

# **Systems Reform in Virginia: Assessment Findings and Preliminary Recommendations**

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Our mission is driven by a core set of beliefs and we seek partnerships with leaders who share them

## CASEY STRATEGIC CONSULTING MISSION

Casey Strategic Consulting provides intensive strategic consulting that facilitates significant, measurable, and enduring human service system transformations

### GUIDING PRINCIPLES

**We believe fundamentally that children do better in strong families, and that families do better in supportive communities:**

- ▶ Every child needs and deserves a lifelong connection to a family
- ▶ Strong families provide the most stable and nurturing environment for healthy child development
- ▶ Strengthening communities provides local support for families to build the capacities to provide for their children
- ▶ Services for vulnerable children and families should be provided close to their homes in a family-supportive, culturally-sensitive manner
- ▶ Services should focus on prevention, build on family strengths, and provide an integrated continuum of care

### IMPLICATION

**Since our work is built upon these beliefs, it is imperative that our client partners embrace these principles as well**

## Four major issue areas were identified to further explore during the Assessment & Analysis Phase

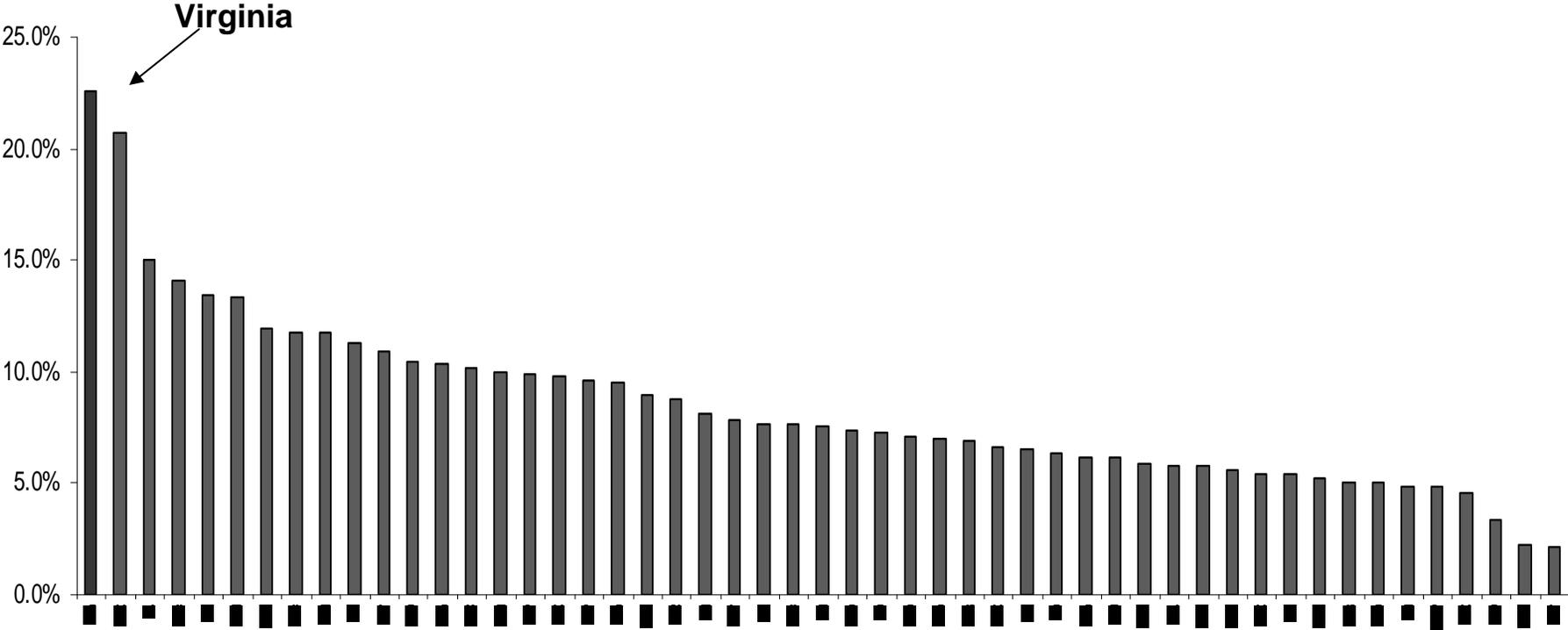
Summary of Issue Areas			
<i>Out-of-home Care</i>	<i>DSS Central Office Role</i>	<i>CSA (Local/State)</i>	<i>Richmond DSS</i>
<ul style="list-style-type: none"> <li>• Residential care</li> <li>• Foster care</li> <li>• Availability of community-based services</li> <li>• Placement decision-making</li> <li>• Permanence for teens</li> </ul>	<ul style="list-style-type: none"> <li>• Quality assurance</li> <li>• Support and guidance provided to localities</li> <li>• Data tracking/ database compatibility</li> </ul>	<ul style="list-style-type: none"> <li>• CSA guidelines and policies</li> <li>• CPMT/FAPT</li> <li>• CSA financing structure/ incentives</li> </ul>	<ul style="list-style-type: none"> <li>• Key elements of practice</li> <li>• Child Welfare operations</li> <li>• Key challenges in agency</li> </ul>

### Methods Used for Gathering Information / Data

- **Data Analysis:** Analysis of DSS and CSA performance, compliance and financial data, supplementing analysis of Child Trends
- **Policy Review:** Review of policies, procedures, organizational structure and training
- **Interviews / Observations:** Interviews with DSS / CSA. Observation of practice, including operation of FAPT / CPMT
- **Best Practice:** Highlight and compare best practices learned in Virginia, in Hampton, and nationwide

