

FPO 1603A – Evaluation Protocol

Specialized Foster Care Evaluation and Reporting Process

Evaluation Process

The DCFS Planning and Evaluation Unit (PEU) will complete the statewide evaluation of the Child Welfare Agency Specialized Foster Care Program (SFCP) on an ongoing basis. The outcomes will be reported on an annual basis per Senate Bill 107 (2015 Legislative Session).

Primary criteria tracked will continue to be:

- Consumer satisfaction
- Educational status
- Hospitalizations
- Legal status/delinquency information
- Performance on clinical standardized assessment tools
- Placement stability (e.g., placement changes, runaways)
- Progress towards permanency
- Psychotropic medication usage

Information to complete the evaluation will come from a variety of sources. Data and demographics will be provided by the local child welfare agencies via UNITY and any online data submission forms provided by DCFS PEU (e.g., Survey Monkey questionnaires). All identified resources for information collection must be utilized to ensure capture of all required data points.

The data collected is analyzed utilizing the Statistical Package for the Social Sciences (SPSS).

Evaluation Protocol & Data Collection Elements

A detailed breakdown of what is examined and required for the evaluation is outlined below. Please also reference the Appendix for operational definitions of each outcome variable.

Data Collection and Reporting

Baseline data comprises the natural history of the child's life for the six months prior to admission into the SFC Program (observational data). The majority of program evaluation data is collected every six months beginning with youth's date of entry into the SFC Program. For example, a child admitted on 4/13/16 is due for 6-month data collection 180 days later on 10/10/16; 12-month data collection is due 365 days after admission on 4/13/17. At each assessment time point, the following must occur: Applicable standardized measures are administered; applicable consumer satisfaction measures are administered; all UNITY data (or other applicable continuously occurring events or services) for the prior six months are reported. Fidelity forms are collected and submitted on a separate schedule (see p. 6).

Admission data must be gathered within 2 weeks of the child's SFC Program admission date. Follow-up time point data must be gathered within 3 weeks of the follow-up due date. Discharge data must be gathered within 4 weeks of the child's SFC Program discharge date. "Admission" is defined as the date of entry of an eligible child into a placement that is receiving the specialized foster care rate of payment, or the date that the eligible child's current placement begins receiving the specialized foster care rate.

Please Note: If the child is discharged less than 90 days from their most recent data collection time point, use their most recent data for the discharge time point. If it has been 90 days or more since their last assessment, a new assessment is needed for discharge.

An adequate dose of treatment of SFCP is 90 days. That is, youth discharged fewer than 90 days into the program will be excluded from comparison analyses. All children will be included in demographic reporting.

Data Collection Form

The data collection form is downloaded from UNITY and then uploaded when it is complete. UNITY will then extract the information needed from the Data Collection Form. Any information that has already been entered into UNITY will be pre-populated onto the form when it is downloaded. Any information that is not yet in UNITY needs to be filled in by the worker onto the Data Collection Form prior to the form being uploaded. This is a temporary data collection solution and by 2017, all data within the Data Collection Form will be collected through user input directly into UNITY. The information currently collected on the Data Collection Form is as follows:

Demographic Information *(pre-populates when available)*

Demographic and background information will be collected from UNITY including:

- Date of birth
- Gender
- Region (Clark County, Washoe County, rural)
- Ethnicity
- Dates of admission and discharge
- Name of social worker
- Placements – current and past 6 months
- Permanency goal
- Reason for entry into child welfare (list all reasons)

Legal Information *(pre-populates when available)*

Indicate whether or not the youth is on probation. At admission, information on the number of arrests and number of days in detention will be collected for the six months prior to the youth's admission in the program. At six month intervals including at program discharge, information will be collected on the past 6 months.

Services Youth Is Receiving

Service type is usually a Medicaid reimbursed service such as individual or family psychotherapy or psychosocial rehabilitation (PSR). The service provider is usually an agency or an individual. The service units are the dosage the youth is projected to receive, e.g., one hour of individual therapy per week or two hours of PSR three times per week. Service units are reported in the spreadsheet as number of hours per month so in the previous example, the dosage that should be reported is 4 hours of therapy per month or 24 hours of PSR per month.

