Child Welfare
Targeted Case Management:
Current Practices and Implications for Statewide Dissemination and Implementation  June 2003

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Executive Summary

This report presents the findings of the FY2002–2003 study of Child Welfare Targeted Case Management (CW-TCM). CW-TCM is a Medicaid-funded service, which is intended to optimize service coordination for children in child protection.

Information was gathered using a variety of research methods. To learn about state policies governing Child Welfare Targeted Case Management, interviews were conducted with key informants (to identify issues affecting the program; the philosophy and approach to service delivery; interpretation of program goals; perceptions of program strengths and weaknesses). The research plan also included administration of a structured response instrument to staff, observations of case staffings (to measure group problem solving and decision-making processes), and a review of documents (i.e., policy guidelines, satisfaction surveys, case manager time tracking) as well as Medicaid claims data.

Findings

Children who are 0 to 21 years of age, are Medicaid eligible, are not receiving any other Medicaid funded case management services, require at least two services, and meet one of the following three conditions fulfill the criteria to receive CW-TCM: (1) the child is placed under protective supervision by a protective investigator based on a determination of some indication of maltreatment or verified maltreatment, (2) the child has been court ordered into shelter, or (3) the child has been court ordered into foster care. An important aspect of CW-TCM eligibility criteria is that children are not required to have a mental health diagnosis. Thus any preemptive labeling of children, particularly very young children, in order to access funding is avoided.

To comply with the requirements of CW-TCM, case managers have to see the child twice a month and maintain verbal or written contact with at least two separate service providers (e.g., foster parents, counselor, school, etc.) to determine the adequacy of the amount and type of services in meeting the child's needs. Prior to billing, an assessment of the child's strengths, weaknesses, needs, natural supports, and required services must be completed within 30 days of referral. A service plan, which is based on the assessment, is developed. A new assessment
must be completed every six months and updates are required whenever there is a change in the child’s status. The services are funded at $450.00 a month for each qualifying child who receives the prescribed set of services. In order to fulfill the service requirements, it is estimated that case managers will provide approximately three hours of service per week for each child.

As a result of the implementation of CW-TCM, stakeholders noted that the community can now provide the specialty interventions to children which were not funded through the Title IV case management services. The most critical outcome of CW-TCM is its central role in facilitating the reduction of caseloads by providing the necessary funds for employment of additional case managers. The reduction in caseload sizes has heightened the intensity of services provided and increased the quality of coordination on behalf of the child and family. Subsequently, the length of time that children are in the system is diminished since enhanced services expedite achievement of desired outcomes.

**Policy Implications**

The findings from this study have important policy ramifications for both the mental health and child welfare reforms taking place in Florida, since entry into the child welfare system provides an opportunity for secondary prevention with regard to child behavioral health problems. One challenge is to better understand how to design child welfare privatization reforms so that child and family outcomes are optimized.

Other revenue maximization efforts have been proposed in Florida to draw down additional federal funds by using local monies as match. These funds would be directed toward enhancing services that meet the educational, developmental and safety needs of children at risk for abuse and neglect. Given the overall success achieved with CW-TCM in fostering enhanced services, pursuit of other revenue maximization efforts could similarly foster positive outcomes for children in the State. Declines in State general revenue resources combined with diminished TANF funding for child welfare services may detract from efforts to provide an array of support services. Subsequently, alternative resources for prevention and early intervention are critical to diminish foster care placements.

Medicaid funding for child welfare services has increased over 25% from FY1998 to FY2000 (Bess et al., 2000). This increase reflects greater efforts to maximize funding through targeted case management services. Yet this initiative has required improved information management systems to carefully track casework activities that are eligible for Medicaid funding. Further investment in an integrated information system is important not only for accountability, but also to ensure continuity and quality of services that are provided. Further developments of HomeSafeNet must focus on time saving efforts to support enhanced service delivery.
Other policy recommendations include:

- The development of a Medicaid handbook for CW-TCM and ongoing training will be necessary if statewide implementation is approved at the Federal level. A process to train the trainers at various sites and subsequently build capacity for technical assistance is recommended.

- As new agencies begin implementing CW-TCM they will need extensive guidance to understand the match and billing process. Moreover, AHCA could experience a greater deficit situation due to the one to two-month time lag before payment is received since DCF needs to mediate the billing process. A more direct invoicing process with the Community-Based Care lead agencies may eliminate issues with cash flow.

- Availability of the resources of the community needs to be considered prior to statewide implementation of CW-TCM. For example, in rural counties, reimbursements for transportation may need to be incorporated in order to facilitate service delivery based on the requirements for CW-TCM.

- Creation of a model process for implementation of CW-TCM, including budget amendments, TCM projections, cost allocations/analysis for hiring new staff, and monitoring of activity logs will be necessary for new sites to learn from the experience of existing service agencies.

- New implementation sites should begin with a pilot. Technical assistance to help with confusion over documentation and ongoing supervision are essential to the success of implementation efforts. Subsequently, the initial pilot group can be trainers and mentors to additional staff that are introduced to the services.

- If Federal approval of statewide implementation is not granted, alternative funding mechanisms need to be explored in order to support enhanced services for children.

Implementation of statewide auditing and monitoring mechanisms is needed to collect data to support the rate for CW-TCM. Existing information could be collected from time logs and established information systems in order to minimize the burden on the lead agencies and providers.
Introduction

By tracking Medicaid services provided to children in the Florida child protection system, researchers at the Louis de la Parte Florida Mental Health Institute (FMHI) have identified the strengths and challenges in meeting the behavioral health needs of the children and families served. Ongoing changes in the child welfare system have highlighted the importance of understanding shifts in expenditures for children’s behavioral health services as child protection reforms are implemented.

In 2000, researchers at FMHI were funded by the Agency for Health Care Administration (AHCA) to study Medicaid services for children in the Florida child protection system who had mental health needs (Berson & Armstrong, 2000). FMHI researchers analyzed Medicaid claims data for FY 1997–1998 in AHCA Areas 4 and 6. The study found that access to mental health services varied based on the health plan in which the child was enrolled. Overall, high percentages of children accessed physician services related to mental health issues as opposed to other specialized interventions.

In 2001, clinical case record reviews were designed to assess (a) access to and level of care provided to child welfare clients by fee for service and managed care plans/providers; (b) the appropriateness of provider networks for this population; and (c) whether the mental health needs of the children receiving protective services are being met (Berson, Roggenbaum, & Vargo, 2001). Specific attention was paid to examining linkages between characteristics of abuse/neglect, the traumatic effects of the maltreatment, and provision of trauma-based interventions. It was found that children who have accessed services have much higher rates of mental health symptomatology than their counterparts who have not received some form of Medicaid-funded mental health services. In addition, the children who did not access Medicaid-funded mental health services displayed much higher levels of resiliency overall, including stronger interpersonal relations, relationship permanence, and educational/vocational capacities. Common barriers to accessing necessary mental health services included client noncompliance with treatment, client lack of proper financial or emotional support to properly access and benefit from services, and client relocation. Other clients experienced problems during therapy due to the severity of their mental illness or the severity of past abuse.
More intensive clinical case studies on currently open Department of Children and Families (DCF) foster care cases in the SunCoast Region were completed in 2002 (Berson, Vargo, Roggenbaum & Baker, 2002). Specifically, this study was designed to examine: (1) how demographic, behavioral, attitudinal, family and service system factors are related to service use patterns; (2) how foster care outcomes (child safety, permanence, child well-being and family stability) are supported through the mental health services received; and (3) whether interventions have been designed to include multiple systems (the child, foster parents, peers, school staff, behavioral and mental health professionals, and the broader community). This study focused on twenty-one youth ages 10–17 years old in foster care placements. The case studies consisted of a triad of semistructured interviews with a youth, a caregiver, and a primary behavioral health service provider.

Among the findings, it was apparent that service coordination was critical to facilitate communication between the child welfare system and foster families and to follow-up after intensive services have ended in order to make sure necessary supports are in place. Moreover, it was important to involve the youth and family in defining needs and identifying solutions. Improvements were suggested to better coordinate transition services for the child and to explore how funding mechanisms could be used to optimize continuity in access to services. Specifically, child welfare goals of permanency and placement stability needed to be incorporated into the behavioral treatment plan to help ensure that coordination of service delivery emphasized common desired outcomes for the youth and included transition planning. The findings of this study highlighted the importance of a sense of belonging and connectedness for a child's long term functioning. While the foster care experience, combined with the abuse and neglect that resulted in foster care placement, can create barriers to promoting well-being in youth, the positive development of young people could be achieved through supports, stabilized care, and coordinated services.

Building on previous research which highlighted the importance of coordinated service delivery across domains as well as integration of child protection goals with other identified areas of need, this report presents the findings of the FY 2002–2003 study of Child Welfare Targeted Case Management (CW-TCM). CW-TCM is a Medicaid-funded service which is intended to optimize service coordination for children in child protection.

In 1998, Florida embarked on an effort to privatize child welfare services through contracts with community-based agencies. Referred to as Community-Based Care, the privatization plan is built on the belief that communities will be more accountable for children in their local area and can maintain greater flexibility for innovative practices than found in a large state agency (For a more in-depth discussion of Florida's Community-Based Care see Paulson et al., 2003). Concurrent with its
privatization initiative, Florida submitted a child welfare waiver application to the U.S. Department of Health and Human Services (HHS), requesting that it be allowed to integrate Title XIX (Medicaid) and Title IV-E (foster care and adoption) funding streams and services (Appendix A). The rationale for the State’s waiver was built on recognition that child welfare services required a new set of resources to facilitate caseload reduction. CW-TCM could potentially foster a more favorable fiscal environment for statewide privatization of the child welfare system. Moreover, funding for case management of services which addressed the children’s behavioral, emotional, or educational needs would address an important deficit in the service delivery system and facilitate better coordination among caseworkers and direct service providers in the community.

The Role of Case Management

The ubiquitous role of case management has established it as a cornerstone of human service delivery across diverse systems of care. Case management is a strategic mechanism for controlling costs while facilitating quality outcomes. There is not one uniform definition of case management, and programs often use terms interchangeably to refer to the concept of coordinating care. Case management models also vary; however, they share a common goal to integrate services across fragmented health and social service delivery systems.

Various forms of case management programs have been developed to improve the service delivery process for children. These programs have been considered critical to optimizing the service delivery for children with challenging social and family needs who subsequently need to access services from a variety of agencies. Outcome studies on case management services suggest that overall functioning of youth improves; however, controlled studies are lacking which can attribute these outcomes to the case management interventions employed (Frankel & Heft-La Porte, 1998).

Case Management in Child Welfare

Children and families involved with child protection services exhibit a multiplicity of needs. Since no one service or program component is sufficient to address all of these needs, case management incorporates essential features to access a broad array of services on behalf of the child and family. Case management has been described as the “glue that holds the system together, assuring continuity of services for the child and family” (Stroul & Friedman, 1986). Case management can be a strength of the system by counteracting service fragmentation and promoting customization of services to the individual needs of youth and families. The role of case management can be focused on cost
containment through service linkage and monitoring of cost effectiveness. Case study analyses have suggested that case managers have played an integral role in coordinating service plans, linking providers, and supporting children and families (Burchard et al., 1991; Stroul & Friedman, 1994).

In child welfare, case management was initially addressed in the 1974 Child Abuse Prevention and Treatment Act. Case management has continued to be a critical service component in subsequent legislation on the needs of vulnerable children who have been abused (i.e., Child Welfare & Adoption Assistance Act, 1980; Family Support Act, 1988; Family Preservation & Support Services of Omnibus Budget Reconciliations Act, 1983).

Case management in the child protection system provides a structured mechanism for informing the family about resources or interventions in the immediate community. The inclusion of strength-based assessments facilitates the individualization of services, and families are engaged as active partners with a voice in the development and implementation of the case plan. Interagency collaboration is evident in successful models where effective team management is fostered. Integration of services offers a cost effective option to coordinate care for clients with complex needs. Moreover, the care planning process provides and promotes fiscally accountable decisions which maintain quality of care.

Child welfare programs have traditionally encompassed a range of programs and services, with funding primarily authorized under Title IV-E of the Social Security Act (Appendix B). Recent initiatives to shift child welfare services to private entities have brought about concomitant changes in the provision of the array of child welfare services and efforts to supplement the contract rate with funds from other sources. Medicaid, a federally reimbursable program, has provided an additional source for subsidizing the cost of services. Traditionally restrictions on eligibility and prohibition on the use of funds, as well as service access problems, have been commonplace. The new service delivery system initiated efforts to blend funds and locate alternative funding sources to increase flexibility in purchasing individualized, family-based services.

The role of Medicaid as a funder of case management services has continued to evolve over time. A series of demonstration projects have included a waiver of traditional funding restrictions so that Medicaid funds could support community-based care services (Austin & McClelland, 1997). Other approaches have involved the capitation of negotiated daily rates for Medicaid enrollees. Although these models of program funding can facilitate improved coordination, these efforts have typically perpetuated categorical programming that allows for only incremental system change.
Florida’s Medicaid-Funded Child Welfare Targeted Case Management

Targeted case management has attracted a tremendous amount of attention throughout the state of Florida both as a beneficial intervention for children who are involved with the child protection system, and also as a funding stream which can foster a standard of care critical for effective and efficient service delivery. The importance of developing coordinated networks of service providers has resulted in the shift of many case management responsibilities from the public agency to private contractors. These case management functions include assessment and identification of treatment goals and needed services, coordination of service delivery, tracking the child’s progress toward treatment goals, and gauging the appropriateness of services provided. Interest in targeted case management has heightened, since there is an anticipated substantial increase in the rates of utilization of this intervention as the service expands throughout the state of Florida. Before the quality of care provided to children receiving targeted case management can be assessed, the structure of the delivery system and the context in which it operates must be clarified.

Child Welfare Targeted Case Management initially was provided only in Sarasota County. Recently the service expanded to Manatee, and expansion has been planned for statewide implementation. All Medicaid eligible children, ages 0–21, who have been placed under protective supervision by a protective investigator based on a determination of either some indication of maltreatment or verified maltreatment, or have been court ordered into shelter or foster care can receive child welfare targeted case management.

Under the child welfare targeted case management:

- Case management is defined as those activities which will assist Medicaid eligible children, ages 0–21, in Florida in accessing services across several areas, including mental health, medical, social, and educational needs.
- The case manager, in partnership with the child, family, significant others, or identified caregivers, facilitates access to and coordinates the services, treatments, and supports necessary to achieve the goals and objectives stated in the service plan, based on a needs assessment which includes identified strengths, cultural characteristics, and natural support.
- Qualified CW-TCM case managers must meet certification standards and requirements.

Since children in the child protection system often have a range of medical, mental health, and developmental problems, they require services from several providers, necessitating collaborative planning and assistance in accessing needed supports. The child welfare targeted
case management services provide that child recipients who have been placed under protective supervision, or have been court ordered into shelter or foster care, receive service delivery which is integrated with the case plans developed by the Department of Children and Families, or the Community-Based Care provider contracted with the Department. The intent is to foster a model of active collaboration between the service agencies, which minimizes duplication of case management. This is a creative strategy to overcome the traditional barriers which have prevented children in the child welfare system from accessing appropriate care.

**Purpose of the Study**

This study aims to analyze the targeted case management approach as a systematic strategy to ensure that the mental health and support needs of children in the child protection system are adequately met. A crucial step in demonstrating the effectiveness of this intervention is to establish that it has been adequately described and implemented. At the formative stages of the implementation of child welfare targeted case management, a process for operationally defining the intervention based on theoretical and procedural designs of the model is needed. The complexity and flexibility of the targeted case management process requires careful consideration and a systematic assessment of implementation. Before outcomes can be measured, stakeholders need to understand what elements of the process are being implemented by practitioners in the agencies, expectations for what can be achieved need to be clarified, and the role of fidelity in diffusion of the intervention statewide needs to be considered. This project was designed to define the delivery of targeted case management to children and youth in a system of community based care. The study focused on identifying the active ingredients of child welfare targeted case management which may subsequently contribute to client outcomes. The analysis was inferential based on empirical research as well as commentary from stakeholders in the field. The purpose was to describe the key factors associated with Child Welfare Targeted Case Management.
Research Design

This study expands on our understanding of Child Welfare Targeted Case Management and delineates the roles and activities associated with this service. Information was gathered using a variety of research methods. To learn about State policies governing Child Welfare Targeted Case Management, interviews were conducted with key informants (to identify issues affecting the program; the philosophy and approach to service delivery; interpretation of program goals; perceptions of program strengths and weaknesses). The research plan also included administration of a structured response instrument to staff, observations of case staffings (to measure group problem solving and decision-making processes), and a review of documents (i.e., policy guidelines, satisfaction surveys, case manager time tracking) as well as Medicaid claims data.

