Strong Families New York City

Final Evaluation Report

June 2019

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Background and Context

On January 1, 2014, New York State, through the Office of Child and Family Services (OCFS) formally entered into an agreement with the Children's Bureau to participate in the Title IV-E Waiver Demonstration Project. Under the Waiver Demonstration Project, participating child welfare systems are encouraged to test new ways of improving outcomes for children. Chief among those outcomes is a reduction in the number of days children spend in foster care – and in restrictive (and expensive) forms of foster care, in particular. That reduction in care day utilization ultimately translates into a cost savings for systems; under the Waiver, systems are able to take those savings and invest them in strategies designed to further improve outcomes for children.

New York State has a state-supervised, county-administered child welfare framework. The state's Waiver Demonstration Project was an initiative of the NYC Administration for Children's Services (ACS), and was implemented only in the five boroughs of New York City.

The design of the ACS Waiver Demonstration Project was informed by a needs assessment conducted by Dr. Allison Metz of the National Implementation Research Network. Strong Families NYC (SFNYC) sought to improve case practice and thereby permanency and child-being through lowered caseloads and supervisory ratios; a uniform assessment tool; and two evidence-based interventions, Attachment and Bio-behavioral Catchup (ABC, to improve caregiving and attachment) and Partnering for Success (PFS, to child welfare/mental health collaboration).

Specifically, ACS decided to make investments in the following areas:

Reduce caseloads for case planners. ACS provided support to the SFNYC-participating agencies to enable them to bring caseloads down to a ratio of 12:1, with 10 active cases and 2 "suspended pay" cases (such as children on trial discharge or otherwise no longer in 24-hour care) per case planner. This would allow case planners more time to provide high quality casework services to children and families. This shift towards reduced caseloads was one of the first SFNYC strategies that was initiated, beginning in January 2014.

Reduce supervisory ratios for supervisors. ACS also provided support to the SFNYC-participating agencies to enable them to bring supervisory ratios down, so that each supervisor would oversee the work of four case planners. This would allow for more frequent and higher quality supervision, as well as better clinical and administrative case oversight. The shift towards reduced supervisory ratios was also initiated in January 2014, alongside the reduction in caseloads.

Child and Adolescent Needs and Strengths – NY Version (CANS-NY). Beginning in 2014, private agency case planners and their supervisors were trained to use the CANS-NY as an assessment of child and family well-being and a decision/planning support tool. The CANS-NY is intended to help agency staff identify specific areas where children, youth, and families could use additional support, so that service referrals best fit families' actual needs.

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Partnering for Success (PFS). A model for improving both caseworker competencies and the relationship between child welfare and mental health providers, PFS helps critical service providers use a common, evidence-based, trauma-informed approach (CBT+) to working with children, youth, and caregivers (parents and foster parents). Training in PFS began in the second half of 2015 and continued through the spring of 2016.

Implementation Findings

ACS set out to implement a number of strategies under SFNYC, strategies that involved the deep engagement and coordination of a number of system stakeholders, such as senior leadership at 17 different private agencies; staff within various ACS divisions; foster care supervisors and case planners; and, foster parents.

- Within nine months of initiating the ***caseload reduction***, almost all of the SFNYC agencies were following the new caseload requirements. For the most part, the SFNYC agencies have sustained the reduced caseloads over time.

- Over the course of SFNYC, case planners reported more negative perceptions of ***supervision***, increased feelings of overwhelm, and higher levels of burnout amongst supervisors, despite caseload reductions. While these findings are worthy of follow-up, we caution that the response rate to the survey in which case planners and supervisors were asked about these issues was very low, with less than half of the workforce participating.

- Since the ***CANS-NY*** went live, approximately two-thirds of children who have been admitted to an SFNYC agency and placed in regular family foster care have had at least one CANS-NY completed. Almost all children who were eligible for a reassessment CANS-NY have had one completed on their behalf.

- More than 500 children have completed a course of ***ABC***. Caregivers who participated in ABC exhibited significant improvements in ABC-relevant skills, such as following the lead, recognized intrusive behaviors that may be frightening to a child, and assessing a child's development and behavior problems.

- ACS adapted the National Center for Evidence Based Practice in Child Welfare's model, ***Partnering for Success***, and developed the capacity for the Workforce Institute to house and deliver the training to both child welfare and mental health staff.

Impact Findings

- The caseload reduction, as an intervention, was found to have a significant, positive effect on permanency outcomes. Exit rates increased by 9 percent during the post-caseload reduction period compared to the period prior to the caseload reduction.

- The total number of care days used by each of the five SFNYC entry cohorts is markedly lower than the number of care days used by a historical comparison group.

- Children admitted in 2015, 2016, and 2017 used fewer care days, on average, than children in the historical comparison group.

- There are signals that the reentry rate for babies is on the decline. There is still year-to-year variability, but the overall trend is in the right direction.

Cost Study Findings

- Despite a reduction in out-of-home board and maintenance expenditures, total child welfare expenditures increased, largely due to increased funding directed toward preventive and in-home services.

- The average daily out-of-home unit cost rose during the Waiver period, largely due the rising costs of residential care. However, NYC reduced overall out-of-home expenditures during the SFNYC period, primarily by reducing the *quantity* of care provided.

Future considerations

ACS has engaged in a methodical and deliberate process, co-facilitated by Chapin Hall and the National Implementation Research Network, whereby the implementation and impact of each component of SFNYC was interrogated singly, with an eye toward future sustainability. The discussions involved senior leadership within ACS and were driven, to the extent possible at the time, by scientifically-derived evidence. The discussions also included – again, to the extent possible at the time – feedback from the private agencies on the frontline of the implementation effort.

Not surprisingly, there was near unanimous consensus around the value of sustaining reduced caseloads. Not only is there a shared feeling that smaller caseloads are be better for children and families, the evaluation actually found that smaller caseloads *do* make a difference for children and families, specifically in the way of permanency outcomes.

While a lot of headway was made in the implementation of the CANS-NY, there is yet work to do in terms of staff in the field seeing the value-add of the tool.

The process by which to refer children and their caregivers to ABC was honed over the past two to three years. We see evidence of that in the nearly 1,000 children who were referred to ABC and the over 500 children who, as of June 30, 2018, had completed the training along with their caregiver. At the same time, the agencies have the potential to achieve higher referral rates. While the obstacles in the referral process are fairly well known, the way around those obstacles are still coming into focus for ACS and the providers. Like with the caseload reduction, the providers and ACS seem to agree on the value of ABC. Furthermore, there is early evidence that ABC is having its intended effects, at least on caregiver skills.

Partnering for Success was probably the component of SFNYC that experienced the greatest implementation challenge. Engaging mental health practitioners proved extremely difficult. Across agencies, child welfare case planners and supervisors participated in elements of PFS training at a much higher rate than mental health practitioners, it was not common for case planners, at least, to see the PFS training through to its full completion to obtain certification.

It is difficult to comment with confidence on the extent to which children suffering from depression, anxiety, behavior problems, and/or trauma are receiving CBT (or some other

evidence-based treatment), as intended by the PFS approach. Case planners are not yet entering information into the dedicated automated data tracking system on a regular enough basis for ACS to draw conclusions about practice in this area.

Implementing new ideas in the oft-times temperamental environment that is child welfare services is, in nearly all cases, a difficult thing to do. It takes commitment and time – more time than is usually available. ACS has already seen some of the investment made under SFNYC pay off in real terms (caseload reduction) in the few years available under the IV-E Waiver Demonstration Project. If the objective of the Waiver demonstration project was to reduce total and average care day utilization, then under SFNYC, ACS has certainly achieved that objective. More so, ACS has created an environment in which evidence rules the day. It's the driving force in conversations about the problems in which ACS should invest, the actual investments to make, and the extent to which those investments are having their intended effects. It's reflective of an overarching commitment to doing what works for children and families.

Introduction and Overview

Background and Context

On January 1, 2014, New York State, through the Office of Child and Family Services (OCFS) formally entered into an agreement with the Children's Bureau to participate in the Title IV-E Waiver Demonstration Project. Under the Waiver Demonstration Project, participating child welfare systems are encouraged to test new ways of improving outcomes for children. Chief among those outcomes is a reduction in the number of days children spend in foster care – and in restrictive (and expensive) forms of foster care, in particular. That reduction in care day utilization ultimately translates into a cost savings for systems; under the Waiver, systems are able to take those savings and invest them in strategies designed to further improve outcomes for children.[1]

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Specifically, ACS decided to make investments in the following areas[2]:

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[1] New York City has been the primary participant in the IV-E Waiver Demonstration Project in New York. The public child welfare system in New York City is the Administration for Children's Services, known as ACS. The child welfare system in New York is a state run, county-administered system.

[2] The SFNYC logic model was unveiled in the first quarter of 2015. Updates to the Initial Design and Implementation Report (IDIR) and evaluation plan were submitted in April/May of 2015 and approved by the Children's Bureau in June 2015.

quality supervision, as well as better clinical and administrative case oversight. The shift towards reduced supervisory ratios was also initiated in January 2014, alongside the reduction in caseloads.

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Evaluation of the Waiver Demonstration

Broadly speaking, the purpose of the SFNYC initiative is to reduce lengths of stay and improve well-being outcomes for children in foster care. The focus is on children placed in regular family foster care. Children and youth placed in treatment foster care, specialized/medical foster homes, and residential treatment centers are outside the focus of the initiative.

Our key research questions are organized around the three facets of the evaluation:

Implementation Study

1. To what extent are SFNYC strategies implemented with adherence to original Waiver-specific strategic plans?
2. To what extent are Waiver strategies implemented with fidelity (following model protocols)?
3. What associations exist between (a) staff attitudes about child welfare work, their jobs, and SFNYC strategies, (b) adherence to SFNYC plans, (c) implementation fidelity, and (d) worker time use?

Outcomes Study

1. What is the impact of SFNYC on the number of care days used, on average (both for children who enter placement after the implementation of SFNYC as well as children in-care at the time SFNYC is implemented)?

2. What is the impact of SFNYC on the likelihood that children will experience a permanent exit within set periods of time?

3. What is the impact of SFNYC on the likelihood that children will experience reentry?

4. To what extent are target children participating in the appropriate SFNYC interventions; namely, Attachment and Biobehavioral Catchup and Partnering for Success?

Cost Study

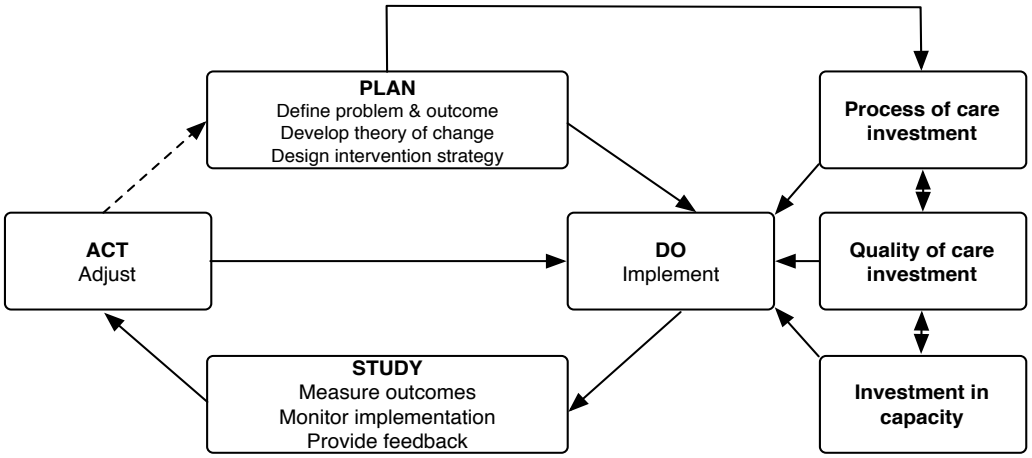
1. What effect does SFNYC have on child welfare expenditures in NYC?

2. What are the costs of the SFNYC services received by children and families?

The evaluation framework

In the Interim Evaluation Report, we discussed our evaluation framework as one rooted in what we have termed the Continuous Quality Improvement Evaluation Framework (CQI/EF). Briefly, the CQI/EF stresses state-of-the-art methodology (the technical aspects of which are described in later sections) whereas the CQI component acknowledges the need to provide meaningful, formative feedback to stakeholders who are working with children and families. The evaluation framework overcomes the methodological weaknesses of many CQI models; the CQI framework manages the need for actionable knowledge well before the summative evaluation is complete.

Figure 1. *Continuous Quality Improvement Evaluation Framework*



Again, the CQI/EF was discussed in some detail as part of the Interim Evaluation Report. Inarguably, most of Chapin Hall's effort over the last few years has been in the PLAN and STUDY phases (see Figure 1). The theory of change that undergirds the SFNYC initiative (PLAN) is referred to again and again throughout the Final Evaluation Report. Similarly, as we discuss what we've learned about the implementation and impact of SFNYC, we return to the problems that ostensibly served as the catalysts for the various investments made under SFNYC (PLAN). As to the STUDY phase, where most of Chapin Hall's work has concentrated, we would underscore here our commitment to the priority concepts in measurement that are, in many respects, the foundation of all of the work done by the Data Center.[3] These priority concepts, listed below, show up not only in the evaluation work detailed throughout the pages of this Final Evaluation Report, but surfaced time and again during the technical assistance and support

[3] The Center for State Child Welfare Data (the Data Center) is a partnership between state child welfare agencies, Chapin Hall at the University of Chicago, the American Public Human Services Association, and the Center for Social Services Research, University of California at Berkeley. Core support for the Data Center comes from the Annie E. Casey Foundation and Casey Family Programs.

activities in which Chapin Hall participated through the course of New York's Waiver, particularly during the last six months during which conversations about impact and sustainability were front and center.

1. **Know your question**. Measurement starts with a question; the question being asked points to the appropriate approach to measuring change.

2. **Stock and flow**. The only way to change the characteristics of the children you have in care now is to change how children enter and exit. When measuring the impact of an intervention, you need to think differently about the children already in care when your intervention goes live (stock) and the children who enter care at some point after the intervention is in place (flow). We take this approach when talking about the impact of SFNYC strategies (caseload reduction and ABC, specifically) on permanency. We also separate out the stock and the flow when looking at system-wide trends.

3. **Know the population from which you are measuring**. The choice of population depends on the question you're trying to answer. While the population for SFNYC, broadly speaking, includes children in regular family foster care being served by any of the 17 participating foster care agencies, the population shifts when measuring change in relation to specific interventions. For example, for ABC we are measuring change in permanency outcomes for children who were between the ages of 6 to 48 months at some point during their time in care. For CANS-NY implementation we are looking at children who spent at least 30 consecutive days with a provider agency before looking for the presence of a CANS-NY assessment.

4. Almost always, **use an entry cohort** to answer questions about typical performance. In the Outcomes Study, all system-wide measures are considered longitudinally, using entry cohorts. The one exception is reentry, for which we use exit cohorts.

5. **Working with parameters**. A parameter is a number that characterizes a population. Parameters can be used to describe baseline outcomes and, as such, can be used to predict future performance. We use historical parameters as a way to help us make assessments as to whether performance trends during the SFNYC period have improved.

6. **Know your data and organize it well**. This involves understanding the variables available to you in the databases that serve as the seed files of the analysis, as well as the date through which activity is reflected (the censor date). It also involves using an event structure to organize data, so that events (admission, placement change, exit, reentry) are stacked in time.

7. **Use of likelihood**. Looking at likelihoods, or probabilities, helps see how the odds of something happening – children exiting to permanency, for example – have changed over time.

8. **Identify the window**. Reform can only affect that which has yet to happen. We use this structure when looking at care day utilization.

9. **Stratify**. Establishing diagnostically relevant groups helps in identifying variation in performance. In this report, we stratify by child age at the time foster care began, the amount of time children spent in care prior to SFNYC (for the in care group), and by entry cohort year (for the admissions group).

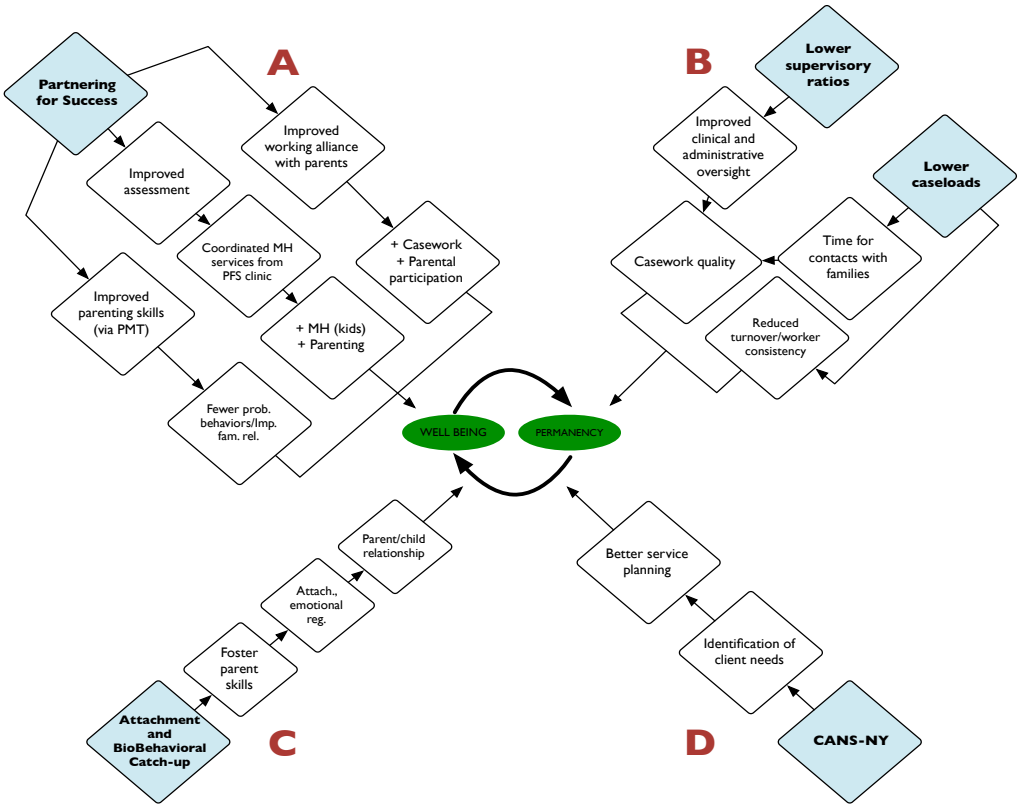
Orientation to the Final Evaluation Report

Chapin Hall produced a comprehensive Interim Evaluation Report in 2016. In many ways, the Final Evaluation Report serves as an update to that document. By and large, the structure of this report is the same as the structure used for the Interim Evaluation Report. Major headings and subheadings have been retained. There may be fundamental sections, such as the section on the theory of change for SFNYC, that we have retained in its entirety, as that material remains unchanged from November 2016 to the present. Otherwise, we summarize findings relayed in the Interim Evaluation Report to make room for updated information that speaks to activities that have transpired since November 2016, when the Interim Evaluation Report was issued. The Interim Evaluation Report will be sent along with this report for ease of reference.

Theory of change/logic model

The SFNYC logic model is presented in Figure 2 (below). The model is intended to depict how the statistical modeling of effects will likely unfold.

Figure 2. *The Strong Families NYC Logic Model*



As the graphic depicts, all roads lead to the middle, where we find the recursive feedback loop between well-being and permanency, both of which are expected to improve as a result of the various strategies. The relationship between permanency and well-being is reciprocal: in some instances, the improvement in well-being is what 'leads to' better permanency outcomes. In other instances, it is the establishment of permanency that enhances well-being. The boxes that lead from the investments (shaded in blue) to the outcomes (well-being, permanency) speak to the indicators of fidelity – that the models are being implemented (and playing out) as expected.

The outcomes associated with the changes proposed under SFNYC are explicated in the pages that follow.

System-Wide Structural Changes

Reduced caseloads and shifts in supervisory ratios are hypothesized to have their own direct effects on permanency and stability. Lower caseloads provide an opportunity for caseworkers to spend more time with each case. This additional time can be spent more closely monitoring the stability of children's placements, so that difficult situations that might have otherwise escalated to the point of placement disruption can be diffused and placements preserved.

The additional time caseworkers can dedicate to each case will also help with permanency planning. Caseworkers will have more time to spend with birth parents, during which they can provide a deeper level of support for their planning efforts. When parents remain attached to their children and supported by attentive caseworkers, *the likelihood of reunification will increase*. In line with the principles of concurrent planning (per ASFA), caseworkers can also reinforce the relationships being developed between children in care and their foster homes. Developing pre-adoptive homes early can help *expedite the process of adoption* when reunification is no longer the primary permanency goal.

CANS-NY

The CANS-NY will be used as the primary measure of well-being. The CANS-NY domains (each of which contains various sub-scales) of particular interest include:

1. Child/Youth Medical Health Domain
2. Child/Youth Behavioral Health Domain
3. Child/Youth Substance Abuse Domain
4. Child/Youth Developmental Domain
5. Child/Youth Adjustment to Trauma Domain

The CANS-NY is expected to help case planners better identify what clients need to resolve the safety concerns that led to the need for foster care. As a result, service planning will be enhanced (quicker linkage to appropriate services, etc.).

Partnering for Success

Partnering for Success (PFS) is hypothesized to help reduce the number of care days used and improve well-being through the following process:

Case planners will be trained in the use of the CANS-NY with a particular focus on scales related to mental and behavioral health of the child. Better child assessments will lead to appropriate referrals to PFS-trained clinicians, which will result in better mental and behavioral health for children. As a result of caregivers' participation in children's mental health treatment, parenting skills will also improve.

Case planners who are trained in the PFS model will learn how to better talk about and engage family members in mental health services and more effectively use evidence-based and trauma-informed treatment modalities. Specifically, PFS training teaches case planners how to:

1. **Screen** children for mental and/or behavioral health service needs

2. **Target** particular problems for focused treatment

3. **Link** children with appropriate (i.e., evidence based) mental and/or behavioral health treatment

4. **Engage** caregivers (foster parents, biological parents) in the process of treatment

5. **Collaborate** with mental health clinicians around treatment plans and recommendations as well as

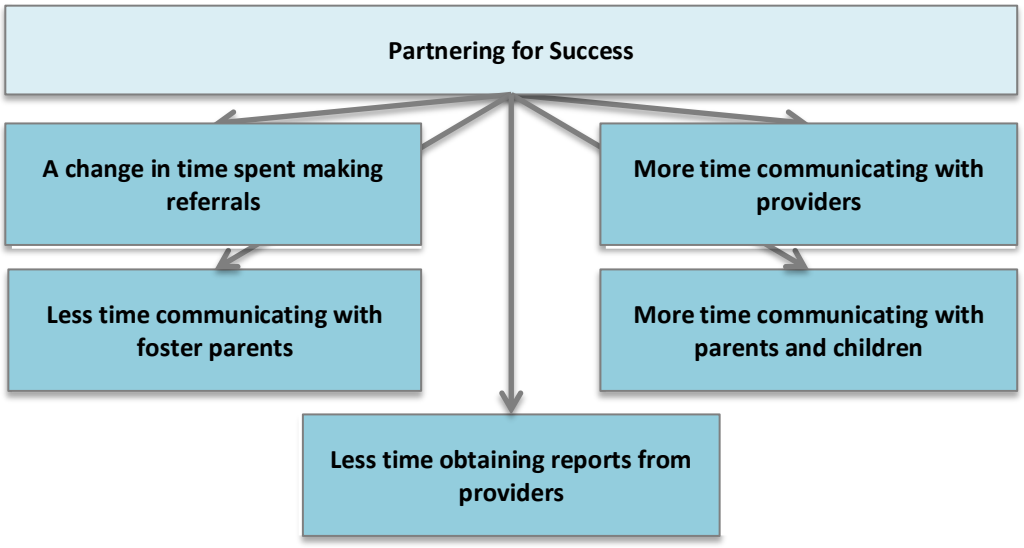
6. **Monitor**, in partnership with mental health clinicians, children's progress towards treatment goals

7. **Support** the process of treatment by infusing interactions with children and caregivers with elements of treatment models, specifically CBT+

The PFS training described above should improve the extent to which children who need mental health treatment will actually get it, and with the support of caregivers.

Further, PFS may have effects on the way in which caseworkers use their time. Figure 3 depicts some of these potential shifts.

Figure 3. *Hypothesized effects of PFS on worker time use*



Because of the enhanced, collaborative nature of the working relationship between child welfare case planners and mental health practitioners, case planners may find they are spending more time communicating with providers – be it about case goals, progress, or techniques being used in clinical sessions or in the home to help reduce problem behaviors and increase caregivers' coping skills. However, we would expect to see case planners spending less time tracking down treatment progress reports. PFS may also position case planners to spend more time communicating with parents and children , and less time communicating with foster parents, who may find themselves in crisis less often given the practical, evidence-based support they'll be receiving, not only from the mental health practitioner but from the case planner as well.

It is unclear if case planners will wind up spending more or less time making referrals to mental health practitioners on behalf of children in care. On the one hand, case planners may find it easier and quicker to make this kind of service referral, given the partnerships expected to be established between caseworkers and mental health practitioners during the joint PFS training. On the other hand, if agencies are truly prioritizing referrals to CBT+ trained practitioners and there isn't enough capacity on the mental health side, making service referrals could wind up taking longer.

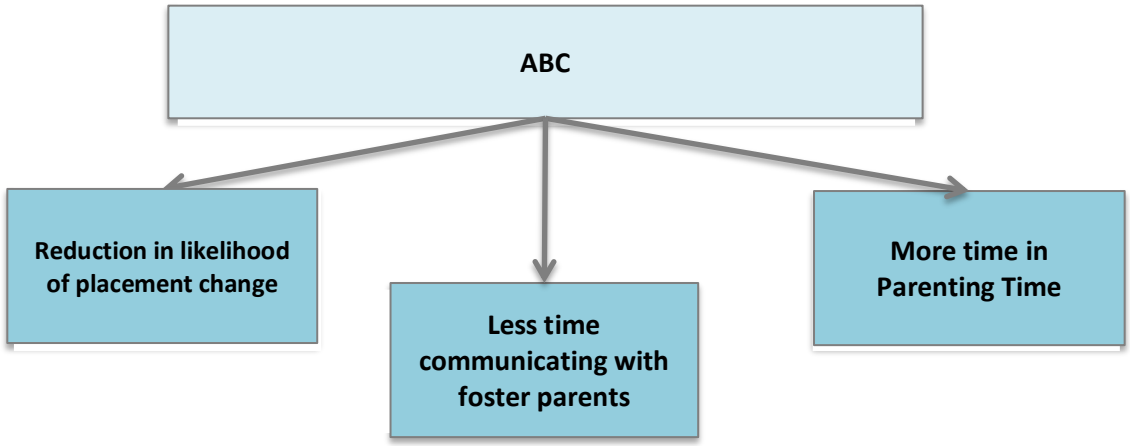
Attachment and Bio-Behavioral Catch-up

ABC is expected to reduce the utilization of care days and improve well-being as follows:

Participation in ABC will lead to an increase in caregiver skills. When caregivers are better able to respond to young children's verbal and non-verbal cues, children are better able to form secure attachments to caring adults and, as a result, to regulate their emotions – a vital skill for developing and sustaining relationships.

There are also hypotheses related to the ways in with ABC may affect the way caseworkers use their time on the job:

Figure 4. *Hypothesized effects of ABC on worker time use*



As Figure 4 depicts, the support and enhanced skills caregivers receive via ABC may have the effect of reducing placement changes. This is not only better for children but it also frees up valuable casework time, as each individual placement change takes a certain number of hours to execute (with higher order placement changes typically taking even more caseworker hours). Caseworkers may find they spend fewer hours offering support and counsel to foster parents, who may be better able to manage the young child placed in their home after receiving parenting and attachment coaching from an ABC parent coach. Lastly, caseworkers may find they spend more time supporting families during parenting time. Part of the underlying theory of the specific roll-out plan of ABC in the case of SFNYC is that children's increased capacity to attach and positively relate to caregivers will transfer from their foster parent to their parent. More positive parent/child interactions during family time will be reinforcing for the parent. It may, the thinking goes, have the effect of increasing parents' commitment to family time.

Data sources and analytic plans

In the sections that follow we provide details on the data sources, data collection methods, and analytic methods that were used to answer the key research questions posed earlier in this report.

Implementation study

A range of qualitative methods were used to monitor the development of SFNYC and to understand whether caseload reductions, improved supervisory ratios, the integration of the CANS-NY into case practice, and the implementation of ABC and PFS influence behaviors in the expected ways.

Content Analysis: Planning and Implementation

Chapin Hall staff reviewed written materials related to pre-implementation decision-making, such as key findings from focus groups and the case record review, data products, and any other written material that served to document the process through which EBIs were selected, implemented, and monitored.

Structured interviews, Focus Groups, and Online Surveys: Implementation Attitudes

Key stakeholders from the provider agencies implementing SFNYC were engaged in various ways over the course of the evaluation. The following topics were addressed:

1. Case skills (technical and interpersonal)
2. Job satisfaction, intent-to-leave, and workload
3. Supervision
4. Organizational culture and climate
5. Availability of services to meet client needs
6. Attitudes on reunification and the role of well-being in permanency decisions
7. Attitudes about specific SFNYC investments, such as the CANS-NY, Partnering for Success, and ABC

Fidelity: Worker Time Use

The process for estimating the amount of time caseworkers spend on casework activities (all of the tasks associated with their job) started with a series of focus groups, in which caseworkers and supervisors provided estimates of the number of minutes it takes to complete various casework tasks. Eight focus groups were held (each at a different private agency) in order to ensure each casework category was covered twice - and by staff at various agencies.[4]

The time use estimates that emerged from the focus groups informed the construction of a survey that was administered to all front-line casework staff and supervisors in the 17 agencies participating in SFNYC. In particular, the focus groups helped ensure the reasonableness of the answer options and the correct wording of questions. Ultimately, the survey allowed for the production of time use estimates that are organized around the eight core processes or sections of casework that together make up the total set of case-specific activities for which caseworkers are responsible.

Administrative data: Fidelity of EBI implementation

The evaluation is fortunate to have at its disposal automated systems for tracking referrals to both Partnering for Success and ABC. As to PFS, ACS maintains an electronic data management system whereby case planners can enter information about children's mental health needs directly into the system, which informs eligibility and referral decisions related to PFS. Those data can be linked to CANS-NY data as well as to the seed analytic files (child and agency spell data) that

[4] Harriet Ward and colleagues at Loughborough University in the UK originally developed the time use methodology being employed in this study. It has been adapted for use in the US, first in California and Oregon and now in Tennessee, New York City, Michigan, Oklahoma, and two counties in California. For more details we would refer you to the following paper: Chamberlain, P., Snowden, L.R., Padgett, C., Saldana, L., Rolls, J., Holmes, L., Ward, H., Soper, J., Reid, J. & Landsverk, J. (2011). A strategy for assessing costs of implementing new practices in the child welfare system: Adapting the English Cost Calculator in the United States. *Administration and Policy in Mental Health, Vol. 38*, p. 24-31.

serve as the foundation for much of the analytic work Chapin Hall does on ACS' behalf (see description in the following section). Ultimately, these linked files allow for a full tracking of (1) children who would be considered eligible for CBT+, given their CANS-NY scores, (2) caseworkers' decision-making as it relates to making referrals for CBT+, and (3) actual referrals to PFS-trained clinicians, who are trained in the provision of CBT+.

Power of Two, the organization with whom ACS has contracted to provide ABC services to foster parents, biological parents, and young children, maintains their own database that includes identifying information about caregiver/child participants, program participation, and coach fidelity scores.[5] Power of Two shares these data with ACS, who then attaches to each caregiver/child dyad observation a child ID that can then be linked back to the source child/agency spell files. Then, as above, the evaluation team can consider (1) children who would be deemed eligible for participation in ABC, (2) children referred for ABC, (3) children who actually received ABC, and (4) progress for those children who received ABC.

Outcomes study

The available data allow for the development of a child/agency specific data file that extends as far back as 1998. Using these seed databases, we developed an agency specific person-period data file that records the time each child spends with a specific agency. The agency specific spells (or episodes) are divided into time intervals of a given length (3-month person periods are a starting point). Each person period has associated with it a series of flags indicating whether (or not) certain events occurred within the period, notably exposure to an evidence-based intervention and discharge from the agency. The underlying statistical model evaluates the log odds of exit; the SFNYC effect is captured by whether person-periods that include SFNYC (i.e., during which caseloads were reduced and/or the presence of EBIs) are more likely to end with an exit to permanency. The person period model can be extended to incorporate a multi-state, competing risk framework.[6]

This approach allows for the effect of the various SFNYC components to be evaluated singly given that SFNYC components were phased in separately. That is, the structural changes were introduced at the start of Waiver Year 1 (caseload reductions); CANS-NY was introduced mid-way into Year 1.[7] Partnering for Success and ABC were phased-in during Year 2. However, the *actual* timing of caseload reductions and at-scale implementation are an important factor when considering the extent to which the roll-out of SFNYC model components were really separate enough in time to allow for independent analyses.

Because children are clustered within an agency, we account for the nested structure using a multi-level model. In the unconditional model, the level-one intercept is the average rate of exit to permanency, as one example. The multilevel model produces properly weighted estimates of the exit rate (to account for the fact that large agencies contribute more information). Addition of

[5] Not every case (caregiver/child dyad) is subjected to fidelity monitoring. Power of Two selects a small number of cases across a coach's caseload for fidelity monitoring.

[6] Steele, F., Goldstein, H., & Browne, W. (2004). A general multilevel multistate competing risks model for event history data, with an application to a study of contraceptive use dynamics. Statistical Modeling, 4(2), 145–159.

[7] Caseloads will be reduced through reductions in each agency's census. Agencies were expected to demonstrate an 11 percent reduction in their census in Waiver Year 1, and an additional 6 percent reduction in Waiver Year 2.

the SFNYC effect shows the impact of SFNYC on the average rate. Adding time covariates (i.e., indicating the year during which the interval was observed), controls for any trends in the underlying data as well as other contemporaneous factors present in or affecting the child welfare system that are unrelated to the implementation of the SFNYC initiative.

SFNYC targets all children between the ages of 0 and 21 placed in regular family foster homes supervised by a subset of 17 contract foster care agencies. The sample includes the children in care at the start of SFNYC (the legacy caseload, referred to above as the "stock") and all admissions involving children entering family foster care (the "flow"). The agency-specific, person periods provide a concise way to introduce SFNYC components at the specific time it occurs. For the legacy caseload, this method addresses the fact that children will be at different points in their placement history. Because the log odds of exit differ with respect to how long children have been in care, the person periods assess the treatment effects after controlling for the timing of the treatment.

As a general matter, the analysis will use an intent-to-treat design to understand treatment effects in practice. An Intent-to-Treat (ITT) approach requires that everyone assigned to a SFNYC agency be included in the analysis of treatment effects, regardless of refusal, noncompliance, protocol deviations, withdrawal, or anything else that interferes with post-selection uptake of treatment. ITT analysis avoids biased estimates of the efficacy of an intervention resulting from the removal of non-compliers by accepting that noncompliance and protocol deviations are likely to occur in actual practice. As a consequence, in ITT analysis, the estimate of the treatment effect is generally conservative because of dilution attributable to the non-compliance of individuals assigned to the intervention group.[8]

Cost study

The NYC Cost Study database represents all child welfare related expenditures for three and a half years prior to the Waiver and for each of the five years during the Waiver. The database's structure contains the flexibility to compare financial data across fiscal years, and within specific expenditure categories. The NYC Cost Study's analysis integrates fiscal data from three city and state claiming systems and begins by categorizing costs into four major categories: Direct City Administration, Purchased Out-of-Home, Guardianship and Adoption, and Purchases In-Home. Trends in expenditures over time are explored within these categories. Additional analysis is conducted to understand the structure and trends specifically within the Purchased Out-of-Home expenditure category.

The SFNYC Cost Study database was fully populated using information provided to researchers by ACS fiscal administrators. Using the data available to date, researchers examined the following dependent variables:

1. Child welfare expenditures
2. Paid care days
3. Average daily out-of-home unit cost

[8] Brown, C. H., Wang, W., Kellam, S. G., Muthén, B. O., Petras, H., Toyinbo, P., et al. (2008). Methods for testing theory and evaluating impact in randomized field trials: Intent-to-treat analyses for integrating the perspectives of person, place, and time. *Drug and Alcohol Dependence, 95*, S74–S104.

For each dependent variable listed above, we present the indicator across eight and a half fiscal years. Since NYC's Waiver went into effect on January 1, 2014, available cost data covers three and a half years prior to the Waiver and the full five years of activity since the Waiver was implemented. For each dependent variable, we also present the Waiver change – calculated by looking at the percent change from FY 2013 (the last full fiscal year prior to the start of the Waiver) to FY 2018 (the last full fiscal year under the Waiver). Although projected annual FY 2019 values are displayed, these projections could be impacted by seasonality and are not used to measure Waiver change.

Sampling plan

The nature of the sampling plan varies somewhat depending on the component of the SFNYC initiative under consideration. For the most part, the sampling plan for the evaluation follows what was previously laid out above, in the section related to the methodology for the outcomes study. That is, for population-level/ITT analyses we will include in the 'treatment condition' the experiences of all children in the SFNYC group (children age 0 to 21 placed in regular family foster care in one of the 17 SFNYC agencies), giving consideration to whether a given child was already in care at one of the SFNYC agencies when the SFNYC initiative began or whether a given child was admitted to care at one of the SFNYC agencies on or after the date the SFNYC initiative got underway.[9] We compare children over time, looking separately at entry cohorts (historical entry cohorts (2010 through 2012) compared to SFNYC-period entry cohorts) and in-care groups (historical in-care groups (2010 through 2012) compared to the single SFNYC-period in-care group).

Methodologically, we are focusing on agency spells, not child spells. A single child spell may be comprised of any number of agency spells. If a child enters care and exits care and never leaves the custody of the agency, then that single child spell is comprised of a single agency spell. If a child enters care at a certain agency, transfers to another agency, then transfers to another agency from which they ultimately exit care, that single child spell would be comprised of three agency spells.

Limitations

Of course, in any major evaluation effort there are bound to be obstacles of one sort or another – some foreseeable, others less so. The major logistical challenge we confronted in the evaluation of SFNYC was coordinating evaluation activities across 17 different contracted foster care agencies. Because of Chapin Hall's long history of working with ACS and its network of private providers, Chapin Hall researchers have, over the years, established fairly good working relationships with senior staff at many of the agencies participating in SFNYC – staff who tend to be designated as point-people ("program champions") for the implementation of initiatives such as SFNYC. However, these individuals are almost always staff who have significant responsibilities outside of coordinating/overseeing the agency's implementation of new initiatives. As such, their ability to be responsive to evaluation-related requests was at times constrained.

[9] Because the caseload reductions were introduced right from the start and is not attached to any specific eligibility criteria (as in the case of ABC, which targets younger children), we can use as the SFNYC 'go live' date January 1, 2014.

Implementation Study

The Implementation Study set out to address three key research questions:

1. To what extent are SFNYC strategies implemented with adherence to original SFNYC-specific strategic plans – or, more specifically, to the underlying theory of change?
2. To what extent are SFNYC strategies implemented with fidelity (following model protocols)?
3. What associations exist between (a) staff attitudes about child welfare work, their jobs, and SFNYC strategies, (b) adherence to SFNYC plans, (c) implementation fidelity, and (d) worker time use?

Data Sources and Data Collection

Different data collection mechanisms were used to understand the implementation of the various components of SFNYC. For example, we conducted interviews with child welfare staff and mental health staff at PFS-participating agencies, during which questions were specific to the issue of PFS. A series of 16 focus groups were conducted at eight different provider agencies that were specific to the issue of CANS-NY implementation. The General Staff Survey and the Time Use Survey ask questions that speak to caseload reductions as well as experiences with implementing PFS, ABC, and the CANS-NY.

