the Program

Data: For the past three FYs, the reported client data shows a completion rate of about 76%. See “Performance Measure 1: Clients Served” above for a graph. Data are not kept on the explicit reasons why non-completers end participation.

Trend: Stable completion rate; the completion status is unknown for a small and declining number of clients included in the data (7 in FY 08, and 2 in FY 09).

Story Behind the Baseline: Looking at Performance Measures 1 and 4 together, over the past three years, the program appears to have served more people each year (8.9% increase in clients in FY 08, 5.4% increase in FY 09) and kept the completion rate stable. However, it is unclear whether the increase in clients served was a true increase, or merely a reflection of more clients being reported by the providers. DCF’s client database information indicates that certain families are less likely to complete the program, when accounting for program services delivered. These families have: caregivers other than a two-parent, blended, or relative/guardian; no primary support group; and/or are served by a few particular providers. Certain caregiver information – ethnicity and age – that could be associated with completion are not included on the client form, only on the service plan assessment currently being used (the GAIN-Q, and that data cannot be easily merged with the client data). The provider information is not disclosed in this report because staff lacked the time to more fully investigate; however, DCF should periodically analyze its data and, when significantly lower completion rates are discovered, work to understand why those exist and how they could be improved.

To better understand the clients for whom IFP works or does not, DCF should add additional caregiver demographic characteristics – including ethnicity/race, age, language – and initial child placement status items to the client form submitted by providers.

To do this work of program management and improvement, DCF should:

- *Designate an IFP program lead (i.e., manager) to analyze the client data (as recommended above) and improve IFP practice*

The IFP program lead’s efforts should include developing efforts to improve completion of client families who have characteristics associated with non-completion.

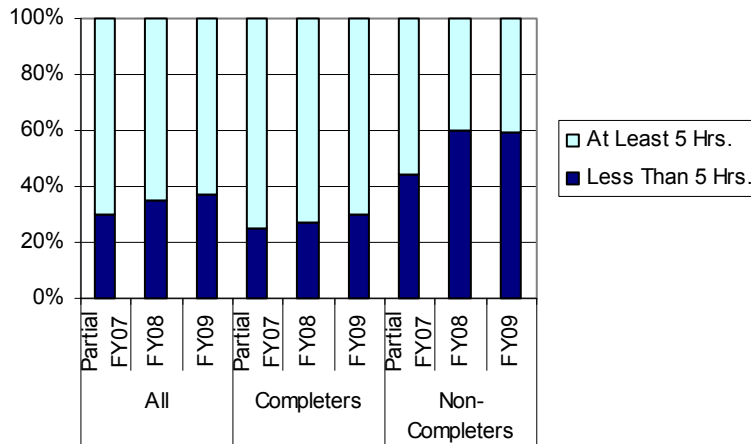
Appendix F

RBA Program Performance Profile

Intensive Family Preservation (IFP)

Performance Measure 5: Meeting Program Standards

a. Receiving five hours of face-to-face services weekly from IFP worker



Source of data: DCF

Trend: Increasing number are not meeting five-hour standard (worse); on average, non-completers consistently have fewer hours of face-to-face services than completers

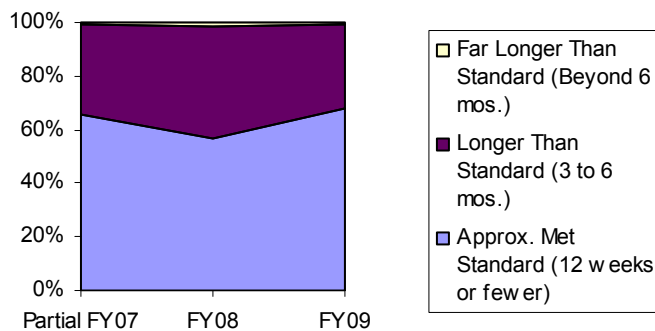
Slightly more than one-third (37%) of all reported IFP clients who started the program in FY 09 received less than the model's standard of 5 hours of face-to-face services.

Completers' services much more frequently meet the

standard, than non-completers (30% compared to 59%). The face-to-face hours spent has been declining among all three groups over the last three FYs.

Story Behind the Baseline: It is interesting to note that although the hours of service have declined, and hours of service are lower for non-completers, the program's reported completion rate has remained stable. No potential explanations for this were given by DCF. Department staff noted this is the service standard that is most important to them, and so they were troubled by this finding. Their concern is well-founded: regression analysis completed by PRI staff found that receiving fewer than five hours of service was significantly related to program non-completion (as might be expected from reviewing the chart above), controlling for other significant factors among those data items collected in the IFP client database. In addition, five hours weekly was cited as the minimum intensity for an IFP program by the Center for the Study of Social Policy in 2009 in a review of common IFP program characteristics. Nearly all provider survey respondents indicated they expected IFP workers to be with each family for five hours weekly; one reported an expectation of 3-4 hours.

b. Program completers finished in 12 weeks



Source of data: DCF

Trend: Fluctuating; recently, more meeting – i.e., not exceeding – the standard

Sixty-eight percent of reported program completers who began IFP in FY 09 participated for about 12 weeks or less (i.e., did not receive services much beyond the maximum duration). This is an improvement over 58% in FY 08. Non-completers (not included in chart above) who

Appendix F

RBA Program Performance Profile

Intensive Family Preservation (IFP)

began in FY 09 ended participation in the program at 6.5 weeks, on average (not shown) – well below the program’s intended duration because, as non-completers, they, by definition, stopped participation early.

Story Behind the Baseline: DCF staff considers this finding reasonable as they believe services sometimes need to be extended if the family is making progress but is not to the point of ending services. In addition, central office staff believes the area office staff is sufficiently familiar with the families who are either receiving or waiting for IFP services to be good judges of whether services can reasonably be extended. *Connecticut’s IFP program duration standard is already long compared to other states’ IFP programs. In addition, keeping clients in the program longer than expected means that the provider’s capacity to serve other, new clients is diminished.* The longer-than-expected duration likely is one reason why so many fewer families are served, than should be according to the contract Scope of Services. Provider survey respondents indicated about one-quarter of providers expect IFP services to be given for six months or longer.

The designated program lead, recommended above, should work with providers and area offices to improve program compliance so that: 1) client families meet the key standard of receiving at least five hours of services weekly; and 2) services extend beyond three months only when necessary.

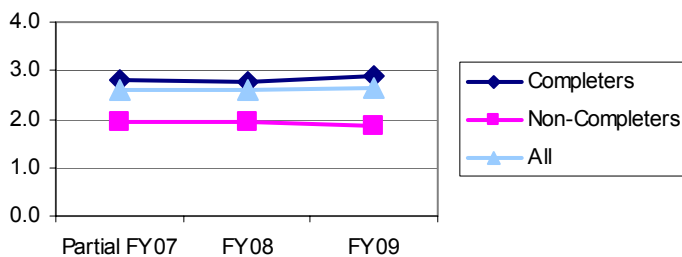
c. IFP worker is visiting each family twice weekly

Data: This measure is not collected by DCF in the IFP client database.

Story Behind the Baseline: DCF staff does not believe it is necessary to collect this information because it should be discussed as part of the biweekly case conferences between the family’s DCF worker and the family’s contracted IFP provider staff person.

d. The DCF family worker and the IFP provider staff person together are visiting the family’s home monthly

Number of Joint Monthly Home Visits Over Program Participation



Source of data: DCF

IFP non-completers had an average of 1.8 visits, which makes sense given their shorter term of program participation.

Trend: Slightly higher number of average monthly joint home visits overall and for completers, and slightly fewer visits for non-completers

Reported IFP program completers who started the program in FY 09 had an average of about 3 (2.9) joint visits, which meets the target when considering the average service duration is about 3 months.

Story Behind the Baseline: Further examination of the data would be necessary to determine what percents of completers and non-completers had the appropriate number of monthly joint home visits,

Appendix F
RBA Program Performance Profile
Intensive Family Preservation (IFP)

given their length of engagement in the program. However, it appears likely compliance with this program aspect is high.

e. The family's IFP provider staff person and the family's DCF case worker are meeting to discuss the family's case every two weeks, for each family

Data: Nearly all the 12 area offices that gave information to PRI staff reported these meetings occur every two to three weeks; the remainder indicated the meetings occur monthly. This information is tracked in the IFP client database.

Story Behind the Baseline: *Providers and area offices largely are adhering to this standard, indicating DCF manages individual IFP cases.* Those who are not meeting biweekly, usually meet less often due to a high volume of clients being served by the provider.

f. Meeting the IFP service timeframe standards: Time between –

- a. Program intake and:
 - i. Start of program services: 2 business days
 - ii. Assessment by worker: 5 business days
 - iii. Development of IFP plan: 2 weeks
- b. Second assessment administration and program discharge
- c. Referral and service start date

Data: These measures are not collected by DCF in the IFP client database. Most IFP providers who responded to the PRI staff survey reported generally beginning services within 2-3 days of receiving the referral from DCF. Those who stated it takes longer, attributed the delay to several reasons: the inability of the family's DCF worker to quickly be present at the initial home visit (a requirement in the contract Scope of Service to which some providers strictly adhere), difficulty finding a time that works for the family and the IFP worker, and trouble contacting / locating the client.

Story Behind the Baseline: DCF believes it is unnecessary and duplicative to collect this level of information on the IFP client form, as it should be monitored at the family case conferences, which are attended by the family's DCF and IFP workers, as well as DCF and IFP provider supervisors.

Performance Measure 6: Satisfying Clients

Data: This measure is not collected by DCF in the IFP client database. However, all IFP providers who responded to the PRI staff survey, reported surveying their clients for satisfaction and analyzing the results.

Story Behind the Baseline: Many of the DCF staff interviewed were skeptical of the value of administering a customer satisfaction survey. The range of reasons included doubt that the client would provide anything but positive feedback given that DCF has the power of child removal; the providers would agree to ask uniform questions on their client satisfaction surveys; and the responses would be fully representative of the range of client experiences. Collecting and using client satisfaction data, however, is considered a contracting best practice, and all providers who reported to the survey do it, anyway.

To move toward contracting best practices, DCF should add client satisfaction items to the client form submitted by providers, and then analyze as well as use the information to improve IFP services.

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

These items should be simple; for example: “How satisfied were you with the IFP services you received?” and “How satisfied were you with “How satisfied were you with your IFP worker’s sensitivity to your culture and traditions?” (since cultural competence is a focus of DCF). This information will help DCF better monitor whether IFP and its providers are meeting clients’ needs.

Performance Measure 7: Managing Cost Per-Client

Per-Client Costs Across Providers, Using IFP Database for Client Count*			
	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
Average	\$10,121	\$11,151	\$8,731
Median	\$9,068	\$6,889	\$8,350
Max	\$21,383	\$35,942	\$17,058
Min	\$5,102	\$3,765	\$3,934
*Excluding providers who reported fewer than two clients. Source: PRI staff analysis of provider expenditures and IFP client database			

FY 09 Per-Slot Costs Across Providers*	
Average	\$5,157
Median	\$5,014
Max	\$7,437
Min	\$3,381
Source: PRI staff analysis of provider expenditures and contracts	

Note: Dividing DCF’s total expenditure on providers by total slots, the average per-slot cost was \$5,441.

Trends: There are no consistent trends.

Story Behind the Baseline: *DCF does not examine per-client or per-slot costs for IFP.* The department expressed doubt whether either measure is useful, for a variety of reasons – particularly that contracts are handled aggregately for each provider so the per-client or per-slot cost for any specific program may not reflect actual expenses. The department’s provider budgeting for IFP is based on the provider’s historical IFP spending, not on a per-slot amount. These results should also be interpreted with caution because it is possible the IFP client database does not accurately reflect the number of client families actually served. Yet, it is clear that, no matter that reasons or calculation methods, *per-client costs vary among providers.*

To ensure that per-client costs are reasonable, DCF should:

- *Examine variations in per-client costs, to determine whether there are legitimate reasons for substantial variations from the median cost, and if there are none, financially penalize those providers.*

This recommendation aims to: 1) encourage providers to accurately report data, and DCF to make sure providers can correct their data when necessary; and 2) ensure per-client costs are reasonable while adequately accounting for special circumstances that might result in higher costs.

Performance Measure 8: Managing Provider Performance Using Data

Provider Completion Rates Over Three FYs (FY 07 – FY 09)	
Average	76%
Median	76%
Max	86% for a large provider 100% for a small provider
Min	43-44% for two smaller providers
Source: PRI staff analysis of IFP client database	

Trend: Not applicable

Story Behind the Baseline: *Completion rates vary across providers, although 10 of the 16 reporting providers had rates between 70-79%. One provider has not submitted any client data.* It should be noted that most providers who shared aggregate client data through the PRI staff survey

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

reported higher completion rates than shown by the data, which could mean the client database does not provide an adequate picture. Regression analysis performed by PRI staff indicated that completion rates were significantly different for a few providers, but that the differences could sometimes (though not always) be attributed to the family characteristics of the provider's clients. Time was insufficient to more fully explore possible reasons for variation. DCF has not analyzed the IFP client data since early 2008 and it is unclear whether provider variation was examined at that time.

The designated program lead, recommended above, should conduct analysis of the IFP client database and, as necessary, work with providers to improve performance.

The data could be used to pinpoint high-performing providers, so their practices could be shared with the others, and low-performing providers, which could receive improvement assistance.

ADDITIONAL PERFORMANCE MEASURES

a. Having well-prepared IFP provider staff

Staff Education Level	
Unknown	0.5%
Less than a Bachelor's	2.3%
Bachelor's degree	54.6%
Master's degree	35.3%
Licensed	7.2%
Total	100.0%
Source: PRI staff analysis of IFP client database	

Staff Experience Level	
Unknown	0.2%
<1 year	10.1%
1-3 years	39.9%
3-5 years	16.1%
>5 years	33.6%
Total	100.0%
Source: PRI staff analysis of IFP client database	

Story Behind the Baseline: The provider contract requires each IFP worker to have a minimum of a bachelor's degree. It should be noted that while a small percent of workers did not meet that requirement, those workers actually had the highest collective completion rate of all education levels. It is unclear why this is; perhaps these workers had more experience, were such outstanding performers that providers hired them despite not meeting the educational requirement, or worked with families that had characteristics positively associated with program completion. Half of all IFP workers are relatively inexperienced (having fewer than three years). Those with the least experience (<1 year) had a lower client completion rate and those with the most experience (>5 years) had a higher rate, compared to those with 1-5 years of experience. This indicates providers should give special attention and assistance to new IFP workers. IFP providers see a need for additional training of their workers: Nearly three-quarters of the survey respondents indicated it would make a major improvement to the program's effectiveness. Some of the topics in which they would like staff training are evidence-based practices, handling poverty and generational DCF involvement, domestic violence, and substance abuse. A few providers noted having some clinicians as IFP staff would also be helpful to handle domestic violence and substance abuse cases.

The designated IFP program lead, recommended above, should work with providers to develop and provide periodic free training for IFP provider staff, especially those who are new to the program.

b. Understanding why non-completers did not successfully finish the program

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

Data: This data is not collected in the IFP client database.

Story Behind the Baseline: Reasons for non-completion are important to collect because they can indicate areas for program improvement.

Reasons for non-completion should be added to the IFP client data form.

c. Satisfying providers regarding guidance, consistency, and model

A majority of provider respondents was *satisfied* with:

Time the family's DCF workers devote to them while receiving IFP services	92%
Communication between family's DCF and IFP workers	100%
Written program policies	67%
Equity of funding across providers (n=7)	57%
Equity of funding across area offices (n=6)	67%
Number of respondents for each item was between 15 and 18, except where noted.	

Only two of twelve provider survey respondents are satisfied with the current program model.

A majority of provider respondents was *dissatisfied* with:

Feedback on program performance	58%
Training and technical assistance	67%
Adequacy of funding for program services	75%
Adequacy of funding for program administration	57%
Consistency of client level of need across providers	56%
Consistency of program operations across providers	70%
Consistency of program operations across area offices	67%
Number of respondents for each item was between 15 and 18, except where noted.	

Story Behind the Baseline: Overall, survey data indicate provider respondents were satisfied with DCF family workers' roles while IFP clients are receiving services (although one provider was strongly dissatisfied because their clients' DCF workers had played no role), with written policies, and funding equity. Providers who responded to the survey were dissatisfied with guidance and consistency from DCF, funding levels, and the program model. All respondents reported DCF providing training / technical assistance would result in major (75%) or some (25%) improvement to program services.

