Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Continuum of Care Report

Chapter 36, Laws of 2016
2ESHB 2376 Section 202(20)
Supplemental Budget

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Executive Summary

The 2016 Supplemental Budget Section 202(20) directed the Children's Administration (CA) to examine the foster care placement continuum and formulate a plan for improving placement stability.

Specifically, the legislature requested the following:

- An analysis of cost-effectiveness and outcomes of existing placement options
- The development of common and consistent assessment criteria for determining appropriate level of care
- The delineation of a continuity of care continuum
- An identification of gaps in services with recommended strategies and costs for addressing those gaps, and
- The development of models for stabilizing funding, including forecasting models for all components of the service continuum.

The information utilized to develop this work included:

- A literature review and prior analysis of placement services and outcomes
- An analysis of CA budget and administrative data
- A review of current CA assessment tools used to determine service needs and appropriate level of care
- Interviews and small group discussions with external stakeholders including foster parents and caregivers, contracted service providers, child placing agencies, Passion to Action foster alumni, and child welfare experts
- Interviews and small group discussions with internal stakeholders including Division of Children and Family Services (DCFS) and Division of Licensed Resources (DLR) staff.

Funding, placement stability, and continuity of care

By 2012, within three years of the 2009 recession, the out-of-home care budget had been reduced by $50,000,000. In 2010, the Behavioral Rehabilitation Services (BRS) budget was removed from the forecasted adjustable funding model, and allotted a much-reduced fixed budget. While budget cuts across government were necessary as a result of the economic downturn, an increasingly healthy economy has not resulted in a restoration of pre-recession rates. The elimination of forecasting BRS, a service intended to meet the needs of behaviorally challenging children and youth with mental health needs, has resulted in a compression and reduction of resources. Many BRS placement providers stepped up their efforts to meet the placement need, but the combination of low rates, children with increasingly severe behavioral and mental health challenges, and mixed messages from CA resulted in a loss of confidence in CA by providers.

CA is currently seeing the impact of the reductions incurred during the recession in the lack of receiving and interim care, resources for emergent placement, and placement resources that are capable of caring for children and youth with challenging medical, developmental, and behavioral health issues. The effects can be seen in the recent increase in the placement instability and use of hotels as an emergent placement options as a last resort. After such reductions in resources, the development of plans with cost neutral solutions is extremely challenging, if not impossible.

Gaps in the Continuum and Recommendations for Improvement

The challenge CA faces is not only the placement capacity, but also the fragmentation of placements that affect continuity of care, and can be observed throughout the continuum, but are most apparent in three areas:

- **Entering into care.** CA currently lacks an adequate number of foster homes for children of all ages at all levels of care, but particularly resources for children first coming into care. Placement of children occurs 24 hours per day, seven days a week. Particularly difficult placements are those occurring after-hours, on weekends, on holidays and those requiring staff to locate emergent placement for children and youth coming into care who are already exhibiting externalizing behavioral issues or are from families with large sibling groups.

- **The transitional challenge between foster care and BRS**. Federal law[1] requires that case plans include placement of a child in the least restrictive setting available and appropriate. This requirement means that most children in the care and custody of CA are placed in family foster care or kinship care. If a child's behavior escalates and cannot be stabilized in his/her current placement, he/she may need to be moved to a BRS placement. Because of the reduced resources and capacity of BRS, it can take two weeks to two months to find a BRS placement option for these children and youth. This delay is due in part to the limited BRS placements and the current rate structure. Delays are also the result of the ability of foster homes, contracted providers, or agency partners to decline or discontinue to serve children in CA care and custody. These children and youth need an interim short term placement while new, more permanent, placements are arranged. While children wait for a BRS placement, CA works to provide and pay for the services, in-home aides, or other supports as necessary to maintain the child in placement while awaiting BRS.

- **The children transitioning into or out of other administrations** (Juvenile Rehabilitation, Behavioral Health, and Developmental Disability). CA is sometimes responsible for providing safe and appropriate out-of-home care for children and youth being released from detention or juvenile institutions or hospitalization. These children and youth can present with physically and sexually aggressive behaviors, recent history of suicide efforts and self-harm making it impossible to place them in homes with other more vulnerable children or where line-of-sight supervision is needed to keep them safe. There are a limited number of Children's Long-term Inpatient Program (CLIP) and psychiatric beds available for children in the State, and accessing these resources through local county jurisdictions can be complicated and time consuming. Having no placements or treatment options within an integrated continuum for acute hospitalization and intensive residential treatment options causes significant disruption in the continuity of care for a child.

Recommendations

- **Increase number of facilities able to accept children and youth on an emergency basis.** These facilities provide short-term, no more than 30 days, care 24 hours per day, 7 days a week**.** This increase would meet a critical need for after-hours, weekend, and holiday placement of children and youth. CA has established contracts in parts of

[1] P.L. 96-272 Adoption Assistance and Child Welfare Act of 1980

the state which have included a no decline policy for up to 80% of the facility's capacity.

- **Explore establishing a category of professionalized foster care.**

- **Using currently unoccupied state-owned facilities as possible placement options.** The state has a number of unused state owned facilities. CA is exploring the use of those facilities by private organizations to operate BRS or other step-up and step-down placement options.

- **Facilitate cohesive integration of behavioral health services under a Managed Care Organization (MCO).** All levels of behavioral health services provided through Health Care Authority, Division of Behavioral Health and Recovery, Behavioral Health Organizations, and CA will transition to the MCO, Coordinated Care, in 2018. As this care transitions, careful consideration should include the highest level of psychiatric care at hospitals, the CLIP, evaluation and treatment facilities, and Wraparound with Intensive Service (WISe), and evaluate how a single MCO can manage or coordinate high level treatment to provide seamless care for children in foster care

- **Reexamine the referral process, easing and broadening access to non-facility based BRS.** Allowing earlier access to non-facility based BRS can help address behaviors and stabilize children prior to a point of crisis. Recognizing a child's behavioral escalation and intervening sooner could decrease stress and trauma for children, reduce placement moves, and help a child achieve success. Easing and broadening the clients' access to non-facility-based BRS should follow the completion of the cost of care analysis and rate adjustments.

<u>Recommendations to Pilot</u>

- **Develop Treatment Foster Care (TFC) under the MCO (Pilot Project).**
  CA should contract with the MCO to develop capacity for new TFC beds across the state. The newly developed TFC will provide clinical intervention with specifically trained foster parent homes for children and youth with severe mental, emotional, or behavioral health needs requiring more intensive clinical intervention than can be provided in conventional foster care homes. The MCO could bring a unique opportunity to seamlessly combine CA placement resources with behavioral health services provided through BHA.

- **Develop a Predictive Model Assessment Process (Pilot Project).**
  There is a need for a consistent and objective assessment at the earliest stage possible, ideally at the time children and youth enter CA care. Using predictive analytics with data available at the time the child is initially placed in out-of-home care may allow CA to objectively assess the need level of the children coming into care expeditiously.

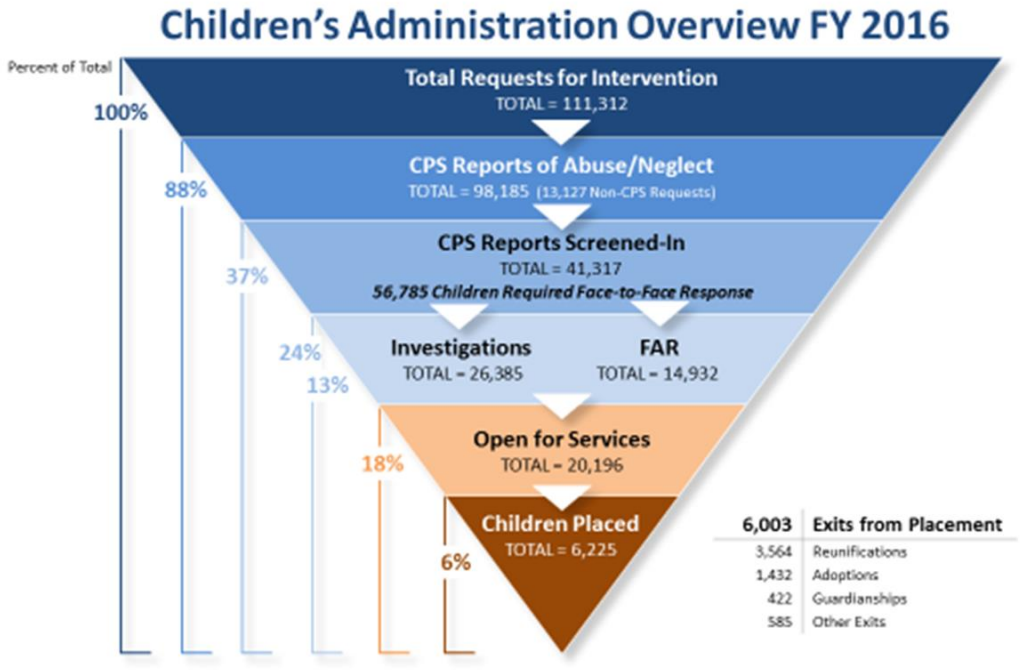
- **Develop Comprehensive TFC Service Package Payment for CPA (Pilot Project)**
  CA can contract with both the CPA and BRS providers to provide emergent crisis intervention, therapeutic support, and case coordination. At this time, CPAs have been limited to providing services based on a fee-for-service, per-activity payment model.

Providing CPAs with an option to participate in an inclusive comprehensive service payment package to operate TFC will allow agencies flexibility to manage their budgets, and more timely and effectively provide services to respond to the specific needs of children and families in need.

Agency Overview

CA receives approximately 9,000 phone calls every month reporting possible child abuse and neglect or requesting services for children and families. About 37% (≈3,400 calls) of calls are screened in for further CA intervention, and every month nearly 513 children enter out-of-home care through CA. CA conducts a variety of screenings and assessments from the time children and families come into contact with CA until a decision is made to place the child into out-of-home care because his/her safety cannot be secured in his/her own home. As of December 2016, of the children placed in out of home care, over 45% of children were placed in relative and kinship homes, over 40% in foster care and approximately 6% of children receive Behavioral Rehabilitative Services (BRS).[2] Figure 1 summarizes CA interventions from the time CA receives requests for intervention to children exiting from care.

Figure 1 Agency Overview FY 2016



Process of Out-of-Home Care Services

Federal law requires that children placed in out-of-home care are placed in the least restrictive (most family-like) setting appropriate and available for the child. The case plan and court report provide information about the child's placement and its suitability in meeting the child's needs.

Typically, a number of screenings (detailed in the Assessment and Screening section) is completed for every child who comes into CA care. CA conducts a Family Team Decision Making (FTDM) meeting when a child is being placed with the goal of making the best placement decision for the child. After the FTDM is completed, an assigned caseworker completes the Child Information and Placement Referral (CIPR) form and refers the child for

[2] Administrative data from the Department of Social and Health Services' FamLink CA's Statewide Automated Child Welfare Information System (SACWIS).

placement. CA placement caseworkers use the completed CIPR form to search for available and suitable placements for each child (methods of identifying and communicating with potential caregivers may vary depending on the region). Discussions and decisions about services provided through Child Placing Agencies (CPAs) and/or the need for an Exceptional Cost Foster Care Plan (ECP) may take place between CA and prospective caregivers. In some areas, specific contracts exist for receiving and interim care to respond to emergent placement needs.

Generally, BRS programs are used when a child's specific needs exceed state and/or CPA foster caregiver capability. At the FTDM, a topic of discussion can be whether a BRS program is needed and, if so, the assigned caseworker completes a BRS packet, which includes a profile of the child, detailing the child's specific behavioral and mental health challenges. When there is no available or appropriate BRS program to meet the child's needs, CA can create a Child Specific contract[3] which is negotiated between the BRS program managers and the providers. Utilization of specialized mental health or developmental disabilities programs can take place concurrently. Reliance on out-of-state programs occurs only when all available in-state resources are researched and exhausted.

Current CA Placement Continuum

When children must be placed out of the home because their own home is unsafe, they usually come into one of the four general types of care: unlicensed kinship and relative care, state licensed family foster home care levels one (basic foster care) to four (including licensed kin and relatives) , CPA licensed foster home which also operates under the same rate level system, or BRS which includes in-home BRS, foster care BRS (non-facility therapeutic foster home), and facility-based BRS(licensed group homes or staffed residential homes).

There are some specialized placement resources such as Special CPA Receiving Care and Resource and Assessment Centers (RAC) which are not consistently available throughout the state. Some of those programs are identified as potential solutions to fill identified placement resource gaps, and strategies to rebuilding the capacity and/or replicating these program statewide is explored in this report.

Family Foster Home

Foster homes provide care for children of all ages who need temporary or extended out-of-home placement usually because they cannot be safely maintained in their own homes. Foster care is provided by licensed foster parents, licensed relatives or kin or unlicensed relatives or kin and is viewed as a short-term solution to an emergent situation. The goal of foster care services is to provide a safe, stable, and nurturing temporary home environment for the child while the parents work to be reunified with their child.

Foster Care Rate Assessment (FCRA)

The FCRA is a four-level system to assess appropriate levels of payment to foster parents for the care of the child: Level 1 is basic care and levels 2-4 represent increased levels of non-routine caregiving provided by the foster parent to maintain the child in care. The rate is set according to the caregiving time and effort needed to

[3] When the child's needs exceed the BRS level care, a Child Specific contract is developed with a plan to meet the specific needs. The costs of care are usually negotiated with contracted agencies.

meet a child's needs, rather than a child's diagnosis or condition. See Table 1 below for foster care reimbursement rates.

Table 1 Foster Care Rate

AGE OF CHILD	BASIC	LEVEL II (includes Basic Rate)	LEVEL III (includes Basic Rate)	LEVEL IV (includes Basic Rate)
0 through 5 years	$562.00	$739.92	$1,085.51	$1,364.30
6 through 11 years	$683.00	$860.92	$1,206.51	$1,485.30
12 and older	$703.00	$880.92	$1,226.51	$1,505.30

A Child-Placing Agency (CPA) is an agency licensed by the Division of Licensed Resources in CA to place children for foster care or adoption. CA licenses CPAs, including tribal CPAs, to supervise foster homes. CPAs are authorized to certify to CA that a foster home meets the licensing regulations. CPAs have the discretion to certify or not certify a foster home, and have discretion to develop additional regulations for a foster home to become and remain a licensed foster home under their supervision. CA has the final approval authority for licensing a foster home that a CPA has certified.