Research Questions

The research was designed to examine the following questions:

1. What are the critical program components of Child Welfare Targeted Case Management services?
2. What percent of eligible children are served by Child Welfare Targeted Case Management?
   a. Given the limited amount of funding available for this service, what is the process used to prioritize cases which will receive CW-TCM?
3. What quality of change has been noticed as a result of implementation of Child Welfare Targeted Case Management?
4. How are targeted case management services structured to contain costs while optimizing child welfare outcomes?
5. How is Child Welfare Targeted Case Management coordinated with other services and funding mechanisms?
6. What case manager characteristics and behaviors contribute to effective practice?
7. What are the benefits of targeted case management?
8. What barriers to effective implementation of targeted case management exist?

Methodology

Two stakeholder meetings were held in order for the research team to establish a working relationship with agencies providing child welfare targeted case management services and the Community-Based Care organizations governing their service delivery. The research team introduced the project focus and solicited feedback on the research questions, methodology, and data analysis in addition to collecting
pertinent documents and information on organizational procedures related to targeted case management services. As Dixon-Woods, Fitzpatrick, and Roberts (2001) suggest, this initial qualitative activity helps to refine the research questions, identify the pertinent outcomes of interest, and gain background information on relevant types of participants and interventions. It is important to learn which issues stakeholders view as important and what they believe should drive the research study (Fetterman, 1998). Stakeholders provided input in terms of variables that were observed and the issues that were addressed. Views of opposing stakeholders were gathered and multiple opinions woven together.

Procedural documents were collected from various stakeholders and providers at each site. This approach provided information on how organizations conceptualize their child welfare targeted case management services, specific details of organizational procedures related to service delivery, and organizational or procedural changes which may have occurred with the addition of child welfare targeted case management services. The research team also attended an intensive training program on targeted case management for child welfare clients, hosted by a local Community-Based Care lead agency and geared toward service delivery and provider level implementation.

A semi-structured interview protocol was developed regarding the implementation of child welfare targeted case management (Appendix C). The questions assessed the salient features of child welfare targeted case management services. Face-to-face interviews were conducted with 25 stakeholders, including child welfare administrators and caseworkers, mental health agency administrators and workers, and mental health providers. Questions were designed to assess: (a) work roles and activities associated with child welfare targeted case management; (b) access to targeted case management services; (b) mechanisms to avoid duplication of services; (c) benefits of targeted case management; and (d) barriers to effective implementation. Qualitative research such as stakeholder interviews offers thick description that can shed light on the contextual basis for quantitative results or larger social issues. Qualitative research is suited to the study of process, implementation, communication, and negotiation/conflict resolution. It can often uncover unexpected consequences of service developments and system-wide implementations and will generate further research questions (Barbour, 2000).

In order to gain more knowledge about front-line staff, data was requested from AHCA and the provider agencies to answer questions pertaining to demographics and professionalization of staff (e.g., date of hire, date of certification, race/ethnicity, educational background). A brief email survey (Appendix D) was also sent to the child welfare targeted case managers in order to gain their perspectives on service provision. Specifically, the provider survey contained both close-ended and open-
ended questions pertaining to types of services offered and perceived benefits of and barriers to targeted case management services.

Upon the suggestion of local stakeholders, the research team observed case staffings in which the caregivers were often present. An observation protocol was adapted from the Team Meeting Observation Form (Epstein et al., 1998; Appendix E) that examines service coordination and tailoring of services to the needs of individual children and families. The caregiver was then asked to debrief with an interviewer for a short period of time immediately following the staffing in order to gauge their impressions of the staffing as well as targeted case management services and service coordination. A portion of the questions asked of the caregiver were adapted from the Service Coordination Scale (Regional Research Institute for Human Services, 1992; Appendix F). Data collected was used to identify critical elements of targeted case management approaches for children in the child welfare system.

Participants
This study focused on children and families who currently receive Child Welfare Targeted Case Management. Respondents to interviews and surveys also included key informants, such as child welfare administrators and caseworkers, mental health agency administrators and workers, and mental health providers.

Data Analysis
Content analysis of the documents, the open-ended survey questions, and the in-depth interview responses were used to analyze the qualitative data collected for this study. Content analysis involved reviewing interview transcripts to select common themes and trends in the data. One may also note similarities and differences in the implementation process by stakeholders and service provider sites. The primary goal of content analysis is to condense the amount of qualitative data into a list of variables that can be examined for correlations. The research team began with text (qualitative data), made formal hypotheses as to the nature of the text's content, performed systematic coding and analysis, and finally interpreted the results in conjunction with quantitative data, thus allowing for the triangulation of data sources. Based on qualitative analysis of interview data, quantitative analysis of administrative data, and a review of existing standards for targeted case management with children in the child protection system, a framework of critical components that are needed to meet the mental health needs of children in the child welfare system were developed.
Results

The Rationale for Implementation of Child Welfare Targeted Case Management (CW-TCM)

A review of documents from AHCA and stakeholder interviews provided background information on the catalyst for implementing CW-TCM. A common issue identified by stakeholders was the perception that funding for child welfare services was inadequate. Child welfare services are funded by federal, state, and local funds. The two largest federal programs with funding appropriated specifically for child welfare services are Titles IV-B and IV-E of the Social Security Act. See Appendix B for a table of key federal child welfare funding sources (For an in-depth discussion of fiscal issues in child welfare see Bess et al., 2002).

Several of the stakeholders also noted that children in the child protection system had been an overlooked population in terms of case management. Many studies have documented that children in foster care are more likely to experience emotional, behavioral, educational and physical deficits or delays than children in parent care. Although foster or relative placements are intended to create a safe and nurturing environment for the child, nearly 25% of these children live with caregivers experiencing high levels of distress. Moreover, many children who are involved in the child welfare system and present with significant behavioral and emotional problems do not receive intervening services (Kortenkamp & Ehrle, 2002). Similar results were found in studies of the Florida child welfare population (Berson, Vargo, Roggenbaum, & Baker, 2002). Stakeholders indicated that many of these children had the need for similar kinds of services as those children in the mental health system, but the child welfare children did not necessarily have a diagnosis for a mental health disorder. Without having to “bend the rules” and label every child with a mental health condition, advocates of CW-TCM wanted to find a way to cover this population so that the child could benefit from enhanced services. Precedent had been established by other states which had already explored accessing Medicaid dollars in order to maximize the State’s general revenue and draw down additional federal dollars for the provision of services. The supplemental dollars could then be used to offset costs of providing specialized services and hiring more caseworkers, subsequently decreasing caseload sizes.

Legal authority for targeted case management is authorized under Section 1915(g) of the Social Security Act. This authority provides that a State may elect to furnish case management services as a service covered under the State plan to specified groups. It also provides an exception to the comparability requirement of Section 1902(a)(10)(B) of the Act by allowing a State to furnish case management to any specific group (targeted case management). The purpose of this case
management is to assist individuals in gaining access to necessary medical, social, educational, and other services identified as appropriate to address an individual’s specific needs. Groups that were already approved for targeted case management included:

- Children’s Mental Health Target Group: birth through 17 years old
- Adult Target Group: age 18 and older (Adult Group includes those who qualify for Intensive Case Management Team Services)
- Children's Medical Services: recipient of CMS services

Proponents of providing services to children in the child protection system suggested developing a Child Welfare Target Group for those children who had a multiplicity of needs and involvement as cross service entities but did not qualify for any other targeted case management services. Consequently, children in the child welfare system would not need to be diagnosed with a mental health disorder in order to receive enhanced services to optimize their care.

Another impetus for CW-TCM was a dedication by the community to ensure that children received the highest quality of care and that continuity of services was maintained. The traditional system of child protection had resulted in a fragmented process where the child's needs often were overlooked due to poor or nonexistent coordination. Caseworkers previously were overwhelmed by excessive caseloads and struggled to provide basic services to address the safety and permanency needs of the child, the primary focus under Title IV case management services. Conversely, CW-TCM offered an opportunity to support a primary case manager with a reasonable caseload size. As a result, increased attention could be focused on the broader needs of the child and family. One stakeholder commented that since Medicaid also required an enhanced level of accountability in the form of documentation and adherence to service guidelines, accessing these resources to fund child welfare case managers could further contribute to improvement of the quality of services provided.

A State Plan Amendment to implement CW-TCM in Sarasota and Manatee Counties under the Sarasota YMCA, the Community-Based Care lead agency, was approved by the Florida legislature in 1998 (Appendix A). Expansion of CW-TCM has proceeded to Family Continuity Programs, the Community-Based Care lead agency in Pinellas and Pasco Counties, but approval of an amendment for statewide implementation has been delayed due to federal inquiries into further expansion of targeted case management services.
Critical Program Components of Child Welfare Targeted Case Management Services

During interviews with stakeholders, respondents’ estimates on the percentage of children on their caseload who received CW-TCM ranged from 16% to 80%. On average, across all service providers, approximately 25% of children served receive CW-TCM. Eligibility requirements, availability of certified staff, and amount of state match available are contributing factors which determine whether CW-TCM services can be offered to a child. Children who are 0 to 21 years of age, are Medicaid eligible, are not receiving any other Medicaid funded case management services, require at least two services, and meet one of the following three conditions fulfill the criteria to receive CW-TCM:

• The child is placed under protective supervision by a protective investigator based on a determination of some indication of maltreatment or verified maltreatment;
• The child has been court ordered into shelter; or
• The child has been court ordered into foster care.

Issues related to eligibility of children for CW-TCM can be complex since a child’s status may change over time. Some agencies have designated staff to check children’s eligibility on a monthly basis. Stakeholders noted that careful monitoring is needed to ensure that children’s services are appropriately billed; however, there is a universal desire to streamline the eligibility criteria for CW-TCM and MH-TCM and create a more generic Children’s TCM that covers both service criteria, thus fostering greater continuity in service provision. Children who do not qualify for CW-TCM services include protective service cases, illegal immigrants, and individuals with private insurance. Very young children may require CW-TCM in order to assist with coordination of behavioral interventions, daycare, medical needs (e.g., Cocaine exposed infant), and developmental issues. Eligibility of children can shift from month to month due to changing life circumstances, and some children transition from CW-TCM to MH-TCM and vice versa depending on the presence of a diagnosed mental health disorder.

In order to comply with the requirements of CW-TCM, case managers must see the child twice a month. One of these visits is required to be in the home and include a face-to-face meeting with the child to assess the child’s and family’s progress towards the goals and objectives pertaining to the child’s needs and stability in the living environment and as stated in the child’s service plan. A second face-to-face visit can be conducted in the place of residence or any other setting where the child spends a significant amount of time. The case manager also has to maintain verbal or written contact with at least two separate service providers (e.g., foster
parents, counselor, school, etc.) to determine the adequacy of the amount and type of services in meeting the child's needs. Prior to billing, an assessment of the child's strengths, weaknesses, needs, natural supports, and required services must be completed within 30 days of referral. A service plan, which is based on the assessment, is developed. On a monthly basis most agencies have opted to complete a functional assessment with input from service providers, teachers, family members, and other significant persons in the child's life. Alternately, case managers have the option to complete a client satisfaction survey instead. The functional assessment is done within 30 days of billing Medicaid. Case managers develop a comprehensive summary depicting the child's progress toward specified goals as well as the stability of the living arrangement. A new assessment must be completed every 6 months and updates are required whenever there is a change in the child's status. Individualized service plans must be developed to include long-term outcomes for the child as well as a long-term permanency plan. It must outline a comprehensive strategy for assisting the child in attaining the outcomes, including identifying service needs and providers. Measurable goals and objectives related to each service must be clearly stated, and the interventions by the multiple service providers should be integrated to optimize effectiveness and avoid duplication of effort. The services are funded at $450.00 a month for each qualifying child who receives the prescribed set of services. In order to fulfill the service requirements, it is estimated that case managers will provide approximately three hours of service per week for each child.

The provider agencies must be careful to clearly differentiate their case manager activities which are covered by Title IV-E from Medicaid funded activities. In addition to Title IV-E case management, other services which are not billable under CW-TCM are initial and annual adoption subsidy development, review, and processing; transportation; consultation with child welfare legal services, preparing legal documents, court prep and appearances; performing adoption pre-placement and placement activities; arranging termination of parental rights; out-of-home care placement Services; relative Caregiver Program oversight; or clinical, therapeutic or counseling services.

Medicaid claims data for FY 1999–2000 were analyzed to gauge access to CW-TCM services within District 8 (Sarasota), the primary region for implementation. Of the 1900 claims filed for CW-TCM, over 78% of the services were provided to children 8 years of age or younger, with the majority in the 0-3 age grouping. These 1900 claims were filed for 471 users (Table 1).
The higher prevalence of users in the 0–8 year age range can be attributed to the tendency for younger children who have multiple needs for coordinated services to present with behavioral issues rather than a diagnosable mental health disorder. Without a mental health diagnosis these children cannot qualify for mental health targeted case management services; however, they can receive the needed care coordination through CW-TCM.

Over time, implementation sites have noted that the number of children served with CW-TCM can vary from month to month due to changes in children’s eligibility, staff turnover, and the amount of general revenue match available for cost sharing with the federal resources from Medicaid. If an agency must remove a child from CW-TCM because of one of the reasons cited above, the agencies cannot fund the comprehensive and intensive services for the child; however, they will continue to provide basic child welfare case management which is funded through different funding streams.

**Case Manager Characteristics**

Case managers have to be approved and certified by the Community-Based Care lead agency (Chapter 409.1671, F.S.). They must have a minimum of a B.A. in a human services field and one year of experience in working with children who have been, or are at risk of being, abused, neglected, or abandoned. All of the caseworkers and supervisors complete the State mandated training through the Professional Development Centers in a track which is focused on casework services as well as provides information on signs and symptoms of abuse and neglect. Training enhancements which are more specific to the community in which the case manager works are offered by the lead agency subsequent to the basic six week coursework. The training is followed by supervised field work and a Field Based Performance Assessment.
All caseworkers and supervisors are required to obtain and maintain State Certification. The lead agency and provider agencies strive for the staff to be State-certified within one year of employment. To maintain certification, the case managers have to participate in at least 48 hours of continuing education over a three year period.

The rate of turnover of case managers was very high during 2002. Some stakeholders attributed this in large part due to adverse events occurring throughout Florida’s child welfare system, including child deaths, missing children, extensive media attention, and punitive consequences for case managers who failed to provide competent and professional services. Some agencies reported difficulty in locating qualified people who possessed one year experience with at-risk populations while others lamented that they struggled to find anyone interested in working within the child protection system. Efforts to nationally recruit personnel have been underway with moderate success. However, since many new employees have needed to fulfill their one year of experience on the job, the agency has had to wait until the experience requirement was met before the person could be certified and begin billing for CW-TCM.

Training has been an important component of preparing people for their role as case managers. Following the six week training with the Professional Development Centers (PDC), the case managers receive a week of training in community-based issues, time management skill development, paperwork orientation, and mentorship by a supervisor or coordinator who is experienced in case management services. Ongoing training is necessary due to poor staff retention and the complex service delivery process. In some areas case workers are trained to provide both CW-TCM and MH-TCM in order to ensure continuity of service delivery to children and families. Other providers have structured services so that child welfare case management is separated from Mental Health TCM with different staff providing the respective services. Greater vigilance for open communication among service entities is necessary for the latter paradigm.