The designated IFP program lead, recommended above, would work with providers to address their concerns.

d. Satisfying area offices

Data: PRI staff interviews and the survey indicate area offices are satisfied with their IFP providers. *A majority of area offices would like providers to have more staff who speak Spanish and other non-English languages, and about half believe program results would improve if provider staff were made available more frequently in the evenings and on weekends.*

Story Behind the Baseline: As Connecticut becomes increasingly diverse, it is likely the need for bi- and multi-lingual provider staff will grow. Regarding provider staff availability, the contract scope of services states, "The IFP services staff will work a flexible schedule, adhering to the needs of the family. Early evening meetings will be considered routine, not after-hours," but perhaps either "early evening" is

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

not late enough for some families, or providers are not meeting this requirement. Either way, providers need to be able to work with families whose caregiver is employed and/or whose children are in school during weekdays. At the same time, PRI staff recognizes that some providers struggle with staff turnover and have difficulty filling vacant positions.

To ensure services are available when families are, while being considerate of provider staffing concerns, DCF should:

- *Contractually expect provider staff to be available on weekends or evenings for regular family appointments; for instance, perhaps each provider staff member should be required to work one evening or weekend day, each week.*
- *Work with Connecticut colleges and universities to improve the supply of bilingual provider staff; for example, take steps to encourage language majors to double-major in social work / psychology or become social workers, and social worker / psychology majors – as well as current provider staff – to become fluent in an additional language.*

III. Is Anyone Better Off?

The impact of the program is unknown due to a lack of data. DCF should consider whether to adopt a program model that has proven cost-effective.

Performance Measure 9: Children Are Free From Repeat Maltreatment; and

Performance Measure 10: Children Remain In or Successfully Moved Back Into Home

Data: None kept by DCF. These measures are not collected by DCF in the IFP client database, which could capture both measures during program participation, or regularly tracked by DCF beyond program exit, which would involve matching the cases in the IFP client database, with those in the LINK system. In 2007, department staff performed short-term outcome analysis for a very small group of IFP clients (93 families). The usefulness of the results is doubted by PRI staff because: 1) the sample size is very small; 2) the study was conducted more than two years ago, and programs change over time; and 3) the time period under examination was only six months after program intake, which, for program completers, would have been just three months after exit. Keeping those substantial caveats in mind, the rates for both these measures were under 15%.

Trend: None

Story Behind the Baseline: The child welfare literature indicates it is important to track the rate of adverse child welfare events both during program participation and afterward (at least six months post-exit) to evaluate program effectiveness. PRI staff believes repeat maltreatment and reunification/out-of-home placement should be included in the IFP client database. Although the family's IFP worker might not be aware of repeat maltreatment events, the family's DCF social worker should be and share that information at the biweekly case conferences, so it is not unreasonable to expect the family's IFP worker to collect and report that information. Indeed, several providers who responded to the PRI staff survey already keep it.

Child welfare outcomes should be added to the IFP client data form and analyzed by the designated program lead.

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

Performance Measure 11: Family Functioning Has Improved

Data: An adequate tool to collect this data is not used.

Story Behind the Baseline: Since 2006-07, IFP providers have been contractually required to use the Global Appraisal of Individual Needs-Quick (GAIN-Q), a proprietary assessment, to measure caregiver well-being in a variety of domains (including substance abuse, mental health, and other stressors) at the start and end of program services. The assessment results are supposed to guide the development of the family's plan for IFP services. Due to both provider complaints over the instrument's relevance, depth, and overall usefulness, and concern over whether the instrument accurately captures family functioning, the department is considering whether to replace GAIN with a different uniform assessment. A decision will be made within the next few months as the GAIN-Q contract (with Chestnut Health Systems, the instrument's owner) is up for renewal soon; DCF needs to decide whether to renew by spring 2010. DCF has dedicated a portion of a central office staff person's time to evaluating the instrument.

PRI staff's survey of IFP providers found that few providers are satisfied with the GAIN-Q; most believe it does not adequately either measure family functioning or guide the family's IFP service plan. Fewer than half of survey respondents administer the evaluation at the end of program services, and one provider does not use it, at all. There was strong support among survey respondents for replacing the GAIN-Q with another instrument, either NCFAS (used by the Supportive Housing for Families program, with some difficulty) or a tool developed specifically for IFP; one provider favored the Ohio scales, another well-known tool.

Given the lack of provider support for GAIN-Q, as well as the department's concern over whether it is useful, DCF should cut short its evaluation of whether to renew the GAIN-Q contract and instead focus its efforts on selecting and training staff in a new instrument that adequately measures family functioning.

Performance Measure 12: The Service is Cost-Effective

Data: Adequate data to assess this performance measure is unavailable.

Story Behind the Baseline: *The cost-effectiveness of IFP cannot be determined* because three things critical to determining cost-effectiveness are unclear or unknown: 1) per-client cost; 2) the "better off" performance measures; and 3) whether clients would be facing imminent child removal without the program. Adding the "better off" measures (as described above) and an indication of client risk level to the IFP client database, as well as coming to an understanding of the actual per-client cost, would enable at least a basic measure of cost-effectiveness to be calculated.

All but a few of the IFP providers surveyed expressed interest in changing the model of services. Nearly all believed services could be more effective with lower caseloads, and several providers mentioned their desire for services to have a clinical aspect, especially for cases that involve domestic violence and substance abuse. *In a few of the DCF area offices, staff interviewed expressed skepticism over whether IFP really works; they believe, based on their experiences but not on data, that many families who finish IFP eventually are reported to DCF again for alleged abuse or neglect.*

In a recent review of several published intensive family preservation program studies, *the Washington State Institute for Public Policy found that only models that adhere closely to the Homebuilders® model*

Appendix F

RBA Program Performance Profile Intensive Family Preservation (IFP)

are cost-effective, with a return of \$2.54 for every \$1 spent on the program, due to the program's significant effects on repeat maltreatment and out-of-home placement. When Connecticut's IFP program was initially launched more than 15 years ago, it was a Homebuilders® program (information on fidelity to the model was unavailable). DCF noted that IFP moved away from Homebuilders® because it was too expensive to adequately meet client demand. Currently its model does not resemble Homebuilders®, which involves more intensive work with families and worker supervision, as well as a much shorter duration (about four weeks) with booster sessions as needed by the families.

However, Homebuilders® might not actually be more expensive – especially in the long-term – or fall shorter of meeting client demand. A Homebuilders® worker carries a caseload of one to three client families for one month each, for an estimated annual volume of 18-19 clients. A Connecticut IFP worker carries a caseload of five client families for about three months each, for an estimated annual volume of 20 clients. A more recent Washington study that evaluated the cost-effectiveness of various child welfare interventions estimated the Homebuilders® per-client cost to be \$3,484 – much lower than the actual per-client cost of Connecticut's IFP program, \$8,731. When allowing for an equal number of clients to be seen over the year, Homebuilders® is still much less expensive (annually, \$69,680 compared to \$174,620). This is also true when comparing the per-slot cost of Connecticut's IFP program (\$5,441 per-slot, for \$108,827 annually). There may be additional start-up or other costs associated with adopting Homebuilders. It should be noted, as well, that even Homebuilders® yields fewer benefits than two highly cost-effective primary prevention programs, Chicago Child Parent Centers and the Nurse Family Partnership for Low-Income Families (which is the basis for Connecticut's Nurturing Families Network programs).

Given the substantial evidence showing Homebuilders® – but not other, less intensive family preservation programs – to be effective, DCF should consider whether to adopt the Homebuilders® model for its highest-risk families as part of its re-examination of child welfare programs (see “Report Card: Program Area Level” recommendation #2).

Previous family involvement with DCF generally and in IFP specifically should be added to the IFP client data form and analyzed by the designated program lead.

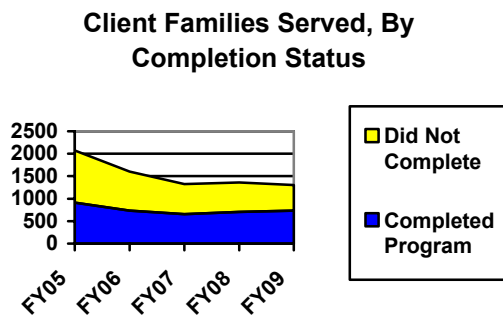
Appendix F RBA Program Performance Profile Parent Aide

<u>Background</u>	
<i>Parent Aide, which provides in-home visits, is the less intensive of the two core child welfare FPS services available to families with open child maltreatment cases.</i>	
Purpose (CW bureau)	Improve parenting and life skills to prevent repeat abuse / neglect
Target Population	Families with an open DCF abuse / neglect case at low to medium risk of out-of-home placement
Services	In-home visits to provide: parent education and skill-building; assistance with basic needs; and links to community services and supports, over two hours each week (minimum), for up to 17 weeks; contracted provider is on-call 24 hours a day
Partners	<ul style="list-style-type: none"> • 24 contracted providers, including two municipalities and three hospitals (two providers work out of two area offices and 22 work out of a single area office) • Other community agencies that provide services through referrals from Parent Aide workers
Upcoming Changes	DCF is working with the contracted providers to redesign and combine Parent Aide and the smaller Parent Education and Assessment Services (given to families with DCF open cases whose children are young and at less risk for out-of-home placement) into a new parenting improvement program, Family Enrichment Services (FES). Currently implementation of the new program is set to begin January 2010.

I. How Much Did We Do?

Parent Aide's client data indicate fewer clients have been served recently, compared to FY 05, but it is unclear why. A variety of program, client demand, and data reporting reasons could be contributing – in whole or part – to the decline.

Performance Measure 1: Clients Served (reported)



Source of data: DCF

Trend: Total number reported served dropped from FY 05 to FY 07 and stable since

Clients are referred to Parent Aide by the family's DCF social worker. Providers reported that 1,306 DCF families began participation in Parent Aide in FY 09. Of these, about 56% completed the program. The completion rate has steadily increased since FY 05, when it was 44%. At the same time, since FY 07 the program has been seeing far fewer families. It should be noted that DCF funded between 1,991 (DCF-reported) and 2,566 (PRI staff count of total slot capacity in provider contracts) Parent Aide client slots in FY 09.

The FY 09 Parent Aide data cover 51-66% of those amounts, respectively.

Appendix F RBA Program Performance Profile Parent Aide

Story Behind the Baseline: DCF staff believes the data show some providers are serving fewer clients than contracted for two reasons: 1) their impression that the duration of services has extended beyond the four months set out in the contracts; and 2) incomplete provider reporting. The thirteen providers who shared data through the PRI staff survey indicated they submit complete data to the department. Five noted they serve fewer clients than contracted, and for a range of reasons that included not enough referrals from DCF (two providers), long duration of services, and a change in the local area office policy about who is eligible for Parent Aide. *Comparison of DCF's client data to the contracted slot amounts indicates all but two providers reported serving substantially fewer clients than they were contracted to serve.*

It is possible the DCF data are not accurate, as the client data shared by providers with PRI staff differed from DCF's data – and not in a consistent manner. Five of the eight providers who gave FY 09 data reported serving more clients than recorded by DCF, while the other three reported serving fewer than recorded.

DCF is planning to overhaul its data collection tool when its redesigned program, Family Enrichment Services, joins the new data system, PSDCRS, which is scheduled to be July 2010. Until then, DCF indicated the current data collection tool will continue to be used. PRI staff believes the tool should be immediately replaced because: 1) most of the data supplied are not actually kept by DCF; and 2) there are serious concerns that the data it is collecting are not useful.

DCF has not analyzed the Parent Aide data in several years. As with other child welfare programs such as IFP, the department has not dedicated resources to periodic analysis, even of the numbers of clients served. DCF area office staff and providers are not given access to the data so they cannot check the accuracy. To improve data quality so that the information may be used for program management and improvement, DCF should:

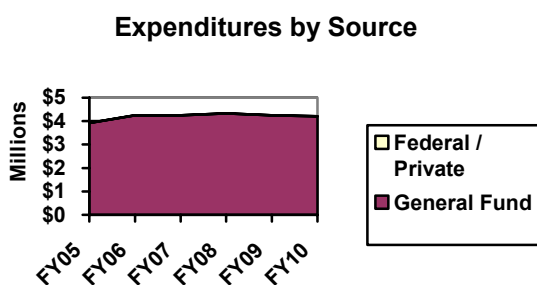
- *Allow providers and area offices to view their respective data so: 1) providers may correct data as necessary; and 2) area offices can monitor whether providers are serving their amounts of contracted capacity (client families), and if not, understand why*
- *Dedicate a program lead (who could be the lead for several programs) to, every six months, analyze the client data, among other activities (described below)*

To improve the accuracy of provider reporting, DCF should:

- *Immediately replace the current data collection form with a simple monthly report from each provider, until FES data can be submitted using PSDCRS.*

For example, a provider could be asked to report: how many clients started the program, how many completed, and of completers, the number of cases that had repeat maltreatment and (separately) out-of-home placement during program participation.

Performance Measure 2: Expenditures



Source of data: DCF

Trend: Initial small increase, then flat (neutral)

The projected expenditures for FY 10 are \$4,211,987. Expenditures grew more than 8% in FY 06, from about \$3.9 million to \$4.2 million, but since then have held steady, with no changes greater than 2%. The General Fund covers all Parent Aide costs. (Note: The FY 10 amount was projected by DCF in August 2009.)

Appendix F RBA Program Performance Profile Parent Aide

Story Behind the Baseline: DCF has not submitted any recent requests to change Parent Aide funding. PRI staff heard in interviews with Parent Aide providers that the department wanted to eliminate the program about 5-6 years ago but the legislature prevented that move, due in part to vocal advocacy from the providers.

II. How Well Did We Do It?

Client demand is met reasonably quickly in nearly all area offices. The program's reported completion rate has improved, but it appears the program's DCF client data might not be accurate. Data are not collected regarding program standards. Providers would like training to be made available to their Parent Aide workers, while area offices would like more Spanish-speaking provider staff, and greater provider staff availability on evenings and weekends. A few area offices also would like services to focus more on improving parenting skills.

Performance Measure 3: Meeting Client Demand

a. Frequency of Waitlist for Parent Aide

	<i>Area Offices*</i>
Always	(None)
Most of the time	Norwich
Sometimes	Bridgeport Hartford New Haven Willimantic
Rarely	Danbury Manchester Meriden Middletown Milford Norwalk-Stamford Torrington Waterbury

Source: PRI staff interviews and web survey
*No information was provided by New Britain.

b. Average Length of Waitlist

	<i>Area Offices*</i>
3-6 days	(None)
1-2 weeks	Danbury Meriden Hartford New Haven Willimantic
3-4 weeks	Milford
1-2 months	Norwich
Not applicable: rarely is a waitlist	Manchester Middletown Norwalk-Stamford Torrington
Unknown (new staff liaison)	Waterbury
Varies: 2 out of 3 programs serve distinct populations	Bridgeport

Source: PRI staff interviews and web survey
*No information was provided by New Britain.

Trend: Unknown

Story Behind the Baseline: Generally, *client demand for the Parent Aide program is met*. Nearly all of the 13 offices from whom information was received reported having a waitlist only sometimes or rarely. When a waitlist is kept, it only takes 1-2 weeks to get access to services, in most offices. *A single office – Norwich – reported consistently having a waitlist, with a wait that extended one to two months.*

When better-quality provider data have been collected, to better meet area office demand, DCF should:
 ➤ *Examine the numbers of clients served and area office waitlists to shift capacity so demand is better met in the area office(s) whose clients persistently have long waits for Parent Aide services*

DCF should also *include on the FES PSDCRS client data form: time spent on the waitlist.*

Appendix F RBA Program Performance Profile Parent Aide

A few area offices reported they sometimes refer Parent Aide clients to Intensive Family Preservation because they were more confident of the services provided in IFP. PRI staff heard in several interviews that the programs in some areas are well-respected, while others are not. This indicates the waitlist data from area offices might not be indicative of the true demand for a robust, parenting skills-focused Parent Aide program.

Performance Measure 4: Completing the Program

Data: About 56% of reported FY 09 program participants completed the program. The completion rate has steadily increased since FY 05, when it was 44%. See the graph in “Performance Measure 1: Clients Served” above.

Trend: Better

Story Behind the Baseline: Looking at Performance Measures 1, 2, and 4 together, *over the past three years, the program appears to have served fewer client families and improved the completion rate, with level funding. However, it is unclear whether the data are accurate*, as described in the “Story Behind the Baseline” under Performance Measure 1.