In order to place children in a CPA certified home, CA contacts the designated person at the CPA rather than the foster parent directly. The CPA determines whether or not they have a home available for a child, based on the child's needs and fit with available caregivers. CPA providers are not usually available afterhours.

Children in the custody of CA placed in a CPA foster home may receive one or more of the services below. The rates paid to CPAs differ depending on the services provided.

- Case management
- Parent-child visits
- Borrowed bed
- Follow-up services
- Case aide services
- Intensive case management (ICM)[4]

Behavior Rehabilitative Services

CA contracts with community agencies to provide BRS for children and youth with serious emotional, behavioral or medical challenges who cannot be served in regular family foster homes. BRS provides a high level of structured care and treatment for children and youth with the most severe and intensive needs[5]. Services are offered in three different placement settings including the child's home, a treatment foster care (TFC) home or a facility-based setting. The details of BRS service division types are outlined in the BRS Handbook[6].

[4] Intensive Case Management (ICM) is the additional support provided to children receiving case management services when extensive coordination of services is required

[5] The original design of BRS was intended to stabilize the child or youth who was then moved to a less intensive service. Over time, BRS has come to be regarded as a placement for high-needs children and youth.

[6] BRS Handbook: https://www.dshs.wa.gov/sites/default/files/CA/pub/documents/BRSHandbook.pdf

Below is a breakdown of the average numbers and percentages of children placed in each of the three BRS placement settings :[7]

Table 2- BRS Client Counts

	Annual		Monthly Average	
BRS Duplicated Client Counts, SFY 2015	NUMBER	PERCENT	NUMBER	PERCENT
In-Home BRS	141	14.2%	51	8.5%
Treatment Foster Care (non-facility)	648	65.3%	313	51.9%
Facility-based (includes Staff residential and group homes)	601	60.6%	295	48.9%
BRS Duplicated Total	1,390		659	
BRS Unduplicated Total	992		603	

Within the TFC and facility-based setting, most children and youth are served in the longer term Behaviorally/Emotionally Disordered category and at the highest rates and service level which is based on frequency, duration and intensity of the behaviors or disorder.

There are fewer children in the specialty category: Sexual Aggression, Developmentally Disabled, Medically Fragile, Residential Assessment and Interim Care. Below is a description of these categories:

1. The Behaviorally/Emotionally Disordered category serves children with difficult behavioral or emotional challenges and sometimes those children who are professionally diagnosed with serious mental health disorders.
2. The Sexually Aggressive category serves children who present sexually aggressive behavior as the primary behavioral indicator. Many of these children/youth have experienced sexual abuse themselves. These children may have been criminally adjudicated for these acts and present a potential risk to the community where they live.
3. The Developmentally Disabled category is reserved for children who are developmentally disabled, including those who suffer from Fetal Alcohol Syndrome and Alcohol Related Neurological Disorder. They may also have behavioral disabilities, serious physical health impairments and require partial or total personal care.
4. Medically Fragile Services are for children with medically intensive needs who require more individual and continuous care than is available from an intermittent visiting nurse. Services are supervised by a Registered Nurse (RN) and provided in a licensed foster home, group home, or licensed facility for severely and multiply handicapped children. (More specific description of Medically Fragile Group Homes and foster homes will be noted in the following section "Other Out-of-Home Care Placement Resources").
5. Residential Assessment and Interim Care focuses on short-term and emergent service needs. These services are provided 24 hours a day, seven days a week. Contractors

7 Data Source: Administrative data NOTES: BRS categories are not unduplicated; youth may experience BRS in more than one setting in the fiscal year. BRS categories based on placement information in Children's Administration's FamLink database.

providing Residential Assessment or Interim Care must be able to begin services within four hours of referral. Assessment Services can be authorized up to 90 days, and Interim Care Services can be authorized up to 180 days.

Other Out-of-Home Care Placement Resources (Not available statewide)

Staffed Residential Homes

Families may also choose to become licensed as a staffed residential home, which is a hybrid model developed that provides for 24 – hour care to six or fewer children requiring more supervision that can be provided in a foster home. A staffed residential facility license allows for either a family to live in the home, or revolving staff to provide supervision. This category is similar to professional foster care, in that it would allow a family to reside in a home, provide skilled services for children or youth in out-of-home care with more challenging behavior as their employment. There are increased licensing requirements beyond the family foster care regulations. There are no income requirements for the family, and Washington State Patrol fire marshal and department of health reviews are not required if the facility is licensed for five or fewer children. The program must be contracted with the department, and the income earned by the home would be considered business income. There are currently 86 facilities licensed as staffed residential facilities; a number of these are contracted through Developmental Disabilities Administration.

Short-Term Crisis Placement Services

Short term crisis placement resources with contracted agencies are available for children who have disrupted from their previous placement, and need a short term resource until they can return to their original placement, or a new long term resource is available. These services are time-limited to serve clients from 72 hours to a maximum of 30 days. These services are designed to have capacity to accept emergent referrals after hours, weekends, and holidays. These services include:

- Resource Assessment Centers (RAC) -Provide services for children aged birth through 12 years, sibling exceptions are considered. Services are intended to be short-term emergency and crisis care for children. The contractor receives a payment rate of $25 per day for each CA referred child. (Currently available in Everett and Bellingham)
- CPA Special Receiving Care-Provide services for children aged birth through 20 years. Services are intended to be short term up to 14 calendar days. However, CA may authorize services for up to 30 days. The contractor receives a payment rate of $103.75 per day per child/youth. (Currently available in Everett, Tacoma, Seattle, Port Orchard, and Silverdale)
- Group Receiving Care-Provide services for children ages 2 to 12 specifically in the greater Spokane County area. The contractor provides up to 18 receiving care beds, based on age, gender, room configuration, and availability. The service contract is an annual contract with a fixed maximum amount with a $1/12^{th}$ payment (per bed cost is higher than other receiving care options). CA may authorize services up to 30 days. (Currently only available in Spokane)
- Emergent Placement Facilities-Provide services for children aged birth through 20 years. Services are intended to be no more than15 days. However, CA may authorize services for another 15 days total, up to 30 days. The contractor receives payment for a negotiated Monthly Based Rate (aka retainer payment) in addition to a Daily Rate of $144 for each child placed. The contract stipulates that the program must accept and

serve at least 80% of the children referred, be available to accept referrals and placement 24 hours, 7 days a week, and respond within two hours of a referral. (Currently available in Yakima, Seattle, and Everett)

Responsible Living Skills Program (RLSP):
The purpose of RLSP is to provide a supervised residential program that encourages positive youth development and teaches youth independent living skills. The provider receives payment of $3,098.07 per month per youth. Youth may reside in an RLSP until 18 years old, or until 21 years old if the youth is continuously enrolled in Extended Foster Care.

Crisis Residential Centers (CRC)**:** Secure Crisis Residential Centers (S-CRC), Semi-secure Crisis Residential Centers, and HOPE Centers moved under the authority of the Department of Commerce in July 2016. These placement resources serve youth aged 12 through 17 who have run away from their caregivers and need a safe place to stay until they can be reunified with their family or provided an alternative living arrangement. The total number of consecutive days spent in a CRC may not exceed 15 days. S-CRC providers received payment rate of $152 per youth per day under CA contract.

Pediatric Interim Care (PIC):PIC provides specialized services to drug or alcohol affected children under the age of two years, primarily to infants under the age of six months. The provider receives an agreed upon monthly payment rate (depending on program capacity). To be eligible for the service, a child must exhibit signs of withdrawal as determined by a medical professional. CA can authorize services up to 45 days per family. PIC is provided in the home or in a facility.

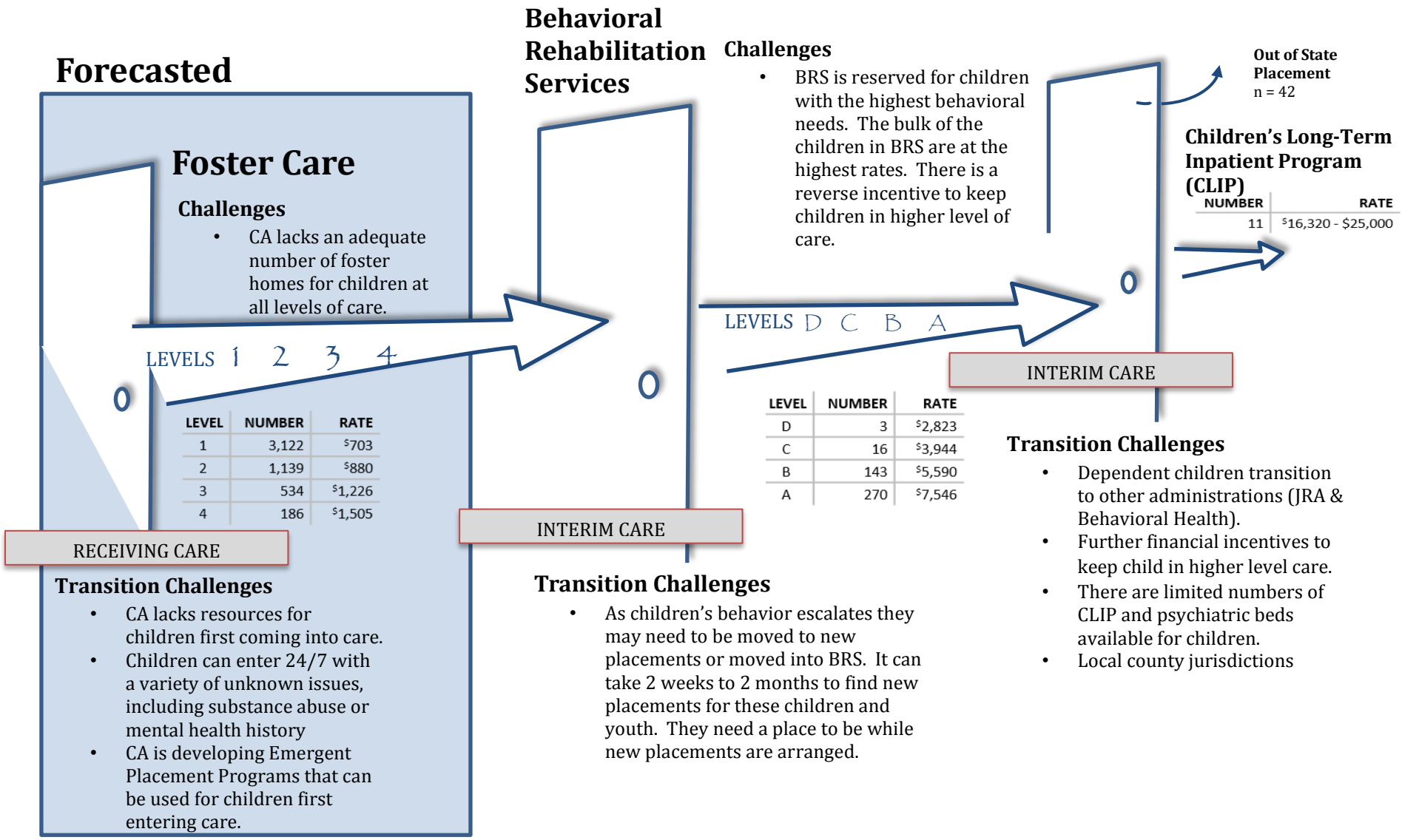
Medically Fragile Group Homes: Children placed in these homes are typically reliant on technology such as ventilators and have tracheotomies which require frequent monitoring and adjustment. The facilities are staffed with nurses, nursing assistants, and social workers. CA provides these services under the BRS contract; however, Developmental Disabilities Administration (DDA) also contracts with these providers. In medically fragile group homes, nursing care is provided 24 hours a day, and for children meeting the Medically Intensive Children's Program (MICP) requirements, nursing care cost is provided by MICP overseen by DDA. These group homes are located in Olympia, Centralia, College Place, Tacoma, Federal Way, Kent, Enumclaw, Woodinville, and Tulalip.

Licensed and unlicensed foster homes for medically complex or medically fragile children**:**
Some medically complex or medically fragile children are placed with individuals who are medical professionals. These medical professionals may be licensed foster homes or relative caregivers. Services are available to provide a nurse in the home when the child meets eligibility requirements for the MICP. MICP is a Medicaid program overseen by the DDA.

Children's Long Term Inpatient Program (external to CA continuum)
CLIP is a statewide system designed to provide the most intensive inpatient psychiatric treatment available to all Washington State residents, ages 5-18 years of age. CLIP utilizes a medically based treatment approach, providing 24-hour psychiatric care, provided in a secure and highly structured setting designed to assess, treat and stabilize youth diagnosed with psychiatric and behavioral disorders, and funded by Medicaid dollars. There are 82 CLIP beds across the state. The average length of stay is three to six months.

Figure 2 Out-of-Home Placement Continuum and Challenges

Current Out-of-Home Placement Continuum



Source: Numbers provided are the average monthly headcounts for FY 16 as pulled from Famlink Payment Data on 8/23/16

Gaps in the Placement Continuum and Transition Challenges

The challenge CA faces today is not only placement capacity, but also the fragmentation of placements that affect continuity of care. This challenge can be observed throughout the continuum, but is most apparent in three areas:

1. **Entering into care.** CA currently lacks an adequate number of foster homes for children at all levels of care, but particularly resources for children first coming into care. Children can enter CA care at any time, with a variety of unknown issues, including substance use or mental health history. Particularly difficult placements are those that occur after-hours, on weekends, or holidays, and/or those for which the caseworker must locate emergency placement for children and youth coming into care already exhibiting externalizing behavioral issues, and families with large sibling groups. CA has moved away from its reliance on the use of receiving care because of the concern about increasing the number of the placements children and youth experience in CA care; however, CA must balance this concern with its ability to respond to emergency placement needs.

   Example[8]*:* Samantha, an 11-year-old, her brother Tom, 7, and sister Cindy 5, have been living with their grandmother due to their parents' incarceration. The grandmother had a medical emergency on Saturday at 2:00am and Samantha called 911. Emergency medical service (EMS) and law enforcement (LE) arrived. Upon arrival, LE noted there were no responsible adults capable of caring of the children. LE contacted CA, and an after-hours caseworker attempted to locate other relatives or suitable placements. Samantha's aunt answered the call but she is in Chicago for 10 days on business and cannot return any sooner. The grandmother's condition requires extended hospitalization. Samantha, Tom, and Cindy need a safe place to stay together in their community so they can remain in their school while they wait for their aunt to return.