Once they are certified for billing, case managers must average a caseload size of 20 children. Because the rate for CW-TCM was based on three hours of service delivery per week, the intensity of the required services necessitates that case workers maintain a mixed caseload with some cases that involve CW-TCM (in addition to IV-E case management) and others that only receive Title IV-E services. In compliance with Medicaid criteria, extensive documentation is required. Medicaid has stringent requirements, including activity logs to track adherence to service specifications and avoid billing for ineligible activities. Despite vigilance in monitoring service provision, there is lingering confusion over differentiating case management activities between the various funding sources. Specific areas of uncertainty involve situations where case
activities which are funded by different entities converge (i.e., court and service coordination activities; transportation and functional assessment). Some providers also struggle in differentiating between services which are provided to the family for the benefit of the child, thereby qualifying for coverage by CW-TCM, and other individual services to a parent or caregiver which must be funded through alternative resources.

**Survey of Child Welfare Targeted Case Managers**

In order to gain more knowledge regarding child welfare targeted case management, a survey (see Appendix D) was distributed to the child welfare targeted case managers and supervisors. The survey focused on demographics, professionalization issues, and service provision. Additionally, the surveys contained both close-ended and open-ended questions pertaining to types of services offered and perceived benefits of and barriers to targeted case management services.

A list of child welfare targeted case managers who had billed for services from October to December 2002 was supplied by the Agency for Health Care Administration. The Sarasota YMCA (the Community-Based Care lead agency) reviewed the list, and names of staff that were no longer employed were removed. Four attempts were made to contact child welfare targeted case managers. First, an email survey was sent to the remaining 42 child welfare targeted case managers. A second email accompanied by the survey was sent. Third, the research team sent a reminder email. Finally, a lead agency representative distributed hard copies to staff mailboxes on-site. This final distribution included child welfare targeted case manager supervisors.

Fourteen child welfare targeted case managers (33%) completed surveys. The 14 staff represented three child welfare targeted case management agencies: Manatee Glens (N=2), Child Development Center (N=5), and Family Counseling Services (N=7).

Staff responding to the survey ranged in age from 26 to 64 years old. On average they were 42 years of age and had completed their most recent degree over 12 years ago. The respondents were predominantly female (92%) and white (64%). The racial/ethnic breakdown of staff (N=14) was: White (N= 9), African American/Black (N=3), Asian (N=1), and Hispanic/Latino (N=1).

Nearly 86% of the child welfare targeted case managers reported earning a Bachelor’s degree, and two respondents had completed a Master’s degree. Most degrees were in the human services: education, social work, psychology, sociology and criminal justice/criminology. Eight staff indicated prior experience with abused/neglected children, ranging from one to 6.5 years. The mean number of years of experience with abused/neglected children for these eight staff was 2.75. Additionally,
over half of the respondents had prior experience providing case management functions, ranging from one to 18 years. The mean number of years experience providing case management functions for these eight staff was 8.13. Conversely, 43% of the respondents indicated no prior experience with abused/neglected children. These six child welfare targeted case managers also noted that they had not previously worked in a position providing case management functions.

Among the respondents who carried a caseload, the mean number of cases served was 18.8, ranging from 15 to 20 children served. On average over 14 cases serviced by each case manager received CW-TCM. Child Welfare Targeted Case Management cases ranged from 9 to 20 children per caseworker. The average number of hours per week spent on required services to each child/caregiver currently receiving Child Welfare Targeted Case Management services (e.g., home visits, documentation, contact with service providers, observation of child, survey and assessment, etc.) was reported at four hours per week and ranged from two to eight hours, depending on the needs of the child during a specified timeframe.

Respondents were asked to rank ten activities in order from highest to lowest regarding their current allocation of time for each activity. The activities which were identified as the most time consuming were:

- Making home visits and required face-to-face visits for assessing, arranging, integrating, coordinating, and ongoing monitoring of the services and supports necessary to achieve the child's stability.
- Maintaining required paperwork (e.g., case notes, monthly billing forms, face-to-face contact verification, etc.).
- Communicating and collaborating with the biological parents or other family members regarding the child's care, needs, and progress if the child is in foster/out of home care.
- Advocating for and assuring access to services and supports that address the unique needs of the child which were identified in the assessment.

Child Welfare Targeted Case Managers also ranked the same ten items in the manner respondents would ideally allocate their time. The following four items received the highest rankings:

- Communicating and collaborating with the biological parents or other family members regarding the child's care, needs, and progress if the child is in foster/out of home care (six responses).
- Promoting coordination, integration, and continuity of services (social, medical, educational, etc.) for the child by multiple providers, including involving and updating providers on developments in the child's situation (six responses).
• Advocating for and assuring access to services and supports that address the unique needs of the child which were identified in the assessment (five responses).

• Encouraging and supporting the child and family’s participation in the services offered as part of the case plan (five responses).

Respondents were asked to identify benefits of child welfare targeted case management. Four case managers listed child safety and protection as primary benefits while two other respondents indirectly cited child safety (i.e., “Promotes regular and frequent contact with children,” and “Better able to monitor child and build better relationships.”). Four respondents described the benefits of enhanced service provision. Conversely, barriers to effective implementation of CW-TCM included excessive paperwork (i.e., too much, duplicative reporting, unnecessary) and frustration with the time demands for HomeSafeNet (HSN).

Child Welfare Targeted Case Managers shared a number of suggestions to improve the provision of CW-TCM. Some of the suggestions focused on improving administrative requirements (i.e., duplicative paperwork and information systems) and increasing time spent with children and families. The importance of maintaining small caseloads was highlighted as well as ongoing resource development in the community to allow parents to access services without fees and sustain access to supports when the case closed.

Fiscal Issues

Since the lead agency holds the contract with the Department of Children & Families, any general revenue match has to be administered by the CBC lead agency. Each CBC provider that participates in the program must provide the State’s share of the match for AHCA. Contracts are written with the lead agency at the beginning of the year, and based on the funding that is provided in those contracts, the CBC lead agency determines how much the providers anticipate billing to AHCA. This calculation is used to project the portion of general revenue which is needed for the match. That portion of the general revenue is amended out of the lead agency’s contract and the DCF district or regional office uses the bills that are received on a monthly basis from AHCA to reimburse AHCA for the State’s portion of the match. In other words, the lead agency must inform DCF of the estimated amount of funds to be held from the CBC contract to provide the required General Revenue State match for this service. This process requires the lead agency to track its sources of funding and what has been billed every month. Careful attention to the funding categories allows for more accurate annual projections. It is an ongoing process throughout the year because it is based on estimates. Although attempts are made to get a large portion of the State match amended out early in the year, as the time period draws to a close, budget amendments are needed. This billing
process results in a one to two month lag between the time the provider submits a Medicaid claim and it is paid. The lag is necessary in order to determine how much general revenue or other state funds are needed to transfer to AHCA.

The lead agency also provides general oversight to ensure that providers are accurately implementing the service, documenting the needs of the children, and monitoring the eligibility of the child. Provider agencies defer to the lead agency for management of the fiscal issues, but the provider is responsible for billing Medicaid and letting the lead agency know what amount it billed per month. By keeping the provider abreast of how much has been used and how much has been drawn down, the lead agency must make sure that the general revenue funds are available for the Department to pay AHCA in a timely manner. Budget amendments are often necessary to move the budget authority from one particular set of funding to another category. Projections are difficult to structure during early implementation phases, since it requires that the lead agency use the prior year’s expenditures, amend the costs out early in the contract term, and hold it in reserves to be able to pull out of the budget to pay AHCA on time. The lead agency needs to have enough flexibility to keep a cushion so that general revenue resources can be held in reserve but money can still cover other service needs, even if the basis for holding the money is in anticipation of monies that they have not yet earned.

The current State Match percentage is 41.17% of $185.27 dollars a month for every child served with CW-TCM. In order to generate this revenue some stakeholders indicate that it would be easier for AHCA to directly bill the lead agency and have the lead agency directly pay AHCA without DCF mediating the process. However, AHCA has preferred to have one government entity oversee the fiscal issues rather than deal with multiple private vendors.

**Service Delivery Changes Resulting from Implementation of Child Welfare Targeted Case Management**

As a result of the implementation of CW-TCM, stakeholders noted that the community can now provide the specialty interventions to children which were not funded through the Title IV case management services. The most critical outcome of CW-TCM is its central role in facilitating the reduction of caseloads by providing the necessary funds for employment of additional case managers. The reduction in caseload sizes has heightened the intensity of services provided and increased the quality of coordination on behalf of the child and family. According to the stakeholders interviewed, the length of time that children are in the system is diminished since enhanced services expedite achievement of desired outcomes.
In addition to increasing the amount of contact with the child, more stringent documentation required by Medicaid necessitates a quality assurance process that accounts for the adequacy of the services provided and the appropriateness of the funding sources. Time logging methods provide a mechanism to track different funding sources that are involved and provide some degree of certainty that the allocations that are being performed by these CBC lead agencies are fairly reflective of what the actual activity is that is going on out there. Of course, as funding sources are added, the overall complexity increases.

Extensive monitoring of the CBC sites has focused on verifying consistency in what has been submitted for billing and what is in the master case file. In addition to external monitoring, there is a quarterly internal monitoring process which examines staff development, staff retention, level of supervision, consistency of billing and documentation, and achievement of desired outcomes in cases. Each month, supervisors review cases and reassess the eligibility of the child for ongoing CW-TCM. Peer reviews also create opportunities to review progress while mentoring staff on standards of practice.
Staffing Observations

In order to explore the strengths and weaknesses of implementing services consistent with the principles of family engagement, service integration, and outcomes directed across domains, eight observations of staffings were completed between January and April 2003. Staffings were selected in cases where the child was determined to be receiving child welfare targeted case management services. In all cases, a targeted case manager and a staffing facilitator were present at these meetings. Biological parents, foster parents, relative caregivers, Guardian Ad Litems (GAL), lawyers, and service providers from other agencies such as Developmental Disabilities, were invited to the staffings and were often present. Specifically, caregivers were present at half of the observed staffings. The majority of the staffings covered domains such as family, legal, residential, substance abuse, and mental health. Approximately half of the staffings touched on issues of education, safety, and vocation. Only a few covered cultural, social, or recreational issues.

The Staffing Observation Form (see Appendix E) was used for the observations. This form was created for quantification of Wraparound practices (Epstein et al., 1998). It covers seven domains determined to be of value in successful practice and meeting facilitation: (1) identification of community resources, (2) individualization of service plan, (3) sensitivity to family needs, (4) interagency collaboration, (5) desired outcomes, (6) management of the staffing, and (7) assessment of the staffing facilitator.

Community Resources

Information about resources and interventions in the local area were offered to the team in the majority of staffings, and normally the service plan included at least one public or private community resource or service such as the local YMCA daycare, parenting classes, and the First Step substance abuse program. Schools at all levels were also mentioned as collaborators in working on a child’s emotional and social development.

Unfortunately, families were not always able to afford the resources or services that were suggested. Families noted that they had delayed seeking services such as marital or psychological counseling due to lack of funds. One father noted that better access to community mental health services is very much needed — particularly for those families who are middle class, or in other words, somewhere in between poverty and being able to afford counseling. Funding for daycare was also discussed, particularly at closure staffings because funding for subsidized day care is cut after a case is closed. Families were told that they would have to reapply for the daycare and then it would be determined, based on the family’s income, how much the fees would be.
Informal supports were included less often in the service plans, and friends and relatives of the family were not likely to be present at staffings. However, when residential placement was discussed during the staffing, the team most often chose a placement situation that was within a child’s previous community or geographic area.

**Individualization of the Case Management Plan**

In the majority of cases, the targeted case manager would advocate for services and resources for the family. Families were also allowed to share their opinions on what services they viewed as most critical to their family’s progress. In the cases observed, all of the services that the family and team identified as necessary were included in the service plan. For example, one family identified their goal as working towards a loving and nurturing household. The parents went through an anger management class in order to learn different ways of communicating and less harmful words and phrases to use when expressing themselves. The biological father went through a “nurturing dads” class that was a strength-based parent behavior modification program. The biological mother attended substance abuse treatment, and Healthy Families was also involved with the family.

In most cases, the service plan was amended as a result of the staffing. Many of the staffings also included a discussion of barriers to services and interventions, and solutions were discussed. However, at some staffings parents were not asked what they perceived to be the barriers to their compliance with the service plan. For example, it was stated in one staffing that continued drug involvement and a parental arrest were of concern to the team. However, rather than revising the service plan to address the present barriers, the team thought the best course of action was to close the case and leave the children in the care of the maternal grandmother.

In the majority of the staffings, discussion with the caregivers led to specification of new and revised steps needed to implement the service plan were clearly specified by the team (e.g., how to achieve certain goals in specific behavioral terms). The case plan was tailored to move toward reunification based on measurable progress of the mother going through substance abuse treatment. For example, the purpose of one staffing was to begin overnight visits based on the biological mother’s consecutive sobriety and the success of unsupervised visits between the biological mother and infant.

In addition, these supports and services included in the service plan most often referenced the child’s assessment. For example, it was mentioned that a child had a speech delay and possibly some delay in gross motor functioning; however, the daycare in which he is enrolled could accommodate his delays. The team also questioned how premature
the child was and whether or not he was substance-exposed and to what extent; however, this does not affect the service plan. Another example involved an adolescent with developmental issues who needed a new placement situation (he was currently in a regular foster home and required a higher level of care). It was identified that he had a low IQ level and needed constant supervision due to mild behavior issues. He also suffered from diabetes, a seizure disorder, a palate problem, an inability to feed himself, and incontinence. Long-term residential placements were discussed that might meet these criteria and adequately care for this boy.

Strengths of family members and children, such as skills, actions, or knowledge competencies, were identified and discussed during the staffing. For example, in the previously mentioned staffing it was noted that the adolescent boy involved was generally compliant, nice, and liked helping his teacher. In approximately half of the staffings observed for this report, it was apparent that the service plan was individualized and reflected the family’s and child’s strengths. For example, in one staffing, five brothers were discussed on an individual basis. Only two of the boys were currently placed together and it was suggested that they modify the service plan in order to attempt to reunite all of the brothers within one residential setting.

In addition, a safety plan was discussed in half of the staffings observed. For example, in one staffing it was discussed that the biological mother would have many eyes in the community watching her as she eventually spent more and more time with her child (e.g., child at day care). It was also discussed that the team would make sure that the biological mother did not stop attending NAA meetings and that they knew she would be allowed to bring her baby with her to the meetings (and thus would not have a legitimate excuse for missing the meetings).

Family
This section pertains to the family’s involvement in these staffings. As stated previously, caregivers were present in half of the staffings observed. All caregivers that were present arranged their seating such that they could be actively involved in discussion. Additionally, family members who were present were treated mostly in a courteous fashion; for example, in one staffing the strengths of the biological mother were repeatedly mentioned by the entire team. The case manager’s supervisor even commented that were it not for confidentiality issues, she would have liked to use this biological mother as an example for all the other caregivers dealing with substance abuse. The biological mother’s vocational pursuits were also heralded as noteworthy in that she was employed full time at a steady job and worked overtime for extra money to prepare for the child being returned to her care. However, there was
one staffing in which the caregivers were not consistently treated respectfully by all members of the team. Some team members whispered privately during the meeting in front of the caregivers, presumably about the caregivers. This was both observed by the research team and noted by the caregivers subsequent to the staffing.

In the majority of cases, the family’s perspective was presented to everyone at the staffing; however, it was not routine to ask family members what goals they would like help to work on, change, or improve. In addition, it was not observed that family members had significant input into the designing of the service plan. However, in one staffing, the facilitator asked for feedback from the biological mother and grandfather about progress/satisfaction and they expressed gratitude for assistance and agreement with the service plan. In another staffing, the biological mother took the initiative to bring copies of her parenting class certificate to share with the team.