Performance Measure 5: Meeting Program Standards

a. Receiving 2 hours of services weekly; and b. Finished in 17 weeks (4 months)

Data: Not kept by DCF; the client information form providers submit appears to collect this information

Story Behind the Baseline: DCF believes it is important that the 2 hours of services per week be provided to families, but that families may need longer than 17 weeks to complete the program. The PRI staff survey of providers and area offices indicate that *while a majority of each group’s respondents holds the program standards as their expectations, some have higher expectations regarding both intensity and duration*. Two provider (n=13) and two area office (n=7) respondents expected services to last 6-7 months, and two additional provider respondents expected duration to exceed 8 months. Duration that exceeds the program standard negatively impacts the number of client families that can be seen, but with one area office exception, provider capacity does not appear to be substantially lower than demand. PRI staff heard from providers that the current contractual duration likely is insufficient for some families, and that the expected duration and intensity of the program was longer several years ago. These same providers believed the program was, at that time, more effective.

As part of the merging of Parent Aide and PEAS into Family Enrichment Services, DCF has aimed to standardize program expectations and services.

To measure and ensure ongoing compliance with the program standards, DCF should *include on the FES PSDCRS client data form: program standards items (hours of weekly services and length of program participation)*.

The designated program lead, recommended above, should also work with providers and area offices to improve model adherence so that client families meet the key standard of receiving at least two hours of services weekly.

Appendix F RBA Program Performance Profile Parent Aide

Performance Measure 6: Satisfying Clients

Data: This measure is not collected by DCF. However, all Parent Aide providers who responded to the PRI staff survey, reported surveying their clients for satisfaction and analyzing the results.

Story Behind the Baseline: Many DCF staff interviewed were dubious about the value of administering a customer satisfaction survey. The range of reasons included doubt that: the client would provide anything but positive feedback given that DCF has the power of child removal; the providers would agree to ask uniform questions on their client satisfaction surveys; and the responses would be fully representative of the range of client experiences. Collecting and using client satisfaction data, however, is considered a contracting best practice, and all providers who reported to the survey do it, anyway.

To move toward contracting best practices, DCF should include on the FES PSDCRS client data form: client satisfaction.

These items should be simple; for example: “How satisfied were you with the Parent Aide services you received?” and “How satisfied were you with your Parent Aide worker’s sensitivity to your culture and traditions?” (since cultural competence is a focus of DCF). This information will help DCF better monitor whether Parent Aide and its providers are meeting clients’ needs.

Performance Measure 7: Managing Cost Per-Client

Per-Client Costs Across Providers, Using IFP Database for Client Count					
	<i>FY 05</i>	<i>FY 06</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
Average	\$2,274	\$3,155	\$4,116	\$3,966	\$3,751
Median	\$ 2,025	\$2,971	\$3,040	\$3,276	\$3,831
Max	\$4,403	\$9,608	\$8,964	\$13,508	\$7,717
Min	\$789	\$909	\$1,039	\$1,367	\$1,526

All amounts presented in FY 09 dollars (adjusted for inflation using the US DOL Bureau of Labor Statistics’ online CPI tool)
Source: PRI staff analysis of provider expenditures and Parent Aide client data from DCF

FY 09 Per-Slot Costs Across Providers*	
Average	\$1,700
Median	\$1,649
Max	\$2,876
Min	\$396
Source: PRI staff analysis of	

Note: Dividing DCF’s total expenditure on providers by total slots, the average per-slot cost was \$1,658.

Trends: Per-client costs appear to have increased in FY 09 compared to FY 05 in each way measured in the table above; the median and minimum have steadily increased.

Story Behind the Baseline: *DCF does not examine per-client or per-slot costs for Parent Aide.* The department expressed doubt whether either measure is useful, for a variety of reasons – particularly that contracts are handled aggregately for each provider so the per-client or per-slot cost for any specific

Appendix F RBA Program Performance Profile Parent Aide

program may not reflect actual expenses. The department’s provider budgeting for Parent Aide is based on the provider’s historical Parent Aide spending, not on a per-slot amount. These results should also be interpreted with extreme caution because it is possible DCF’s Parent Aide client data do not accurately reflect the number of client families actually served. Yet, it is clear that, no matter the reasons or calculation methods, *per-client costs vary among providers*.

To ensure that per-client costs are reasonable, DCF should:

- **Examine variations in per-client costs, to determine whether there are legitimate reasons for substantial variations from the median cost, and if there are none, financially penalize those providers.**

This recommendation aims to: 1) encourage providers to accurately report data, and DCF to make sure providers can correct their data when necessary; and 2) ensure per-client costs are reasonable while adequately accounting for special circumstances that might result in higher costs.

Despite these concerns, overall it seems unlikely most providers are over-charging to maintain the contracted level of Parent Aide capacity. Many providers – as well as some DCF employees – are concerned the program funding level does not allow them to attract and retain adequately skilled staff, as described in Performance Measure c below. A review of contract data showed a few providers seek and use non-DCF funding to support their Parent Aide programs, which allows them to have higher-cost programs. PRI staff heard that one provider uses trained volunteers in combination with masters-level supervisors, which may be a staffing model that other providers and DCF may wish to explore further.

Performance Measure 8: Managing Provider Performance Using Data

Client Completion Rates by Provider, FY 05 – FY 09					
	<i>FY 05</i>	<i>FY 06</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
Average	45%	45%	48%	55%	58%
Median	45%	45%	47%	56%	57%
Max	89%	77%	82%	100%	82%
Min	7%	12%	19%	22%	23%
Source: PRI staff analysis of DCF Parent Aide data					

Trend: Increasing average, median, and minimum provider completion rates

Story Behind the Baseline: The reported client completion rates vary across providers. Completion rates over two of the last three FYs (FY 07 – FY 09) were significantly better for three providers, and significantly worse for two, according to PRI staff correlation analysis (Chi-square statistic). Time was insufficient to explore why the completion rates varied. It should be noted that a few of the providers who shared aggregate client data through the PRI staff survey reported higher completion rates than shown by the data, which could mean the client database does not provide an adequate picture. This is possibly due to variation in *who* was reported, and *how* they were reported. A few providers noted that, unlike the client data form, they did not consider program exit reasons such as out-of-home placement to be “non-completers” or “unsuccessful exits.” Given those responses, PRI staff encourages DCF to clarify client data definitions and expectations.

The designated program lead, recommended above, should conduct analysis of the Parent Aide/FES

client data and, as necessary, work with providers to improve client completion rates, particularly after data definitions are clarified.

To make the data more useful (e.g., account for case mix when examining provider completion rates, understand for whom the program is working well or not), DCF should include on the FES PSDCRS client data form: client family characteristics, previous family DCF and/or Parent Aide involvement, and Structured Decision Making risk rating of client families. (SDM is the tool DCF social workers are to use to inform their child placement and family contracted services decisions.)

The data could be used to pinpoint high-performing providers, so their practices could be shared with the others, and low-performing providers, so they could receive improvement assistance.

ADDITIONAL PERFORMANCE MEASURES

a. Having well-prepared Parent Aide provider staff

Data: Not collected by DCF

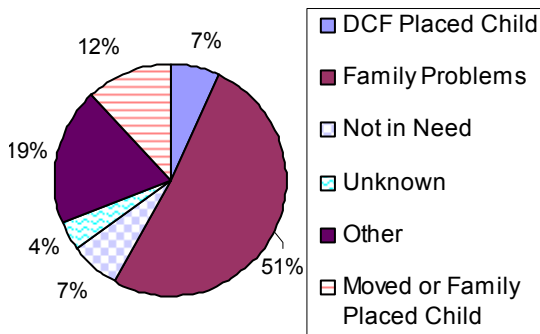
Story Behind the Baseline: The provider contract Scope of Services requires each Parent Aide worker to have a minimum of a high school diploma or its equivalent. *Because DCF does not collect that information, it is impossible to tell whether the requirement is being met.* The survey respondents were split over whether requiring a Bachelor’s degree would improve the program, but a strong majority (12 of 14) responded that more training would result in improvement. (At least a few provider organizations require staff to have a Bachelor’s degree, according to the PRI staff survey.) A few area offices with whom PRI staff met expressed their belief that Parent Aide staff would benefit from training because they seemed to need substantial guidance on what types of assistance should be delivered to families.

DCF is planning to conduct periodic free training for provider staff as part of the new program, FES.

b. Understanding why non-completers did not successfully finish the program

Non-Completion Reasons Given by Providers

Trend: Stable FY 05 - FY 09



Source of data: DCF

Story Behind the Baseline: *Difficulties working with families accounted for about half of non-completions*, and included: “family failed to engage,” “family not available for services,” “family terminated services,” and “potential for violence too high to continue service.” “Other” and “unknown” together account for nearly one-quarter of non-completions. Although not fully analyzed due to time constraints, PRI staff review of the provider- level non-completion data showed substantial differences in the proportion of each reason, across providers. PRI staff believes

these data are a matter of concern and merit examination by DCF to understand how programs can better work with families, especially at the initiation of services; similar data should be collected for FES.

Appendix F
RBA Program Performance Profile
Parent Aide

c. Satisfying providers regarding guidance, consistency, and model

A majority of provider respondents to the PRI staff survey was *satisfied* with:

Time the family’s DCF workers devote to them while receiving IFP services	82%
Communication between family’s DCF and IFP workers	94%
Feedback on program performance	69%
Written program policies	59%
Number of respondents for each item was between 15 and 18.	

A majority of provider respondents to the PRI staff survey was *dissatisfied* with:

Training and technical assistance	65%
Adequacy of funding for program services	76%
Adequacy of funding for program administration	75%
Equity of funding across providers	60%
Number of respondents for each item was between 15 and 18.	

The respondents were about evenly split between satisfied and dissatisfied regarding equity of funding across area offices and consistency of: program operations across providers, client level of need across providers, and program operations across area offices.

Provider satisfaction with the model was not measured through the PRI staff survey because the program is in transition.

Story Behind the Baseline: Survey data indicate provider respondents were satisfied with DCF family workers’ roles while Parent Aide clients are receiving services, written program policies, and feedback on program performance. (One provider noted that DCF had given substantial feedback and clarity this fall, as the program transitioned to FES.) On the other hand, provider respondents were dissatisfied with the level of training and technical assistance (reported as the top priority among several options by providers, on a separate question), funding adequacy, and funding equity across providers and area offices. Respondents were about split on the three questions regarding the consistency of the program.

PRI staff heard from provider staff that DCF used to offer substantially more guidance to providers, which was helpful, but that stopped when DCF transitioned to the area office model several years ago.

The designated Parent Aide program lead, recommended above, should work with providers to address their concerns.

d. Satisfying area offices

Data: PRI staff interviews and the survey data indicate area offices are satisfied with their Parent Aide providers, although in interviews, a few discussed having problems in the past with program quality. ***About half the area offices would like providers to have more staff who speak Spanish and other non-English languages, and about half believe program results would improve if provider staff were made available more frequently in the evenings and on weekends.*** A few of the area offices each had other recommendations, including improved staff engagement of clients, improved staff focus on helping clients learn skills – which is supposed to be the focus of the program – and use of an evidence-based model.

Story Behind the Baseline: As Connecticut becomes increasingly diverse, it is likely the need for bi- and multi-lingual provider staff will grow. Regarding provider staff availability, the contract scope of

Appendix F RBA Program Performance Profile Parent Aide

services states, “The Contractor will assure that parent aides will work a flexible schedule, to include evening and weekend hours as identified below. Early evening meetings will be considered routine, not after-hours.” A review of the Parent Aide contracts indicates some providers do not list hours beyond 6 PM or include weekends. Providers need to be able to work with families whose caregiver is employed and/or whose children are in school during weekdays. At the same time, PRI staff recognizes that some providers struggle with staff turnover and have difficulty filling vacant positions.

To ensure services are available when families are, while considering provider staffing concerns, DCF should:

- *Expect provider staff to be available on weekends or evenings for regular family appointments – for instance, perhaps each provider staff member should be required to work one evening or weekend day, each week – and add such language to contracts where it does not exist*
- *Encourage providers to actively recruit from communities and work with Connecticut colleges and universities to improve the supply of bilingual provider staff*

PRI staff believes the new standardized program intake (assessment) and service plan documents developed by DCF and the providers who are assisting in the program redesign are good steps toward focusing services on improving parenting and family functioning.

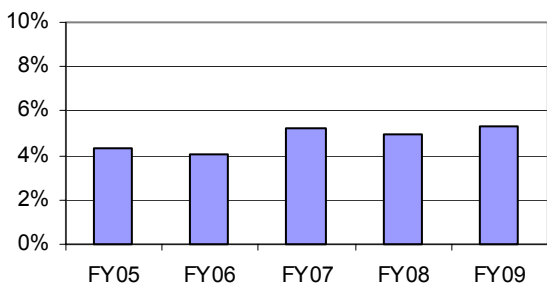
To further ensure providers are focusing on improving caregivers’ parenting skills, DCF should:

- *Devote most staff training sessions to teaching the providers’ staffs how to improve parenting skills*
- *Consistently convey that program focus to providers during the monthly meetings between providers and area office staff*

III. Is Anyone Better Off?

Performance Measure 9: Children Are Free From Repeat Maltreatment

Substantiated Repeat Maltreatment While Participating in Parent Aide



Trend: Generally stable – about 5% repeat maltreatment – after a small increase in FY 07 (neutral)

In FY 09, 5.3% of families reported to be receiving Parent Aide services had substantiated repeat maltreatment (69 of 1,306 families). The repeat maltreatment rate has hovered around 5% for the last three FYs.

Source of data: DCF

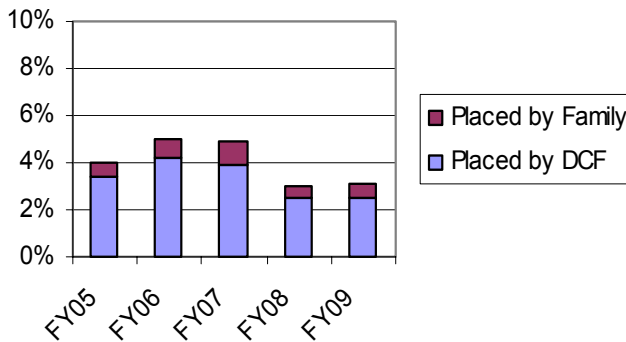
Story Behind the Baseline: DCF had no comment on the data due to its concern regarding the data quality. Its concern may be well-founded: *Provider respondents to the PRI staff survey reported different rates of repeat maltreatment than were indicated by DCF’s data.* Nonetheless, PRI staff analysis of the DCF data by provider showed a few providers each had significantly worse or better

Appendix F RBA Program Performance Profile Parent Aide

performance for two of the last three FYs. DCF does not track child welfare client outcomes, by program, on repeat maltreatment or out-of-home placement after the specific program services have ended.

Performance Measure 10: Children Remain At Home

Child Out-of-Home Placement While Participating in Parent Aide



Trend: Lower in last two years (better)

Of reported Parent Aide client families in FY 08 and FY 09, 2.5% had children placed out-of-home while receiving program services; another 0.5% voluntarily placed their children out-of-home. These rates are somewhat lower than in FY 05 – FY 07.

Source of data: DCF

Story Behind the Baseline: DCF had no comment on the data due to its concern regarding the data quality. As in Performance Measure 9, the department’s concern may be well-founded: *Provider respondents to the PRI staff survey reported different rates of out-of-home placement than were indicated by DCF’s data, in a few cases.* PRI staff analysis showed that no provider had significantly different performance for two of the last three FYs. As noted above, DCF does not track child welfare client outcomes, by program, on repeat maltreatment or out-of-home placement after the specific program services have ended.

DCF is planning to include repeat maltreatment and out-of-home placement measures in the FES client data collection through PSDCRS.

Performance Measure 11: Family Functioning Has Improved

Data: Not collected because the Parent Aide program does not use a family or head-of-household assessment that is standardized across providers.

Story Behind the Baseline: The new FES program will include a way to measure family progress made during and over the course of program participation. The earlier, tentative plan was to formulate a standardized assessment of family functioning, drawing on components of existing assessments. After further discussions between DCF and providers, it was decided the Parent Aide worker would: 1) comprehensively assess the family at intake, using a standardized form; 2) with the family, develop a service plan using a standardized form; and 3) assess both overall family progress using a uniform scale, and progress toward each of the family’s goals, monthly and at program exit.

PRI staff recommends that DCF to adjust the:

- *program exit form so progress may be analyzed for each service area indicated necessary on the service plan.* This change will enable PSDCRS analysis by service area so that DCF,

Appendix F
RBA Program Performance Profile
Parent Aide

providers, and area office staff can track whether progress is more or less likely by each area, thereby indicating areas of program strength and challenge.