The main data collection activities undertaken as part of the process study are described below, and fall into four overarching categories: surveys and questionnaires, interviews, focus groups, and documentation review.

Surveys and Questionnaires

Four different instruments will be covered in this section: (1) a survey of worker time use, (2) a survey of worker/supervisor attitudes about/perspectives on a range of topics related to their work and SFNYC, (3) the Ages and Stages Questionnaire, and (4) the Brief Infant Toddler Social Emotional Assessment.

Time Use Survey (TUS)

The TUS was first administered to case planners and supervisors at all SFNYC agencies in the summer of 2015, and then again in March 2019. Prior to each administration of the TUS, Chapin Hall coordinated with ACS as well as their contacts at each of the 17 SFNYC agencies. The coordination was designed to make sure senior staff were aware of the upcoming survey and to help senior staff communicate about the survey to case planners and supervisors. Chapin Hall provided ACS and the agencies with language to send to staff to help encourage participation and answer any questions about the survey. Chapin Hall also instituted a "contest" of sorts: any agency that achieved at least an 85 percent response rate was rewarded with an agency-wide pizza party. Staff had approximately three weeks to respond to the survey, during which time multiple reminders about the survey were sent.

A total of 395 staff members from across 17 private provider agencies participated in the first administration of the TUS. This accounted for 53 percent of recruited staff. A total of 328 staff members from across 17 private provider agencies participated in the second administration of the TUS. This accounted for 61 percent of recruited staff.

General Staff Survey (GSS)

The GSS was administered to case planners and supervisors at all SFNYC agencies at three points in time: in the fall of 2015, in March 2017, and in April 2019.

A total of 429 staff members participated in the GSS1, representing an overall response rate of 58 percent. 404 staff members participated in the GSS2, for a response rate of 61 percent. The GSS3 had 227 staff participants, with a response rate of 43 percent. For each administration of the GSS we rely on staff from the private agencies to provide us with up-to-date staff rosters. Interestingly, the number of staff we invited to take the GSS for the third administration was notably smaller than in previous administrations of the GSS. It is unclear why that is, particularly in light of the caseload reductions, which would point to an increase in staff, not a decrease. However, the more important issue from an evaluation perspective is the response rate: less than half of those invited to take the GSS in 2019 completed the survey.

Recruitment methods for each administration of the GSS were essentially the same as those described just above with respect to the Time Use Survey. The Chapin Hall team coordinated with ACS and the program champions from each of the SFNYC agencies. Staff were given ample time to respond to the survey (about three weeks for each administration of the GSS), with multiple reminders sent out during that period. Again, a contest was instituted to try and encourage staff participation in the survey. Table 1 displays the response rates to each of the GSS surveys, by agency.

Table 1. *General Staff Surveys 1, 2, and 3: Response Rates, by Agency*

	GSS1		GSS2		GSS3	
Agency	Number participated	Response rate	Number participated	Response rate	Number participated	Response rate
Abbot House	19	86%	13	68%	8	73%
Cardinal McCloskey	20	77%	25	93%	6	32%
Catholic Guardian	41	55%	46	72%	24	50%
Children's Aid	21	49%	20	54%	26	60%
Children's Village	13	38%	30	94%	15	60%
Edwin Gould	44	94%	26	47%	5	18%
Forestdale	15	38%	29	81%	22	67%
Graham Windham	39	81%	50	70%	6	18%
Heartshare/St. Vincent	22	37%	12	24%	20	47%
Little Flower	30	44%	26	52%	12	26%
Lutheran	13	81%	8	62%	8	62%
Mercy First	13	33%	14	45%	7	35%
Ohel	4	57%	5	83%	5	100%
Rising Ground	26	100%	23	92%	11	58%
SCO	52	46%	36	44%	11	22%
Seamen's Society	38	86%	17	47%	19	42%
Sheltering Arms	18	50%	24	75%	6	15%
Did not consent/Missing	-	-	-	-	16	-
TOTAL	**428**	**58%**	**404**	**61%**	**227**	**43%**

GSS response rates varied widely from agency to agency, ranging from as high as 100 percent to as low as 15 percent.

Power of Two Parenting Scales, Ages and Stages Questionnaire (ASQ) and Brief Infant-Toddler Social Emotional Assessment (BITSEA)

The ASQ and BITSEA were administered to get a read on children's social-emotional development (BITSEA) and their general development across domains (ASQ). Additional parenting scales were administered to determine the extent to which caregivers improved in terms of their ability to display positive regard for the child; to demonstrate "follow the lead" behavior; and, to demonstrate restraint in the use of intrusive behaviors. The BITSEA is intended for children between the ages of 12 to 36 months. The ASQ can be administered to children six months of age and older. There are multiple versions of the ASQ; the version to be used depends on the child's age at the time of administration.

Only children between the ages of 6 to 48 months in regular family foster care are eligible for ABC.

Interview and Focus Group Data

Senior Leader Interviews

In the Fall/Winter of 2014, Chapin Hall conducted 30 interviews with senior staff from across the 17 SFNYC participating agencies. The interviews covered topics such as the integration of well-being into casework practice; implementation of the CANS-NY; caseload and census reductions; current utilization of evidence-based models; and how agencies use various forms of evidence to think about permanency outcomes. Participants were recruited via email. These data were detailed in the Interim Evaluation Report; we do not include them again in this report, but instead refer you to the Interim Evaluation Report for more information.

Partnering for Success Interviews

From December 2015 through March 2016, the Chapin Hall team conducted a series of structured interviews with PFS trained staff at the first two PFS participating agencies (HSVS and Mercy First). Eighty-three staff members from across both PFS pilot agencies were invited to participate. Multiple invitations were sent to interview candidates. Senior leadership at the agencies were engaged to help boost participation. Ultimately, a total of 20 interviews were completed with both child welfare and mental health staff (response rate = 24 percent). These data were detailed in the Interim Evaluation Report; we do not include them again in this report, but instead refer you to the Interim Evaluation Report for more information.

During the first few months of 2018, the Chapin Hall team spoke with staff from ACS' Workforce Institute (n=6) to learn more about adaptations to the PFS curriculum and to gather insight into the implementation of the training curriculum, both for child welfare as well as mental health staff.

Time Use

In 2015, researchers conducted eight focus groups with case planners and supervisors from a sample of SFNYC agencies (six to 10 participants in each). Time use estimates gleaned from the focus groups were used to help construct the Time Use Survey. The purpose of these groups was to help researchers understand the process of care at each agency and to gather time-use estimates that would be used to create response options that accurately reflect the on-the-ground experience of caseworkers in NYC.

CANS-NY

In the summer of 2018, 16 focus groups were conducted across eight provider agencies: eight focus groups with supervisors and eight focus groups with case planners. The purpose of the focus groups was to discern the extent to which the theory of change that underlies the implementation of the CANS-NY is playing out as expected.

Documentation review

Through 2014 and 2015 Chapin Hall staff reviewed SFNYC planning materials associated with the reassessment of needs conducted by the National Implementation Research Network (NIRN); ACS' proposal to the National Center on Evidence Based Practice in Child Welfare to implement the Partnering for Success pilot program; background materials on ABC; and, assorted documents related to the implementation of the CANS-NY. The overarching purpose of this review was to clarify the intervention parameters and to assist ACS with the development of both the fidelity monitoring and evaluation strategies.

As other documentation has been developed that had relevance for the evaluation, those materials have been reviewed as well.

Data Analysis (Implementation Findings)

In the following section we discuss the findings related to the Implementation Study: specifically, on the implementation of the caseload reduction, the CANS-NY, PFS, and ABC. We conclude the section with findings from our study of time use, the implications of which cut across the various SFNYC strategies.

Caseload Reduction

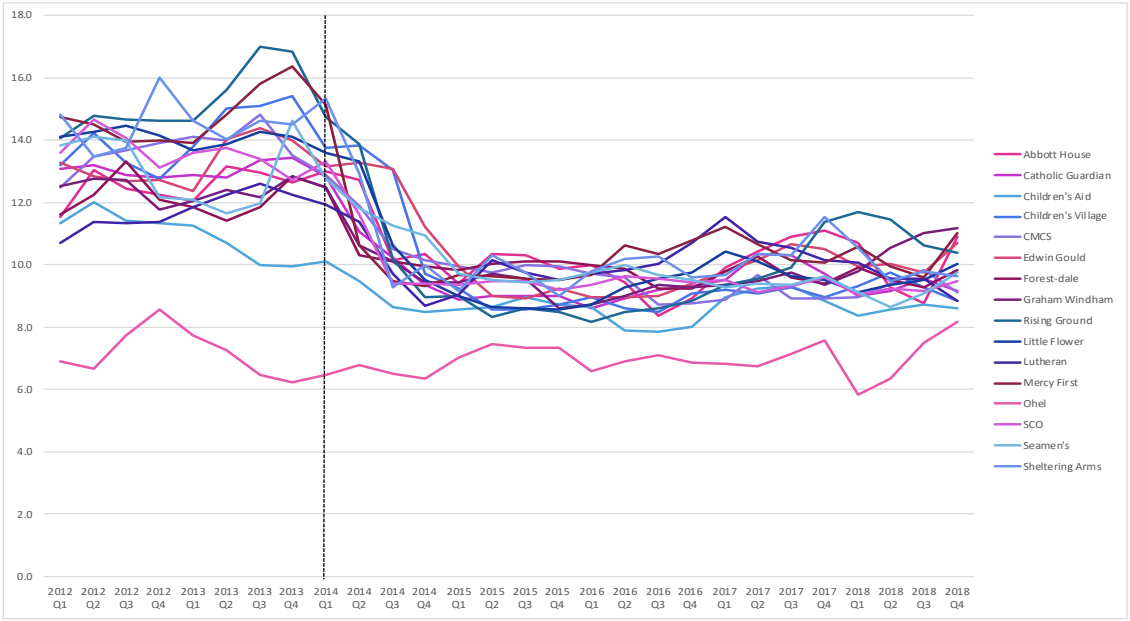
The theory of change that underlies the investment in reducing caseloads holds that reduced caseloads should allow case planners to spend more time in direct contact with families, which should improve the quality of the casework they are able to do. As well, lower caseloads are expected to reduce case planners' and supervisors' feelings of burnout, thereby reducing turnover. These two processes – better casework, less turnover – should, the thinking goes, have a positive effect on both the likelihood and timing of permanent exits from care. In this section, we look at whether caseloads actually came down to the desired level – the first threshold that needs to be met in considering the implementation of this particular strategy. We also look at case planners' and supervisors' feelings of burnout over time.

Actual Caseload Reduction

To determine whether caseloads came down, on average, for the 17 SFNYC agencies, we identified all children in regular family foster care at each SFNYC agency on the first day of every month for a seven-year window (2012 - 2018) using agency and program spell files, derived from NYS' CCRS database. We counted the number of children assigned to each worker on each of 84 point-in-time dates. Consistent with ACS' method of calculating caseloads, we restricted our view to caseworkers with caseloads of five or more. Cases on suspended payment are included in the count, as they are counted as part of the 12:1 ratio.

Figure 5 shows the average quarterly caseloads, by agency, from January 1, 2012 (two years prior to the onset of SFNYC), through the end of 2018, when the formal Waiver period ended.

Figure 5. *Average Quarterly Caseload, by Agency*



Prior to January 1, 2014 (the date SFNYC went into effect in NY; see dotted, black vertical line), there were five agencies with caseloads steadily above 15 (Children's Village, Rising Ground, Little Flower, Mercy First and Sheltering Arms). There were only two agencies with caseloads steadily below 12 (Children's Aid and Ohel). The remaining 9 agencies were hovering in the 12 to 14 range for 2012 and 2013 (Abbott House, Catholic Guardian, Cardinal McCloskey, Edwin Gould, Forestdale, Graham Windham, Lutheran, SCO and Seamen's). During 2014, we can clearly see a shift in the pre-Waiver trend. By 2015, most agencies have lowered their caseloads and have moved into the range of 10 to 13 cases per worker. This pattern continues throughout 2015. During 2016, a few agencies experienced an uptick in caseloads (i.e., Forestdale, Mercy First and Sheltering Arms) while several other agencies continued to see a decrease in caseload averages (i.e., Cardinal McCloskey, SCO and Seamen's). In 2017 and 2018 there is noticeably less variability.

Case Planner and Supervisor Burnout

With the reduction in caseload having been established, we arrive at the next check point in the theory of change: whether feelings of burnout have shifted over the period during which caseloads came down. While the Maslach Burnout Inventory (MBI) has only been administered twice during the SFNYC period (in 2017 and again in 2019), questions related to feelings of overwhelm on the job have been asked three times: in 2015, 2017, and again in 2019. Table 2 has the details.

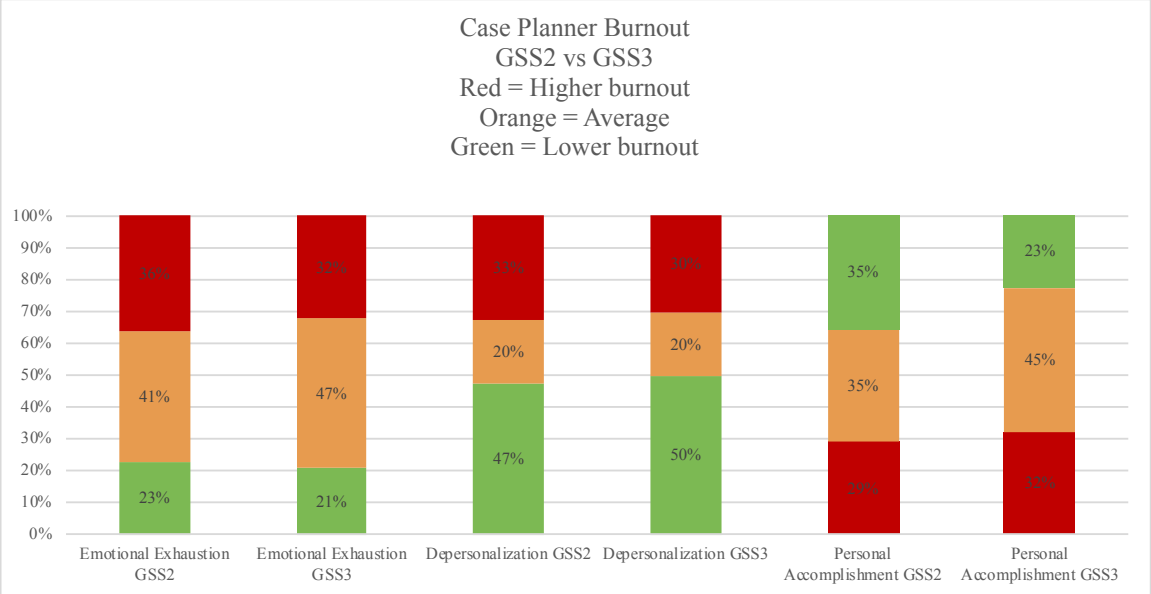
Table 2. *Case Planner Feelings of Overwhelm: GSS1, GSS2, and GSS3*

	GSS1 (n=295)	GSS2 (n=300)	GSS3 (n=150)
Even working overtime, I cannot finish all of my work.	42%	72%	62%
My caseload is too high.	16%	51%	38%
I have too many cases to do a good job, yet I am expected to do so.	21%	51%	43%
I cannot spend enough time with the families on my caseload.	20%	52%	46%
It is difficult for me to keep up with agency policies and guidelines.	21%	46%	40%

Across the board, case planners reported feeling more overwhelmed at the time of the second administration of the General Staff Survey (GSS2, 2017) than they did at the time of the first General Staff Survey (GSS1, 2015). However, feelings of overwhelm seemed to go down from 2017 to 2019, although the 2019 levels are still higher than what was reported in 2015. A word of caution, though: the response rate for case planners in 2019 was very low. Approximately 38 percent of invited case planners actually responded to the survey, so the values represented here may not be representative of the entirety of case planners at this time.

As to the issue of burnout, specifically, we compared burnout levels – again, as measured by the Maslach Burnout Inventory – from 2017 to 2019. Figure 6, below, looks at the three dimensions of burnout measured on the MBI, for case planners in particular: emotional exhaustion, depersonalization, and personal accomplishment.

Figure 6. *Case Planner Burnout: GSS2 and GSS3*[10]



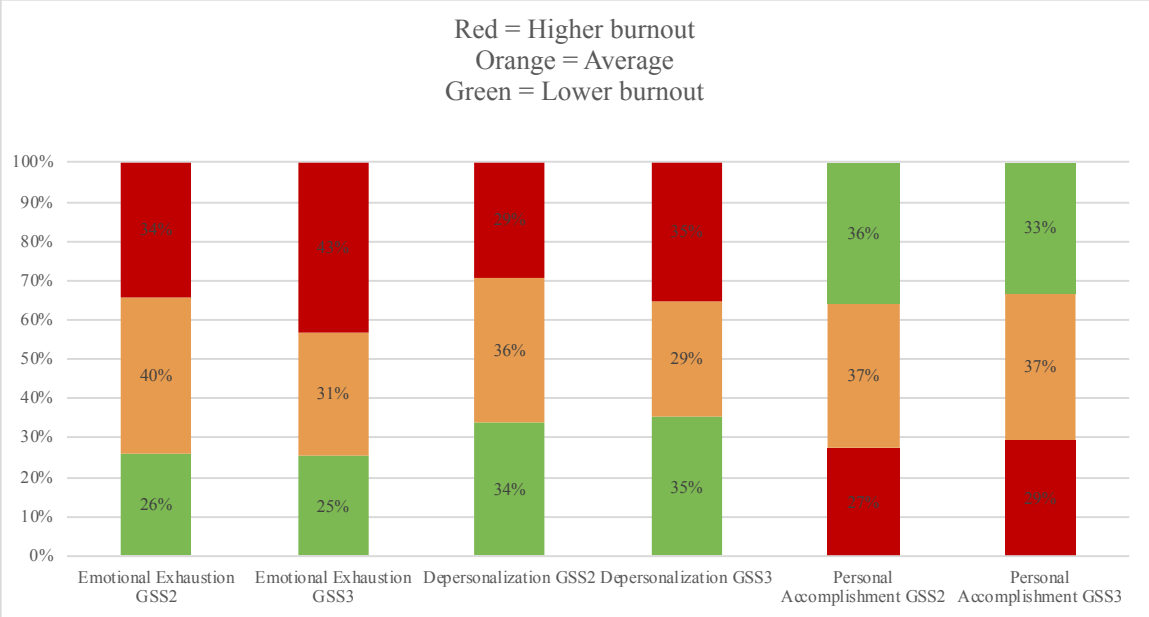
By and large, burnout levels have remained stable from 2017 to 2019, with some slight improvements in the areas of emotional exhaustion and depersonalization. About one-third of

[10] Note, the color coding for Personal Accomplishment is flipped because in this case, "lower burnout" is negative (less Personal Accomplishment) and "higher burnout" is positive (more Personal Accomplishment). In all cases, the color green indicates something favorable; red indicates something unfavorable.

case planners report high levels of emotional exhaustion and depersonalization. Case planners were somewhat less likely to report feelings of personal accomplishment in 2019 (23 percent) compared to 2017 (35 percent); note, most of the shift went from feelings of high personal accomplishment to feelings of average personal accomplishment, as opposed to feelings of *low* personal accomplishment.

Figure 7 displays GSS2 and GSS3 burnout levels for supervisors.

Figure 7. *Supervisor Burnout: GSS2 and GSS3*[11]



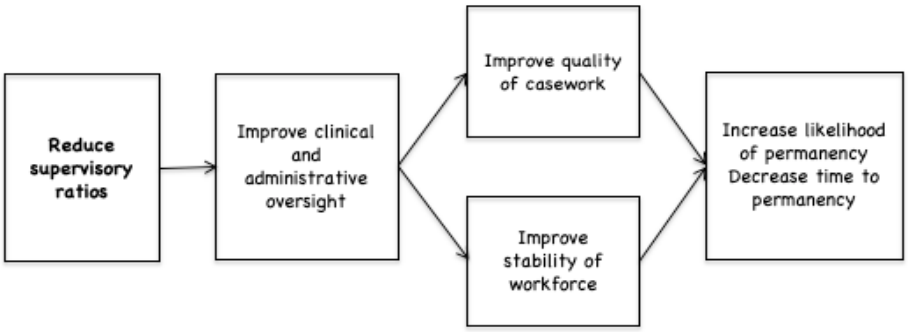
There appears to be some evidence of increased feelings of burnout amongst supervisors, particularly as it relates to feelings of emotional exhaustion (34 percent in 2017 versus 43 percent in 2019) and depersonalization (29 percent in 2017 and 35 percent in 2019). Supervisors' feelings of personal accomplishment remained fairly stable from 2017 to 2019. We would offer the same caution here, though, as we did above with respect to case planners: less than 45 percent of eligible supervisors responded to the survey, so these findings may not be representative of supervisors on the whole.

Quality of Supervision

Under SFNYC, ACS also invested in reducing the case planner to supervisor ratio, introducing a new standard of 1:4 (one supervisor to four case planners). The theory of change underlying this particular investment is explicated in Figure 8:

[11] Note, the color coding for Personal Accomplishment is flipped because in this case, "lower burnout" is negative (less Personal Accomplishment) and "higher burnout" is positive (more Personal Accomplishment). In all cases, the color green indicates something favorable; red indicates something unfavorable.

Figure 8. *Reduced Supervisory Ratios: Theory of Change*



Chapin Hall was unable to systematically track supervisory ratios using administrative data in the same way we did for the reduction in caseloads, although this is information ACS collects in self-report format and through their internal dashboard. However, we did collect data – from both case planners and supervisors – about the *quality* of supervision. Case planners and supervisors were both asked to reflect on the quality of supervision across three dimensions:

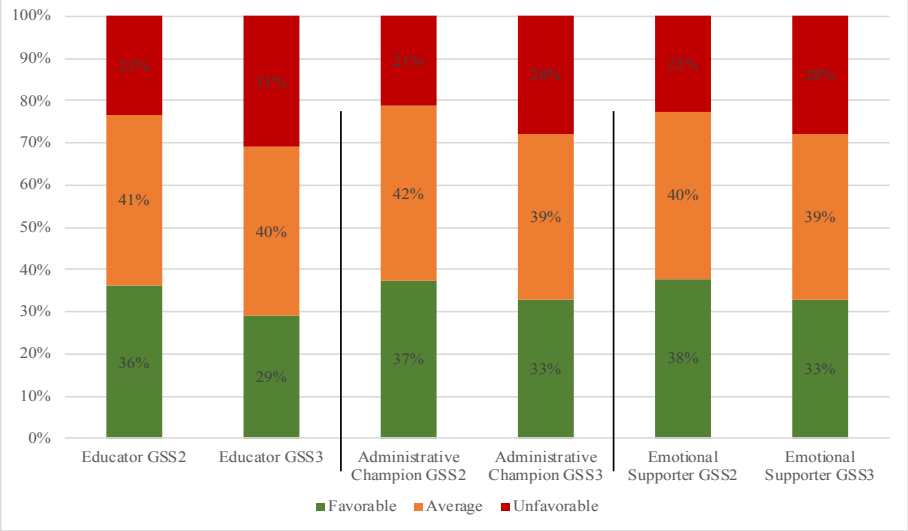
1. Education (12 items, for example:)
    a. Uses observations of my work in the field to help improve practice skills.
    b. Uses own experience doing the job to teach how to do the job better.
2. Administrative Support (seven items, for example:)
    a. Filters policy and practice changes to get exactly the information needed to do the job.
    b. Implements strategies or develops resources to help manage unreasonable caseloads.
3. Emotional Support (17 items, for example:)
    a. Provides a safe place to talk about feeling overwhelmed.
    b. Helps me to recognize when a particular case is stressing me out.

The following sections look at case planners' views on supervision and supervisors' views on supervision, and the extent to which views, on average, have changed from 2017 to 2019.

Case Planners' Views on Supervision

Figure 9 displays case planners' views on supervision, from the GSS2 (n=300 case planners) to the GSS3 (n=150). These are average ratings, across all of the case planners who participated in each of the surveys.

Figure 9. *Case Planners' Views on Supervision: GSS2 and GSS3*

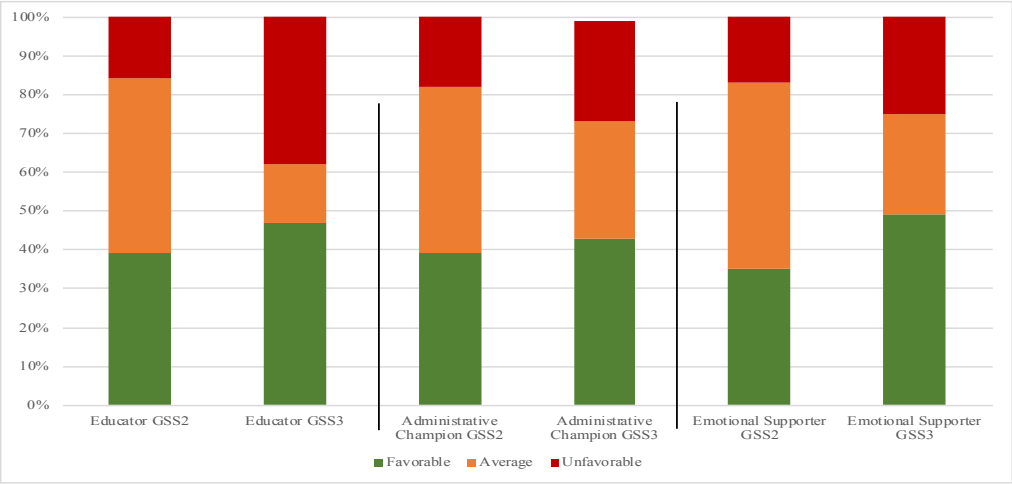


Case planners' perceptions of the quality of supervision have generally gone down from 2017 to 2019. Case planners were less likely to hold favorable views of their supervisors as educators, administrative champions, and emotional supports. The proportion of responding case planners who held "average" views stayed the same over time. What changed is the proportion of case planners who hold positive views (this went down) and the proportion of case planners who hold negative views (this went up). While these data may seem alarming on their face, it is again important to caution that the response rate for the GSS3 was very low for case planners: just 38 percent of all invited case planners responded. That is, the views reported here may not be indicative of case planners' views on the whole.

Supervisors' Views on Supervision

Supervisors were also asked to comment on the quality of supervision across the three domains listed above (educator, emotional support, administrative support). Figure 10 displays supervisors' views on their own supervision, for both the GSS2 and the GSS3.

Figure 10. *Supervisors' Views on Supervision: GSS2 and GSS3*



Supervisors have generally become more outspoken about their views of their own supervision, noted by the reduced prominence of responses in the "Average" range. For the education and administrative support (champion) areas, the increase in unfavorable ratings outpaced the increase in favorable ratings, although there was an increase in both favorable *and* unfavorable ratings. For the emotional support area, the increase in favorable ratings outpaced the increase in unfavorable ratings.

Summary comments: Caseloads and Supervision

One of ACS' central investments under SFNYC – indeed, the foundational investment, in many respects – was the reduction of caseloads within the 17 participating agencies. Not only did average caseloads come down shortly following the onset of SFNYC, but average caseloads have stayed down over time.

During this period of reduced caseloads, we see some evidence of case planners feeling slightly less burned out from their jobs. The shift from the GSS2 to the GSS3 was small but in the right direction.

As for the less favorable results – more negative perceptions of supervision, increased feelings of overwhelm, higher levels of burnout amongst supervisors – it is difficult to know the extent to which these attitudes are shared by the more than half of the workforce that declined to participate in the GSS3. It is entirely possibly that these results reflect a fair amount of selection bias, where staff who hold a particular set of views or have had a certain type of experience in their work or with their supervisor were more motivated to respond to the survey than staff who hold more favorable views or have had more positive experiences.

<u>CANS-NY</u>

Our goal in this section is three-fold: (1) to review CANS-NY compliance (are case planners completing a CANS-NY for eligible children?), (2) to review CANS-NY "findings" with respect to the presence of actionable needs in areas of particular importance for children in out of home care, and (3) to discuss case planners' and supervisors' attitudes about the CANS-NY and the extent to which it is being used as intended.

As a general matter, we think about the CANS-NY in the same way we think about outcomes in general: separately for children who were in care at the time the CANS-NY went live (around 10/1/14) and children who were admitted to care on or after that date. We further distinguish the in-care group by the length of time children were in care on 10/1/14.

Note, the CAN-NYS has been rolled out across the 17 SFNYC agencies as well as the five pilot (CSNYC) agencies. The data we present in this section is inclusive of all 22 agencies. When we provide data by agency we highlight those agencies that are pilot/CSNYC agencies.

Compliance

In this section we answer the following questions as it relates to compliance with CANS-NY guidelines:

1. To what extent are children who are eligible for a CANS-NY having at least one completed on their behalf?

2. To what extent are children who are eligible to be reassessed (using the CANS-NY) having a reassessment CANS-NY completed on their behalf?

3. To what extent does CANS-NY completion vary by agency (i.e., depending on the agency in which the child is placed)?

We address the first question in Table 3, below.

Table 3. *CANS-NY completion, by Group Type (as of December 31, 2018)*[12]

	Count			Percent		
	NO CANS	**YES CANS**	**TOTAL**	**NO CANS**	**YES CANS**	**TOTAL**
In care on 10/01/14, by time in care						
0-6 Months	497	1,171	1,668	30%	70%	100%
6-12 Months	261	1,066	1,327	20%	80%	100%
12-18 Months	213	838	1,051	20%	80%	100%
18-24 Months	190	702	892	21%	79%	100%
24-30 Months	201	736	937	21%	79%	100%
30-36 Months	191	603	794	24%	76%	100%
More than 36 Months	948	2,626	3,574	27%	73%	100%
Entry cohorts						
2014 Entry Cohort	323	602	925	35%	65%	100%
2015 Entry Cohort	1271	2274	3545	36%	64%	100%
2016 Entry Cohort	1170	2122	3292	36%	64%	100%
2017 Entry Cohort	1191	2159	3350	36%	64%	100%
2018 Entry Cohort	1401	1256	2657	53%	47%	100%

We see that children who were in care on 10/1/14 for six to 18 months are currently the most likely to have a CANS-NY completed. Generally, the rate of CANS-NY completion for newly admitted children is hovering at 65 percent.[13] As to the second question regarding reassessment using the CANS-NY, we only looked for the presence of a reassessment CANS-NY in cases where children would be eligible for one according to ACS' guidelines.[14] Table 4 displays the extent to which case planners are completing reassessment CANS-NY in situations where a reassessment CANS-NY is warranted.

[12] The values for 2018 are likely depressed due to censoring: when we received the CANS file it is possible that children admitted in 2018 had not yet had. CANS entered on their behalf.

[13] Note, the initial CANS-NY is due after 30 days of placement with a provider.

[14] Caseworkers are expected to complete a re-assessment CANS-NY every six months and/or at case closure. This analysis focused only on whether 6 months had passed since the first CANS-NY had been completed. Some children who have initial CANS-NY after the spell stops are not considered as "eligible" for reassessment.

Table 4. *Reassessment CANS-NY*

	Total	Initial CANS? NO	Initial CANS? YES	Eligible for Reassessment? NO	Eligible for Reassessment? YES	If Eligible, Reassessment? NO	If Eligible, Reassessment? YES*	If Eligible, Reassessment? % Reassess.
Children in care on 10/01/14, by time in care								
0-6 Months	1,668	497	1,171	262	909	63	846	93%
6-12 Months	1,327	261	1,066	180	886	56	830	94%
12-18 Months	1,051	213	838	151	687	62	625	91%
18-24 Months	892	190	702	107	595	49	546	92%
24-30 Months	937	201	736	159	577	61	516	89%
30-36 Months	794	191	603	137	466	39	427	92%
More than 36 Months	3,574	948	2,626	661	1965	207	1758	89%
Entry cohorts								
2014 Entry Cohort	925	323	602	117	485	34	451	93%
2015 Entry Cohort	3,545	1,271	2,274	581	1693	109	1584	94%
2016 Entry Cohort	3,292	1,170	2,122	503	1619	109	1510	93%
2017 Entry Cohort	3,350	1,191	2,159	575	1584	128	1456	92%
2018 Entry Cohort	2,657	1,401	1,256	885	371	84	287	77%

Reassessment CANS-NY are being completed in the vast majority of cases.

Turning our attention to the last question regarding agency-level variation in CANS-NY completion, the general finding is that there is a fair amount of variation in CANS-NY completion rates – across placement groups (in care versus admits) and across agencies. Table 5 displays CANS-NY completion rates by agency for the in-care and admissions groups.

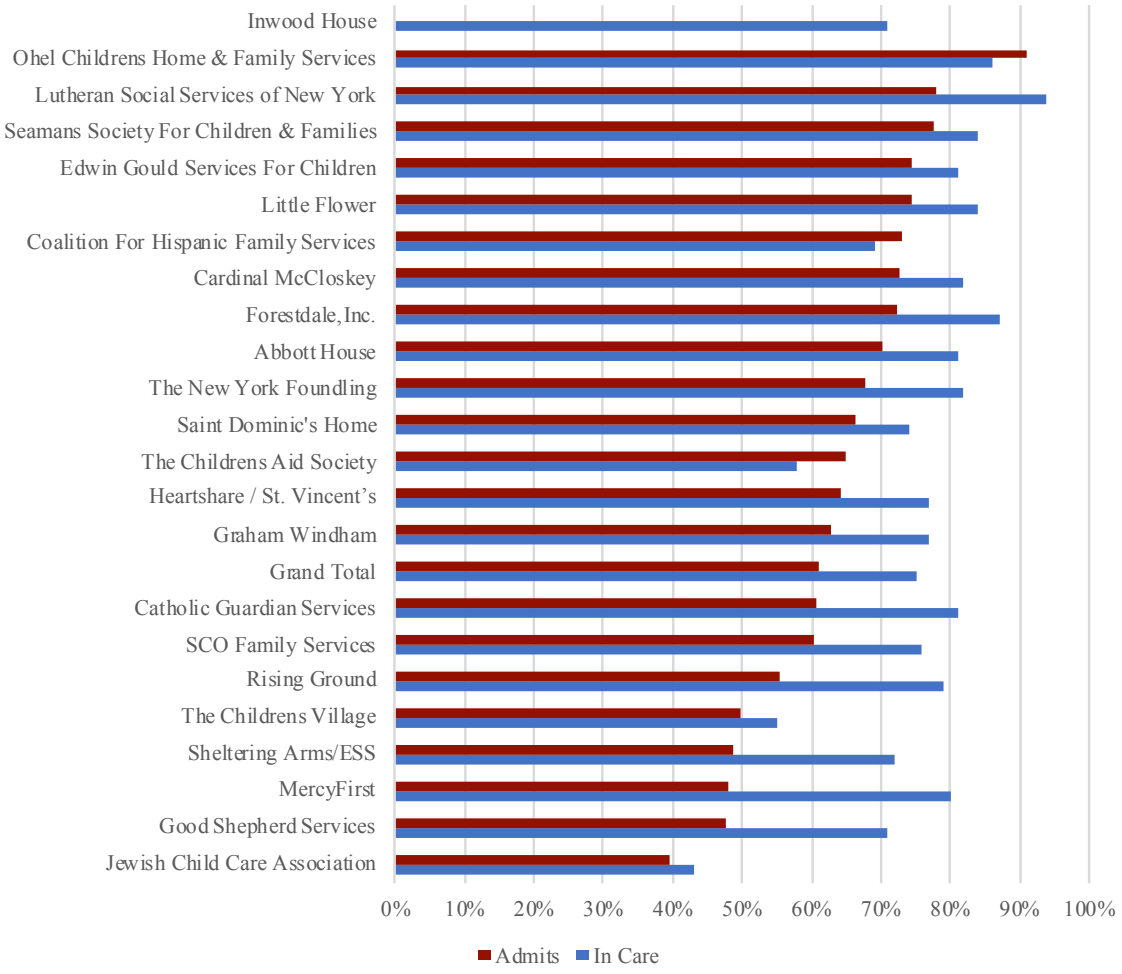
Table 5. *Completion of at Least One CANS-NY, to Date: In Care and Admissions, by Agency*[15]

	In Care Group		Admission Groups	
	At Least 1 CANS	Percent of Elig.	At Least 1 CANS	Percent of Elig.
Abbott House	168	81%	234	70%
Cardinal McCloskey	225	82%	237	73%
Catholic Guardian Services	574	81%	514	61%
Coalition For Hispanic Family Services	152	69%	231	73%
Edwin Gould Services For Children	500	81%	296	75%
Forestdale,Inc.	295	87%	388	72%
Good Shepherd Services	323	71%	411	48%
Graham Windham	518	77%	554	63%
Inwood House	15	71%	-	-
Jewish Child Care Association	234	43%	348	40%
Rising Ground	198	79%	252	55%
Little Flower	540	84%	587	74%
Lutheran Social Services of New York	133	94%	178	78%
MercyFirst	335	80%	298	48%
Ohel Childrens Home & Family Services	32	86%	30	91%
Saint Dominic's Home	208	74%	342	66%
SCO Family Services	996	76%	589	60%
Seamans Society For Children & Families	307	84%	414	78%
Sheltering Arms/ESS	312	72%	530	49%
The Childrens Aid Society	278	58%	488	65%
The Childrens Village	196	55%	302	50%
The New York Foundling	649	82%	795	68%
Heartshare / St. Vincent's	554	77%	395	64%
Grand Total	7742	75%	8413	61%

[15] Shaded rows are CSNYC (pilot) agencies.

The agency-level variation is made clearer in Figure 11, below.

Figure 11. *CANS-NY Completion Rates, by Agency and Placement Group (In Care and Admits)*



With limited exceptions, agencies are more successful completing CANS-NY on behalf of children who were already in care at the time the CANS-NY went live versus children who were admitted to care on or after October 1, 2014. Note, the values for the Admits group represents the average across the five entry cohorts (children admitted from 2014 through 2018).

CANS-NY "Findings"

Broadly, the CANS-NY has two main purposes. The first purpose of the CANS-NY is to inform service planning. It is a tool for case planners to help them detect areas where children and caregivers need support and the immediacy of the need. The second purpose of the CANS-NY is to track changes in child and caregiver functioning over time. Because the CANS-NY is expected to be completed upon placement into out of home care and at regular intervals thereafter, there is the capacity to collect multiple data points on a given child/family, to see the extent to which progress is made in identified need areas. Looking at CANS-NY scores in the aggregate – for example, looking at the set of CANS-NY scores from all children's initial CANS-NY – can go a long way to help child welfare administrators understand the needs of children and

families and to make sure that investments into improving the quality of care are properly targeted.

The tables below give snapshots of how children in foster care are doing along five domains: behavioral health, trauma, medical health, developmental delays, and substance use. Each of these domains has what's called a 'trigger item' on the CANS-NY. When a worker indicates *at least* a suspicion or history of a problem in a given area the full module is triggered, which includes additional questions about the child's functioning within that domain.

In each section below are two tables, each of which has the same general structure from one domain to the next. The first provides some basic information about the children who triggered each module. The second provides item-level information within each domain.

Behavioral Health. Of the 16,155 children for whom we have at least one CANS-NY, 5,085 (31 percent) triggered the Behavioral Health module. Table 6 details the extent to which different age groups triggered the Behavioral Health module, and how these values compare to what was reported at the time of the Interim Evaluation Report.

Table 6. *Behavioral Health Module, by Age at Spell Start and Reporting Period*

	Values at Interim Evaluation Report			Current Values (as of 12/31/18)		
Spell Start Age	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:
Under 1	2869	361	13%	4051	369	9%
1 to 5 Years	3415	1241	36%	5004	1627	33%
6 to 12 Years	2854	1304	46%	4115	1769	43%
13 to 17 Years	1914	870	45%	2663	1166	44%
Over 17 years	165	86	52%	322	154	48%
Total	11217	3862	34%	16,155	5,085	31%

As expected, of all the children who triggered the module, babies continue to be the least represented. Most of the children who trigger this module are between the ages of 1 and 12 years; about a quarter of the children who trigger the module are teenagers. We also note a slight reduction in the proportion of children who triggered the Behavioral Health module at this reporting moment compared to when the Interim Evaluation Report was released in 2016.