Medications (*pre-populates when available*)

When possible, medication information will be gathered from the Division of Healthcare Financing and Policy. For each youth, total number of unique psychotropic medications prescribed within the data collection window (not just what is currently prescribed at the time of data collection) will be analyzed. Additionally, average and maximum number of medications prescribed at any one time during the data collection window will be reported. Change in number of medications prescribed will be examined intra-individually over time; a sub-category of antipsychotic medications will be examined separately. Changes in dosage will also be examined.

Clinical Information (*pre-populates when available*)

Clinical information such as diagnosis and SED status can be pulled from the most recent FH11-A form required by Medicaid. If an FH11-A is not used, the youth's clinician, case worker, or case manager is to provide the information. Also, some of the program children may have a Wraparound in Nevada (WIN) worker. The WIN worker can be utilized as another source of data. For some children the information may be in Avatar, the DCFS electronic record.

Whether or not the youth is Severely Emotionally Disturbed (SED) needs to be indicated. Youth must meet the criteria for Severe Emotional Disturbance as provided in the Nevada Medicaid Services Manual* Chapter 100, Section T (p. 4):

Children from birth through 48 months who currently or at any time during the past year (continuous 12 month period) have a:

- a. DC:0-3 Axis I diagnostic category in place of a DSM-IV Axis I diagnostic category; or
- b. DC:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or

Children with a SED are persons age 4 to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

- a. Diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the DSM-IV. This excludes substance abuse or addictive disorders, irreversible dementias, as well as mental retardation and V codes, unless they co-occur with another serious mental illness that meets DSM-IV criteria that results in

- functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities, and
- b. These disorders include any mental disorder (including those of biological etiology) listed in DSM-IV or their International Classification of Diseases (ICD)-9-Clinical Modification (CM) equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however they vary in terms of severity and disabling effects; and
 - c. Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

** Please note that the Medicaid Services Manual is currently undergoing revisions to reflect the currently accepted diagnostic systems of DSM-5 and ICD-10.*

Educational Information (*pre-populates when available*)

Indicate the school, the grade, the date started at the current school, and special education status (IEP/504 Plan).

At program admission, information on the most recent completed semester start date and end date is collected. For example, if a youth entered the program in January 2016 he/she probably just completed a semester that began in August 2015 and ended in December 2015. The number of credits completed in high school, or whether or not the youth passed if in middle or elementary school, is collected. The number of absences and days in attendance are also collected for this time period.

At six month intervals and at program discharge, educational information will be collected on the most recently completed semester. Educational information is collected at the end of semesters (or trimesters depending upon the school's schedule). If a data collection time point falls mid-semester, please report on the most recently completed semester or trimester.

Indicate if the youth changed schools in the most recently completed semester.

Beginning in 2017, all education information will be obtained directly from the Department of Education and workers will no longer need to submit this information.

Child Behavior Checklist (CBCL) T-scores: See p. 7.

Child and Family Team Information (*pre-populates when available*)

Number of Child and Family Team meetings for the previous six month period will be reported at each time point. Child and Family Team is defined in the NV Medicaid Services Manual (Chapter 100 Section C Page 5) as: A family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child and family. The team consists of the child recipient (as appropriate), parents, service professionals and may also consist of family members, care providers, and other individuals identified as being integral to the child's environment or mental health rehabilitation.

Casey Child Permanency Status Form

The child welfare case worker or other program or agency staff will complete the Child Permanency Status form at admission, every six months, and discharge.

Consumer Satisfaction

Every six months (beginning at the 6-month data collection time point) and at discharge, foster parents and youths age 11 and over will be asked to rate their satisfaction with the services and supports they are receiving. In the case of multiple SFCP children in one home, the foster parent must complete one consumer satisfaction measure per child per data collection time point.

The consumer satisfaction measures are anonymous and confidential. Results will be used for statewide system-level program evaluation and quality improvement purposes (i.e., the purpose is not to identify child and family needs for any individual youth).

In addition to paper forms that are provided by DCFS PEU, the surveys may also be accessed at the links below:

Foster Parent Survey: <https://www.surveymonkey.com/r/SB107parent>

Youth Survey: <https://www.surveymonkey.com/r/SB107youth>

DCFS PEU suggests that when possible, the parent and/or youth be provided directly with the Survey Monkey link. When this is not possible, the parent and/or youth should fill out the survey on paper. Then a staff member who does not work with the family should transfer their answers into the Survey Monkey form.