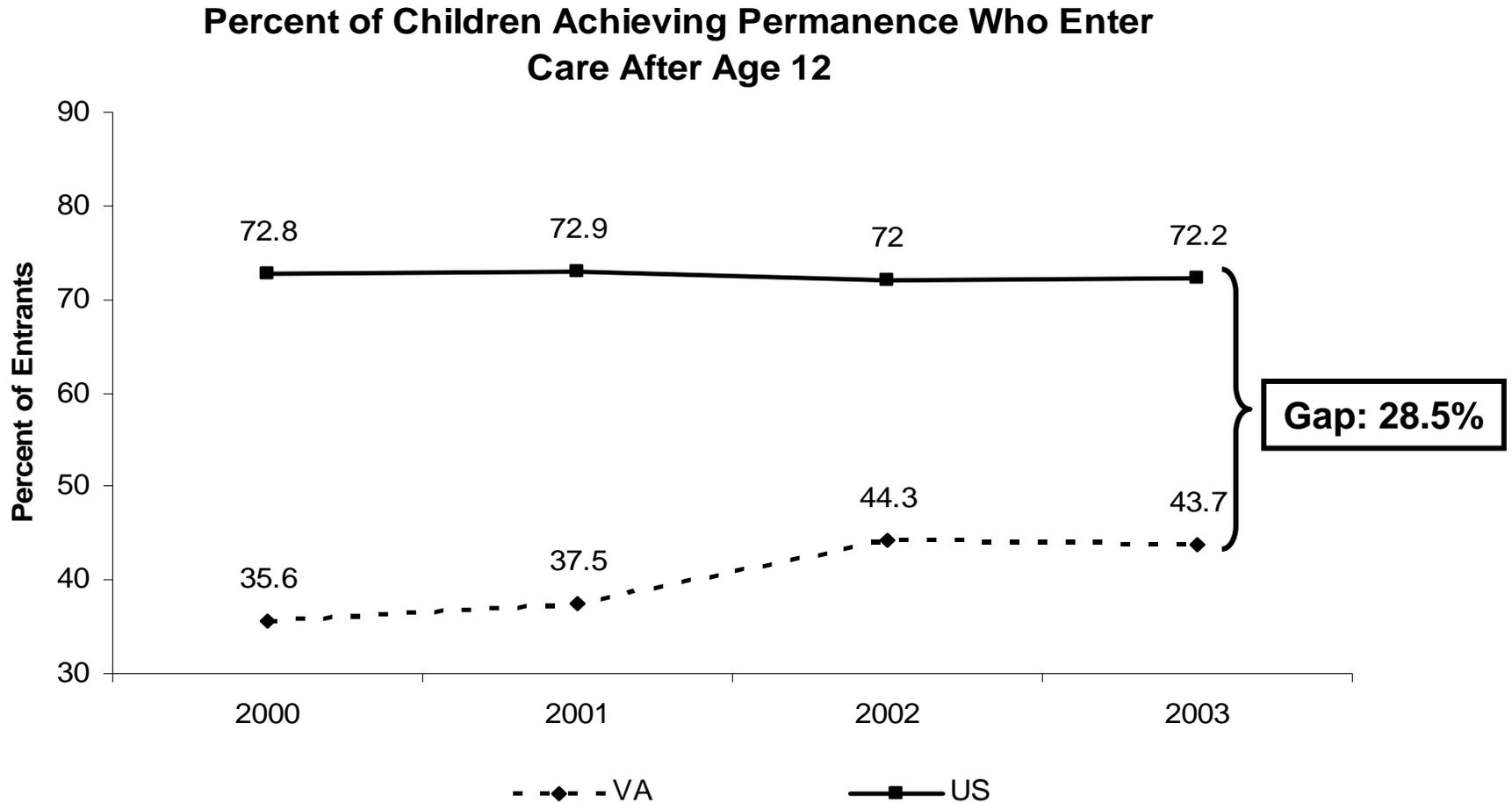
# VA has the highest percentage of teens aging out of foster care in the country