2. **The transitional challenge between foster care and BRS**. As children's behavior escalates they may need to be moved to new placements or moved into BRS. Because of the reduced resources and capacity, it can take 2 weeks to 2 months to find new placements for these children and youth. The factor that can complicate the placement challenge is that foster homes, contracted providers, or agency partners retain the right to decline or discontinue to serve children in CA custody. As a result, some children need an interim placement while new, more permanent, placements are arranged. One of the most significant impacts of the BRS budget reductions CA has experienced is the loss of BRS Interim Care and Residential Assessment Beds which CA relied on during these transitional periods.

   Example: This is the 3rd foster home placement in last 3 months for 14-year-old Josh. Josh can be disrespectful; he has hard time following basic expectations of the house such as attending school regularly and returning home on time. He doesn't communicate his whereabouts with his foster parents, and at times when he returns home he appears intoxicated and smells of alcohol and marijuana. He has a

[8] Case examples are based on actual CA cases. All names and identifying information have been changed to protect confidentiality and anonymity of the clients.

tendency to be more aggressive when he is intoxicated, makes verbal threats to harm caregivers and can be mean toward his foster siblings. When he returned home at four a.m. intoxicated and yelled profanities at a younger child in the home, the foster parent contacted the caseworker about her concern for the safety of other children in the home, and that she is unable to care for him any longer. The assigned caseworker requested a new placement, but there are no foster homes in the area willing to accept Josh, and it would take at least a week to locate a suitable BRS provider who can provide care for Josh.

3. **The children transitioning into or out of other administrations** (Juvenile Rehabilitation, Behavioral Health, and Developmental Disability) is the other area of significant challenge. In some situations, CA must locate a placement for them with no or very little time to make arrangements. Also, there are limited numbers of CLIP and psychiatric beds available for children in the State, and accessing these resources through local county jurisdictions can be extremely complicated and time consuming. Having no placements or treatment options within an integrated continuum for acute hospitalization and intensive residential treatment options can cause significant disruption in the continuity of care for a child.

   Example: Jenny, now 12 years old, had a medical issue at birth and had a major organ transplant, and has an ileostomy which requires consistent monitoring. Also she takes anti-rejection medications, and if she doesn't take her medication regularly her body may reject the transplant. Because of substance use and mental health issues, her mother has not been in her life since her birth, and her father has never been identified. In addition to her medical condition, Jenny has been struggling with depression and anxiety. Jenny had been living with her grandmother who was a nurse, but she passed away last year and since then she has been in the care of a foster parent who specializes in caring for children with serious medical conditions. For about the last four months, through a social networking website, her mother has found her and has been contacting her. Jenny has been extremely agitated, isolating herself from her caregivers, and at times being verbally and physically aggressive towards them. She then refused her medication for some time and needed to be hospitalized. The CA caseworker and the hospital social worker were extremely concerned about her and contacted the local CLIP committee to seek treatment. The local CLIP committee informed CA that her condition was behavioral, not a psychiatric issue, and CLIP would not be appropriate for her. Even if Jenny agrees to CLIP treatment, there is a long waiting list, and she will not be able to get in for another 90 days. In the meantime, Jenny was deemed medically stable and needs to be discharged from the hospital. The previous care giver sincerely cares for Jenny, but believes Jenny's condition exceeds her abilities to provide care. The assigned caseworker and local BRS manager have been searching for an appropriate care provider throughout the state, but no one is willing to take Jenny.

Current Screening, Assessment and Placement Decision Making

CA gathers and reviews information concerning the children and families it serves to assess the safety of children and provide the most appropriate services in the least restrictive environment appropriate for the child and family.

Intake Screening
The primary purpose of intake screening is to gather enough information to determine the immediate safety and risk of harm to children. The intake worker gathers information from the caller, reviews any family history in the Statewide Automated Child Welfare Information System (SACWIS), FamLink, reviews available databases, and uses the information to complete an initial risk assessment of child maltreatment.

The intake worker completes the sufficiency screen focusing on three questions:

1. Is the victim under 18 years of age?
2. If the allegation were true, does the allegation minimally meet the WAC definition of CA/N?
3. Does the alleged subject have the role of parent/caregiver, acting in loco parents, or unknown?

If the allegation meets sufficiency, the screened-in intake is referred to the CPS Investigations or CPS Family Assessment Response (FAR) pathway. The assigned worker conducts a face-to-face interview with child victims within 24 or 72 hours depending on the urgency to assess the safety of all children in the home. Intakes with allegations of physical abuse of children ages birth to three years old that meet the sufficiency screen-in criteria will always be assigned to the CPS investigation pathway for a 24-hour response. Any screened-in intake alleging a possible crime against a child is referred to local law enforcement.

Face-to-face contact with all children
The primary purpose of face-to-face contact with children is to assess the immediate safety of the child and, whenever age appropriate, interview the child.

At the face-to-face meeting, the caseworker attempts to complete and document the following:

- Physical observation of the child's condition.
- Condition of the child's living environment.
- An interview with the child who has the ability and developmental maturity to communicate.
- Gather pertinent and sufficient information to help the caseworker complete an accurate and thorough Safety Assessment and take any protective action necessary for child safety.

Face-to-face interviews with the child's caregiver and alleged perpetrators
The primary purpose of face-to-face interviews with the child's caregiver and the alleged perpetrator is to inform them of the report, provide them with an opportunity to share information pertinent to the report, and provide them an opportunity to respond, and begin to gather information to assess the caretaker's ability to safely care for the children and protect them from harm.

Safety Assessment
The Safety Assessment is used throughout the life of a case to identify whether a child is safe or unsafe. It is based on comprehensive information about the family available at the time of its completion.

Structured Decision Making Risk Assessment [9](SDM):
The Structured Decision Making® (SDM) risk assessment is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. The assessment tool is required as part of the Investigative Assessment and is completed on screened-in intakes (including risk-only and FAR intakes) requiring a CPS intervention.

Investigative Assessment
The Investigative Assessment is completed in FamLink within 60 calendar days of receiving the intake.

A complete Investigative Assessment contains the following information:

- A narrative description of the following:
    - History of CA/N (prior to the current allegations, includes victimization of any child in the family and the injuries, dangerous acts, neglectful conditions, sexual abuse and extent of developmental/emotional harm).
    - Description of the most recent CA/N (including severity, frequency and effects on child).
    - Protective factors and family strengths.
- Results of the structured Decision Making Risk Assessment tool.
- Documentation that a determination has been made as to whether it is probable that the use of alcohol or controlled substances is a contributing factor to the alleged abuse or neglect.
- Disposition, e.g., case status.
- Documentation of findings regarding alleged abuse or neglect.[10]

Family Team Decision Making (FTDM)

An FTDM meeting is a facilitated team process which can include birth/adoptive parents, guardians, extended family members, youth, community members, service providers, child welfare staff and caregivers. These meetings are held to make decisions regarding the placement of children following the emergent removal of a child from his or her parent's custody by law enforcement or court order. FTDM meetings are also held to discuss changes in out-of-home placement, reunification of a child with his or her parents or placement into a permanent home.

The goal of the FTDM is to reach consensus about the safest and least-restrictive placement that is in the best interests of the child and where the child's safety will be assured. The priorities of the FTDM are to protect children, preserve or reunify families, and/or prevent placement disruption.

Child Health and Education Tracking (CHET)
The CHET identifies each child's long-term needs at initial out-of-home placement by evaluating his or her well-being within 30 days of the child's original placement date (OPD). The results of the evaluation are used to develop an appropriate case plan and assist with placement decisions. The CHET evaluates all children in the care and custody of CA who are

[9] The Structured Decision Making System: http://www.childsworld.ca.gov/res/pdf/SDM_Manual.pdf
[10] CA uses a civil or a "more likely than not" standard to determine findings of abuse or neglect.

expected to remain in care 30 days or more. Well-being factors include five domains: physical health, developmental health, educational, emotional/behavioral health, and connections with others.

CHET utilizes numerous age-appropriate assessment tools according to the child's age at the time of the assessment.

Apple Health Core Connection (AHCC) Care Management Program
The MCO, Coordinated Care AHCC Program, provides health care coordination for children placed out-of-the-home. After placement notification, the AHCC assigns a care manager for the child and youth with an identified need for physical or behavioral health care coordination. The care manager contacts the caregiver to ensure that the child or youth is receiving the care necessary for his/her specialized need. The care manager receives a copy of the CHET report which is used to inform the child's level of health care coordination.

Children in Out of Home Care

There are over 8,500 children in DCFS placement and care authority under age 18 placed in out-of-home care on any given day. In additional to these children, Children's Administration supports over 900 children age 0-20 in non-DCFS custody primarily through payments for tribal foster care, and nearly 500 youth age 18-20 in Extended Foster Care. In addition, CA supervises more than 1,000 Children returned home by the court on a trial return home. This report focuses on children in DCFS custody under age 18 placed in out–of-home care.

On October 31, 2015, 8,554[11]children and youth age 0-17 in DCFS custody were placed in out-of-home care in Washington. Of those 8,554 children in out-of-home care, nearly 40% were placed in unpaid/unlicensed relative/kinship care, 55% were placed in state licensed care, and 6% were in other resources not funded by CA, such as hospitals, detention centers, or were missing from care. Over 85% of these 8,554 children were placed in family homes, either with relatives or in licensed foster homes.

Of the 55% of children placed in state licensed care, 86% of these children were placed in licensed family foster homes (Levels 1-4); 14% were placed in higher levels of care, including BRS, and while 10.7% of children in licensed care are served in BRS, only 6% of all children placed in out-of-home care are served by BRS.

This distribution by type of care is illustrated in Figure 3[12]

[11] October, 2015 Administrative Data from the Department of Social and Health Services' FamLink CA's Statewide Automated Child Welfare Information System (SACWIS)
[12] Data Source: October 2015, Administrative Data from the Department of Social and Health Services' FamLink CA's Statewide Automated Child Welfare Information System (SACWIS)

Figure 3. Distribution by Type of Care

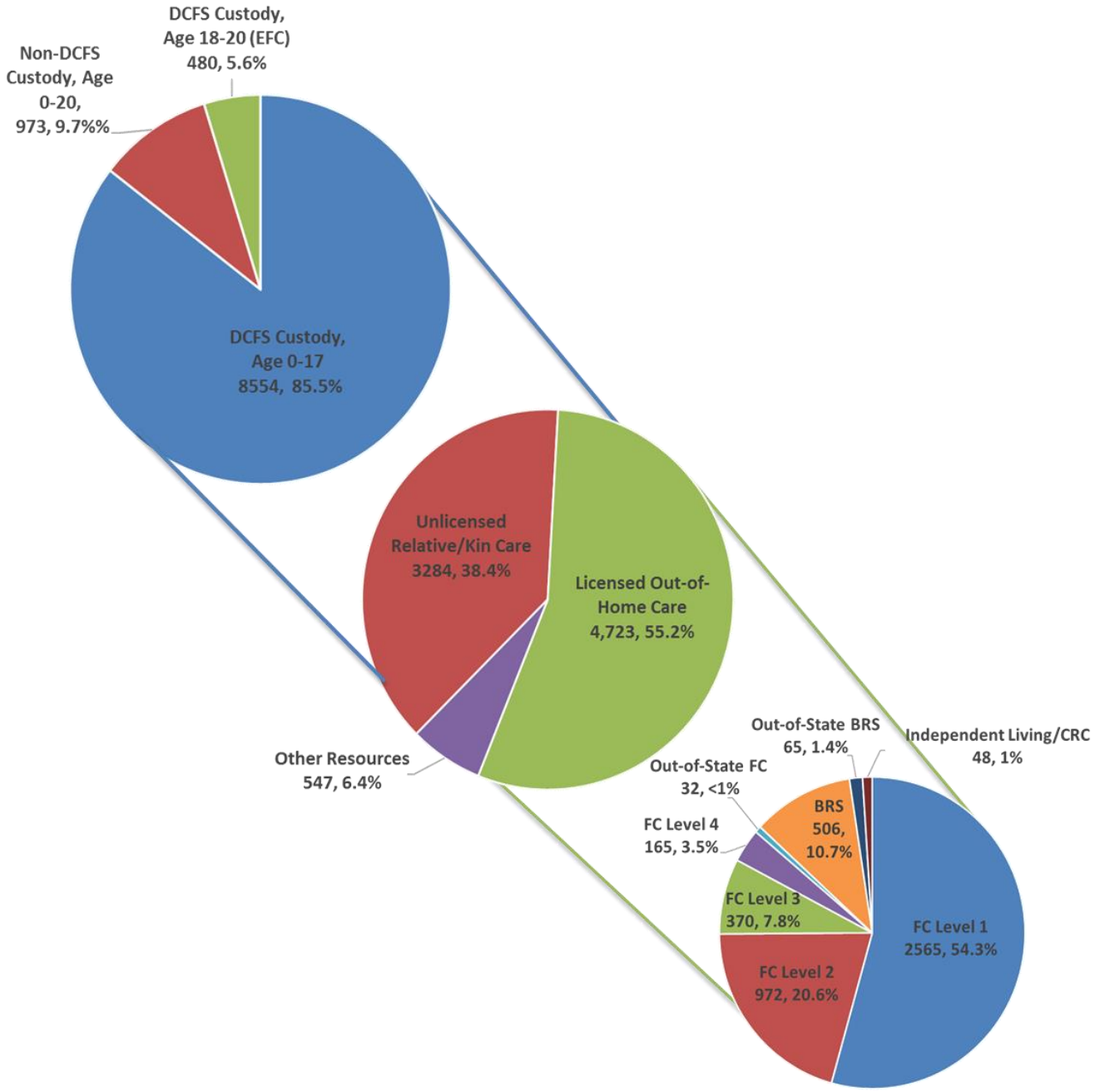
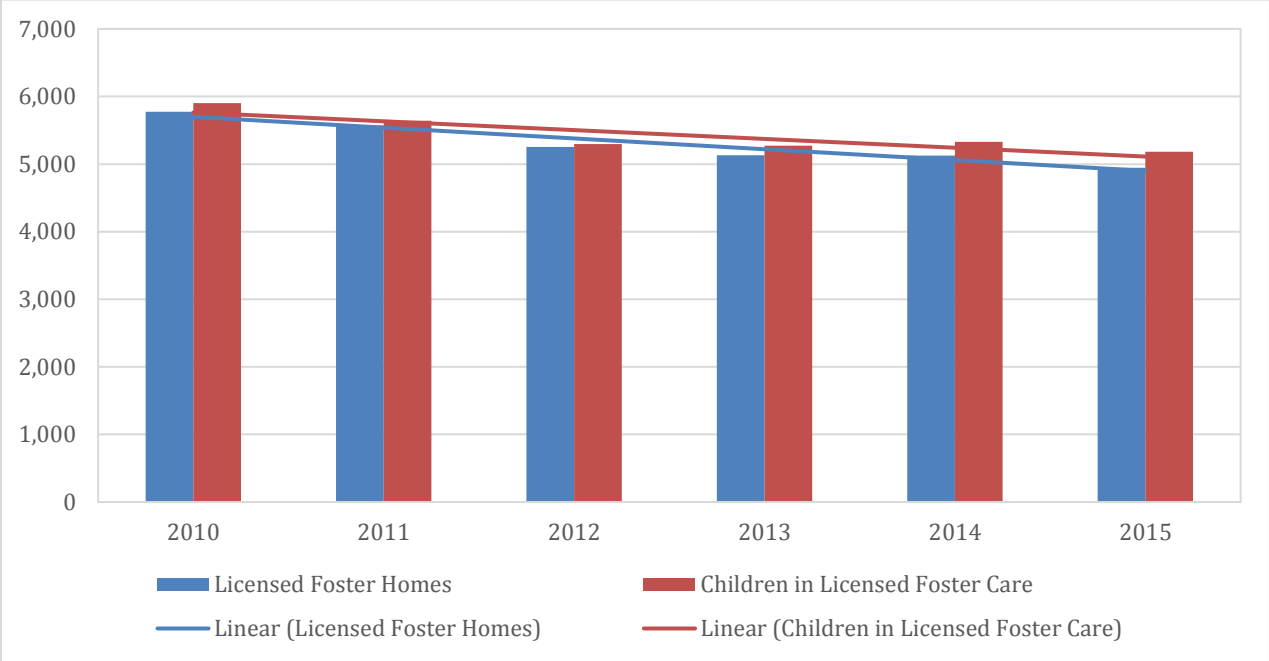