Although not heavily involved in the creation of the service plan, families (as well as providers) were assigned tasks and responsibilities that promoted the family’s independence (e.g., accessing resources on their own, budgeting, or maintaining housing). It was observed that family members often voiced agreement and/or disagreement with aspects of the service plan. In one case, the biological parents were asked if they were in agreement with the decision to close the case. The mother stated that she felt she had no choice. The facilitator explained that the parents had a choice and reviewed the process. He clarified that in the future, if the parents want to regain custody, they bear the burden of documenting that they have completed the case plan. In addition, they will need to offer a compelling reason for the judge to decide to change the child’s placement, particularly if an extended amount of time has passed.

In the majority of cases, the plan was to keep the biological family intact or to reunite the family. In one case, the foster mother’s views were presented to the team. The foster mother was upset about losing the child to the biological mother; however, she wanted to make sure that the child’s services (day care) continued. The Guardian Ad litem stated that he frequently emailed back and forth with the foster mom and agreed with the case manager’s assessment of the foster mom’s distress in letting go of the child. In another case, the children had never left their parents’ custody or care while the parents completed their court-ordered services. In yet another case, the team spoke about continuing to move towards reunification despite problems with the parent.

**Interagency Collaboration**

At the majority of the staffings observed, staff from other agencies that care about or provide services to the family were present at the meeting and offered an opportunity to provide input. In some cases, these external providers (external to the Sarasota YMCA) added to the dialogue...
on resources and interventions available within the local community. For example, in one case, both an alternate foster home and the Sheriff’s Youth Ranch were reviewed as placement options. Other times they were able to provide updates on the family. For example, the GAL in attendance at one staffing strongly favored having the child remain with the maternal grandmother. She was very complementary of the maternal grandmother and tried to give the biological parents the impression that by closing the case now they could still work toward their service plan goals while retaining the possibility of regaining custody in the future. In this particular case, the rest of the team agreed with the GAL and decided to close the case, leaving the child with the maternal grandmother.

In many cases, it was evident that the targeted case manager had been in contact with other providers prior to the staffing and could offer updates on their part. For example, a representative from Healthy Families visits one couple’s home on a regular basis and the targeted case manager has observed her interaction with the family. Healthy Families was brought into the picture to work on the children’s delayed speech, which the parents were told was associated with a bilingual home. The family noted improvements in their son’s speech and that both children had done well in preschool. As mentioned earlier, informal supports were not present at most of the staffings and did not have a chance to share their opinions.

Problems that can develop in an interagency team (e.g., turf problems, challenges to authority) were not evident during the staffings. Team members were very cordial to each other. They expressed disagreement at times, but were always able to come to a consensus. In approximately half of the staffings, alternative funding sources were discussed before general funds were committed. For example, the team discussed an unfortunate turn of events in a case in which the biological mother had been making remarkable progress in caring for her developmentally disabled 17 year old son. For this reason, developmental services had not been brought into the picture, because it looked like the mother would be able to soon care for her adult son; however, the mother fled, and the foster care agency then faced the challenge of finding and funding a placement that was both long term and equipped to handle the boy’s serious and multiple medical conditions. In this particular case, the foster care agency offered to fund the boy’s placement for three additional months, with the understanding that a waiver be sought and a transition support plan application be filed.

**Unconditional Care**

Termination of child welfare targeted case management services was discussed in a few of the staffings due to improvements with the child and family’s behavior or problems. Termination of other services such as subsidized childcare as a result of a family’s improvement in functioning
was also discussed. This service is normally provided to assist families with open cases while they worked on other issues. In general, if service plan goals were met, the staffing team moved to close the case. In many situations, severe behavior challenges were not present, and thus did not warrant additional safety or crisis planning.

In contrast, termination of services was also discussed due to parent’s lack of progress on service plan goals. In one staffing, services were being terminated because the team felt that the parents were not making progress, and the team was able to convince the parents that it was in the child’s best interest to remain with the maternal grandmother and close the case early. Finally, in some staffings, it was simply noted that termination of services would be discussed as the team and family move closer to reuniting the biological parents with their child.

**Outcomes**

Only in half of the staffings observed were service plan goals discussed in objective terms. For example, the term “stable” was the only criteria given as a goal in one staffing. In another staffing, the service plan goals and outcomes were discussed in terms of failed drug tests and a recent arrest. Similarly, another staffing discussed service plan goals in terms of clean drug screens and the mother’s ability to take on increased care of her child with unsupervised visits and overnight stays. Yet another staffing discussed goals and outcomes in terms of achieving transition to long-term placement as a developmentally disabled adult.

In the majority of staffings, long-term permanency was discussed in relation to short-term goals and intermediate steps. Everyone at the staffings agreed that they were present to advocate what is best for the child. Short-term goals included improvement in the child’s functional assessment, improvements in the child’s speech, the completion of parent training, marriage counseling, and substance abuse treatment. The criteria for ending child welfare targeted case management services were discussed in approximately half of the observed staffings; however, in all cases, this criteria was based on completion of (or noncompliance with) service plan goals. In one staffing, noncompliance on behalf of the biological parents led to the permanency plan of terminating the parents’ rights to custody (while retaining general parental rights) and placing the child with the maternal grandmother until the age of 18. However, if the parents complete the service plan on their own, they were told that they could return to the judge to ask for the child's placement to be reconsidered.

In approximately half of the staffings, objective or verifiable information on child and parent functioning was used as outcome data. One mother reported that she was benefiting from services and learning to be a better parent. According to the targeted case manager, this
mother had started to put her daughter first and was providing a more stable and consistent environment for her child. The child was described as calmer, happier and starting to do well in school. In addition, the therapist reported that the child and mother have increased communication and been happier together. The staffing team was impressed that the biological mother was able to gain steady employment despite her criminal record. The targeted case manager also assessed the biological mother’s home for safety and adequacy to provide for the child. The targeted case manager reported that the biological mother had all of the necessary equipment for caring for a young child.

**Management**

In the majority of staffings, key participants were invited to the meeting (e.g., family members, therapist, case manager, clinical supervisor). There was evidence that although family members and their supports were notified of the staffing, this notification came within 48 hours of the staffing and the staffing was not scheduled around any of the family member’s constraints. For example, one family’s lawyer was not given enough forewarning to be able to attend the staffing, while it appeared that his attendance could have led to a very different outcome for the parents who relinquished custody of their child during the staffing, somewhat reluctantly. However, since there were a few weeks before the case could be brought to the judge, the parents were told that they could still follow up with their attorney and talk about their options.

In another case, key participants were invited to the meeting but the biological mother and the foster mother were not present. Everyone at the meeting agreed that it was in the biological mother’s best interest to be at work rather than at the staffing. Although the mother’s perspective could not be heard first-hand, all team members were very praiseworthy of her and the reunification effort; it is reasonably safe to assume the biological mother was optimistic towards the outcome. However, it may still be the case that the staffing could have been coordinated so that the mother was able to attend. It was not stated why the foster mother was not present at the staffing, although it was acknowledged that she was unhappy because she would be losing the child to the reunification effort.

Current information about the family was shared through a one page document that the targeted case manager prepared in advance and distributed to those present at the staffing. One staffing focused on information regarding the process of closing the case and transitioning the youth to adult services. Similarly, another staffing focused on information regarding the process of closing the case and justification for proceeding with this course of action. The barriers to fulfilling the existing service plan were not addressed.

It was witnessed in several staffings that the facilitator had trouble getting his staff together. While family members were on time, staff were
not. In all but one of the staffings, all participants introduced themselves. The exception to this was a staffing in which family members were not present and the key players appeared to be very well acquainted. In a few of the staffings, the families were very vocal and were able to provide the team with many of the updates on the children from service providers not present.

The service plan was agreed on by all present in most of the staffings, however some biological parents were in reluctant agreement when it came to their custody rights. If family members were present at a staffing, they were always asked to review and sign the updated service plan. Prior to the close of the staffing, a general date for the next staffing was usually announced.

**Staffing Coordinator/Facilitator**

In the majority of staffings, the facilitator (who was not the targeted case manager) made the agenda for the staffing clear to all of the participants. The staffing facilitator reviewed goals, objectives, interventions, and progress of the service plan, and revised this service plan during the course of the staffing. The facilitator asked many times throughout the staffing, as he was writing/revising the service plan, “Does everyone agree with this?” In one staffing, the facilitator asked the biological mother and father if they understood what was happening. The facilitator explained that the parents were losing custody of their child but their parental rights would not be terminated. He explained what the parents would need to do to regain custody of their child, although he encouraged them to do this soon or not at all because he believed the child would suffer if it occurred years down the road.

In many cases, the facilitator kept the meeting going and contributed to a more formal atmosphere. The facilitator stated whether or not the caregivers were in compliance with the services plan, read important dates to the group (e.g., court hearings), and read the changes he was making to the service plan aloud. The staffing facilitator was excellent in keeping the team focused on identifying solutions for meeting the needs of the youth. The facilitator responded to a mother’s concerns regarding a GAL, Medicaid care and coverage, and summer vacation related to supervision. The facilitator created a plan to permit mother and youth to go on vacation. He suggested an interstate compact for supervision over the summer while the mother and child are visiting relatives in Michigan for six weeks. This also resolved the targeted case manager’s questions about her required visitation and documentation within HomeSafeNet.

The staffing facilitator also led the team in discussing child and family strengths. Throughout one staffing, the team members discussed the strengths of the child and the maternal grandmother. The strengths of the
biological parents were framed as acting in the best interest of the child by agreeing to close the case. In another case, strengths of the family were not explicitly discussed, but the fact that the children were “full” brothers was mentioned several times, and was cited as a good reason to keep them together. The facilitator echoed this sentiment of keeping the children together.

**CW-TCM Case Manager**

In the majority of the staffings observed, the targeted case manager updated the team on developments in the child’s situation and level of functioning. The targeted case manager also discussed activities that assisted the child in accessing needed services and providers. For example, in one staffing, the targeted case manager said several times something to the effect of, “we are here to help and support you as much as possible.” The targeted case manager offered a referral for one set of parents to participate in the First Step Substance Abuse Program, which provides services on a sliding scale fee. However, the parents were told that they would have to follow up on the services by themselves and cover all costs. In another case, the targeted case manager rephrased the term Economic Self Sufficiency office as food stamps so that the mother could better understand.

In another case, the targeted case manager had completed a home study to assess the biological mother’s home for safety and adequacy to provide for her child. The targeted case manager reported that the biological mother had all of the necessary equipment for caring for a young child. The targeted case manager stressed that the biological mother had never been late and never missed an appointment. The targeted case manager had also run the biological mother through FDLE and FAHIS and shared with the staffing team that she did not discover any safety concerns.

While the staffing facilitator was usually the one to tie service plan goals to services and outcomes, the targeted case manager was normally able to update the team on progress from service providers who were not present at the staffing. In one staffing, the targeted case manager reported that he was working with the legal people. In another staffing, the targeted case manager reported that both parents had completed all of the tasks they were given, with the exception of recommended marital counseling. He also mentioned the parents’ strengths, such as their ability to complete parenting classes and the mother’s completion of the First Step substance abuse program.

In another staffing, the family complemented the case manager on being very respectful, competent, non-intimidating, and professional, and
the targeted case manager was very supportive of efforts displayed by the biological parents. In only one case, it was observed that the targeted case manager was helpful only toward the maternal grandmother in assuring her that she would be getting foster care monies, and did not seem to have developed a rapport at all with the biological parents. In this case, the only reference to services provided to child was the delay in the relative caregiver payments.

The observations examined concordance between implementation of the CW-TCM and the intended procedural design of the services. A crucial initial step in demonstrating the effectiveness of an intervention is to ensure that it has been adequately described and implemented. Multiple methods were used to examine fidelity of implementation, including interviews with the caregivers.
Caregiver Interviews

A brief interview format was designed specifically for this study and typically took 40 minutes to an hour to complete. The interview included questions about contact with targeted case managers, involvement in case planning activities, satisfaction with services, and involvement in staffings (see Appendix F). When family members were present, consent was obtained for the observation and/or the interview. Seven caregiver interviews took place with biological parents, foster parents, and relative caregivers. In two of the interviews, both the biological mother and father were interviewed together.

Children had been living with their caregiver anywhere between less than one month and the entirety of their lives. Biological parents often had their children remain in their care, relative caregivers had been caring for their children the second longest, and the foster parent interviewed had been caring for their children for the shortest amount of time. While the foster parent interviewed was female, both relative caregivers and biological parents were equally represented by both genders. The majority of caregivers were Caucasian, particularly in cases where relative caregivers were involved. The foster mother interviewed was African American and one biological mother was Hispanic.

Contact with Targeted Case Manager

Relative caregivers and biological parents reported working with the targeted case manager for the longest period of time (e.g., one to two years), while the foster parent had only been in contact with the targeted case manager for less than a month. While one biological parent reported having no contact with their child’s targeted case manager, relative caregivers reported monthly contact, and the foster parent weekly contact. The remaining biological parents saw the targeted case manager either weekly, monthly, or every few months, depending on how far along in the reunification process they were. One caregiver described the targeted case manager as “very faithful” and was pleased that she visited the child in daycare on a weekly basis. The foster mother was also glad that the targeted case manager was willing to go to the children’s school.

Relationship with Targeted Case Manager

Most caregivers thought that their child and family’s situation had improved since they had started working with their targeted case manager; however, one set of biological parents felt the situation had gotten worse and one relative caregiver had not seen any improvements. All caregivers except one set of biological parents felt that their family and
the targeted case manager were able to work as partners for their family.

One foster mother that was interviewed described her targeted case manager as “pretty helpful, caring, compassionate, makes things easier, helps coordinate things.” The foster mother was informed when to expect people to call, what to expect next, etc. The foster mother also liked the way the targeted case manager took charge during crisis situations (e.g., when one of the children ran away). “She knew what she needed to do and she did it,” said the foster mother.

A set of biological parents described their relationship with their targeted case manager as being “very positive”. The targeted case manager asked the couple what referrals they wanted and needed. He served as a facilitator and assisted them in a friendly manner rather than acting like he was “policing” them, building a mutual system of trust. The targeted case manager also communicated well with the psychiatrist that performed the couple’s evaluations. The biological parents indicated that the targeted case manager was truly caring despite his large caseload.

A relative caregiver described her targeted case manager as “excellent; she makes sure the appointment times are convenient, she answers my calls and questions, she lets me know what’s going on with court and meetings, and she checks on us every month.” The relative caregiver believed her targeted case manager was very professional, kind, prompt and courteous. She commented sadly, “She seems to want to help. We’ve developed a friendship that now feels like I’m losing a friend.”

Additional positive comments regarding the caregiver’s relationship with the targeted case manager included:

- She checks on my daughter’s progress and my progress.  
  (biological parent)
- The case manager provides knowledge. She cares and is concerned about us.  
  (biological parent)
- She was like a supervisor. She provided guidance to receive services. She alerted me to the consequences of my behavior.  
  (biological parent)
- I developed a trust/confidence in her because she knew me and my situation.  
  (biological parent)
- She’s nice and can be firm when necessary.  
  (biological parent)
- Took care of any needs, like Medicaid for (child), and a drug treatment program for her mother.  
  (relative caregiver)
- The case manager is not jaded by the system yet.  
  (relative caregiver)
Organized, prompt response to phone calls, always been there when we needed her. *(relative caregiver)*

As might be found in any observation process, there was only one family that reported a very poor relationship with their targeted case manager. The biological mother explained that she tried calling the targeted case manager up to twice a day, but her calls were not returned. At one point, the biological mother was told that she needed a parenting class. She repeatedly sought the targeted case manager's help in accessing the class, but did not receive any assistance. Finally, the mother went in search of a parenting class on her own and was able to locate one. The biological father explained that at the staffings, the targeted case manager grossly underreported the support he provided to his child. In addition, both parents were disturbed subsequent to their staffing that the targeted case manager and clinical supervisor were whispering about their case at the staffing. The father lamented that this type of disrespect had happened to the couple throughout their case. The father also indicated that he felt pushed to sign the service plan and that “98% of what's on this paper isn't true.” Overall, the couple felt their contact with the targeted case manager was detrimental to their family; however, it should also be noted that this was the only staffing observed in which the caregivers lost custody of their child.