Table 7, below, looks at the item level and describes the extent to which children scored in the actionable range (moderate to severe problems) on any of the items in the Behavioral Health module.

Table 7. *Item Level Scores, Behavioral Health Module*

Module Items	Values at Interim Evaluation Report				Current Values (as of 12/31/18)			
	History or suspicion of problems	Percent of Total (n=3,862)	Moderate to severe problems	Percent of Total (n=3,862)	History or suspicion of problems	Percent of Total (n=5,085)	Moderate to severe problems	Percent of Total (n=5,085)
Psychosis	199	5%	40	1%	206	4%	246	5%
Attention/Concentration					418	8%	418	8%
Impulsivity	1,488	39%	605	16%	1810	36%	2415	52%
Depression	899	23%	197	5%	1153	23%	1350	28%
Anxiety	879	23%	169	4%	1159	23%	1328	27%
Oppositional	1,043	27%	399	10%	1279	25%	1678	35%
Conduct	810	21%	277	7%	948	19%	1225	26%
Enotional Control					338	7%	338	7%
Anger Control	1,317	34%	440	11%	1648	32%	2088	43%

Most children are not scoring in the actionable range on any of the Behavioral Health items. This was true at the time of the Interim Evaluation Report and remains true at this reporting moment. By and large, the proportion of children scoring in the actionable range on any of the items in the Behavioral Health module has remained fairly consistent over time. Anger control, oppositional/defiant behavior, and impulsivity and hyperactivity are the items most likely to be rated in the actionable range, although even these items are not rated in the actionable range with great frequency. Caseworkers are much more likely to use a score of 1 when scoring items in this module, which denotes that a child either has a history of the problem or the worker suspects there may be a problem in a given area. Note, data regarding Emotional Control and Attention/Concentration was not a part of this module at the time of the Interim Evaluation Report

Trauma. Of the 16,155 children for whom we have at least one CANS-NY completed, 5,112 (32 percent) triggered the Trauma module. Table 8 offers a breakdown by age and reporting period.

Table 8. *Trauma Module, by Age at Spell Start and Reporting Period*

Spell Start Age	Values at Interim Evaluation Report			Current Values (as of 12/31/18)		
	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:
Under 1	2,869	249	9%	4051	486	12%
1 to 5 Years	3,415	938	27%	5004	1570	31%
6 to 12 Years	2,854	1,135	40%	4115	1768	43%
13 to 17 Years	1,914	777	41%	2663	1144	43%
Over 17 years	165	67	41%	322	144	45%
Total	11,217	3,166	28%	16,155	5,112	32%

As with the Behavioral Health module, we see most of the children who triggered the Trauma module were between the ages of 1 and 12 years, with 35 percent of children who triggered the module falling between 6 to 12 years of age. Looking from one reporting period to the next, we see an increased likelihood that a child will trigger the Trauma module.

Table 9, below, looks at the item level and describes the extent to which children scored in the actionable range (moderate to severe problems) on any of the items in the Trauma module.

Table 9. *Item Level Scores, Trauma Module*

	Values at Interim Evaluation Report				Current Values (as of 12/31/18)			
Module Items	History or suspicion of problems	Percent of Total (n=3,116)	Moderate to severe problems	Percent of Total (n=3,116)	History or suspicion of problems	Percent of Total (n=5,112)	Moderate to severe problems	Percent of Total (n=5,112)
Traumatic Grief					670	13%	114	2%
Re-Experiencing	421	13%	106	3%	659	13%	181	4%
Hyperarousal					168	3%	44	1%
Avoidance	745	24%	132	4%	995	20%	180	4%
Numbing	386	12%	81	3%	511	10%	113	2%
Dissociation	456	14%	45	1%	567	11%	71	1%
Affective or Phys. Dysregulation	681	22%	215	7%	838	16%	289	6%

Very few children score in the actionable range on the items contained in the Trauma module. The proportion of items that were scored in the actionable range held pretty steady from the 2016 reporting period to the current reporting period. Note, Traumatic Grief and Hyperarousal were not items on which we reported in the 2016 Interim Evaluation Report.

Medical Health. Of the 16,155 children for whom we have at least one CANS-NY completed, 1,250 (8 percent) triggered the Medical Health module. Table 10 offers a breakdown by age and reporting period.

Table 10. *Medical Health Module, by Age at Spell Start and Reporting Period*

	Values at Interim Evaluation Report			Current Values (as of 12/31/18)		
Spell Start Age	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:
Under 1	2,869	289	10%	4051	414	10%
1 to 5 Years	3,415	253	7%	5004	350	7%
6 to 12 Years	2,854	190	7%	4115	260	6%
13 to 17 Years	1,914	148	8%	2663	193	7%
Over 17 years	165	17	10%	322	33	10%
Total	11,217	897	8%	16155	1250	8%

Of all the children who triggered the Medical Health module babies represent the largest subgroup (33 percent of all children who triggered the module) followed by toddlers (28 percent of all children). This is very consistent across reporting periods. Table 11, below, looks at the item level and describes the extent to which children scored in the actionable range (moderate to severe problems) on any of the items in the Medical Health module.

Table 11. *Item Level Scores, Medical Health Module*

	Values at Interim Evaluation Report				Current Values (as of 12/31/18)			
Module Items	History or suspicion of problems	Percent of Total (n=897)	Moderate to severe problems	Percent of Total (n=897)	History or suspicion of problems	Percent of Total (n=1,250)	Moderate to severe problems	Percent of Total (n=1,250)
Life threatening	80	9%	43	5%	107	9%	59	5%
Chronicity	125	14%	412	46%	262	21%	461	37%
Diagnositic complexity	92	10%	35	4%	129	10%	40	3%
Emotional response	133	15%	31	3%	158	13%	31	2%
Impairment in functioning	198	22%	47	5%	261	21%	52	4%
Intensity of treatment	51	6%	155	17%	95	8%	187	15%
Organizational complexity	208	23%	154	17%	293	23%	164	13%
Family stress	269	30%	31	3%	336	27%	39	3%

Thirty-seven percent of the children who triggered the Medical Health module (n=461) have medical problems that are moderate to severe in their chronicity. For most items on the Medical Health module (Chronicity and Intensity of Treatment being the exceptions), case planners were more likely to indicate either a history or suspicion of the problem than to indicate the presence of a moderate to severe problem. Looking across reporting periods, we see a slight drop in the proportion of children scoring in the actionable range on several of the Medical Health module items, but the difference, again, is slight.

Developmental Delay. Of the 16,155 children for whom we have at least one CANS-NY completed, 1,901 (19 percent) triggered the Developmental Delay module. Table 12 offers a breakdown by age and reporting period.

Table 12. *Developmental Delay Module, by Age at Spell Start and Reporting Period*

	Values at Interim Evaluation Report			Current Values (as of 12/31/18)		
Spell Start Age	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:
Under 1	2,869	466	16%	4051	782	19%
1 to 5 Years	3,415	719	21%	5004	1461	29%
6 to 12 Years	2,854	446	16%	4115	557	14%
13 to 17 Years	1,914	248	13%	2663	306	11%
Over 17 years	165	22	13%	322	40	12%
Total	11,217	1,901	17%	16155	3146	19%

Almost 50 percent of the children whose initial CANS-NY triggered the Developmental Delay module were toddlers; we see a pronounced rise in the proportion of toddlers for whom the Development Delay module was triggered from 2016 to the current reporting period. Of all the children who triggered the Developmental Delay module, teenagers represent the smallest group. Table 13, below, looks at the item level and describes the extent to which children scored in the actionable range (moderate to severe problems) on any of the items in the Developmental Delay module.

Table 13. *Item Level Scores, Developmental Delay Module*

	Values at Interim Evaluation Report				Current Values (as of 12/31/18)			
Module Items	History or suspicion of problems	Percent of Total (n=1,901)	Moderate to severe problems	Percent of Total (n=1,901)	History or suspicion of problems	Percent of Total (n=3,146)	Moderate to severe problems	Percent of Total (n=3,146)
Cognitive	1,020	54%	239	13%	1267	40%	307	10%
Agitation	675	36%	359	19%	1064	34%	495	16%
Self stimulation	287	15%	90	5%	392	12%	121	4%
Motor	491	26%	85	4%	685	22%	123	4%
Communication	791	42%	397	21%	1084	34%	517	16%
Developmental delay	1,139	60%	277	15%	1417	45%	353	11%
Sensory	160	8%	101	5%	219	7%	125	4%

Overall, children generally do not present with evidence of moderate-to-severe problems in any of the eight areas highlighted in the Developmental Delay module. The proportion of children for whom there is either a history or a suspicion of problems related to any of the specific aspects of development is similar for the current reporting period as it was at the time of the Interim Evaluation Report, although the proportions are, across the board, lower.

Substance Use. Of the 16,155 children for whom we have at least one CANS-NY completed, 746 (5 percent) triggered the Substance Use module. Table 14 offers a breakdown by age and reporting period.

Table 14. *Substance Use Module, by Age at Spell Start and Reporting Period*

	Values at Interim Evaluation Report			Current Values (as of 12/31/18)		
Spell Start Age	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:	CANS completed (at least one)	Triggered module (Score of 1, 2, or 3)	Percent of children who triggered module:
Under 1	2,869	23	1%	4051	23	1%
1 to 5 Years	3,415	14	0%	5004	17	0%
6 to 12 Years	2,854	102	4%	4115	104	3%
13 to 17 Years	1,914	397	21%	2663	489	18%
Over 17 years	165	49	30%	322	113	35%
Total	11,217	585	5%	16,155	746	5%

Most of the children who triggered the Substance Use module (80 percent) are teenagers. Fourteen percent of the children who triggered the module are on the younger side, though – 6 to 12 years of age (n=104). The proportion of children who triggered the Substance Abuse module stayed fairly stable from one reporting period to the next, although children over 17 years of age experienced an uptick.

Table 15, below, looks at the item level and describes the extent to which children scored in the actionable range (moderate to severe problems) on any of the items in the Substance Use module.

Table 15. *Item-level scores, Substance Use module*

	Values at Interim Evaluation Report				Current Values (as of 12/31/18)			
Module Items	History or suspicion of problems	Percent of Total (n=585)	Moderate to severe problems	Percent of Total (n=585)	History or suspicion of problems	Percent of Total (n=746)	Moderate to severe problems	Percent of Total (n=746)
Severity of use	164	28%	269	46%	204	27%	473	63%
Duration	217	37%	236	40%	275	37%	511	77%
Peer influences	261	45%	224	38%	338	45%	562	75%
Stage of recovery	68	12%	297	51%	90	12%	387	52%

The proportion of children for whom this module was triggered that scored in the actionable range on the module items is much higher than we have seen in previous domains. We also see a substantial increase in the proportion of youth who triggered the Substance Use model who have item-level scores in the actionable range. Over 60 percent of children for whom the Substance Use module was triggered (n=473) have moderate to severe substance use problems in terms of the gravity of the substance use. Seventy-seven percent (n=511) youth have been using substance for a length of time that is considered moderate to severe. This is up from 40 percent at the time of the Interim Evaluation Report.

Summary of Descriptive Report

To sum, compliance with CANS-NY regulations has been fairly variable – both across agencies and over time. A solid majority (65 percent) of children are having at least one CANS-NY completed on their behalf; most of the children who are eligible to be reassessed with the CANS-NY are, in fact, being reassessed.

Most of the time, caseworkers assessing children using the CANS-NY are not identifying actionable problems in any of the major domains. The Behavioral Health module was the most likely to be triggered (34 percent of children for whom at least one CANS-NY was available triggered this module); the Substance Use module was the least likely (5 percent). This was true at the time of the Interim Evaluation Report and remains the case at this reporting moment. As well, children who triggered a module were fairly unlikely to have actionable problems related to that domain, although in several domains we see an uptick in the proportion of children who are scoring in the actionable range on module-specific items.

The reliability of caseworkers' scores on CANS-NY items is, of course, an important topic to consider, and one that ACS and the Workforce Institute have spent a lot of time contemplating and addressing. The utility of the CANS-NY – the extent to which the CANS-NY is the service planning tool it was intended to be per the theory of change – has a lot to do with caseworkers' perspectives on the tool and their comfort in completing it. These issues are considered in more detail in the section that follows.

CANS-NY: Case Planner and Supervisor Perspectives

In July and August 2018, members of the Chapin Hall evaluation team conducted a series of focus groups. The purpose of the focus groups was to unpack the extent to which the theory of change that underlies the implementation of the CANS-NY is playing out as expected. To review, the theory of change for the CANS-NY holds that if the CANS-NY is completed – with fidelity and collaboratively with family members, case planners will be better able to identify family members' needs and strengths. This should contribute to higher quality service planning, which should increase the likelihood of and decrease the time to permanent exits from care.

Chapin Hall and ACS partnered to recruit agencies to participate in this round of data collection. Recruitment efforts targeted nine agencies; eight agencies ultimately participated. Two focus groups were held at each of the eight agencies: one case planners and one for supervisors. All in all, 74 case planners and 43 supervisors participated in the focus groups.

The sections that follow provide a summary of the main themes that emerged regarding the CANS-NY and its application to casework and service planning. The main ideas are organized to reflect the structure of the theory of change, depicted and described above.

Why the CANS-NY? There was no clear consensus around the principal intention of the CANS-NY among the case planners and supervisors who participated. Some staff pointed to practical reasons, like Medicaid eligibility, while others thought the CANS-NY may be part of a broader research agenda on the part of ACS. Others wondered if the CANS-NY was intended to track well-being over time.

Much of staff's confusion around the intention behind the requirement to complete the CANS-NY centered on its apparent redundancy with existing tools - particularly the FASP, which staff described as more comprehensive and useful than the CANS-NY in its ability to provide a full description of the case at a given point in time.

Training and Certification. Case planners and supervisors alike consistently reported that the CANS-NY training curriculum does not prepare them for the certification test, which was described as very difficult to pass. Staff talked about feeling demoralized by repeatedly failing the certification test, despite (in several cases) years of experience doing what they believe to be high quality casework.

Supervisors described their training as near-identical to the training for case planners. They do not receive additional training on how to use the CANS-NY in supervision or to promote case planners' use of the CANS-NY in their work with family members.

Staff also noted that *not* passing the test does not preclude a case planner from completing the CANS-NY or an uncertified supervisor from approving the CANS-NY. Note, this particular policy stands in contrast to policies in other CANS-NY-using jurisdictions, where staff are only permitted to complete (or, in the case of a supervisor, approve) a CANS-NY if certified.

In collaboration with, or on behalf of? There was near-unanimous agreement across role types and agencies that case planners do not go through the CANS-NY **with** family members. They use notes from DCP in addition to other sources of information (i.e., their own observations) to complete the CANS-NY on their own, in the office.

CANS-NY data entry system. Case planners and supervisors alike voiced universal frustration with the CANS-NY data entry system. Simple functions reportedly take a very long time. Toggling from one CANS-NY to another can be very cumbersome. Across agencies, the message was that the time it takes staff to complete the CANS-NY acts as a disincentive to triggering any additional CANS-NY modules that could otherwise be avoided (and, thus, additional CANS-NY items).

Staff – both case planners and supervisors alike – also complained that the current version of the CANS-NY data entry system does not generate a summary report that can be used to spark conversation about the case or the needs of children and their caregivers.

The second component of the theory of change has to do with the extent to which the CANS-NY serves as an aid in the identification of family needs and strengths. The main themes to emerge on this topic are summarized below.

Experience matters. Across agencies and role types the feedback was that newer case planners benefit more readily from the CANS-NY than do more experienced case planners. The perceived utility of the CANS-NY to frame thinking about needs and strengths appears to be conditioned on experience. Experienced caseworkers often rely on other concrete sources of information in addition to their working knowledge of individual and family system assessment, a knowledge base that is still forming for newer caseworkers.

Clinical skills required. Both case planners and supervisors discussed case planners' sense that they do not possess the clinical skills to complete several items on the CANS-NY, particularly items within the Behavioral Health and Trauma domains.

The third component of the theory of change underlying the CANS-NY has to do with the notion that the CANS-NY will contribute to higher quality service planning.

Timing is everything. Across role types and agencies, focus group participants reported that the service plan is already developed by the time the initial CANS-NY is completed; that is, the CANS-NY does not contribute to the development of the service plan. Indeed, case planners and supervisors alike stated that they complete the CANS-NY in order to be compliant with regulations, not as a means to improve their casework or the quality of the service plans developed for children and families.

Build the service infrastructure. While the CANS-NY may allow for the identification of nuanced clinical needs, caseworkers cannot follow that with nuanced clinical services. One example of this is the identification of needs that would lead a case planner to seek out CBT services. For example, in a number of focus groups it was reported that CBT services are difficult to find for children suffering from depression, anxiety, trauma symptoms, or exhibiting other externalizing behavior problems. This is notable given SFNYC's focus on providing CBT services, specifically, for children suffering from these conditions.

The feedback from case planners and supervisors detailed above points to an opportunity for ACS to consider the extent to which current training protocols and supports around the CANS-NY effectively promote the realization of the theory of change behind the implementation of the CANS-NY. Put another way, if the thinking holds that caseworkers who use the CANS-NY will do a better job (1) identifying family members' needs and strengths and (2) developing customized service plans, there is work yet to do to connect those dots for staff in the field.

In particular, caseworkers were uncertain about the rationale behind the CANS-NY. Both case planners and supervisors expressed cynicism in light of the persistent challenges they've faced in becoming certified CANS-NY users. Respondents also questioned the sequence of the CANS-NY in the actual flow of casework. As well, case planners in particular lack confidence in their ability to complete several key CANS-NY items related to children's behavioral and mental health. Taken together, these themes could compromise the ability of ACS and its providers to realize the potential benefits of the CANS-NY.

ACS already has a plan in place to respond to many (if not all) of the challenges staff detailed related to the CANS-NY's data entry system. Based on the feedback from staff – case planners and supervisors across all eight of the agencies – this would appear to be a critical piece of course correction. In particular, ensuring that case planners and supervisors have access to a summary of family members' strengths and needs could go some distance in helping to make the connection between the faithful completion of the CANS-NY and targeted, effective casework on behalf of children and families.

Partnering For Success

In March and April 2018, the Chapin Hall team had a series of conversations with key stakeholders at ACS' Workforce Institute about the implementation of PFS training and the core lessons staff learn as part of PFS training.

Training and Participation

Prior to any in-person training, case planners and mental health practitioners are required to complete a pre-test as well as a number of online modules (two hours of modules for child welfare staff; 10 hours for mental health staff). Three days of in-person training follows. During the first two days, child welfare staff and mental health staff are learning separately. They come together on the third training day to talk about how they can partner together around shared client families. A post-test comes next, followed by three practicum assignments designed to provide case planners the opportunity to demonstrate the integration of core PFS concepts. Case planners are then expected to participate in three practicum consultation calls; the culmination of the training is a Capstone presentation. Soup to nuts, the entire training process should take about six months.

Workforce Institute (WI) staff involved in the delivery of the PFS curriculum report that although a "50/50 split" of case planners and mental health practitioners was the hoped-for breakdown during any given PFS training session, more typically they find that the split is "90/10" in favor of case planners. Indeed, recruiting mental health practitioners to participate in PFS in the manner originally intended has proven very difficult. Foster care agencies that do not have an embedded mental health clinic were originally asked to establish Memoranda of Understanding with outside providers of mental health services – agreements that, the thinking went, would serve as the foundation of a partnership between the organizations and promote the joint training of staff from the two organizations: mental health clinicians who would ultimately provide CBT+ for eligible children and the case planners that would make those referrals and follow up on treatment and progress. These MOU's did not materialize as expected, though, and the Workforce Institute did not successfully recruit mental health clinicians from outside of embedded clinics or organizations that had, in fact, established an MOU with one of the SFNYC agencies.

WI staff had a number of ideas as to why there was so little success at getting mental health clinicians involved. First, it is the opinion of the WI staff with whom we spoke that mental health practitioners do not have the structural support they need to really practice CBT with fidelity. They lack the supervision they would need (supervisors trained and experienced in the model) as well as the time to really get trained in the model. The time mental health clinicians would need to spend in PFS training (on site, practicum hours, etc.) is time that they would otherwise be seeing clients (i.e., billable time). Second (and related), WI staff believe that many mental health practitioners use a psychodynamic or psychoanalytic approach in their work, which is generally at odds with the core principles that underlie cognitive behavioral approaches to behavior analysis and, ultimately, change.

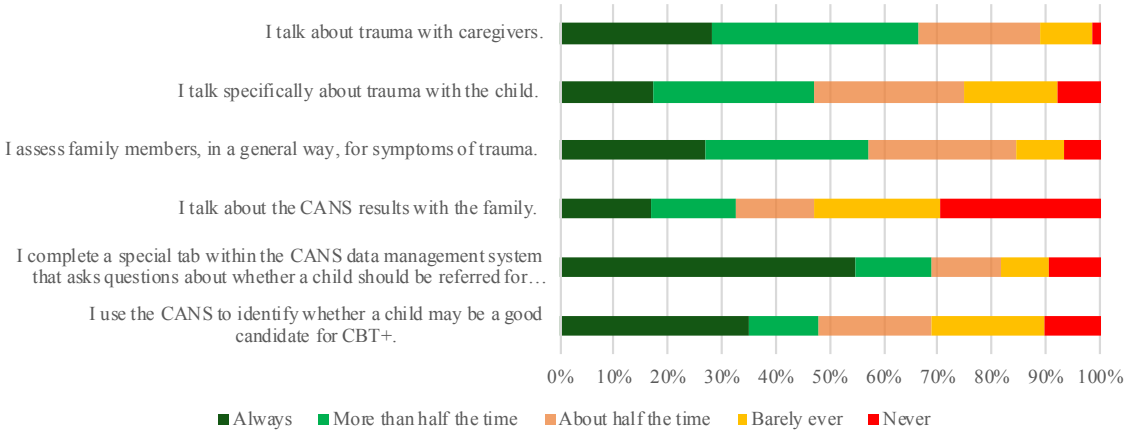
As of March 2019, 42 mental health practitioners have completed the training (i.e., submitted a Capstone project/presentation); approximately 163 child welfare staff completed the training. It should be noted that many more child welfare staff began the PFS training and completed some portion of the training, be it the online modules, the modules plus some amount of the three-day training, or the modules, the in-person training, and some amount of post-training consultation. However, the proportion of child welfare staff that saw the training through to its full completion is fairly low. To the extent that proficiency in the core concepts of PFS is dependent on the full PFS training experience, there would appear to be an opportunity reconsider the manner in which the material is delivered, both in terms of the number of different steps and the time within which those steps are delivered.

PFS in Action

In April 2019, we asked case planners to answer a series of questions about Partnering for Success and the specific skills that are taught during PFS training: engagement, screening, targeting, linking, and collaboration and monitoring. We also asked case planners to report on their typical contact with mental health clinicians, both in terms of content and frequency.

We begin with screening, which has a fair amount to do with the ways in which case planners use the CANS-NY to help identify mental and/or behavioral health problems that could benefit from the attention of a mental health clinician – perhaps one particularly trained in CBT+. Figure 12 looks at the extent to which case planners engage in specific screening behaviors that would be consistent with the PFS training modules on this topic.

Figure 12. *Self-Reported Screening Behavior: SFNYC Case Planners (n=133)*

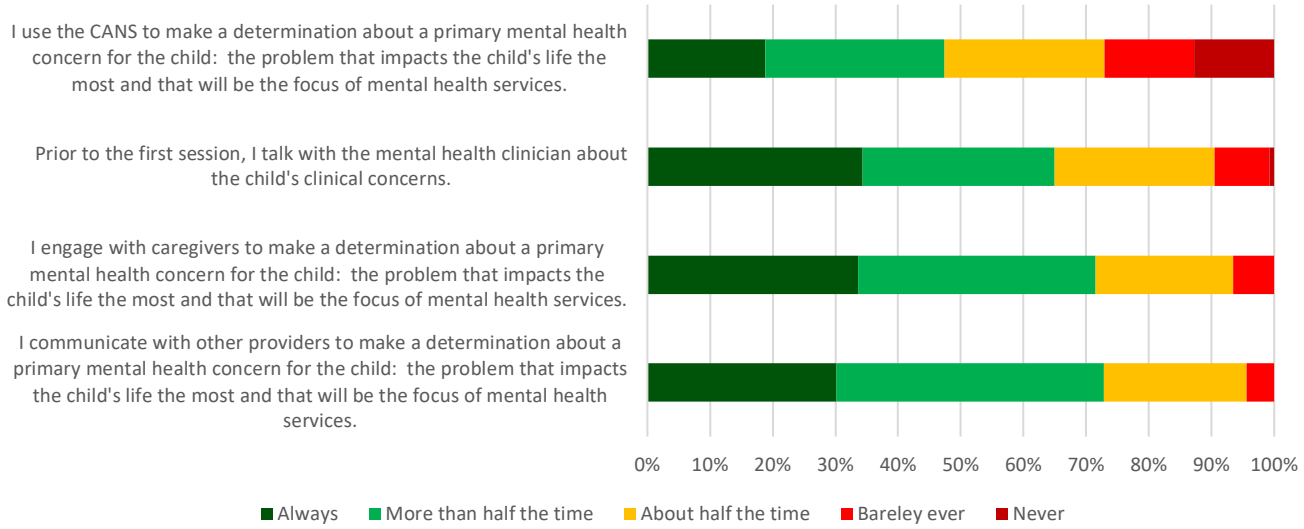


One hundred and thirty-three case planners responded to questions about screening behaviors. Trauma is one of the issues that PFS specifically intended to target, both by increasing case planners' proficiency in identifying the presence of trauma symptoms (and documenting those symptoms using the CANS-NY), but also because there is evidence that CBT can be an effective approach to alleviating trauma symptoms. Two-thirds (66 percent) of responding case planners report that they talk about trauma with caregivers "More than half the time" or "Always." Less than half of responding case planners (47 percent), however, report that they speak about trauma with children more than half the time or always. Fifty-seven percent of the case planners who responded to the questions about screening behaviors reported that they assess family members, in a general way, for symptoms of trauma.

The case planners who responded to the screening items on the General Staff Survey reported a somewhat limited use of the CANS-NY to screen for mental or behavioral health problems. Almost one-third of responding case planners reported that they "Barely ever" or "Never" use the CANS-NY to identify whether a child may be a good candidate for CBT+; more than half of responding case planners (53 percent) report that they "Barely ever" or "Never" talk about the CANS-NY with the family.

Figure 13, below, displays information about the extent to which case planners report engaging in what are referred to as "targeting" behaviors, per the PFS training.

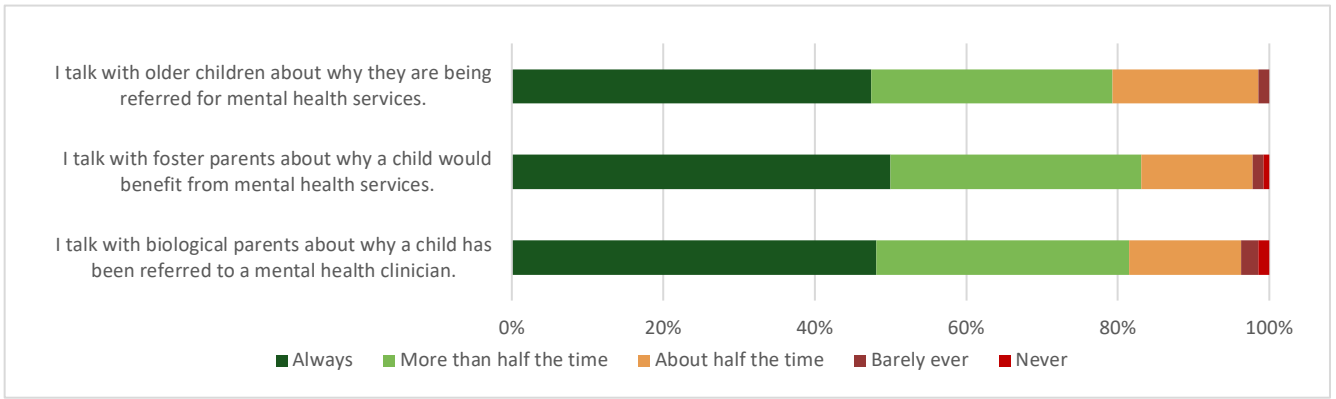
Figure 13. *Self-Reported Targeting Behavior: SFNYC Case Planners (n=135)*



Most of the case planners who responded to the GSS items on targeting behaviors report that they are, in fact, engaging in those behaviors: communicating with caregivers and providers to determine the primary target for treatment, and talking with clinicians prior to the first session with a child about the target for treatment. When it comes to using the CANS-NY as a tool to assist with targeting, though, we see less commitment: just under half of responding case planners (48 percent) indicate that they use the CANS-NY to identify a primary mental health concern to target for treatment either, "More than half the time" or "Always."

Figure 14 looks at engagement, behaviors that are designed to help caregivers and older children get on board with and commit to mental health treatment.

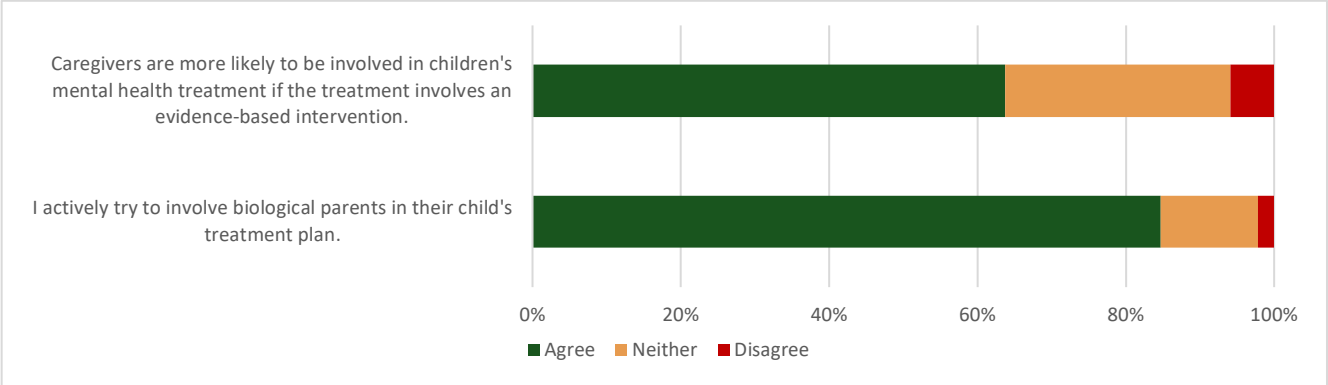
Figure 14. *Self-Reported Engagement Behaviors, I: Case Planners (n=135)*



The vast majority of responding case planners report that they talk with family members (children, parents, foster caregivers) either "Always" or "More than half the time" about mental health services. On average, about half of the case planners who responded to the engagement items on the GSS report talking with family members in this way all the time.

Figures 15 and 16 detail responses to items that have to do with linking behaviors: activities designed to connect children to high quality mental health clinicians.

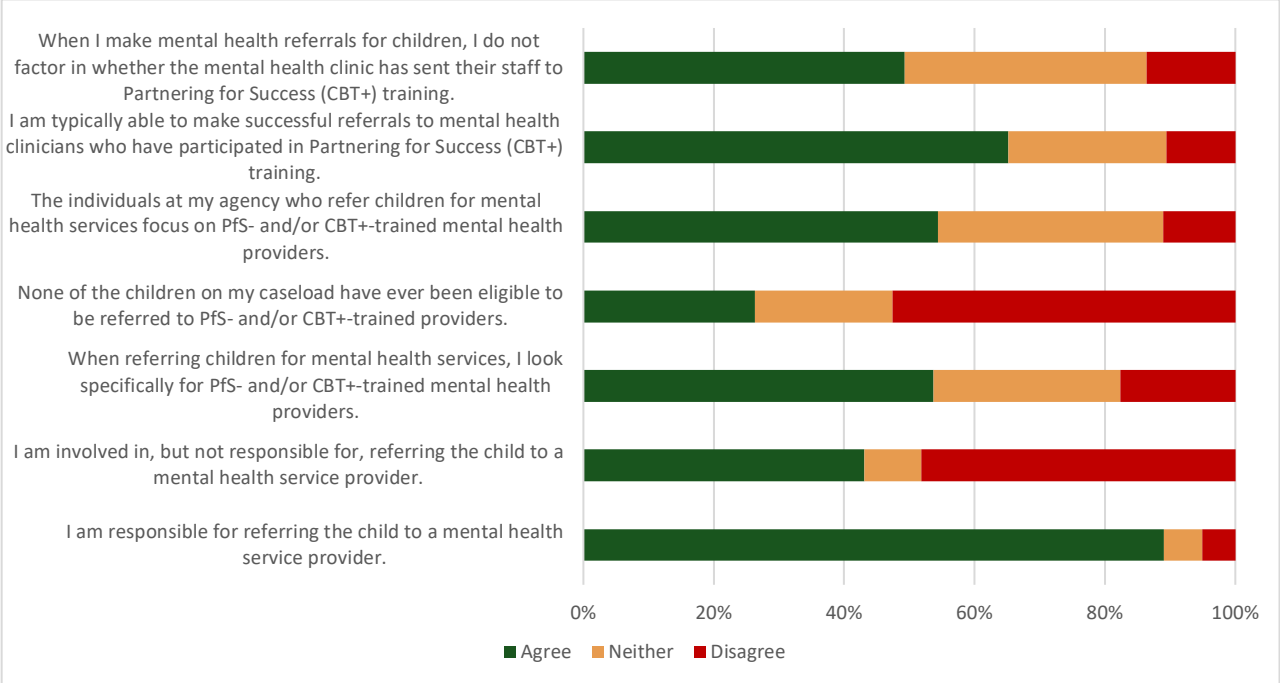
Figure 15. *Self-Reported Linking Behaviors, I: Case Planners (n=132)*



Nearly two-thirds of responding case planners perceive that caregivers are more likely to be involved in children's mental health treatment if the treatment involves an evidence-based intervention (for example, CBT). Eighty-five percent of responding case planners report that they actively try to involve biological parents in their child's treatment plan.

Figure 16 looks at additional linking behaviors.

Figure 16. *Self-Reported Linking Behaviors, II: Case Planners (n=132)*



The theory of change for PFS rests, in large part, in case planners prioritizing referrals to PFS-trained clinicians – both because of the specific training they would have in an evidence-based treatment for depression, anxiety, trauma, and other problem behaviors, but also because of the

training they would have about the value of working collaboratively with child welfare staff. Responses on the GSS to items having to do with "linking" were mixed:

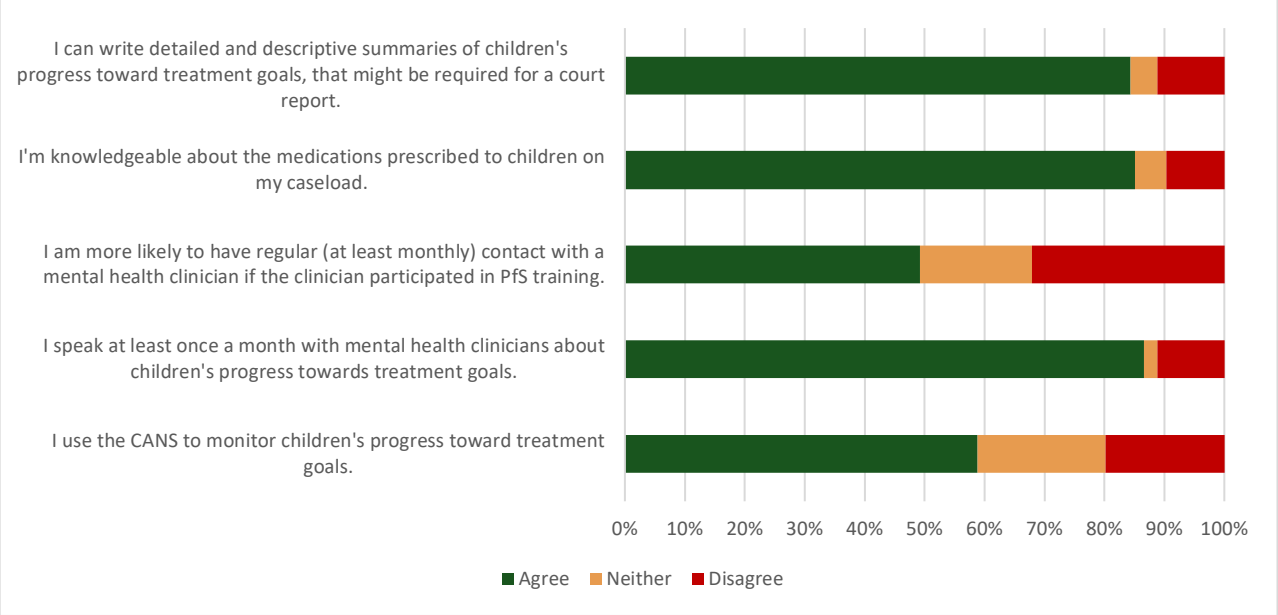
- Forty-nine percent of responding case planners indicated that they do **NOT** factor in whether a mental health clinician has been sent to PFS training when making referrals for treatment,

- Fifty-four percent of responding case planners indicated that they **DO** look specifically for PFS and/or CBT-trained clinicians; the same proportion of responding case planners reported that the individuals at their agency who are responsible for making mental health referrals look specifically for PFS/CBT-trained clinicians.

Either way, it appears that the responding case planners were split, just about down the middle, in terms of the primacy they place on finding a clinician either trained in PFS or trained in CBT, specifically.

Figures 17 and 18 display information about case planners' responses to items having to do with collaboration and monitoring.

Figure 17. *Self-Reported Collaboration and Monitoring Behaviors, I: Case Planners (n=134)*



The vast majority of responding case planners seem to engage in monitoring behaviors as it relates to children's mental health treatment:

- Eighty-four percent agreed with the statement, "I can write detailed and descriptive summaries of children's progress towards treatment goals that might be required for a court report."

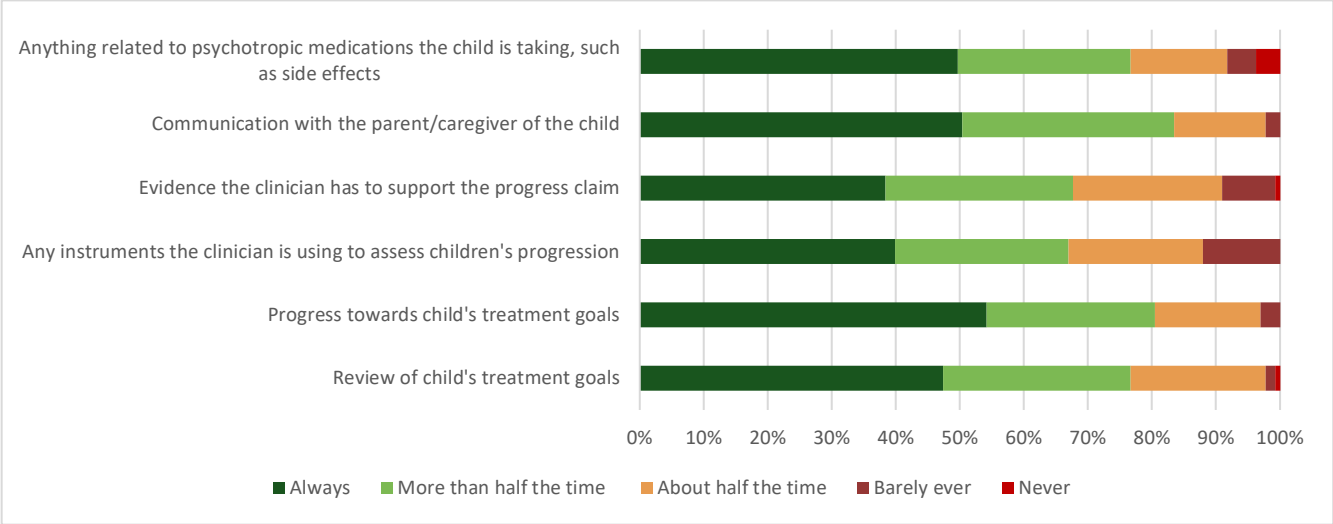
- Eight-five percent affirmed that they are generally knowledgeable about the medications prescribed to children.