Figure 4. Number of Licensed Foster Homes and Children in Licensed Homes

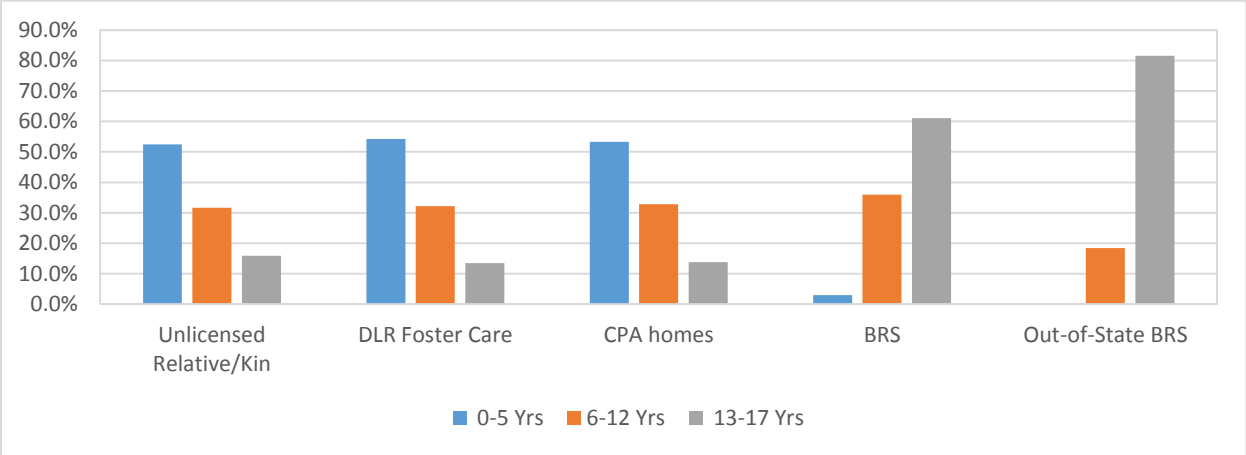


The number of licensed foster homes has steadily declined since 2010. Over the same time period, the number of children placed in licensed foster homes has also declined (Figure 4). One of the reasons for the decline in the number of children in licensed foster homes is the state's intentional effort to place children with relative and kinship caregivers whenever safely possible. Appendix D illustrates the availability of licensed foster homes by county as of June 30, 2016. [13]

[13] Administrative data from the Department of Social and Health Services' FamLink CA's SACWIS, the figure was also shown in a Report to the Legislature regarding **Foster and Adoptive Home Placement RCW 74.13.031 (2)** December, 2015. The Foster and Adoptive Home Placement outlines CA's specific efforts for foster care recruitment, retention, and cause of turn-over and recommendations to address these issues.

Demographic Characteristics of Children in Foster Care

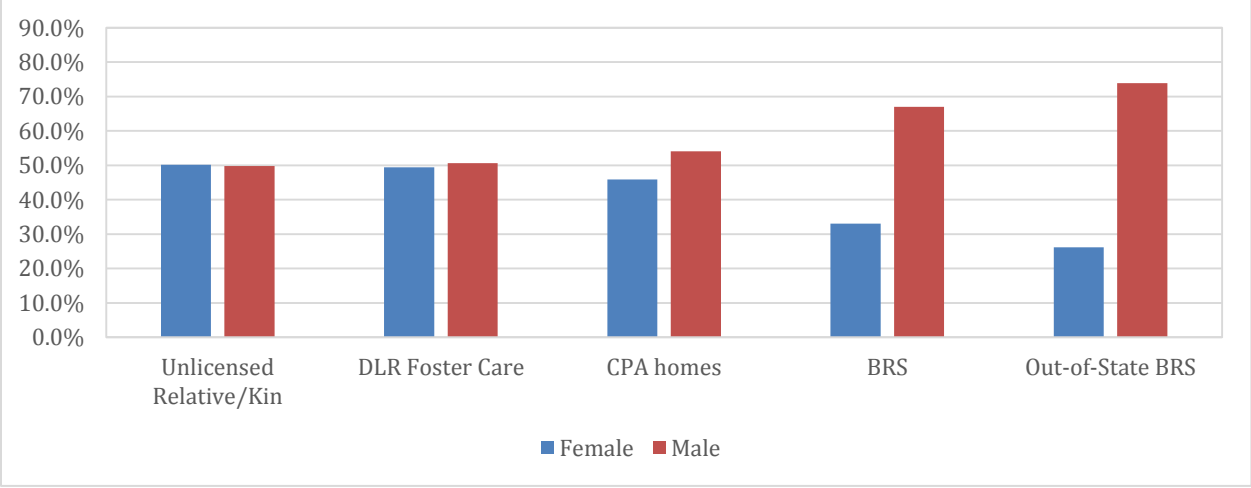
Figure 5. Child Demographics-Age – as of 10/31/15



In relative/kin, foster and CPA care , 80% of the population is younger than 13 years; more than 60% of the BRS population is aged 13-17 years and 81.5% of the youth in out-of-state BRS care are 13 years and older.

There are no major gender differences, in relative and kinship care, foster and CPA homes; but in higher levels of care, BRS and out-of-state BRS, greater proportions of the children are male. See figure 6.

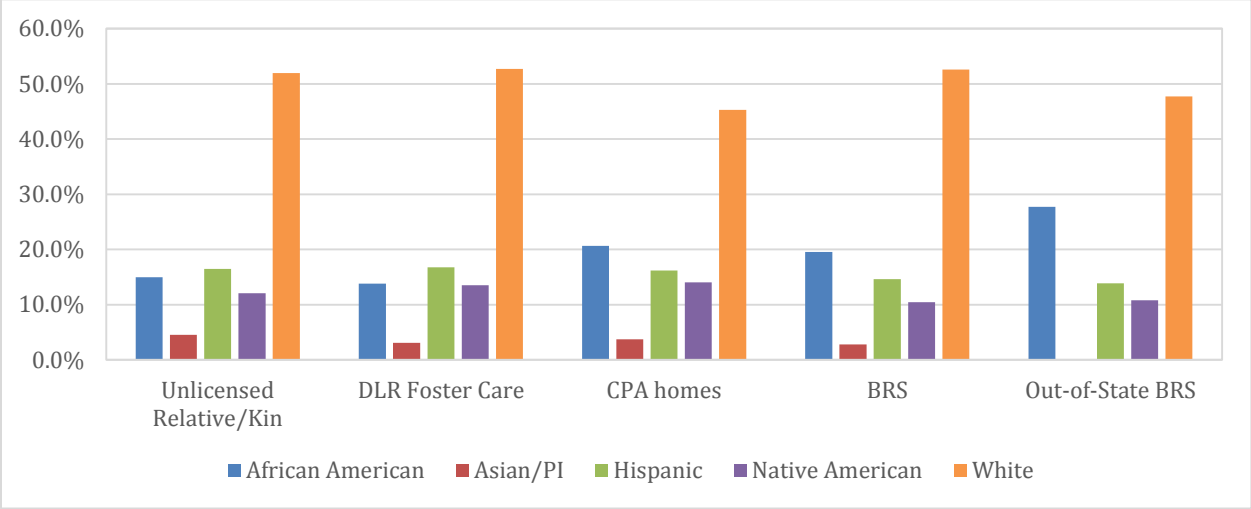
Figure 6. Child Demographics – Gender – as of 10/31/15



Racial differences are not significant across the care types in the point in time snapshot data of Oct. 31, 2015.[14]

[14] Administrative data from the Department of Social and Health Services' FamLink CA's SACWIS.

Figure 7. Child Demographics – Race – as of 10/31/15



Placement Stability:

Placement stability varies greatly by type and level of care. Looking at the median number of placements, there is no sizable difference in stability between children placed in CPA certified and CA licensed foster care. However, as expected, the number of placements experienced by one child steadily increases as the level of care increases. The median number of placements experienced by a child by the time he or she is placed in a BRS placement compared to foster care increased three-fold. Children in out-of-state BRS placements show the highest median placements at 11, five times that of the foster care population. Length-of-stay exhibits similar tendencies except that both mean and median length-of-stay for CPA foster care is notably shorter than that of State Family Foster Care. Across the board, the unlicensed relative and kinship care category exhibits the lowest number both in the number of the placements and length-of-stay. Table 3 outlines the number of placements and length-of-stay by placement type.

Table 3 Placement Stability (October 31, 2015, DCFS Children and Youth < 18 in out-of-home care N=8,554)

	Number of Placements		Length-of-Stay (days)	
	Mean	Median	Mean	Median
Relative and Kinship Care	**2.6**	**2**	**485.5**	**369**
DLR Licensed Foster Homes	**3.0**	**2.0**	**595.9**	**470.0**
Level 1	2.6	2.0	533.0	444
Level 2	3.3	3.0	605.0	461
Level 3	4.5	3.0	762.0	590
Level 4	3.5	3.0	1141.5	801.5
CPA Certified Foster Homes	**3.1**	**2.0**	**588.4**	**434**
Level 1	2.8	2.0	497.9	404
Level 2	3.1	3.0	613.3	495
Level 3	5.7	4.0	954.2	678
Level 4	5.5	4.0	1194.1	655
BRS	**8.8**	**6.0**	**1160.8**	**886.5**
Out-of-State BRS	**14.2**	**11.0**	**1496.1**	**1060**

Cost of Out-of-Home Care

As outlined in the Delineation of Current CA Placement Continuum section of this report, the cost of foster care can range from $562 to $1,565.30 per child per month, depending on the age of the child and the level of care needed based on the Foster Care Rate Assessment. Exceptional Cost Foster Care Plans (ECP) can be used in combination with any level of foster care and rates can be negotiated on a case by case basis up to $3,000 per child per month.

CPAs receive fee-for-service payment for a variety of services they provide, and the payment range varies widely depending on the service, from providing case coordination and support activities at $447.56 per month, to providing special supervision and coordination of care for children and youth with difficult medical, behavioral or physical conditions at $3,000 per month per child/youth.

BRS rates are also stratified into four levels from level D to A, level A being the highest level of care. The BRS monthly payment rate for level D is $2,823, level C is $3,944, level B is $5,590, and level A is $7,546. When a child's needs exceed the capacity of existing BRS programs, contracted providers can work with CA to develop a child specific program. The cost of developing a child specific program varies depending on the presented need of the child, but typically falls in the $7,000 to $15,000 per month per child range.