Fidelity to Evidence-Based Model

Together Facing the Challenge workers will complete three fidelity monitoring tools, the NV-TFTC Strategic Home Visit Form, the NV-Supervisor TFTC Evaluation Form, and the NV-TFTC Implementation Survey. Please see table below for the submission schedules for each fidelity form. Until fidelity forms can be entered directly into UNITY, it is not necessary to submit the NV-TFTC Strategic Home Visit Form or the NV-Supervisor TFTC Evaluation Form to DCFS PEU. In the case of multiple SFCP children in one home, the foster parent must complete one NV-TFTC Strategic Home Visit Form per child per week.

TFTC Fidelity Form	Frequency	Submission Schedule
NV-TFTC Strategic Home Visit Form	Weekly	Weekly
NV-Supervisor TFTC Evaluation Form	Monthly	Monthly (no later than 31 st)
NV-TFTC Implementation Survey	Yearly	September 1 st of each year

In the case of child welfare agencies utilizing an alternate approved nationally recognized model, all fidelity requirements within the alternative model must be met and documented by the child welfare agency. Fidelity forms for the alternate model must be submitted to DCFS PEU for evaluation per the fidelity requirements of the model or as identified by DCFS PEU for statewide consistency/comparability in evaluation of the statewide SFCP.

Incident Reporting Form

The child welfare case worker or other SFC Program or agency staff will ensure the foster parents receive and implement the Incident Reporting form. Only incidents that occur while youth are in the care of the foster parent should be reported (i.e., they are in the specialized foster home and not a temporary placement). All incidents will be documented on the form as required and sent to the licensing authority and DCFS PEU. Agency or SFC Program supervisors will need to reinforce the use of the form and ensure the submission of the completed form after an incident. Specific incidents that need to be reported include:

- Abuse of youth
- AWOL/runaway
- Child death
- Criminal activity by foster parent/staff
- Criminal activity by youth
- Injury or illness (medical severity = minor, moderate, and serious)
- Medical emergency
- Medication errors
- Physical restraint
- Psychiatric emergency (e.g., hospitalization, psychosis)
- Self-harm (medical severity = minor, moderate, and serious)
- Sexual acting out
- Suicide attempt
- Suicide completion
- Youth arrested/law enforcement involvement
- Other (e.g., fire, natural disaster, foster parent crisis)

Standardized Instruments

Local child welfare agencies may choose to purchase the standardized assessments, or they may require the specialized foster care agencies to purchase them. The local child welfare agencies are responsible for ensuring that the standardized assessments are conducted and scored, and the local child welfare agencies are responsible for submitting final scores to the DCFS PEU. Local child welfare agencies are encouraged to develop policies and procedures outlining who is responsible for ensuring data is collected and submitted. The

scored instruments will be given to the Together Facing the Challenge coach or supervisor to share with the Child and Family Team and/or the clinician for use in treatment planning with the youth.

Table 1. Data Collection Schedule

Measure	Admission	Every Six Months	Discharge	Reporter
Adverse Childhood Experience Score	✓			Worker
Caregiver Strain Questionnaire*		✓	✓	Foster Parent
Child Behavior Checklist (CBCL) – Ages 1 ½ to 18	✓	✓	✓	Foster Parent
Child PTSD Symptom Scale (CPSS)	✓	✓	✓	Youth Age 11-18
Consumer Satisfaction*		✓	✓	Foster Parent, Youth Age 11+
Nevada Child and Adolescent Needs and Strengths tool (NV-CANS)	✓	✓	✓	Mental Health Counselor

* In the case of multiple children placed in one SFCP home, the foster parent completes one questionnaire per youth per data collection time point.

Adverse Childhood Experience score: The ACE score attributes one point to each of several abusive, neglectful, and/or violent experiences that may occur during childhood. Higher ACE scores have been linked with increasing prevalence of negative health and mental health outcomes in adulthood. These include heart disease, alcoholism, and suicide risk. The ACE questionnaire is in the public domain (free) and is available in UNITY forms. The completed form should be uploaded into UNITY.

Caregiver Strain Questionnaire: The Caregiver Strain questionnaire measures the level of stress and burden a caregiver is currently experiencing as a result of caring for a child or adolescent with emotional and behavioral disorders. In the case of multiple SFCP children in one home, the foster parent must complete one Caregiver Strain measure per child per data collection time point. The Caregiver Strain Questionnaire is not administered at admission. The Caregiver Strain questionnaire is in the public domain (free) and is available in UNITY forms. The completed form should be uploaded into UNITY.