Percent of Youth Aging out of Care



Source: Child Welfare Outcomes 2003 Annual Report, HHS Children's Bureau

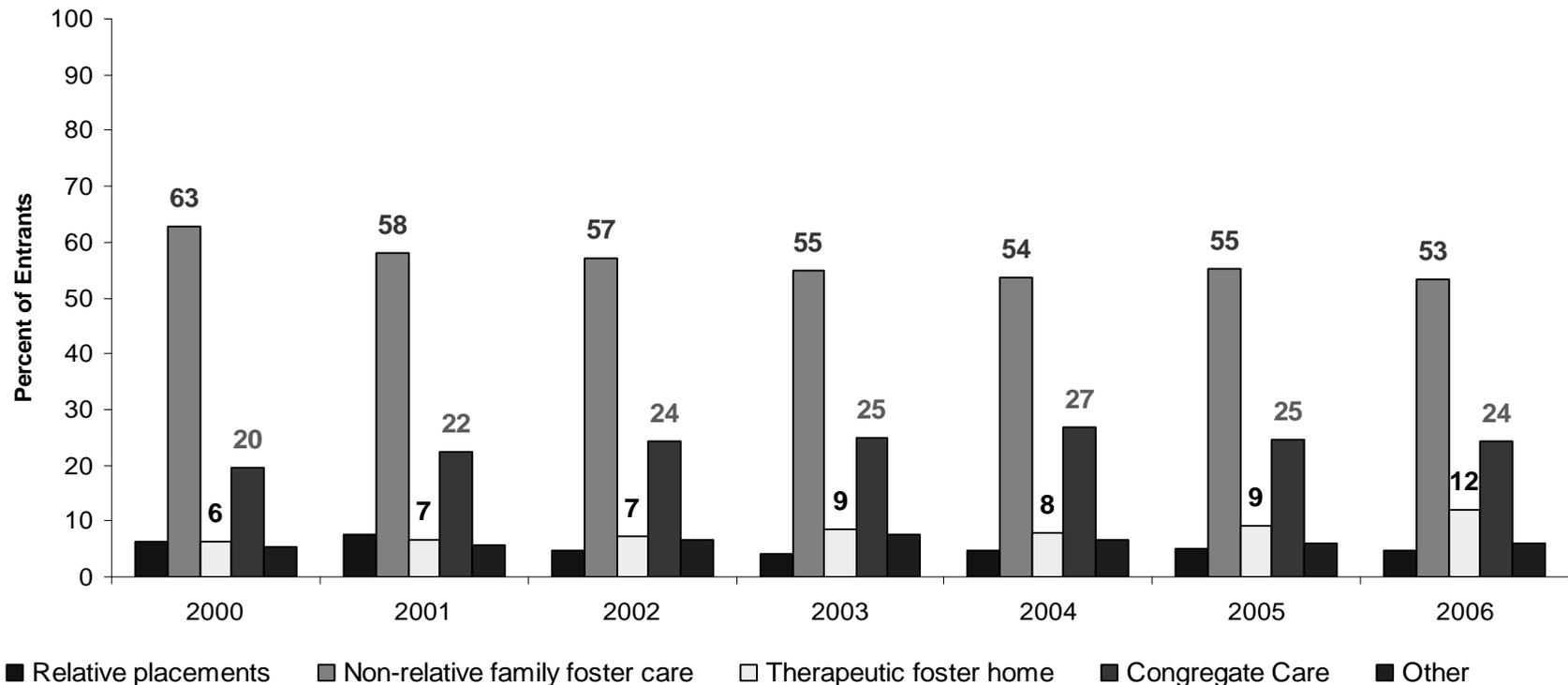
Overall, Virginia's performance in achieving permanence for teens in foster care is below the national average



Not only are children in care too long without permanence, Virginia places too many children in congregate care settings, especially as the initial placement type

**In 2006, 24% of initial foster care placements were in congregate care. The national average is 18%. Model jurisdictions place less than 10% in congregate settings.**

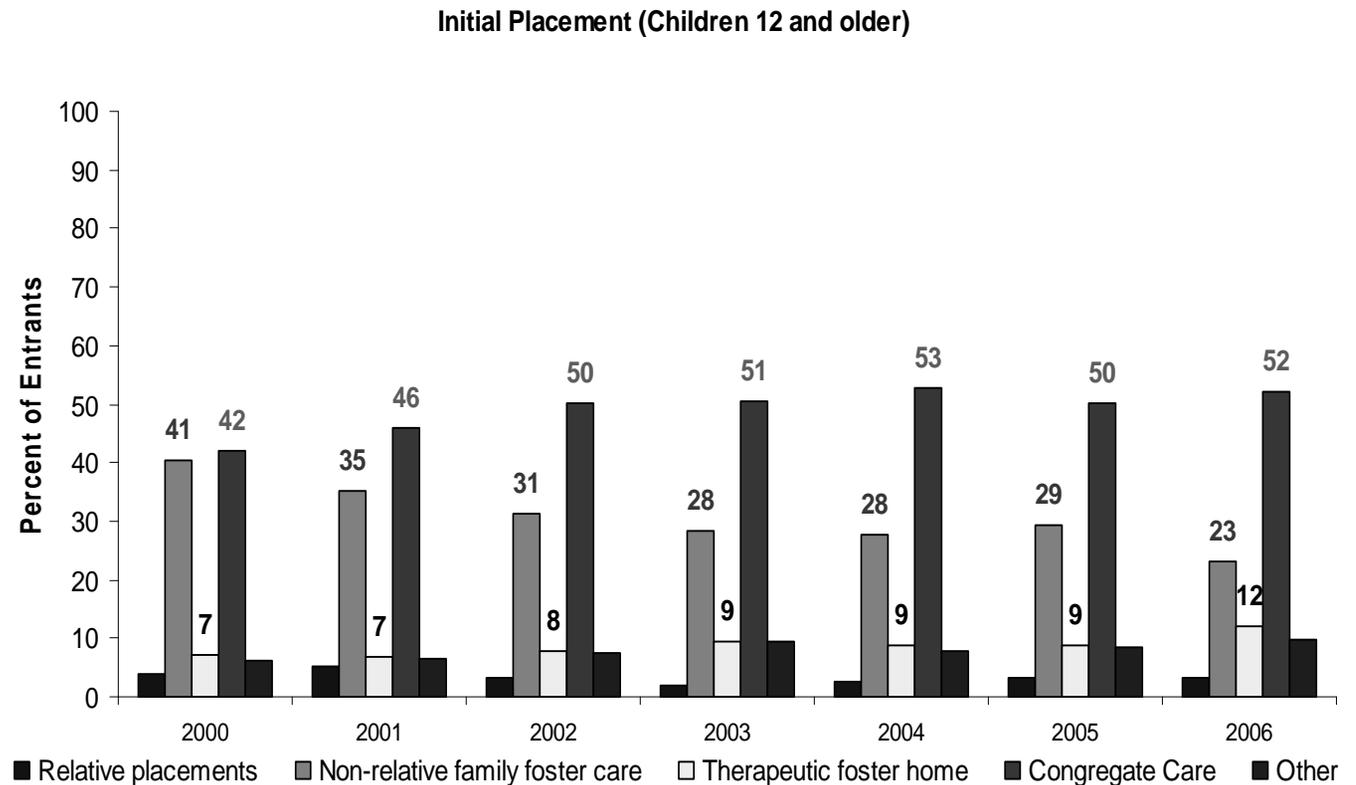
Initial Placement (All children)