- Eighty-seven percent reported that they speak with mental health clinicians at least once a month about children's progress towards treatment goals.

- However, just under half of responding case planners claimed that they are more likely to have regular contact with clinicians who have been trained in PFS than those that have not participated in the training.

Figure 18 details the kinds of topics that might be covered during follow-up calls between the case planner and the mental health clinician providing treatment to a child. Self-Reported Collaboration and Monitoring, II: Case Planners (n=133).

Figure 18. *Self-Reported Collaboration and Monitoring, II: Case Planners (n=133)*



Most responding case planners reported that they tend to speak about all of the topics covered in Figure 18 when speaking with mental health clinicians, especially the clinician's communication with the child's parent/caregiver and the child's progress towards treatment goals.

Monitoring PFS Implementation

In the Interim Evaluation Report, we discussed some of the apparent challenges around understanding the implementation of PFS and, in particular, the component of PFS that has to do with children receiving CBT+ services, ideally from a PFS-trained clinician. To review, ACS has put in place a data management system that houses not only CANS-NY data but also data specific to PFS. Specifically, the questions contained in the PFS-specific tables ask users a range of questions about children's eligibility for PFS, their current mental health treatment (if any), and whether the user (typically the case planner) recommends that the child be referred to a PFS-trained clinician for the purpose of receiving CBT+. However, data entry in this part of the CANS-NY data management system has been uneven.

Throughout December 2017, Chapin Hall partnered with ACS to conduct three focus groups, the objective was to gain additional insight into some of the perceived obstacles to regular data collection around PFS. The conversations focused on value of collecting information related to children's mental health service trajectories (particularly as it relates to PFS/CBT) and on steps that can be taken to improve staff compliance with data entry protocols as they relate to PFS.

Working with mental health providers. For those agencies in which there is an embedded mental health clinic, it is typically someone from the clinic that provides the mental health services directly or who manages referrals to community-based clinics. It is often someone from the agency's internal mental health clinic who will manage the ongoing communication about children's treatment. Under this workflow model case planners are apprised of children's mental health service plans and progress, but are not directly involved in establishing or monitoring those services. However, it is still the case planner who is responsible for entering data into eCANS about the need for mental health services, the type of service that will be provided, and progress to date.

Focus group participants familiar with this workflow scenario agree that when decisions around mental health services and referrals are handled by an agency-based mental health professional – not the case planner – the mental health staff should be responsible for entering that information into eCANS (and the relevant PFS decision-making tabs). Participants described how the movement of information from one person to another and then into the database often leads to information "falling through the cracks."

However, for those agencies who do not have an embedded mental health clinic, caseworkers need to refer to and follow up with clinicians from community-based clinics. According to the participants in this series of focus groups, the experience of communicating with mental health clinicians is something of a mixed bag. Some clinicians are responsive; others, much less so. This limits the quantity and quality of information caseworkers can record about mental health services experiences for children found to be eligible for CBT+.

More Hands on Deck. Across the three agencies that participated in this series of focus group there was agreement that enabling other staff to contribute to data entry – particularly around data that needs to be entered over time, such as the tracking of treatment sessions and communication with mental health providers – would go a long way to improving the extent to which this kind of data is entered at all. Be it case aides, social work interns, or other program support staff, focus group participants (case planners and supervisors alike) reported feeling like they did not have time to update the eCANS database in a manner that would advance ACS' and Chapin Hall's ability to study the implementation of PFS.

Challenges with CANS-NY. Several issues with the current eCANS database were raised during this series of focus groups although to be sure, focus group participants were clear that these were issues they had already brought to ACS' attention. For example, staff noted that before they can complete the CBT+ tab in eCANS they first have to complete the entire CANS-NY data entry process, which includes completing the CANS-NY, receiving supervisory feedback, editing the CANS-NY, and then re-review and approval by the supervisor. There is also a window within which data needs to be entered that can also interfere with case planners entering data as they come to know it. As well, we understand the current PFS tab only allows tracking for up to 10 CBT+ sessions, after which the worker has to start another service track.

Tracking PFS Decision-Making

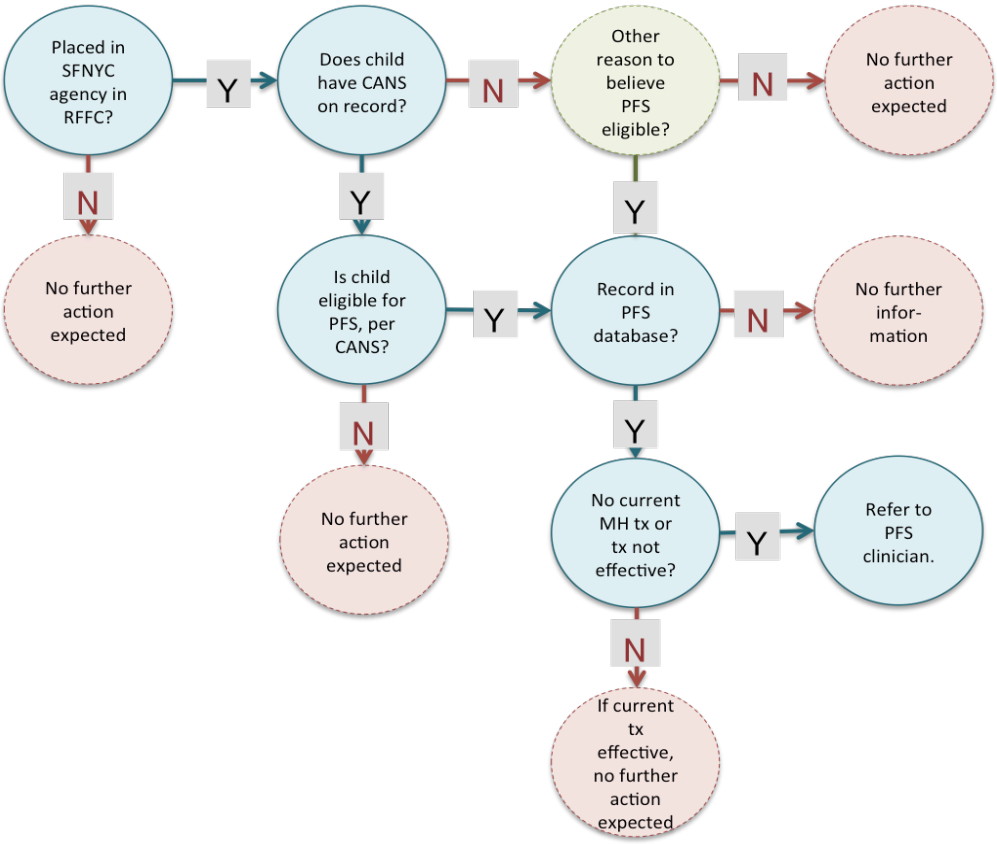
In this section we will focus on the implementation of PFS for the group of children who are expected to derive additional benefits from the model by virtue of their receiving evidence-based (CBT+) treatment for issues related to depression, anxiety, behavior problems, and/or trauma symptoms.

For the most part, the CANS-NY can be used to help determine whether a child should be considered eligible for PFS. Criteria include a score of 1, 2 or 3 on the following items:

1. Behavioral Health module trigger item
2. Depression-specific item in the Behavioral Health module
3. Anxiety-specific item in the Behavioral Health module
4. Conduct item in the Behavioral Health module
5. Oppositional item in the Behavioral Health module
6. Anger control item in the Behavioral Health module
7. Impulsivity/hyperactivity item in the Behavioral Health module
8. Adjustment to Trauma module trigger item
9. One or more of the Trauma Experiences items
10. One or more of the Trauma Stress Symptoms items

Because the CANS-NY data (and the PFS data) are organized around a common child identifier, the administrative data holds a lot of promise in tracking the flow of children into care, into eligibility groups per the CANS-NY, into eligibility groups per current treatment status, and, finally, into PFS treatment. Figure 19 below, was included in the Interim Evaluation Report but serves as a useful reminder of the pathways toward treatment.

Figure 19. *Conceptual Model, Analysis of PFS Implementation*



We start by looking at the extent to which SFNYC children had at least one CANS-NY on record with which to determine eligibility for CBT+. We then look at the extent to which those children met the basic criteria for consideration for CBT+. Next, we look to see whether those children who (a) had at least one CANS-NY completed and (b) met the eligibility criteria for PFS, per the CANS-NY, are (c) represented in the PFS database.

Table 16, below, displays the extent to which children in regular family foster care had at least one CANS-NY on record.

Table 16. *Availability of CANS-NY Data, by Placement Group*

	No CANS	**At least one CANS**	**Total**
Admitted on/after 3/1/16	5008	8773	13781
In care on 3/1/16	917	20,210	21,127
Total	5925	28,983	34,908
	Percent		
Admitted on/after 3/1/16	36%	64%	100%
In care on 3/1/16	4%	96%	100%
Total	17%	83%	100%

Most of the children in placement had at least one CANS-NY on record; about two-thirds of children in the PFS admissions group had a CANS-NY on record. Table 17, below, looks at those 28,983[16] children who had at least one CANS-NY completed and displays the proportion of those children who were eligible for CBT+, given their item-level CANS-NY scores.[17]

Table 17. *Eligibility for CBT+, per CANS-NY*

	Elig for CBT	Not Elig for CBT	Total
Under 1	2006	7472	9478
1 to 5 Years	3128	7267	10395
6 to 12 Years	2276	4095	6371
13 to 17 Years	1190	1539	2729
Total	8600	20373	28973
		Percent	
Under 1	21%	79%	100%
1 to 5 Years	30%	70%	100%
6 to 12 Years	36%	64%	100%
13 to 17 Years	44%	56%	100%
Total	30%	70%	100%

Most of the children assessed with the CANS-NY did not meet the eligibility requirements for CBT+ (70 percent). Teenagers were the most likely to be deemed eligible for CBT, based on their CANS-NY item scores.

The next threshold question has to do with whether we have additional information about children whose CANS-NY item scores put them in the "eligible" category for CBT+ services. This is information that case planners are responsible for entering into a special tab within the CANS-NY data entry system. Table 18 has the details.

Table 18. *Children eligible for CBT+ (as per CANS-NY): Presence of additional information regarding PFS eligibility and recommendations*

	Count	Percent
Record in PFS database	3671	43%
No record in PFS database	4936	57%
Total	8607	100%

The total (n=8,607) reflects all children who meet the following criteria:

[16] The total in Table 17 is slightly lower than the 28,983 total cited in Table 16 because children with missing age data have been eliminated from view.

[17] While children under 1 year of age may not actually be eligible for CBT+, they were still being scored as such on the CANS-NY.

1. Children in care on March 1, 2016, and in a PFS-eligible placement (regular family foster care) **OR**

2. Children admitted to care and placed in regular family foster care) after March 1, 2016, **AND**

3. Children (either in care or admits) who scored a 1, 2, or 3 on any of the CBT+-relevant CANS-NY items enumerated above.

Of the children in care at the relevant time for whom we have at least one CANS on record, and who also met the basic eligibility requirement for CBT+, 43 percent (n=3,671 of 8,607) have a corresponding record in the PFS-specific database. That we have PFS-specific data for less than half of the children determined to be eligible for CBT+ - one of the cornerstones of the PFS model – aligns with the qualitative data collected from case planners and supervisors about the functionality of the CANS-NY data entry system.

Interestingly, of those 3,671 children eligible for CBT+ based on one or more CANS-NY-item scores – CANS-NY items that map to the mental and behavioral health issues best suited for CBT+ (anxiety, depression, behavior problems, trauma symptoms), just over a third (37 percent) were determined to have initial mental health issues related to these conditions (Table 19, below).

Table 19. *Determination of Mental Health Issues: PFS Decision Tab*

	Count	Percent of Total
No mental health treatment needed	1178	32%
Issues not clinically significant or not eligible for CBT+ and child/youth is currently in treatment	683	19%
Other issues	113	3%
Initial mental health issues(s) exist related to anxiety, behavior problems, depression and/or trauma	1349	37%
Issues not clinically significant or related to CBT+ and child/youth is currently not in treatment	348	9%
Total	3671	100%

Lastly, we consider the treatment status and referral decisions for children who have a CBT-relevant mental health issue. Table 20 displays information for the 1,349 children (see Table 20) who were determined to present with an initial mental health issue that would be suited for treatment using CBT.

Table 20. *Treatment Status and Referral Decisions: Children Eligible for CBT+*

	Stay with current therapist	Refer to CBT therapist	Total
In Treatment	857	117	974
Not Yet In Treatment	352	22	374
		Percent	
In Treatment	88%	12%	100%
Not Yet In Treatment	94%	6%	100%

The data in Table 20 contain some apparent inconsistencies that likely speak to data entry issues. For example, of the children described as "Not Yet in Treatment, the decision for 94 percent was to "Stay with current therapist."

PFS Implementation: Summary

Overall, the implementation of PFS fell short of original expectations. Partnering for Success, as an approach, hinges on the presence of a partnership between child welfare caseworkers and mental health practitioners. However, mental health practitioners did not participate in PFS training as specified by the model. While case planners were much more likely than their mental health counterparts to participate in elements of PFS training, relatively few case planners saw the PFS training through to its final end (the completion of the Capstone project). According to staff at the Workforce Institute, one potential reason why this is the case is the sheer length of the PFS training process. If condensed, the thinking went, there may be a different completion rate.

Responses to PFS-specific items on the General Staff Survey suggest that case planners are practicing PFS skills, albeit with some variability across PFS skill areas. As noted elsewhere, though, the response rate to the GSS3 was low – low enough that it is questionable whether findings from the GSS3 can be generalized to the broader group of case planners.

The last point we would make about PFS has to do with the investment ACS has made in developing a tracking mechanism for mental health treatment decision making. To be sure, the investment is, on its face, worthwhile. It is critical to have a record of children's mental and behavioral well-being (via the CANS-NY) and a corresponding record of what kinds of treatment decisions are being made in light of those well-being determinations. This kind of electronic record keeping of core decision-making within the context of child welfare services is, to be certain, a huge step forward for the field.

The tables above make clear, though, that the part of the workforce responsible for building the database – for entering valid, reliable information into the data management system – is not yet using the system as it is intended to be used. Treatment decisions are being tracked for less than half of eligible children; further, there is some suggestion that data is not being entered as thoughtfully as possible, evidenced by conflicting responses to various questions. Whether the issue has to do with the computing environment or the need for additional training is unclear; likely, it is some combination of the two. But in either case it is a worthwhile pursuit, whether in service of the sustainment of PFS or outside the purview of the PFS model.

<u>ABC</u>

The approach we are taking for the evaluation of ABC is the same as what we use for the evaluation at large: an intent to treat design that looks at the group of children intended to be "touched" by the intervention – not just those who received it. The 'ABC Eligible Group' includes all children who were deemed eligible for ABC, regardless of whether they were referred for ABC or not. In order to be included in this group, children have to be between the ages of 6 to 48 months and be placed in regular family foster care with one of the SFNYC agencies.

With the help of ACS and Power of Two (the organization responsible for the implementation of ABC), Chapin Hall created a database that includes the administrative records of all ABC-eligible children and linked these data with any associated test scores (ASQ, BITSEA) as well as any available (ABC) treatment information (i.e., referral date, session date, status).

Table 21 provides a breakdown of the number of children referred to ABC, as of June 30, 2018.[18]

Table 21. *Children Referred to ABC, by Agency: March 2016 through June 2018*

	Treatment Status of Referred Children						Not Referred		Total
Agency	Complete	Declined	Discont.	In Progress	Total Referred	Percent Referred	Not Referred	Percent Not Referred	Total Eligible
Abbott House	22	3	5	8	38	29%	91	71%	129
Cardinal McCloskey	28	12	10	1	51	41%	73	59%	124
Catholic Guardian	25	9	9	5	48	16%	252	84%	300
Children's Aid Society	42	17	16	11	86	23%	282	77%	368
Children's Village	28	9	8	8	53	36%	96	64%	149
CHFS	25	6	3	10	44	32%	92	68%	136
Edwin Gould	37	8	10	4	59	22%	213	78%	272
GSS	19	9	15	5	48	22%	167	78%	215
Graham Windham	36	20	12	9	77	23%	255	77%	332
HSSV	36	8	6	8	58	19%	251	81%	309
JCCA	33	14	12	10	69	29%	170	71%	239
Little Flower	31	16	8	3	58	19%	247	81%	305
Lutheran	11	2	1		14	13%	94	87%	108
MercyFirst	21	7	6	9	43	27%	119	73%	162
Ohel	2	0	0	0	2	29%	5	71%	7
Rising Ground	28	5	12	2	47	42%	64	58%	111
Saint Dominic's Home	29	6	13	6	54	29%	132	71%	186
SCO Family Services	38	9	7	3	57	14%	365	86%	422
Seamans Society	15	10	8	6	39	16%	201	84%	240
Sheltering Arms	12	3	9	8	32	11%	260	89%	292
Total	518	173	170	116	977	22%	3429	78%	4406

As of June 30, 2018, approximately 22 percent of ABC-eligible children had been referred to ABC; of those referred, approximately 65 percent have either completed ABC or were in progress as of June 30, 2018 ((518+116)/977). At the agency level, referral rates vary from 11 percent of ABC-eligible children to 42 percent. Thirty-five percent of referrals did not pan out because the services were either declined or discontinued.

Tables 22 and 23 provide additional detail about the children eligible to receive ABC. In Table 22, spell year refers to the year in which children entered care. Age refers to children's age when they came into care.

[18] Table 21 accounts for the incremental timing of the ABC roll-out, with boroughs introducing ABC over time.

Table 22. *ABC-Eligible Children, by Referral Status and Age*

	Age of Referred Children					Age of Non-Referred Children					
Spell Year	Under 1	12-24 months	24 to 36 months	36 to 48 months	Total Referred	Under 1	12-24 months	24 to 36 months	36 to 48 months	Total Not Referred	**Grand Total**
2011						11				11	11
2012	1				1	99				99	100
2013	28				28	277	24			301	329
2014	100	10			110	289	118	35		442	552
2015	147	31	6		184	286	88	90	35	499	683
2016	166	65	18	15	264	316	137	143	113	709	973
2017	188	73	72	28	361	424	181	172	178	955	1316
2018	24	22	11	4	61	103	130	86	94	413	474
Total	654	201	107	47	1009	1805	678	526	420	3429	4438
	Percent of Eligible Children Referred to ABC					**Percent of Eligible Children NOT Referred to ABC**					**Grand Total**
2011	0%	0%	0%	0%	0%	100%	0%	0%	0%	100%	100%
2012	1%	0%	0%	0%	1%	99%	0%	0%	0%	99%	100%
2013	9%	0%	0%	0%	9%	84%	7%	0%	0%	91%	100%
2014	18%	2%	0%	0%	20%	52%	21%	6%	0%	80%	100%
2015	22%	5%	1%	0%	27%	42%	13%	13%	5%	73%	100%
2016	17%	7%	2%	2%	27%	32%	14%	15%	12%	73%	100%
2017	14%	6%	5%	2%	27%	32%	14%	13%	14%	73%	100%
2018	5%	5%	2%	1%	13%	22%	27%	18%	20%	87%	100%
Total	15%	5%	2%	1%	23%	41%	15%	12%	9%	77%	100%

Referrals to ABC picked up over time, with a peak in 2017. The younger a child is, the more likely they are to be referred to ABC. Infants are the most likely: the infants who were referred to ABC represent 15 percent of all ABC-eligible children; 65 percent of all referred children were infants when they came into care. The likelihood steadily goes down with every successive year at entry into foster care.

Table 23 provides information on the types of caregivers that participated in ABC.

Table 23. *Caregiver Types: ABC Participants*

Agency	Caregiver Type					
	Blank	Foster Parent	Grand-parent	Aunt/ Uncle	Other Relative	Grand Total
Abbott House	5	46	3	1	2	57
Cardinal McCloskey	11	41	4	9	4	69
Catholic Guardian Services	14	50	4	5	1	74
Children's Aid Society	12	63	18	13	6	112
Coalition for Hispanic Fam	4	42	9	3	2	60
Edwin Gould Services	16	49	4	8	8	85
Good Shepherd Services	17	42	6	3	2	70
Graham Windham	9	55	11	9	14	98
Heartshare	14	61	8	10	7	100
JCCA	19	60	9	9	8	105
Rising Ground	20	39	8	6	1	74
Little Flower	7	37	14	10	8	76
Lutheran Social Services	3	10	6	0	2	21
Mercy First	8	37	4	7	6	62
NY Foundling	1	0	0	0	0	1
Ohel	1	2	0	0	0	3
SCO Family of Services	18	55	4	5	9	91
Seamen's Society	13	22	17	4	3	59
Sheltering Arms	7	35	6	4	0	52
St. Dominic's Home	3	46	9	5	4	67
The Children's Village	13	40	14	6	7	80
Self Referral	1	0	0	0	0	1
Grand Total	216	832	158	117	94	1417

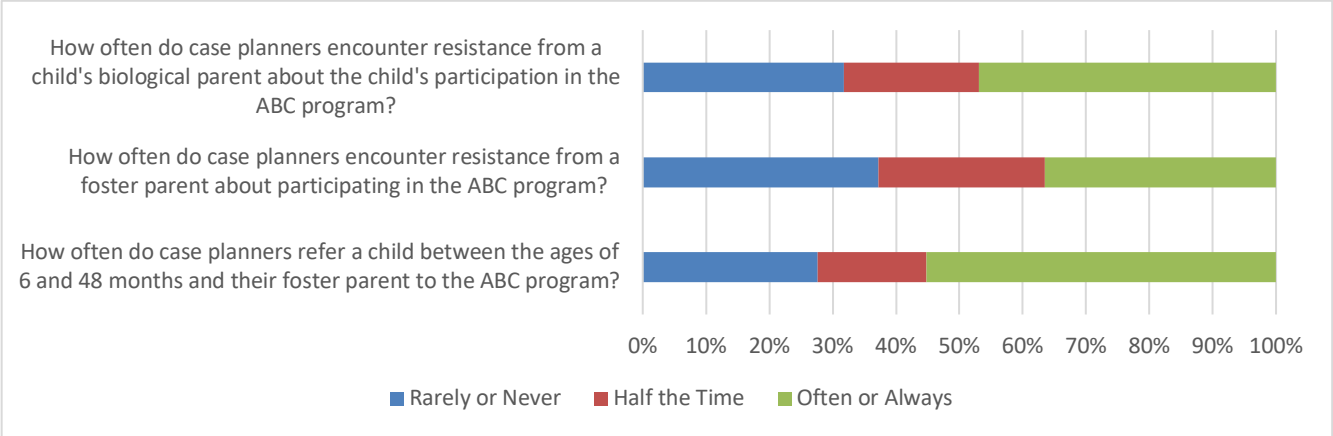
The total number of caregivers represented includes caregivers who participated in ABC on behalf of a child in care as well as caregivers who participated in ABC as a part of in-home, preventive services or post-placement, reunification services for birth parents. Most of the caregivers were foster parents and grandparents, who may have been serving as foster parents to children in care.

Staff Perspectives on ABC

One hundred and fifty case planners and 53 supervisors at the 17 SFNYC agencies responded to questions about the implementation of ABC as a part of the General Staff Survey administered in the spring of 2019. Questions had to do with referrals – how often case planners perceive they are making referrals for ABC on behalf of eligible children, resistance case planners encounter when making referrals, and why case planners sometimes don't make referrals for eligible children. Case planners and supervisors were also asked to comment on senior leadership support for ABC.

Figure 20, below, displays information about case planners' experiences making referrals to ABC.

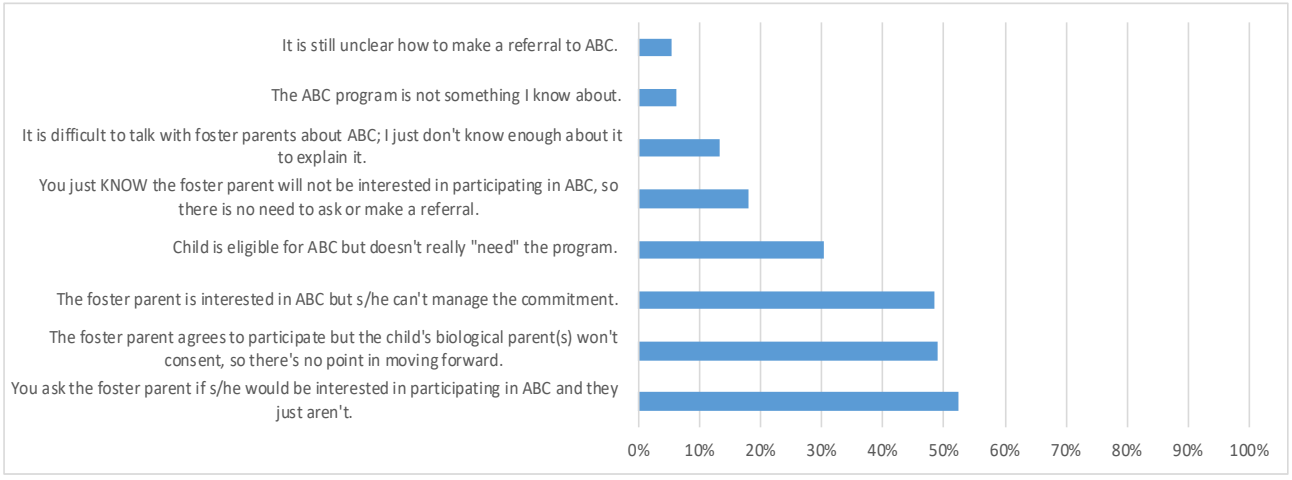
Figure 20. *Referrals to ABC: Case Planners, April 2019 (n=145)*



It is typical for case planners to encounter resistance when making referrals to ABC. The resistance is more pronounced from children's biological parents, although it is still quite common from foster parents, too. Still, for those case planners who participated in the GSS earlier this year, most report making referrals to ABC for eligible children at least half the time; more than half of the case planners report making referrals for eligible children "often or always."

We asked case planners to report on the reasons why children eligible for ABC might not get referred to the program. For this question, case planners were able to choose multiple answers. The most frequently cited reasons why an ABC-eligible child might not get referred for ABC are (1) foster parent disinterest in participating in ABC; (2) biological parent refuses to consent to their child's participation in ABC; and, (3) despite being interested, the foster parent is unable to manage the commitment required to participate in ABC. Figure 21 has the details.

Figure 21. *Reasons for Non-Participation in ABC: Case Planners (n=145)*



Lastly, we asked case planners and supervisors to report on their perception of senior leadership support for ABC. Among those case planners and supervisors who responded to the General

Staff Survey, 70 percent either "Agreed" or "Strongly Agreed" that senior leadership at their agency demonstrate a commitment to staff referring young children and their caregivers to the ABC program. However, in response to a similar item that read, "From my perspective, senior leadership at my agency rarely mention the ABC model," only 47 percent of responding staff indicated disagreement (either "Disagree" or "Strongly Disagree"); 26 percent of responding staff indicated they either "Agree" or "Strongly Agree" with that statement. (The remaining 26 percent chose "Neither Agree nor Disagree" in response to the item.).

ABC Implementation: Summary

ABC is an evidence-based model designed to improve the self-regulatory capacities of young children through improving their attachment to primary caregivers. Its application to foster care is innovative, as it has typically been implemented in non-custodial situations. Beyond innovative, though, the implementation of a model like ABC within the foster care context is logistically difficult. ABC is a time-intensive model that involves regular home visits and a willingness to be video-taped. Even if a foster parent consents to participate, the child's biological parent has to also consent, as their child will be participating and be captured on video. It stands to reason, then, that implementation levels are lower than anticipated and that we are seeing as much agency variation in implementation as we are.

Time Use

The premise underlying the study of time use is the potential inherent in understanding the value, in terms of improved outcomes, in changing the *amount of time* caseworkers spend doing certain tasks (reduce caseloads) and changing *the quality of the time* caseworkers spend doing certain tasks (i.e., by leveraging PFS training).

As depicted in the introduction to this report, the strategies ACS is employing under SFNYC are hypothesized to shift caseworkers' time use patterns in various ways. For example:

1. Caseworkers may spend more time communicating with biological parents and children as a result of enhanced relationships derived from Partnering for Success. Generally, more direct contact with children and families is desirable, in that it promotes better assessment and greater capacity of caseworkers to reinforce gains in permanency planning (or provide additional support).

2. Caseworkers may spend less time making referrals throughout the life of a case due children's improved capacity to attach and self-regulate, per ABC coaching. Less time making service referrals could mean more time spent having important direct contact with children, caregivers, and families.

The preceding examples consider how outcomes might improve as a result of changes in the way caseworkers use their time; namely, less time on indirect casework activities and more time on direct casework activities. However, better outcomes can be achieved without a noticeable shift in time use patterns. That would suggest a change in the *way* caseworkers are spending their time – as opposed to the *amount* of time they are spending.

In order to carefully track shifts in time use, the Time Use and Costing System (TUCS) method of studying time use separates casework into eight processes (categories of activity). The eight

processes are well established and have been shown to have applicability across jurisdictions (Holmes et al., 2012; Holmes & McDermid, 2012; Ward, Holmes and Soper, 2008).[19]

Table 24 details the eight processes of the TUCS method.

Table 24. *The Eight Casework Processes of the TUCS Method*

Process 1	Making the decision to place a child in out-of-home care	Includes all activities up to and including the decision to place a child in foster care.
Process 2	Developing the initial permanency plan	Includes all activities that contribute to the development of the initial permanency plan. Usually occurs within the first 30-45 days of a case.
Process 3	Maintaining the case	Includes all activities related to the ongoing maintenance of the case except for non-court case reviews (such as conferences) and court related activities. "Starts" after the initial service (or permanency) plan is developed.
Process 4	Ending a case	Includes activities specifically related to ending a case. Does not include tasks covered in Process 3.
Process 5	Placement change	Includes activities related to a placement change (from one foster home to another, or from one level of care to another). Does not include activities related to the ongoing maintenance of a case (Process 3).
Process 6	Non-court case reviews	Includes the tasks required to hold a single non-court case review, such as family-team conference. Includes such tasks as scheduling the conference, attending the conference, and debriefing with case stakeholders following the conference.
Process 7	Legal activities	Includes activities related to court hearings, such as traveling to court, preparing for court, and appearing in court.
Process 8	Independent living services	Includes activities related specifically to the provision of (or connection to) services related to preparing adolescents for adulthood.

The process by which time use data is collected (focus groups, online survey) and verified was detailed in the Interim Evaluation Report. The Time Use Survey was administered at two points in time: fall 2015 and early spring 2019. Reported time use is compared from one time period to

[19] Holmes, L., McDermid, S., Padley, M., & Soper, J. (2012). An exploration of the costs and impact of the Common Assessment Framework. Department of Education: London.

Holmes, L., & McDermid, S. (2012). Understanding costs and outcomes in child welfare services: A comprehensive costing approach to managing your resources. Jessica Kingsley Publishers: London.

Ward, H., Holmes, L., & Soper, J. (2008). Costs and consequences of placing children in care. Jessica Kingsley Publishers: London.

the next, enabling an examination of the extent to which time use patterns have changed as a result of SFNYC strategies.

Time Use Findings

In July 2015 and March 2019, case-carrying caseworkers and their supervisors from the 17 SFNYC participating agencies were invited to participate in a Time Use Survey. Overall, we heard from 55 percent of those invited to participate. At the agency level, response rates varied from 0 to 100 percent.

Table 25 displays TUS response rates for both administrations of the tool, by agency.

Table 25. *Time Use Survey Response Rates, by Time and Agency*

	Time Use Study 1		Time Use Study 2	
Agency	Number participated	Response rate	Number participated	Response rate
Abbot House	20	87%	12	100%
Cardinal McCloskey	14	54%	15	75%
Catholic Guardian	43	52%	17	35%
Children's Aid	4	9%	36	84%
Children's Village	7	23%	25	100%
Edwin Gould	42	70%	21	75%
Forestdale	19	49%	26	72%
Graham Windham	14	22%	25	71%
Heartshare/St. Vincent	50	68%	20	43%
Little Flower	40	69%	19	41%
Lutheran	12	63%	9	75%
Mercy First	18	39%	12	55%
Ohel	6	86%	5	100%
Rising Ground	20	77%	19	100%
SCO	48	40%	10	20%
Seamen's Society	37	90%	27	60%
Sheltering Arms	0	0%	10	25%
Did not consent/Missing	-	-	20	-
TOTAL	**395**	**53%**	**328**	**61%**

As Table 25 displays, there was wide variation in response rates across the agencies, in both administrations of the Time Use Survey.

The full set of time use data tables are available in Appendix A. Below we provide general observations related to both Time 1 and Time 2 of the TUS. In each section, we note whether there have been changes in the way caseworkers in NYC allocate their time.

Developing the Initial Service (Permanency) Plan. At the Time 1 administration of the TUS (2015) case planners reported spending, on average, approximately 37 hours over the course of

the initial 30 days developing the permanency plan for one child in foster care. At the Time 2 administration (2019), case planners reported slightly less time for this category of activities: 31.3 hours. Supervisors, on the other hand, reported about the same amount of time on this cluster of casework/supervisory tasks: 12 hours at Time 1, and 11.4 hours at Time 2.

Of the 37 hours case planners reported spending developing the initial permanency plan at the Time 1 administration of the TUS, approximately eight of those hours were spent scheduling, supervising, and documenting family visits. In 2019, at the Time 2 survey, case planners reported spending slightly less time on this set of activities: 6.4 hours were spent scheduling, supervising, and documenting family visits during the first 30 days of a case for a SINGLE child in out of-home care.

In 2015, case planners reported spending approximately 8.5 hours in face-to-face contact with the child and caregivers during the initial permanency plan development phase. This is separate from the time caseworkers spend on family visits that occur within the first 30 days. In 2019, this figure came down significantly: just under 5 hours spent in face-to-face contact with children and caregivers during the initial permanency plan development phase. Generally, this time was broken down as follows:

1. Time with the child (Two hours reported in 2015; 1.3 hours reported in 2019)

2. Time with the biological family (3.5 hours reported in 2015; 1.5 hours reported in 2019)

3. Time with foster caregivers (Three hours reported in 2015; 1.4 hours reported in 2019)

Setting family members up with services also takes time. Case planners reported spending, on average, about 2.5 hours on researching, making, and documenting referrals when asked in 2015 about their time use habits. This figure was about the same in 2019: 2.7 hours reported on researching, making, and documenting referrals during the initial phase of a case (first 30 days).

A big change in reported time use has to do with travel. In 2015, case planners reported that travel took up about 17 percent (37 hours) of the total time they spent on casework related tasks during the first 30 days of a case. This figure included travel to the biological home, foster home and school. In 2019, case planners reported much less travel during this period: 3.4 hours, accounting for just 7 percent of the total amount of time spent on tasks associated with the development of the initial permanency plan.

Maintaining the Case. There is a set of ongoing activities that go into maintaining a case while a child is placed in foster care. These are routine case management responsibilities, many of which happen each month. In both 2015 and 2019, case planners reported that it took 26 hours of their time on a monthly basis in order to maintain a child's placement in foster care. The figures are also just about the same for supervisors when comparing 2015 and 2019 survey data: approximately four hours of supervisor time was spent - on a monthly basis - in order to maintain a child's placement in foster care. These figures are for a simple (base) version of a case, one involving a single school aged child with no complex special needs. This 26-hour figure does not include time spent in court, or time spent on FTCs, or time spent managing a change in placement.

1. Almost 25 percent of this time is dedicated to casework related to family visits (supervising, scheduling, documenting). That is, caseworkers in NYC are spending, on average, 6.5 hours handling family visits for a single child in a one-month period.

2. In 2015, case planners reported spending an additional 11 hours during a standard month in direct contact with children and their parent(s). This amount went up to 16 hours in 2019.

Ending a Case. On top of the time caseworkers spend monthly maintaining one case, they report to spend an additional six to seven hours on a case if it is exiting to reunification (6 hours were reported by case planners in 2015, seven hours were reported by case planners in 2019). Supervisors reported spending an additional 3.4 hours (on average) on activities related to the closing of that same case; this is on top of the 4.3 hours they spend in an average month on activities related to maintaining the case. For supervisors responding the survey in 2019 the "Ending a Case" figures are slightly higher: an additional 4.7 hours were reported for case closing activities that are specific to the reunification scenario.

Placement Changes. Each time a child requires an unplanned change of placement, there is additional time case planners need to spend in additional to the monthly time they spend managing the case. In 2015, case planners indicated they spend 10 additional hours of tending to tasks specifically related to the change of placement; this figure is about the same in 2019, with case planners reporting that they spend an additional 9 hours on an unplanned placement change. Supervisors taking the survey in 2015 reported an additional 7 hours of supervisor time required for activities associated with an unplanned placement change. Supervisor respondents in 2019 reported even more time spent on a single unplanned placement change: 13.4 hours, on top of the time they spend maintaining the case on a monthly basis.

1. In 2015, it was reported that of the 10 caseworker hours dedicated to a placement change, nearly two of those hours are spent traveling to and from the new foster home. This is essentially unchanged in 2019: Two hours were reported traveling to and from the new foster home, of a total of nine hours spent on placement change activities for a single child experiencing an unplanned placement change.

2. Arranging, attending and documenting the Placement Preservation Conference takes two hours of a case planner's time (related to one placement change). This figure is the same in both the 2015 and 2019 surveys.

Non-Court Case Reviews (FTCs). Executing one FTC – including scheduling, attending, debriefing, and documenting – takes a case planner about 4 hours. This is the same for the 2015 case planners and the 2019 case planners who participated in the Time Use Survey. Supervisors in 2015 reported spending nearly 3.5 hours on that same conference; supervisors in 2019 reported spending just under five hours. Approximately 25 percent of that time is spent on administrative tasks such as scheduling and securing a room (for both the 2015 and 2019 sample of case planners).

Legal Activities. Each permanency hearing consumed a total of 7.4 hours of a case planner's time per the 2015 survey. In 2019 this estimate went down somewhat to 6.3 hours. For supervisors the value is about the same from 2015 to 2019: nearly 6 hours of a supervisor's time is spent on a single permanency hearing for a simple version of a case.

Time Use Summary

Overall, the 2015 and 2019 time use estimates are very similar. There are two notable exceptions: the time case planners reported spending on activities that have to do with the development of the initial service plan and the time they spend in direct contact with children in

families during a standard month, while maintaining the case. Regarding the development of the initial service plan, reported time use is down in 2019 compared to 2015 figures. Case planners reported spending less time in face-to-face contact with key stakeholders (children, biological parents, and foster caregivers) in 2019 compared to 2015 during the first 30 days of the case. However, case planners reported spending considerably MORE time in direct contact with children and families during a standard month, while maintaining the case: five more hours per month, on average, compared to 2015 figures. This kind of increase in direct contact time is important to note because it is part of the theory of change that underlies the caseload reduction and its hypothesized relationship with improved outcomes.

It is important to note, however, that we are not comparing time use patterns for the same group of case planners over time. Response rates for both administrations of the TUS were somewhat low (53 percent in 2015, 61 percent in 2019). Further, the overlap in case planners and supervisors from the 2015 survey to the 2019 is also quite low.

Outcomes Study

At the heart of the outcomes study are four research questions:

Key Questions

1. What is the impact of SFNYC on the likelihood that children will experience a **permanent exit** within set periods of time?

2. What is the impact of SFNYC on the likelihood that children in out-of-home care will experience a **movement** from one foster home to another?

