

Evaluation Board Agenda
Date: 1/20/09
Location: Teleconference
Conference Call #: 1-888-751-0624; Participant #: 604110



Partnership Goals:

- #1** ~ Improve retention of Workforce and Resource Families
- #2** ~ Improve Recruitment of Workforce and Resource Families
- #3** ~ Decrease Disparate Outcomes in Child Welfare

Attendance: Brian Baldwin, Marian Woods, Oscar Morgan, Chuck Halligan, Patty Gregory, Roxanne Printz, Wes Engel, Rick Phillips, Kathy Tidwell, Alberta Dooley, Ed Byrnes, Robert Hernandez (Notes)

AGENDA ITEM	TIME	DISCUSSION	DECISION	ACTION
Welcome, Minutes Review	1:00	The board decided to review the minutes during the week and notify Robert if there were any changes. After the week, Robert will post them on the Partnership website.		
Evaluation Board Changes teleconference /videoconference membership new chair needed July 2009		<p>Travel Limits. Due to budget cuts, there will not be any travel for Partnership meetings until further notice. The plan is to schedule video conferences when the rooms are available.</p> <p>New Partnership Director. Marian Woods is now the PET Manager and Partnership Director. She will also be a member of the Evaluation Board. Frank Sesek has recently resigned from IDHW. When his replacement is hired, that individual will also take Frank's position on the board.</p> <p>Board Members. The board recommended having Ken Craft and some chiefs as additional members of the Evaluation Board. Ken has had some evaluation experience and did critical data review for the state of WA. Although there will be a learning curve, he will offer a fresh perspective. The board wants to have members who are interested in evaluation and research, rather than just grabbing someone to fill a position. Marian will speak with Michelle to see if IDHW can offer someone. She asked that suggestions be sent to her.</p> <p>Board Chair. It was mentioned that the board will have to decide who the next chair will be in July 2009. July is the month when there is a board chair transition. Along with the Evaluation Board, the Scholars Board will also be deciding on their next chair.</p>		Marian will see if IDHW can provide someone for the board.

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<p>FGDM- Dr. Ed Byrnes presentation of FGDM evaluation data briefing</p>		<p>FGDM Report Introduction. Dr. Ed Byrnes gave a briefing of his Family Group Decision Making (FGDM) report. This was a seven page evaluation briefing from the data warehouse which was extracted from FOCUS. The structure in FOCUS made it difficult to connect points. The family identifiers are sometimes tied to other identifiers, resulting in information going in different directions. This then required doing different queries. Here are some of the items that were reviewed.</p> <p><u>REPORT PAGE 1</u> Out of forty cases in FGDM, there were twenty-seven families and eighteen children. Work is being done to improve the algorithms. Understanding the data will help with the directory.</p> <p><u>REPORT PAGE 2</u> Time From Assessment. The graph shows that the quickest turnaround time was eight days, 25% of the turnarounds were in thirty days. The preference is to see this earlier to have FGDM and then perhaps have a clinician utilize this. After being asked if the data was divided by regions for the differences, Ed indicated he'll write a better algorithm for this.</p> <p>CPS History. 78% had prior CPS referrals. This seems to be high. When ask about referrals, are they substantial? FGDM families have been through the system more than once. These are families with more than a low risk. There is a need to define prior CPS reports for better clarification; also to clarify if the referral is substantiated.</p> <p>Clarification. This report is looking at a percent of the cases; these are not substantiated reports.</p> <p><u>REPORT PAGE 3</u> Family Risk Level. In Figure 3, 1/5 came out as a "no to low risk," while 4/5 were "moderate to higher risk." The pattern is that FGDM is not being applied to the lower risk, thus showing that workers are willing to look at FGDM for higher risk families.</p> <p>Percent From Total Cases. It was not certain what percentage of cases in FGDM were from the total cases, but this information can be obtained from the data warehouse. Regions 1 and 2 had a lower rate compared to the other regions.</p>		