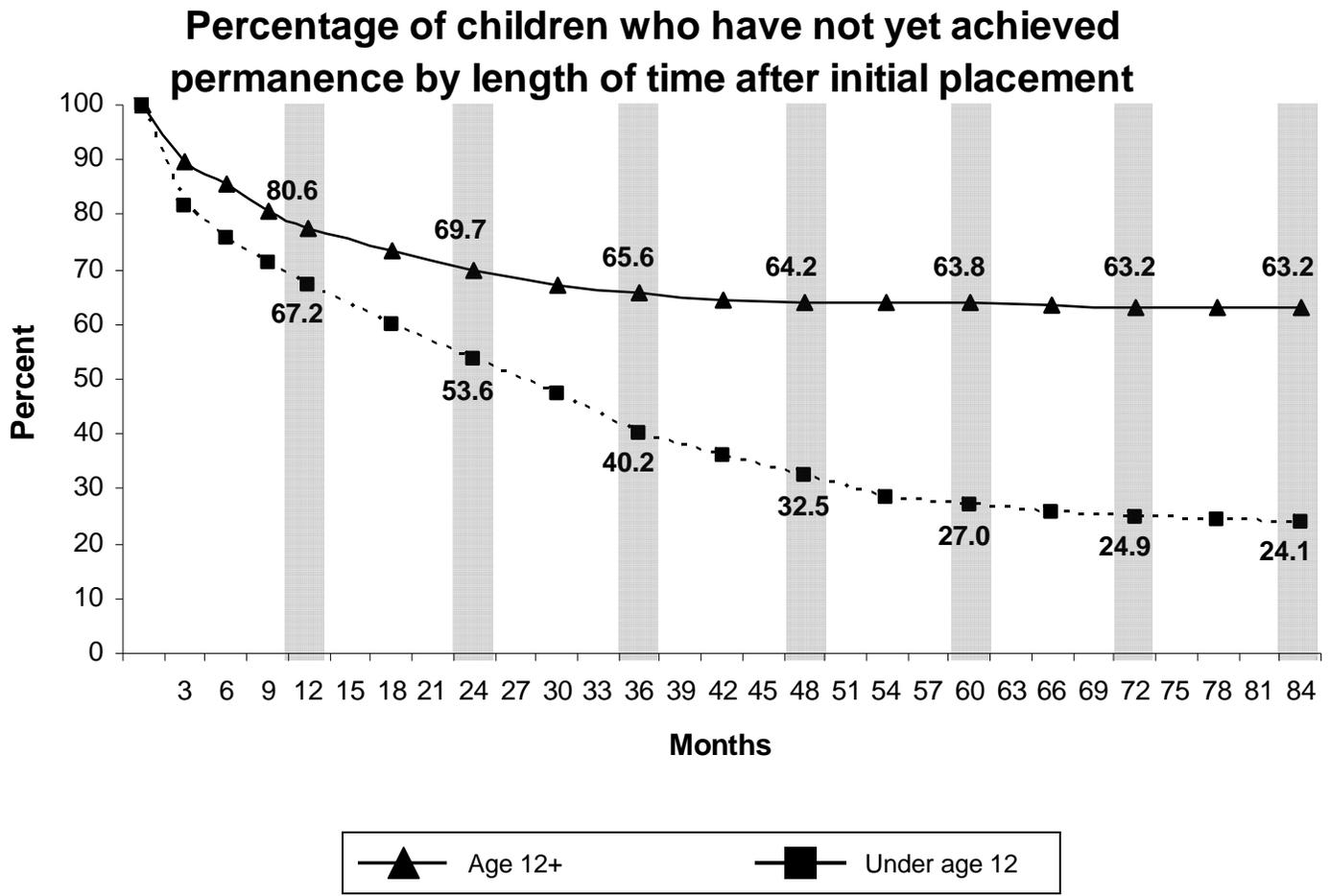
# Congregate care is used most often for teens, who are initially placed in that setting type more than half of the time

Of children 12 and older, 52% were first placed in congregate settings in 2006, a 24% increase since 2000.

- Less than 5% were placed with relatives.
- 23% were placed in regular foster care and 12% were placed in treatment foster care.
- The use of regular foster care for teens has decreased from 41% in 2000 to 23% in 2006.