**Strengths of Family**

Nearly all of the caregivers also felt that the targeted case manager had taken a strengths-based approach with their child and family situation. When asked what strengths the targeted case manager was aware of in their child, caregivers commented, “They're thoughtful and caring about each other, close in age, and have a strong bond that we try to nurture”; “She is very bright, above age level in speech and motor skills”; “He gets along with others, eats well and plays well”; and “She sings, plays music, plays the clarinet, and is also improving in school.” In most cases, the targeted case manager had sought information about the child's behavior at home, at school, and in the community. In addition, nearly all of the caregivers held no current concerns regarding their child's or family's safety.

**Natural Supports**

With the exception of one set of biological parents, all caregivers reported that the targeted case manager had made them aware of additional programs within their local community that they might benefit from. Examples of suggested resources included Al-Anon (AA) meetings, anger management classes, psychological services, medical assistance, financial assistance, housing, and parenting classes. However, only half of these caregivers (biological and relative) had received any help in accessing these programs. In half of the cases, the targeted case manager had asked the caregiver about any personal supports, such as family and friends that they might have. In only the cases with biological parents had
the targeted case manager ever talked with these informal supports.

**Staffings**

Half of the caregivers reported that someone had explained the purpose of the staffing to them prior to the meeting, particularly relative caregivers. However, the majority of caregivers also reported that no one had helped them prepare to participate in the staffing. Biological parents were more likely to feel out of the communication loop and unsure of their role in the staffing. One biological father complained that the foster care agency always seemed to be switching the times of the staffings at the last minute, which then made the father look bad if he arrived late. In contrast, another biological parent said that the targeted case manager let her know ahead of time what was going to occur and what the targeted case manager’s recommendations would be. A foster parent said that no one had explained the purpose of the meeting to her; she was only told that it was a staffing, but did not understand what that meant. She thought there would be more people present that were involved with her children.

Fortunately, all caregivers reported that once the staffing had started, they were able to discuss what they wanted. One relative caregiver commented, “I felt comfortable that I could speak whenever I wished to.” The foster parent was in agreement with her children’s service plan; however, if she had not agreed, she would have felt comfortable speaking up about it. All but one set of biological parents felt that their input was valued by the rest of the staffing group. The relative caregiver associated with these parents commented, “The meeting went well. They were patient with them (the biological parents). They answered questions and listened to the parents.” However, the biological parents said that their role in the staffing was “to be present but not be listened to.” Another set of biological parents saw their role as simply being present and on time. Other caregivers described their role in the staffing as:

- I didn’t have a role—I was just an observer. I didn’t have anything to say. *(foster parent)*
- My role was to represent my family. *(biological parents)*
- My role was to become the long-term caregiver. *(relative caregiver)*
- They listened to my plan for a vacation this summer. *(biological parent)*

In terms of staffings occurring at convenient times, the sample was biased because if the caregivers were present to be interviewed subsequent to the staffing, then they had been able to attend the staffing. However, the majority of biological parents, in contrast to the relative caregiver and the foster parent, felt that the staffings were not scheduled
at times that were convenient for their family. One set of biological parents explained that they were not told about the staffing until 4 p.m. the previous day. This made the mother look bad at work because she had to call in at the last minute. Both parents indicated that an afternoon rather than a morning time would be better. In addition, a relative caregiver commented, “they’ve been convenient but they don’t consult with us. I think they would reschedule if needed.”

**Suggestions for Improving Services**

Two of the biological fathers commented on their desire for more front end services. One father really expected DCF to come into their situation sooner. He was surprised that it took three domestic violence calls and several interactions with the police before anyone referred them for help from DCF. The father stated that it is unfortunate there is not a lot of early intervention going on. He believed that the foster care agency needed to implement more proactive and preventative measures. Another biological father felt that he would not be in his current situation if the Department had given assistance to his family in the past. He believed that DCF did not adequately help his own mother who was a drug addict, a situation which forced him to be on the streets at age 12 and to raise his younger brother on his own.

One of the fathers reflected on his experience with the foster care agency and believed that the biggest challenge is getting families through their denial and getting them to admit they have a problem. He also stressed that anytime DCF encounters a domestic violence situation, both caregivers should have to take the anger management and parenting classes. This is what was done in his family’s case; however, he believes it is not done in other cases. Finally, one biological father emphasized that DCF should screen the employees they hire more thoroughly and do more extensive background checks. According to the father, “right now some of the people they have representing them are a joke and disappointing.”
Discussion

The findings from this study demonstrate that CW-TCM services are generally implemented as intended with the desired outcomes achieved. A number of strengths and weaknesses associated with current implementation and subsequent expansion of the approach were identified.

Overall Benefits of CW-TCM

Successful implementation of CW-TCM should be marked by a shift in coordination among service systems, community-based services and individualized approaches to service delivery. Since children in the child protection often require numerous interventions from different providers, CW-TCM provides a funded mechanism to advocate and coordinate the supports needed by the child. Overall, the redundancy of services is diminished as a result of an enhanced level of communication between providers.

Child welfare has traditionally been an under-funded system. Access to Medicaid resources maximizes funding available to achieve a benchmark of quality service delivery. Small caseload sizes enable the case manager to facilitate individualized services which are specific to the child's needs and maintain a high level of vigilance in achieving goals for stability, permanency, safety, and well being of the child. Additionally, through increased involvement with the child and caregivers, the case manager is viewed by the family as a resource person who wants to assist the family in meeting the case plan goals. Without CW-TCM services, children in the child welfare system may not have the facilitated access to consistent care which can optimize the child's level of functioning and enhance the family's outcomes on behalf of the child.

As noted by the comments of two stakeholders involved in the implementation of CW-TCM:

- It allows us to have more time with the child, has increased the level of service in terms of the face-to-face contact requirement and I believe the more you see a child the more you are improving your ability to keep that child safe. If you have eyes on the child and you are seeing bruises and marks and how that child might be responding emotionally as well as how the parents may be interacting with that child, we can enhance and improve the ability to keep the child safe.
- Since you see the child more often, interact with the family more frequently, communicate with the service providers more often, you have to update that assessment and service plan at least every six months, so you are on top of where they are and what their needs are and what is going on. One of the biggest reasons that kids remain safe is the case manager's visibility in the community, so as
you are talking to the service providers and red flags are raised, the schools say all of a sudden the child's grades dropped off dramatically or they started acting out and getting into fights and things, it doesn't sort of languish a long time before we know what is going on and try to find out what the cause is.

Challenges to Statewide Implementation

One of the greatest challenges to statewide implementation of CW-TCM is receiving federal approval for expansion. Florida's State Plan Amendment (SPA) 02–15 has been under federal review and clarifications have been requested of the state. Areas requiring explanation include differentiating between case management services which are under Title IV and Medicaid funded services. Since the activities under Title IV-E are limited to child placement related activities and permanency planning, only the Medicaid targeted case management allows for enhanced services which address the child's educational, social/behavioral, and mental health needs. Other questions have been raised about freedom of choice of providers. Since CW-TCM is under Medicaid eligibility, there is a voluntariness clause; however, in the child welfare system once you are adjudicated, there is no voluntariness about whether you are in the identified service group. To ensure freedom of choice Medicaid policy requires participating agencies to notify recipients that they may request another targeted case manager provider if they are not satisfied with the services they are receiving. Although areas which have access to broad networks of provider agencies can accommodate this requirement, smaller regions may have greater difficulty in ensuring choice among service agencies.

Another concern identified by stakeholders is Florida's reliance on TANF resources to fund child welfare services, which has minimized the allocation of general revenue to draw down Title IV-E dollars. If the Medicaid block grant is approved for the state, Florida has not been optimizing its use of general revenue as a match for child welfare services. As one stakeholder noted: “If the Feds go back three years and look at the state’s average draw down and cap it at that level for the last two years Florida basically has very little 4E draw down, it would negatively affect the State’s block grant.” There is concern that the Medicaid block grant will not provide a favorable fiscal situation for meeting the needs of children in Florida’s child protection system.

The following issues were highlighted as potential barriers to statewide implementation of CW-TCM:

- Without a manual to guide implementation it has been difficult to find resources that provide a structure for service deliver.
• Confusion in differentiating between CW-TCM and Title IV-E case management needs to be clarified in order to ensure the integrity of the services, avoid duplication in billing, and establish consistency in standards of care. The dual roles of case managers can be difficult to understand and coordinate.

• Documentation is time consuming and often necessitates duplication of effort.

• Some stakeholders perceive that CW-TCM is better suited for smaller regional areas. There is concern that larger implementation areas will struggle to achieve the required caseload ratio in order to initiate billing to Medicaid.

• Eligibility, staff turnover, and match requirement restrict how many children an agency can serve with CW-TCM. These are complex dynamics that require careful monitoring and an in-depth understanding of the implementation process.

• Currently there is not a designated person who has time specifically allocated to provide training and ensure consistency in technical assistance. As a result, training has lacked uniformity and thoroughness.

• Flexibility in implementation is needed for communities with unique challenges (i.e., limited resources and supports for children and families, rural reimbursements needed for travel).

• Additional resources are needed to maintain the standard of care for children and family served. While the rate for CW-TCM was based on the funding level for MH-TCM, child welfare services have not experienced an increase in the rate while mental health case management has been increased over time.

Limitations and Recommendations for Future Studies

Information from this study contributes to understanding trends in service implementation for CW-TCM and identifying variations which might warrant closer examination. Many stakeholders noted that different levels of utilization across sites might reflect divergent practice patterns which impact outcome and/or process indicators. While the positive results of this study are encouraging, some limitations must be noted. While the research examined the occurrence of specific activities identified with CW-TCM, it did not measure the effectiveness of implementation. A small number of cases were observed which may or may not be representative of typical service delivery, and the majority of the findings were based on interviews with key informants, with limited triangulation of data sources.
to provide a strong basis for determining how fidelity to CW-TCM relates to child and family outcomes. Since the purpose of this study was to provide a descriptive picture of how CW-TCM is being implemented in Community-Based Care settings, suggestions for ongoing studies were solicited from stakeholders:

- Interest in ongoing outcome research, particularly studies which examined the impact on children's behavior, movement toward permanency, and enhanced safety. Many respondents would like to know if the enhanced services and communication facilitated by CW-TCM expedited beneficial outcomes for the child's global functioning as well as child welfare goals.
- A cost benefit analysis which differentiates between CW-TCM services and Title IV-E child welfare case management could demonstrate if children who access CW-TCM services more quickly achieve their case plan goals for safety and permanency while minimizing length of stay and reabuse/reneglect rates.
- Efforts to track expenditures by funding source could be illustrative of the funding mechanism for new implementation sites.
- Comparisons of parent/caregiver and worker satisfaction which explore the effect of CW-TCM on engaging the family and thereby enhancing outcomes.
- An evaluation of case manager effectiveness based on funding streams, including assessment of the number and type of referrals; identification of needs addressed; and examination of outcomes achieved (i.e., safety, permanency, stability).

Implications for Child Welfare and Behavioral Health Services

The findings from this study have important policy ramifications for both the mental health and child welfare reforms taking place in Florida, since entry into the child welfare system provides an opportunity for secondary prevention with regard to child behavioral health problems. One challenge is to better understand how to design child welfare privatization reforms so that child and family outcomes are optimized.

Other revenue maximization efforts have been proposed in Florida to draw down additional federal funds by using local monies as match. These funds would be directed toward enhancing services that meet the educational, developmental and safety needs of children at-risk for abuse and neglect. Given the overall success achieved with CW-TCM in fostering enhanced services, pursuit of other revenue maximization efforts could similarly foster positive outcomes for children in the State. Declines in state general revenue resources combined with diminished
TANF funding for child welfare services may detract from efforts to provide an array of support services. Subsequently, alternative resources for prevention and early intervention are critical to diminish foster care placements.

Medicaid funding for child welfare services has increased over 25% from FY1998 to FY2000 (Bess et al., 2000). This increase reflects greater efforts to maximize funding through targeted case management services. Yet this initiative has required improved information management systems to carefully track casework activities that are eligible for Medicaid funding. Further investment in an integrated information system is important not only for accountability, but also to ensure continuity and quality of services that are provided. Further developments of HomeSafeNet must focus on time saving efforts to support enhanced service delivery.

Other policy recommendations include:

- The development of a Medicaid handbook for CW-TCM, accompanied by ongoing training will be necessary if statewide implementation is approved at the Federal level. A process to train the trainers at various sites, and subsequently build capacity for technical assistance is recommended.

- As new agencies begin implementing CW-TCM they will need extensive guidance to understand the match and billing process. Moreover, AHCA could experience a greater deficit situation due to the one to two-month time lag before payment is received since DCF needs to mediate the billing process. A more direct invoicing process with the lead agencies may eliminate issues with cash flow.

- Availability of the resources of the community need to be considered prior to statewide implementation of CW-TCM. For example in rural counties, reimbursements for transportation may need to be incorporated in order to facilitate service delivery based on the requirements for CW-TCM.

- Creation of a model process for implementation of CW-TCM, including budget amendments, TCM projections, cost allocations/analysis for hiring new staff, and monitoring of activity logs will be necessary for new sites to learn from the experience of existing service agencies.

- New implementation sites should begin with a pilot. Technical assistance to help with confusion over documentation and ongoing supervision are essential to success of implementation efforts. Subsequently, the initial pilot group can be trainers and mentors to additional staff that are introduced to the services.
• If Federal approval of statewide implementation is not granted, alternative funding mechanisms will need to be explored in order to support enhanced services for children.
• Implementation of statewide auditing and monitoring mechanisms is needed to collect data to support the rate for CW-TCM. Existing information could be collected from time logs and established information systems in order to minimize the burden on the lead agencies and providers.
References


Appendix A:

State Plan Under Title XIX of the Social Security Act

State/Territory: **Florida**

TN No. 98–27 Supersedes TN No. NEW Effective 10/1/98

Case Management Services

A. **Target Group:**

By invoking the exception to comparability allowed by 1915 (g) (1) of the Social Security Act, this service will be reimbursed when provided to:

All Medicaid eligible children, ages 0–21, who have been placed under protective supervision by a protective investigator based on a determination of either some indication of maltreatment or verified maltreatment, or have been court ordered into shelter or foster care. (See Chapters 415 and 39, F.S.)

B. **Areas of the State in which services will be provided:**

The authority of section 1915 (g) (1) of the Act is invoked to provide services on a less than statewide basis. Services shall be provided in Sarasota County.

C. **Comparability of Services:**

Services are not comparable in amount, duration and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. **Definition of Services:**

Case management is defined as those activities which will assist individuals eligible under the Plan in gaining access to needed medical, social, educational, and other services. The case manager, in partnership with the child, family, significant others, or identified caregivers, facilitates access to and coordinates the services, treatments and supports necessary to achieve the goals and objectives stated in the service plan.
Case management activities include:

1. Completion of a comprehensive needs assessment, which identifies the service needs of the child. The process of completing the needs assessment includes assisting the eligible child in obtaining access to providers who will perform the full range of assessments necessary to identify the biological, psychological, social, developmental and environmental aspects of the child's needs.

2. Assuring access to the needed services and supports, which have been identified in the assessment of the eligible child and are reflected in the child's service plan.

3. Ongoing monitoring and follow-up of the services and supports being provided as indicated in the service plan. This includes determining the degree to which the plan is being followed, progress is being achieved on plan objectives, and ensuring that services are coordinated with the active participants in the child's life. Monitoring is accomplished through face-to-face, telephone, or written contact with the child or others on behalf of the child (physicians, therapists, teachers, other service providers, etc.), as appropriate.

4. Development of the service plan that identifies services, assistance, and activities which are needed to address the child's needs that are represented in the comprehensive needs assessment. Service planning includes participating in meetings with the child, family members and appropriate others (physicians, therapists, teachers, other service providers) to develop goals, objectives and tasks directed toward addressing the child’s needs in all areas. The case manager is responsible for activities that will assure that the unique needs of the child are responsible for activities that will assure that the unique needs of the child are being addressed, and for promoting integration and continuity of services.