- ***service plan so each goal is directly connected to a service area, and all service areas are addressed by a goal.*** This alteration will make clear how needs are connected to goals and tasks, and that each need must be addressed by the plan.

PRI staff also proposes that DCF collect a very brief evaluation of progress made by service area from each DCF family social worker at the end of the family's participation in FES. The DCF social worker's assessments, when aggregated, will provide ground-level information regarding program strengths and challenges.

The designated program lead, recommended above, should conduct analysis of the Parent Aide/FES client data, including child welfare outcomes and family progress made during program participation, and, as necessary, work with providers to improve performance.

Appendix F
RBA Program Performance Profile

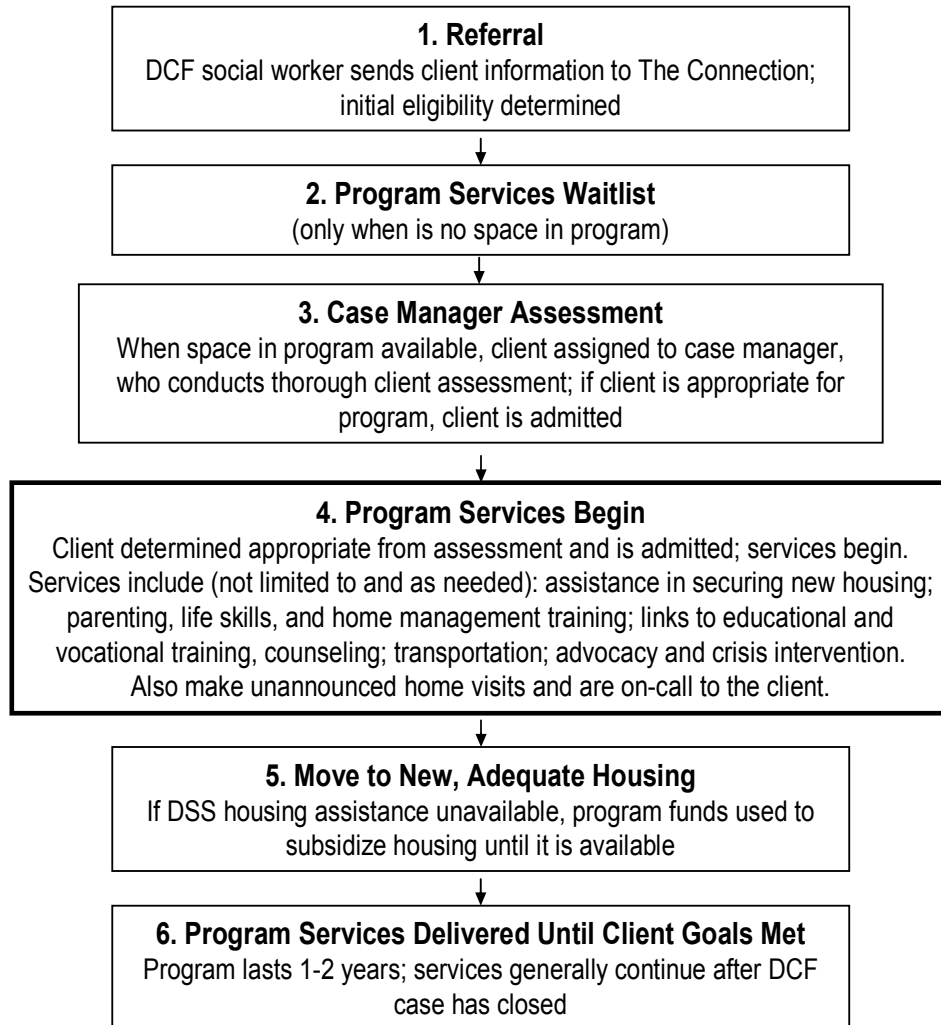
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Appendix F
RBA Program Performance Profile
Supportive Housing for Families (SHF)

<u>Background</u>	
<i>SHF helps families acquire adequate housing and case management; recently it has focused on families needing reunification.</i>	
<i>Purpose (BH bureau)</i>	Help families acquire permanent, adequate housing by guiding them through the process and provide case management services for family preservation and reunification
<i>Target Population</i>	Families with an open DCF abuse / neglect case either at risk of out-of-home placement due to housing or experiencing housing barrier to reunification
<i>Services</i>	<p>Throughout program participation, meet with client family's head of household at least once a week, for a minimum of one hour, to provide:</p> <ul style="list-style-type: none"> • household management and parenting education; • links to community services; • links to education and employment resources; and • crisis intervention. <p>For housing aspect of program, provide guidance with housing search and through DSS housing voucher (Section 8 voucher or Rental Assistance Program certificate) process, and access to program housing stipend if suitable new housing is found before DSS voucher is obtained. Services can last up to two years from program entrance (even after DCF case has closed), with the family's SHF worker on-call 24 hours a day.</p>
<i>Partners</i>	<ul style="list-style-type: none"> • One contracted provider and its 8 sub-contractors • Clients' pre-SHF providers of services (e.g., substance abuse, mental health) • Community agencies that provide services through referrals from SHF workers • A team of University of Connecticut (UConn) faculty and graduate students on contract with the provider to conduct evaluations of SHF; FY 09 cost of \$38,937.
<i>Recent and Anticipated Changes</i>	<p>Budget constraints that had led the program to close its waitlist in spring 2009 were lifted when the budget that passed this fall took about \$2.21 million in FY 10 and an additional \$2.46 million in FY 11 (accounting for the governor's recent rescissions) from the DCF Board and Care (i.e., foster care) account and allocated it as additional SHF funding. Consequently, the program was able to take in clients from the waitlist. The budget act shifted the program's client mix, as it required SHF to give priority to reunification cases (i.e., families whose children have been placed out-of-home and primarily have a housing barrier to reunification).</p> <p>With the new funding, the program has focused its efforts on serving new (and continuing) clients. The program's DCF and provider managers still anticipate a major program change: to vary program services based on client circumstances. They are piloting a draft assessment that could help determine what level and types of services the client needs most, and hope to move to a tiered model in FY 10.</p> <p>The program relies on a supply of DSS housing vouchers to provide clients with permanent housing. When the supply of DSS vouchers is severely limited (as program managers report has been the case recently, even with the additional SHF funding), clients with new housing rely on SHF housing subsidies, which come from program funds. Consequently, SHF has less money available to deliver program services and so needs to either serve far fewer people, or develop less costly ways to provide services.</p>

Appendix F

RBA Program Performance Profile
Supportive Housing for Families (SHF)
SHF Service Delivery Process



Appendix F

RBA Program Performance Profile

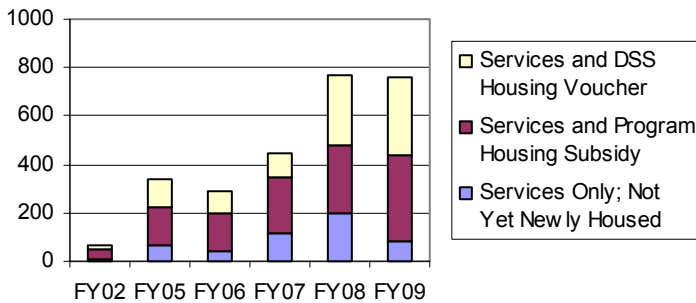
Supportive Housing for Families (SHF)

I. How Much Did We Do?

The number of families served is increasing; it is highly dependent on the levels of DCF program funding received and DSS housing assistance available. Recently about one-quarter of the program funding goes toward client direct financial assistance, including program housing subsidies in the absence of DSS housing assistance. A very small portion of DSS housing assistance – which is in high demand – is devoted to SHF clients.

Performance Measure 1: Clients Served

**Client Families Being Served at End of FY,
by Stage in SHF Program**



Source of Data: DCF

larger since FY 02 (69 clients being served), the first year for which data was available. In FY 07 and FY 08, the client count grew by 52% and 72%, respectively, and leveled off in FY 09.

It is important to note that clients receive services for more than one year, so the same client families will be included across the annual counts (point-in-time or cumulative) of families being served. The program managers reported that 1,664 client families had been served (either completed the program, or did not) since the program's inception (September 1998 through August 2009).

Story Behind the Baseline: Program staff note that the number of new clients (those most likely to be just receiving services – not yet newly housed) that can be served changes with how much SHF program funding and DSS housing funding is received. (See “Background” on previous page for more information.)

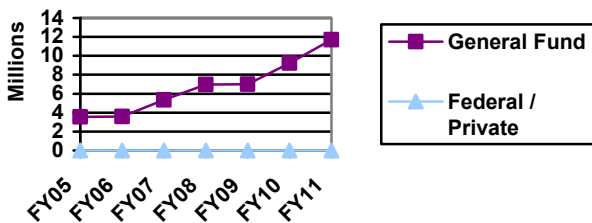
Trend: Number of families served is increasing

At the end of FY 09, 760 families were being served in SHF. Of these, about 89% had recently received stable housing through the program, while only 11% (a 5-year low) were just receiving services (i.e., had not yet been newly housed).

The number of clients being served at the end of the fiscal year has grown unevenly in recent years. The program has clearly grown much

Performance Measure 2: Expenditures – SHF Program Services

Expenditures by Source



Source of data: DCF

after the governor took back 5% as part of the November 2009 rescissions. This two-thirds increase

Trend: Increasing (neutral)

Program services expenditures grew by 26-50% in FYs 07, 08, 10, and 11. There has been no federal or private funding of this part of SHF.

Story Behind the Baseline: The legislature substantially increased SHF funding for FY 10 (32% increase from previous FY) and FY 11 (27% increase from FY 10), for a total program budget of more than \$11.68 million in FY 11,

Appendix F

RBA Program Performance Profile

Supportive Housing for Families (SHF)

(from FY 09) in the program budget came with language directing SHF to prioritize families awaiting reunification and report to the legislature on January 1, 2010 regarding who had been served with the additional funding.

Performance Measure 2a: Expenditures – SHF Program by Type

SHF Expenditures: Percent of Total Expenditures Spent on Each Type					
	<i>FY 05</i>	<i>FY 06</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
Client Financial Assistance (including program housing subsidy; not including DSS housing assistance)	13%	18%	29%	32%	26%
The Connection, Inc. only					
Staff (salaries and fringe benefits)	31%	32%	28%	31%	34%
Staff Training	3%	1%	1%	1%	1%
Supplies, Equipment, Rent, Etc.	14%	9%	11%	8%	9%
Corporate Office Allocation	11%	11%	11%	11%	11%
Sub-Contractors (eight)	29%	29%	21%	18%	19%
<i>Total</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>

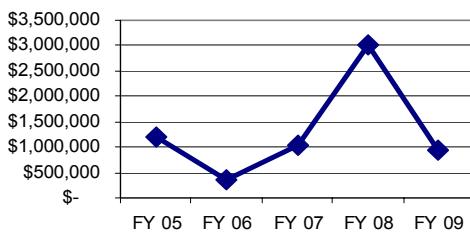
Source of data: DCF

Trends: Increase in client financial assistance, decline in sub-contractor expenditures

Story Behind the Baseline: DCF and The Connection, Inc. believe a greater share of expenditures lately has been devoted to client financial assistance for three reasons. First, the program’s client expansion directly results in more client assistance, while staff expenditures increase less since each staff member carries a caseload of several families. Second, as clients are taken into the program, many first receive the program housing subsidy, which is costly. Third, security deposits, rents, and utilities costs may have increased.

Performance Measure 2b: Expenditures – DSS Housing Assistance

Annual New Cost of New DSS Housing Assistance to SHF Clients



Percent of All DSS Vouchers and Certificates Held Devoted to SHF, According to DSS

<i>FY 05</i>	<i>FY 06</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
0.4%	0.5%	0.6%	0.9%	0.8%

Source of data: DSS for annual cost of vouchers and certificates, as well as total numbers of households receiving assistance and number of vouchers designated for SHF clients

Trends: New cost has been uneven but generally around \$1 million; percent of DSS vouchers and certificates dedicated to SHF families has increased over time but remains quite small (<1%)

Story Behind the Baseline: SHF program clients receive DSS Section 8 vouchers or state Rental Assistance Program (RAP) certificates as permanent housing subsidies. *A very small percent – not quite 1% recently – of DSS housing assistance is used by SHF clients.*

In years when Section 8 vouchers or RAP certificates are not available – either because additional funding

Appendix F

RBA Program Performance Profile Supportive Housing for Families (SHF)

has not been received by DSS for these programs, or recipients are not giving up their vouchers due to steady (but not self-sustaining) employment and no program violations – then SHF program funds are used to subsidize the clients’ housing, until DSS assistance is available. This means that, *in order to keep taking in and serving new clients, the current program model depends on either: 1) new or turned-over DSS assistance; or 2) annually increasing program funding so SHF may subsidize the rent of the new housing, in the absence of DSS assistance.* DCF and provider staff indicated having a consistent supply of DSS vouchers would be their preferred way to give the program stability.

DCF reported that 1,064 client families received DSS housing assistance from FYs 00-09. That number likely includes assistance that was “recycled” (i.e., a voucher or certificate had been used and then turned in by an SHF family who had lost eligibility or need, and then given to new SHF families). The turnover of vouchers explains why DSS reported that 805 units of housing assistance were used by SHF families in FYs 08 and 09. (The number of new DSS housing assistance units dedicated to SHF is smaller than the number of SHF families who newly received that assistance, indicating at least some turned-in assistance is returning to the SHF families.)

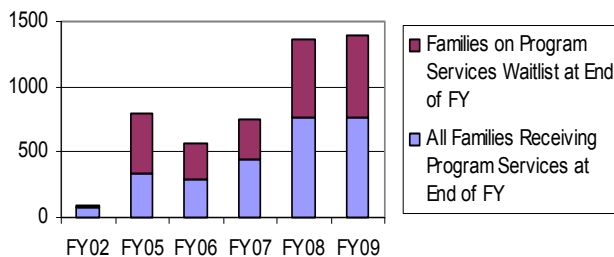
Provider staff and DCF would like to have a consistent supply of DSS housing assistance in order to have consistent client caseloads and be able to plan expenditures reliably. DSS and OPM determine the amount of housing assistance that will be made available to SHF; it varies annually. DCF believes that in the early days of the program, the housing assistance available was more consistent, possibly because in that department’s opinion, DSS felt greater co-ownership of the program. DSS staff, however, notes that housing assistance is in very high demand, with waitlists longer than a year, and questions whether it is fair to make some clients wait a long time, and others very little. Section 8 resources are a function of turned-in vouchers and new federal assistance, while the supply of new RAP certificates is a function of turned-in certificates (including any DSS-OPM agreements regarding the number of turned-in certificates that are to be used for SHF) and new state assistance.

II. How Well Did We Do It?

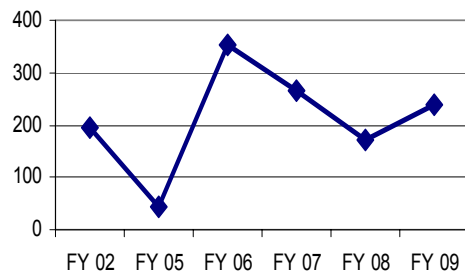
The program cannot quickly meet client demand; it consistently has a lengthy waitlist. The completion rate has been about 80% for clients accepted into the program. About 20% of referred families who are still eligible for the program when they can move off the waitlist, are not accepted into the program because they fail the intake assessment. On average, the program meets its standard of one hour of services weekly, and clients are in the program for a year or more. Clients and area offices appear to be satisfied with the program. The discharge reasons need to be simplified. The estimated per-client cost of program services (only, but including the program’s housing subsidy) has recently declined to about \$9,000 annually.

Performance Measure 3: Meeting Client Demand

Number of Families on SHF Program Waitlist Compared to Families Receiving SHF Services, At End of FY



Average Time to Move off Program Waitlist, in Days, for Families Who Moved Off Waitlist in the Given FY



Source of data: DCF

Appendix F

RBA Program Performance Profile

Supportive Housing for Families (SHF)

Trend: Fluctuating but consistently not meeting demand (worse); wait to enter the program has been longer than five months since FY 06

Since at least FY 05, SHF consistently has had a long waitlist at the end of each FY. The length recently has ranged from a low of 274 families in FY 06 to a high of 632 in FY 09 – even though the program stopped accepting names for the waitlist three months before the end of the FY. As the graph on the left shows, in several FYs, the number of families on the waitlist approaches the number of families who received services that year.