3. What is the impact of SFNYC on the likelihood that children will experience **reentry** following a permanent exit from care?

4. What is the impact of SFNYC on the number of **care days** used, on average, both for children who enter placement after the implementation of the project as well as children in-care at the time SFNYC rolled out?

Sample

SFNYC targets all children between the ages of 0 and 21 placed in regular family foster homes supervised by the 17 SFNYC agencies. The sample includes both children in care at the start of SFNYC (the legacy caseload) and all admissions involving children entering family foster care. SFNYC officially began on January 1, 2014. We use the experiences of children from those agencies who belong to the 2010 through 2013 entry cohorts as comparison groups.

In order to determine whether children would be included in the SFNYC (or comparison) group we linked CCRS (placement) data with a "program spell file" that reports the type of setting in which children were placed over the course of their spell, such as residential treatment facilities, family foster care, treatment (therapeutic) foster care, or specialized medical foster care. Only children placed in regular family foster care at the beginning of their spell were considered eligible for inclusion in the sample (SFNYC or comparison group).

Table 26 enumerates the breakdown of the admissions sample (SFNYC agencies only) across the four possible eligibility designations.

Table 26. *Entry cohorts, by eligibility status and year (SFNYC agencies only)*

Entry Year	Eligible	Ineligible	Dropped ID	Unknown	Total
2010	3,973	1,006	89	42	5,110
2011	3,430	766	71	25	4,292
2012	2,964	755	55	17	3,791
2013	2,610	625	31	8	3,274
2014	2,416	538	16	2	2,972
2015	2,071	498	8	2	2,579
2016	1,785	537	1	1	2,324
2017	1,889	530	2	0	2,421
2018	1,611	399	0	1	2,011
		Percent of Total			
2010	78%	20%	2%	1%	100%
2011	80%	18%	2%	1%	100%
2012	78%	20%	1%	0%	100%
2013	80%	19%	1%	0%	100%
2014	81%	18%	1%	0%	100%
2015	80%	19%	0%	0%	100%
2016	77%	23%	0%	0%	100%
2017	78%	22%	0%	0%	100%
2018	80%	20%	0%	0%	100%

The vast majority of children who entered care at the 17 participating agencies were initially placed in regular family foster homes. The balance includes children who were initially placed in alternative settings: treatment family foster care, congregate care, or specialized medical care. We were unable to determine eligibility for approximately 1 to 3 percent of entrants, either because of a misalignment of child ID's between our seed analytic files (derived from CCRS) or because of missing data. These are the children in the Dropped ID and Unknown columns.

In Table 27 we look at children in the legacy or "in-care" groups – both the SFNYC group (the 2014 in-care group) and the comparison group (in-care groups 2010-2012).

Table 27. *In care groups, by eligibility status and year (SFNYC only)*

Entry Year	Eligible	Ineligible	Dropped ID	Unknown	Total
2010	8,188	1,942	1,572	251	11,953
2011	8,425	1,830	1,009	188	11,452
2012	8,313	1,626	612	105	10,656
2013	8,022	1,633	372	60	10,087
2014	7,389	1,523	203	57	9,172
		Percent of Total			
2010	69%	16%	13%	2%	100%
2011	74%	16%	9%	2%	100%
2012	78%	15%	6%	1%	100%
2013	80%	16%	4%	1%	100%
2014	81%	17%	2%	1%	100%

We see a similar breakdown for the in-care groups as we did for the admissions groups. Most of the children in care on January 1 of the given years were in an eligible placement: a regular family foster home. Most of the remaining children were placed in an "ineligible" placement – treatment foster care, specialized medical care, or congregate care. A greater proportion of

children have either dropped IDs or unknown program type. This is likely due to the progressive improvement of the data management system over time; there are children in the in-care group whose spell began before these improved data recording and management systems were put in place.

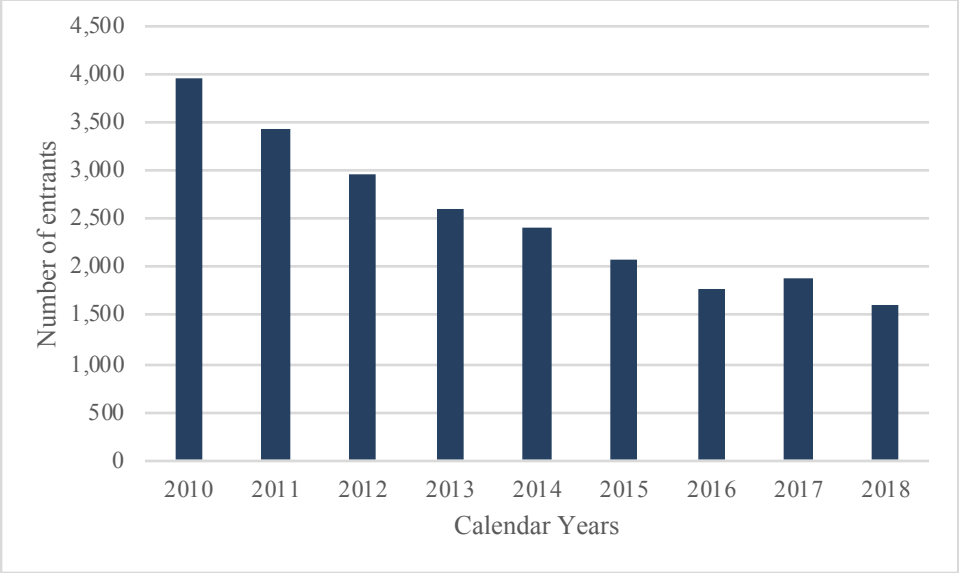
Table 28 provides additional information about the make-up of children in the SFNYC admissions group.

Table 28. *Entry cohorts: Eligible children, by age (SFNYC only)*

	Age Groups				
Entry Year	**Under 1**	**1 to 5**	**6 to 12**	**13 to 17**	**Total**
2010	1,032	1,311	1,085	544	3,972
2011	961	1,186	792	489	3,428
2012	841	923	744	456	2,964
2013	763	874	581	390	2,608
2014	677	811	624	303	2,415
2015	605	658	520	286	2,069
2016	521	606	429	227	1,783
2017	540	697	437	214	1,888
2018	522	552	361	175	1,610
			Percent		
2010	26%	33%	27%	14%	100%
2011	28%	35%	23%	14%	100%
2012	28%	31%	25%	15%	100%
2013	29%	34%	22%	15%	100%
2014	28%	34%	26%	13%	100%
2015	29%	32%	25%	14%	100%
2016	29%	34%	24%	13%	100%
2017	29%	37%	23%	11%	100%
2018	32%	34%	22%	11%	100%

We see slightly higher proportion of babies entering care over time, and a slightly lower proportion of 6 to 17-year olds entering care. We also see a steady decline in the overall number of children admitted to care, depicted below in Figure 22.

Figure 22. *SFNYC-Eligible Entrants, by Entry Year (SFNYC Eligible Only)*



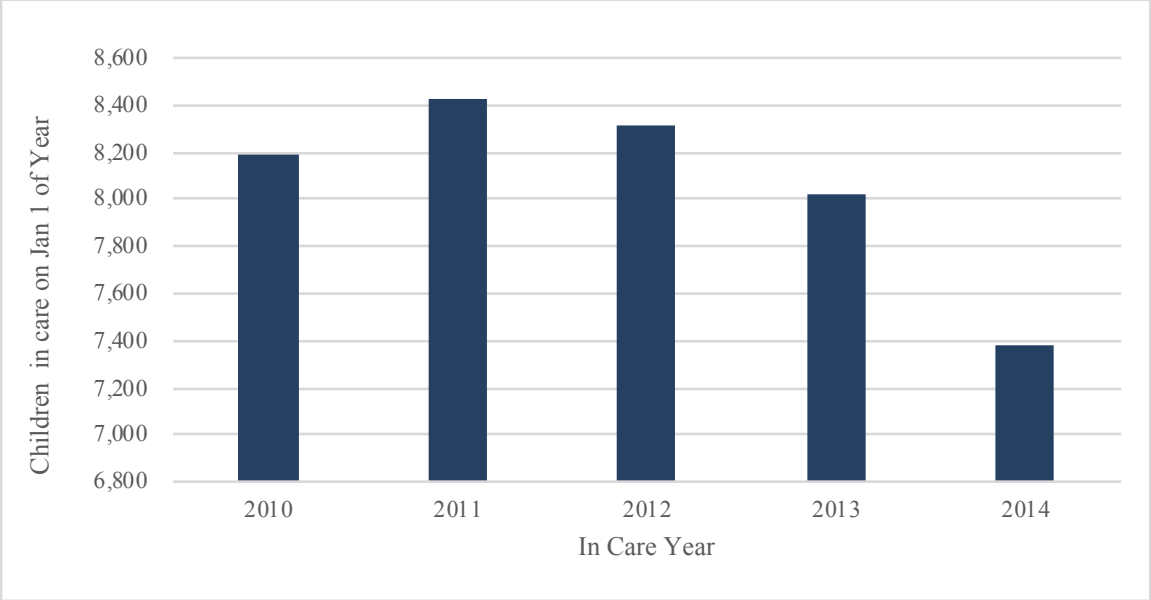
As for the children in the in-care groups, we see very stable breakdowns by age over the five years represented below, in Table 29.

Table 29. *In care groups: Eligible children, by age (SFNYC only)*

	Age Groups				
In Care Year	**Under 1**	**1 to 5**	**6 to 12**	**13 to 17**	**Total**
2010	2,488	2,741	1,904	1,053	8,186
2011	2,538	2,804	1,951	1,131	8,424
2012	2,646	2,769	1,826	1,070	8,311
2013	2,621	2,604	1,752	1,043	8,020
2014	2,468	2,398	1,564	956	7,386
			Percent		
2010	30%	33%	23%	13%	100%
2011	30%	33%	23%	13%	100%
2012	32%	33%	22%	13%	100%
2013	33%	32%	22%	13%	100%
2014	33%	32%	21%	13%	100%

As with the admissions group, we see a steady decline in the total number of children in care on January 1 of the year beginning with the 2011 in-care group, depicted below in Figure 23.

Figure 23. *Children in-care on January 1 of the year, by year (SFNYC)*



Data Sources

The primary source of data for the outcomes study is CCRS, which includes information related to children's placements in out-of-home care. As noted above, the administrative records of children included in the sample (children in the admissions groups – SFNYC and comparison – as well as children in the in-care groups, also SFNYC and comparison) were linked with data supplied to the evaluators separately from the CCRS tables used to construct the core analytic child and agency spell files. This separate database included information about placement type. Placements in regular family foster care were distinguished from other family-based placements such as treatment foster care and specialized medical foster care; the dates of any placements in congregate care were also included. Together, these data were used to identify the group of children that would be included in the sample: children age 0 to 21 who were placed with any of the 17 SFNYC agencies on or after January 1, 2014, as well as children in care and in the custody of any of these 17 agencies ON January 1, 2014.

The resulting analytic file is organized around agency spells, not child spells. That is, for each child included in the sample there are as many "rows" or observations as there are agency spells associated with the relevant child spell(s). For example, a child placed with one of the SFNYC agencies on May 15, 2014, (after SFNYC began, so a member of the SFNYC group – the 2014 entry cohort) may have experienced an inter-agency move at some point during the time in out-of-home care. Each agency "spell" is retained in the data file; the start and stop dates of each agency spell are retained. Included in each agency spell record is the child spell start and stop dates that establish the various agency spells as part of the same single child spell.

Analysis

The basic monitoring of core performance outcomes vis-à-vis SFNYC is based on an analytic file that is organized around agency spells, as described just above. These core outcomes include:

Placement stability

We take two approaches to considering the extent to which children have stability in their out-of-home placements. The first approach is a simple count of children who experience two or fewer moves during their agency spell. The focus is on children in the admissions group, comparing children in the SFNYC entry cohorts (entry cohorts 2014 through 2018) with the comparison cohorts (entry cohorts 2010, 2011, and 2012). We exclude from the count moves that are designed to reunite siblings, moves that place children in pre-adoptive homes, and moves from non-kinship to kinship homes. What remains are lateral moves that do not meet these criteria and step-ups to higher levels of care. Those counts are presented, below, by year and by age at spell start.

The second approach we use to measuring placement stability is the conditional probability, here in six-month intervals. The conditional probability answers the question, what is the probability that a child will experience *an initial* placement move in the first six months of their foster care spell? For children who are still in care during the second six-month interval and didn't move in the first six months, what is the probability that they will have a *first* move in that second interval (and so on)? We focus on the first-ever placement change because the best way to prevent children from serial moves during their foster care spell is to avoid the first-ever move. Understanding when the probability of that first-ever move is highest gives agencies actionable information, so that they may try and get ahead of those experiences and avoid them altogether. As with the counts described above, data on the conditional probability of an initial placement change is organized around children's developmental stage at the time their spell began.

Permanency

We also take a number of different approaches to measuring permanency: one for the admissions cohorts and one for the in-care group. For the admissions cohorts we use the cumulative probability of a permanent exit, using six-month intervals. The cumulative probability is organized around the age of children in the sample at the time their child spell began. For permanent exits we are including reunification, adoption, and discharges to relatives. Note for this measure we look at children in their first-ever agency spell (first agency spell within their first ever child spell) separately from the children in their first agency spell within a reentry child spell. We know from prior research that trajectories through the foster care system are different for children in their first-ever foster care spell than they are for children in a subsequent spell in out-of-home care (Wulczyn, Barth, Ying-Ying, Harden, & Landsverk, 2006).[20]

For the in-care group, we use the residual duration as a measure of permanency. The residual duration tells you how long, in days, it takes some percent of a group of children to leave foster care, given that the entire group may not have exited by the time this report is being written. (Here we use the 75 percent median duration.) To level the analysis, we organize these data according to the length of time members of the various in-care groups (2010 through 2013 for the comparison; 2014 for the SFNYC/treatment group) had been in care as of January 1 of the given in-care year: zero to six months; six to 12 months, 12 to 18 months, 18 to 24 months, and 24+ months.

Reentry

[20] Wulczyn, F., Barth, R.P. Ying-Ying, T., Harden, B. & Landsverk, J. (2006). *Beyond Common Sense Child Welfare, Child Well-Being, and the Evidence for Policy Reform*. Aldine Transaction: Chicago.

We use the conditional probability of reentry as our main measure of children's reentry into care, organized in three-month intervals. The data are organized by exit year and age at exit. Here, the question we are answering is, what is the probability that a child will reenter care in the first three months after their exit from care? For children who have not yet reentered after three months, what is the probability they will reenter in the next three-month interval (and so on)? Using small intervals of time makes it easier for agencies to consider what might be driving the reentries, when they do occur.

To assemble the reentry-specific analytic file we focus on children who exit from foster care from the 17 SFNYC agencies and who had been in regular family foster care at the time of their exit. As noted above, we re-categorized the age variable as well, so that we are focusing on the child's age at the time of their discharge from care rather than their age at the time of their entry into care.

Care days

At the heart of the Waiver demonstration model is the goal of reducing the number of foster care days systems use, which is, of course, simply the aggregate form of reducing the number of foster care days individual children are using. We provide counts of care days for the 2014 through 2018 entry cohorts. We follow the 2014 entry cohort for 5 years (through the end of the Waiver demonstration period), the 2015 cohort for 4 years, the 2016 cohort for 3 years, and so on.

Conceptually, what we do with each entry cohort is identify the group of children who entered care in the relevant time period (within each calendar year) and who were eligible for SFNYC and then watch them flow out of care over the course of the Waiver period (until December 31, 2018). Each performance year starts with a group of children. For each entry cohorts, the first performance year starts with all of the eligible children admitted to care during that year. For each subsequent performance year, the performance year starts with all of the children (of those admitted in the first performance year) still in care at the beginning of the next performance year.

Intervention-specific impact analyses

In this section we look at the impact of two of the SFNYC investments on permanency: the reduction in caseloads and ABC. We do not look at PFS in the same way because the implementation of PFS did not unfold as anticipated; namely, the mental health practitioners did not participate in PFS training as assumed by the theory of change. Relatedly, children were not referred to PFS-trained clinicians (those trained not only to collaborate with child welfare staff but those trained to provide CBT+ for children suffering from depression, anxiety, trauma, or other behavior problems) consistent with the theory of change. The caseload reduction *did* occur, though; so did ABC, although the penetration of the model did not rise to original expectations.

In this first section, we provide general performance trends over time. In following sections, we look at the impact of SFNYC strategies (caseload reductions and ABC, in particular) on permanency.

Performance trends

As described above, the core outcomes of central concern under SFNYC include placement stability, permanency, reentry, and care day utilization. We take each one in turn in the sections that follow.

Placement stability

In this section we provide data related to the stability of children's placements. The focus is on children in the admissions groups: the SFNYC entry cohorts and the comparison entry cohorts.

Two or Fewer Moves

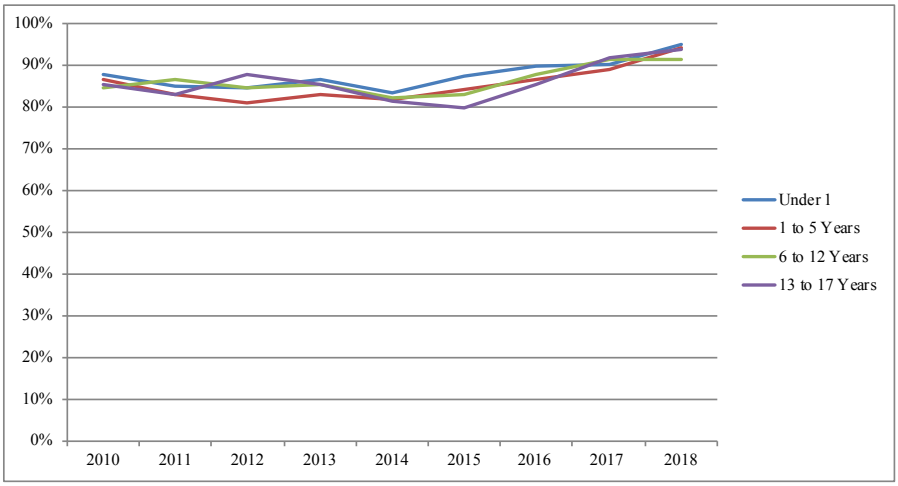
Table 30 displays the counts (and corresponding percent) of children in each entry cohort that experienced two or fewer moves. The data is further organized by children's age at the time their spell began. As a reminder, these counts do not include moves that served the purpose of reuniting siblings, placing children in pre-adoptive homes, or placing children in kinship foster homes.

Table 30. *Placement Stability: Two or Fewer Moves During the Agency Spell*

	Total Entries SFNYC Only					Number Two or Fewer Moves					Percent Two or Fewer Moves				
Entry Year	Under 1	1 to 5 Years	6 to 12 Years	13 to 17 Years	Total	Under 1	1 to 5 Years	6 to 12 Years	13 to 17 Years	Total	Under 1	1 to 5 Years	6 to 12 Years	13 to 17 Years	Total
2010	1,130	1,483	1,257	660	4,530	991	1,281	1,061	562	3,895	88%	86%	84%	85%	86%
2011	1,064	1,284	952	572	3,872	903	1,065	824	473	3,265	85%	83%	87%	83%	84%
2012	925	1,023	830	515	3,293	782	827	701	451	2,761	85%	81%	84%	88%	84%
2013	854	985	659	436	2,934	739	816	561	371	2,487	87%	83%	85%	85%	85%
2014	766	908	713	376	2,763	637	741	586	306	2,270	83%	82%	82%	81%	82%
2015	656	754	621	338	2,369	572	635	514	269	1,990	87%	84%	83%	80%	84%
2016	587	716	518	308	2,129	525	619	454	263	1,861	89%	86%	88%	85%	87%
2017	663	869	601	304	2,437	597	772	549	278	2,196	90%	89%	91%	91%	90%
2018	705	768	495	232	2,200	669	722	452	217	2,060	95%	94%	91%	94%	94%

Generally speaking, the proportion of entry cohorts who experience two or fewer moves has remained between 82 and 94 percent, with a slight dip for the 2014 entry cohort. Note, the recent shift in the desired direction – particularly for the 2017 and 2018 entry cohorts – may be an artifact of censoring; that is, these most recent cohorts have not yet had sufficient time to experience a placement change.

Figure 24. *Placement Stability: Two or Fewer Moves to Date, by Year and Age at Spell Start*



Overall, the proportion of children experiencing two or fewer moves is fairly consistent across the age groups, with toddlers (1 to 5-year olds) and, at certain points, teens, experiencing slightly more moves than the other age groups.

As noted just above, the observation that a smaller proportion of the 2017 and 2018 entry cohorts appear to have experienced three or more moves is likely explained, at least in part, by these groups not yet having enough time to experience a move. Looking at the likelihood of movement within specific intervals within the spell helps in comparing groups over time, when censoring is an issue to contend with.

Conditional Probability of Initial Move

We calculate the conditional probability of an initial placement change for children in the SFNYC and comparison admissions groups. We separate children experiencing their first ever spell in foster care (first agency spell within first child spell) from children in a subsequent/reentry spell (first agency spell within reentry spell). We do this because the relative risk of placement disruption is often different for children in their subsequent spell.

In Table 31 (below) we look at the conditional probability of an initial placement change for children in their first-ever agency spell within their first-ever child spell. Regardless of age, the likelihood of an initial placement change is highest in the first six months of placement. The risk of a placement change goes down considerably in the second six months for children who are still in care at the six-month mark and have not yet experienced a placement change. Generally, the risk continues to decline with time, although in some years and for some age categories the risk does not decline as much from one interval to the next.

For children who entered care as babies or toddlers (0 to 5 years old) and, to a lesser extent, children who entered as teens, the likelihood of an initial move within the first six months of care has gone up a bit over the SFNYC period.[21] For babies and toddlers, though, the likelihood of an initial move in the second six-month interval has declined over time.

Table 31. *Conditional Probability of Initial Placement Move: First Ever Spells, SFNYC*

	Under 1 Six Month Intervals						**1 to 5 Years** Six Month Intervals					
Entry Year	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.
2010	0.14	0.09	0.06	0.04	0.05	0.07	0.17	0.11	0.10	0.10	0.06	0.09
2011	0.18	0.09	0.06	0.05	0.06	0.05	0.23	0.11	0.09	0.05	0.08	0.05
2012	0.19	0.07	0.06	0.04	0.05	0.07	0.23	0.14	0.07	0.05	0.08	0.02
2013	0.25	0.04	0.09	0.05	0.06	0.11	0.20	0.09	0.08	0.09	0.07	0.06
2014	0.30	0.09	0.07	0.05	0.05	0.07	0.29	0.11	0.08	0.05	0.07	0.06
2015	0.31	0.03	0.04	0.04	0.04	0.06	0.33	0.09	0.09	0.01	0.00	0.02
2016	0.31	0.00	0.02	0.03			0.36	0.00	0.05	0.06		
2017	0.34	0.00					0.32	0.00				
2018	*0.39*						*0.33*					
	6 to 12 Years Six Month Intervals						**13 to 17 Years** Six Month Intervals					
Entry Year	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.
2010	0.18	0.11	0.08	0.10	0.06	0.08	0.13	0.13	0.09	0.12	0.08	0.08
2011	0.20	0.09	0.08	0.06	0.07	0.10	0.16	0.20	0.10	0.07	0.09	0.07
2012	0.24	0.15	0.08	0.09	0.05	0.05	0.21	0.09	0.04	0.11	0.07	0.11
2013	0.20	0.10	0.08	0.05	0.04	0.05	0.18	0.18	0.16	0.07	0.13	0.09
2014	0.27	0.09	0.04	0.05	0.06	0.04	0.27	0.07	0.22	0.09	0.10	0.10
2015	0.27	0.08	0.05	0.04	0.04	0.05	0.29	0.16	0.14	0.16	0.11	0.05
2016	0.22	0.00	0.03	0.02			0.28	0.00	0.09	0.08		
2017	0.25	0.00					0.22	0.00				
2018	*0.22*						*0.13*					

Table 32, below, presents similar data on the conditional probability of an initial placement change but here we look at children experiencing a subsequent or reentry spell.

Over the SFNYC period, children experiencing a reentry spell generally appear to have a lower likelihood of an initial placement change within the first six months of care. For the most part, the likelihood of an initial placement change diminishes as time goes on; that is, if children are still in care after six months and have not yet experienced an initial placement change, the likelihood that they will experience an initial placement change in subsequent intervals goes down, fairly substantially.

[21] Italicized and lightened text in the table reflects censoring: as of the censor date (12/18/31), not all children who entered care in 2018 had the opportunity to experience six months in care.

Table 32. *Conditional Probability of Initial Placement Move: Reentry Spells, SFNYC*

	Under 1 Six Month Intervals						**1 to 5 Years** Six Month Intervals					
Entry Year	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.
2010	0.38	0.08	0.13	0.04	0.07	0.09	0.42	0.14	0.07	0.08	0.12	0.05
2011	0.43	0.09	0.11	0.03	0.09	0.03	0.38	0.16	0.10	0.06	0.08	0.14
2012	0.30	0.07	0.03	0.00	0.03	0.08	0.33	0.15	0.12	0.04	0.07	0.02
2013	0.40	0.08	0.02	0.06	0.08	0.05	0.39	0.14	0.10	0.08	0.07	0.06
2014	0.32	0.13	0.10	0.07	0.03	0.06	0.44	0.09	0.06	0.04	0.07	0.09
2015	0.34	0.09	0.05	0.03	0.10	0.11	0.39	0.12	0.02	0.05	0.09	0.03
2016	0.30	0.06	0.10	0.10			0.31	0.07	0.11	0.07		
2017	0.34	0.06					0.35	0.12				
2018	*0.32*						*0.30*					

	6 to 12 Years Six Month Intervals						**13 to 17 Years** Six Month Intervals					
Entry Year	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.	0-6 Mo.	6-12 Mo.	12-18 Mo.	18-24 Mo.	24-30 Mo.	30-36 Mo.
2010	0.34	0.10	0.09	0.20	0.20	0.17	0.28	0.23	0.06	0.05	0.14	0.13
2011	0.41	0.14	0.15	0.08	0.06	0.07	0.31	0.16	0.19	0.12	0.18	0.25
2012	0.36	0.10	0.04	0.15	0.12	0.11	0.30	0.08	0.12	0.19	0.10	0.08
2013	0.43	0.10	0.13	0.17	0.16	0.15	0.33	0.17	0.12	0.00	0.08	0.00
2014	0.45	0.13	0.13	0.10	0.10	0.13	0.34	0.08	0.24	0.22	0.25	0.33
2015	0.45	0.10	0.13	0.04	0.10	0.00	0.36	0.27	0.15	0.14	0.20	0.00
2016	0.36	0.10	0.09	0.08			0.25	0.23	0.15	0.00		
2017	0.30	0.11					0.23	0.14				
2018	*0.11*						*0.10*					

Notice, although it is typically the case that the likelihood of an initial placement is higher in each interval for children experiencing a reentry spell it is not categorically the case. For some children in some years, the likelihood of an initial placement change is slightly higher for children experiencing their first ever spell. However, the general finding is that children in a reentry spell have a somewhat higher likelihood of experiencing a placement change, particularly within the first six months of care.

Permanency

In this section we look separately at children in the admissions/entry groups and children who were in care at the time SFNYC took effect (the in-care group).

SFNYC Entry Cohorts

Permanent exits are typically defined as either reunification, discharge to relatives, or adoption. All other exit types are generally considered non-permanent exits. As we did when looking at placement stability, we look at permanency separately for children experiencing their first ever spell from children in a subsequent or reentry spell.

Whereas for movements we used the conditional probability to compare trends over time, for permanency we use the *cumulative* probability. The cumulative probability answers the question, what proportion of an entry cohort had a permanent exit within one year? What proportion of the entry cohort had a permanent exit within two years (and so on)? That is, the probabilities accumulate over time intervals.

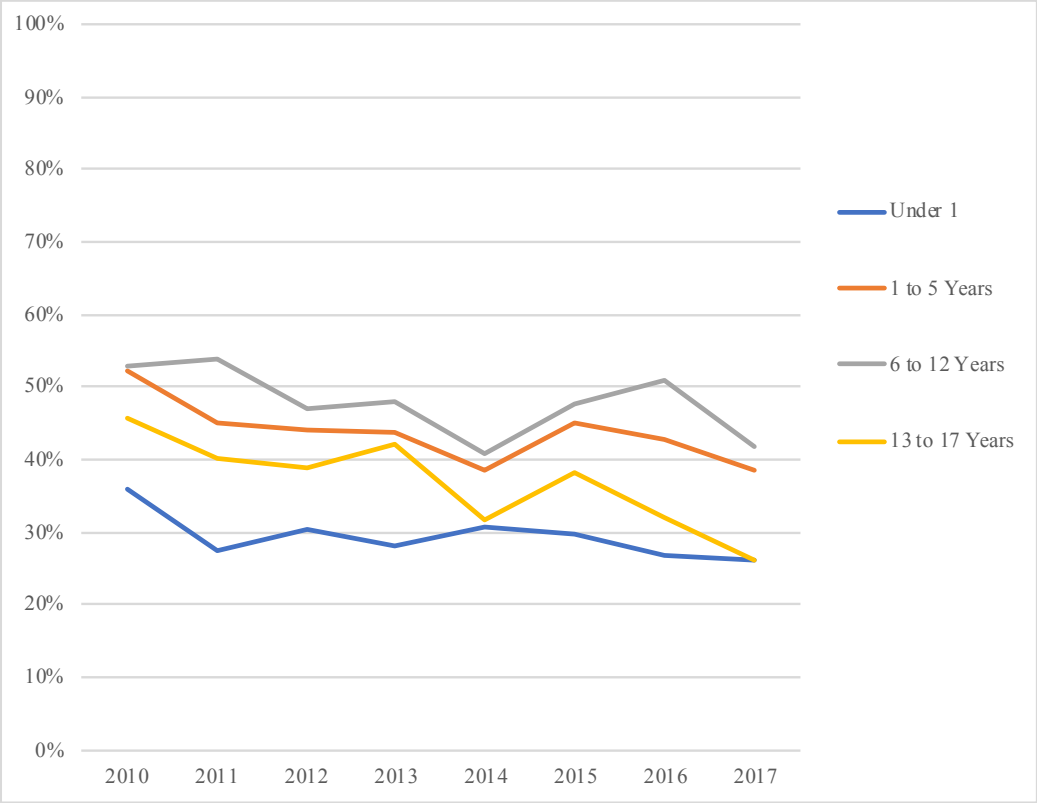
Table 33. *Cumulative Probability of Permanent Exit, by Age and Entry Cohort: First-Ever Spells*

Entry Age	Entry Year	Witin 6 months	Within 1 year	Within 1.5 years	Within 2 years	Within 2.5 years	Within 3 years	Within 3.5 years
Under 1	2010	24%	36%	40%	45%	50%	58%	67%
	2011	20%	27%	34%	38%	44%	52%	61%
	2012	21%	30%	36%	43%	49%	57%	63%
	2013	21%	28%	34%	39%	46%	56%	64%
	2014	18%	31%	37%	44%	50%	58%	66%
	2015	21%	30%	35%	44%	52%	61%	
	2016	21%	27%	33%	41%			
	2017	17%	26%					
	2018	*12%*						
1 to 5 Years	2010	35%	52%	58%	62%	67%	72%	75%
	2011	32%	45%	52%	56%	61%	65%	69%
	2012	32%	44%	51%	59%	63%	67%	71%
	2013	31%	44%	50%	58%	62%	66%	70%
	2014	27%	39%	45%	53%	61%	66%	72%
	2015	31%	45%	53%	59%	67%	72%	
	2016	31%	43%	53%	62%			
	2017	24%	38%					
	2018	*19%*						
6 to 12 Years	2010	39%	53%	58%	62%	66%	69%	72%
	2011	39%	54%	60%	64%	67%	71%	74%
	2012	35%	47%	53%	58%	63%	68%	72%
	2013	36%	48%	56%	63%	70%	74%	75%
	2014	31%	41%	52%	58%	66%	70%	75%
	2015	32%	48%	56%	65%	72%	75%	
	2016	41%	51%	60%	70%			
	2017	31%	42%					
	2018	*18%*						
13 to 17 Years	2010	36%	46%	49%	51%	53%	54%	55%
	2011	31%	40%	44%	47%	47%	49%	50%
	2012	29%	39%	42%	46%	48%	49%	50%
	2013	32%	42%	50%	54%	55%	57%	58%
	2014	24%	32%	36%	39%	42%	45%	46%
	2015	28%	38%	41%	45%	47%	48%	
	2016	23%	32%	36%	38%			
	2017	19%	26%					
	2018	*10%*						

For children in their first ever child spell, the likelihood of a permanent exit within set intervals of time appears to vary from year to year, and from one age category to the next. As a general matter, six to 12-year olds appear to have the highest likelihood of permanency within a year; nearly half of these children who enter in a given year will have a permanent exit within one year. Children who enter as babies have the lowest likelihood of permanency within a year; just over a quarter of babies entering care will have a permanent exit within a year.

Figure 25, below, displays the likelihood of a permanent exit within one year of entry, by age at spell start and entry cohort.

Figure 25. *Cumulative Probability of a Permanent Exit Within 1 Year of Entry, by Age at Spell Start and Entry Cohort: First-Ever Spell*



Across age categories, we see a decline in the proportion of each entry cohort that has a permanent exit within the first year leading up to 2014, with some year-to-year fluctuation. The likelihood of a permanent exit within one year rises for the 2015 entry cohort. It stays up for children who enter care between the age of 6 and 12 in 2016, but comes back down for all other children. Overall, the likelihood of a permanent exit within one year has been the most stable over time for children who enter as babies (under 1 year of age).

Table 34 looks at permanency outcomes for children in a reentry spell.

Table 34. *Cumulative Probability of a Permanent Exit, by Age at Spell Start and Entry Cohort: Reentry Spell*

Entry Age	Entry Year	Witin 6 months	Within 1 year	Within 1.5 years	Within 2 years	Within 2.5 years	Within 3 years	Within 3.5 years
Under 1	2010	29%	37%	44%	48%	50%	56%	58%
	2011	18%	28%	35%	42%	47%	50%	54%
	2012	19%	28%	32%	41%	48%	52%	55%
	2013	17%	27%	32%	36%	41%	46%	51%
	2014	17%	26%	37%	40%	40%	44%	53%
	2015	19%	29%	34%	42%	48%	56%	
	2016	22%	35%	43%	45%			
	2017	10%	23%					
	2018	*10%*						
1 to 5 Years	2010	26%	34%	42%	50%	52%	58%	61%
	2011	24%	33%	41%	47%	53%	58%	61%
	2012	18%	34%	41%	43%	49%	54%	59%
	2013	19%	27%	33%	35%	40%	46%	49%
	2014	13%	31%	37%	44%	51%	54%	57%
	2015	15%	24%	30%	36%	41%	48%	
	2016	20%	30%	41%	45%			
	2017	14%	21%					
	2018	*13%*						
6 to 12 Years	2010	24%	30%	39%	47%	48%	50%	51%
	2011	16%	21%	26%	29%	33%	37%	39%
	2012	21%	27%	34%	41%	43%	44%	46%
	2013	20%	30%	33%	35%	37%	39%	43%
	2014	16%	23%	28%	39%	44%	49%	52%
	2015	15%	22%	28%	34%	37%	41%	
	2016	12%	18%	30%	35%			
	2017	11%	17%					
	2018	*13%*						
13 to 17 Years	2010	9%	13%	17%	20%	20%	20%	21%
	2011	16%	19%	22%	22%	24%	24%	25%
	2012	4%	9%	10%	14%	17%	19%	21%
	2013	7%	11%	12%	14%	14%	16%	16%
	2014	7%	8%	10%	10%	10%	10%	10%
	2015	0%	2%	3%	5%	5%	5%	
	2016	10%	13%	13%	13%			
	2017	4%	9%					
	2018	*3%*						

The likelihood of a permanent exit within two years for children in a reentry spell has generally been on the decline over the last eight years. Babies have seen the most stability over time; the decline has been the most pronounced for children who enter between the ages of six and 12 years.

Figure 26. *Cumulative Probability of Permanent Exit Within 1 Year, by Age and Entry Cohort: Reentry Spells*

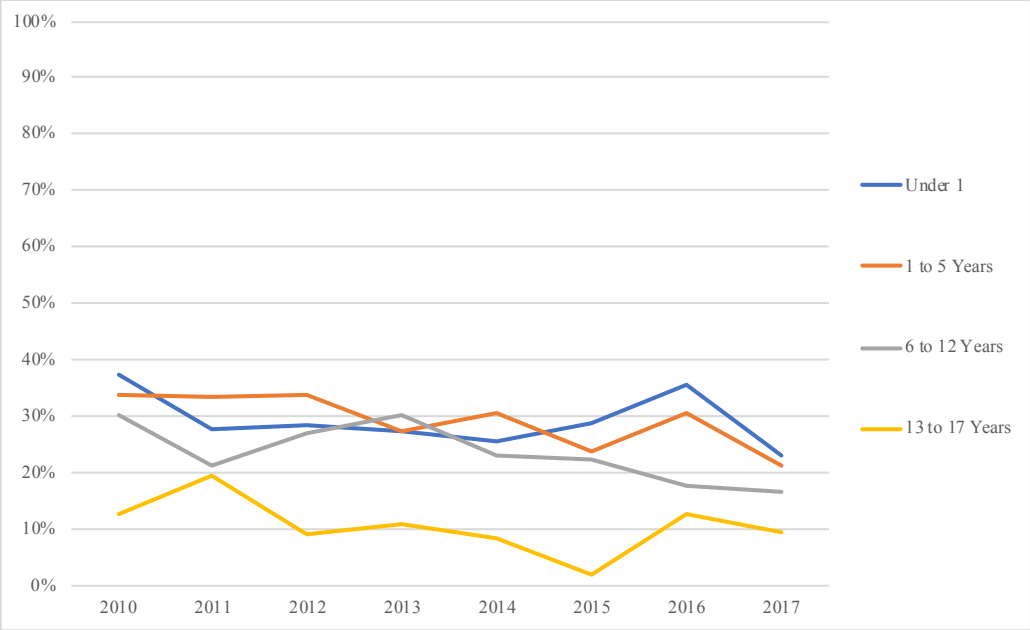


Figure 26 (above) displays the likelihood of permanent exit within one year, over time and by children's age at the time they enter their reentry spell. As with children in their first-ever spell, we see year to year variability in the likelihood of a permanent exit within one year of entry, with babies experiencing the most stability over time (as well as an uptick in timely permanency, for the 2016 entry cohort). Teens in a reentry spell have seen a marked decline over time in the likelihood of permanency within one year, but the trend has reversed somewhat during the SFNYC period. A similar picture emerges for toddlers in a reentry spell: we see an overall decline in the likelihood of a permanent exit within one year, with an uptick during the SFNYC period, in 2016.

SFNYC In-Care Group

Children in the in-care groups – the SFNYC in-care group, comprised of children in regular family foster care at an SFNYC agency on January 1, 2014, and four comparison groups, comprised of children in regular family foster care at an SFNYC agency on January 1 of four successive years (2010 through 2014) – have, of course, a varied set of experiences with regards to the "amount" of foster care they have accumulated as of January of the given in-care year. The 75th quartile residual duration analysis, the results of which are presented below, take this reality into account.