# Teen permanence is especially poor, but younger children also fail to achieve timely permanence

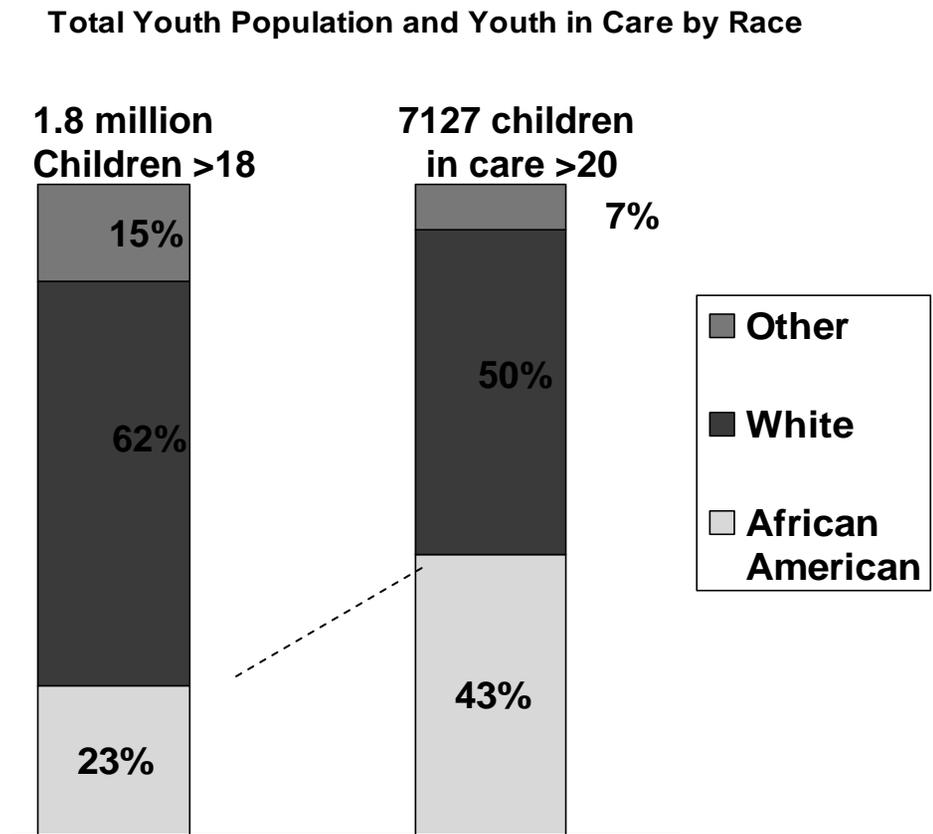


- 24% of young children had not achieved permanence after 7 years.
- These children may “age in” to teens who won’t achieve permanence.

Cohort: Virginia children entering care in 2000. Source: OASIS.

# The poor permanence achieved for children in foster care and the high use of congregate care in Virginia disproportionately affects African American children

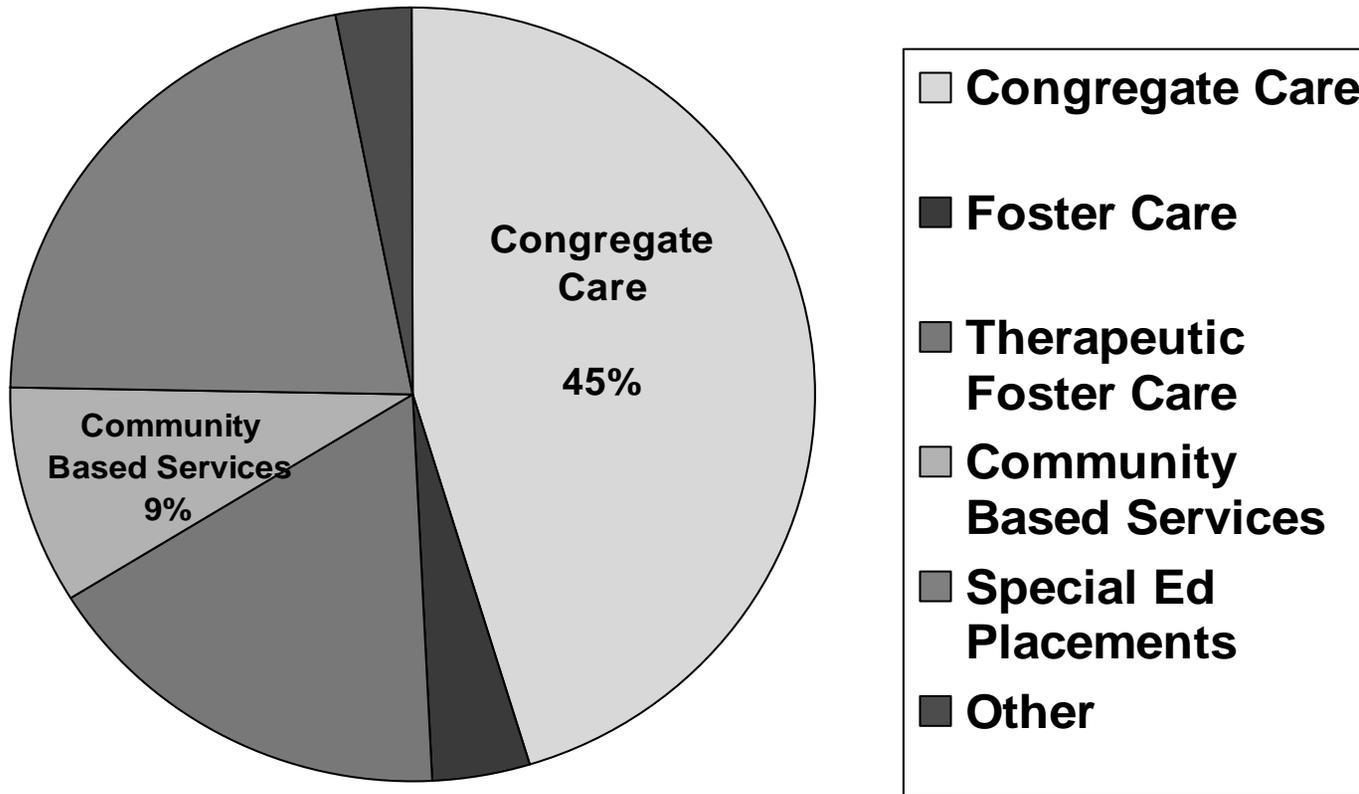
- In 2005, Virginia had 1.8 million children under 18 years old. Of that population, 23% were African American
- At the end of 2006, of the 7127 children in care age 19 and under, 43% were African American.