Story Behind the Baseline: The ability to meet demand for the program depends on two types of funding, as described above: 1) SHF program funding from DCF; and 2) Section 8 and RAP voucher spaces made available to SHF by DSS, which is determined by Section 8 and RAP voucher funding received by DSS. PRI staff believes it would be helpful to know whether client families on the waitlist are experiencing negative events, such as out-of-home placement, repeat maltreatment, or caregiver arrest. If negative events while on the waitlist are prevalent, then the program should consider finding a way to offer some services to clients quickly, and/or request additional resources.

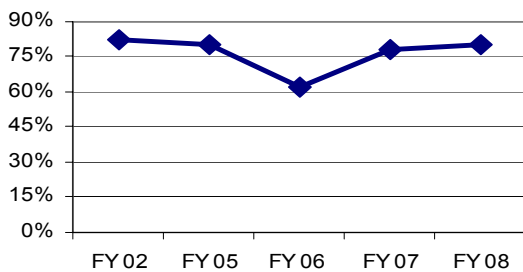
To determine whether time on the waitlist is detrimental to families, DCF should:

- *Track negative events experienced by families on the program waitlist*

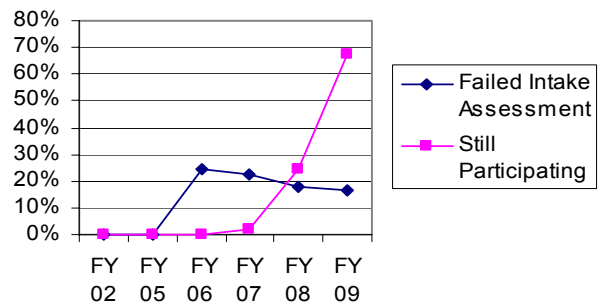
Program staff should learn of these events when it is the family’s turn to move off the waitlist and into the program.

Performance Measure 4: Completing the Program

Program Completion Rate by FY of Program Entry (simplified)



Percent of FY Entry Cohort With Status Other Than Successful or Unsuccessful Completion



The chart on the left includes only participants with PRI-determined discharge status of “successful” or “unsuccessful,” as the program’s data system appeared to misclassify some reasons for completion that should have been designated as “unsuccessful.” It does not include clients who failed the intake assessment or are still participating; those clients are represented in the chart on the right.

Source of data: DCF

Trend: No steady trend for completion rate, though rebounded recently to previous level after dip for the FY 06 cohort; percent of cohort failing the intake assessment is declining

Story Behind the Baseline: The program completion rate dipped in FY 06; neither DCF nor the provider

Appendix F

RBA Program Performance Profile

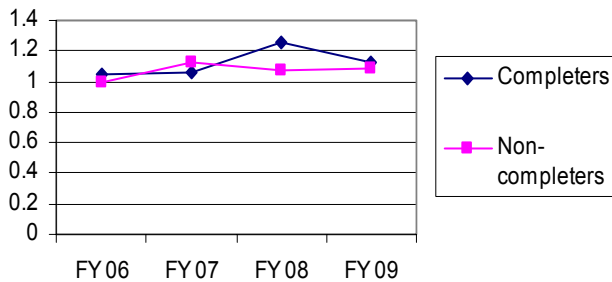
Supportive Housing for Families (SHF)

understood why. It may be an aberration due to the low number of clients taken into the program that year. A substantial but declining portion of potential clients fails the intake assessment (i.e., is never fully entered into the program because the family’s case worker judges them not ready). In addition to the data shown in the graphs above, a small percent (1-3%) of clients exits the program due to administrative discharge.

Performance Measure 5: Meeting Program Standards

a. Receiving 1 hour of services weekly

Average Time Spent Meeting Weekly In-Home (in hours)



Source of data: DCF

Trend: Both completers (i.e., successful clients) and non-completers (i.e., unsuccessful clients) met the standard; completers’ time increased since FY 07 and non-completers’ time increased since FY 06

Story Behind the Baseline: This standard is being met, on average. It would be helpful to know the percent of clients (separated by completers and non-completers) that met the standard, instead of the gross measure of average time spent. It should be noted that time spent meeting weekly is expected to vary substantially over participation, with more than one

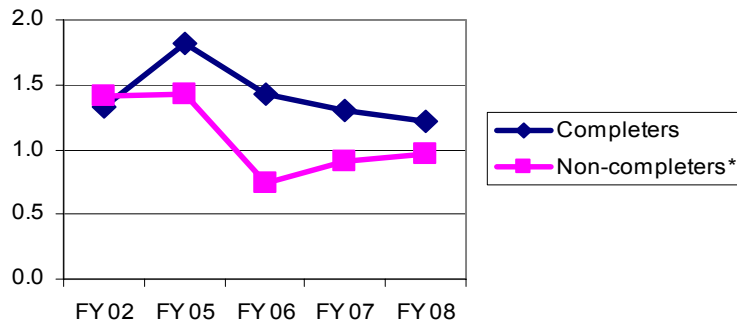
hour weekly likely to be spent through the first month or so of the client’s time in new housing.

To improve understanding of the program and its performance, DCF and the provider should:

- *Analyze data to understand how much time on average is spent with clients at each stage of the program (e.g., first six months, 6-12 months, beyond 12 months), consider whether the standard should vary by stage, and then track what percent of clients at each stage are meeting the standard(s)*

b. Duration of 2 years

Median Program Duration for Completers and Non-Completers (in years)



Source of Data: DCF

Trend: Overall decline since FY 05

Story Behind the Baseline: The median program duration is meeting the standard of below two years’ duration. As with the weekly hours spent meeting in-home, it would be useful to know the percent of participants who exceeded two years. It is unclear whether the duration of the program for non-completers means anything; if the program had data and analysis that showed a longer duration – regardless of completion status – led to positive impacts, then the program would

Appendix F
RBA Program Performance Profile
Supportive Housing for Families (SHF)

need to emphasize trying to serve non-completers as long as possible.

Performance Measure 6: Satisfying Clients

Client Satisfaction Surveys: Response Rate and Results						
	<i>FY 02</i>	<i>FY 05</i>	<i>FY 06</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
Response Rate	39%	15%	18%	9%	11%	15%
% Satisfied with Worker	100%	Unknown	95%	100%	100%	100%
% Satisfied with Worker's Cultural Competence	91%	Unknown	95%	100%	100%	98%

Source of Data: DCF

Trend: Consistently low response rate except FY 02; very high client satisfaction with improved satisfaction with worker's cultural competence

Story Behind the Baseline: The client satisfaction survey is given in hard copy, along with a stamped envelope addressed to the provider, to SHF clients who are exiting the program. Clients mail the survey back to the provider. Usually only highly motivated people respond to a mail survey – either those who had bad experiences, or very good experiences. The lack of negative responses indicates that very few had poor experiences. It should be noted that the sub-contracted UConn evaluators conducted a small-sample focus group study of client satisfaction, of clients in the program, and did find clients largely were satisfied and engaged. *To better understand the level of client satisfaction and how the program can improve, given the low response rate, PRI staff recommends the provider should:*

- *Consider ways to improve customer satisfaction survey response*

Options for improving the response rate are giving a small incentive (such as a \$5 gift card, or entry into a prize drawing) or supplementing the survey with follow-up postcards or phone calls.

The provider managers reported *that mandatory annual training regarding cultural competence was initiated in about 2006 to improve performance in that regard. The training might have worked:* satisfaction with worker cultural competence improved to 95% as of FY 06, and recently has been no lower than 98%, although these results should be interpreted with caution because of the low response rate. It appears that *if or when other DCF programs struggle with worker cultural competence, training could be effective.*

Performance Measure 7: Managing Cost Per-Client

Estimates of Annual Program Per-Client Cost					
	<i>FY 05</i>	<i>FY 06</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>
To DCF: Including only clients who passed intake	\$10,569	\$12,210	\$12,023	\$9,116	\$9,225
To DCF: Including all clients (regardless of whether intake was passed)	Unknown	\$12,141	\$11,830	\$9,045	\$9,167

Note: On average, clients who do not successfully complete the program receive program services for about one year, while clients who successfully complete receive services for more than one year.

Source of data: DCF, and for housing assistance costs, DSS

Appendix F
RBA Program Performance Profile
Supportive Housing for Families (SHF)

Trend: Program services per-client cost has declined in the last few FYs

Story Behind the Baseline: The program services cost of SHF has declined from about \$12,000 in FY 06 and FY 07 to just over \$9,000 in FYs 08 and 09. This change is due to a greater proportion of SHF clients receiving the DSS voucher, instead of the program housing subsidy. That move allowed SHF to take in more clients, at a lower per-client cost (to the program), as shown in Performance Measure 1.

The average annual per-client cost of the DSS housing assistance (which continues after SHF program completion) is about \$8,803, using a cost weighted for Section 8 – RAP mix multiplied by the percent of clients that obtain housing (from the most recent cohort whose clients have exited the program, FY 07).

Performance Measure 8: Managing Provider Performance Using Data

Data: Data by sub-contractor was received but time was inadequate for PRI staff analysis

Story Behind the Baseline: The contracted provider reviews its own cases weekly and sub-contractor cases monthly to examine how the individual client families are being served. The provider’s SHF directors, clinical directors, program managers, and QI specialist meet monthly or more to review problems that were identified and, when needed, put in place performance improvement plans. Data are reviewed quarterly at the program level, both in aggregate and by sub-contractor, by the provider and the DCF program lead. These data are for the clients currently being served or, for certain items, who were discharged (either for successful completion or unsuccessful exit [i.e., non-completion]) over the year. It seemed to PRI staff that some of the data items were not that useful, and that it would be more helpful to examine data at the cohort level (i.e., by period of entry into the program). *To improve oversight, PRI recommends the provider and DCF program lead should:*

➤ *Examine quarterly the performance measures in this report by cohort*

ADDITIONAL PERFORMANCE MEASURES

a. Understanding why non-completers did not successfully finish the program

There are 69 discharge reasons – most of which are not being used currently for new clients – in the SHF provider’s database. The reasons are divided into three categories: Administrative, Successful, or Unsuccessful. Some reasons appear to be inappropriately categorized. A few administrative reasons seem like the client was unsuccessful, and a few successful reasons seem like the client was discharged for reasons that should be considered administrative or unsuccessful. In addition, the meaning of a few reasons is unclear. Properly categorizing and clarifying discharge reasons is important because the data need to be accurate and make sense, in order for program managers to use it for program improvement. If, for example, many clients are being discharged due to a specific “unsuccessful” reason, then the program managers should know that and consider how to “turn the curve” on that trend.

The provider recently changed its client database’s discharge categories to match those on the SHF PSDCRS client form: 1) completed program (successful); 2) agency discontinued clinical (unsuccessful or failed intake); 3) child is deceased; 4) client is hospitalized; 5) client incarcerated; 6) agency discontinued administrative (return to waitlist because not ready for program); and 7) family discontinued (family chose to drop out). It should be noted that there are 15 additional discharge categories on the PSDCRS client form. *To make the data more useful in understanding program exit and therefore how the program could improve, PRI staff recommends DCF should:*

➤ *Change the SHF discharge categories on both the PSDCRS client form and in the provider’s*

Appendix F
RBA Program Performance Profile
Supportive Housing for Families (SHF)

database to: 1) lost eligibility during time on waitlist (along with specific, plain-language reasons why); 2) administrative mistake (data accidentally entered, should not be counted in cohort); 3) failed intake (along with specific, plain-language reasons why); 4) successful; and 5) unsuccessful (along with specific, plain-language reasons why)

These categories should enable quick, accurate analysis to understand how each cohort is faring. Further, separating out certain categories will be extremely informative. Recording whether eligibility was lost during the time on the waitlist, and how it was lost, could help the program, DCF, and legislators understand whether there are costs to a lengthy waitlist. Similarly, making clear whether clients failed intake, and why, will help the program exclude those clients from completion analysis, and help DCF understand whether there need to be different services offered – or better referral to existing programs – for clients who are not appropriate for SHF.

Family demographic and other characteristics could also be impacting program completion. The provider’s data system collects this information but the data were not sufficient to allow for that analysis. In spring 2009, the provider began using a new data system and DCF expects the family characteristics information from that system to be more useful. ***PRI staff encourages the provider and DCF, after a sufficient amount of data has been collected in the new system, to conduct analysis to determine whether any particular family characteristics are associated with completion – and if so, to work toward eliminating those differences.***

b. Satisfying area offices

Data: The staff at all five of the area offices visited by PRI staff were completely satisfied with the program except for the long waitlist.

Story Behind the Baseline: None had any criticisms and the only recommendation for improvement was offering more slots.

III. Is Anyone Better Off?

Child welfare outcomes after participation were analyzed by DCF upon PRI staff’s request, and although the results should be interpreted with great caution, they are promising. The outcomes regarding caregiver employment also are promising but should be interpreted with caution. A few adjustments should be made to data systems to allow for better understanding of these measures. Due to the lack of full outcome information, cost-effectiveness cannot be determined.

Performance Measure 9: Children Are Free From Repeat Maltreatment

Data: *This measure is not being tracked as of program exit by either the provider’s data system or PSDCRS, although it previously was tracked on an ongoing basis (i.e., percent of all client families currently being served). It is not currently being tracked by either system.*

Repeat maltreatment post-program completion was examined through a study conducted by the DCF program lead and the department’s Office of Research and Evaluation, in response to PRI staff’s request. The study involved matching program and LINK records for clients who exited the program FYs 05-09.

The analysis should be interpreted with extreme caution, due to five problems. 1) Roughly one-third of program clients could not be included due to data quality / availability. 2) The time periods being compared are different for completers and non-completers, because the date of program exit – not program start – was

Appendix F
RBA Program Performance Profile
Supportive Housing for Families (SHF)

used. 3) All who did not successfully complete were aggregated, when there may have been important differences among why they did not complete. 4) It is possible – even likely – that some or all of the difference between the two groups is due to family characteristics associated with both the likelihood of completion and of repeat maltreatment, since the analysis did not control for any characteristics. 5) It was not clear whether or how repeat maltreatment or out-of-home placement that may have occurred during program participation was taken into account. ***Keeping all these caveats in mind, the analysis showed promising results.*** Overall, there was no difference in the rate of repeat maltreatment between completers and non-completers one year after program exit, but between the second and third years, a difference emerged: completers had a five percentage point lower rate of maltreatment (25%) than non-completers (30%).

Story Behind the Baseline: It is important to collect information on repeat maltreatment as of program completion. ***PRI staff recommends DCF should:***

➤***Ensure the provider and PSDCRS collects and reports information on repeat maltreatment as of program exit***

Performance Measure 10: Children Remain In or Successfully Moved Back Into Home

Data: Until recently, this measure was not tracked as of program exit by the provider’s data system, although it was tracked on an ongoing basis (i.e., percent of all client families currently being served). The provider made substantial changes to the data system in spring 2009, and information on out-of-home placement as of program exit is now kept. Due to the small sample size, however, those data are not reported here.

Story Behind the Baseline: The DCF Office of Research and Evaluation analysis discussed above also examined child out-of-home placement (i.e., future entry into DCF care) beyond program completion. ***The same substantial caveats apply, but again, the analysis showed promising results.*** A difference emerges in the first year, and by the end of the third year, completers have a 12 percentage point lower rate of removal (9%) than non-completers (21%). In other words, non-completers were more than twice as likely to have children removed, than were program completers. PRI staff encourages DCF to examine out-of-home placement as of program exit when that data become available.

It is important to note that ***the PSDCRS client discharge form for SHF does not fit the program.*** It does not allow discharge status (as discussed above) and living arrangements of child(ren) and caregivers to be clearly and adequately characterized. In addition, important desired outcomes, such as employment, are not included.

This problem seems to be a result of the PSDCRS being used for programs that focus on improving behavioral health, while SHF is a wraparound program that does not focus solely or even primarily on behavioral health. PRI staff understands that it can be helpful to have uniform client data forms when the programs are similar in focus, but SHF appears sufficiently dissimilar to merit unique forms. The DCF program lead reported attempting trying to work with the PSDCRS vendor to make the forms more appropriate to SHF but the vendor was not receptive.