5. Developing referral review packets.

6. Referring the child to service providers and establishing a linkage between providers for the child.

7. Activities to assist the child in accessing needed services and service providers so that the objectives and goals identified in the service planning documents can be achieved. The case manager is responsible for coordinating and ensuring continuity of services (social, medical, educational, etc.) for the child by multiple providers, involving and updating them on developments in the child’s situation and advocating on behalf of the child for needed community resources.
8. Communicating and collaborating with the biological parents or other family members as appropriate regarding the child’s care, needs and progress if the child is in foster/out of home care.

9. Making home visits and phone calls for the purpose of assessing, arranging, integrating and coordinating the services and supports which have been identified as necessary to achieve the child’s stability.

10. Encouraging and supporting the child and family’s participation in the services offered as part of the case plan.

Activities that are not included are:

1. Title IV-E eligibility determination and redetermination.
2. Initial and annual adoption subsidy development, review, and processing.
3. Transportation.
4. Consultation with child welfare legal services, preparing legal documents, court preparation and appearances, staff travel related to court preparation and appearances.
5. Performing adoption pre-placement and placement activities, arranging termination of parental rights.
6. Placement services including locating initial out-of-home care, managing the disruption of a placement and re-placement if necessary. Working with the foster family to avoid disruptions and coordination of placement visits.
7. Relative Caregiver Program oversight.

E. Qualifications of Providers:

Providers will be approved and certified by either the designated public entity or the eligible lead community based privatization provider. (Chapter 409.1671, F.S.) Payment for services will be made to the case management provider. The public or community based provider will accept applications for provider enrollment from any provider meeting the following requirements:

1. Agency providers must meet all of the following criteria:
   a. Be knowledgeable of and comply with state and federal statutes, rules and policies that pertain to this services and target population.
   b. Have the ability to administer case management services to the target population as evidenced by sufficient numbers of managerial staff, targeted case management supervisors and certified case managers.
c. Be a community based provider agency with at least five years of prior professional experience with this target population.

d. Have the financial management capacity and system to provide documentation of costs.

e. Have established linkages with the local network of human services providers, schools and other resources in the service area.

f. Have a Quality Improvement Program with written policies and procedures, which include an active case management peer review process and ongoing recipient and family satisfaction surveys.

g. Have established pre-service and in-service training programs that promote the knowledge, skills, and competency of all case managers.

h. Have an established credentialing process which will assess and validate the qualifications of all case managers and supervisors of case managers.

i. Have the capacity to provide supervision by a person who has a Masters degree in a human services field and three years of professional case management experience or other professional experience serving this target population. In addition, the individual must have completed the state approved child welfare and case management training and any other training, including periodic retraining, which is required and offered by the Department of Children and Families.

j. Maintain for a period of five years after the delivery of service, programmatic records that include clearly identified targeted case management certifications for eligibility, assessments, services plans and service documentation.

k. Cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Department of Children and Families, Office of Family Safety and Preservation.

2. Agency providers agree that the services identified below shall constitute the minimum amount of service to be provided by the targeted case manager to the child on a monthly basis.

a. A home visit, which shall include a face-to-face meeting with the child. The home visit shall be for the purpose of assessing the child and family’s progress toward the
achievement of the goals and objectives, which specifically pertain to the child’s needs and stability in the living environment and are stated in the service plan.

b. The case manager shall have verbal (i.e., telephonic or face-to-face) or written contact with a minimum of two separate providers who are rendering services to the child or the child’s family as related to assisting the child toward achievement of identified needs. This contact shall be for the purpose of determining whether the child, and family as appropriately related to meeting the child’s needs, are responding to services and if said services are appropriate and rendered at the correct level of intensity.

c. A second face-to-face visit with the child, which may occur in the home or in the setting in which the child spends most of his or her time. The case manager shall observe the child and assess whether or not his or her level of functioning has remained unchanged, improved, deteriorated or stabilized.

d. The case manager shall complete or obtain at least one of the following:

1. A client satisfaction survey
2. A Current Status Summary that includes descriptions of functional issues, behavior problems, or developmental concerns. The summary is developed by gathering information from various service providers, teachers, family members or caretakers, and other significant individuals involved in the child’s life.

or

3. A comprehensive summary statement which depicts the child’s progress toward the achievement of established goals and objectives and addresses the status of the child’s stability within the identified living environment.

3. Individual case manager providers must meet all of the following criteria:

a. Be employed by or under contract with an agency that has been certified by the Agency for Health Care Administration as qualified to provide case management services to the target population.
b. Have a minimum of a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, child development or a related human services field and have a minimum of one year of professional experience working with children who have been abused, neglected or abandoned, or are at risk of abuse, neglect or abandonment.

c. Have successfully completed the state mandated child welfare and case management training and any other training, including periodic retraining, which is required and approved by the Department of Children and Families.

d. Be certified by the Department of Children and Families district office as meeting the requirements to be a Children’s Protection Group targeted case manager.

e. Be enrolled as a Medicaid approved individual treating provider, Provider Type 32.

f. Specific to the identified service area, have knowledge of the resources that are available for children who are abused, neglected or abandoned or at risk for abuse, neglect or abandonment.

g. Be knowledgeable of, and comply with, the state and federal statutes and rules and policies that pertain to this service and target population.

F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the individual case management providers.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

1. Providers shall bill a monthly rate of $450.00 per child. In order for reimbursement to occur, the clinical record must contain documentation, which indicates that the services identified above in section E-2a-d, were provided.
Appendix B:

Federal Funding Resources for Child Welfare Services

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Table 2.
General Revenue, Tobacco Settlement Trust Fund
and Operations & Maintenance Trust Fund

<table>
<thead>
<tr>
<th>Purpose, Awards, Match</th>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
<th>Ineligible Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose: To provide reimbursement for services and activities not related or reimbursed by any federal fund.</td>
<td>Requirements: There are no specific eligibility or reporting requirements associated with these fund sources</td>
<td>All the activities described in this document for each of the fund sources are eligible.</td>
<td>Generally, no activities performed by Family Safety are ineligible.</td>
</tr>
<tr>
<td>Award: Appropriated annually by the Legislature.</td>
<td>Reporting: There are no reporting requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Match: None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Purpose, Awards, Match

**Purpose:** To provide reimbursement for activities related to the foster care program. Grants are received for (1) maintenance costs, (2) administration, and (3) training for the foster care program.

**Awards:** Funds are received on a quarterly basis.

**Match:** There are 3 different reimbursement rates for each of the Title IV-E Foster Care grants received. (Maintenance – 56.52%, Administration – 50%, Training – 75%) Public funds must be used as match.

Requirements & Reporting

**Requirements:** Claiming Title IV-E:
1. Maintenance claiming is based on the eligibility of a specific child. The child must (1) meet income and resource standards, (2) deprivation of parental support, (3) have lived with a specified relative, (4) reside in a licensed placement, (5) have court findings of contrary to the welfare and reasonable efforts, (6) continued evidence of permanency hearings.

**Eligible Activities**
1. Maintenance costs include the cost of room, board, clothing, allowance, incidentals, and supervision. When a child is in a child-caring facility, it is allowable to identify a reasonable costs associated with providing for the maintenance of the child. This may include cost for direct childcare staff and houseparents, and some of the costs for administration and overhead for running the facility.

2. Administration claiming is based on the statewide Title IV-E Foster Care eligibility rate. The eligibility rate is calculated quarterly and applied to the total eligible expenditures.

3. Training claiming is based on the statewide Title IV-E Foster Care eligibility rates that is applied to the expenditures associated with the staff in training status.

**Ineligible Activities**
1. Maintenance costs that are paid to unlicensed placements (i.e. specialty hospitals, public-run facilities), and costs associated with therapy, social or psychiatric services.

2. Costs associated with the delivery of services, in-home counseling, parent training, child abuse investigations, and risk assessments.

3. Costs that are for in-service or ongoing training needs or opportunities. The costs associated with providers’ pre-requirements.

---

**Table 3.**  
**Title IV–E Foster Care**

<table>
<thead>
<tr>
<th>Purpose, Awards, Match</th>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
<th>Ineligible Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> Title IV-E:</td>
<td>Maintenance claiming is based on the eligibility of a specific child. The child must (1) meet income and resource standards, (2) deprivation of parental support, (3) have lived with a specified relative, (4) reside in a licensed placement, (5) have court findings of contrary to the welfare and reasonable efforts, (6) continued evidence of permanency hearings.</td>
<td>Maintenance costs include the cost of room, board, clothing, allowance, incidentals, and supervision. When a child is in a child-caring facility, it is allowable to identify a reasonable costs associated with providing for the maintenance of the child. This may include cost for direct childcare staff and houseparents, and some of the costs for administration and overhead for running the facility.</td>
<td>Maintenance costs that are paid to unlicensed placements (i.e. specialty hospitals, public-run facilities), and costs associated with therapy, social or psychiatric services.</td>
</tr>
<tr>
<td><strong>Awards:</strong> Funds are received on a quarterly basis.</td>
<td>Administration claiming is based on the statewide Title IV-E Foster Care eligibility rate. The eligibility rate is calculated quarterly and applied to the total eligible expenditures.</td>
<td>Administrative costs include case management and planning, eligibility determinations, placement activities, recruitment and retention of foster parents, in-service training, and rate setting.</td>
<td>Costs associated with the delivery of services, in-home counseling, parent training, child abuse investigations, and risk assessments.</td>
</tr>
<tr>
<td><strong>Match:</strong> There are 3 different reimbursement rates for each of the Title IV-E Foster Care grants received. (Maintenance – 56.52%, Administration – 50%, Training – 75%) Public funds must be used as match.</td>
<td>Training claiming is based on the statewide Title IV-E Foster Care eligibility rates that is applied to the expenditures associated with the staff in training status.</td>
<td>Training costs must be for preparation for employment with the single state agency, and are time-limited.</td>
<td>Costs that are for in-service or ongoing training needs or opportunities. The costs associated with providers’ pre-requirements.</td>
</tr>
<tr>
<td>Purpose, Awards, Match</td>
<td>Requirements &amp; Reporting</td>
<td>Eligible Activities</td>
<td>Ineligible Activities</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| **Purpose:** To provide reimbursement for activities in the adoption assistance program. Grants are received for (1) adoption subsidy payments, (2) administration, and (3) training for the adoption assistance program.  
**Awards:** Funds are received on a quarterly basis.  
**Match:** There are 3 different reimbursement rates (FFP) for the adoption assistance grant.  
(Maintenance – 56.52%, Administration – 50%, Training – 75%) Public funds must be used as match. | **Requirements:** Claiming Title IV-E.  
1. Adoption assistance payments are based on a child’s eligibility. To be eligible, a child must (1) meet Title IV-E foster care requirements or receive benefits from Supplemental Security Income prior to finalization, (2) meet the definition of “special needs,” (3) have financial need of the child established, (4) there must have been a reasonable effort to place child without providing adoption assistance, and (5) the child must be under the age of 18 years and never have been legally married.  
2. Administration claiming is based on the statewide Title IV-E eligibility rate multiplied by eligible activities performed. These statistics are calculated quarterly and applied to the total eligible expenditures.  
3. Training claiming is based on the statewide Title IV-E eligibility rate that is applied to the expenditures associated with the staff in training status. | 1. Adoption assistance payments are the costs in support of the adoption of children who meet the definition of special needs and must documented on an annual subsidy agreement. Non-recurring costs of adoption are those related to the placement and adoption of children. The payments may be for psychological or psychiatric testing, travel to and from prospective adoptive placements, court costs and attorney fees up to $1,000 per adoption placement.  
2. Costs associated with the delivery of services to the adoptive family, in-home counseling, and parent training.  
3. Costs that are for in-service or ongoing training needs or opportunities. The costs associated with providers’ pre-certification training requirements. |
Table 4.
Title XIX — Medicaid Administration

<table>
<thead>
<tr>
<th>Purpose, Awards, Match</th>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
<th>Ineligible Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> To provide reimbursement for the costs associated with administrative case management of health-related activities.</td>
<td><strong>Requirements:</strong> Medicaid Administration claiming is done through the department’s Random Moment Sampling System or a time log methodology used by providers. The child must be Medicaid eligible as defined by ACHA and determined by Economic Self-Sufficiency. <strong>Reporting:</strong> The reporting requirements for this fund source are done quarterly through the ACHA, as the cognizant agency for the state.</td>
<td>Administrative costs include eligibility determinations and case management for health-related activities which might include coordinating appointments, receiving and conveying information to healthcare professionals and foster parents, arranging for transportation, and staffings or conferences on behalf of a child’s health care. Health care refers broadly to the child’s physical, mental, or emotional health.</td>
<td>Costs such as the actual transporting of a child to an appointment, providing or disbursing medication.</td>
</tr>
<tr>
<td><strong>Awards:</strong> Each quarter the earnings are transferred from the Agency of Health care Administration to the department’s Federal Grants Trust Fund. <strong>Match:</strong> The reimbursement rate (FFP) is 50%. Public funds must be used as match.</td>
<td><strong>Eligible Activities:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.
Title IV-B, Subpart 1, Child Welfare Services

<table>
<thead>
<tr>
<th>Purpose, Awards, Match</th>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
<th>Ineligible Activities</th>
</tr>
</thead>
</table>
| **Purpose:** To ensure that states provide judicial oversight for children in out of home care, that an inventory of children in the child protection system is available and there are safeguards and protections for children, biological parents and foster parents. **Awards:** The amount varies year to year, with little change. The awards are received quarterly. **Match:** The federal financial participation (FFP) is 75% for this grant. The state must identify 25% of public funds to use as match. | **Requirements:** For states to receive these federal funds, there must be:  
- A periodic (judicial) system which reviews all cases in out of home care.  
- Case plans which identify the issues that placed the child at risk, and the reasonable efforts made to prevent removal from the home. | 1. Maintenance payments for children who are non IV-E eligible.  
2. Costs of personal (salaries and expenses) to provide protective services to children.  
3. Services to children and their families that will prevent removal or remedy the situation within the home. | 1. Services for children over 18.  
2. Purchase of or construction of facilities. |

1. **Table 4.**

   **Title XIX — Medicaid Administration**

2. **Table 5.**

   **Title IV-B, Subpart 1, Child Welfare Services**
### Purpose, Awards, Match

**Purpose:** To fund (1) community-based family support services, (2) family preservation services, (3) time-limited reunification services and (4) adoption support services.

**Awards:** Grants are awarded on an annual basis and received in quarterly installments. Florida’s share in 99/00 was estimated at 12.6M.

**Match:** The federal financial participation for this grant is 75%. The state’s match may be public funds, local contributions, and in-kind donations.

### Requirements & Reporting

**Requirements:**
1. No less than 20% is to be designated for each categorical activity.
2. No more than 10% identified for administrative costs.
3. A state plan filed each year, which outlines all the estimated activities and expenditures for the coming year.
4. Community collaboration and involvement in the development of the plan and the designation of resources.

**Reporting:** An annual report is prepared each year to report on the status of the 5 year comprehensive plan approved by Administration of Children and Families Central Office requires the following reports on a monthly basis:
- Verification of match
- Activity logs with the time distribution.
- Reporting tool form which breaks down services in categories.

### Eligible Activities

1. **Family support services** are community-based services to promote the well-being of the children and family. Services may include:
   - In-home visits, parent support groups
   - Respite care of children
   - Structured activities to guild the parent-child relationship
   - Transportation, information and referral
   - Early developmental screening

2. **Family preservation services** are designed to help families (including adoptive and relative placements) who are at risk of removal or in crisis. Services may include:
   - Intensive in-home services
   - Follow-up services with families when a child has been out of the home and is reunited
   - Parenting strengthening and skills classes
   - Respite care for parents and other caregivers

3. **Time-limited reunification services** are provided to assist with timely return of a child to the home. Services must be provided in the first 15 month of removal and may include:
   - Individual, group and family counseling
   - Inpatient or outpatient substance abuse treatment services
   - Mental health services
   - Temporary child care and therapeutic services while a child is in an emergency placement

4. **Adoption support services** are services and activities which encourage adoption from the foster care system. Services may include:
   - Recruitment of adoptive families
   - Respite care for adoptive parents

### Ineligible Activities

1. Any services which are provided to a child and family that is already known to the department by way of the hotline or services to foster parents.