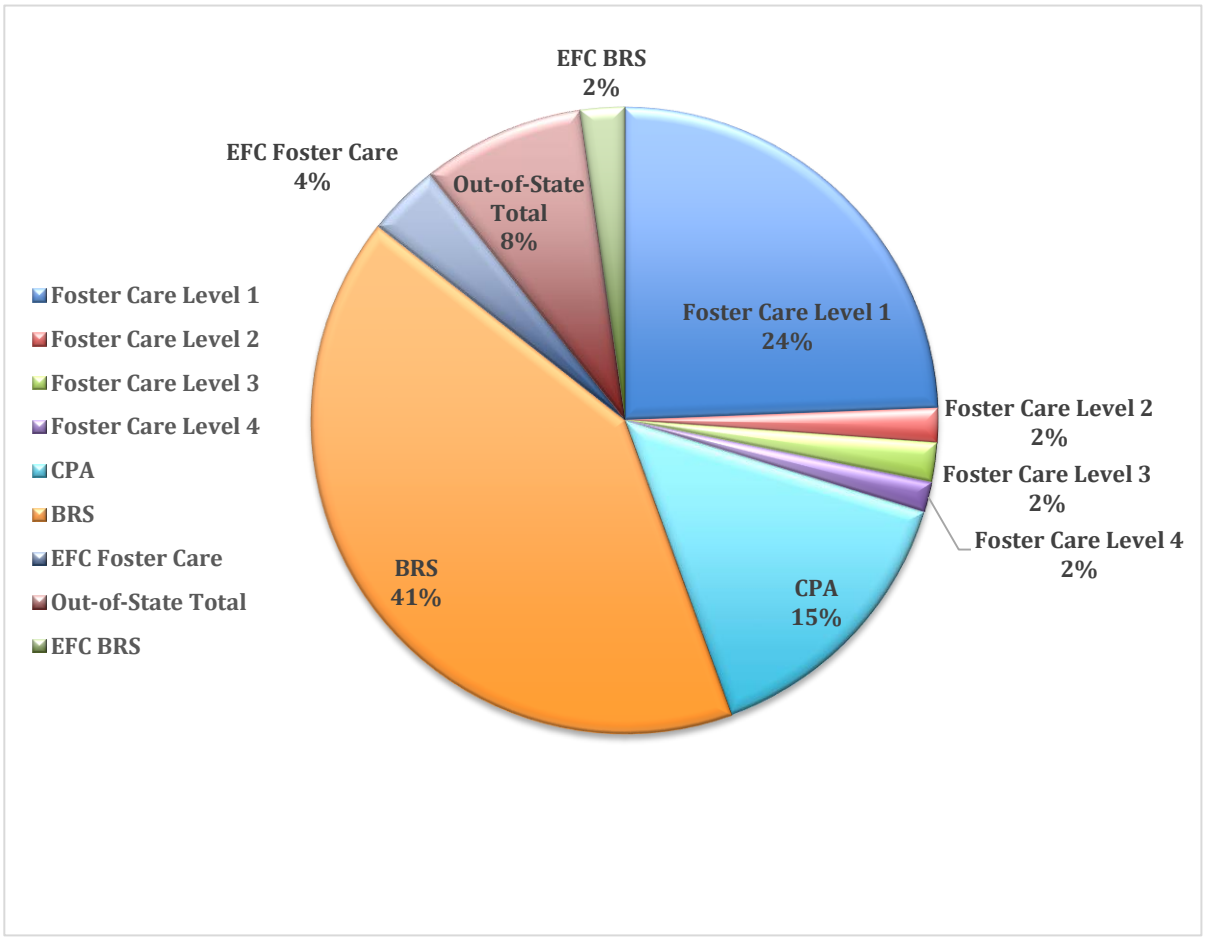
Cost of services also varies within the array of short-term crisis placement services that are not consistently available statewide (also detailed in Delineation of Current CA Placement Continuum section) depending on program focus and scope of the work provided. The costs range from $25 per day per child for the Resource Assessment Center contract to $144 per day per child plus the negotiated monthly based retainer payment for an Emergency Placement Facility.

Expenditure by Type of Care

In FY 2016, 30% of the total out-of-home care expenditures were for state licensed foster care (Level 1: 24%; Level 2: 2%; Level 3: 2%; Level 4: 2%), 15% of expenditures were for CPA homes, 41% of expenditures were for BRS, 8% of expenditures were for out-of-of state placement, and 6% of expenditures were for youth aged 18-21 years who were receiving EFC services. Although it is not a direct comparison, looking at a point-in-time population distribution and annual expenditure break-down by type of care, disproportionately higher expenditures at higher care levels are evident (BRS represented 5.9% of the population with 41% of the total expenditures, out-of-state placements represented approximately 1.2% of the population and 8% of the expenditures).[15]

Out-of-Home Care and BRS Expenditure

Figure 8 . Out-of-Home Care and BRS Expenditure



[15] Administrative data from the Department of Social and Health Services' FamLink CA's Statewide Automated Child Welfare Information System (SACWIS), and the Social Service Payment System (SSPS) outlines demographics, placement variety, and cost.

Figure 9 Trend out-of-home care expenditures

Figure 9 shows the trend of out-of-home care expenditures. The total out-of-home care expenditures decreased by nearly $50 million between 2009 and 2012. It should be noted that in 2010, the legislature removed BRS from the Out-of-Home Forecasting and Adjustable Funding Model, and set aside a fixed budget specifically for BRS. The number of foster homes has declined, as seen in Figure 4, and the capacity of BRS has significantly decreased partially as a result of the legislature's reduction in funds from 2009-2012 of close to $20 million. BRS payment rates have gradually increased since 2014, though not to the 2008-09 pre-recession level. Providers have consistently stated that the current rates are insufficient for the level of care they are responsible for providing. The recent increase in out-of-home care and BRS expenditures can be partly explained by the expansion of the EFC program[16] and the resources needed to serve youth aged 18-21 years. Reduced capacity of the BRS and foster care resources is illustrated in Appendix E[17]

Foster Care Children: In-Depth Cohort Analysis

The cohort study being conducted by the CA Data Management and Reporting Section provides a deeper exploration into understanding the characteristics of children served in Washington's child welfare system.

Cohort Study

In 2016, the CA Data Management and Reporting Section conducted a study examining a cohort of children placed between Jan. 1, 2012 and June 30, 2013. The data set included one child randomly selected from each family with a placement episode during the study time period. Only children in care for at least 60 days were included in the study. This cohort of children was then followed until June 30, 2016. The resulting data set included 4,264 children (Table 4 provides descriptive information about this sample).

[16] CA served 578 youth aged 18 to 21 in SFY 2016 under EFC program.
[17] Administrative data from the Department of Social and Health Services' FamLink CA's Statewide Automated Child Welfare Information System (SACWIS), and the Social Service Payment System (SSPS) outlines demographics, placement variety, and cost.

The data set included a large amount of information that will provide insight into placement trends for children placed in out-of-home care, including placement cost and outcome and possible predictive properties of some of the identified data points.

Data collected for this study included the following:

- Prior reports of child maltreatment involving the family;
- Prior placement of the child in out-of-home care;
- Item scores on the Safety Assessment;
- Total scores on the Structured Decision Making (SDM) tool;
- Caseworker reason for placement of the child;
- Item scores on the CHET screening tools;
- Placement type;
- Cost of placement; and
- Number of moves while in placement.

Although the data continues to be analyzed, one of the early findings appears to be the distinction between two subpopulations: those who received BRS[18] and those who did not. There are a number of factors that distinguish the 336 children who experienced a BRS placement event from the 3928 children never placed in BRS. Table 4 shows comparisons of a sample of characteristics for the two groups.

Table 4 Descriptive data comparing ever-placed-in-BRS and never-placed-in-BRS children (N=4264)

	BRS placement	No BRS placement	Total	Percent of total population
African American	10.5% (59)	89.5% (503)	100% (562)	13.2% (562)
Asian/PI	4.8% (6)	95.2% (118)	100%(124)	2.9% (124)
Hispanic	6.8% (34)	93.2% (463)	100%(497)	11.7% (497)
Native American	7.5% (58)	92.5% (720)	100%(778)	18.2% (778)
White	7.8% (179)	92.2% (2124)	100% (2303)	54% (2303)
Male	8.9% (192)	91.1% (1975)	100% (2167)	50.8% (2167)
Female	6.9% (144)	93.1% (1953)	100% (2097)	49.2% (2097)
Mean removal age	11.28	4.02***	4.59	
Mean number of reports on family prior to placement	6.26	4.22***	4.38	
Child had a prior removal episode	17.30%	6.1%***	7.90%	
Mean length of stay	970	739***	757	
Mean cost per day	$160.38	$30.01***	$40.28	
Mean Total score on PSC-17	13.12	9.96***	10.58	
Total N	336	3928	4264	100% (4264)

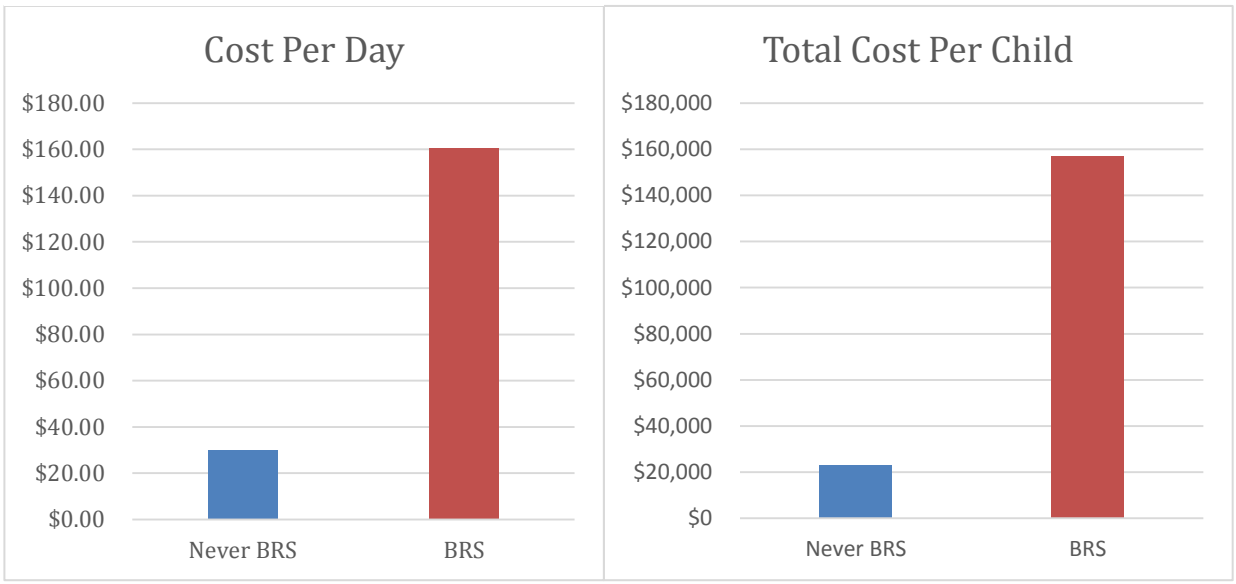
*** means statistically significant difference derived though t-test ($p < .001$)

[18] For this analysis the BRS population includes children who experienced more than three days of BRS placement.

Cost and Outcome

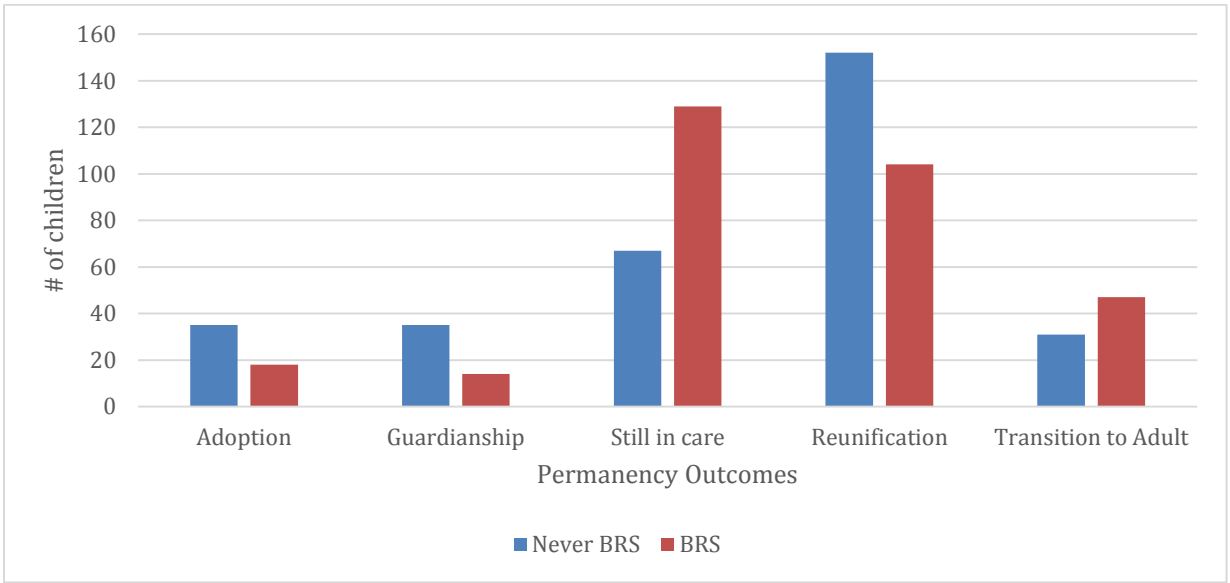
As stated previously, the cost per day of children with a BRS placement in their placement history is considerably higher than those never placed in a BRS facility ($160/day compared to $30/day). See Figure 10. The significant cost differences are also represented in total cost for children in out-of-home care.

Figure 10 Cost per day and total cost per child



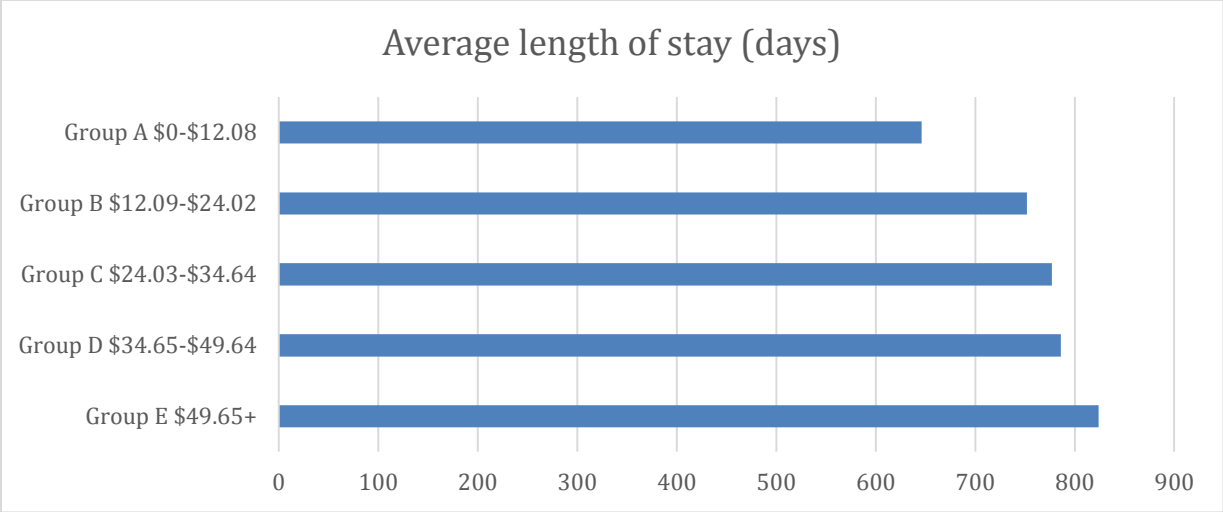
In addition to a higher cost of care, children and youth who spent time in BRS had lower rates of reunification, adoption and guardianships and higher rates of transitioning out of foster care (turning 18 years old) or still being in care (EFC) (Figure 11).