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		<p><u>REPORT PAGE 4</u> Immediate Safety Decisions. More than half of the families were unsafe or in a home with supervision. A small percentage is safe. This shows that the workers have been consistent in taking on cases that were a higher risk. There is a link with unsafe placement and the time of the assessment to FDGM. The goal is to line that up. FGDM is being used as a reunification method, but when it is done earlier there are system issues that can inhibit FGDM. Dr. Byrnes wants to put this together in a productive model and glean other information about the cases so that this works better sooner than later.</p> <p>Child Characteristics. In Figure 5, 44% had behavior problems, 22% had prior removals, and 72% had vulnerable special needs. This shows a natural support for meeting special needs by workers.</p> <p><u>REPORT PAGE 5</u> Family Characteristics. There are eighteen risk factors. The graph on page six shows that the maximum risk factors were eleven. The graph's middle group of four to seven risk factors suggests that families are a moderate risk, which fits in with the safety data. Case workers are reluctant to refer families where there are abuse factors.</p> <p><u>REPORT PAGE 6</u> Caregiver. In Figure 7 one sees that about 40% of families have a violent caregiver. This shows a cross section of the family being referred. There are two groups, mental and alcohol. Case managers are trying to provide a natural support for those with substance abuse.</p> <p>Increasing Natural Support. There is no data to show that FGDM increases natural support. The caseworker should have this data prior to the referral as he/she is working with the family; which is happening. The workers can go to FOCUS for data although it is not the most user friendly means of obtaining data.</p> <p><u>REPORT PAGE 7</u> Two Conclusions. 1) Case managers seem to understand the importance of a family support system when there is a disability, etc. 2) Workers are willing to use FGDM when there is a higher risk.</p>		

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		<p><u>OTHER OBSERVATIONS</u></p> <p>Document Review. Dr. Byrnes looked at the documents the workers were using to make referrals and made the following observations:</p> <ul style="list-style-type: none"> • 49% of the referrals had words about this being long term, others had engaging natural support system. • 35% had information on engaging the family. • 25% of the family plans had discussion on substance abuse. • 14% had Children’s Mental Health (CHM) in the family plan. • Respite is not showing up in the referral but in the family plan and shows the family plan’s benefit. • The median time for referral and FGDM is six months. • The family plan has a different roster on who shows up. • The plan is a deliverable. • This is a family plan from the FGDM meeting. <p>Outcomes. Work is now being done on outcomes, which is an important part of the work. This will involve using a comparison group. The feeling is that a comparison group can be obtained. The result is that we may find that FGDM, when factored in with other services, may not have a big impact which means we might not get all the outcomes.</p> <p>Timeline. It was pointed out that this was only a brief and other briefs will be submitted within two to three weeks for the case connection to be done. There will be a family profile by mid-February and a comparison group worked on by the end of March. The goal is to complete everything by the end of March.</p> <p>This report will be on the Program Managers meeting agenda in February 3rd and 4th, 2009.</p>		
<p>CW Conference Focus Group Data -How to get the raw data -Headline News story</p>		<p>Focus Data in Headline News. It was brought up that there may not be the same interest in this data now since it has been almost five months since the focus group data was first given. Some of the points brought up at Andrew’s presentation may be able to be used as a Headline News to encourage the workforce. Brian is working with Emily and will find out where she is at on this.</p>		<p>Brian will contact Emily on the Focus Group Data Headline News</p>

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<p>Data Sharing Workgroup -On Hold</p>		<p>Data Sharing Workgroup. The project is on hold right now due to budgeting constraints. Brian still wants to keep the group intact and have this project continue. The discussion should not stop due to budget cuts. This way the data sharing is poised for implementation when the budget will accommodate it. EWU students are working on this at no cost and can continue until its implementation. There stills needs to be a mutual understanding of the database's purpose and use. This shared database would benefit the Scholars Board in tracking stipend students. The group still needs to work through the challenges of sharing data.</p> <p>Acquiring Data To Share. The boards should decide what they want the shared data to accomplish and provide this to the Data Sharing Workgroup. Brian recommended that the workgroup meet with each board representative to get their board's needs. Data sharing should be priority and follow the outcomes for the Partnership. Brian will have the workgroup get the specific needs from each board and inform the Admin Board so they will know what is being done. Since the Admin Board may have specific needs, it would be good to ask them what they need.</p>		<p>Brian will have the data sharing workgroup get specific needs from each board for data sharing and report this to the Admin Board.</p>
<p>Adjourn</p>	<p>4:00</p>	<p>Brian will put out dates for the next meeting and set a meeting date based on the supplied board response.</p>		

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Family Group Decision Making Evaluation Data Briefing
Idaho Dept of Health and Welfare Evaluation Board
January 20, 2009

Introduction

Today's presentation is based on data collected from the FOCUS database through the data warehouse. The queries were based on cases originally identified from Regions 1 and 2 who participated in a FGDM meeting between September 2005 and September 2007, which allows for at least a one year follow up period for all families.