2. Services to families not identified as at risk or in crisis, or services after the removal and prior to reunification (i.e. in foster care or adoption).

3. Services provided to intact families, or services to children and families beyond the 15 months time limit.

4. Services that do not support the successful adoption of foster children.
### Table 7. Social Services Block Grant

<table>
<thead>
<tr>
<th>Purpose, Awards, Match</th>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
<th>Ineligible Activities</th>
</tr>
</thead>
</table>
| **Purpose**: SSBG is a consolidated effort by the federal government to provide funds for social services  
**Award**: An annual federal appropriation is made available.  
**Match**: The grant is 100% federal funds. | **Requirements**: The funds must be spent for the following goals: (1) achieving or maintaining economic self-support, (2) reduction or prevention of dependency, (3) preventing or remediying abuse, neglect or exploitation of adults and children, (4) preventing or reducing inappropriate institutional care, and (5) providing services to individuals in institutions.  
**Reporting**: This grant requires that a pre-expenditure report to be submitted identifying anticipated expenditures and a post-expenditure report recording the actual expenditures in specific service areas. | Activities for these funds may include:  
- Child care  
- Protective services for children and adults  
- Foster care services for children and adults  
- Day care services for adults  
- Transportation services  
- Family planning  
- Information and referral counseling  
- Employment and training  
- Personnel training | Activities which cannot be used include:  
- Purchase or improvement of land  
- Case payments for subsistence  
- Payment of wages as a social service  
- For provision of medical care  
- Social services in a hospital, skilled nursing facility, prison |

### Table 8. Social Services Block Grant 2

<table>
<thead>
<tr>
<th>Purpose, Awards, Match</th>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
<th>Ineligible Activities</th>
</tr>
</thead>
</table>
| **Purpose**: SSBG 2 is the 10% transferability from the Temporary Assistance for Needy Families Block Grant.  
Beginning 10/1/2000, the allowed transferability will be 4.25%. This has required a fund shift within the dept. to accommodate.  
**Award**: The award for this grant is 10% of the overall TANF Block Grant, or $59M.  
**Match**: The grant is 100% federal funds. | **Requirements**: The funds transferred must be spent on the same goals as SSBG and a determination of the family meeting the less than 200% of poverty. The goals for SSBG are: (1) achieving or maintaining economic self-support, (2) reduction or prevention of dependency, (3) preventing or remedying abuse, neglect or exploitation of adults and children, (4) preventing or reducing inappropriate institutional care, and (5) providing services to individuals in institutions.  
**Reporting**: This grant requires that a pre-expenditure report be submitted identifying anticipated expenditures and a post-expenditure report recording the actual expenditures in specific service areas. The reporting for SSBG 2 is maintained and reported separately from SSBG. | Activities for these funds may include only salaries and expenses. | Activities which cannot be used include:  
- Purchase or improvement of land  
- Case payments for subsistence  
- Payment of wages as a social service  
- For provision of medical care  
- Social services in a hospital, skilled nursing facility, prison  
In addition, activities which cannot be used include:  
- Those to families over 200% of poverty level |
### Purpose, Awards, Match

**Purpose:** To provide assistance to needy families, to end dependency of needy parents by promoting job preparation, work, and marriage; to reduce and prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. TANF is used through Family Safety for (1) the Relative Caregiver Program, (2) the first 12 months of substitute care, and (3) in-home services and supervision (Protective Investigations, Protective Services, and Intensive Crisis Counseling).

**Award:** An annual appropriation is made available to the states in quarterly payments.

**Match:** No match is required. Funding is 100% federal funds.

### Requirements & Reporting

TANF funding is used in several ways in the Family Safety program. Each use of TANF ties back to either the purposes of TANF, the Title IV-A/Emergency Assistance state plan, or the transfer authority to Social Services Block Grant.

1. **Relative Caregiver Program** requires that: (a) a child resides with a specified relative, (b) there is a court approved home study recommending the placement, (c) court order giving custody to the relative, (d) the child must be adjudicated dependent, and (e) the child meets other technical and financial criteria.
2. The first twelve months of substitute care is utilizing the guidelines of the Title IV-A/Emergency Assistance per the state plan, September 1995. Title IV-A/EA requires that: (a) the child has lived with a specified relative within the last six months, (b) an emergency exists that requires services, and (c) the family does not have resources to meet this need.
3. The requirements for TANF use for in-home supports must tie to one of a federal purposes. In addition, F.S. 414.158 the Diversion program to prevent or reduce child abuse and neglect allows for provision of services to reduce the risk of removal. The requirement for this is that the family with children be in need of services and have income below 200% of the federal poverty level.
4. The requirements associated with the Social Services Block Grant transferability include: (1) meeting the requirements of SSBG purposes, and (2) meets the less than 200% of poverty level.

**Reporting** for this fund source is compiled with the annual TANF report prepared and submitted for review.

### Eligible Activities

- Relative subsidy (funded through ESS)
- Administrative activities which focus directly on the child and relative caregiver, which may include: case management and supervision, eligibility determinations, court preparation and participation, and referrals to Economic self-sufficiency.
- Maintenance payments for first twelve months of out of home care for all children.
- Services for children and families that are experiencing an emergency that might include clothing, respite, incidentals, and school expenses.
- Services allowed include:
  - Protective investigations
  - Protective services
  - Intensive Crisis Counseling
  - In-home support services

### Ineligible Activities

- Subsidy to non-relatives
- Activities which are not performed in conjunction with the Relative Caregiver Program
- Maintenance payments beyond first twelve months of placement.
- Title IV-E and Medicaid reimbursable services or activities.
- Services that do not support the purposes of Social Services Block Grant.

### Services charged to Social Services Block Grant 2 include:

- Administrative costs for in-home services
- Support services for children to prevent out of home placement
Purpose, Awards, Match

Purpose: The funding mix program has occurred in response to how the State claimed Title IV-A/Emergency Assistance prior to October 1996. The activities for this program were directly linked to the IV-A/EA fund source and provided services as a result of an emergency and the efforts to prevent the removal of children from the home.

The funding (SSBG 2 and General Revenue-MOE for TANF) resulted from the 10% transfer of TANF to SSBG. The MOE for TANF is required to demonstrate that the state is maintaining the same level of GR funding that was provided before the block grant. The Legislature identified family builders as a source of meeting this funding level.

Awards: Family Builders is a direct appropriation from the Legislature each year.

Match: There is no match requirements for these funds due to either the funds being 100% GR-MOE or SSBG 2

Due to the funding mix provided in the family builders appropriation, the requirements are also mixed. The distinction has been identified by two different Other Cost Accumulators. The two are 2L000 and 2LMOE

<table>
<thead>
<tr>
<th>Requirements &amp; Reporting</th>
<th>Eligible Activities</th>
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</tr>
</thead>
</table>
| 1. 2L000 requires an Eligibility Determination form is complete and placed in the child’s file and that an entry into the Client Information System (CIS) be completed | 1. Any activity that is eligible under SSBG which may include: protective services for children, foster care services for children, transportation services, information and referral, counseling, employment and training, and personnel training. | 1. Activities which cannot be used include:  
• Purchase or improvement of land  
• Case payments for subsistence  
• Payment of wages as a social service  
• For provision of medical care |
| 2. 2LMOE is more prescriptive and requires that services be provided to an eligible family. An eligible family must meet two criteria: (1) includes a child living with his or her custodial parent or other adult relative and (2) be financially eligible by being less than 200% of poverty and is documented on an eligibility form. Additionally there must be evidence that the activity is necessary to prevent the removal or stabilize the child’s placement with parents or relatives and the client information is entered into the Client Information System (CIS). | 2. The services provided for this fund source must be provided to a family where a child is residing. It may include: in-home counseling and behavior management, parenting classes, protective services for children, child protective investigations, and respite child care. | 2. The funds associated with this category cannot be used for:  
• Reunification activities  
• Foster care services, (i.e. transporting foster children, foster parent support)  
• Activities provided to a non-family placement |

Table 10.
Family Builders  
(General Revenue, GR-MOE [TANF], SSBG 2)
Appendix C:
Targeted Case Management for Child Welfare Implementation Interview Protocol

Name of interviewer(s) ______________________________
Date/time of interview ______________________________
Name of stakeholder ______________________________
Name of Agency ______________________________

Introduction

The Louis de la Parte Florida Mental Health Institute of the University of South Florida is under contract with the Agency for Healthcare Administration (AHCA). The purpose of this interview is to explore the services associated with child welfare targeted case management as part of a systematic strategy to ensure that the mental health and support needs of children in the child protection system are adequately met. Specifically, we need to gather information about the benefits and challenges of providing child welfare targeted case management services, the conditions and resources supportive to implementation, any conditions that have hindered implementation, and the role of AHCA, the lead agency, the provider network agencies, and the child welfare targeted case managers.

Introductory

1. What is your current position?

2. How long have you been in your current position?

3. How long have you been with your current agency?

4. How long have you been involved with the implementation/provision of CW-TCM?

5. What has been your role in CW-TCM?
   a. ___ CW-TCM Provider Agency Staff
   b. ___ Targeted Case Manager
   c. ___ CW-TCM Lead Agency
   d. ___ AHCA Administration
   e. ___ DCF Administration
   f. ___ Other ______________________
6. What is your understanding of the key components of CW-TCM?

7. What is your understanding of the role of the CBC lead agency in CW-TCM?

8. Compared to the past, how has CW-TCM changed the way in which child welfare services are provided to children/families?

**Operation & Funding of CW-TCM**

9. Approximately how many children (or what percent of children) at your agency receive CW-TCM services?

10. How do you determine which children receive CW-TCM services?

11. What happens to children who can’t access CW-TCM?

12. What services, if any, do you/your agency provide to caregivers whose children receive CW-TCM services?

13. How are these activities funded?

14. If serving caregivers with Medicaid funding, how do you make sure services are still child focused?

15. What other programs are run by your agency which serve children and families in the child protection system?

16. What is your agency’s target population?
   a. What is your agency’s acceptance/eligibility criteria (for all services)?

17. What are the qualifications/education/training of your staff?

18. Do you have any difficulty finding staff with the necessary child welfare experience?
   □ Yes
   □ No

**Clarity of CW-TCM Policies & Standards**

19. Do you have any areas of confusion about CW-TCM and how it operates?
   □ Yes
   □ No

   a. If you do have areas of confusion, please describe them.
20. When you have had questions or concerns about CW-TCM, whom have you gone to for clarification?
   a. How helpful were their responses?

21. What kind of technical assistance has been made available to provider agency staff and CW targeted case managers?
   a. Who provided the technical assistance and what was the nature of it (e.g. formal or informal, in what areas)?

22. How are policy decisions made for CW-TCM?
   a. Is everyone involved who should be in policy decisions?
      ☐ Yes
      ☐ No
   b. If no, please explain.
   c. Are parents of children receiving CW-TCM services involved in policy decisions?
      ☐ Yes
      ☐ No
   d. Have you felt you have had sufficient input into CW-TCM policy?
      ☐ Yes
      ☐ No
   e. Do you feel the AHCA administrators and staff have listened to you?
      ☐ Yes
      ☐ No

23. Have the appropriate procedures and organizational structures been established to facilitate the smooth operations of CW-TCM and its working relationships with other child serving agencies?
    ☐ Yes
    ☐ No
    a. Please explain.
24. Have the following been adequate?
   a. Information Systems
      □ Yes
      □ No
      Comments __________________________
   b. Fiscal Policies
      □ Yes
      □ No
      Comments __________________________
   c. Reporting Mechanisms
      □ Yes
      □ No
      Comments __________________________
   d. Policy Oversight
      □ Yes
      □ No
      Comments __________________________
   e. Personnel Oversight
      □ Yes
      □ No
      Comments __________________________

25. Has AHCA been willing to make the necessary organizational and procedural changes to make CW-TCM work most effectively?
   □ Yes
   □ No
   Comments __________________________
   a. How about the lead agency?
      □ Yes
      □ No
      Comments __________________________

Caseload

26. What effect has the implementation of CW-TCM had on caseload sizes?

27. What happens when provider agencies cannot bill for CW-TCM (e.g., caseload over limit, case manager not certified)?

28. What funds are used to supplement?

29. What effect, if any, does this have on the agency and/or individual providers?

Service Delivery

30. How does your agency divide CW-TCM duties among staff and still maintain continuity of care for the children? Please share specific examples.
31. Is there a standard format/process for CW-TCM staffings or does it vary by agency (or county)?

32. Who participated in staffings?
   a. How often are cases staffed?

33. How are children/families involved in their:
   a. staffings?
   b. case plans?

34. What is the quality assurance/quality improvement process for CW-TCM?
   a. How is it working?

35. Has participation in CW-TCM required you to shift your priorities?
   □ Yes
   □ No
   a. What other major issues were/are competing for your attention?
   b. Have these other major issues affected your ability or willingness to fully participate in CW-TCM?
      □ Yes
      □ No
   c. In what ways, if any, have you not been able to participate?

36. Has working with CW-TCM presented conflicts with any of your current activities or procedures?
   □ Yes
   □ No
   a. If so, how?

**Outcomes/System Change**

37. Do you think the addition of CW-TCM has helped children and their families?
   □ Yes
   □ No
   a. If so, how?

38. What mechanisms and/or policies have been put into place through CW-TCM that attempt to ensure that children are safe from risk?

39. What is being done through CW-TCM to make sure that children are residing in stable and permanent placements?
40. What systems changes have resulted from CW-TCM?

41. What other system changes do you think should have occurred?

**Future Implementation of CW-TCM**

42. What issues would you be interested in learning more about through an evaluation of CW-TCM?

43. What issues are involved in developing standards for statewide implementation while remaining flexible to local culture and circumstances?

44. Is there anything else you wish to comment on?

*Thank you* very much for your time.
Appendix D:
Child Welfare Targeted Case Manager's Questionnaire

Please read prior to completing: All responses provided on this questionnaire are strictly confidential, and the analysis will be presented in a summarized format without individually identifiable information. Your responses will help describe background, characteristics, and experiences of staff providing targeted case management services to children in the child protection system.

A. Agency that currently employs you:
   - Manatee Glens
   - Child Development Center
   - Family Counseling

B. Your Date of Birth. ______/______/_______
   Month/Day/Year

C. Gender:  □ Male    □ Female

D. With which ethnic group or groups do you identify?
   - White
   - African-American
   - Black
   - Asian
   - Pacific Islander
   - Native American
   - Hispanic/Latino
   - Other (specify)

E. What is your highest academic degree or level of education:
   (Check only one)
   - Less than High School
   - High School or
   - Beyond High School but no degree
   - Associate’s (AA/AS)
   - Bachelor’s (BA/BS/BSW/BSN)
   - Master’s (MA/MS/MSW/MSN/MED/MPH)
   - Doctorate (Ph.D./Ed.D./Psy.D./DSW/Dr.PH.)
   - Diploma LPN
   - Diploma RN
F. What was the year you received this degree? 19_____ or 20_____ 

G. What is the primary field in which you received this degree? Please check only one: If dual degree, please check other and specify types of degrees.