Figure 11. Permanency outcomes for children who did and did not spend time in BRS placements



The data also indicates that in the total population, the cost per day was associated with outcomes such as length-of-stay. As shown in Figure 12, when the cohort is split into five equally sized groups there is a trend for each progressively more expensive group to stay in care longer.

Figure 12. Cost per day split into five groups and length of stay in out-of-home care



Predictive and Risk Factors for those Placed in BRS

The prior number of CA/N reports and prior placements in out-of-home care appear to be risk factors for children and youth placed in BRS. While 6.1% of children without a prior removal were placed in BRS, this number was 17.3% for those children with a prior removal. Additionally, being placed in BRS is also associated with a number of other risk factors for children while in out-of-home care. For example, 45.9% of youth placed in BRS ran at some time during the placement episode while this number was only 5.1% for those never placed in BRS. Similarly, 32.7% of children placed in BRS also spent some time in detention during the study period, while this number was 1.7% for those children never placed in BRS.

As shown in Table 5, there are a number of factors indicating that those placed in BRS have identifiable behavior challenges when they come into care, separating them from the broader population of children placed in care. For example, when a child is placed into out-of-home care, the caseworker indicates a reason for placement, 5.6% (n = 238) of placements indicated the reason for placement as "child behavior problems" and half of the children indicated in this measure spent time in BRS (n = 119). Likewise, on the SDM assessment, caseworkers indicated that about 15.2% (n = 576) of families had a child with a mental health/behavior problem and 145 of the children from families identified with this item (child with a mental health/behavior problem) spent time in BRS. When these two measures are combined they identify 60% of those children who spent at least some time in BRS. It is notable that both the SDM and the "reason for placement" scores reflect all children in a family, which may or may not include the child from the family selected for this study. It is likely that the accuracy of these measures would show even stronger correlations with BRS placement if they were attached to the individual children in the family home.

Another indication that many of those children who spent time in BRS have a unique set of characteristics even at the time they are first removed from their families is how quickly many of these children enter their first BRS placement. As indicated in Figure 13, about 60% of children's first BRS placement occurs within their first three placements. Additionally, as shown in Figure 14, the vast majority of first BRS placements occur within the first 180 days of placement. Taken together with the other assessment items which are completed before a child comes into care, this information suggests that the majority of children who spent time in BRS have challenging behaviors when they are initially placed into out-of-home care, as opposed to developing these behavioral challenges while in out-of-home care

Figure 13. Number of placements prior to first BRS placement

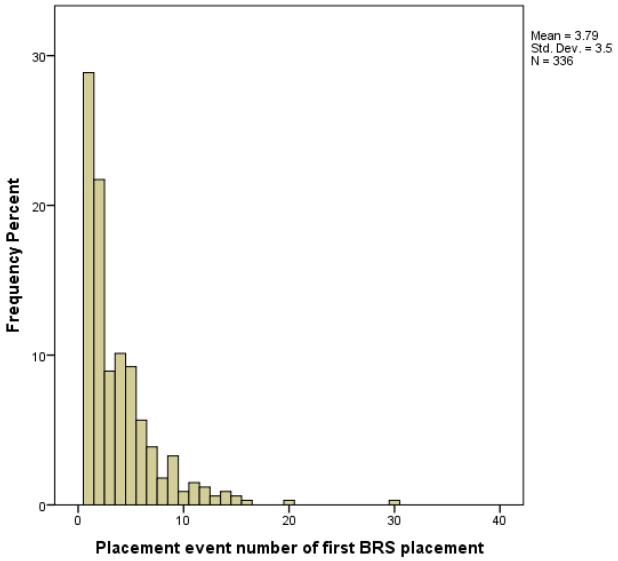
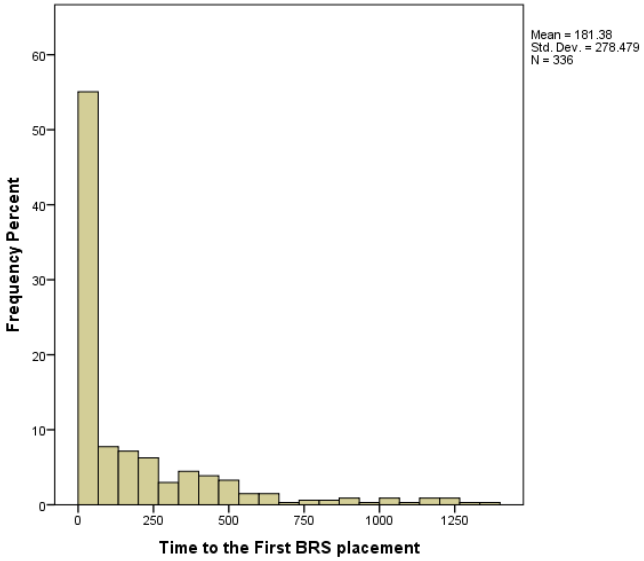


Figure 14. Number of days prior to first BRS placement



Predictive and Risk Factors for those Not Placed in BRS

Because of the strength of the correlation between the gathered variables and placement in BRS, it is helpful to look separately at the 3928 children never placed in BRS. Examining these children separately allows for a better understanding of the factors associated with outcomes for children not at the highest end of the continuum of care.

An initial look at the data indicates that the correlations with the collected variables and the outcomes of interest (e.g. cost per day and length of stay) are smaller when not including those placed in BRS. However, there are still a number of significant findings which could help guide case planning discussions for children placed in out-of-home-care. Table 5 provides a sample of how the measures in the different assessments completed by CA at or near the time of removal correlate to the cost per day and the length of the placement episode for children in out-of-home care[19].

[19] Not shown, but these various factors also show relationships to outcomes such as number of placement moves, and likelihood of reunification.

Table 5 Comparison of various measures for those children never placed in BRS

		Cost per day	Length of placement episode (days)
1-2 reports on family prior to placement		$29.97	704
3-6 reports on family prior to placement		$29.59	745***
7 or more reports on family prior to placement		$30.78	779***
Caseworker reason for placement – Parent drug use	No	$31.66	726*
	Yes	$27.79***	756*
Caseworker indicates on SDM that family is either homeless or has unsafe housing	No	$29.48	713
	Yes	$31.05	784***
Caseworker indicates on the Safety Assessment that there is no adult in the home performing childcare duties	No	$29.70	716
	Yes	$30.98	758**
Indicated on the PSC-17 Total Score	No	$23.06	747
	Yes	$29.10***	758

*s indicate statistically significant difference derived though t-test *p < .05, **p < .01, *** p < .001

As can be seen in Table 5, the number of prior reports is a significant predictor of length-of-stay but is unrelated to the cost per day of caring for the child in out-of-home care. Parent drug use is associated with a slight reduction in cost per day to care for the child.[20] Homelessness or unsafe housing is associated with significantly longer stays in out-of-home care but no increase in cost per day. Similarly, the item on the Safety Assessment measuring whether or not there is an adult in the home performing child care duties is associated with longer stays in care but not associated with cost per day.

Implications

These examples demonstrate how the data available at or near the time of placement may provide insight into the potential outcomes for children placed into out-of-home care. It is still early in the process of exploring the current data set, but it is anticipated that more refined trends will be found and will allow for the possible creation of a model to further guide case planning and service provision for children entering out-of-home care.

Review of Existing Level of Care Instruments

General Recommendations

In order to provide the right service in the most appropriate setting, it is essential for CA to construct a common and consistent method to determine children's level of needs at the earliest possible point in time, ideally at the time children are placed out of the home for the first time.

As shown earlier in the report, CA utilizes a number of instruments and processes throughout the life of a case to determine level and need for intervention, case planning,

[20] It is important to note that these findings represent the risk factors examined independent of other risk factors. For example, it is possible that parent substance abuse is related to lower cost because younger children are at greater risk to be removed if they have a substance abusing parent, additionally, younger children may also be less expensive to care for. To get at the interactions between the variables more complex modeling is needed.

placement decisions, and service delivery methods. Both from the quantitative (analysis of the administrative data) and qualitative (results from small group discussions) data, it is evident that CA has access to adequate information to advise critical case decisions. The task and challenge is not the volume of information, rather its integration and utilization.

TFC and Professionalization of Foster Care

Background and Context:
The concept of professional foster care has been discussed within CA, and was raised in the small group discussions with external stakeholders. It is apparent that the term "professionalization" is used in varying ways, lacking a common, universal definition. The term can mean the provision of clinical interventions by specifically trained caregivers for children and youth with severe mental, emotional, or behavioral health needs who cannot be successful in conventional foster care. Another use of the term refers to the status, position, and remuneration for more clinical services provided by a professional caregiver. Stakeholders expressed the idea that establishing professionals with competitive salaries, rather than per diem payment linked to cost of care of the child, may act as a method of recruiting potential caregivers. Recognizing caregivers as professionals could ultimately allow caregivers full and expedited access to information about the child in care, ensure a prominent role within the treatment team, and allow them to be members of the case planning and permanency processes.

In January 2008, pursuant to Chapter 413, Laws of 2007, Section 11 (ESHB 1624), CA produced a report to the legislature titled *Feasibility and Need for Creating Tiered Classification for Foster Parent Licensing and a Professional Foster Classification.* [21] Following the recommendation from the report based on the workgroup sessions with representatives from CA, University of Washington School of Social Work, Partners for Our Children, tribal representatives, foster parents, FPAWS members and child welfare professionals, the legislature passed SHB 3145 *Foster Care-Intensive Resource Home Pilot project.* SHB 3145 required CA to select two geographic areas with high concentrations of children with significant needs in foster care for the implementation of an intensive resource home pilot.

In consultation with the 1624 workgroup and others, CA began developing a model to comply with SHB 3145. A solicitation letter was sent to licensed foster parents in two major counties in Washington that were identified as pilot areas. The response back from foster parents was minimal; only about five foster parents responded showing interest in being contracted. Overwhelmingly, the reason for the dearth of response to the solicitation was that foster parents at that time did not want to be considered businesses and show taxable income, but desired to be recognized as skilled professionals at being caregivers.

It is feasible to consider being recognized as professionals, earning slightly more than basic foster care. But as a taxable income with closer monitoring, more administrative work, higher qualification requirements, and demanding training hours, it may not attract more caregivers especially when the existing structures provide the caregiver with nontaxable compensation at similar or at times higher rates.

[21] CA report to legislature Feasibility and Need for Creating Tiered Classifications for Foster Parent Licensing and a Professional Foster Parent Classification: http://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=FeasibilityNeedforCreatingTieredClass_76f08fea-1b76-49c7-ae11-8d819289f56f.pdf

Status:
In SFY 2016 roughly 430 youth were served in BRS TFC[22]. There are approximately 30 CPAs that also have BRS contracts. It is these CPAs that operate the TFC facilities. There are also experienced foster homes known as "specialized homes" that are known in the community to be skilled at working with particular populations of children. These specialized homes develop their own programs independently from BRS or CPA, and payment rates are negotiated within the Foster Care payment levels, and ECP on an as needed basis, and children served in these homes are not included in the count.

Operation of BRS-TFC varies depending on the agency, although there are common denominators for TFC operating in Washington under BRS contracts, including but not limited to:

- Comprehensive support: 24-hour crisis intervention, consultation and support (care coordination, clinical consultation, case aides, etc.);
- Built-in respite days (minimum 2 days per month);
- Initial and ongoing trainings above the DLR minimum licensing requirement (30 hours of training annually);
- Weekly treatment/support meetings with member(s) of the Child and Family Team;
- Monthly informal support and/or training meetings; and
- Compensation ranging from $1,500 to $1,900 per month[23].

In order to operate foster care in the intended fashion of "Professionalized Foster Care," many states including Washington would need to revise their rules to eliminate income requirements and allow foster parents to provide foster care as a profession and use the payment as a primary means of income.

The depth and complexity of defining and operationalizing a professionalized foster care model can be seen in examples from other states. In Missouri, a program called Missouri Career Foster Parent Program[24] exists, yet the state minimum qualification for foster parent(s) includes a process of home-study which asks prospective foster parents about their employment status. Also, although the program is identified as Career Foster Parent Program, Level A (a level above the basic foster care payment rate) is compensated at $720 per month, and the highest level, compensated at $40 per day (approximately $1,200 per month), is hardly a livable salary, and is less than current average BRS-TFC rate in Washington. Another example is Florida's Professional Therapeutic Foster Parents (P.A.T.H).[25] The program description states that P.A.T.H. homes are professional foster homes requiring a higher standard of care, though Florida's licensing requirements read "Financial Capacity and Income: Describe and document the applicant's current financial capacity and how the impact of the additional financial responsibilities for fostering will be addressed." It is unclear if the caregiver payment is

[22] It is difficult to precisely calculate the number of children who have been served in TFC. CPAs are licensed for bed capacities per agency rather than number of TFC homes designated to serve CA children and youth, and children and youth who receive BRS are fluid and transition through services within the BRS array. SSPS payment records from the last five SFY show an average of about 10% of BRS are provided to children in their own homes (in-home BRS), 45% provided to children in out-of-home placement not in a facility, including foster care, therapeutic foster care, and relative placements, and 45% provided to children in out-of-home placement facilities (group care/facility-based BRS in group home or staff residential home). The estimated number of children who received TFC in SFY 2016 was based on the total number of children receiving BRS in SFY 2016, 957 to which that 45%, 45%, 10% breakdown structure was applied to arrive at 430.65 for TFC, and is not an exact number.

[23] BRS contracted CPA licensed homes receive monthly payment (reimbursements) from the agencies in place of State foster care reimbursement (level 1-4, and ECP in some cases), not in addition.