Data source: Kids Count, Annie E Casey Foundation, 2007

# CSA budget is dominated by congregate care costs

**Total CSA Costs (2006) = \$295 million\***



Source: CSA Data 2006

\* Does not include Medicaid dollars, which comprise \$66.5 million in additional funds in congregate settings (OCS Report, July 2005-June 2006)

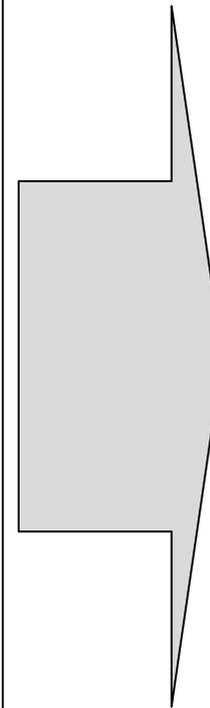
## Child Trends Data Summary

- ✓ 23% of Virginia's children age out of foster care without permanent connections, which is the highest percentage of children in the country
- ✓ 43.7% of teens (12 & older) achieve permanence, this is 28.5% below the national average of 72.2%
- ✓ After 7 years in the foster care system, 24% of younger children had not achieved permanence; therefore, "aging in" to the teen population, which has a very poor chance of achieving permanency
- ✓ In 2006, 24% of children that came into care would experience their first placement in a group setting (congregate care), rather than a family-based environment. For teens that figure is 52%. The national average is 18%; however best practice is closer to 10%.
- ✓ Fewer than 5% of children in foster care are being placed with relatives
- ✓ CSA budget is dominated by congregate care costs (45% of \$295 million budget = \$133 million (excluding Medicaid))

Although there is an incentive for localities to use less restrictive care, the incentive is too weak, and the accountability to the State is not sufficient to motivate change

**Weak incentive, insufficient accountability**

- The State guarantees payment of 64% of the cost of any service, regardless of the level of spending
- There is limited accountability or oversight at the local level for how funds are spent – local decision makers often do not believe there is a way to contain costs
- There is a common misperception about flexibility of CSA funds -- localities do not believe they can use funding to start up community based services because of the belief that funds follow the child



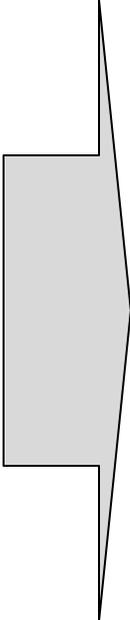
**RESULT**

Significant growth in the use of congregate care, and growth in expenditures for congregate care

There is no clearly articulated practice model in DFS or OCS, which is reinforced by mandatory training at the local level

**No practice model, limited training**

- Current practice model in many localities results in less permanence for children
- Programmatic training for DSS caseworkers/their supervisors and local CSA staff and FAPT/CPMT teams is inconsistent and availability is limited
- Existing state training programs have not been held to performance standards and have not been consistently evaluated for effectiveness
- Limited collaboration or integration between among key agencies around practice principles or expectations
- Casework staff focused on safety and not on permanence; DSS continues to use permanent foster care as a goal



**RESULT**

Overuse of  
congregate  
care and  
poor  
permanence  
outcomes

# There is insufficient attention to, and support for resource families

## Limited support for resource families

- **Inadequate support for resource family development by State DSS (technical assistance and financial support for recruitment and development)**
- **Inadequate reimbursement rates to attract and keep foster parents (A forthcoming study that computes “minimally adequate foster care” rates indicates that current rates fall far short of the actual cost of care in VA)**
- **Inadequate support provided to relatives and foster parents with CSA funds**
- **JLARC study indicates high percentage of youth in residential care would otherwise be in foster care or other less restrictive placements if foster homes or community based services were available**

## Foster Care Rate Comparison (monthly rate)

Recommended Minimum Adequate Rate*	VA Rate as of July 2007
Age 2: \$605	\$368
Age 9: \$694	\$431
Age 16: \$760	\$546

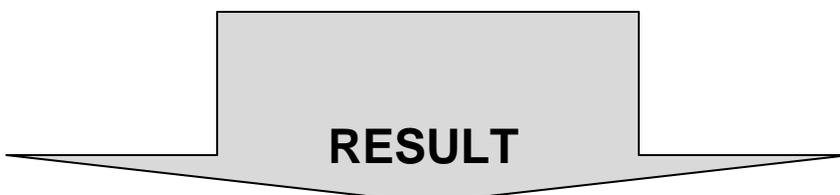
## RESULT

**Insufficient foster families in some areas and over-reliance on congregate care**

*\*Source: Establishing Foster Care Minimum Adequate Rates for Children (Report Forthcoming October 2007). Children’s Rights. Note: CSCG defines resource families as kin, foster and adoptive families.*

State capacity at DFS and OCS to support localities is very limited

- **Few staff in DFS and OCS offices to disseminate policies/best practices and provide support and technical assistance to localities**
- **At State DFS, a large percentage of staff are in temporary positions with high turnover**
- **Limited DFS and OCS staff dedicated to data analysis, performance management, training or policy**