- Alcohol Counseling (exclude other substance)
- Substance Abuse Counseling (exclude alcohol)
- Clinical counseling (i.e., marriage, family, group)
- Psychology (clinical)
- Psychology (non-clinical)
- Health care Administration
- Business Administration/Accounting
- Nursing (Psychiatric/Mental Health)
- Public Health
- Occupational Therapy
- Social Work (clinical)
- Social Work (non-clinical)
- Mental Health/Community MH
- Education
- Creative Arts Therapy (i.e., dance, music)
- Computer Science/Data Processing
- Other non-mental health (specify field)
- Other Human Services/Social Services (specify field)
- Physical Therapy
- Speech therapy/Audiology
- Sociology
- Theology
- Other (specify field)

H. Prior to becoming a child welfare targeted case manager, how many years work experience did you have working with abused/neglected children? 
   _____ Years experience with abused/neglected children

I. Prior to becoming a child welfare targeted case manager, how many years had you worked in a position providing case management functions? 
   _____ Years providing case management

J. During a one-month period, what is the average number of children on your caseload? 
   _____ Average number of children on caseload per month
K. Of these children/cases, approximately how many involve child welfare targeted case management services?

_____ Children/cases with child welfare targeted case management services

L. For only those children currently receiving child welfare targeted case management services:

What is your Average number of hours per week spent on required services to each child/caregiver (e.g., home visits, documentation, contact with service providers, observation of child, survey and assessment, etc.)?

_____ Hours per week for each child

M. We realize that each child's case is unique; however, considering your work duties overall, please rank in order beginning with those activities which you find yourself spending the most time on to those which are least time-demanding (Please use a “1” for the activity you do the most, “2” for the activity you spend the next highest amount of time on, numbering up to “10” for the activity you do the least). Please note: if you do not engage in a specific activity, write N/A (not applicable) and continue numbering up to the total number of activities you do conduct.

_____ Completing comprehensive needs assessment

_____ Developing service plans that identify services, assistance, and activities that address identified needs in the comprehensive needs assessment.

_____ Advocating for and assuring access to services and supports that address the unique needs of the child which were identified in the assessment.

_____ Developing referral review packets, referring the child to service providers, and establishing linkages between yourself and the child’s providers.

_____ Promoting coordination, integration, and continuity of services (social, medical, educational, etc.) for the child by multiple providers, including involving and updating providers on developments in the child’s situation.

_____ Communicating and collaborating with the biological parents or other family members regarding the child's care, needs, and progress if the child is in foster/out of home care.
____ Making home visits and required face-to-face visits for assessing, arranging, integrating, coordinating, and ongoing monitoring of the services and supports necessary to achieve the child’s stability.

____ Encouraging and supporting the child and family’s participation in the services offered as part of the case plan.

____ Maintaining required paperwork (e.g., case notes, monthly billing forms, face-to-face contact verification, etc.).

____ Matching appropriate billing resources (i.e., Medicaid, IV-E, etc.) to services provided.

N. If you could redesign your role and responsibilities, how would you ideally rank these items to best serve the children and families with whom you work? (Please use a “1” for the activity you would like to spend the most time on, numbering up to “10” for the activity you would ideally prefer to spend the least time on). Please note: if you would not spend any time on one or more of the activities, write N/A (not applicable) and continue numbering up to the total number of activities you would conduct.

____ Completing comprehensive needs assessment.

____ Developing service plans that identify services, assistance, and activities that address identified needs in the comprehensive needs assessment.

____ Advocating for and assuring access to services and supports that addresses the unique needs of the child, which were identified in the assessment.

____ Developing referral review packets, referring the child to service providers, and establishing linkages between yourself and the child’s providers.

____ Promoting coordination, integration, and continuity of services (social, medical, educational, etc.) for the child by multiple providers, including involving and updating providers on developments in the child’s situation.

____ Communicating and collaborating with the biological parents or other family members regarding the child’s care, needs, and progress if the child is in foster/out of home care.

____ Making home visits and required face-to-face visits for assessing, arranging, integrating, coordinating, and ongoing monitoring of the services and supports necessary to achieve the child’s stability.

____ Encouraging and supporting the child and family’s participation in the services offered as part of the case plan.
Maintaining required paperwork (e.g., case notes, monthly billing forms, face-to-face contact verification, etc.).

Matching appropriate billing resources (i.e., Medicaid, IV-E, etc.) to services provided.

O. Please take a few moments to express what you see as benefits of providing child welfare targeted case management.

P. Please take a few moments to express what you see as barriers to providing child welfare targeted case management.

Q. Please describe your experiences with the provision of child welfare targeted case management given current realities (e.g., interaction with HomeSafeNet, current political climate, community support).

R. Please share any ideas/suggestions you have on ways to improve the provision of child welfare targeted case management.

Please email completed survey to:
Stephen Roggenbaum at roggenba@fmhi.u.sf.edu

If you have any questions please call:
Stephen Roggenbaum at 813-974-6149 or suncom 574-6149

Thank you for your assistance, time, and valuable input into this questionnaire.
**Appendix E:**

**CW-TCM Staffing Observation Form**

CODE ___________________________________________
Adoption Meeting ________________________________
Case Closure Meeting ___________________________
Location of Meeting ______________________________
Permanency Meeting _____________________________
Reunification Meeting ____________________________
Observer 1 ______________________________________
Status Meeting _________________________________
Enrollment Date _________________________________
Observer 2 ______________________________________
Meeting Start Time ______________________________
Today's Date _____________________________________
Meeting End Time ________________________________

**Team Members Present** (First Name Only)

<table>
<thead>
<tr>
<th>Role: Agency/Family/Community</th>
<th>Ag</th>
<th>Fm</th>
<th>Cm</th>
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<td>10. ___________________________</td>
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</tbody>
</table>
Life Domain Areas Addressed/Mentioned During the Staffing (Check all those discussed at meeting.)

1. Cultural ____________________________
2. Education __________________________
3. Family ____________________________
4. Legal ______________________________
5. Medical/Self Care ____________________
6. Mental Health _________________________
7. Residential __________________________
8. Safety ______________________________
9. Social/Recreational ____________________
10. Substance Abuse _____________________
11. Vocational __________________________

Community

1. Information about resources/interventions in the area is offered to the team.
   ☐ Yes ☐ No ☐ NA (Not Available)
2. Service plan/plan of care includes at least one public and/or private community service/resource.
   ☐ Yes ☐ No ☐ NA
3. Service plan/plan of care includes at least one informal resource.
   ☐ Yes ☐ No ☐ NA
4. When residential placement is discussed, team chooses community/local placements for child(ren) rather than out-of-community placements, whenever possible.
   ☐ Yes ☐ No ☐ NA
5. Informal supports important to the family are present at the meeting.
   ☐ Yes ☐ No ☐ NA
Individualized

6. If an initial service plan/plan of care meeting, the parent is asked what treatments or interventions he/she felt worked/didn’t work prior to CW-TCM/current services.
   □ Yes □ No □ NA

7. Case Manager advocates for services and resources for the family (e.g., identifies and argues for necessary services).
   □ Yes □ No □ NA

8. All services family/team identifies as necessary are included in service plan/plan of care (i.e., no identified services were not offered).
   □ Yes □ No □ NA

9. Barriers to services or resources/interventions are identified and solutions discussed.
   □ Yes □ No □ NA

10. New or revised steps needed to implement the service plan/plan of care are clearly specified by the team. (i.e., how to achieve certain goals in specific behavioral terms).
    □ Yes □ No □ NA

11. Supports and services discussed by team make reference to the child’s assessment.
    □ Yes □ No □ NA

12. Strengths of family members are identified and discussed at the meeting (skill, action, or knowledge competency).
    □ Yes □ No □ NA

13. Service plan/plan of care that includes life domain(s) goals, objectives, and resources/interventions is discussed.
    □ Yes □ No □ NA

14. Service plan/plan of care goals, objectives, or interventions are individualized and based on family/child strengths.
    □ Yes □ No □ NA

15. Safety plan/crisis plan developed/reviewed.
    □ Yes □ No □ NA
### Family

16. Convenient arrangements or family's presence at meeting are made (e.g., location, time, transportation, day care arrangements).
   - [ ] Yes
   - [ ] No
   - [ ] NA

17. The parent/child is seated or invited to sit where he/she can be included in the discussion.
   - [ ] Yes
   - [ ] No
   - [ ] NA

18. Family members are treated in a courteous fashion at all times.
   - [ ] Yes
   - [ ] No
   - [ ] NA

19. The family's perspective is presented to everyone at the meeting.
   - [ ] Yes
   - [ ] No
   - [ ] NA

20. The family is asked what goals they would like help with to work on, improve, or change.
   - [ ] Yes
   - [ ] No
   - [ ] NA

21. The parent is asked about the types of services or resources/interventions he/she would prefer for his/her family.
   - [ ] Yes
   - [ ] No
   - [ ] NA

22. Family members are involved in designing the service plan/plan of care.
   - [ ] Yes
   - [ ] No
   - [ ] NA

23. In the service plan/plan of care, the family and team members are assigned (or asked) tasks and responsibilities that promote the family's independence (e.g., accessing resources on own, budgeting, maintaining housing).
   - [ ] Yes
   - [ ] No
   - [ ] NA

24. The team plans to keep the family intact or to reunite the family.
   - [ ] Yes
   - [ ] No
   - [ ] NA

25. Family members voice agreement/disagreement with service plan/plan of care.
   - [ ] Yes
   - [ ] No
   - [ ] NA
Interagency/Collaboration

26. Staff from other agencies who care about or provide resources/interventions to the family are present at the meeting.
   □ Yes □ No □ NA

27. Staff from other facilities or agencies (if present) have an opportunity to provide input.
   □ Yes □ No □ NA

28. Informal supports (if present) have an opportunity to provide input.

29. Problems that can develop in an interagency team (e.g., turf or are resolved.
   □ Yes □ No □ NA

30. Staff from other agencies describe support resources/interventions available in the community.
   □ Yes □ No □ NA

31. Statement(s) made by a staff member or an informal support indicate that contact/communication with another team member occurred between meetings.
   □ Yes □ No □ NA

32. Availability of alternative funding sources is discussed before flexible funds are committed.
   □ Yes □ No □ NA

Unconditional Care

(*If one NA, all NA)

33. Termination of CW-TCM services is discussed because of improvements with the child’s/family’s behaviors/problems.
   □ Yes □ No □ NA

34. Termination of other services (non CW-TCM) is discussed because of improvements with the child’s/family’s behavioral problems.
   □ Yes □ No □ NA
35. For severe behavior challenges (e.g., gangs, drugs), discussion focuses on safety plans/crisis plans (e.g., services and staff to be provided) rather than termination.

☐ Yes  ☐ No  ☐ NA

**Outcomes**

36. The service plan/plan of care goals are discussed in objective, measurable terms.

☐ Yes  ☐ No  ☐ NA

37. Long-term permanency is discussed in relation to short term goals and intermediate steps.

☐ Yes  ☐ No  ☐ NA

38. The criteria for ending CW-TCM involvement are discussed.

☐ Yes  ☐ No  ☐ NA

39. Objective or verifiable information on child and parent functioning is used as outcome data.

☐ Yes  ☐ No  ☐ NA

**Management**

40. Key participants are invited to the meeting (i.e., family members, CPS worker, teacher, therapist, others identified by the family)

☐ Yes  ☐ No  ☐ NA

41. Current information about the family (e.g., social history, behavioral and emotional status) is gathered prior to the meeting and shared at meeting (or beforehand).

☐ Yes  ☐ No  ☐ NA

42. All meeting participants introduce themselves (if applicable) or are introduced.

☐ Yes  ☐ No  ☐ NA

43. Service plan/plan of care is agreed on by all present at the meeting.

☐ Yes  ☐ No  ☐ NA
Staffing Coordinator/Facilitator

44. Staffing Coordinator makes the agenda of meeting clear to participants.
   □ Yes  □ No  □ NA

45. Staffing Coordinator reviews goals, objectives, interventions, and/or progress of service plan/plan of care.
   □ Yes  □ No  □ NA

46. Staffing Coordinator directs (or redirects) team to discuss family/child strengths.
   □ Yes  □ No  □ NA

47. Staffing Coordinator directs (or redirects) team to revise/update service plan/plan of care.
   □ Yes  □ No  □ NA

CW-TCM Case Manager

48. Targeted Case Manager updates team on developments in child’s situation and level of functioning.
   □ Yes  □ No  □ NA

49. Targeted Case Manager discusses activities that assist the child in accessing needed services and providers.
   □ Yes  □ No  □ NA

50. Targeted Case Manager ties service plan goals to plan of care services and outcomes.
   □ Yes  □ No  □ NA

51. Targeted Case Manager is able to update team on progress from service provider(s) who may not be present at meeting.
   □ Yes  □ No  □ NA
Appendix F:

Targeted Case Management for Child Welfare

Caregiver Interview Protocol

Name of interviewer(s) ______________________________
Date/time of interview ______________________________
Name of stakeholder ______________________________
Name of Agency ______________________________

Introduction

You have been selected for this interview because your child has received targeted case management for child welfare services. Your experience is very valuable to us and we believe that the information you will share with us can be very useful for improving programs and helping children and families who need these services. Your participation in this study is voluntary and you will not be identified by name. Any information we receive from you will be kept confidential. When we ask you questions please keep in mind that they are related to your experiences with the child welfare system and targeted case managers in the state of Florida.

1. What is your relationship to the child?

2. How long has the child been in your care?

3. (Interviewer: please mark gender for each caregiver who is present)

   First Caregiver: ______________________________
   Gender   □ Male
            □ Female

   Second Caregiver: ______________________________
   Gender   □ Male
            □ Female
4. What do you consider to be your race/ethnicity?  
   (Interviewer: Please check one box for each caregiver present)

   First Caregiver: ___________________________
   Race/Ethnicity
   □ African American  
   □ Caucasian  
   □ Hispanic/Latino  
   □ Asian/Pacific  
   □ Native American  
   □ Other

   Second Caregiver: ___________________________
   Race/Ethnicity
   □ African American  
   □ Caucasian  
   □ Hispanic/Latino  
   □ Asian/Pacific  
   □ Native American  
   □ Other

5. How long have you been working with your child’s case manager?

6. How often do you or your child have contact with the case manager?

7. How would you describe the case manager’s role with working with your family?

8. How have things been going for the child and your family since the case worker became involved?
   □ Better  
   □ Same  
   □ Worse

9. Has your case manager made you aware of additional programs within your local community that you might benefit from?
   □ Yes  
   □ No
   a. Please describe any other program that has been suggested.
   b. Has your case manager helped you access this (these) program(s)?
      □ Yes  
      □ No

10. Does the case manager seek information about your child’s behavior (at home, at school, in the community)?
    □ Yes  
    □ No
11. Do you have any concerns with the safety of:
   a. your child?
      □ Yes
      □ No
   b. your family?
      □ Yes
      □ No
   c. If yes, have you been able to get help from your case manager to resolve these issues?
      □ Yes
      □ No

12. Has your case manager ever asked you about your personal supports, such as family or friends?
   □ Yes
   □ No
   a. Has your case worker ever talked with them?
      □ Yes
      □ No

13. What do you see as your child’s assets or strengths?
   a. Has your child’s case manager ever asked about these strengths or does he/she seem to recognize them?
      □ Yes
      □ No

14. Do you feel like you, your family, and your child’s case manager work as partners for your family?
   □ Yes
   □ No

15. Please describe, from your perspective, the benefits of working with your case manager. Feel free to use examples of specific situations.

16. Have you observed any particular strengths of this case manager you would like to tell me about?

17. What things would you like to change about working with the case manager that would be more helpful?

18. How do you feel today’s case / service plan meeting (staffing) went?
   a. Did someone explain the purpose of this meeting to you before it was held?
      □ Yes
      □ No
b. Did someone help you prepare to participate in today’s staffing?
   □ Yes
   □ No

c. If so, who were they?

d. What was your role in today’s meeting?

e. Were you able to discuss what you wanted?
   □ Yes
   □ No

f. Do you feel your input was valued by the rest of the group (i.e. were your views made part of the plan)?
   □ Yes
   □ No

g. Please explain.

19. Was today’s meeting typical of the others you’ve attended?
   □ Yes
   □ No

   a. If not, how was it different?
   b. Are these meeting planned at a time convenient for your family?
      □ Yes
      □ No

20. Is there any other information that you feel would be helpful for us to know about the case management services you have received?

Thank you very much for your time.