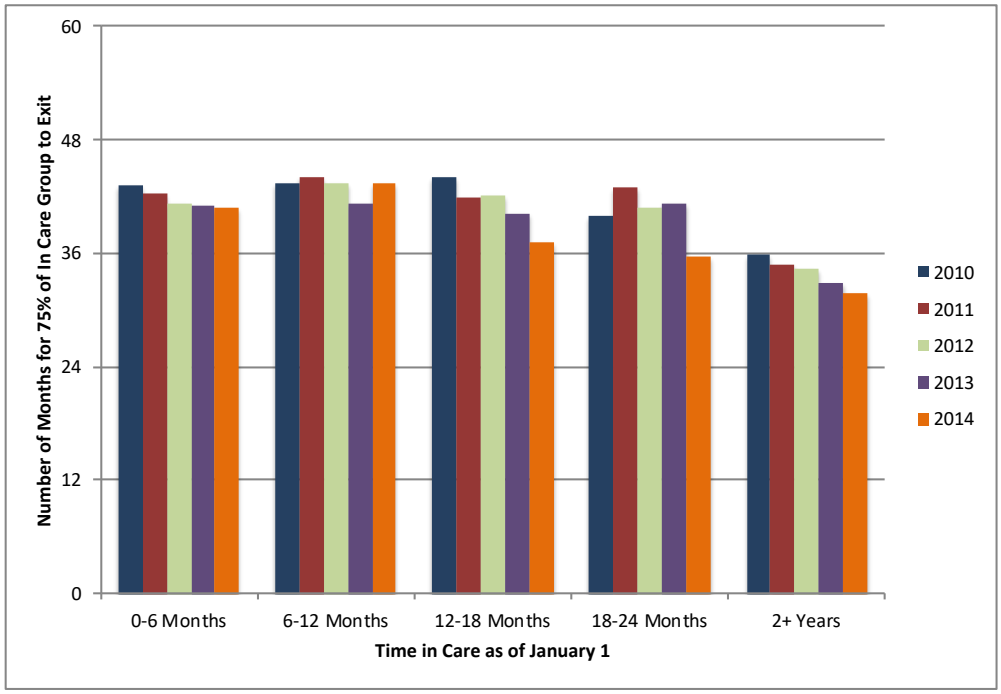
Essentially, the 75th quartile residual duration reports the number of days it took for 75 percent of each in-care group to exit care. Whereas the interim evaluation report relied on the median residual duration – the amount of time it took for 50 percent of each in-care group to exit care – enough children have exited at this point to allow for the 75th quartile residual duration.

Table 35. *75th quartile residual duration, in days, by in-care year and time in care*

	Time in Care, As of 1/1 of the Year				
In Care Year	0-6 Months	6-12 Months	12-18 Months	18-24 Months	2+ Years
2010	1,295	1,298	1,322	1,196	1,077
2011	1,271	1,318	1,258	1,291	1,045
2012	1,236	1,299	1,259	1,222	1,027
2013	1,230	1,236	1,203	1,238	987
2014	**1,224**	**1,303**	**1,114**	**1,066**	**951**

Comparing the 2014 (SFNYC) group to the preceding in-care years, we see improvement (reductions) in the number of days it took 75 percent of the in-care group to leave foster care, particularly for children who had been in care for at least 12 months when January 1 hit. The graphic view, in Figure 27, brings the narrative out a bit more clearly.

Figure 27. *75th Quartile Residual Duration, by Time in Care as of 1/1 of the Year*



The data in Figure 27 are displayed in months (the unit in Table 34 is days). Overall, it has taken the 2014 in-care group less time to exit care than previous in-care groups, with the exception of children who had been in care for 6 to 12 months as of the in-care date (January 1 of the given year).

Reentry

A single measure was used to monitor the extent to which children who exit from foster care reenter at some future date: the conditional probability of reentry, in three-month intervals. This is a useful way to think about reentry because it tells you not only how likely reentry is but when it is most likely to occur, so that ACS and its provider agencies can be strategic in the nature and

timing of the support they offer. Table 36, below, displays the conditional probability of reentry for children in the series of admissions cohorts at the heart of the analysis.

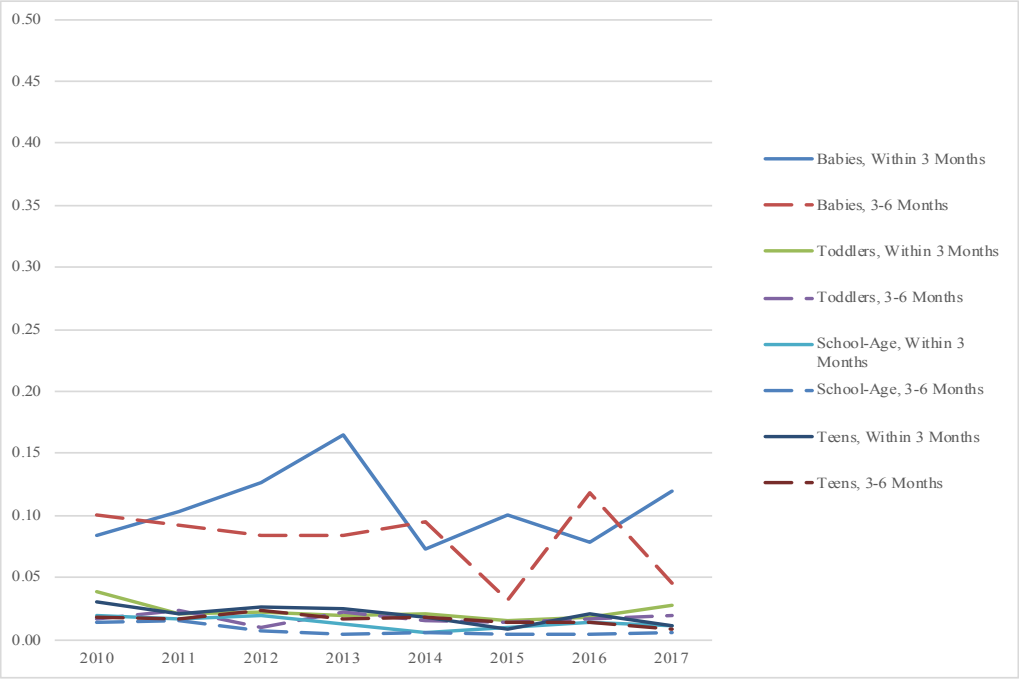
We see relatively stable reentry patterns for all children except for babies. Children over the age of 1 are much less likely than babies (children under the age of 1) to reenter. The likelihood is lowest for school-age children (6 to 12 year olds). About a quarter of babies reenter within the first nine months following a discharge. We also notice a spike in the reentry for babies placed with one of the pilot agencies who exited in 2014; however, reentry rates for babies leaving care from the pilot agencies has historically been fairly variable.

Table 36. *Conditional Probability of Reentry, by Exit Year and Age at Discharge: Three-Month Intervals*

	Under 1							**1 to 5 Years**						
	Three Month Intervals							Three Month Intervals						
Exit Year	0-3 Mo.	3-6 Mo.	6-9 Mo.	9-12 Mo.	12-15 Mo.	15-18 Mo.	18+ Mo.	0-3 Mo.	3-6 Mo.	6-9 Mo.	9-12 Mo.	12-15 Mo.	15-18 Mo.	18+ Mo.
2010	0.08	0.10	0.04	0.01	0.01	0.06	0.30	0.04	0.02	0.02	0.03	0.01	0.02	0.10
2011	0.10	0.09	0.05	0.04	0.04	0.03	0.22	0.02	0.02	0.03	0.02	0.02	0.02	0.10
2012	0.13	0.08	0.03	0.01	0.04	0.04	0.18	0.02	0.01	0.02	0.02	0.01	0.01	0.08
2013	0.16	0.08	0.06	0.03	0.02	0.07	0.17	0.02	0.02	0.03	0.01	0.02	0.01	0.07
2014	0.07	0.10	0.07	0.02	0.02	0.02	0.12	0.02	0.01	0.03	0.02	0.01	0.01	0.08
2015	0.10	0.03	0.05	0.00	0.00	0.02	0.09	0.02	0.01	0.03	0.01	0.01	0.01	0.05
2016	0.08	0.12	0.02	0.06	0.00	0.02	0.04	0.02	0.02	0.03	0.02	0.01	0.01	0.04
2017	0.12	0.05	0.07	0.00				0.03	0.02	0.01	0.02			
2018	*0.07*							*0.02*						
	6 to 12 Years							**13 to 17 Years**						
	Three Month Intervals							Three Month Intervals						
Exit Year	0-3 Mo.	3-6 Mo.	6-9 Mo.	9-12 Mo.	12-15 Mo.	15-18 Mo.	18+ Mo.	0-3 Mo.	3-6 Mo.	6-9 Mo.	9-12 Mo.	12-15 Mo.	15-18 Mo.	18+ Mo.
2010	0.02	0.01	0.01	0.03	0.00	0.01	0.12	0.03	0.02	0.04	0.03	0.03	0.01	0.06
2011	0.02	0.02	0.02	0.01	0.01	0.01	0.10	0.02	0.02	0.04	0.03	0.01	0.01	0.05
2012	0.02	0.01	0.03	0.02	0.01	0.01	0.08	0.03	0.02	0.05	0.04	0.02	0.02	0.05
2013	0.01	0.00	0.02	0.01	0.02	0.01	0.07	0.03	0.02	0.03	0.03	0.02	0.01	0.06
2014	0.01	0.01	0.02	0.01	0.01	0.00	0.05	0.02	0.02	0.03	0.04	0.01	0.02	0.05
2015	0.01	0.00	0.02	0.01	0.01	0.02	0.03	0.01	0.01	0.05	0.01	0.02	0.03	0.04
2016	0.01	0.00	0.02	0.01	0.01	0.01	0.04	0.02	0.01	0.04	0.02	0.01	0.00	0.03
2017	0.01	0.01	0.01	0.01				0.01	0.01	0.06	0.02			
2018	*0.01*							*0.00*						

Figure 28, below, shows the probability of reentry within the first and second three-month intervals following a child's exit from care, by exit year, age at discharge, and reentry interval. Here we see clearly the set of patterns described just above.

Figure 28. *Reentry into care, by Exit Year, Age at Discharge, and Reentry Interval*



Again, children over one year of age at the time of discharge have a fairly low likelihood of returning to care. This is fairly consistent year to year. Babies, however, are at much higher risk of reentering. However, we see the likelihood of babies reentering within the first three months following their exit dropped in 2014 (after a spike in 2013) and has remained lower than previous levels for all successive exit cohorts. Babies who have not yet reentered in the first three months following their discharge are somewhat less likely to reenter in the next three-month interval.

Care Day Count

The purpose of this section is to detail the utilization of care days by children eligible for SFNYC and a historical comparison group of children (children from previous entry cohorts who also meet the eligibility criteria for SFNYC). As noted above, we do this separately for each SFNYC entry cohort.

The first group we will look at is the 2014 admissions cohort: the group of children admitted to any of the 17 SFNYC agencies and placed in regular family foster care at the time of admission.

2014 Entry Cohort

We compare care day utilization for the 2014 entry cohort with the average of three historical entry cohorts: 2010, 2011, and 2012. Table 37, below, delineates the starting population – the number of children admitted in 2014 (and the average number of entrants in three consecutive historical entry cohorts), broken down by the age at spell start. Starting with Year 2, the starting population represents the number of children from the original entry cohort still in care at the beginning of the performance (Waiver) year. For each group we report the percent that exited within the given Waiver year. The percent exited is always the percent of the original cohort – the number of children admitted in the given cohort year (in Table 37 this is the 2014 entry cohort). Last, we report the total number of care days and the average number of care days.

The average number of care days used by children in the 2014 entry cohort was generally similar to the average number of care days used by children in the historical comparison cohorts. However, year-to-year, regardless of age group, the total number of care days used by the 2014 entry cohort is far lower than the total number of care days used by the average of the historical comparison groups.

Table 37. *Exits, Average Care Days, and Total Care Days: 2014 Admissions Cohort (SFNYC), by Age at Spell Start*

Age Categories	Corresponding Waiver Year	Dates	Starting Population		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
			Baseline/ Historical Comparison	2014 Admissions Group	Baseline/ Historical Comparison	2014 Admits Group	Baseline/ Historical Comparison	2014 Admits Group	Baseline/ Historical Comparison	2014 Admits Group
Under 1	SFNYC Year 1	1/1/14 - 12/31/14	945	677	24%	20%	156	156	147,267	105,660
	SFNYC Year 2	1/1/15 - 12/31/15	721	542	17%	20%	319	312	229,643	169,156
	SFNYC Year 3	1/1/16 - 12/31/16	596	406	13%	14%	325	320	182,217	130,064
	SFNYC Year 4	1/1/17 - 12/31/17	471	310	15%	16%	304	304	132,300	94,212
	SFNYC Year 5	1/1/18 - 12/13/18	326	199	18%	17%	287	281	83,504	55,933
1 to 5 Years	SFNYC Year 1	1/1/14 - 12/31/14	1,140	811	33%	24%	140	154	158,130	124,707
	SFNYC Year 2	1/1/15 - 12/31/15	766	614	22%	24%	294	302	224,892	185,440
	SFNYC Year 3	1/1/16 - 12/31/16	510	417	12%	17%	317	300	161,776	125,140
	SFNYC Year 4	1/1/17 - 12/31/17	371	280	10%	12%	307	299	113,661	83,847
	SFNYC Year 5	1/1/18 - 12/13/18	257	180	15%	15%	301	298	77,319	53,724
6 to 12 Years	SFNYC Year 1	1/1/14 - 12/31/14	874	624	37%	29%	135	146	116,871	91,099
	SFNYC Year 2	1/1/15 - 12/31/15	551	446	23%	26%	285	296	156,479	131,827
	SFNYC Year 3	1/1/16 - 12/31/16	346	283	12%	16%	310	299	107,502	84,544
	SFNYC Year 4	1/1/17 - 12/31/17	243	186	8%	11%	313	295	76,244	54,834
	SFNYC Year 5	1/1/18 - 12/13/18	176	115	14%	14%	300	312	52,864	35,912
13 to 17 Years	SFNYC Year 1	1/1/14 - 12/31/14	496	303	33%	25%	138	153	68,380	46,398
	SFNYC Year 2	1/1/15 - 12/31/15	331	227	25%	28%	286	285	94,403	64,659
	SFNYC Year 3	1/1/16 - 12/31/16	207	143	10%	14%	316	307	65,404	43,851
	SFNYC Year 4	1/1/17 - 12/31/17	155	102	10%	12%	311	298	48,450	30,446
	SFNYC Year 5	1/1/18 - 12/13/18	107	66	13%	12%	288	260	30,861	17,167

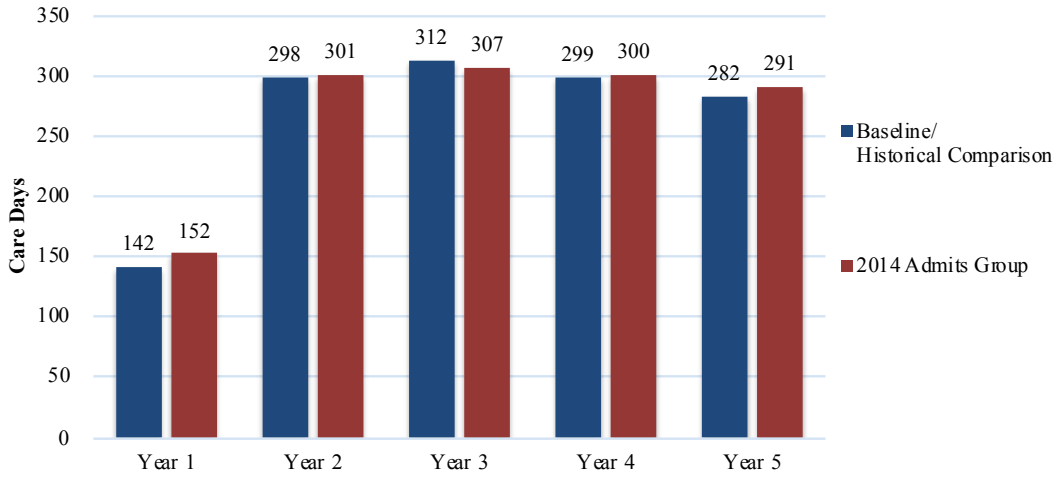
Table 38, below, collapses the age strata and looks at the 2014 admission cohort's use of care days over the course of the five-year SFNYC period.

Table 38. *Exits, Average Care Days, and Total Care Days: 2014 Admissions Cohort (SFNYC), by Performance/Waiver Year*

`	Starting Population		Number Exited		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
	Historical Comparison^	2014 Admissions Group	Baseline/ Historical Comparison	2014 Admits Group	Baseline/ Historical Comparison	2014 Admits Group	Baseline/ Historical Comparison	2014 Admits Group	Baseline/ Historical Comparison	2014 Admits Group
Year 1	3,455	2,415	1,087	586	31%	24%	142	152	490,647	367,864
Year 2	2,368	1,829	745	580	22%	24%	298	301	705,417	551,082
Year 3	1,658	1,249	419	371	12%	15%	312	307	516,898	383,599
Year 4	1,240	878	373	318	11%	13%	299	300	370,655	263,339
Year 5	866	560	519	358	15%	15%	282	291	244,548	162,736

On average, members of the 2014 admission group used a similar number of care days compared to the children included in the historical comparison group. Figure 29 lays this out, below.

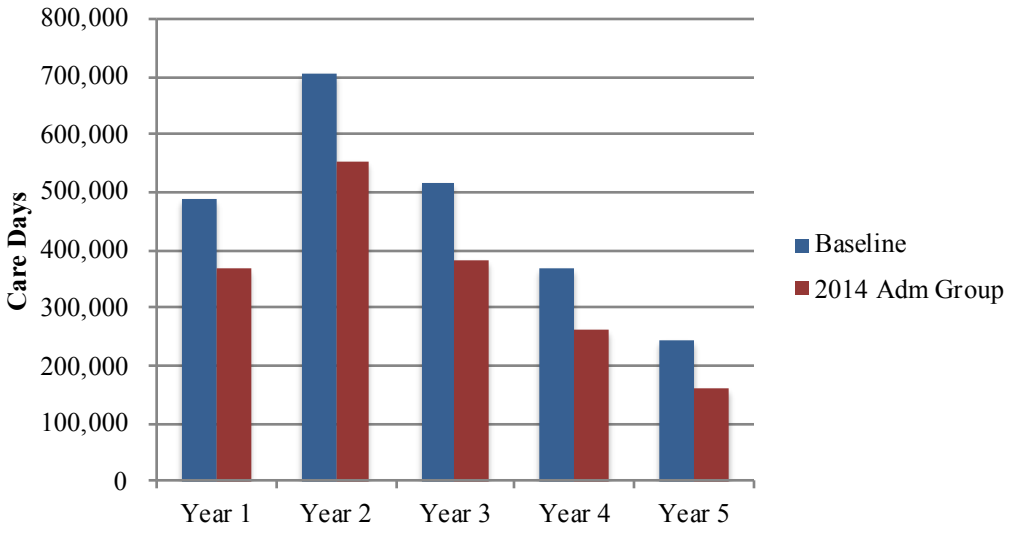
Figure 29. *Average Number of Care Days: 2014 Admissions Cohort and Comparison Cohorts (Averaged), by Waiver Year*



By the third year of SFNYC, the 2014 admissions group was using fewer care days, on average, then we would have projected based on historical data (312 care days on average for the comparison group; 307 care days on average for the 2014 admissions group).

Total care days are represented in Figure 30, below.

Figure 30. *Total Care Days: 2014 Admissions Cohort and Comparison Cohorts (Averaged), by year*



Looking across performance years, we see the same trend: the 2014 entry cohort has been using fewer care days than the historical comparison groups.

2015 Entry Cohort

The observational window for the 2015 entry cohort is 4 years. Table 39 provides a detailed view of exits, average care day utilization, and total care day utilization.

Table 39. *Exits, Average Care Days, and Total Care Days: 2015 Entry Cohort, by Age at Spell Start*

			Starting Population		(% of Initial Starting Pop)		Average Care Days		Total Care Days	
Age Category	**Waiver Year**	**Time Period**	Baseline/ Historical Comparison	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort
Under 1	SFNYC Year 2	1/1/15 - 12/31/15	945	605	24%	21%	156	157	147,267	95,170
	SFNYC Year 3	1/1/16 - 12/31/16	721	478	17%	19%	319	319	229,643	152,583
	SFNYC Year 4	1/1/17 - 12/31/17	560	365	13%	17%	325	315	182,217	114,882
	SFNYC Year 5	1/1/18 - 12/13/18	435	262	15%	15%	304	294	132,300	76,902
1 to 5 Years	SFNYC Year 2	1/1/15 - 12/31/15	1,140	658	33%	30%	140	153	158,130	100,611
	SFNYC Year 3	1/1/16 - 12/31/16	766	460	22%	24%	294	293	224,892	134,662
	SFNYC Year 4	1/1/17 - 12/31/17	510	299	12%	14%	317	311	161,776	92,841
	SFNYC Year 5	1/1/18 - 12/13/18	371	210	10%	10%	307	289	113,661	60,647
6 to 12 Years	SFNYC Year 2	1/1/15 - 12/31/15	874	520	37%	31%	135	154	116,871	80,107
	SFNYC Year 3	1/1/16 - 12/31/16	551	361	23%	31%	285	269	156,479	97,193
	SFNYC Year 4	1/1/17 - 12/31/17	346	200	12%	15%	310	287	107,502	57,313
	SFNYC Year 5	1/1/18 - 12/13/18	243	121	8%	7%	313	308	76,244	37,266
13 to 17 Years	SFNYC Year 2	1/1/15 - 12/31/15	496	286	33%	33%	138	150	68,380	42,926
	SFNYC Year 3	1/1/16 - 12/31/16	331	191	25%	27%	286	280	94,403	53,475
	SFNYC Year 4	1/1/17 - 12/31/17	207	114	10%	13%	316	303	65,404	34,529
	SFNYC Year 5	1/1/18 - 12/13/18	155	77	10%	7%	311	315	48,450	24,262

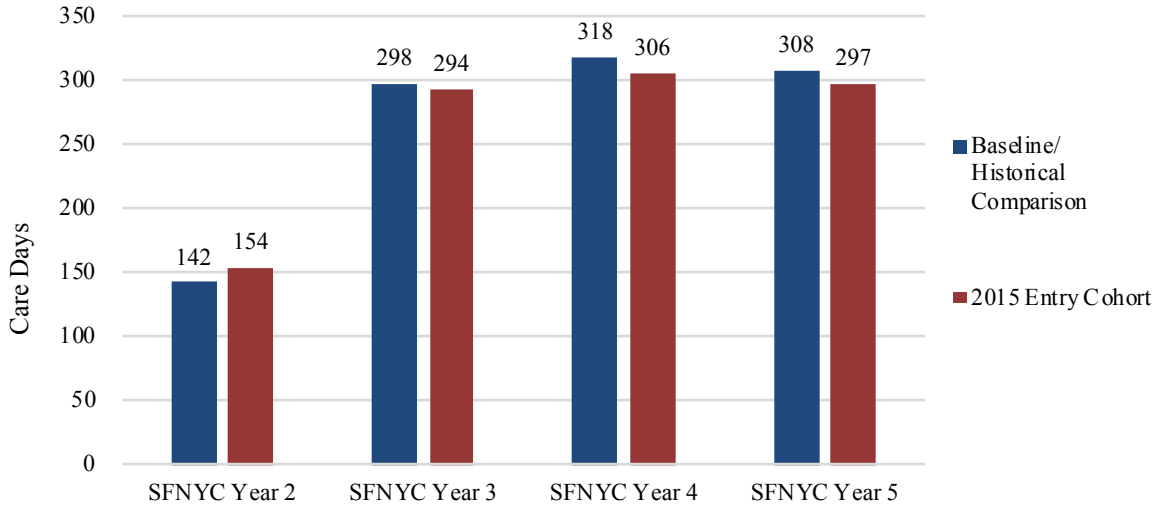
A condensed view that looks at performance years across age categories helps make clear the difference in care day utilization (the 2015 entry cohort compared to the historical comparison groups; see Table 40).

Table 40. *Exits, Average Care Days, and Total Care Days: 2015 Entry Cohort, by Waiver Year*

	Starting Population		Number Exited		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
	Historical Comparison^	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort	Baseline/ Historical Comparison	2015 Entry Cohort
SFNYC Year 2	3,455	2,069	1,087	579	31%	28%	142	154	490,647	318,814
SFNYC Year 3	2,368	1,490	745	512	22%	25%	298	294	705,417	437,913
SFNYC Year 4	1,623	978	419	308	12%	15%	318	306	516,898	299,565
SFNYC Year 5	1,204	670	373	215	11%	10%	308	297	370,655	199,077

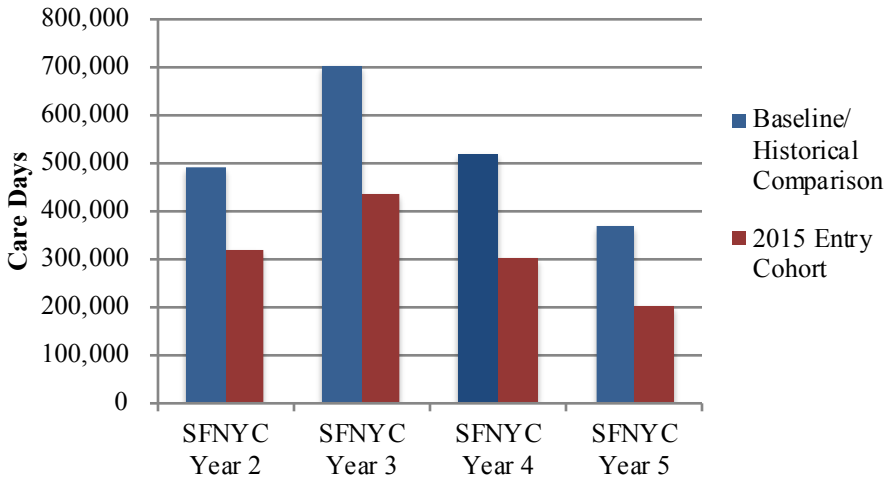
With the exception of the first performance year for the 2015 entry cohort (corresponding to SFNYC Year 2), the members of the 2015 entry cohort used fewer care days on average than the historical comparison group. Figure 31, below, gives a graphic view.

Figure 31. *Average Number of Care Days: 2015 Admissions Cohort and Comparison Cohorts (Averaged), by Waiver Year*



As with the 2014 entry cohort, the 2015 entry cohort also used far fewer total care days (see Figure 32).

Figure 32. *Total Number of Care Days: 2015 Admissions Cohort and Comparison Cohorts, by Waiver Year*



2016 Entry Cohort

We had three years to observe the care day utilization patterns of the 2016 entry cohort. Table 41 displays the full set of information for this cohort.

Table 41. *Exits, Average Care Days, and Total Care Days: 2016 Entry Cohort, by Age at Spell Start*

			Starting Population		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
Age Category	Waiver Year	Dates	Baseline/ Historical Comparison	2016 Entry Cohort	Baseline/ Historical Comparison	2016 Entry Cohort	Baseline/ Historical Comparison	2016 Entry Cohort	Baseline/ Historical Comparison	2016 Entry Cohort
Under 1	SFNYC Year 3	1/1/16 - 12/31/16	945	521	24%	21%	156	142	147,267	74,183
	SFNYC Year 4	1/1/17 - 12/31/17	721	411	17%	18%	319	321	229,643	131,922
	SFNYC Year 5	1/1/18 - 12/13/18	560	317	13%	14%	325	322	182,217	102,080
1 to 5 Years	SFNYC Year 3	1/1/16 - 12/31/16	1,140	606	33%	27%	140	135	158,130	81,845
	SFNYC Year 4	1/1/17 - 12/31/17	766	441	22%	28%	294	291	224,892	128,387
	SFNYC Year 5	1/1/18 - 12/13/18	510	272	12%	11%	317	314	161,776	85,281
6 to 12 Years	SFNYC Year 3	1/1/16 - 12/31/16	874	429	37%	29%	135	134	116,871	57,596
	SFNYC Year 4	1/1/17 - 12/31/17	551	305	23%	31%	285	279	156,479	85,147
	SFNYC Year 5	1/1/18 - 12/13/18	346	172	12%	14%	310	281	107,502	48,333
13 to 17 Years	SFNYC Year 3	1/1/16 - 12/31/16	496	227	33%	26%	138	150	68,380	34,012
	SFNYC Year 4	1/1/17 - 12/31/17	331	167	25%	25%	286	298	94,403	49,756
	SFNYC Year 5	1/1/18 - 12/13/18	207	111	10%	7%	316	334	65,404	37,020

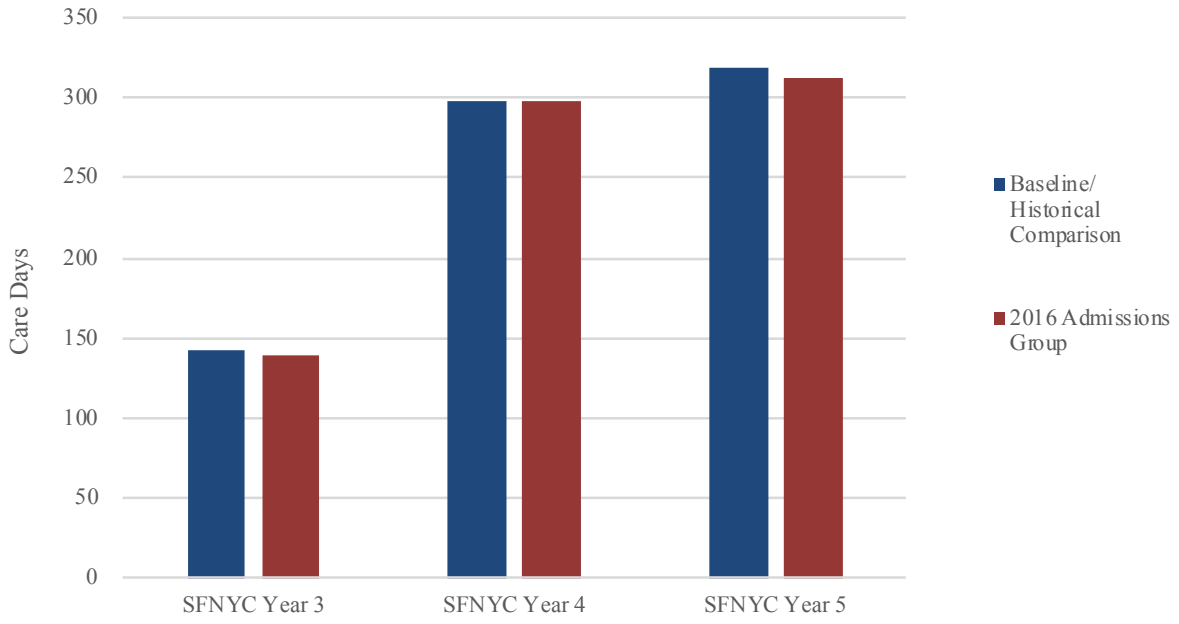
Across the board, the members of the 2016 entry cohort used fewer care days, on average, than the baseline/historical comparison group. Table 42 shows the collapsed view.

Table 42. *Exits, Average Care Days, and Total Care Days: 2015 Entry Cohort, by Waiver Year*

	Starting Population		Number Exited		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
	Baseline/ Historical Comparison	2016 Entry Cohort	Baseline/ Historical Comparison	2016 Entry Cohort	Baseline/ Historical Comparison	2016 Entry Cohort	Baseline/ Historical Comparison	2016 Admissions Group	Baseline/ Historical Comparison	2016 Entry Cohort
SFNYC Year 3	3,455	1,783	1,087	459	31%	26%	142	139	490,647	247,636
SFNYC Year 4	2,368	1,324	745	452	22%	25%	298	298	705,417	395,212
SFNYC Year 5	1,623	872	419	219	12%	12%	318	313	516,898	272,714

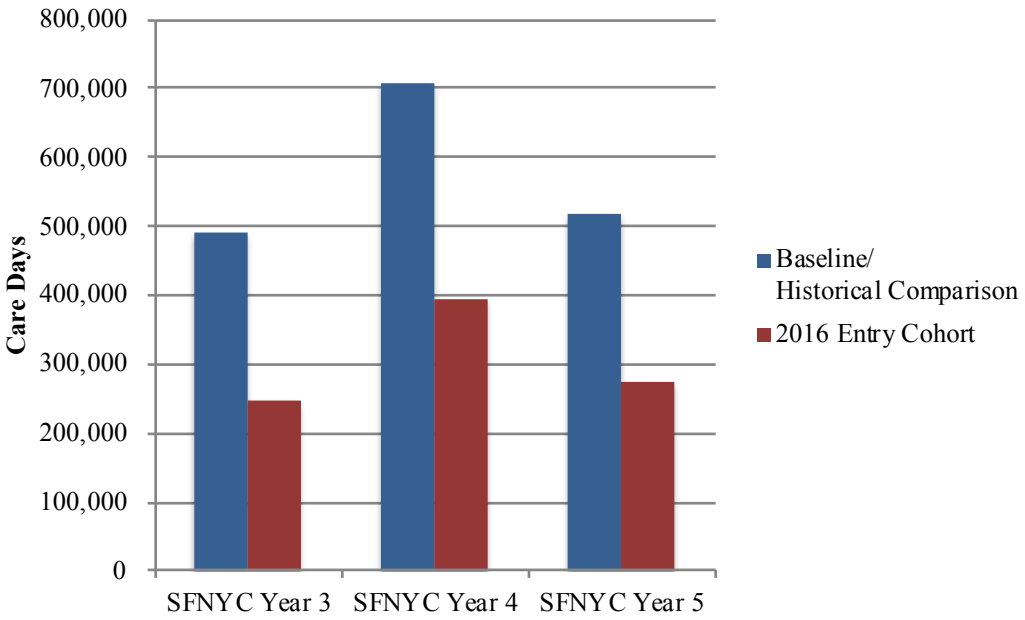
Average care day utilization was either the same as or less than that of the historical comparison group. The graph in Figure 33 makes it clear.

Figure 33. *Average Number of Care Days: 2015 Admissions Cohort and Comparison Cohorts (Averaged), by Waiver Year*



Lastly, in Figure 34 we show the difference in total care day utilization, comparing the 2016 entry cohort with the historical comparison group.

Figure 34. *Total Number of Care Days: 2016 Admissions Cohort and Comparison Cohorts, by Waiver Year*



The difference in the total number of care days used (2016 entry cohort versus the historical comparison group) grows more pronounced with each successive entry cohort.

2017 Entry Cohort

The 2017 entry cohort had just two years during which care day utilization could be observed. Table 43 provides the details for this entry cohort.

Table 43. *Exits, Average Care Days, and Total Care Days: 2017 Entry Cohort, by Age at Spell Start*

			Starting Population		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
Age Category	Waiver Year	Dates	Baseline/ Historical Comparison	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort
Under 1	Waiver Year 4	1/1/17 - 12/31/17	945	540	24%	17%	156	154	147,267	83,319
	Waiver Year 5	1/1/18 - 12/13/18	721	446	17%	19%	319	312	229,643	139,350
1 to 5 Years	Waiver Year 4	1/1/17 - 12/31/17	1,140	697	33%	22%	140	150	158,130	104,259
	Waiver Year 5	1/1/18 - 12/13/18	766	545	22%	24%	294	290	224,892	157,902
6 to 12 Years	Waiver Year 4	1/1/17 - 12/31/17	874	437	37%	28%	135	154	116,871	67,259
	Waiver Year 5	1/1/18 - 12/13/18	551	314	23%	24%	285	286	156,479	89,704
13 to 17 Years	Waiver Year 4	1/1/17 - 12/31/17	496	214	33%	21%	138	154	68,380	33,054
	Waiver Year 5	1/1/18 - 12/13/18	331	170	25%	24%	286	289	94,403	49,124

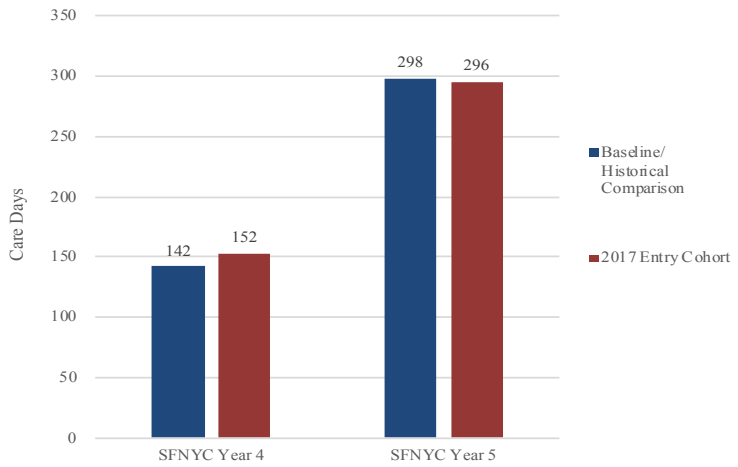
Here we see a little more variability in average care day utilization than we have seen for the last two entry cohorts. Table 44 shows the view collapsed across age categories.

Table 44. *Exits, Average Care Days, and Total Care Days: 2015 Entry Cohort, by Waiver Year*

	Starting Population		Number Exited		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
	Historical Comparison^	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort	Baseline/ Historical Comparison	2017 Entry Cohort
SFNYC Year 4	3,455	1,888	1,087	413	31%	22%	142	152	490,647	287,891
SFNYC Year 5	2,368	1,475	745	430	22%	23%	298	296	705,417	436,080

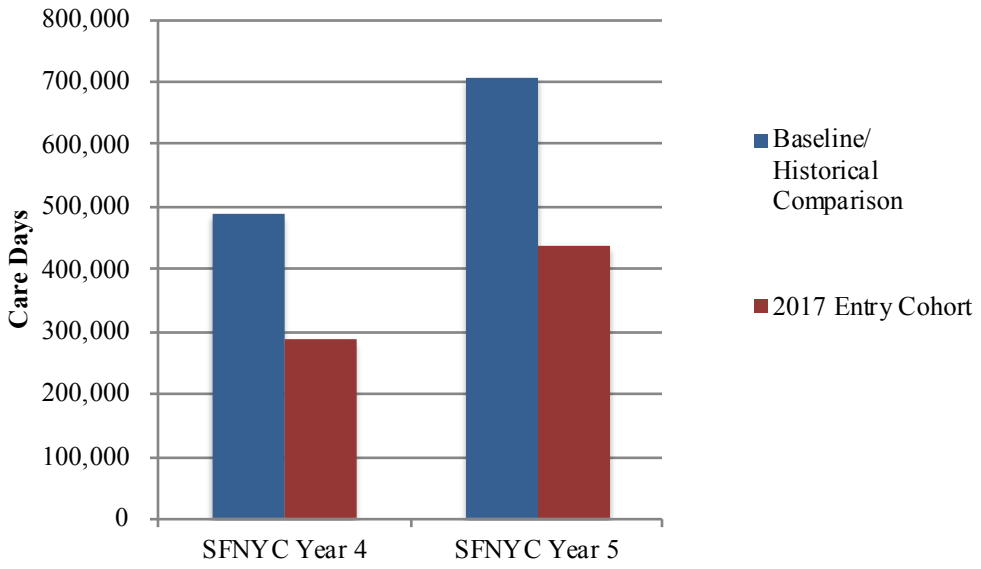
During 2017, this entry cohort's first performance year, average care day utilization was higher for the SFNYC group than for the historical comparison group. This reverses in the second performance year, during which the 2017 entry cohort uses slightly fewer care days (on average) than the historical comparison group. Figure 35 provides another view.

Figure 35. *Average Number of Care Days: 2017 Admissions Cohort and Comparison Cohorts (Averaged), by Waiver Year*



As with all other SFNYC entry cohorts, total care day utilization is much lower for the 2017 entry cohort compared to the historical comparison group (Figure 36).