[24] Source: http://dss.mo.gov/cd/fostercare/

[25] Source: http://www.copecenter.org/directory-of-services/specialized-childrens-services/path-therapeutic-foster-home

considered compensated taxable salary or nontaxable foster care reimbursement. In 1993, Michigan, partnering with Judson Center (private nonprofit human services agency), operated the Living in Family Environment (LIFE) program which placed developmentally disabled children and state dependent children into the homes of mothers on public assistance who were considered professional foster parents. These mothers, after training and support from their case manager, gave up public assistance and received an annual salary of $21,800. Again, the recent State foster care licensing requirement in Michigan stipulates "Have a defined legal source of income, and be capable of managing that income, to meet the needs of the foster family," and the payment entity and mechanism, or current status of the LIFE program is unclear from literature and website reviews. Lastly, the Professional Foster Care (PFC) Program[26] which began in Illinois in 1994 under a grant, paid foster parents an average annual salary of $16,000 in addition to $600 per month per child monthly board payments, yet current licensing requirements ask for foster parents to be "financially stable."[27]

Options:

1. Develop a State operated, licensed, professional foster care structure and endorsement system. The development of a new licensing category, "professional foster parents," under DLR will require significant cost and policy changes. Conducting a needs assessment to reassess if the level of interest in the professionalized foster care model has increased since 2008 is recommended prior to taking any action in this area.
2. Develop Treatment Foster Care (TFC) under the MCO in a small scale pilot project: Utilizing the opportunity of the behavioral health integration under a single MCO for all foster children, CA could contract with the MCO, Coordinated Care, to develop capacity for new TFC beds across the state. The newly developed TFC system could provide clinical intervention with specially trained foster parent homes for children and youth in CA care and custody who have severe mental, emotional, or behavioral health needs, and whose unique needs require more intensive clinical intervention than can be provided in conventional foster care homes. The MCO may bring an opportunity to combine CA placement resources with behavioral health services provided through Behavioral Health Administration.

Stakeholder Feedback

Small group discussions were held at eight locations across Washington. A total of 105 participants, including CA staff, external stakeholders, and youth and alumni foster care members examined the current CA placement continuum and discussed ideas for improvement. External stakeholders included foster parents, members of provider communities, and child welfare advocates.

Small Group Discussion Feedback

- No new assessments; streamline existing information to assist objective placement decision making.

[26] Source: Testa, M.E, & Rolock, N. (1999). Professional foster care: A future worth pursuing? Child Welfare, 78 108-124.
[27] Source: https://www.illinois.gov/dcfs/aboutus/Pages/ab_about.aspx

An overwhelmingly popular opinion was that CA conducts plenty of screenings and assessments already, and participants did not feel that adding new screening tools, obtaining or buying new screening instruments would be necessary or beneficial. Rather, participants almost unanimously suggested streamlining the information CA already gathers, and utilizing the information to assist in objective placement and service decision making as early as possible.

- Inform caregivers of children's needs to strengthen placement decision-making; more treatment options for mental health and behavioral health for placement stability.
  Stakeholders also expressed the need to inform caregivers about the level of children's needs, regardless of how challenging it may be to find placements for children with mental and/or behavioral health issues. Caregivers need the information to make informed decisions and obtain appropriate supports from day one. CA workers, caregivers and providers also agreed that treating mental health and behavioral health issues is the key to placement stability, and they are frustrated with the lack of available and effective treatment options.

- Compensate caregivers for training and providing care for specific child populations; match child needs with caregiver skill level.
  With regards to funding mechanisms, caregivers and CA workers thought a purely cost neutral system reform would be extremely challenging. They agreed on the need to compensate caregivers who are willing to invest their time and effort, regardless of the placement setting, to be trained to provide care for a specific child population such as children suffering from mental health and behavioral health issues, children with sexualized behavior, children diagnosed with autism or pervasive development disorders, and the need to be supported and compensated accordingly. A variety of ideas around how to support "Professional Foster Parents" or "Therapeutic Foster Care" models were discussed, but commonly suggested strategies included removing the income requirement for foster parents and allowing them to be compensated with a livable income by providing specialized service to specific populations of children.

  In the same conversation, both internal and external groups discussed the importance of matching the children's level of need and the caregivers' experience and skill levels. Both groups had a deep understanding of the current availability-based (not need-based) placement practice necessitated by limited placement resources, but identified that the mismatch of children's needs with caregivers' skill level is causing burn-out of caregivers and unnecessary feelings of rejection for children who often come into care with high adverse childhood experiences. The current practice of greater compensation/payment rate is used to convince otherwise unwilling or unprepared caregivers to take on care of children with high mental health/behavioral health needs, and this practice goes against the best interest of the children.

- Lack of trust between providers and CA; lengthy licensing process; universal appeal of MFM
  In terms of systemic issues, both internal and external teams discussed the issues of liability, lack of trusting relationship between providers and CA, fear of litigation and loss of license. These issues are making it challenging for CPA or group care providers to take on the care of children with acute mental health or behavioral health issues. They also agreed that the long time it takes for any caregiver to be approved or licensed to provide

care for a child is prohibitive and is discouraging to otherwise willing and often able adults to become caregivers for children and youth involved in the child welfare system.

Some stakeholders expressed strong support for the Mockingbird Family Model (MFM). The model's systematic approach to peer support, peer mentorship, built-in respite, and the extended family-like environment it creates to prevent isolation appears to appeal universally to caregivers, providers, and some CA workers. The Washington State Institute for Public Policy is currently evaluating the efficacy of the MFM.

- Incentivize positive outcomes; remove pay cuts for behavior stabilization
  Both groups identified the irrationality of the notion that providers and caregivers virtually receive pay cuts by successfully stabilizing the difficult behavior of children and youth in their care. They suggested redesign of the payment system to financially incentivize positive outcomes.

- More high-level acute mental health services and easier transitions needed
  CA workers, providers and caregivers identified the degree of difficulty to access high-level acute mental health services. Children's Long-Term Inpatient Program (CLIP[28])beds have long waiting lists, are extremely difficult to access, and Wraparound with Intensive Service (WISe[29]) currently does not offer respite or temporary placement options to relieve exhausted caregivers. The stakeholders also identified the difficulty of transitioning in or out of CLIP to BRS or BRS to the WISe program. There was passionate discussion about either creating stepdown treatment foster homes within the public mental health service array and/or integrating some of the CLIP beds into the CA continuum. Some mentioned CA may not integrate CLIP beds in its continuum, but the newly implemented MCO managing full behavioral health continuum may streamline the process and ease the access to high level behavioral health services.

Voice and Choice: Perspectives of Youth and Alumni of Foster Care

CA consulted with Passion to Action (P2A), a statewide youth-led advisory board to CA. P2A consists of youth ages 14-24 who are or have been in foster care in Washington.

The P2A members clearly conveyed the importance of children having a place to call home, a stable place where they feel a sense of belonging, (basic and essential needs of all children), and serve as launch pads into their adult lives. Improved placement stability means better outcomes in all aspects of their lives, and helps develop a sense of identity, who they are and what they will become. When asked what would help to improve placement stability, youth were quick to share the notion of "Nothing about us, without us." Including children, youth, and caregivers in every step of the placement processes, and giving children and youth the voice and choice. (The methodology of the workgroups, and detailed suggestions are outlined in Appendix A).

[28] CLIP is the most intensive inpatient psychiatric treatment available to WA State residents, ages 5-18 years of age. http://clipadministration.org/

[29] WISe is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age, with complex behavioral health needs and their families. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements. https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20Manual%20v%201.7-FINAL.pdf

Gaps in Service and Recommendations

Based on a close examination of the current continuum and with the consultation and recommendations from stakeholders, areas of service gaps, and recommended strategies are outlined below.

CA faces challenges in both placement capacity as well as fragmentation in the continuum. Based upon the information collected for this report, CA identified three specific areas in the continuum needing expansion and/or enhancement:

- Additional emergent placement options for children first coming into care with externalizing behavior and families with large sibling groups, especially when they come into care after-hours, weekends, or holidays.
- The transition between foster care and BRS can be challenging; the reduced and limited placement resources at the BRS level care requires children and youth to be served by caregivers who may not be equipped to handle their needs. A complicating factor is that while CA must always locate an appropriate placement for a child, caregivers and contracted providers can decline or discontinue care of a child at any time, including requesting immediate removal of a child.
- Transitioning of youth across agencies can also be very complex and difficult. Children and youth may not always meet judicial or medical criteria to be adjudicated or hospitalized, and must be released from the institutions or hospitals when they complete their sentence or no longer meet medical necessity. Regardless of the challenging history or complex circumstances of the children and youth while they wait for detention or hospitalization, or as they are being released from these institutions, in some cases, CA must provide them with safe and appropriate placements in which to thrive.

In order to respond to these issues effectively, CA must put in place both the short-term solutions to deal with immediate and impending problems, and the medium to long-term solutions to sustain and build upon the positive changes.

Recommendations:

- Build and expand Emergency Placement Facilities and Resource and Assessment Centers (RAC) statewide

Emergency Placement Facilities and RACs provide short-term emergent and crisis care for children 24 hours per day, seven days per week**.** The unique strength of these services is their focus on after-hours, weekend, and holiday placement needs, and the time limited placement and services they offer.

When children and youth enter placement as the result of an unforeseen emergency or they disrupt from placement, family foster care homes may not be available. As previously stated, caregivers have the right to decline placement of a child. Caregivers may also be unwilling to accept placement of a child because of concerns that the child might endanger others in the home, because they are at their current licensing capacity, or because they believe the home is not set-up to meet the needs of the child. The lack of emergent placement options places tremendous pressure on caregivers, service providers, CA staff,

and administrators. Emergent placement options are available in some areas of the state, but are not consistently represented statewide although the need exists statewide.

- Conduct a feasibility evaluation on the use of currently unoccupied state owned facilities for CA placement continuum. (Facilities would be operated through contracted providers.)

Because of the significant budget reductions during the recession, CA has lost placement options that serve children with significant behavioral needs. Some providers are willing to rebuild program capacity to pre-recession levels, but lack the startup capital funds. Looking into unused state owned facilities could support more expedited rebuilding for the placement option CA has lost.

A benefit of a privately operated program in a state owned facility is the ability to secure dependable placement options that operate under a no-reject and no-eject policy. These facilities have the potential to fill the need for interim placement, serving as a short-term, step-up and step-down facility. These facilities also have potential to provide enhanced emergent placement to aid the transition of children to and from detention, juvenile institutions, hospitals, and CLIP facilities.

- Facilitate cohesive integration of behavioral health services under an MCO.

All levels of behavioral health services provided through Health Care Authority, DSHS Division of Behavioral Health and Recovery, Behavioral Health Organizations, and CA will transition to the MCO, Coordinated Care, in 2018. As this care transitions, careful consideration should include the highest level of psychiatric care at hospitals, CLIP, evaluation and treatment facilities, and Wraparound with Intensive Service (WISe), and evaluate how a single MCO can manage or coordinate high level treatment to provide seamless care for children in foster care. Washington has historically struggled to provide services to children and youth who enter care with special needs, especially in the areas of mental and behavioral health, and developmental disabilities. There is a need for more focused efforts to incorporate the System of Care values and support a cross-system collaboration.

- Develop Treatment Foster Care (TFC) under the MCO/Pilot Project

Utilizing the opportunity of the behavioral health integration under a single MCO for all foster children, CA could contract with the MCO, Coordinated Care, to develop capacity for new TFC beds across the state. The newly developed TFC will provide clinical intervention with specifically trained foster parent homes for children and youth in CA care and custody that have severe mental, emotional, or behavioral health needs, and whose unique needs require more intensive clinical intervention than can be provided in conventional foster care homes. The MCO will bring a unique opportunity to combine CA placement resources with behavioral health services provided through Behavioral Health Administration seamlessly.

CA has joined DBHR in applying for the SAMHSA Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances grant. The estimated award amount for CA is $1.3 million and could assist with the costs of accomplishing the recommendation in the above paragraph.

- **Develop CA Data Analytics Screening Process/Pilot Project**

There is a need for consistent and objective assessment at the earliest stage possible, ideally at the time children and youth enter CA care. Upon close examination of the current data available to CA, including the current screening and assessment tools, it is recommended that CA lead an effort to examine and streamline information already available to design a screening process to be used to support and guide service and placement decisions. Applying predictive analytics to the available data could allow CA to objectively assess the need level of the children coming into care more expeditiously. This is in contrast to the current system in which the rate assessment occurs after the child is already placed in the home and is set according to the caregiver's reported time and effort needed to meet a child's needs.

- **Develop Comprehensive TFC Service Package Payment for CPA/Pilot Project**

Because of the reduction in BRS capacity, placement for children with mid to high behavioral health challenges is being sought in foster homes. However, caregivers are often not appropriately compensated, trained, or adequately supported in providing services to children with special needs. Currently, both the CPA and BRS providers enter into a contract with CA to provide emergent crisis intervention, therapeutic support, and care coordination. At this time, CPAs have been limited to providing services based on a fee-for-service, per-activity payment model. Providing CPAs with an option to participate in an inclusive comprehensive service payment package to operate TFC may allow agencies flexibility which could lead to more timely and effective delivery of services. This pilot project will also bring another opportunity to examine an effective community-based TFC model that has the potential to increase the opportunity for children and youth to stay in homes, neighborhood schools, and local communities to which they belong.

Development of Models for Stabilizing Funding

As stated previously, some of the root cause of the placement stability and continuity of care issues stem from lack of funding. By 2012, within three years of the 2009 recession, the out-of-home care expenditure had been reduced by $50,000,000. In 2010, the BRS budget was removed from the forecasting adjustable funding model, and allotted a much reduced fixed budget. CA is currently seeing the impact of the drastic reduction in placement resources in the lack of receiving and interim care, and other placement resources that are capable of caring for children and youth with challenging medical, developmental, and behavioral health issues. The effects can be seen in the recent increase in the placement instability and use of hotels as an emergent placement option, and the use of CA offices as day treatment centers as options of last resort. After such reductions in resources, to develop plans to combat these issues with cost neutral solutions is extremely challenging.

Both the external stakeholder community and the internal CA workers overwhelmingly support and advocate for a mission-driven, rather than a budget-driven, operation of the child welfare system. Many associate the fixed BRS budget with the budget-driven approach. Also, caregivers and providers have been consistently providing feedback that current payment rates are not sufficient for the level of care they are asked to provide. A rate study that includes a cost analysis to determine the true cost of care has not been conducted in recent years, and such a study is essential to create an effective, efficient, and respectful rate structure.