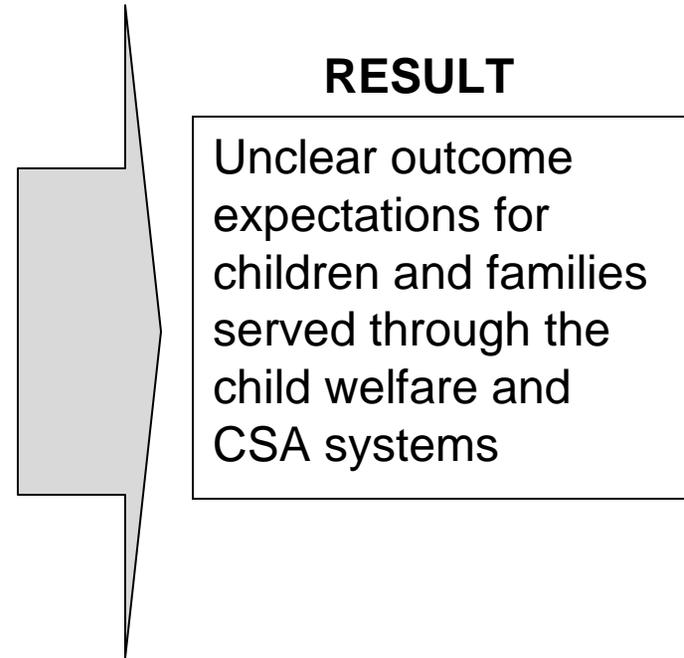
**RESULT**

**Limited level of support provided to localities by the State and varying philosophies and practice across localities.**

# There is limited performance monitoring and oversight by the State and insufficient local accountability to the State

## Little performance monitoring or accountability

- **DFS and CSA are just now beginning to move in right direction to improve performance monitoring / oversight**
- **Currently in DFS, the CFSR (which is a compliance based tool), is the primary method for performance monitoring / oversight\***
- **There is very limited data analysis done at DFS or CSA**
- **State DSS has not worked with localities to develop goals, targets, benchmarks for localities to achieve (those that exist focus on compliance rather than outcomes)**
- **There is no integration of CSA and DSS data for analytical purposes**



\*CFSR is federal Child and Family Service Review

# ***RECOMMENDATIONS***

**Based on our findings, we believe the following steps are essential to improving outcomes for children and families in Virginia:**

1. Strengthen financial incentives to reduce reliance on congregate care and serve children in the least restrictive settings possible.
2. Establish a state-level practice model focused on family-centered care and permanence that is reinforced by a uniform training program for resource families as well as local staff in DSS and CSA (integrated with DMHRSAS practice model).
3. Create and implement a statewide strategy to increase availability and utilization of relative and non-relative foster placements to ensure that children can be placed in the most family-like setting that meets their needs.
4. Enhance State DSS and CSA capacity to develop and disseminate policies and best practices, and provide technical assistance to localities in support of the newly-established practice model.
5. Build on current State efforts to create a robust performance monitoring/quality assurance system to identify and measure outcomes, monitor quality of practice, and improve accountability.

# Family centered care and permanence requires a shift in focus

## ***According to outcome research:***

- There is no evidence that congregate care achieves better outcomes for children, and the cost is 6 to 10 times higher than community-based services or foster care
- According to Dr. Richard Barth, “Children in group care almost certainly have fewer interpersonal experiences that support their well-being, including the chance to develop close relationships with a significant individual who will make a lasting, legal commitment to them.”
- Absence of physical contact, limited one-on-one relationships and few extended interactions due to institutional shift care inhibit educational and emotional development, and the formation of relationships
- There is no evidence that residential care offers greater stability. On average a child has 10 caregivers per day due to staff shift changes, in addition to high rates of staff turnover
- A Chapin Hall study conducted in Illinois between 1993 and 2003 revealed that the next destination for 59% of youth (10 & older) following residential care was a psychiatric hospital, detention, running away, or another residential placement

***To build a healthy system that promotes healthy outcomes, your focus should be on encouraging the development of community-based services and family-based care in order to improve permanency for children.***

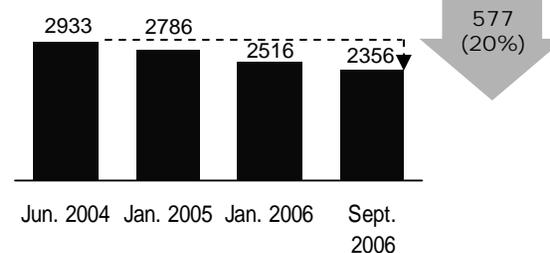
# Example of Casey Strategic Consulting Work in Maine

***Shifting focus to family-based care and permanence can have significant impact on the number of children entering care, and on the number of children entering congregate care***

## IMPACT

- ▶ 20% fewer children in foster care (lowest level since 1996)

### YOUTH IN OUT-OF-HOME CARE

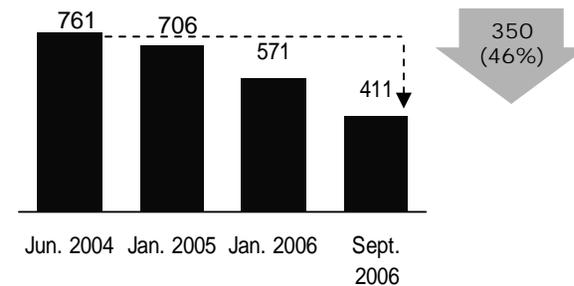


Attributed to reductions in:

- Intake
- Congregate Care

- ▶ 46% fewer children in congregate care

### YOUTH IN CONGREGATE CARE

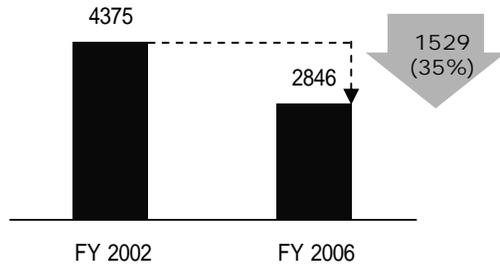


# Example of Casey Strategic Consulting Work in NYC

## IMPACT

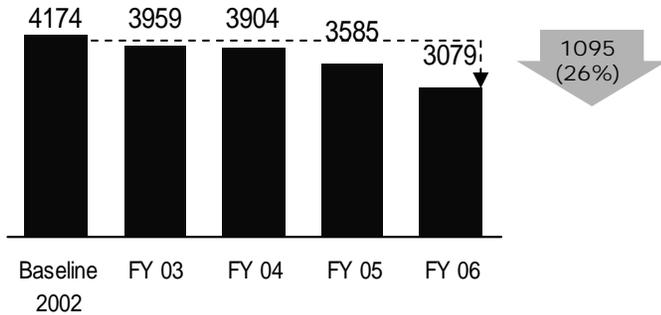
- ▶ 1529 fewer children in congregate care (down 35%)