To make the PSDCRS discharge data useful for SHF program monitoring and improvement, DCF should:

➤***Adjust the program’s PSDCRS client discharge form, working with the provider and using this report to understand what should be included***

Performance Measure 11: Family Functioning Has Improved

Data: None adequate are available

Story Behind the Baseline: Since 2006 (FY 07), SHF has used the North Carolina Family Assessment Scale

Appendix F

RBA Program Performance Profile

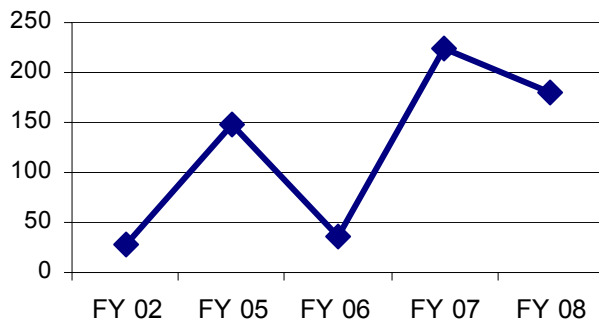
Supportive Housing for Families (SHF)

– Reunification (NCFAS-R) for all client families at the beginning, middle (every six months), and end of program services. NCFAS measures caregiver and child well-being on a range of topics, including safety, health, environment, and family dynamics. NCFAS-R data was shared with PRI staff and showed a majority of families exiting had improved. ***The data are not being presented, however, because of PRI staff concerns about the validity of the data.*** A 2008 UConn evaluation that included an examination of NCFAS’s implementation and use supported those concerns: SHF staff did not believe their initial administration of the tool was a useful indicator of the family’s status. Further, DCF and the provider expressed concerns that NCFAS was meant to be used as a service planning tool, not as a method to collect family outcome data. ***PRI staff recommends DCF should:***

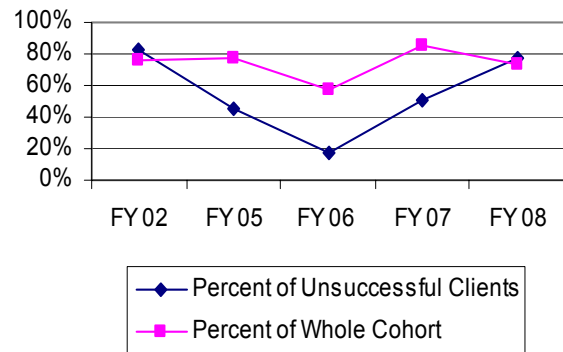
➤ ***Adopt or develop a tool that can adequately measure family functioning***

Performance Measure 12: Families Obtained Better Housing and Remained There

Number of Client Families Successfully Obtained and Remained in New Housing (i.e., completed program), by Cohort (FY of Program Start)



Percent Obtaining New DSS Vouchers, by Cohort (FY of Program Start)



Source of data: DCF

Trend: Uneven for all data

Story Behind the Baseline: By definition, successful families have been placed into new housing and remained there at their program exit. The chart on the left shows the number of successful client families by year in which participation began. The drop-off in FYs 08 and 09 reflects the fact that many families in these cohorts are still participating in the program; the low number in FY 06 is due to the very low number of clients taken into the program that FY. Performance Measure 4 describes the completion rate. In addition to successful families’ re-housing, a portion of unsuccessful clients received DSS vouchers while participating in SHF. These clients may or may not have actually remained in their new housing, with or without continuance of the DSS housing assistance, at program end; no data are collected to determine that. The percent of unsuccessful clients who received new DSS vouchers varied substantially across cohorts, with a low of 17% for the FY 06 cohort (which began in a year when DSS vouchers for SHF participants were scarce) and a high of 83% in FY 02. Out of all program participants, about 75% received DSS vouchers in FYs 02 and 05, with a dip in FY 06 and a return to a high percentage (86%) in FY 07. (A portion of the FY 08 cohort is still receiving services.)

To better understand the housing situations of exiting clients, DCF should:

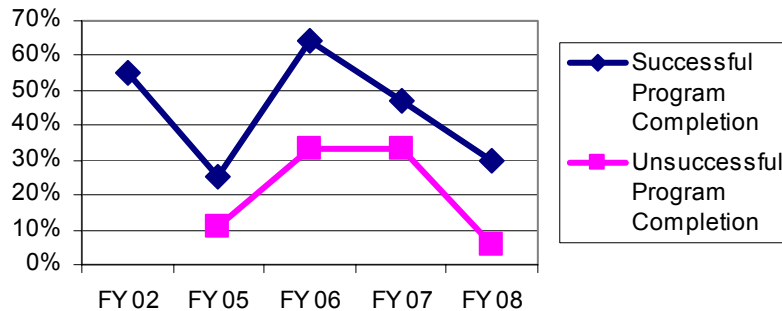
➤ ***Collect and analyze whether unsuccessful clients had retained DSS assistance and new housing at***

Appendix F
RBA Program Performance Profile
Supportive Housing for Families (SHF)

program exit

Performance Measure 13: Caregivers' Employment Status Improved

Percent of Initially Unemployed Caregivers Who Ended the Program Employed, by FY of Program Start (i.e., Cohort)



Change in Employment for Successful (S) and Unsuccessful (U) Clients*, at Program Exit										
	FY 02		FY 05		FY 06		FY 07		FY 08	
	S	U	S	U	S	U	S	U	S	U
n	25	3**	106	27	30	12	177	51	121	26
Employed with no change in PT/FT	12%	--	24%	11%	30%	17%	17%	8%	21%	4%
Lost employment (down to PT, or became unemployed)	16%	--	8%	15%	13%	0%	5%	14%	10%	4%
Gained employment (became employed, or moved from PT to FT) or disabled income (if began unemployed)	44%	--	20%	11%	27%	17%	29%	20%	20%	12%
Unknown (either beginning or end)	8%	--	7%	4%	17%	33%	18%	14%	14%	19%
Stayed unemployed	20%	--	41%	59%	13%	33%	27%	39%	33%	58%
Stayed disabled	0%	--	1%	0%	0%	0%	4%	6%	2%	4%
Moved from employment to disabled	0%	--	1%	0%	0%	0%	2%	0%	0%	0%
	100	--	100	100	100	100	100	100	100	100

*Excludes those with provider code of "Administrative Discharge," which totaled 0 in FYs 02 and 05, 18% in FYs 06 and 07, and 23% in FY 08. FY 09 not shown because substantial portion of cohort is still in the program. Also excludes those for whom no employment data were collected in the provider's data system, >10% for all FYs except 07, and was about 52% for FY 08 (probably because many clients in that cohort are still in the program).
 **Not presented due to the small sample size.
 Source of Data: DCF

Trend: Uneven; from chart, of clients who began program unemployed, a higher percent of successful program completers appear to have ended the program employed, compared to unsuccessful clients

Appendix F

RBA Program Performance Profile Supportive Housing for Families (SHF)

Story Behind the Baseline: The table overall shows better employment changes for clients who successfully completed the program, than for those who did not. Those results, however, are influenced by the percent of clients who begin the program employed – which is higher among completers for each year examined. A more useful comparison, then, is the chart, which indicates that *among only clients who began the program unemployed, a consistently higher percentage of successful program completers than unsuccessful clients ends the program employed*. Although useful, this analysis does not present a full picture of the employment changes for SHF clients for three reasons. First, data on “administrative discharges” were available but not used due to uncertainty over whether those discharges were positive or negative; as noted in the table’s footnote, in recent years these were about one-fifth of the clients for whom employment data was available. Second, employment data were not available on the full cohorts (also as noted in the table’s footnote). Third, a substantial portion of clients for whom either beginning or ending employment status was recorded did not have the other employment status recorded, so calculating the change in employment is impossible.

Analysis of the data also indicated that, among clients who have data sufficient to report employment change, those clients who begin unemployed or with unknown employment have lower completion rates than those clients who begin employed. It is not clear whether the differences are due to personal or family factors associated with both initial unemployment and program non-completion, or to program factors (e.g., how well the caseworker knows or establishes a rapport with the client initially). DCF and the provider believe, anecdotally, those families whose caregivers are unemployed initially often have young children as well as high-level behavioral health needs, which may impact ability to seek and retain employment.

To improve program completion, PRI staff recommends DCF should:

➤ *Consider how to better work with clients who begin the program unemployed and how to build rapport with clients from the beginning of services*

To improve the quality of data and therefore enable better analysis of employment outcomes to occur, DCF should:

➤ *Emphasize to staff the importance of obtaining and recording employment status at both the beginning and end of program services; and, as recommended above, refine the discharge categories*

Performance Measure 14: The Service is Cost-Effective

Data: Adequate data to assess this performance measure is unavailable.

Story Behind the Baseline: *Without adequate data on program outcomes, it is difficult to determine whether any program (including SHF) is cost-effective.* It is possible, due to the high costs of child out-of-home placement, that SHF is cost-effective, particularly if the cost of the DSS housing assistance is excluded. In order to accurately calculate cost-effectiveness at even a basic level, accurate information on child out-of-home placement (including precise type of placement) and repeat maltreatment – both during and after program participation – would need to be collected for all clients. This is the idea behind the budget act language that directed DCF to report on the legislature to SHF clients on January 1, 2010.

A better analysis would collect information on a broader range of outcomes, including child education, caregiver DMHAS and DOC involvement, and caregiver earnings. A stellar analysis would result from a random assignment study, so an evaluator could see what happened to comparable families who were eligible for but did not receive SHF services; however, DCF believes this type of assessment is unethical for the child welfare population.

One way to undertake a cost-effectiveness analysis would be to closely examine the cases of a small number of SHF participants (say, 100 client families), collecting and analyzing the information noted above or beyond if possible, to see how they fared throughout and after program participation on a range of outcomes.

Appendix G

Agency Profile: Department of Children and Families

<u>Agency Background</u>	
Mission	To protect children, improve child and family well-being, and support and preserve families.
Mandates	<p>As the state's consolidated children's agency, responsible by statute for:</p> <ul style="list-style-type: none"> • Protective Services for any child at risk of abuse/neglect by a caregiver • Behavioral Health Services for all children under age 18 • Juvenile Justice Services for juvenile delinquents • Prevention Services related to child abuse/neglect, children's mental illness and substance abuse, juvenile delinquency
Target Population	Children and families who have experienced or are at risk of abuse and neglect, behavioral health problems, and delinquency
Main Partners	<ul style="list-style-type: none"> • Other state and federal agencies serving children and their families • Community-based organizations including private service providers • Children and families in need of agency services and related advocacy groups
Federal Court Oversight of Child Welfare System	<p>Consent decree. A federal class action lawsuit (<i>Juan F.</i>) aimed at reforming Connecticut's child welfare system was settled through a consent decree approved in 1991. DCF efforts to implement improvements mandated by the consent decree are overseen by an independent, full-time, court-appointed monitor. The increased attention and resources prompted by the consent decree resulted in a number of changes in agency operations over time, including lower caseloads, better information systems, and expanded community-based and in-home services for children and families involved with the department. However, after nearly a decade of court oversight, concerns continued over service quality and the ability of DCF to meet the needs of children in its care.</p> <p>Exit plan. Starting in 1999, a number of revisions to consent decree provisions and the monitoring process were negotiated to focus efforts on positive outcomes for DCF-involved children and families. In 2004, the monitor and the parties, with court approval, developed an exit plan that contains measurable outcomes and performance standards for: 1) achieving compliance with <i>Juan F.</i> consent decree provisions concerning child safety, permanency, and well-being; and 2) ending court oversight of DCF.</p> <p>To exit from the consent decree, the department must reach and maintain certain performance levels on 22 specific outcomes, which include, among others, set rates for repeat maltreatment, out-of-home placements, timely permanency through family reunification or alternatives, and meeting children's individual needs.</p> <p>Status. The court monitor reports each quarter on DCF exit plan progress. The agency's compliance status and findings from the most recent exit plan quarterly report are summarized under Selected Agency Performance Measures, below (p. G-7).</p>

Appendix G

Agency Profile: Department of Children and Families

Main DCF Activities	
Agency-wide Client Services	How Much
<ul style="list-style-type: none"> • Casework with DCF-involved children and families provided by the agency's social work staff to achieve safety, permanency and well-being, including: <ul style="list-style-type: none"> ○ Assessment and treatment planning ○ Case management (arranging and coordinating care/services) ○ Counseling and referral 	<p><i>Total FY 08 caseload (protective services): 17,525</i></p> <p><i>Social Worker caseload: 15-20 (maximum); 13 (est. average)</i></p>
<ul style="list-style-type: none"> • Education Services (K-12) provided through the DCF-operated school district (Unified School District II) to children in residential treatment (in state-operated and in some cases private facilities) 	<p><i>Total students served: 913 (FY 08)</i></p>
<ul style="list-style-type: none"> • Medical Services to assure children in DCF care and custody receive optimal health care through case-specific consultation and oversight by central office resource staff (e.g., pediatrician, pediatric nurse practitioners, psychiatrist) 	
<ul style="list-style-type: none"> • Ombudsman's Office activities, which involve receipt, investigation, and attempted resolutions of inquiries and complaints about department services from clients, providers, and the public 	<p><i>Calls handled: 5,048 (CY 08)</i></p>
Child Protective Services	How Much (Total FY 09 Budget: \$464 million)
<ul style="list-style-type: none"> • Receive all reports of alleged abuse/neglect through 24-hour central Hotline; screen and refer to field staff (area offices) for investigation 	<p><i>During FY 08 –</i> <i>Reports Received: 37,314</i> <i>Investigated: 24,429 (66%)</i></p>
<ul style="list-style-type: none"> • "Field Operations" – 14 DCF Area Offices conduct investigations to substantiate abuse/neglect; carry out casework to meet needs of children and families in open protective services cases 	<p><i>Substantiated Cases: 6,639 (FY 08)</i> <i>(27% of Investigated)</i></p>
<ul style="list-style-type: none"> • When possible, provide supports and services to maintain children safely at home and strengthen families 	<p><i>Families receiving in-home services: 4,010 (as of Sept. 08)</i></p>
<ul style="list-style-type: none"> • When safety and/or child's needs require out-of-home placement, provide care in least restrictive, most family-like setting including: <ul style="list-style-type: none"> ○ Foster families, private foster care and licensed relative care ○ Therapeutic Group Homes (TGHs) and other congregate care facilities (e.g., SAFE Homes) • Recruit, license, and support foster care providers 	<p><i>During FY 08 –</i> <i>Foster Care: 3,112 children, on average</i> <i>Relative Care: 878 children</i> <i>273 beds in 54 TGHs</i> <i>178 beds in 15 SAFE Homes</i> <i>Licensed foster care providers: 3,312 (as of 7/1/08)</i></p>

Agency Profile: Department of Children and Families

<ul style="list-style-type: none"> When reunification with child’s family is not possible, establish another permanent home through: <ul style="list-style-type: none"> Adoption Subsidized Guardianship, which offers financial assistance to help relatives care for children as adoptive parents (but parental rights are not terminated) 	<p><i>During FY 08 – Adoptions finalized: 634 Received adoption subsidies: 4,780 children Subsidized guardianships: 234 granted</i></p>
<ul style="list-style-type: none"> Assist youth in DCF care to transition to adulthood successfully through specialized case management and supports (e.g., housing, educational, vocational assistance) 	<p><i>800 youth in independent living programs (on average)</i></p>
<p align="center">Children’s Behavioral Health Services</p>	<p align="center">How Much (Total FY 09 Budget: \$329 million)</p>
<ul style="list-style-type: none"> Provide appropriate mental health and substance abuse assessment, treatment and aftercare services to address the behavioral health needs of Connecticut children through: <ul style="list-style-type: none"> Connecticut Community KidCare, a system of care model designed to enhance access to a full continuum of community-based, residential, and inpatient care, and deliver appropriate behavioral health services in the home or community whenever possible With the Department of Social Services, manage publicly funded behavioral health services for children through the Connecticut Behavioral Health Partnership (BHP), with the assistance of an outside Administrative Services Organization (Value Options) 	<p><i>549 children in residential treatment (Sept. 08)</i></p> <p><i>2,300 children served by intensive, in-home clinical services (Sept. 08 capacity)</i></p>
<ul style="list-style-type: none"> Provide behavioral health services to children with serious mental health and substance abuse problems whose families are not DCF-involved (Voluntary Services) 	<p><i>About 1,000 families served annually</i></p>
<ul style="list-style-type: none"> Fund, license, and monitor a range of behavioral health services for DCF clients that are operated by contracted private program providers 	
<ul style="list-style-type: none"> Operate three state residential treatment facilities for children with behavioral health problems: <ul style="list-style-type: none"> Riverview Psychiatric Hospital (98-bed inpatient facility for patients ages 5 -18) High Meadows (42-bed intensive treatment facility for adolescent males usually with multiple problems; scheduled for closure in FY 10) Connecticut Children’s Place (CCP) (54-bed residential diagnostic center for children and youth ages 10-18) 	<p><i>During FY 08 – Riverview: 236 children served High Meadows: 95 children served (calendar yr. avg.) CCP: 117 children served</i></p>