Figure 36. *Total Number of Care Days: 2017 Admissions Cohort and Comparison Cohorts, by Waiver Year*



2018 Entry Cohort

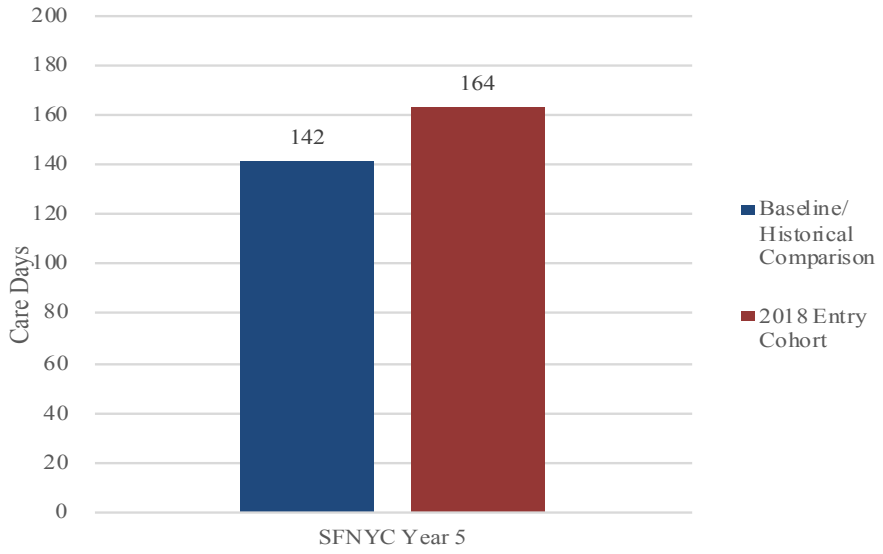
The 2018 entry cohort – the final entry cohort for the SFNYC study – had just one year to be observed. Table 45 displays their performance vis-à-vis care day utilization.

Table 45. *Exits, Average Care Days, and Total Care Days: 2018 Entry Cohort, by Age at Spell Start*

			Starting Population		Percent Exited (% of Initial Starting Pop)		Average Care Days		Total Care Days	
Age Category	Waiver Year	Dates	Baseline/ Historical Comparison	2018 Entry Cohort	Baseline/ Historical Comparison	2018 Entry Cohort	Baseline/ Historical Comparison	2018 Entry Cohort	Baseline/ Historical Comparison	2018 Entry Cohort
Under 1	SFNYC Year 5	1/1/18 - 12/13/18	945	522	24%	17%	156	166	147,267	86,795
1 to 5 Years	SFNYC Year 5	1/1/18 - 12/13/18	1,140	552	33%	25%	140	155	158,130	85,689
6 to 12 Years	SFNYC Year 5	1/1/18 - 12/13/18	874	361	37%	23%	135	169	116,871	60,962
13 to 17 Years	SFNYC Year 5	1/1/18 - 12/13/18	496	175	33%	18%	138	175	68,380	30,568

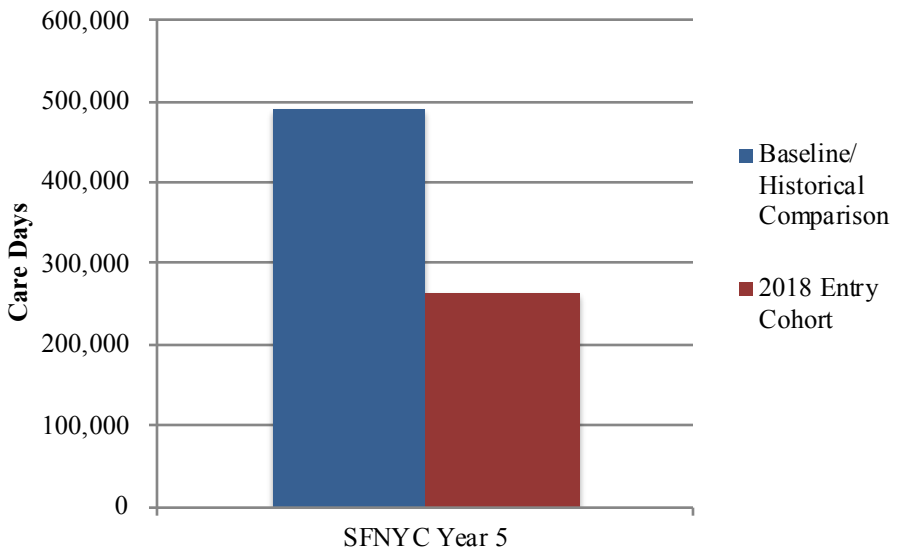
The 2018 entry cohort stands apart from the other four SFNYC entry cohorts in that their average care day utilization is higher than the historical comparison group. This holds for all age categories. Figures 37 and 38 show average and total care day utilization for this entry cohort, respectively.

Figure 37. *Average Number of Care Days: 2018 Admissions Cohort and Comparison Cohorts (Averaged), by Waiver Year*



On average, the 2018 entry cohort used 22 more care days during their initial year (2018) compared to the historical comparison group.

Figure 38. *Total Number of Care Days: 2018 Admissions Cohort and Comparison Cohorts, by Waiver Year*



The historical comparison group used almost twice as many care days during their initial performance year compared to the 2018 entry cohort.

Intervention-Specific Impact Analyses

Caseload Reduction

As part of its Waiver strategy, New York City implemented caseload reductions within the network of private agencies that provide foster care services on behalf of New York's Administration for Children's Services (ACS). The strategy and underlying theory of change are straightforward: to increase the rate of exit, ACS reduced the number of children on each caseworker's caseload. Advocates often target caseloads as an indicator of service quality – too many cases on a worker's caseload limits the amount of time each case receives. Too little time stretches out the work needed to reach a permanency outcome. As a strategy, caseload reduction doesn't per se change the type of work or how the work is done. Rather, productivity improves simply because there are more people doing the work that needs to be done.

Overview

Regarding the evaluation, we asked whether the rate of exit to permanency increased for children whose time in care coincided with when private agencies reached the new caseload target. We did this using a unique file that allowed us to measure child to worker ratios in each agency over time. Then, because ACS implemented the caseload reduction system-wide, we used historical placement data to compare exit rates when caseloads were high to exit rates after caseloads reached their target levels. We expected to see a higher rate of exit for (1) children already in care when the changes went into effect and (2) children admitted to care after the changes went into effect.

To establish whether caseload ratios reached target levels, for each private agency we measured the number of cases per worker on a monthly basis for calendar years 2012 through 2016, inclusive. Reductions in caseloads were authorized in 2014. By the start of 2015, average caseloads across all agencies reached the target level of 12 children per worker (*Technical Details* - Figure 39).

We then examined whether exit rates improved after controlling for characteristics of children (e.g., age, race, and gender) and their placement history (e.g., when did they enter care, how long had they been in care, how many placements had they experienced, and which provider agency provided care?). Detailed findings are included below, in the section *Model Details*. In sum, we found:

- Exit rates increased by 9 percent in the post-implementation years when compared to pre-implementation periods.

- Median length of stay for children admitted to care *after* the caseload reduction was 475 days; median duration for children admitted to care *before* the caseload reduction was 525 days. The pre/post difference is approximately 9 percent.

Technical Details

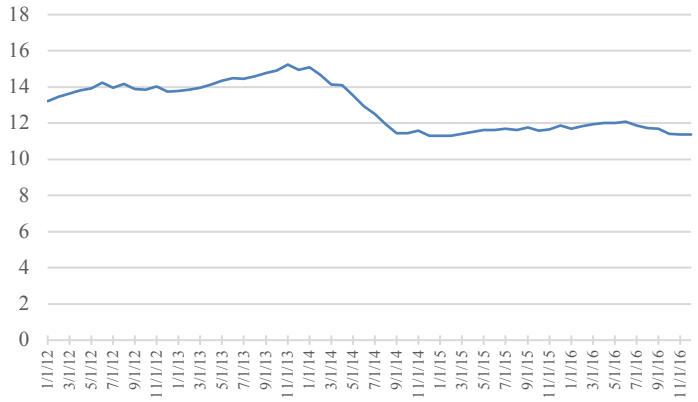
The evaluation uses an interrupted time series model. We elected this approach because implementation of the reductions was system-wide and simultaneous. As a consequence, there is no natural contemporaneous counterfactual. That said, this is a typical situation from the perspective of change initiatives in child welfare systems. Leadership often contemplates a strategic shift in resources that affects the system as a whole. When this happens, the impact assessment has to look for other, reasonable strategies for assessing whether the changes are having their intended impact.

In NYC, the caseload reductions took place over calendar year 2014. In its simplest form, contract agencies adjusted staffing patterns so that the average number of children per caseworker dropped from about 15 (pre-2014) to just under 12 by 2015.

To observe worker caseloads, rather the rely on self-reports of agencies or caseworkers, we used a unique link between agencies, caseworkers and children served to assess on a monthly basis the number of caseworkers working in an agency, the number of children served by those caseworkers at those agencies, and the *monthly* worker/child ratio, separately for each unique agency in the City network. In this way, we were able to ask whether in a given month the standard had been met and whether children served in months when the standard was met were more likely to leave care.

The results from this linked caseworker/child file are found in Figure 39. As depicted, between the start of 2012 and the start of 2014, average caseloads drifted upward from 13 children per worker to about 15 children per worker before starting downward over calendar year 2014, as the caseload reduction was put in place. By the beginning of 2015, the number of children per worker dipped below 12 children per worker where it has remained since.

Figure 39. *Average Number of Children Per Worker*

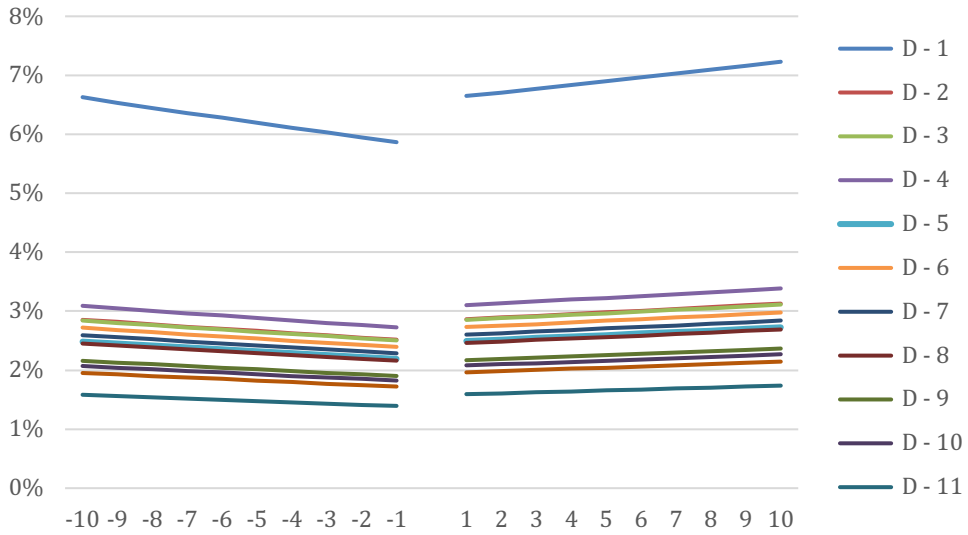


Impact on Permanency

The interrupted time series analysis was done as follows. We marked time in months before the implementation of the caseload standard (-10 to -1) and after implementation (1 to 10). In the statistical model, we used this indicator to assess the time trend. We then looked at who was in care at the beginning of each month and asked whether they left care during the month. We also noted whether the month in question fell within the period when caseloads met the standard. This provides for a more nuanced understanding of the effect insofar as some of the children and young people admitted in 2012-2014 would have been in care when the caseload reductions went into effect. By looking more closely at exposure – i.e., who was in care when the caseload reductions went into effect, while bearing in mind when the admission to care happened (i.e., how long they had been in care already), we give ourselves a better chance of seeing the impact.

These data, found in Figure 40, show a persistent drop in the likelihood a child would leave care in the months leading up to the reduction. For example, D – 1 refers to the first 30 days of a placement. In the months leading up to the caseload reduction (-10 to -1), the likelihood of leaving care dropped from about 6.6 percent to just under six percent. In the months following, the change (1 to 10), the likelihood increased from about 6.6 percent to just above seven percent. The data show a similar pattern across person-periods. The children in care during the second person-period, regardless of when they entered, were less likely to leave care during that person-period as time went on. After the caseload reduction, the rate (or likelihood) increased. It is worth noting that the results presented in Figure 40 hold up after differences in the population served are taken into consideration. As mentioned, this provides a more detailed view of length of stay changes relative to the caseload reduction.

Figure 40. *Change in the Likelihood of Leaving Care by Person-Period Relative to When the Caseload Reduction Started*



Model Details

Details of the model used to understand the Waiver effects associated with the caseload reduction are found in Table 46. Our principal interest is in the Post Implementation x Trend interaction effect, as that represents the treatment effect. Simply put, as a general matter, the trend in NYC indicates the over the period of observation – 2012 through 2016 – exits rates were slowing (see Time trend in Table 46). Post-implementation (in the months after the caseload reduction), exit rates were increasing. When the post-implementation person-periods (i.e., placement months) are adjusted for the time trend, the rates of exit show a significant increase.

The random effects nature of the model accounts for the fact that children placed with some agencies leave care faster because of the agency's own performance. By controlling for the agency effect, we increase the validity of the results.

Other factors in the model account for demographic attributes of the children (age, gender, race/ethnicity) and history of placement. A child placed with an agency today may have been placed with another agency at some earlier time. Adjusting for the number of prior agency spells, as we call them, accounts for the fact children change placements. In an indirect way, this adjustment controls for the mix of reasons children leave placement and what those placement changes mean for when children leave care.

Finally, we control for placement month. The likelihood of leaving care changes with the how long the child has been in care. In this case, we compare exit rates in subsequent months with the exit rate in the first month of placement. Generally, exit rates in the first month are highest, as indicated by the top line in Figure 40.

Table 46. *Random Effects Interrupted TimeSeries Model Using Discrete Time*

Effect	Estimate	Standard Error	t value	Prob.
Intercept	-3.7385	0.08659	-43.17	.0001
Time trend	-0.01894	0.00181	-10.46	.0001
Post implementation	0.08023	0.04463	1.8	0.0723
Post imp. x Trend	0.03692	0.002065	17.88	.0001
Females	Reference			
Males	-0.01294	0.02109	-0.61	0.5393
Whites	Reference			
Blacks	0.15	0.06861	2.19	0.0288
Hispanics	0.1636	0.0702	2.33	0.0198
Other	1.2229	0.06812	17.95	.0001
1st agency placement	Reference			
2nd placement	-0.03555	0.02677	-1.33	0.1842
3rd placement	-0.2017	0.04792	-4.21	.0001
4th placement	-0.5471	0.06972	-7.85	.0001
Infants	Reference			
1 to 5-year olds	0.3721	0.02682	13.87	.0001
6 to 13-year olds	0.4931	0.02901	17	.0001
14 and above	-0.1706	0.0416	-4.1	.0001
Placement month 1	Reference			
Placement month 2	-0.8226	0.04966	-16.57	.0001
Placement month 3	-0.8097	0.0506	-16	.0001
Placement month 4	-0.7152	0.05027	-14.23	.0001
Placement month 5	-0.9295	0.05538	-16.78	.0001
Placement month 6	-0.811	0.05432	-14.93	.0001
Placement month 7	-0.831	0.05606	-14.82	.0001
Placement month 8	-0.9124	0.05897	-15.47	.0001
Placement month 9	-1.0377	0.06309	-16.45	.0001
Placement month 10	-1.0909	0.06554	-16.65	.0001
Placement month 11	-1.3438	0.07362	-18.25	.0001
Placement month 12	-1.1144	0.06832	-16.31	.0001
Placement month 13	-1.0937	0.069	-15.85	.0001
Placement month 14	-1.1361	0.07162	-15.86	.0001
Placement month 15	-1.4116	0.08194	-17.23	.0001
Placement month 16	-1.4642	0.0853	-17.16	.0001
Placement month 17	-1.4591	0.08657	-16.86	.0001
Placement month 18	-1.2098	0.07919	-15.28	.0001
Placement month 19	-1.2329	0.08153	-15.12	.0001
Placement month 20	-1.3441	0.08697	-15.46	.0001
Placement month 21	-1.3998	0.09053	-15.46	.0001
Placement month 22	-1.2444	0.08608	-14.46	.0001
Placement month 23	-1.4544	0.09608	-15.14	.0001
Placement month 24	-1.3098	0.09157	-14.3	.0001
Placement month 25	-1.3733	0.09583	-14.33	.0001
Placement month 26	-1.1415	0.08832	-12.92	.0001
Placement month 27	-1.0575	0.08686	-12.18	.0001
Placement month 28	-1.2913	0.09781	-13.2	.0001

Effect	Estimate	Standard Error	t value	Prob.
Placement month 29	-1.118	0.09247	-12.09	.0001
Placement month 30	-1.1608	0.09613	-12.08	.0001
Placement month 31	-1.2041	0.09993	-12.05	.0001
Placement month 32	-1.2708	0.1047	-12.13	.0001
Placement month 33	-1.1633	0.1017	-11.44	.0001
Placement month 34	-1.2796	0.1088	-11.76	.0001
Placement month 35	-1.2684	0.1105	-11.47	.0001
Placement month 36	-1.3035	0.1141	-11.42	.0001

This person period format is important in the context of the model structure. Children placed *after* the caseload reductions went into effect would have experienced any potential benefit over the entirety of their placement trajectory. Child placed prior to the caseload reduction would have only experienced the potential benefit for those months in care that coincided with the policy change. That might have been the 2nd or the 32nd month of their placement. By the same token, children who enter and leave care before the caseload changes take effect remain in the analysis. By noting whether the person-period/placement month overlaps with the caseload reduction, within the interrupted time series framework, we can directly compare exit rates, with and without exposure to the treatment, after adjusting for the effect of time in care on exit rates.

ABC

As part of their work evaluating SFNYC, the research team at Chapin Hall created an analytic file that links program implementation data (from Power of Two, the local purveyor of ABC) with administrative data related to children's experiences in out-of-home care, current through June 30, 2018. The focal group includes children placed with any of the ABC-implementing agencies after the time ABC was introduced, and who would have been eligible for ABC at some point during their spell in foster care.[22] Eligibility is determined both by children's placement in regular family foster care and their age (6 to 48 months).

Impact on Parenting

The parenting scales, ASQ, and BITSEA were administered not only to children in care who received ABC, but also to children who were receiving ABC as part of preventive, in-home services as well as children who recently reunified with their parents following an episode in foster care. Table 47, below, displays the number of child/caregiver dyads for whom we have a complete set of pre/post data. Many of these data reflect the experiences of children in care who participated in ABC; some of these data reflect the experiences of the other two types of ABC recipients (in-home services, reunification services).

[22] The ABC-implementing agencies include almost all of the SFNYC agencies as well as four "pilot" agencies, including JCCA, Good Shepherd Services, Coalition for Hispanic Family Services, and St. Dominic's Home.

Table 47. *Process Measures, All Dyad Types*[23]

	Pre and Post Data Available	Missing Data
Positive Regard	615	459
Follow the Lead	615	459
Intrusiveness	615	459
BITSEA: Problem Risk	615	410
BITSEA: Competence Risk	615	410
ASQ: Social-Emotional Risk	615	195

Paired t-tests and generalized estimating equation (GEE) regression models were run to determine whether children and caregivers who participated in ABC exhibited changes in behaviors that are consistent with the model's underlying theory of change. The results from the paired T-test are displayed in Table 48; the results from the GEE regression models are presented in Table 49.

Table 48. *Paired T-test results: Effect of ABC on key process indicators*

Indicator	**N**	**Mean**	**Min**	**Max**	**t-value**	**Prob. t**
Caregiver: Positive regard	191	-0.005	-3	3	-0.067	0.9464
Caregiver: Following the lead	191	0.524	-2	3	6.312	0.0000
Caregiver: Intrusiveness	191	-0.573	-4	3	-5.889	0.0000
Child: Problem behavior (BITSEA)	262	-0.099	-1	1	-3.311	0.0011
Child: Competence (BITSEA)	262	-0.073	-1	1	-2.498	0.0131
Child: ASQ risk level	382	-0.113	-1	1	-5.447	0.0000

Overall, the ABC program was found to be effective in:

- Improving the extent to which caregivers are able to engage in "following the lead" behavior in response to children's cues (ORCE)[24];
- Improving caregivers' ability to recognize intrusive or frightening behaviors that may be troubling to the child in their care (ORCE).
- Improving caregivers' assessment of children's behavior problems (BITSEA)
- Improving caregivers' assessment of children's development (BITSEA)

[23] Power of Two provided Chapin Hall with the treatment data, via ACS. We cannot say why there is so much missing data. Many children had pre-test data OR post-test data, but not both. Those children are in the "missing data" category.

[24] Parent behavior during the play assessment was coded using scales adapted from the NICHD Observational Record of the Caregiving Environment: NICHD Early Child Care Research Network Characteristics of infant child care: Factors contributing to positive caregiving. *Early Childhood Research Quarterly*. 1996;11, p. 269–306.

- Improving caregiver's assessment of children's development along five domains: communication, personal-social, gross motor, fine motor, and problem-solving.

No significant effect was detected with regards to caregivers' demonstration of positive regard (ORCE).

The GEE regression model differs from the paired T-test in that it controls for other variables that might influence whether child or caregiver behavior changes in the intended ways; namely, child age at the time ABC began, the nature of the child/caregiver relationship, caregiver age, and child gender. The GEE regression model establishes a reference group to which other groups are compared. For example, the period following the roll-out of ABC (post-ABC) is compared to the pre-ABC period; for gender, the reference group is "females;" for child age, infants are set as the reference group to which other ages are compared; and, for child/caregiver relationship, the reference group is set at "other relationship." Note, in the table below the values for each reference group are set to 0.

Table 49. *GEE Statistical Model: Caregiver Parenting and Child Social Emotional Indicators after ABC*[25]

	Positive Regard		Follow the lead		Intrusiveness		BITSEA: Problem Risk		BITSEA: Competence		ASQ: SE Risk	
Model Parameters	Estimate	ProbZ	Estimate	ProbZ	Estimate	ProbZ	Estimate	ProbZ	Estimate	ProbZ	Estimate	ProbZ
Intercept	4.287	0.000	2.936	0.000	3.429	0.000	-0.338	0.702	-0.995	0.201	-0.905	0.108
Time												
Post-ABC	0.028	0.718	0.641	0.000	-0.649	0.000	-0.535	0.000	-0.348	0.023	-0.547	0.000
Pre-ABC	0.000	0.000	0	0	0	0	0	0	0	0	0	0
Child gender												
Male	-0.151	0.114	-0.246	0.015	0.202	0.083	0.062	0.793	0.280	0.225	0.236	0.164
Female	0.000	0.000	0	0	0	0	0	0	0	0	0	0
Child age in years												
13-24 months	-0.107	0.421	-0.074	0.600	-0.200	0.267	-0.371	0.393	-0.210	0.618	0.132	0.584
25-36 months	-0.098	0.499	-0.027	0.861	-0.400	0.037	0.132	0.769	0.237	0.590	1.004	0.000
37-48 months	-0.259	0.073	0.094	0.527	-0.658	0.000	-0.449	0.669	-1.065	0.355	0.592	0.021
6 to 12 months	0.000	0.000	0	0	0	0	0	0	0	0	0	0
Caregiver Relation to Child												
Aunt/Uncle	-0.239	0.275	-0.223	0.387	-0.109	0.742	0.347	0.635	-0.862	0.200	0.198	0.684
Foster Parent	0.024	0.892	0.189	0.383	-0.273	0.313	1.283	0.035	-0.230	0.617	0.262	0.480
Grandparent	-0.068	0.743	0.048	0.838	-0.122	0.687	0.393	0.572	-0.583	0.274	-0.425	0.313
Other Relative	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Caregiver Age (continous)	-0.014	0.002	-0.009	0.054	-0.005	0.358	-0.016	0.157	0.014	0.249	0.009	0.299

Overall, the findings from the GEE model are similar to those of the paired t-test results (Table 48): caregivers who participated in ABC showed improvements in all process indicators, with the exception of demonstrating positive regard.

[25] Many children do not have assessment data, especially related to ABC parenting indicators and BITSEA-assessed risk level.

Impact on Permanency

To determine whether ABC has the intended effect on permanency we conducted both Intent-to-Treat (ITT) and a Treatment-on-the-Treated (TOT) analyses. The former considers the extent to which improvements in outcomes can be detected within the entire population of children intended to be treated by ABC, regardless of program uptake; in this case, that includes children aged 6 to 48 months placed in regular family foster care. The latter considers the extent to which children who received ABC experienced better outcomes than children who could have received the treatment but did not. Generally speaking, ITT analyses are a more conservative analysis; they are much less sensitive to bias in both the "treated" and "not treated" groups.

As to the ITT analysis, we found that permanency outcomes were significantly better over the period of time during which ABC was being implemented. However, the results of the TOT analysis show no impact of ABC on the participants. Specifically, when compared to children who completed ABC, permanency rates were higher for children who either didn't participate at all or didn't complete the program.

The positive effect from the ITT analysis, which includes all ABC eligible children regardless of participation, may be due to general effect of SFNYC and the changes induced by the reduced caseloads.

Cost Study

Introduction

Simply put, the purpose of the federal government granting Title IV-E Waivers is to provide Waiver jurisdictions the opportunity to use Title IV-E funds more flexibly on behalf of children and families. As part of SFNYC, NYC agreed to replace fee-for-service Title IV-E reimbursement with a fixed payment. Like other Waiver-involved jurisdictions, NYC traded guaranteed, unlimited, fee-for-service federal contributions for IV-E eligible children for a fixed amount of money that can be used for all child welfare services for any child, regardless of their eligibility. The fixed amount of money provided as part of SFNYC is intended to be the same amount as what NYC would have received under normal Title IV-E reimbursement rules (i.e., in the absence of the Waiver). The allocation amount is based on the average gross expenditures for foster care maintenance and foster care administration for federal fiscal years 2009 through 2011.

The NYC Cost Study includes a study at the system level and examines citywide spending patterns. This system level study will present the analysis of fiscal data collected from FY 2011 through December 31, 2018 – the end date of NYC's Waiver project and halfway through FY 2019.[26]

The overarching research questions guiding the NYC Cost Study are:

1. What effect does the Waiver have on child welfare expenditures overall?
2. What are the costs of Waiver services received by children and families?

The basic thesis underlying NYC's Waiver project is that the constellation of interventions made possible through the flexible use of Title IV-E funds would improve child safety, permanency and well-being. As with other Waiver-involved jurisdictions, the expectation in NYC was that foster care expenditures would be reduced under the Waiver. There are several ways to achieve a reduction in foster care spending: by reducing the number of children coming into care, by moving children out of care more quickly, and/or by reducing the use of more expensive types of placements.

As detailed earlier in this report, NYC agreed to implement four interventions as part of SFNYC, which went into effect on January 1, 2014 (halfway into FY 2014):

3. Reduction of caseloads/supervisory ratios
4. Attachment and Bio-behavioral Catch Up (ABC)
5. Partnering for Success (PFS)
6. Child and Adolescent Needs and Strengths (CANS-NY)

In NYC, the theory is that reduced caseloads and reduced supervisory ratios coupled with more effective assessments and other service enhancements will lead to an increase in the likelihood and timing of permanent exits as well as a reduction in reentry rates. Theoretically, these outcomes would reduce overall foster care spending. Whether that is happening and the impact any observed changes are having on spending in other areas of the system is the basis of the discussion below.

[26] A NYC fiscal year being defined as the period from July 1 through June 30. For example, FY 2018 runs from July 1, 2017 through June 30, 2018.

First, we provide a description of NYC's funding structure and give some background on how SFNYC was intended to impact spending. Then, we provide an overview of the data sources used for this portion of the study along with an explanation of our analytic methods. This is followed by findings related to overall child welfare spending as well as foster care and preventive spending patterns. Lastly, we provide summative observations.

Background

NYC operates a largely privatized child welfare system. Direct foster care and preventive services for children and families are provided through contracts with private provider agencies. The providers receive a contract based on the number of children they plan to serve (as submitted via RFP) and subsequent estimates by ACS. Child protection investigations are handled by NYC Administration for Children's Services (ACS) employees. The majority of funding for ACS is derived from federal sources. Approximately 43 percent of ACS' $2.95 billion-dollar budget is supported by Child Care Block Grant (CCBG) funding as well as other federal revenues. Local funding is ACS' second largest funding source (31 percent) followed by New York State.[27]

Since NYC contracts with private provider agencies to administer foster care services, an arrangement was put in place to pass along a portion of the IV-E allocations directly to the providers themselves to support the Waiver interventions. Specifically, NYC agreed to pay each provider agency participating in the SFNYC initiative (17 agencies) a fixed amount in order to implement the first part of SFNYC – the reduction of caseloads and supervisory ratios. The rate in the formula was increased over time from $9.50 to $9.65, as follows:

($9.50 to $9.65) * # of target care days = agency caseload reduction allocation

The set allocation above was based on agreed upon target care days. The agencies were expected to reduce their active census by 11 percent in Year 1 and 6 percent in Year 2, which influenced their allocations for Years 2 and 3, respectively. An additional caseload reduction allocation was distributed to the SFNYC agencies, paid for with federal Title IV-E dollars. Each agency also received separate open-ended preventive funding ($11.00 to $11.14) * # target care days), which incorporated a rate that rose over time, from $11.00 to $11.14. That allocation was paid for with a combination of federal, state and local dollars.[28]

The Cost Study will answer the primary research question of whether the fiscal stimulus of the Waiver and the associated service interventions had an effect on citywide expenditure patterns when the costs of the Waiver interventions are included. To answer this question, evaluators collected expenditure data from NYC dating back five years prior to the start of the Waiver to create and populate a database including all city-wide child welfare financials. Data collected to date will allow for the evaluation of the child welfare spending patterns prior to and during the Waiver demonstration period.

Data Sources

[27] Report on the Fiscal 2016 Preliminary Budget and the Fiscal 2015 Preliminary Mayor's Management Report; Administration for Children's Services; March 17, 2015

28 The five CSNYC agencies had a different arrangement. Their allocation was $23.00 a day. The CSNYC agencies paid intervention consultants directly for the cost of training. The costs associated with the CSNYC agencies are not the focus of this report. Here we focus on the 17 SFNYC agencies.

The central task of this analysis was to create and populate a database including all city-wide child welfare expenditures. The NYC Cost Study database represents all child welfare-related expenditures for three and a half years prior to the Waiver and for each year during the Waiver. The database's structure contains the flexibility to compare financial data within NYC, across fiscal years, and within specific expenditure categories.

The initial tasks central to the creation of this database were documentation reviews and interviews with fiscal administrators. A series of informational interviews were conducted during the early part of 2016. Review of relevant fiscal reports and other documentation was conducted during this time as well. Qualitative data allowed researchers to clarify the fiscal relationships between NYC, individual private provider agencies, the state, and the federal government as it relates to child welfare expenditures and revenue streams. This assisted researchers in outlining the structure, reporting, and processes surrounding the various administrative financial systems.

Key to this evaluation is the fact that there are several city and state claiming systems, each with different purposes and nuances, which are all utilized for the claiming and reporting of child welfare expenditures and associated revenue streams. For this study, researchers received information from ACS fiscal administrators, which were downloaded from the associated system (and transferred to spreadsheets if necessary). The information researchers relied on was downloaded from one of the following three systems:

1. NYC Financial Management System (FMS): New York City's accounting system that records all expense and revenue.
2. NYS Statewide Payment System (SSPS): New York State's payment/claiming system. NYC ACS uses it to records claims.
3. Benefits Issuance Control System (BICS): This is a subsystem of SSPS. The actual claims are produced from this system.
4. Automated Claiming System (ACS): New York State Office of Temporary and Disability Assistance claiming submission system

Data Analysis

The NYC fiscal analysis began with a simple categorization of costs into categories. For the current study, four major categories are included:

Out of Home (Foster Care). When children are removed from their homes due to abuse or neglect, ACS contracts with private foster care agencies to provide foster care services. These agencies place children either with a foster family or in a congregate care facility. Payments to service providers are made per care day. Funding covers costs such as food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance, and travel.

In Home Purchased Services (Preventive). Preventive services are administered by private agencies to avert the need for foster care placement and to expedite the discharge of children from foster care and reunite them with their families. Services offered include case management, homemaking, childcare, and household management services to families.

Adoption and Guardianship (includes adoption subsidies and KinGAP payments). Adoption subsidies are provided to adoptive families to assist with the costs of caring for children who have special needs or who are categorized as 'hard-to-place'. KinGAP provides monthly payments and other benefits to qualified relative guardians.

Direct City Administrative. Includes salaries, benefits and overhead associated with ACS overseeing and managing the entire city-wide child welfare system.

The NYC Cost Study database was fully populated using information provided to researchers by ACS fiscal administrators. Using the data available, researchers examined the following dependent variables:

1. Child welfare expenditures;
2. Total child welfare;
3. Out of home;
4. Intervention specific;
5. Paid care days;
6. Average unit cost;
7. Foster care placement (total foster care expenditures divided by paid care days);
8. Residential placement (total residential care expenditures divided by paid care days);

An adjustment for inflation has been made to allow comparability of expenditures across years. All expenditures, unless otherwise noted, have been adjusted to constant dollars using FY 2019 dollars as the base year and adjusting previous years' expenditures to FY 2019 levels by the Consumer Price Index (CPI)[29].

For each dependent variable listed above, we present the indicator across eight and a half fiscal years. Since NYC's Waiver went into effect on January 1, 2014, available cost data covers three and a half years prior to the Waiver and the full five years of activity since the Waiver was implemented. For each dependent variable, we also present the Waiver change – calculated by looking at the percent change from FY 2013 (the last full fiscal year prior to the start of the Waiver) to FY 2018 (the last full fiscal year under the Waiver). Although projected annual FY 2019 values are displayed, these projections could be impacted by seasonality and are not used to measure Waiver change.

Findings

As discussed previously, under the Waiver, NYC was able to retain federal Title IV-E funding after covering traditional Title IV-E expenditures and use it for other child welfare purposes. As a result, the expectation was that NYC would take action to reduce foster care expenditures in ways that improve outcomes for children and families. By making programmatic changes and investing flexible funds, NYC hoped to reduce the length of stay in foster care, reduce reentry, and reduce the use of high-cost placements. The savings generated as a result of the Waiver were meant to be reinvested in services other than foster care, resulting in a continued decline in the need for foster care. Below we explore this theory of change and the fiscal implications.

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[29] Bureau of Labor Statistics. (2019). *Consumer price index - all urban consumers, 2008-2019* [Time series]. Retrieved from http://data.bls.gov

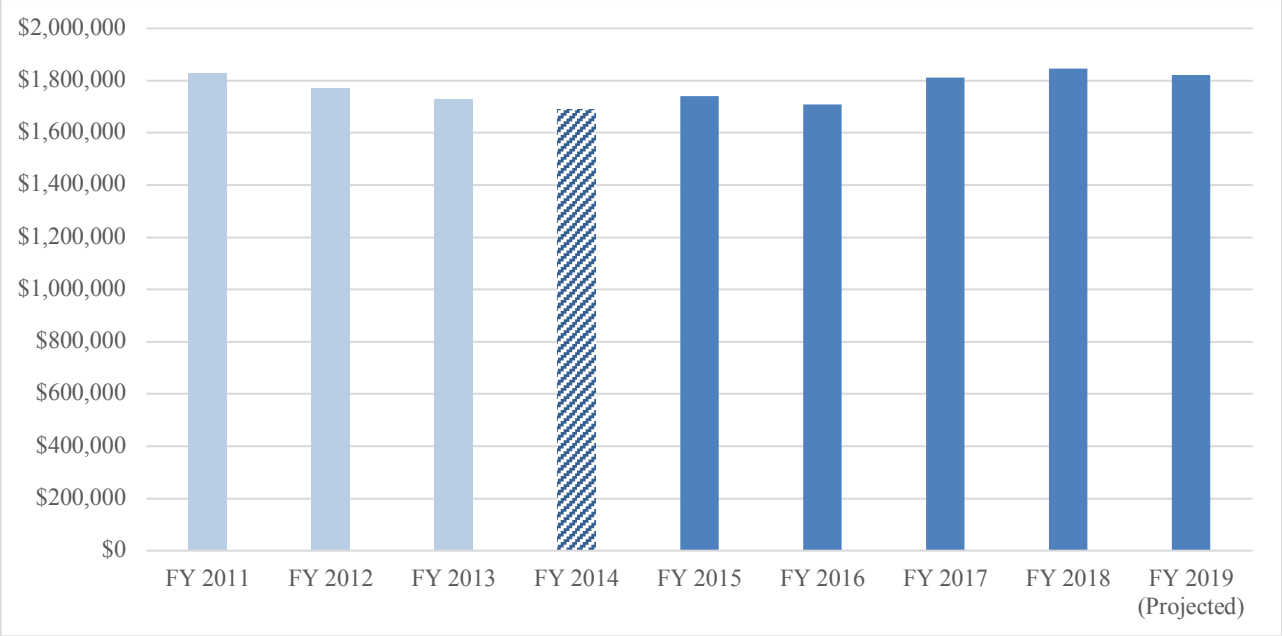
Constant costs are calculated using the following equation: Current Year Real Cost = (Base Year CPI/Current Year CPI)*Current Year Nominal Cost. All constant costs are converted into FY 2019 dollars, so the Base Year is FY 2019. The CPI for FY 2019 is calculated by taking the average CPI of the monthly CPIs for the period July 2018 through December 2018 (252.125).

Overall Child Welfare Expenditures

Total Child Welfare Expenditures

First, the total child welfare expenditures in NYC are reported. These are displayed below in Figure 41 from FY 2011 through a projected total in FY 2019; NYC's Waiver project began midway through FY 2014. In the observed pre-Waiver years (FY 2011 through FY 2013), total child welfare expenditures were decreasing, reducing by six percent from SFY 2011 to SFY 2013. Child welfare expenditures reached a low point of $1.689 billion in the first year of the Waiver (SFY 2014). From there, during the rest of the Waiver, total child welfare expenditures increased through FY 2018, with a slight dip in FY 2016, although expenditures levels are projected to decrease in FY 2019. Overall, total child welfare expenditures increased by seven percent from SFY 2013 levels, after adjusting for inflation. To understand where and why this increase occurred, the child welfare expenditures are broken down into major categories in the next section.

Figure 41. *Total Child Welfare Expenditures by SFY – Adjusted for Inflation, in Thousands of Dollars*



Expenditures by Major Category

Table 50 displays all child welfare spending in NYC from FY 2011 through December 31, 2018 (halfway through FY 2019).[30] A projected annual total for FY 2019 is also presented- calculated by doubling the current half year value. The Waiver Change displays the percent change from FY 2013 to FY 2018. As described in the Data Analysis section, child welfare expenditures can be divided into four broad categories:

[30] We use the term All Child Welfare spending with the acknowledgement that this excludes the following expenses (which are technically overseen by ACS but are not considered part of the traditional child welfare system): HeadStart, Childcare, Detention, Limited Secure and some Medicaid expenses.

1. Out of Home Purchased Services (Foster Care): Payments to private provider agencies for the provision of foster care services.
2. In Home Purchased Services (Preventive): Payments to private provider agencies for the provision of preventive services.
3. Adoption and Guardianship (includes adoption subsidies and KinGAP payments): Category includes adoption subsidies as well as KinGAP payments.[31]
4. Direct City Administration: This includes all administrative and direct expenses incurred by NYC directly for the oversight and the provision of services of the child welfare system. Direct expenses are Child Protection, Family Permanency and Prevention staff.

As seen in Figure 41, total child welfare expenditures have increased overall during the Waiver, but expenditure trends varied by category of expense. Figure 42 breaks down expenditure trends by Major Category. Direct City Administration saw the largest increase over the course of the Waiver, both proportionally and in terms of real dollars. Direct City Administration expenditures increased by 31 percent from FY 2013 to FY 2018, after adjusting for inflation, with an additional increase projected for FY 2019. This increase shifted Direct City from making up 39 percent of expenditures in FY 2013 to 47 percent in FY 2018 and a projected 51 percent in FY 2019 (Table 1). In-Home spending also increased over the Waiver period, increasing by 13 percent from FY 2013 to FY 2018.