There were 40 cases identified who participated in FGDM in these regions during this time period. The data collected on these cases had to be collected on a case by case basis including identifying additional family and child identifiers that were associated with the families that the original index children were associated with in the FOCUS database. The variables included demographic, CPS history, family assessment, care episode and additional service participation data. The PI merged the data into an Access database that he created to organize the data for analysis using SPSS. This report presents a preliminary analysis of data gleaned from the Immediate Risk and Safety Assessment data sets to partially demonstrate the structure of the final report. The PI has encountered unanticipated data management problems associated with multiple family identifiers and multiple children affiliated with each index child from the pool of FGDM cases. Creating effective algorithms for synthesizing these data and hand checking their accuracy is a time consuming effort that remains underway.ⁱ

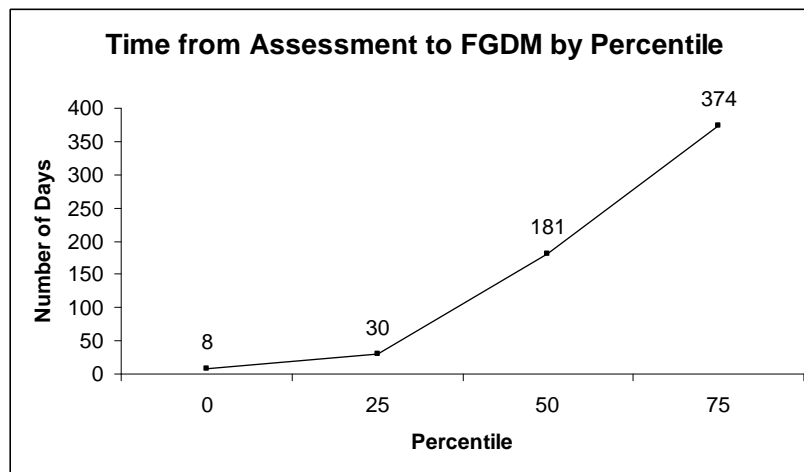
There were assessment data that were clearly associated with 27 families and 18 children to date and these numbers will increase as the PI continues to revise queries and algorithms. The data presented today, all from the assessment data set, include child and family characteristics, CPS history reviews, risk levels and immediate safety decisions from the assessments that were completed most closely in time before the families participated in FGDM services.

The assessment data are presented in this first briefing to answer the evaluation question of "Who are we targeting with FGDM services in Regions 1 and 2?"

Time from Assessment to FGDM

The time from the most proximal assessment preceding FGDM participation ranged between 8 and 2,014 days. Figure 1 displays the number of days between the most recent completed assessment and FGDM participation. As one can see from Figure 1 the median number of days between the most recent assessment and FGDM participation was 181 days, which means that families typically engaged in FGDM about six months into the life of their case. The figures for the lower percentiles reveal that a few cases were referred for FGDM earlier and the 75th percentile figure of 374 days shows that most cases had FGDM services within approximately one year of their case episode beginning. One can conclude from these data, using assessment dates as a proxy that FGDM services rarely occur early in the life of a case, which corresponds to what case managers reported in qualitative interviews with the PI.

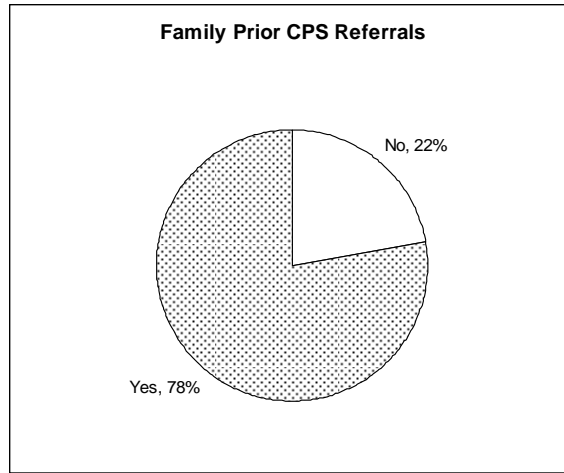
Figure 1. The number of days between the most recent completed assessment and FGDM participation.



CPS History Review

The CPS History Review component of the assessment reveals that a large majority ($n = 21, 78\%$) of the cases referred for FGDM had CPS referrals before their current contact episode. Figure 2 displays the proportion of FGDM families who had prior CPS referrals. These data indicate that FGDM services are being applied to cases that are familiar to the system and who present with more than low risk.

Figure 2. The proportion of FGDM families who had prior CPS referrals.



Family Risk Level

Of the 27 families with currently clear data there were 22 (81%) who were assessed at the “Moderate risk to higher” level using the Immediate Risk and Safety Assessment instrument. Figure 3 displays the proportion of FGDM families who were assessed at the “none to low” and “moderate to high” risk levels. These data coincide with the CPS history findings and support the conclusion that FGDM is not being applied differentially to lower risk cases.