Child Behavior Checklist: The CBCL is a widely-used broadband measure that assesses adaptive and maladaptive functioning. There are two versions, age 1 ½ to 5 and age 6 to 18. The CBCL is proprietary (not free) and can be purchased at the following website: <http://www.aseba.org/sitelicense.html>. It is possible to request a large-volume discount. Please note that in addition to purchasing the CBCL questionnaires, special software is required to score the CBCL and must be purchased from www.aseba.org. Hand scoring is not recommended due to the increased possibility for human error. The Internalizing, Externalizing and Total scores are currently captured in UNITY and in 2017 data capture will be expanded to include all the scores, i.e., Anxious/Depressed, Somatic Complaints,

Thought Problems, Rule-Breaking Behavior, Withdrawn/Depressed, Social Problems, Attention Problems, and Aggressive Behavior as well as the corresponding scores on the age 1 ½ to 5 version.

Child PTSD Symptom Scale: The CPSS is used to measure post-traumatic stress disorder severity in children. The version provided by DCFS PEU also includes a trauma screen (for identifying if there has been exposure to any potentially traumatic events that would require completion of the CPSS; if no exposure, do not administer the CPSS). Scoring instructions are also included. The CPSS is in the public domain (free) and is available in UNITY forms. The completed form should be uploaded into UNITY.

Consumer Satisfaction: See p. 5.

Nevada Child and Adolescent Needs and Strengths: The Nevada CANS is a new tool that will be released in September 2016. The CANS is used in the majority of US states in various capacities including mental health and child welfare. The Nevada CANS was developed to meet the specific needs of our state. The CANS will be used in place of the CAFAS to communicate level of functioning for the purposes of determining treatment intensity as well as for tracking outcomes. The CANS is not an assessment, per se, but rather should be rated at the conclusion of a thorough biopsychosocial assessment. Most items can be rated without asking direct questions of the youth or family following the completion of a thorough record review and clinical assessment. The CANS is in the public domain (free) and will be provided by DCFS PEU. All scores and totals will be captured in UNITY.

Please Note: Any forms that are uploaded into UNITY (e.g., Caregiver Strain, CPSS) can be completed electronically by the caregiver/youth and then emailed to the worker. If this procedure is used, no additional data entry by the worker is necessary. If the caregiver /youth complete the form by hand (pencil-and-paper) then the worker will need to enter that information into an electronic version of the form and then upload it into UNITY.

For more information about specialized foster care evaluation, please contact SFCP@dcfs.nv.gov, Dr. Megan Freeman at megan.freeman@dcfs.nv.gov or Dr. Amy Guevara at aguevara@dcfs.nv.gov.

Appendix

Operational Definitions for Program Evaluation Components

Concept, Variable, or Outcome	Definition
Reason for entry into child welfare custody	<ul style="list-style-type: none"> • Recorded at admission • List all reasons given • UNITY: Case Directory > Legal Status
Placements and placement stability	<ul style="list-style-type: none"> • Placement stability is measured as a function of unique placements • Placement information will be gathered directly from UNITY. • Number is recorded at admission and each time point as total # of unique placements in past 6 months • If the youth remained in the SFCP home throughout the reporting period, the placement count would be 1 for one unique placement during the reporting period • Preplacement visits and short respite stays are NOT included • Transfer to emergency shelter is not considered a new placement unless it lasts 30 days or more • Additionally, final placement type is recorded at discharge as: Adopted, age of majority, independent living, higher level of care, emergency shelter, parent placement, regular foster care, relative placement, residential treatment, runaway, other • Final placement types that are considered disruptions are: Higher level of care, emergency shelter \geq30 days, residential treatment, and runaway \geq 30 days, as well as "other" on a case-by-case basis • UNITY: Case Directory > Placement/Location Directory
Hospitalization	<ul style="list-style-type: none"> • Any initial transfer to acute psychiatric inpatient unit • Transfer to another acute hospital is not counted as a new event • Transfer from an acute hospital to a residential treatment center is considered a transfer to a different type of placement regardless of duration of RTC stay, is counted as a new placement and typically results in discharge from the program • Reported as descriptive statistics (counts) only to date; intra-individual change will be examined in future if possible • Length of stay will be examined when available in UNITY or by using data from the Division of Healthcare Financing and Policy
Runaway	<ul style="list-style-type: none"> • Any report that the youth's whereabouts are unknown to the foster parent for greater than 3 hours and he or she is believed to have left his or her placement voluntarily • Reported as descriptive statistics (counts) only to date; intra-individual change will be examined in future if possible