As Direct City Administration and In-Home expenses increased during the Waiver, both Out-of-Home (OOH) and Adoption and Guardianship expenditures steadily decreased, both before and during the Waiver period. OOH expenses decreased by 11 percent from FY 2013 to FY 2018, with an additional annual 11 percent decrease projected for FY 2019. Prior to the Waiver, OOH expenditures made up a third of total child welfare expenditures, and in FY 2019, OOH expenditures are projected to make up less than a quarter of child welfare spending. Adoption and Guardianship spending decreased by 19 percent during the Waiver.

[31] On April 1, 2011, New York State established the Kinship Guardianship Assistance Program (KinGAP). Under KinGAP monthly payments and other benefits are paid to qualified relative guardians who are approved and enrolled in this program.

Figure 42. *Child Welfare Expenditures by Major Category and FY – Adjusted for Inflation, in Thousands of Dollars*

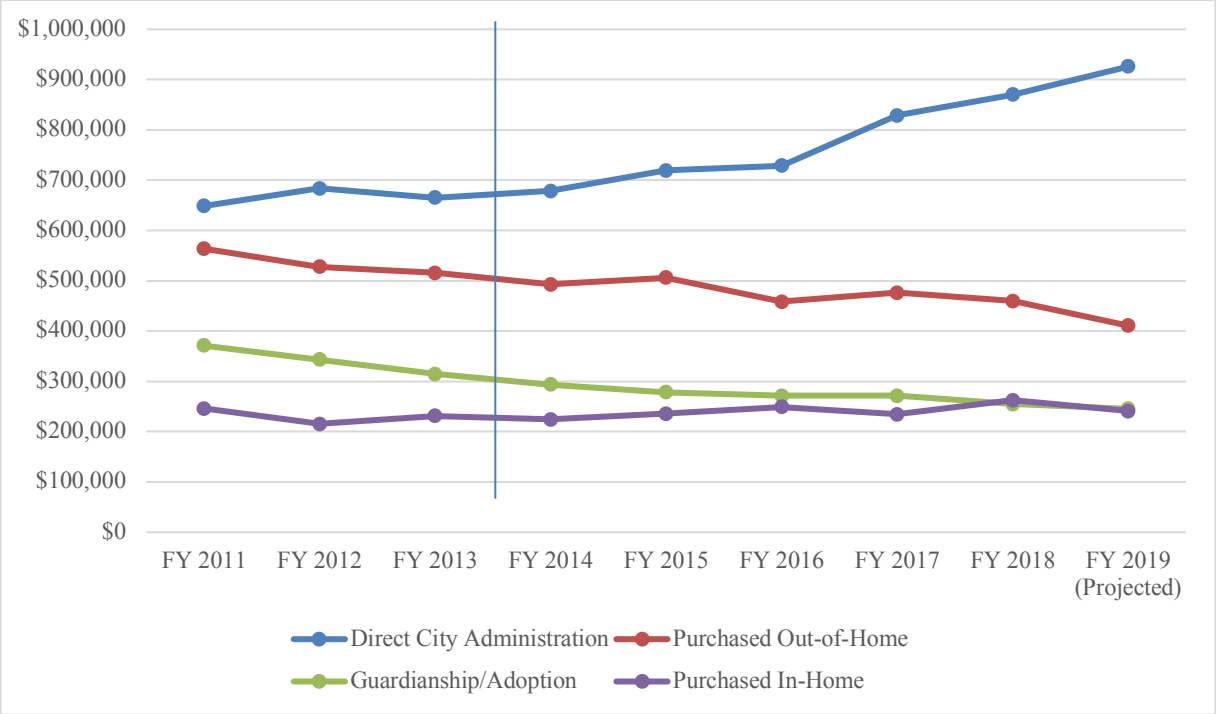


Table 50. *Child Welfare Expenditures by Major Category and SFY- Adjusted for Inflation, in Thousands of Dollars*

Total Expenditures by Major Category

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019 - Actual	*FY 2019 – Proj.*[32]
Direct City Administration	$648,767	$683,404	$665,340	$678,627	$719,315	$728,876	$828,844	$869,893	$462,893	*$925,785*
Purchased Out-of-Home	$563,763	$528,040	$515,417	$492,736	$506,112	$458,341	$476,365	$459,492	$205,417	*$410,834*
Guardianship/Adoption	$371,032	$343,080	$314,964	$293,569	$278,411	$271,645	$271,408	$254,719	$122,676	*$245,351*
Purchased In-Home	$246,043	$215,727	$231,560	$224,573	$235,765	$249,070	$234,516	$262,738	$120,285	*$240,570*
Grand Total	$1,829,605	$1,770,251	$1,727,281	$1,689,504	$1,739,603	$1,707,932	$1,811,134	$1,846,842	$911,271	*$1,822,541*

Proportion by Major Category

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Direct City Administration	35%	39%	39%	40%	41%	43%	46%	47%	51%
Purchased Out-of-Home	31%	30%	30%	29%	29%	27%	26%	25%	23%
Guardianship/Adoption	20%	19%	18%	17%	16%	16%	15%	14%	13%
Purchased In-Home	13%	12%	13%	13%	14%	15%	13%	14%	13%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

Annual & Waiver Change by Major Category

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	*FY 2019 – Proj.*	Waiver Change
Direct City Administration	5%	-3%	2%	6%	1%	14%	5%	*6%*	31%
Purchased Out-of-Home	-6%	-2%	-4%	3%	-9%	4%	-4%	*-11%*	-11%
Guardianship/Adoption	-8%	-8%	-7%	-5%	-2%	0%	-6%	*-4%*	-19%
Purchased In-Home	-12%	7%	-3%	5%	6%	-6%	12%	*-8%*	13%
Grand Total	-3%	-2%	-2%	3%	-2%	6%	2%	*-1%*	7%

[32] Projected FY 2019 figures are calculated by doubling the total FY 2019 expenditures.

Keeping in mind the difficulty involved in establishing causality between changes in spending patterns and SFNYC itself, it is worth reiterating that Figure 2 highlights how some of the trends identified since January 1, 2014 actually began taking shape prior to that date. Regarding OOH expenditures, as hypothesized, we observed a decrease in these costs over the course of the Waiver period. However, there was already an observable decline in this expenditure category in all of the pre-Waiver fiscal years presented here, and it's sunclear how these baseline trends may have impacted fiscal activity during the Waiver.

OOH Care Board and Maintenance Expenditures

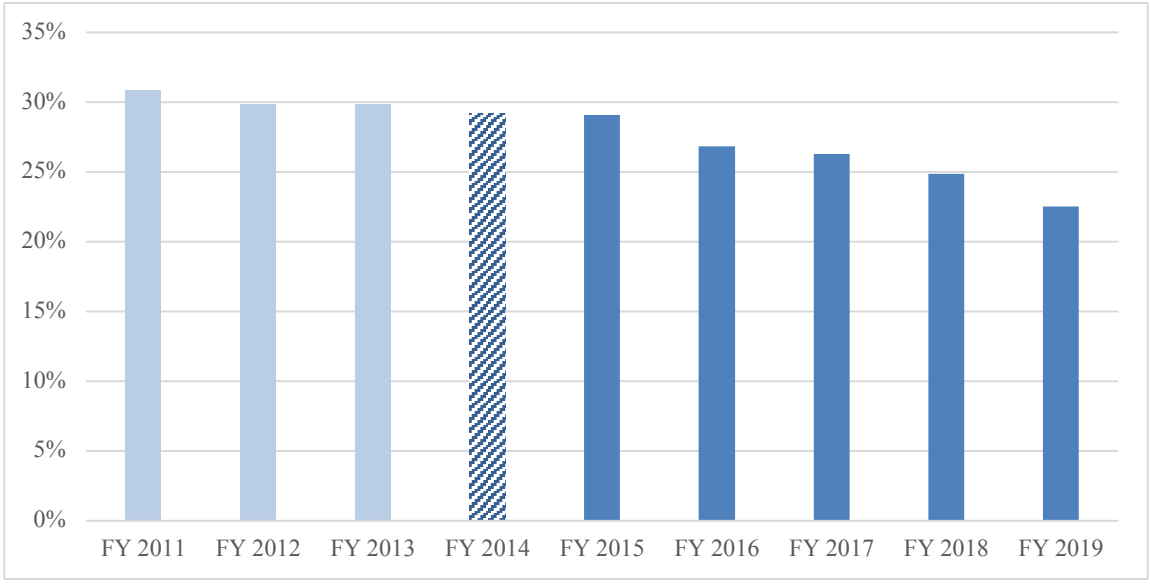
In order to reduce out-of-home placement expenditures, NYC would have had to reduce the number of paid placement days, reduce the average daily cost of care, or both. This section presents data on trends in OOH expenditures, placement days, and unit costs, as well as the proportion foster care expenditures represented of all child welfare expenditures.

OOH Expenditures as a Proportion of Total Child Welfare Spending

Looking at Table 50, the OOH placement expenditures experienced a decline from the first observed fiscal year, FY 2011, into the Waiver, and continued to decline overall during the Waiver period, with occasional upticks in FY 2015 and FY 2017. Overall, OOH placement costs decreased 11% during the Waiver when comparing FY 2013 levels to FY 2018.

It can be valuable to view out-of-home expenditures in the context of total child welfare expenditures. Figure 43 presents out-of-home placement expenditures another way – as a proportion of total child welfare expenditures. The relative proportion of foster care spending could decrease by increasing other child welfare expenditures, decreasing foster care expenditures or some combination of both.

Figure 43. *OOH Expenditures as a Proportion of Total Child Welfare Expenditures*



OOH placement spending, relative to all other child welfare spending, remained relatively stable, around 30%, between FY 2011 through FY 2015. However, two years into the Waiver, beginning in FY 2016, the proportion of OOH expenditures to total child welfare spending begins declining. In the observed fiscal data from FY 2019, OOH expenditures comprise 23% of total child welfare spending. This decrease in proportion is influenced by two trends. One, the other largest Major Category of spending, Direct City Administration, has been increasing during this period. And, two, OOH expenditures have been declining.

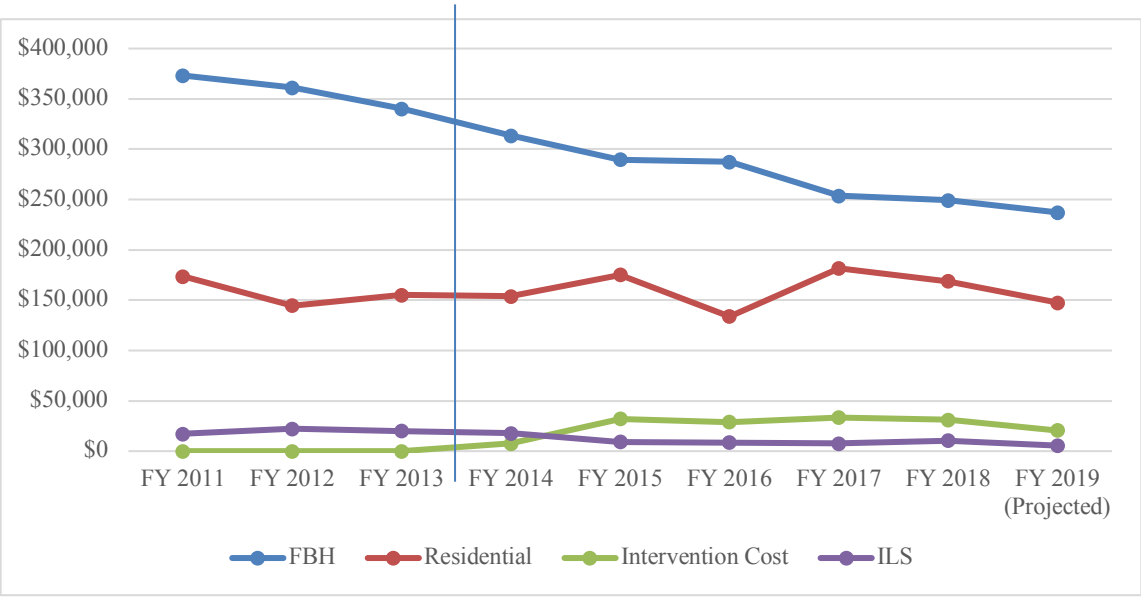
OOH Expenditures by Detail Category

However, as we observe OOH costs declining, the question remains whether there have been changes in how OOH placement dollars are being spent and on what types of placements and services.

The Cost Study breaks OOH spending into four broad categories:

1. Foster Boarding Home (FBH): Spending related to the purchase of out of home foster care services. This includes kinship, regular family foster care and therapeutic foster boarding home placements.
2. Residential Care: Spending related to children placed in congregate care setting such as group homes, institutions or agency operated boarding homes.
3. Independent Living Services (ILS): Expenses related to the provision of ILS training for older youth in foster care.
4. Intervention Costs: This figure only includes payments to provider agencies for the reduction of caseloads and supervisory ratios.

Figure 44. *OOH Expenditures by Detail Category – Adjusted for Inflation, in Thousands of Dollars*



Above, Figure 44 presents the trends in spending by these categories. Making up the largest proportion of OOH spending, FBH expenditures are driving the downward trend in overall OOH costs. Beginning in the first observed fiscal year, FY 2011, FBH expenses experience a relatively steady decline over the pre-Waiver baseline period and during the Waiver years. FBH costs declined nine percent from FY 2011 through FY 2013. Reductions in FBH spending continued in the Waiver period with a further reduction of

27 percent from FY 2013 to FY 2018 (Table 2). In FY 2019, there is an additional annual decrease of five percent projected.

Residential Care spending shows some variation across the observed fiscal years, but overall, Residential Care costs increased nine percent increase over the Waiver period. Although, an annual reduction of 13 percent is projected in FY 2019. Spending for the caseload reduction intervention looks stable across the Waiver years, with the exception of a drop in FY 2019.

Table 51. *OOH Expenditures by Detail Category – Adjusted for Inflation, in Thousands of Dollars*

Total OOH Expenditures by Detail Category

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	*FY 2019 (Projected)*
FBH	$373,192	$361,113	$340,257	$313,548	$289,546	$287,321	$253,645	$249,272	$118,599	*$237,197*
Residential	$173,453	$144,624	$155,052	$153,882	$175,223	$133,732	$181,624	$168,775	$73,690	*$147,381*
Intervention Cost (caseload reduction only)[33]	$0	$0	$0	$7,499	$32,001	$28,757	$33,352	$31,016	$10,373	*$20,745*
ILS	$17,118	$22,304	$20,108	$17,807	$9,342	$8,531	$7,745	$10,429	$2,755	*$5,511*
Grand Total	$563,763	$528,040	$515,417	$492,736	$506,112	$458,341	$476,365	$459,492	$205,417	*$410,834*

Proportion by Detail Category

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
FBH	66%	68%	66%	64%	57%	63%	53%	54%	58%
Residential	31%	27%	30%	31%	35%	29%	38%	37%	36%
Intervention Cost (caseload reduction only)	0%	0%	0%	2%	6%	6%	7%	7%	5%
ILS	3%	4%	4%	4%	2%	2%	2%	2%	1%
Grand Total	31%	30%	30%	29%	29%	27%	26%	25%	23%

Annual & Waiver Change by Detail Category

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	*FY 2019 (Projected)*	Waiver Change
FBH	-3%	-6%	-8%	-8%	-1%	-12%	-2%	*-5%*	-27%
Residential	-17%	7%	-1%	14%	-24%	36%	-7%	*-13%*	9%
Intervention Cost (caseload reduction only)				327%	-10%	16%	-7%	*-33%*	
ILS	30%	-10%	-11%	-48%	-9%	-9%	35%	*-47%*	-48%
Grand Total	-6%	-2%	-4%	3%	-9%	4%	-4%	*-11%*	-11%

[33] The intervention costs highlighted here include payments made to the five CSNYC agencies as well as payments made to 17 SFNYC agencies. Later we break out payments made to the 17 SFNYC agencies as a way of exploring costs associated with the Waiver specifically.

OOH Placement Expenditure Structure

To understand shifts in out-of-home placement costs, one must take into account their expenditure structure. Total out-of-home placement expenditures are influenced by two components: price of care and quantity of care days. In other words, how much a child welfare system spends on out-of-home placements (expenditures) is a function of how much that collection of services costs per day (price) and the number of care days for which it is provided (quantity).

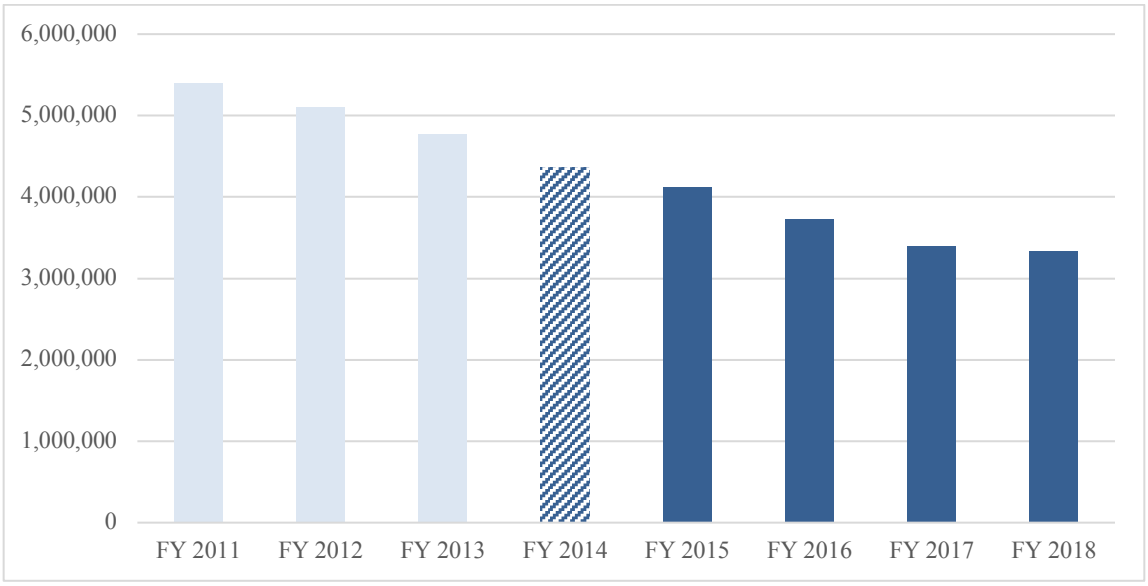
OOH Expenditures = Price * Quantity

In short, a change in the average cost per care day or in the number of care days would affect the total out-of-home expenditures.

Quantity - OOH Placement Care Days

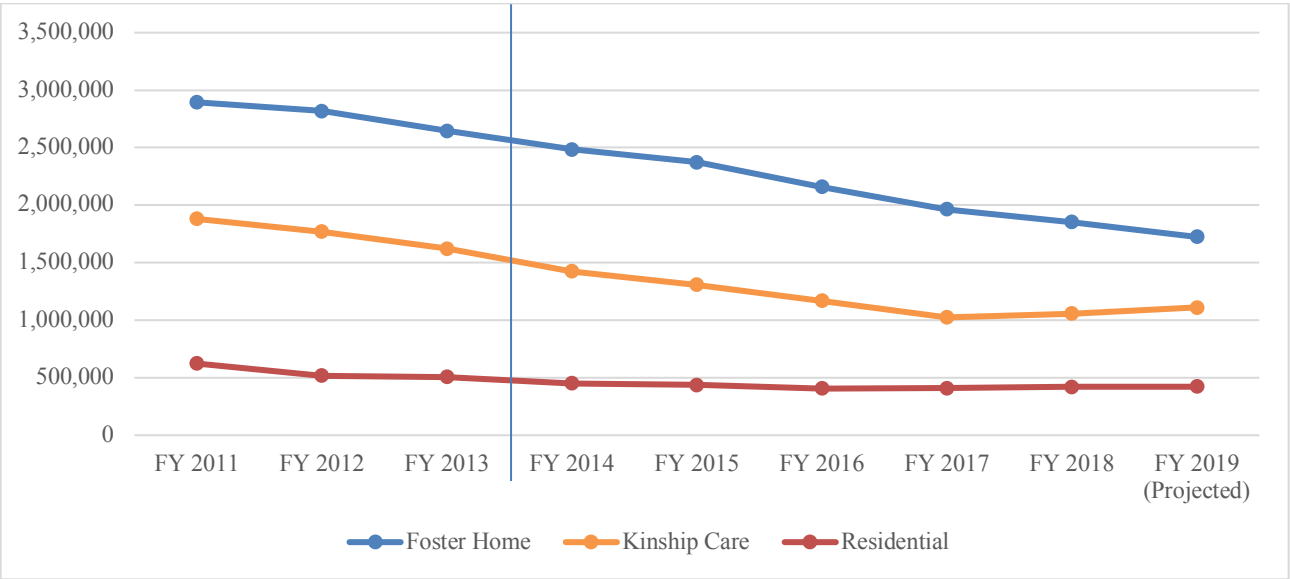
In NYC, the quantity of placement days has decreased each observed fiscal year (Figure 45). In the baseline period, prior to the Waiver, total care days decreased by 12%, and over the course of the Waiver, total care days were cut by another third.

Figure 45. *Total NYC OOH Care Days by FY*



Although care day utilization declined during the observed window within all care types, the speed at which it did so varied by care type. Figure 6 presents the OOH placement day annual utilization by placement type. Foster Home includes all of the days that children spent in foster care (including treatment foster care) during the associated fiscal year, Kinship Care includes all kinship placement, and the Residential grouping includes all the days spent in agency-operated boarding homes, group homes, group residences, institutions, and other placement settings (including independent living). We see that prior to the Waiver, all placement types experienced decreases in utilization with Residential placement days decreasing at the greatest rate – a 19 percent reduction from FY 2011 to FY 2013. During the Waiver period, all three placement types continue to show a reduction in utilization – Kinship Care by 35 percent, Foster Home by 30 percent, and Residential by 19 percent.

Figure 46. *Total NYC OOH Care Days by FY – by Placement Type and FY*



However, as we saw in Table 50, OOH expenditures did not decline as dramatically as placement days. This dynamic was impacted by the other driver of out-of-home expenditures—price, or average daily unit cost–examined below.

Price - Average Daily OOH Unit Cost

Average unit costs are calculated by dividing the total annual out-of-home expenditures by total placement days for each fiscal year. In NYC, the average daily cost of care rose beginning in FY 2013 and peaked in FY 2017 at $140.14 a day across all care types (Table 52). However, the average daily cost decreased in FY 2018 and again in FY 2019.

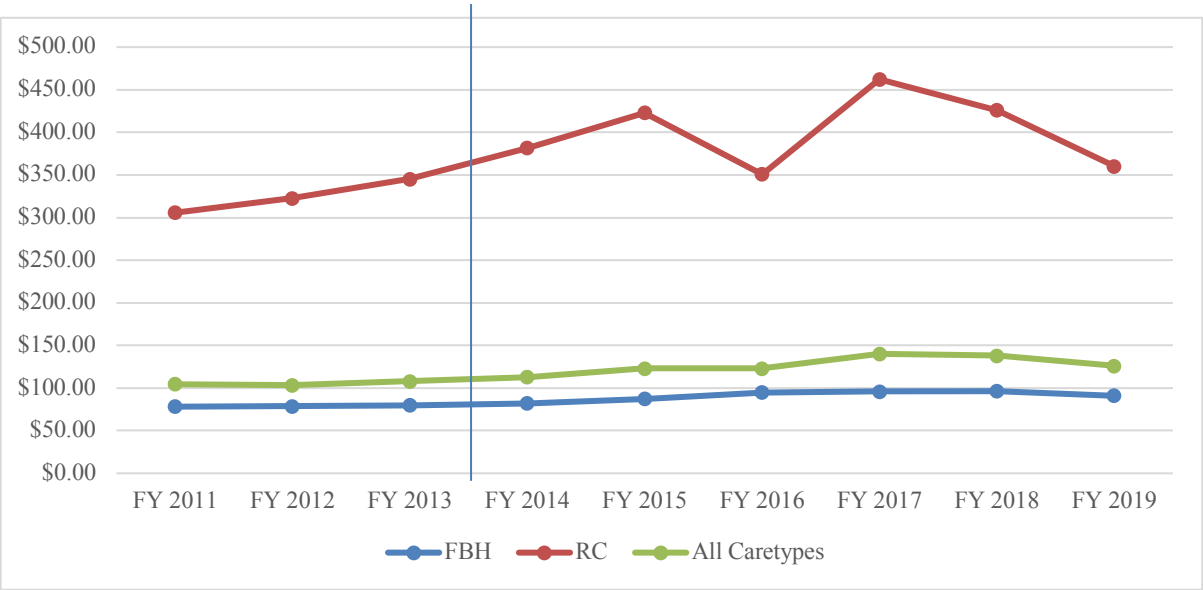
Table 52. *Average Daily Unit Cost – All Care Types, Adjusted for Inflation*

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
OOH Exp. (in thousands)	$563,763	$528,040	$515,417	$492,736	$506,112	$458,341	$476,365	$459,492	$205,417
All Caredays	5,398,445	5,103,915	4,775,972	4,358,482	4,117,491	3,731,486	3,399,175	3,330,229	1,628,975
Avg Daily Cost	$104.43	$103.46	$107.92	$113.05	$122.92	$122.83	$140.14	$137.98	$126.10

However, the trends in average daily cost differed across placement types. Figure 47 displays the average daily unit costs for FBH (which includes costs and days associated to Foster Home, Kinship Care, and the caseload reduction intervention) and Residential Care by fiscal year. Average daily unit costs for FBH placements increased by 21 percent during the Waiver period. Much of this increase is attributable to the additional costs incurred through the caseload reduction intervention. When removing those costs from the calculation, FBH average daily unit costs only increase by seven percent during the Waiver. Average daily unit costs rose by 23 percent for Residential placements. This rise in average daily unit cost, particularly in the Residential category, explains why even though care day utilization dropped by 30 percent in the Waiver period, OOH expenditures only decreased by 11 percent. Even while Residential Care only accounts for approximately 13 percent of care day utilization, Residential Care costs accounted

for up to 38 percent of OOH expenditures during the Waiver period. Subsequently, an increase in the price of Residential Care days would impact total OOH spending.

Figure 47. *Average Daily OOH Unit Cost by Placement Type and FY – Adjusted for Inflation*



Intervention Expenditures

For NYC's Waiver project, intervention costs can be separated into three overarching categories:

1. Payments to the provider agencies for the reduction of caseloads and supervisory ratios
2. Payments to outside consultants for monitoring and implementation support around the interventions (i.e.: NIRN, Power of Two, CANS-NY/Dr. John Lyons).
3. Staff time spent administering the interventions (i.e.: time spent administering a CANS-NY, time spent making an ABC referral etc.…)

Chapin Hall has complete information for the first two items. Table 53 shows the intervention costs through December 31, 2018 for payments to the provider agencies for the reduction of caseloads and supervisory ratios and payments to outside consultants for monitoring and implementation support. The intervention costs here are only those costs associated with the 17 SFNYC agencies. This is a subset of the intervention costs detailed earlier in this report.

Table 53. *SFNYC Intervention Expenditures by Detail Category and FY – Adjusted for Inflation, in Thousands of Dollars*

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Caseload Reduction	$5,310	$24,677	$28,757	$25,091	$26,066	$14,868
Consultants	$0	$1,390	$1,041	$4,009	$3,778	$1,064
Total	$5,310	$26,067	$29,798	$29,100	$29,844	$15,931

Caseload and supervisory ratio reduction payments made up most of the intervention expenditures displayed, about 90%. With some variation year to year, these payments remained relatively stable across the full fiscal years, ending in FY 2018 6% above FY 2015 levels, after adjusting for inflation. When viewed in the context of all child welfare expenditures, these Waiver intervention costs are a small subset of the total, making up only 2% of total child welfare expenditures in FY 2018.

Discussion

The Cost Study provides a way to make a few fundamental statements about NYC's fiscal experience and decision-making during the Waiver. First, NYC increased total child welfare expenditures while decreasing out-of-home care board and maintenance expenditures. Controlling for inflation, total child welfare expenditures increased by 7% over the course of the Waiver while OOH placement expenditures decreased by 11%. Netting out the decrease out-of-home care board and maintenance expenditures, all other child welfare expenditures increased by 14%. The category of spending that increased the most (by 31% over the course of the Waiver) was Direct City Administration spending, in large part due to an increase in EAF Child Preventive and Protective services.

Within the category of out-of-home expenditures over the course of the Waiver, the Cost Study showed a decrease in OOH placement expenditures paired with a decrease in care day utilization (30% decrease from FY 2013 to FY 2018). With placement mix staying stable (56% Foster Home, 32% Kinship, and 13% Residential and Other in FY 2018), this fiscal impact was driven by a decrease in the quantity paired with a rise in the cost of care. Overall, average daily unit cost for all OOH placements in NYC rose by 21% during the Waiver, much of that increase due to additional spending on the caseload reduction intervention and rising costs of Residential Care. Residential placement costs rose by 23% over the course of the Waiver. With Residential Care making up approximately 37% of all OOH spending, this increase coupled with the additional intervention spending impacted the total OOH expenditures, causing the decrease in OOH costs to lag behind the reduction in care day utilization during the Waiver period. Ultimately, as hypothesized, NYC reduced OOH expenditures under the Waiver and did so by reducing the quantity of care provided.

Summary

The Final Evaluation Report covers what will hopefully amount to the *first* five years of the Strong Families NYC initiative. We say *first* five years in acknowledgement of all that has been accomplished during this relatively brief implementation period, and all that could be accomplished with more time:

Implementation

ACS set out to implement a number of strategies under SFNYC, strategies that involved the deep engagement and coordination of a number of system stakeholders, such as senior leadership at 17 different private agencies; staff within various ACS divisions; foster care supervisors and case planners; and, foster parents.

- Within nine months of initiating the ***caseload reduction***, almost all of the SFNYC agencies were following the new caseload requirements. For the most part, the SFNYC agencies have sustained the reduced caseloads over time.

- Over the course of SFNYC, case planners reported more negative perceptions of supervision, increased feelings of overwhelm, and higher levels of burnout amongst supervisors, despite caseload reductions. While these findings are worthy of follow-up, we caution that the response rate to the survey in which case planners and supervisors were asked about these issues was very low, with less than half of the workforce participating.

- Since the ***CANS-NY*** went live, approximately two-thirds of children who have been admitted to an SFNYC agency and placed in regular family foster care have had at least one CANS-NY completed. Almost all children who were eligible for a reassessment CANS-NY have had one completed on their behalf.

- More than 500 children have completed a course of ***ABC***. Caregivers who participated in ABC exhibited significant improvements in ABC-relevant skills, such as following the lead, recognized intrusive behaviors that may be frightening to a child, and assessing a child's development and behavior problems.

- ACS adapted the National Center for Evidence Based Practice in Child Welfare's model, ***Partnering for Success***, and developed the capacity for the Workforce Institute to house and deliver the training to both child welfare and mental health staff.

Impact

- The caseload reduction, as an intervention, was found to have a significant, positive effect on permanency outcomes. Exit rates increased by 9 percent during the post-caseload reduction period compared to the period prior to the caseload reduction.

- The total number of care days used by each of the five SFNYC entry cohorts is markedly lower than the number of care days used by a historical comparison group.

- Children admitted in 2015, 2016, and 2017 used fewer care days, on average, than children in the historical comparison group.

- There are signals that the reentry rate for babies is on the decline. There is still year-to-year variability, but the overall trend is in the right direction.

Cost

- Despite a reduction in out-of-home board and maintenance expenditures, total child welfare expenditures increased, largely due to increased funding directed toward preventive and in-home services.

- The average daily out-of-home unit cost rose during the Waiver period, largely due the rising costs of residential care. However, NYC reduced overall out-of-home expenditures during the SFNYC period, primarily by reducing the *quantity* of care provided.

Future considerations

ACS has engaged in a methodical and deliberate process, co-facilitated by Chapin Hall and the National Implementation Research Network, whereby the implementation and impact of each component of SFNYC was interrogated singly, with an eye toward future sustainability. The discussions involved senior leadership within ACS and were driven, to the extent possible at the time, by scientifically-derived evidence. The discussions also included – again, to the extent possible at the time – feedback from the private agencies on the frontline of the implementation effort.

Not surprisingly, there was near unanimous consensus around the value of sustaining reduced caseloads. Not only is there a shared feeling that smaller caseloads are be better for children and families, the evaluation actually found that smaller caseloads *do* make a difference for children and families, specifically in the way of permanency outcomes.

While a lot of headway was made in the implementation of the CANS-NY, there is yet work to do in terms of staff in the field seeing the value-add of the tool. The early focus on teaching case planners and supervisors how to complete the CANS-NY and ensuring compliance with new practice directives paid off insofar as most children who come into care now have a CANS-NY completed on their behalf – and multiple CANS-NY, when warranted. At this point, though, there appears an opportunity to have a deeper conversation with the field about the actual utility of the tool, whether it be to enhance casework and service planning, as originally intended, or some other function.

The process by which to refer children and their caregivers to ABC was honed over the past two to three years. We see evidence of that in the nearly1,000 children who were referred to ABC and the over 500 children who, as of June 30, 2018, had completed the training along with their caregiver. At the same time, the proportion of eligible children who were referred to ABC was quite low at last check: less than 25 percent of eligible children. Further, nearly half of those referred did not wind up completing the training. While the obstacles seem to be fairly well understood (caregivers being unable or unwilling to commit the time; biological parents refusing to consent), the way around those obstacles are still coming into focus for ACS and the providers. However, like with the caseload reduction, the providers and ACS seem to agree on the value of ABC. Furthermore, there is early evidence that ABC is having its intended effects, at least on caregiver skills.

Partnering for Success was probably the component of SFNYC that experienced the greatest implementation challenge. SFNYC agencies that have an embedded mental health clinic arguably had an experience of PFS that is closer to what was intended than agencies without such a resource. For the SFNYC agencies that do not have the benefit of an embedded mental health clinic, engaging mental health practitioners proved extremely difficult. Across agencies, child welfare case planners and supervisors participated in elements of PFS training at a much higher rate than mental health practitioners, it was not common for case planners, at least, to see the PFS training through to its full completion to

obtain certification: the submission of a Capstone project that serves to demonstrate the integration of the skills taught during PFS training.

Another key component of PFS involves treating children with depression, anxiety, behavior problems, and trauma with CBT, an evidence-based treatment for these common mental and behavioral health conditions. It is difficult to comment with confidence on the extent to which children suffering from depression, anxiety, behavior problems, and/or trauma are receiving CBT (or some other evidence-based treatment), as intended by the PFS approach. The PFS decision tab housed within the CANS-NY data entry system asks case planners the right questions to enable ACS to better understand the actual implementation of PFS – and the extent to which children are actually receiving the mental health services they need. However, case planners are not yet entering information into the system on a regular enough basis for ACS to draw conclusions about practice in this area.

Of course, sustainability decisions need not be all-or-nothing. Elements of PFS can be sustained (i.e., training around screening, targeting, linking, engaging, and collaborating around mental and behavioral health services). ABC can be sustained but certain processes or procedures modified, to better address the barriers case planners regularly encounter when trying to make successful referrals. The infrastructure for implementing and supporting the CANS-NY is already in place; that structure can be called upon to drive conversations with case planners, supervisors, and managers around the ways in which the CANS-NY can be of value, both to brand new caseworkers as well as case planners and supervisors who have extensive experience in their roles.

Implementing new ideas in the oft-times temperamental environment that is child welfare services is, in nearly all cases, a difficult thing to do. It takes commitment and time – more time than is usually available. ACS has already seen some of the investment made under SFNYC pay off in real terms (caseload reduction) in the few years available under the IV-E Waiver Demonstration Project. If the objective of the Waiver demonstration project was to reduce total and average care day utilization, then under SFNYC, ACS has certainly achieved that objective. More so, ACS has created an environment in which evidence rules the day. It's the driving force in conversations about the problems in which ACS should invest, the actual investments to make, and the extent to which those investments are having their intended effects. It's reflective of an overarching commitment to doing what works for children and families.

APPENDIX A: Time Use Data Summary Tables

The full set of time use data is available upon request. It is a multi-tab Excel workbook which details these figures as well as the sub-tasks captured within each category. It also details the additional (or reduced) time spent for case variations.

Developing the Initial Permanency Plan

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
Getting acclimated to the new case	3.9	11%	0.6	2%	1.4	12%	0.6	5%
Direct communication	8.5	23%	7.4	24%	6.3	53%	5.0	44%
Conferences	2.8	8%	1.9	6%	2.3	19%	2.1	18%
Administration	4.8	13%	8.2	26%	0	0%	1.6	14%
Connecting with services	2.5	7%	3.5	11%	0	0%	0.0	0%
Family visits	7.6	21%	6.4	20%	0	0%	0.0	0%
Travel time	6.4	17%	3.4	11%	2	17%	2.1	19%
TOTAL (in HOURS)	36.5	99%	31.4	100%	12	100%	11.4	100%

Maintaining the Case[34]

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
Face-to-face contacts	4.7	18%	2.3	9%	3.3	78%	1.8	44%
Other direct communication	6.6	25%	6.6	25%	0.0	0%	0.0	0%
Family visits	6.5	24%	7.1	27%	0.0	0%	0.0	0%
Assessment	0.1	0%	0.8	3%	0.0	0%	2.3	56%
Other case management tasks	3.9	15%	7.5	28%	0.9	22%	0.0	0%
Travel	4.6	17%	2.2	8%	0.0	0%	0.0	0%
Total (in HOURS)	26.3	99%	26.5	100%	4.3	100%	4.1	100%

Ending a case: Reunification

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
Direct communication	1.8	29%	2.6	37%	0.0	0%	0.0	0%
Discharge conference	2.2	36%	1.0	14%	1.8	54%	1.2	25%
Assessments	0.4	7%	0.5	7%	0.2	6%	0.5	10%
Communicating with service providers	1.3	21%	1.5	21%	0.6	17%	1.1	24%
Administration	0.4	6%	1.4	20%	0.8	24%	1.9	41%
Total (in HOURS)	6.1	100%	7.1	100%	3.4	100%	4.8	100%

[34] Figures are monthly for a single case.

Placement Change: Unplanned

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
Direct communication	2	20%	2.24	25%	1.1	16%	7.26	54%
Conferences	2.1	21%	1.32	15%	2	29%	1.46	11%
Documentation/assessments	1.9	19%	2.9	32%	1	14%	2.82	21%
The new placement	2.2	22%	1.56	17%	1.3	19%	1.81	14%
Travel time	1.8	18%	1	11%	1.6	22%	0	0%
Total (in HOURS)	10	100%	9.02	100%	7.1	100%	13.35	100%

Case Review: Semi-Annual Permanency Planning Conference

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
Preparing parties for the FTC	1	23%	1.03	25%	0.7	21%	1.18	24%
Administration	1.2	29%	1.11	27%	0.7	20%	1.36	27%
Conference itself	1.3	31%	1.24	30%	1.4	41%	1.56	32%
Following the conference	0.7	17%	0.77	19%	0.6	18%	0.85	17%
Total (in HOURS)	4.1	100%	4.15	100%	3.4	100%	4.95	100%

Legal Activities: Permanency

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
Preparing for hearing	3.8	52%	4.18	66%	2.8	47%	3.94	65%
Travel time	1.9	26%	0.91	14%	1.6	27%	0.94	15%
At the court	1.7	23%	1.21	19%	1.5	25%	1.22	20%
Total (in HOURS)	7.4	100%	6.3	100%	5.9	100%	6.1	100%

Independent Living Services

	Case Planner				Supervisor			
	Time 1		Time 2		Time 1		Time 2	
Task	Hours	Percent	Hours	Percent	Hours	Percent	Hours	Percent
IL assessment	0.7	44%	0.67	33%	-	-	0.63	35%
IL service referrals	0.6	38%	0.89	44%	-	-	0.78	44%
Refer to agency IL staff	0.3	18%	0.46	23%	-	-	0.38	21%
Total (in HOURS)	1.5	100%	2.02	100%			1.79	100%