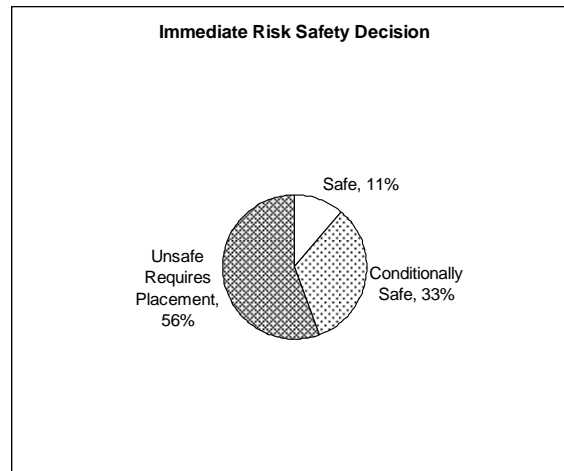
Figure 3. FGDM families’ assessed immediate risk levels.



Immediate Safety Decisions

The immediate safety decisions arrived at by DHW case managers using the assessment instrument are displayed in Figure 4. Of the 27 families with clear data 15 (56%) were identified as being unsafe and requiring placement and 9 (33%) were identified as being conditionally safe and requiring services; taken together 24 (89%) did not meet the standards to be assessed as providing safe environments for their children. These data further support the idea that DHW case managers are referring challenging cases to FGDM services.

Figure 4. Immediate safety decisions concerning FGDM families.

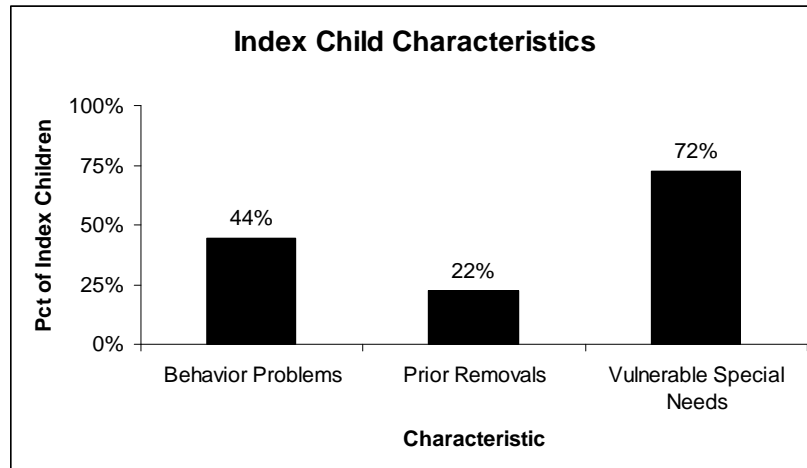


Child Characteristics

Child characteristics identified in the Immediate Risk and Safety Assessment that were included in this analysis included having behavior problems, having prior removals from their homes and being vulnerable or special needs children. The category of other characteristics was not applied because the nature of these characteristics could not be clearly identified from the data provided. Figure 5 displays the proportion of children with risk characteristics. As one can see in Figure 5 a large proportion ($n = 13$, 72% of 18 children with clear data) are vulnerable or special needs children and many ($n = 8$, 44%) have behavior problems. In addition to further indicating that FGDM is not being applied to relatively easy cases a more important finding emerges from these data; case

managers are recognizing the importance of natural supports for families whose children face special challenges.

Figure 5. The proportion of children with risk characteristics.



Family Characteristics

Family characteristics from the Immediate Risk and Safety Assessment are analyzed here in two ways: (1) The number of risk factors identified during assessment; (2) The proportion of FGDM families presenting with each risk factor. There are 18 specific risk factors included in the Immediate Risk and Safety Assessment that include both historical and immediate factors that affect the risk of continued child maltreatment.

The median number of risk factors that FGDM families presented with at assessment was six, within a range from none to 11 factors. Figure 6 displays the number of assessed risk factors of FGDM families by percentile. As one can see in Figure 6 the middle half of FGDM families presented with between four and seven risk factors, again indicating that FGDM is being applied to families with a range of safety risks.

Figure 7 displays the specific risk factors that FGDM families initially presented with. Risk factors that less than 25% of FGDM families presented with were excluded from this figure for the ease of the reader. As one can see in Figure 7 there were a mix of risk factors that these families presented with, ranging from basic neglect through violent behavior (37%) and severe allegations (59%). Two especially noteworthy factors emerged which were: (1) a large proportion of caregivers with mental or physical

Figure 6. The number of assessed risk factors FGDM families initially presented with.