The across the board rate reductions disproportionately impacted the operation of facility-based programs which generally demand higher administrative and maintenance costs. Many providers were unable to sustain the facility-care programs. Although the BRS funding level is gradually recovering, it is certainly not enough for the necessary large capital investment, and providers are understandably hesitant to assume the financial risk.

Additional Recommendations:

- BRS funding restored to forecasted adjustable model.
- Conduct a third party cost of care analysis to accurately understand the up-to-date cost of care for children and youth at all levels of care, in diverse regions, in both urban and rural areas.
- Explore establishing a category of professionalized foster care.
- Assess the feasibility and impact of making "foster care facilities" eligible for the Washington State Housing Trust Fund program or establishment of a trust fund for providers interested in developing property, capital improvements, or expanding service capacity.
- Provide education to potential caregivers and providers regarding State grants like the Building Communities Fund, Youth Recreational Facilities, and Behavioral Health Facilities to provide opportunity to access much needed capital funds.

Future Continuum

Potential New Continuum

The new continuum should focus on identified placement gaps at three targeted areas: emergent entry, Foster Care and BRS transition, and cross-agency transition, with specialized and targeted placement resources that address the specific challenges at each point. Once identified placement gaps are appropriately resourced, and a robust placement continuum becomes a reality, utilization of a consistent and objective placement assessment process at the entry point will further reduce the mismatch between children's needs and the care environment. Identifying and matching the children's level of needs with the most appropriate caregiver at the earliest possible point will positively impact retention of caregivers at all levels and ultimately produce better outcomes for children.

This new continuum will ease the experience of children entering care with ranges of support offered through Resource and Assessment Centers and receiving care homes. Creating capacity for the more challenging emergent placement needs is also critical. The initial placement referral will include the child's initial assigned care level information based on the newly developed placement assessment so all levels of providers and caregivers, including foster parents, CPA and non-facility-based BRS providers, can make informed decisions bearing in mind the child's anticipated level of needs. CA's current assessments, like the CHET program, will serve as follow-up assessments after placement to assure the accuracy of the placement assessment, and provide additional and updated information to assess the child's current level of needs. When indicated by the results of the

follow-up assessments and/or recommendations from caregivers and caseworkers, a shared planning meeting can take place to discuss any need to provide more intensive services like acute mental health and group care. Availability of interim care placement resources, like emergent placement facilities, will assure this already challenging time of transitions for children and youth are appropriately supported.

Appendix A **VOICE AND CHOICE:**

Perspectives of Washington State Youth and Alumni of Foster Care

Seventeen members of P2A were divided into four groups depending on the number of placement changes experienced during their time in care. They discussed three questions: why is placement stability important; why improving placement stability is important; and what can we do to improve placement stability. At the end of the work group, each group presented their findings, then worked on creating a testimonial video on the issue of placement stability using a cell phone camera. Three youth/alumni testimonial videos were submitted at the end of the session and can be accessed here: Voice and Choice

Summary of Discussions

WHY IS Placement Stability Important?	**WHY IS Improving Placement Stability Important?**	**WHAT CAN WE DO to improve Placement Stability?**
• Children need a place to call home • Unstable housing leads to negative mental processes and emotions • Stable homes offer youth a launch pad into life • Stable homes offer safe places for youth • Mental stability while growing up • Schooling interruptions, friendships are harder/healthy relationships • Feeling more control of the youth's life (youth perspective) • Sense of belonging and connection. Multiple placements can cause the youth to feel the need to move, even though the current placement is ok. Fear of being unwanted sometimes pushes youth to test their limits. Blood doesn't always mean they are family and that they are the best placement. • Permanency • Quality • Acceptance • Trust	• Develop social and interpersonal skills and relationships • Stable placements go hand in hand with better services (access, quality) • Gives youth greater sense of family/ investment in family • Feeling of safety/ normalcy • Helps children see good in world and people • Develop personal, academic, professional identity and skills • Gives youth safety and confidence to use voice • Having said stability improves not only a youth's chance of success but allows them to become a more outspoken and prepared adult compared to a youth who didn't have this • Giving a youth a more normalized childhood • Being able to trust someone more and build healthy relationships • Building the bridge to create sense of family • Be heard • Respected/listened to	• Communication is major key • Improved relationships with caseworkers (rating) • Enforced counseling; trained in FC/adoption/ long term service • Put parents on dependency plan • Put parents in mentorship with others who have experienced the system • Meetings set in more public places instead at their home, unless unable to (certain circumstance preventing this) • Checking on caregiver and see if there is anything that they can do, or give, to prevent a youth from moving (like resources, etc.) or if things are going on that need attention • Counseling (group/family) to help keep placements secure • Voice and choices of the youth (child) • Try > ask > understand • Respect individual difference • Parents (foster) and bio parent connection and communication • Honesty • Family – we define • MFM

WHY IS Placement Stability Important?	WHY IS Improving Placement Stability Important?	WHAT CAN WE DO to improve Placement Stability?
• Normalcy in adolescence • Unconditional Care • Consistency • Mental health • Sentimental belongings (photos, etc.) • Memories • Culture • Education stability • Support • Encouragement • Physical/ mental health • Relationship • School interruption • Building relationships with friends and FPs is more difficult without a place called home. • Feeling more in control; there is so much I don't have a control of in my life. • If you don't know where you are going to stay, how do I go about doing anything else? (Basic needs)	• Conversation rather than spoke to • Security • Budgeting for CA (housing/employment) • Established long term relationships • 2nd generation alumni • Ambiguous loss training • Social skills development: Be able to take risks knowing you have a home • Learn and understand what the functional family is and feels like. • My stability will determine my future (to become productive member of society) • Develop self-identity (Who I am and what I value)	• Better evolution of family and child compatibility (when available) • Better matching • Provide support and solution before too late. Preserve placement • Utilize a repetitive respite/foster home for in between placements or family conflict • Mediation (solve the unresolved issues)

Appendix B **COHORT STUDY TABLE OF VARIABLES**[30]

Selection process of the Target Child for the creation of the cohort	
All children with a placement episode that started between 1/1/2013 and 6/30/2013 that lasted at least 60 days (N = 6953) One child per family was randomly selected resulting in 4264 children.	This became the Target Child for which all the other information was attached.
Follow-up time	This cohort of children was followed until 6/30/2016
Variables attached to the Target Child	
Variables	*Details*
Removal Date	Date of the start of the placement episode. If the child was removed more than once during the selection time then the first placement episode was used.
Number of prior screened in reports	All screened in reports prior to the start of the placement episode were included (CPS, Risk Only, and FRS reports). This information was obtained separately using reports attached to the family from which the child was removed from and those reports attached to the Child ID resulting in two separate variables
Prior placement episode	This refers to a prior placement episode (e.g. prior dependency) on either the identified Target Child or the child's family.
Age of the child	The age of the child at the start and end of the placement episode was recorded.
Number of placement events	Placement events refer to the separate placements within the current placement episode (e.g. 3rd placement of the child since the start of the current dependency action). Respite placements were removed from the data set.
Age of the child at the start and end of each placement event	
Type of treatment setting	Indicates the type of treatment setting the child was placed in during the placement event (e.g. foster home, private agency foster home, relative home, BRS placement…)
Treatment end reason	Why the placement event ended (Changed Caregivers, Child on the Run, Adoption, Guardianship, Reunification, Transition to Adult …)
Length of the placement episode	
Length of each placement event	
Race of the child	African American, Asian/Pacific Islander, Hispanic, Native American, and White (Based on the Braam Race categories)
Gender of the child	
Number of children from family placed in out-of-home care	The number of children from each family removed at the time of the removal of the target child was collected
Reason for exit from care	Reunification, Adoption, Guardianship, Transition to Adult, Still in Care…

[30] Cohort study to analyze factors related to placement stability and outcome is currently underway, the completed report is expected in March 2017. Not all variables listed on this table are cited in this report.

Variables attached to the Target Child	
Variables	*Details*
Reason for removal	This information was gathered from a checklist that the caseworker who filed the dependency petition completes to indicate the "reasons for removal". There are 14 reasons for removal (i.e. Abandonment, Unable to Cope, Child Alcohol, Child Drugs, Child Behavioral, Housing, Neglect, Parent Alcohol, Parent Drugs, Parent Death, Parent Incarceration, Physical Abuse, Sexual Abuse, and Relinquishment). A caseworker can indicate more than one reason for removal. Also, the child specific reasons for removal, such as child drugs, may or may not refer to the Target Child in this study.
PSC-17: (Associated with the Removal Episode) • Externalizing Score • Internalizing Score • Attention Score • Total Score	The "indicated" compared to "not indicated" score on the various PSC-17 subscales was collected. As many children have multiple raters an indicated score from any rater on each of the subscales was counted as indicated. Data was also collected on who filled out the questionnaire (i.e. Child, Caregiver, Parent, School personnel). Additionally, the continuous measure for each of the subscales was collected for the assessments completed by the out-of-home caregiver.
Scores on the ASQ	Indicated and not indicated scores on all ASQ subscales were recorded including the: Personal, Fine Motor, Communication, Problem Solving, Gross Motor, and Social Emotional score.
Scores on the Denver	Indicated and not indicated scores on all Denver subscales were recorded including the: Personal, Fine Motor, Language, Gross Motor, and Overall score.
Placement Type	The type of placement the child was in was recorded (e.g. Relative, State Foster Care, Private Agency Foster Care, BRS, Hospital, CRC, Detention…)
Percentage of time spent in each type of care	The percentage of time children spent in each type of care was calculated based on the length in each type of care.
Race of caregiver	The race of the primary and secondary caregiver was collected. If either the primary or secondary caregiver was a minority the home was categorized based on their minority status.
Amount of money spent during placement	All payments made and attached to the child's ID during the placement episode were recorded.
Structured Decision Making Scores (SDM)	The score from each of the 70+ items of the SDM's done within a year prior and 100 days after the placement episode on the family were recorded. If more than one SDM was done on the family within this time range only the SDM done in closest proximity to the placement episode was used.
Safety Assessment (SA)	The score from each of the 21+ items of the SA's done within 70 days prior 60 days after the placement episode on the family were recorded. If more than one SA was done on the family within this time range only the SA done in closest proximity to the placement episode was used.

For those children returned home	
Time to new report	The time from the return home of the child to the next new screened in referral on the family was recorded.
Type of new report	The type of allegation in the new report on children returned homes was recorded (e.g. physical abuse, sexual abuse, neglect).
Time to new placement episode	The time from the return home of the child to the time of the next placement episode of the child was recorded.

Appendix C **REFERENCES**

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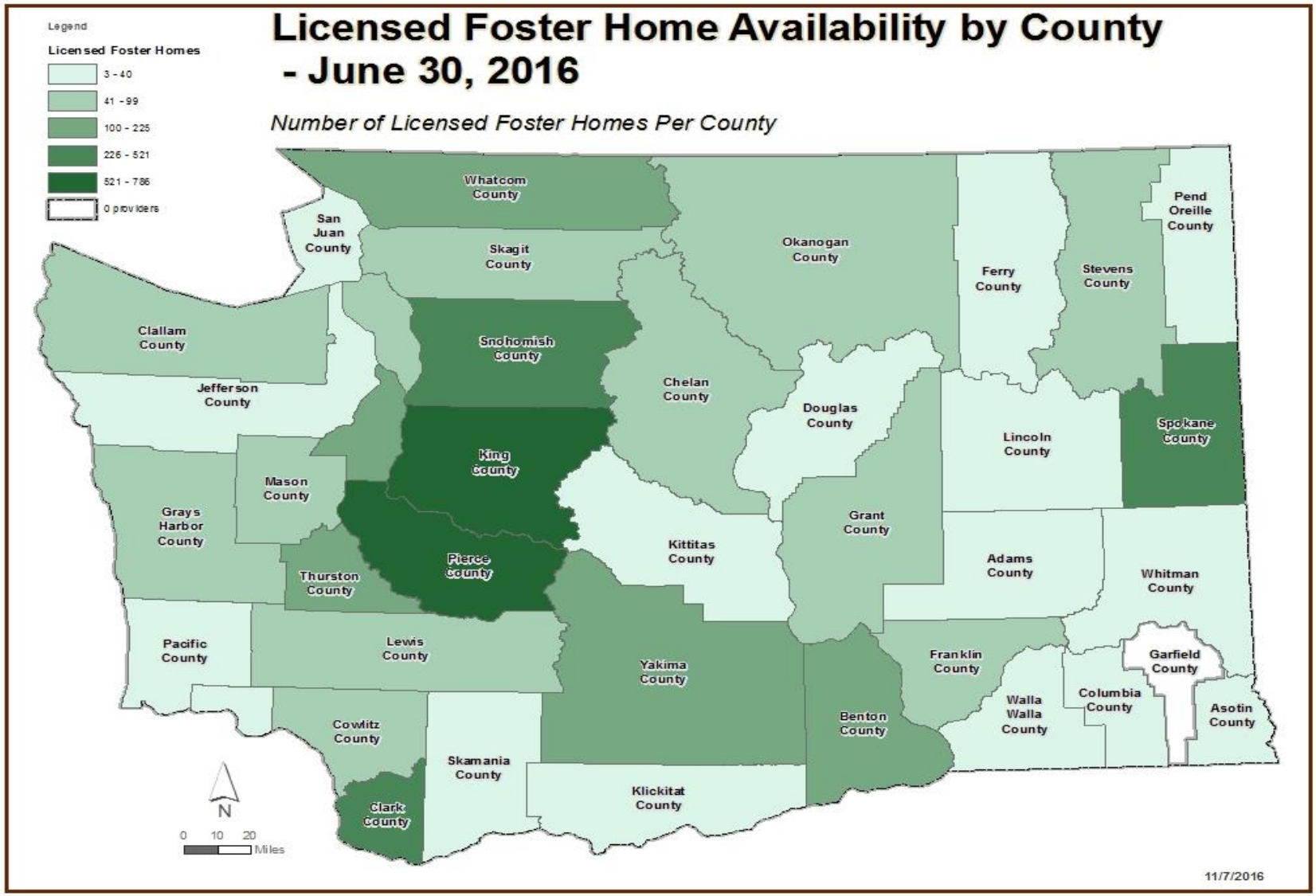
Appendix D **LICENSED FOSTER HOME AVAILABILITY BY COUNTY**



Appendix E **HEAT MAPS: FOSTER CARE AND BRS**