<p>Progress toward permanency</p>	<ul style="list-style-type: none"> • Permanency status noted to be Poor, Marginal, Fair, Good, Very Good, or Achieved based on standardized criteria on the Casey Permanency Status Form • Permanency status monitored every six months and final permanency status recorded at discharge • Continued utility of Casey Permanency Status Form will be reviewed in one year with use of data for decision-making
<p>Legal status</p>	<ul style="list-style-type: none"> • Probation: Yes/No (for prior six month period) • Number of arrests (for prior six month period) • Number of days in detention (for prior six month period) • Currently reported as descriptive statistics only
<p>Educational status</p>	<ul style="list-style-type: none"> • School name • Grade in school • Most recent completed semester start/end dates • Special education status (Yes/No) • Elementary & middle school: Did they pass the most recently completed semester (Passing/Not Passing) • High school: Number of credits earned in most recently completed semester • Number of absences in most recently completed semester • Number of days of school attended in most recently completed semester • Did the youth change schools during the most recently completed semester (Yes/No) • Currently reported as descriptive statistics only
<p>Performance on clinical standardized assessment tools*</p>	<ul style="list-style-type: none"> • Child Behavior Checklist (CBCL): 140 items completed by foster parent; yields T-scores for Aggressive Behavior, Anxious/Depressed, Attention Problems, Rule-Breaking Behavior, Social Problems, Somatic Complaints, Thought Problems, Withdrawn/Depressed, Internalizing, Externalizing, and Total Problems (ages 6-18) • For the CBCL 1.5 to 5 year old version, report the following scores: Anxious/Depressed, Somatic Complaints, Withdrawn, Attention Problems, Aggressive Behavior, Internalizing Problems, Externalizing Problems, Total Problems. • Child PTSD Symptom Scale: 26 items completed by youth ages 11+; yields a total Symptom Severity score plus a severity-of-impairment score; optional PTSD symptom cluster scores (B, C, and D) • Intra-individual change from admission to discharge reported as statistically significant/not (t-test) • At admission, an Adverse Childhood Experiences (ACE) Score will also be calculated

Foster parent well-being	<ul style="list-style-type: none"> • Foster parent completes the Caregiver Strain Questionnaire at each time point • In the case of multiple children placed in one SFCP home, the foster parent completes one questionnaire per youth per data collection time point, since stress/burden may vary on an individual basis
Consumer satisfaction measures	<ul style="list-style-type: none"> • Completed by youth ages 11+ and foster parent • In the case of multiple children placed in one SFCP home, the foster parent completes one survey per youth per data collection time point, since satisfaction with services may vary on an individual basis
Child and Family Team information	<ul style="list-style-type: none"> • Does child and his/her family have a Child & Family Team (Yes/No) • Child and Family Team is defined in the NV Medicaid Services Manual (Chapter 100 Section C Page 5) as: A family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child and family. The team consists of the child recipient (as appropriate), parents, service professionals and may also consist of family members, care providers, and other individuals identified as being integral to the child's environment or mental health rehabilitation. • If yes, how many CFT meetings took place in the past 6 months
Incident reporting	<ul style="list-style-type: none"> • Child welfare case worker or other program or agency staff ensures foster parent utilizes Incident Reporting Form to report adverse events. • Suicide attempt is defined as a non-fatal, self-directed, potentially injurious act performed with the intent to die (may not result in actual injury) - please note that behaviors sometimes referred to as "suicidal gestures" may fit this definition and should be reported • Only incidents that occur while youth are in the care of the foster parent should be reported (i.e., they are in the specialized foster home and not a temporary placement) • Data entry specialist (individual identified by agency/program who will use Excel spreadsheet) will use Incident Forms to separately track suicide attempts, physical restraints, and medical emergencies • A count of each type of event will be entered at each time point. If no such events have occurred, enter 0
Mental health service use	<ul style="list-style-type: none"> • Type of service received along with "dose" reported in monthly units (e.g., weekly therapy = 4 units/month). • Service types include individual therapy, family therapy, group therapy, psychiatrist, substance use treatment, intensive outpatient, etc. • Data from the Division of Healthcare Financing and Policy will be utilized if possible