Appendix G

Agency Profile: Department of Children and Families

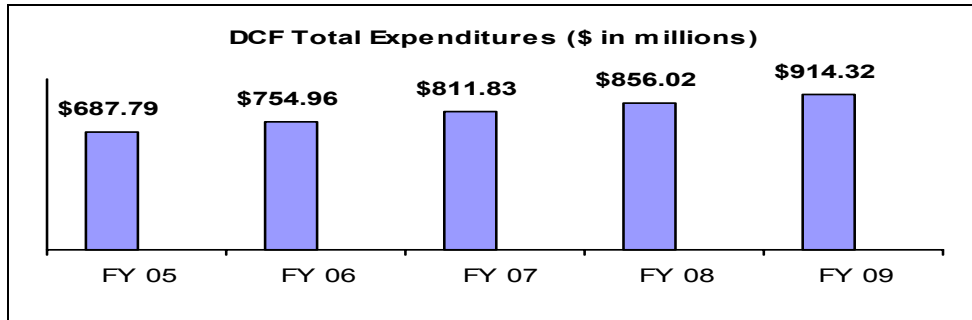
Juvenile Services	How Much (Total FY 09 Budget: \$71 million)
<ul style="list-style-type: none"> • Provide services for children involved in the juvenile justice system to help them successfully re-integrate into their communities while maintaining community safety through: <ul style="list-style-type: none"> ○ Secure residential treatment in state-operated facility for male delinquents, Connecticut Juvenile Training School (CJTS) ○ Contracted residential treatment programs for juveniles ○ Community-based services and supervision (juvenile parole) 	<p><i>Annually serve about 1,200 committed delinquents</i></p> <p><i>During FY 08 –</i> <i>CJTS Admissions: about 200</i> <i>Parole: 628 children served (467 males; 161 females)</i></p>
Prevention Services	How Much (Total FY 09 Budget: \$6 million)
<ul style="list-style-type: none"> • Provide and fund a range of services to prevent or help children and families transition from DCF involvement and promote positive youth development, including: <ul style="list-style-type: none"> ○ Parent education and support ○ Early children intervention programs ○ Suicide prevention ○ Mentoring ○ Juvenile Review Boards ○ DCF-operated Wilderness School (outdoor program for troubled youth; closure in FY 10 recommended by governor) <p>Note: Another, separate agency, The Children's Trust Fund (CTF), funds and administers a number of state and federally funded primary prevention programs and initiatives aimed at preventing child abuse and neglect. CTF spending for child abuse prevention services totaled about \$16 million in FY 09 (estimated agency expenditures).</p>	<p><i>Wilderness School: 700 youths served annually</i></p>
Agency Management and Administration	How Much (Total FY 09 Budget: \$44 million)
<ul style="list-style-type: none"> • Support efficient and effective service delivery to DCF clients through a variety of central office functions including: <ul style="list-style-type: none"> ○ Fiscal Services (which encompasses contract management and information systems) ○ Human Resources ○ Legal Services ○ Quality assurance and improvement (which encompasses research and evaluation and the agency Training Academy that is responsible for workforce development/professional development) 	<p><i>During FY 08 –</i> <i>Training Academy: 2,572 staff attended pre-service and/or in-service training sessions</i></p>

Appendix G

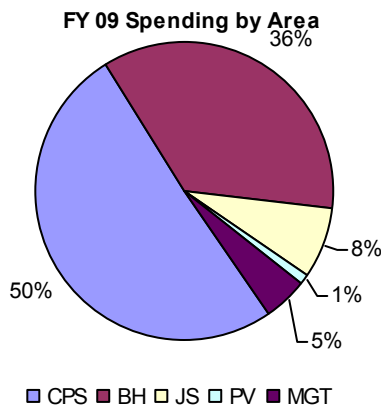
Agency Profile: Department of Children and Families

Resources

- Total DCF expenditures reached over \$900 million in FY 09; adjusting for inflation, this represents a 20% increase over FY 05 spending.

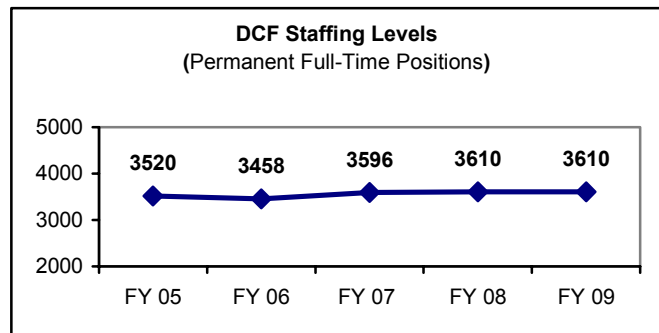


- General Fund monies account for at least 96% of the annual agency budget; DCF received between approximately \$17 million and \$26 million in federal funds per year over the past five years.



- The bulk of DCF spending – over 85% in FY 09 – is allocated to child protective services (CPS) and behavioral health (BH) budget areas.
- Much smaller portions are spent on juvenile services (JS) for the delinquent population and the agency's prevention (PV) efforts (under 10% for both).
- Management expenses consistently are approximately 5% of the department's total budget.

- DCF staff resources have remained relatively steady over the past five fiscal years at about 3,500 to 3,600 permanent full-time positions.
- In response to the state's recent retirement incentive program, 169 DCF employees (nearly 5% of total full-time positions) from across the agency retired effective July 1, 2009.

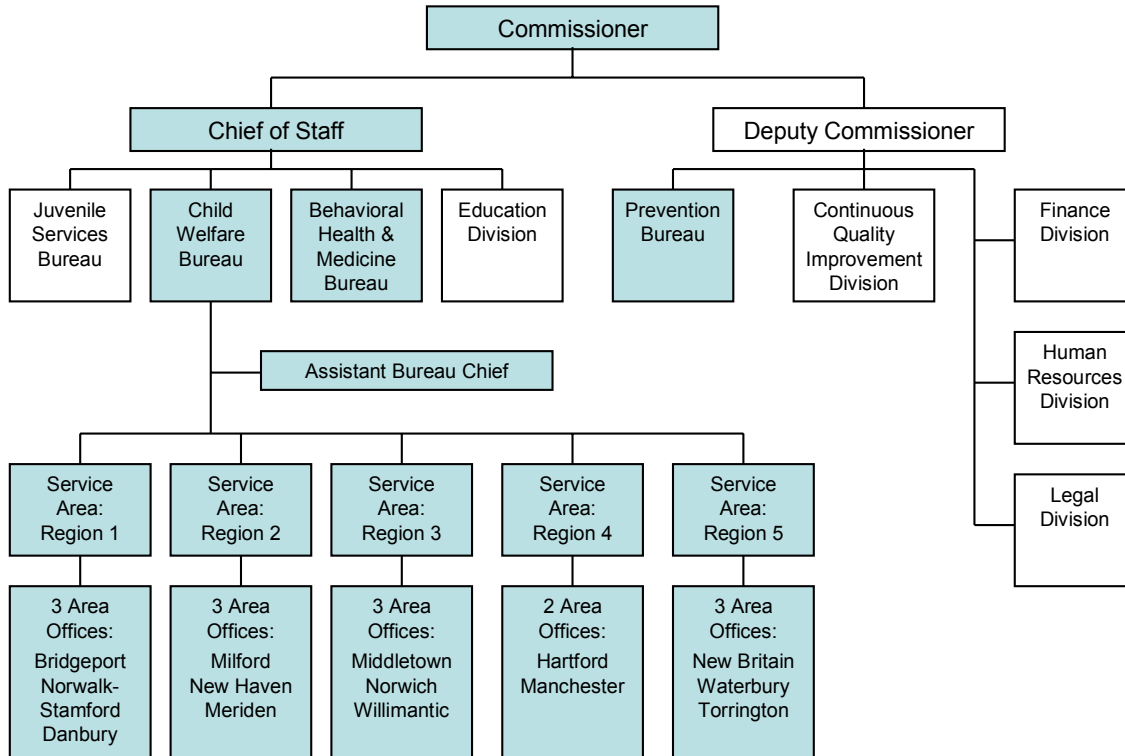


Appendix G

Agency Profile: Department of Children and Families

Organization

Department of Children and Families: August 2009*



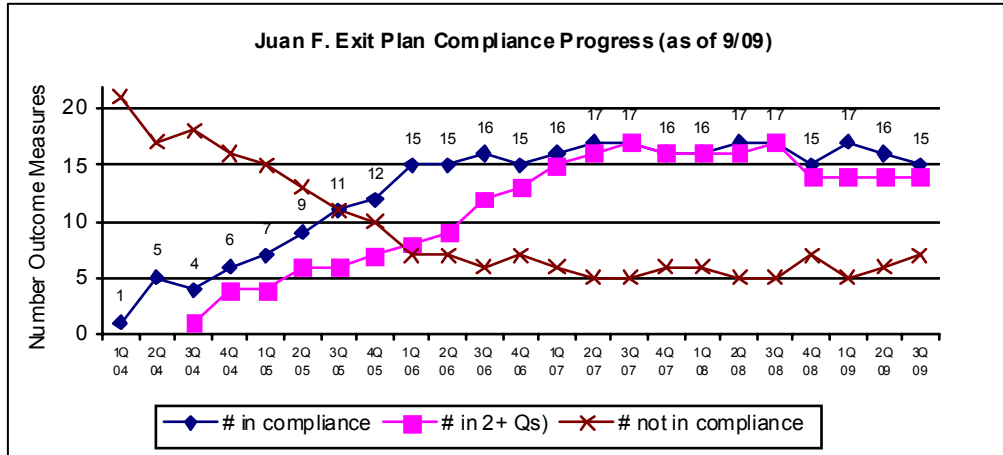
- Newly reorganized effective August 2009 (partly in response to personnel losses under the latest state Retirement Incentive Program)
- Bureaus consolidated (from 6 to 4); several offices and divisions realigned or combined
- 14 Area Offices now overseen by 5 new Service Area Directors
- New Assistant Child Welfare Bureau Chief position created to oversee central office protective services functions (e.g., Hotline, foster care and adoption, quality improvement)
- Quality improvement functions created within each bureau and service area; supplement existing Continuous Quality Improvement Division

**Shaded boxes indicate responsibility for Family Preservation and Supports*

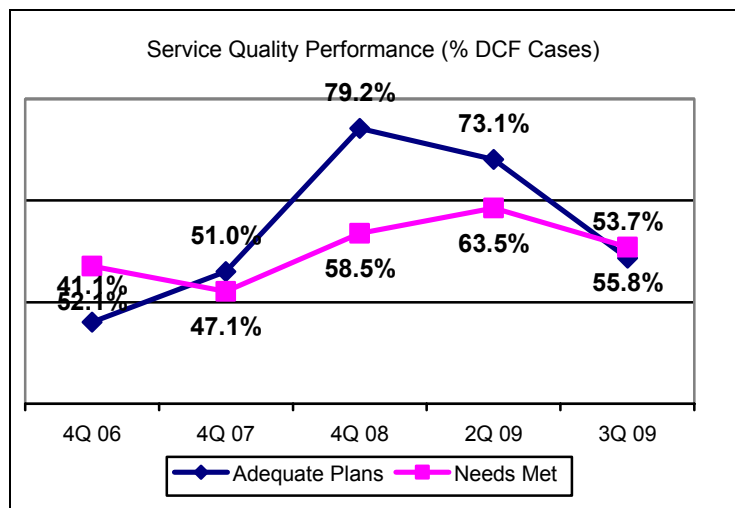
Agency Profile: Department of Children and Families

Selected Agency Performance Measures

- Over the last three and half years, DCF has been in compliance with at least 15 and as many as 17 of the 22 exit plan outcome measures related to child safety, permanency, and well-being.*

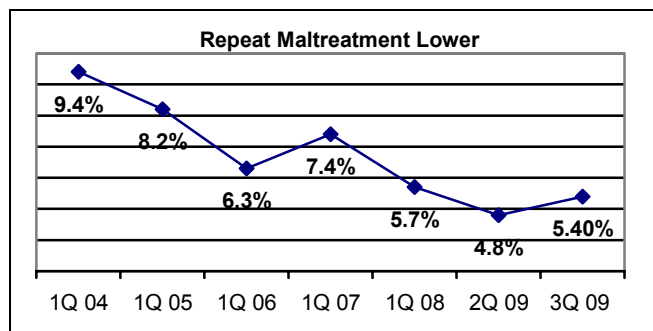


- Performance on two exit plan outcome measures critical to quality services – **adequate treatment planning and meeting children’s needs** – have improved but still well below targets (>=90% and >=80%, respectively).
- As of September 2009, 54% of DCF protective services cases had adequate treatment plans and identified service needs were met in 56% of such cases.



* Compliance with all 22 outcomes measures must be maintained for at least two consecutive quarters before exit plan termination can be considered

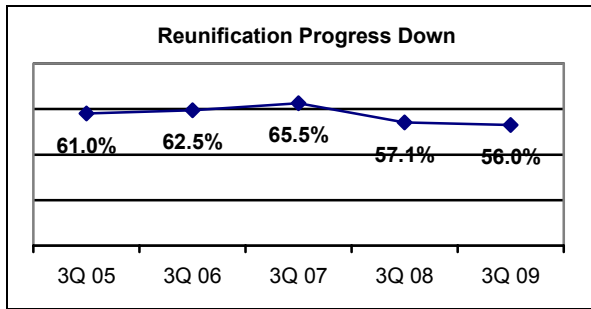
Agency Exit Plan Performance Related to Family Preservation and Support Programs:



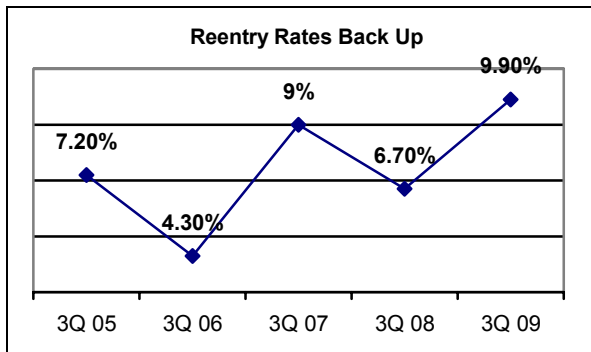
- Four exit plan measures directly reflect success of FPS program area: Repeat maltreatment among in-home cases (#5); Rate of timely reunification (#7); Rate of reentry into DCF custody (#11); Residential placement rates (#19)
- Less repeat maltreatment: Rate for in-home cases dropped from over 9% in 2004 to around 5% in 2009

Appendix G

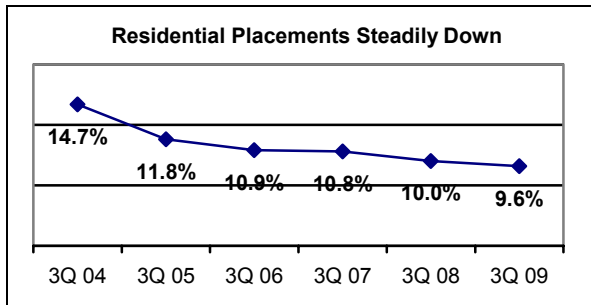
Agency Profile: Department of Children and Families



- Reunification rates dropping off: DCF-involved children reunified with families within 12 months down to 56% for 3Q 09 after rising to high of almost 72% in prior quarter



- Reentry rates continue to fluctuate: After period of significant improvement, children re-entering DCF custody increases again, rising to almost 10% in 3Q 09 compared to a low of 4.3% in 3Q 06



- Fewer DCF-involved children in residential treatment: Steady reduction in residential placement rates since 2004 (from almost 15% to less than 10% in 3Q 09)
- No exit plan measure captures all out-of-home placements: However, DCF recently developed data on rates of entry into foster care/all types out-of-home placement (see below)

- Fewer DCF-involved children entering out-of-home care: Rate of entry into foster care as calculated by DCF dropped from 3.55 to 2.99 per 1,000 children (all in Connecticut under age 18) from FY 06 to FY 09 (See Appendix D, System Performance Measure 2, for more detail)
- More in-home clinical services and supports available for DCF clients: Department reports capacity for intensive home-based programs at 2,300 children per year during 2009 from virtually none prior to 2005

**The Charter Oak Group, LLC:
Summary of RBA Efforts in Connecticut (December 10, 2010)**

Appropriations Committee RBA Pilot Project and Related Efforts in Connecticut
September 2005 through December 2009

I. Appropriations Committee Pilot Project

A. Phase I, 2005-2006

In the first year of its pilot project, the Appropriations Committee focused on two major areas, Long Island Sound and the early childhood result statement, *Ready by Five*. The Department of Environmental Protection (DEP) presented a program template for the clean water fund, and the Early Childhood Cabinet presented 3 templates that represented a small slice of the birth to 5 system.