### YOUTH IN CONGREGATE CARE



- ▶ 26% reduction in contracted congregate care beds

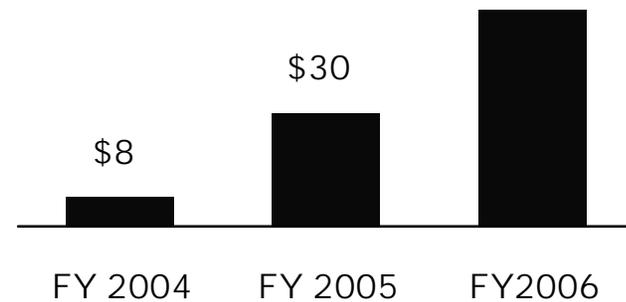
### ELIMINATED CONGREGATE CARE BEDS



## SAVINGS

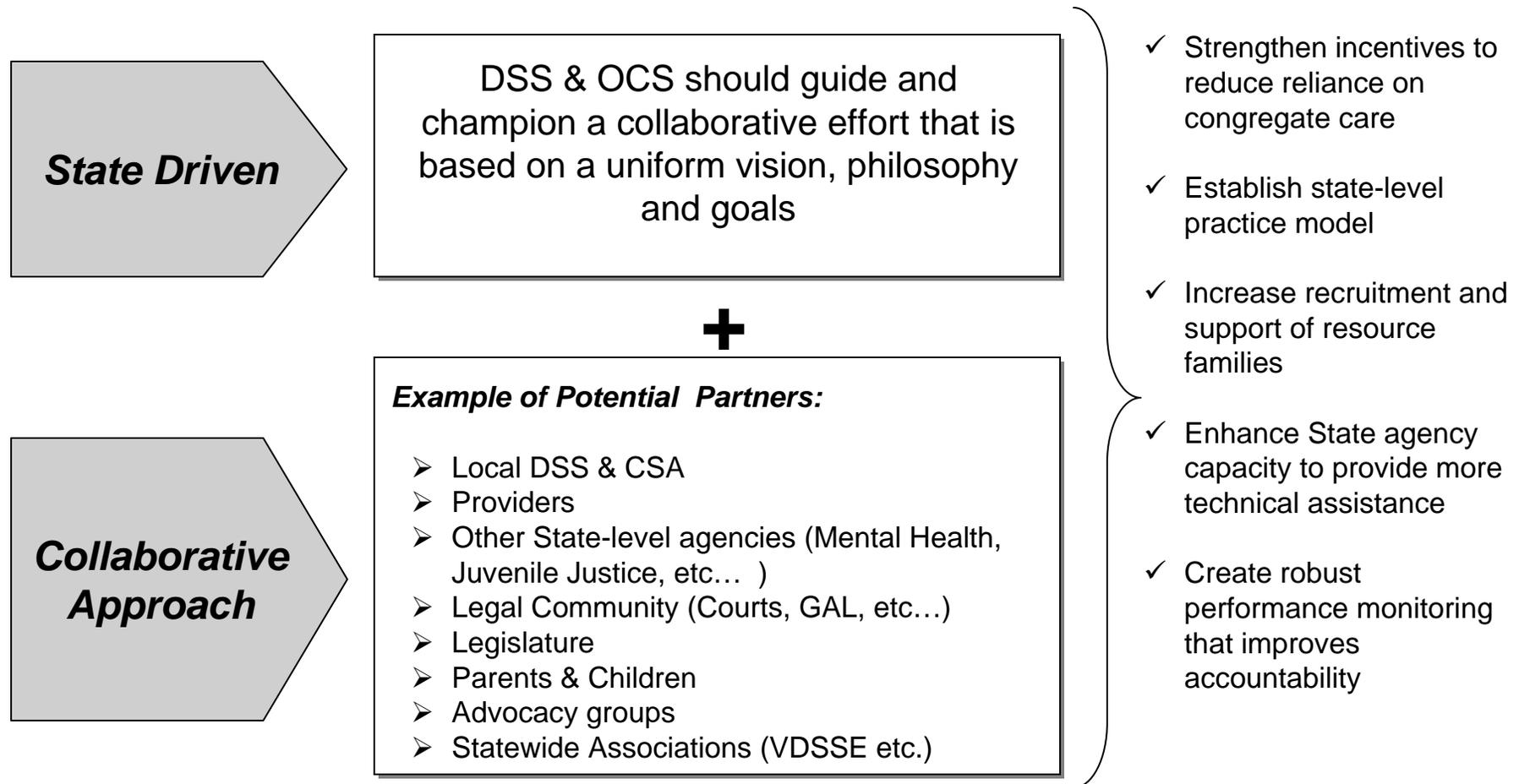
Available to reinvest in community-based service development

- ▶ Estimated savings of \$95 M so far: \$57



ESTIMATED SAVINGS  
(\$ million)

In order to improve outcomes for children and families, and permanence for children statewide, the State should lead a collaborative approach to address each recommendation



We look forward to working with all State/local partners to develop an effective approach during Phase II: Strategy Development 21