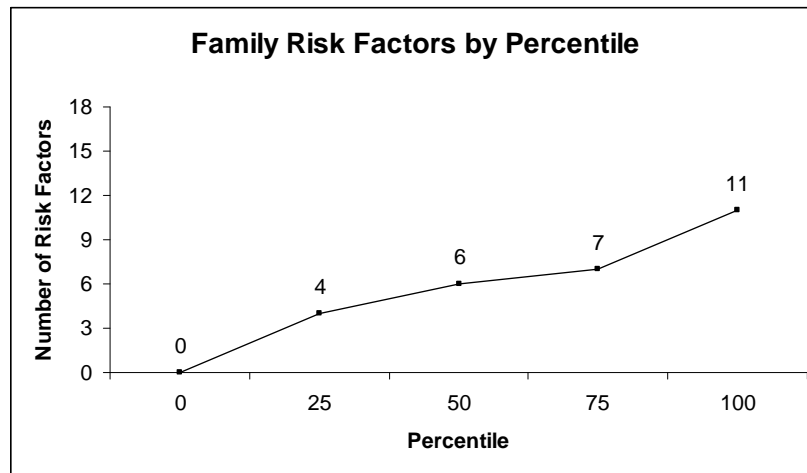
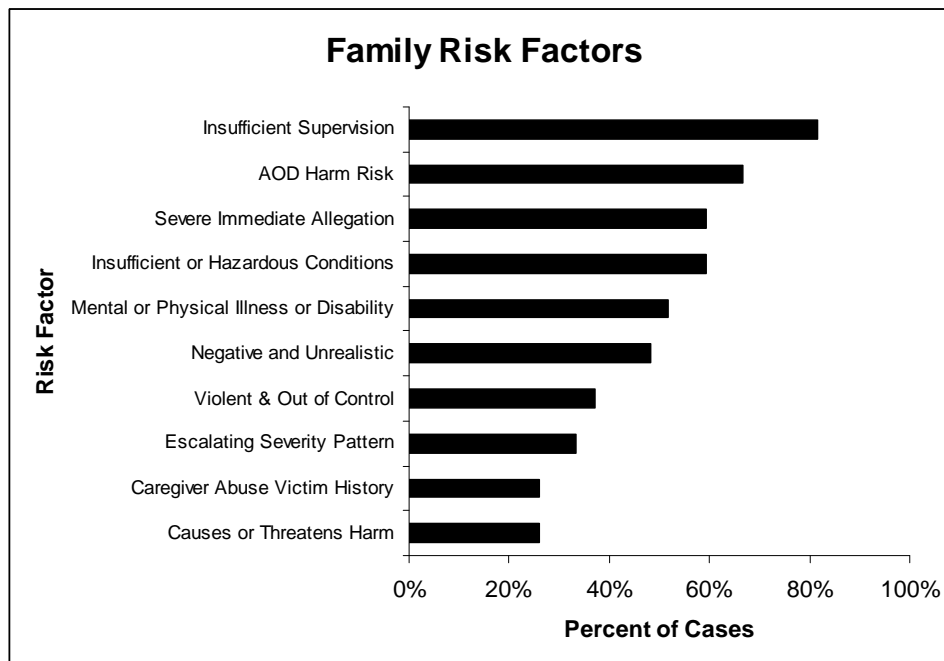


Figure 7. The specific risk factors that FGDM families initially presented with by percent of families.



illnesses or disabilities (52%); (2) a large proportion of caregivers with alcohol or drug (AOD) issues (67%). What makes these factors noteworthy is that DHW case managers seem to recognize the importance of natural supports for individuals who are challenged by illnesses or disabilities or are striving to recover from substance abuse. Additionally, there were very few families referred for FGDM who had immediate sexual abuse risk

(7%) or prior terminations of parental rights (11%) and none who had a child die under suspicious or abusive circumstances in their home. Taken together these data indicate that DHW case managers are appropriately recognizing the potential for FGDM to increase families necessary natural supports while avoiding using FGDM with very high risk families.

Conclusion

These data support the idea that FGDM is being applied with a broad cross-section of families who present with a variety of risks and needs, and who are typically at a moderate or higher risk level based on the Immediate Risk and Safety Assessment. When one considers the data about child and family characteristics it also becomes more clear that DHW case managers:

1. Understand the importance of promoting families natural support systems when they are confronted by mental illness, physical disability or challenging children's problems;
2. Are willing to apply FGDM with higher risk cases, which seem to reflect a commitment to the strengths and empowerment messages embedded in the Family Centered Practice Model.

As the data are further refined and analyzed the connection between these core values and outcomes will be able to be analyzed.

ⁱ For a more detailed discussion about the nature of the data problems being encountered and how they are being addressed please contact the principal investigator (PI):

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