Several critical components of the Appropriations Committee RBA model were developed through these first pilot projects:

- Formal RBA training was offered to all agency, OPM and legislative staff.
- Official RBA templates were developed at the population and program level for use by all agencies and programs reporting to the legislature.
- Extensive technical assistance was given to participating agencies in drafting their templates.
- A review and revision process aided by Appropriations Committee consultants provided agencies an opportunity to revise the templates as needed. Particular attention was paid to program outcome measures.
- A process was developed for the Cabinet and DEP to present the population and system levels before the entire Appropriations Committee. Presentations at the program level were made to the relevant sub-committees.
- Questions were drafted for the Appropriations Committee and each of the relevant sub-committees. The agencies received the written questions prior to the hearings, and both legislators and agency personnel were briefed.
- Agencies were requested to answer written follow-up questions for their sub-committees.

B. Phase II, 2006-2007

In the second year, the Phase I pilot projects were expanded significantly. DEP added public recreation to Long Island Sound as a result area and submitted templates for state parks as well as the Clean Water Fund. The Early Childhood Cabinet presented an updated population template for *Ready by Five* and submitted program templates from 29 programs.

The Appropriations Committee created a formal RBA Sub-committee to guide its RBA work. Also during this year, several new components of the RBA model were put in place:

- An official Connecticut glossary of RBA terms was published. Both the glossary and the RBA templates were widely distributed to agencies and non-profit organizations that were not part of the pilot projects.
- Members of the RBA sub-committee were designated as liaisons to the agencies participating in the pilot projects. Delegations of legislators and staff led by the liaisons visited with the commissioner of each agency at the commissioner's office to discuss the RBA project, respond to any questions or concerns, and learn more about the relevant agency programs.

**The Charter Oak Group, LLC:
Summary of RBA Efforts in Connecticut (December 10, 2010)**

- Using a process similar to the first year, agencies received written questions from their sub-committees after their presentation. Agencies were required to answer in writing before they appeared for their sub-committee work sessions.

In this year, the legislature adopted a new budget for the coming biennium. The Governor's budget had proposed a substantial increase in funding for early childhood, most of it for additional preschool slots. The legislature's budget appropriated approximately the same amount of new money for early childhood, but the money was allocated very differently. Based on the RBA presentations it had received, the Appropriations Committee reallocated significant dollars from funding designed mostly to increase the number of new slots for children and instead supported efforts associated with quality, infrastructure, and accountability. It also required the Early Childhood Cabinet to submit a number of reports to the legislature on its progress in building an early childhood system. In addition, the budget adopted by the legislature required new and expanded programs identified by OPM and OFA to develop RBA models and for agencies that were part of the pilot projects of the Appropriations Committee to continue reporting using RBA.

For its ground-breaking work on RBA, Connecticut received the Con Hogan award from NCSL at its annual meeting.

C. Phase III, 2007-2008

The third year of the pilot project continued to focus on the environment and early childhood. DEP presented updated templates on Long Island Sound and the Clean Water Fund, and the Early Childhood Cabinet presented a full accounting of its activities over the prior year under its new budget and new legislative authority. The Cabinet also presented a new result statement for *Fine by Nine* to complement its result, *Ready by Five*. The Cabinet presented 28 program templates for *Ready by Five* and two new program templates for *Fine by Nine*: Early Reading Success, and Adult Education for the mothers of young children.

The RBA sub-committee conducted agency visits as it had in the prior year, and the sub-committee RBA hearings were conducted as they had been in the prior year. The Appropriations Committee also held a special forum on the Early Reading Success program. Funding for this program had been eliminated in the second year of the biennial budget because of legislative concern about a lack of effectiveness and accountability. At this forum, the State Department of Education made a presentation of a new accountability approach grounded in RBA and engaged in a frank discussion with the Appropriations Committee about what had gone wrong in the administration of this program. On the strength of the RBA presentation, the Appropriations Committee voted to restore and expand funding for ERS. Because there was no new state budget for SFY 09, however, the ERS funds were not in fact restored.

As a result of the Appropriations Committee's use of RBA in the budget process, governing Magazine raised the overall rating of the State of Connecticut on performance from C+ in 2005 to B- in 2008.

D. Phase IV, 2008-2009

In the fourth year of its pilot project, the Appropriations Committee focused on expanding and institutionalizing the use of RBA within the legislature. The previous SFY, OFA hired three new analysts who have primary responsibility for supporting the RBA efforts of the Appropriations Committee. The OFA analysts worked in teams with the Appropriations Committee's RBA consultants in order to effect a skills transfer so that OFA will be able to support future RBA efforts in the legislature.

**The Charter Oak Group, LLC:
Summary of RBA Efforts in Connecticut (December 10, 2010)**

Several of the Appropriations Committee sub-committees used RBA on a pilot basis to explore various aspects of the budget in which they were interested. In addition, the five legislative commissions – aging, children, women, African American, and Latino & Puerto Rican – developed comprehensive RBA frameworks.

In Phase IV, the Early Childhood Cabinet did not submit formal program templates. Instead, it piloted the use of RBA report cards at the population, system, and program levels that can be used as a model for other results statements in future years. The EC Cabinet was also given a legislative forum at which it presented the reports on quality, accountability, workforce, and facilities that the legislature mandated it to submit this year. At this forum, the Cabinet also presented its legislative and budget priorities for the coming biennium.

The major initiative for this legislative session was the use of RBA questions by all Appropriations sub-committees during their budget hearings. A set of common RBA questions was provided to each state agency, and agencies were informed that they should be ready to answer these questions with regard to six specified programs. RBA training and technical assistance were offered to all agencies, and most accepted the offer. In addition, each sub-committee identified one of the programs that it was particularly interested in, and the consultants and OFA developed detailed RBA-based questions related to those programs. The detailed questions were provided to the agencies before their budget hearings. Secretary Genuario of OPM also wrote to all state agencies expressing his support for the use of RBA during the budget hearings and offering to provide assistance to the agencies in preparing for the hearings.

The first 30-60 minutes of each sub-committee's hearing was devoted to the RBA questioning. Nearly all agencies had prepared responses to the RBA questions and, for the most part, both agencies and legislators reported that the hearings had been a success. Agencies subsequently completed an online evaluation of the hearings and nearly all agencies attended one of two debriefing sessions that the RBA sub-committee held in the summer and early fall of 2009. Feedback from the agencies was used to shape the RBA hearing process for Phase V of the RBA project.

E. Phase V, 2009-2010

Phase V has been designed as the final step in the phased implementation of RBA into the budget process. Based on feedback from the agencies that participated in the RBA questioning during Phase IV, the Appropriations Committee has developed a new process for the 2010 budget hearings:

- Each state agency has been requested to identify the three programs in its agency that have the biggest impact on the state budget and to prepare RBA report cards for those programs. In addition, each agency may submit report cards for up to three additional programs that it wishes to bring to the attention of the Appropriations Committee.
- The RBA sub-committee will review the report cards with the relevant subject-matter sub-committees and will select one of the major programs for each agency to participate in a special sub-committee hearing in January, before the start of the regular session. Each agency may also select one of the additional programs to participate in the January hearing.
- During the regular sub-committee budget hearings in February, agencies may be asked RBA follow-up questions about any of their selected programs that are being discussed at the budget hearing; however, there will not be a separate RBA portion of the hearing.
- Agencies have been informed that, starting with the 2010-2011 session, the RBA questions will be incorporated into the regular budget hearings. No extra time will be set

**The Charter Oak Group, LLC:
Summary of RBA Efforts in Connecticut (December 10, 2010)**

aside for RBA, but agencies will be expected to respond as appropriate to RBA questions about any program that is discussed at the budget hearings.

The other major development in Phase V is that the Program Review and Investigations Committee (PRI) has begun a pilot project to apply RBA to the study and evaluation of social service programs. The first report will be formally presented in January 2010, at which time PRI will offer its recommendations about whether and how to continue the pilot project.

The RBA Sub-committee is also considering how the PRI pilot can be connected with the RBA budget process. One option under discussion is for PRI to identify one or two result statements for cross-program, system-wide review and presentation each year. All relevant agencies would be informed of the system selected at least one year before the system would be presented. The RBA sub-committee, PRI, OFA, and the agencies would then work together to design and present a complete RBA framework for the selected system to the Appropriations Committee, PRI, and the committees of cognizance.

II. Other RBA Efforts in Connecticut Prompted by the Appropriations Committee's RBA Pilot Project

1. Early Childhood Cabinet. The EC Cabinet was the focus of the Appropriations Committee's pilot projects in the first three years. The Cabinet has embraced RBA for all of its work and has developed comprehensive plans for infants and toddlers and for children in kindergarten through grade 3 using an RBA framework. The Cabinet is actively pursuing accountability and addressing data issues raised in its RBA presentations to the legislature and is using RBA to guide its system planning and budget processes. It has also submitted to the legislature its first annual Accountability Plan, which is firmly grounded in RBA. The Cabinet's pioneering work in RBA has been recognized by many prominent organizations, including the National Governors Association.

2. Child Poverty and Prevention Council (CPPC). During 2008, the CPPC developed a complete RBA framework to guide its work. A work group met over 5 months to develop a comprehensive framework, which was presented to the full Council in May. As required by law, OPM is incorporating RBA elements into a protocol for state agency contracts dealing with prevention services.

3. Juvenile Justice Planning and Oversight Coordinating Council (JJPOCC). Over the past 18 months, the JJPOCC has developed a comprehensive RBA framework to guide the provision of services to older youth who will be brought into the juvenile justice system as result of the Raise the Age legislation. This framework informed the creation of a service delivery design and the identification of service enhancements necessary for an effective transition.

4. Other State RBA Initiatives. Several state agencies have embraced RBA for purposes unrelated to the Appropriations Committees RBA pilot project.

- The State Department of Education (SDE) initially became involved in RBA through the Early Childhood Cabinet. In 2007, the new commissioner decided to provide extensive RBA training to all senior managers and to make an assistant commissioner the point person for SDE's RBA efforts. Last year, SDE developed its own method for tracking progress on the 7 programs that presented RBA templates to the legislature, and the commissioner has used RBA to guide the other major initiatives of the department in addition to early childhood. In the current year, SDE is developing a comprehensive RBA model for the entire Department. SDE has revised its reporting requirements for Youth Service Bureaus and the service learning contracts and will be piloting those new

**The Charter Oak Group, LLC:
Summary of RBA Efforts in Connecticut (December 10, 2010)**

- reporting requirements in the coming year. SDE is also in the process of developing new reporting requirements for Family Resources Centers.
- The Office for Workforce Competitiveness (OWC) has been using RBA for the past three years. Recently, OWC integrated RBA into its planning. Results statements, indicators, and strategies have been developed that will have an impact on planning, as well as contracting for services associated with particular strategies.
 - The Office for Workforce Competitiveness (OWC) in its role as staff to the Youth Policy Council (established under Special Act 08-3) has developed an RBA report card on the status of youth ages 9-21 in Connecticut. The report includes policy-relevant indicators, the story behind the baselines of these indicators, and recommendations for what works. It also includes a statewide budget scan of the current public investment in youth.
 - The Department of Children and Families (DCF) and the Court Support Services Division (CSSD) of the Judiciary have used RBA to restructure their juvenile justice joint strategic plan. The RBA framework focused and strengthened the accountability components of the original plan.
 - The Department of Correction (DOC) is leading a multi-agency effort to develop a plan for prisoner reentry to the community under the auspices of OPM's criminal justice planning. DOC provided RBA training for the members of its work group and developed an RBA model, including result statement, population indicators, strategies, and program measures.
 - The Permanent Commission on the Status of Women (PCSW) has fully embraced RBA and has created a comprehensive framework with results, indicators, strategies, and system measures that has served as a model for the other commissions in their RBA development work. PCSW has also conducted turn the curve sessions at the system level to identify how PCSW can contribute to system development efforts in the area of gender equity.
 - The working group for parents with cognitive limitations has recently embarked on developing an RBA framework. RBA provides a way of structuring the planning of this cross-agency working group work and incorporating accountability into its efforts at promoting change across the social services system. The working group is also integrating its focus on these parents with broader RBA efforts like those already established by the Early Childhood Cabinet.
 - The Mental Health Transformation Grant, administered by the Department of Mental Health and Addiction Services (DMHAS), is in its fifth and final year of federal funding. DMHAS is providing RBA training and support to enable the three major initiatives under the grant to frame their work using RBA with the aim of supporting the initiatives' sustainability efforts.

5. Community plans for local comprehensive birth-eight systems. Funded jointly by the Early Childhood Cabinet and the Graustein Memorial Fund, 23 communities (all of which are priority or competitive school districts) have developed comprehensive local birth through eight plans that include a full RBA framework to ensure accountability and alignment with state RBA efforts. These plans are based on bringing all of the key stakeholders to the table and obtaining broad community input. Additional communities will be developing comprehensive RBA plans in 2010.

6. Capital Workforce Partners (CWP), the Hartford area workforce investment board. For the past three years, CWP has used RBA to develop a report card of workforce development indicators that has been published by the Hartford Courant. CWP has also developed an RBA framework that it has used to anchor its strategic planning and performance measurement efforts.

**The Charter Oak Group, LLC:
Summary of RBA Efforts in Connecticut (December 10, 2010)**

7. City of Hartford. Hartford began using RBA three years ago to reorganize its services for youth 9-21 as part of establishing a new Hartford Office of Youth Services. In the last year, the city's Office for Young Children has adopted RBA to revise its plan for services to children birth to nine and has provided in-depth RBA training to all of its early childhood and family support providers. Hartford is actively exploring the use of RBA for all other city departments. It has embarked on the use of a data collection system that incorporates RBA principles in its structure and design. The Mayor and Director of the Office for Young Children have recently convened an advisory committee of youth leaders in the capitol region to work with the Director to revise the current RBA plan (now three years old), address the emerging needs of youth in the city, and adjust the Office's strategies to meet future challenges.

8. RBA Initiatives by Other Non-profit Organizations. Several charitable foundations and non-profit organizations have adopted RBA for planning and accountability.

- Graustein Memorial Fund (GMF). As described in #5 above, GMF has been supporting the use of RBA in 23 communities that developed comprehensive local plans for all children birth through age eight. In 2009, GMF has broadened its support for RBA work by offering RBA training and technical assistance to all 54 Discovery communities. GMF has also employed RBA to drive its own strategic plan for 2010-2014.
- Annie E. Casey Foundation (AEC). Long a supporter and advocate of RBA, AEC has been actively promoting the use of RBA among foundations and community-based non-profit organizations in Connecticut. AEC has provided training and financial support for the use of RBA to the Graustein Memorial Fund and the United Healthcare Foundation of Connecticut. It has also provided training to over 100 individuals in 30 non-profit organizations and is currently working with several non-profits in the New Haven area to create a network of RBA coaches.
- United Way of Connecticut. The United Way of America has promoted the use of logic modeling for some time, and all of the United Ways in Connecticut have been using it. However, four large United Ways in Connecticut are currently using RBA in initiatives with their partners (largely for early childhood, youth, and homeless activities). Two of these large United Ways and one small United Way are considering migrating from the logic model to RBA for all of their work, and one small United Way has already made the migration.
- Connecticut Association of Nonprofits. 60 staff and leaders from nonprofit organizations participated in a two-day RBA training designed to give nonprofits a working knowledge of RBA tools. Many attendees indicated that they intend to use RBA within their organizations.

9. Connecticut RBA Practitioners Network. In September 2009, AEC and The Charter Oak Group sponsored the first statewide conference of RBA practitioners. Over 100 active RBA users convened for a day of workshops and plenary sessions, including a keynote address by Mark Friedman and a panel presentation by Connecticut legislative leaders. Attendees decided to form an ongoing community of practice, and 50 representatives of state agencies, municipalities, community organizations, nonprofits, and philanthropy attended the first meeting of the Connecticut RBA Practitioners Network in December. The meeting focused on the various ways in which RBA is being used in Connecticut for planning. CTN broadcast the meeting, and the video is available at <http://ct-n.com/ondemand.asp?ID=4970>.