



HB 1451 Collaborative Management Program Year 2 Statewide Evaluation Findings

NOVEMBER 2011

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STATE OF COLORADO



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people who help people

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November 8, 2011

TO: Lloyd Malone
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FROM: Collaborative Management Program (CMP) Evaluation Subcommittee

On behalf of the Collaborative Management Program's Evaluation Subcommittee, we are pleased to submit the 2011 CMP Evaluation Report. The Evaluation Subcommittee is composed of representatives from CMP counties, state agency partners, and a family-driven organization. Our work over the last 16 months has been reviewed and approved by the CMP State Steering Committee. While the report contains a great deal of information on the performance of the initiative, we wanted to take this opportunity to thank the State of Colorado and the Department of Human Services, in particular, for ongoing support of the Program.

As you are well aware, the current structure of siloed state funding results in significant service fragmentation across agencies. The challenges of providing integrated care are further complicated by data sharing issues, convening staff from multiple agencies, and barriers to joint service planning and delivery. The Collaborative Management Program has provided Colorado communities a critical framework by which to explore, invest in and improve service delivery processes and infrastructure within local systems. As evidenced in the following report, this has led to more efficient, effective and more elegant service delivery which is having profound effects on the lives of Colorado families.

As the initiative matures, we are excited to implement frameworks that will allow us to manage processes more effectively, disseminate lessons learned, further implement evidence-based service models, and evaluate our efforts with greater precision. We recognize that ongoing budget issues mean that difficult choices will need to be made. We hope that the state continues to see the promise of the CMP initiative in breaking down silos, giving voice to involved families, and improving outcomes for children and families involved in multi-system care.

We look forward to being a strong partner in advancing your vision for CDHS and Colorado families.

Sincerely,

A handwritten signature in black ink that reads 'Norman Kirsch'.

Norman Kirsch
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Executive Summary

INTRODUCTION

The following document is based upon the Collaborative Management Program’s (CMP) 70-page Year 2 Evaluation Findings Report. Funded by the Colorado state legislature and administered by the Colorado Department of Human Services, the evaluation has completed the second year of a multi-year statewide evaluation. The focus of the evaluation is on examining the effectiveness of CMP efforts in achieving the legislative goals set out by House Bill 04-1451 (HB 1451). The evaluation design is being implemented in multiple phases, including formative evaluation to describe and inform current practices, infrastructure development to lay the foundation for standard data collection, and summative efforts to assess individual and cross-CMP effects. Evaluation findings to date have illuminated a wide variation in defined target populations, service models, and measured outcomes, as local CMPs have tailored their efforts to match their community’s needs and strengths. As described below, individual CMPs demonstrated progress on key performance measures of each legislative goal. However, the diversity of measurement posed significant challenges to assessing statewide impact of the CMP. To address these challenges, the initiative undertook a process in this second evaluation year to identify indicators and to design a basic data management system to support local efforts. Three future evaluation directions are recommended:

1. Continue to develop and implement systems to collect and analyze well-defined uniform measures of key outcomes and processes, at local and state levels.
2. Monitor and track trends in statewide measures of key CMP outcomes.
3. Continue to define and support dissemination of information on effective CMP interagency structures, service processes, and collaborative practices.

CMP BACKGROUND AND PARTICIPANTS

Collaborative Management Program (CMP) Initiative

In 2004, the Colorado General Assembly passed House Bill 04-1451 based on the assertion that “development of a uniform system of collaborative management is necessary for agencies at the state and county levels to effectively and efficiently collaborate, share resources or manage and integrate the treatment and services provided to children and families who benefit from multi-agency services.”ⁱⁱ This led to the creation of the Collaborative Management Program (CMP) which sets forth the following goals:

1. Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent or family advocacy organizations.
2. Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi-agency services.
3. Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services.
4. Encourage cost sharing among service providers.
5. Lead to better outcomes and cost-reduction for the services to children and families in the child welfare and foster care system in the state of Colorado.

CMP statewide program evaluation

House Bill 08-1005 authorized an annual external evaluation of the CMP initiative. The legislation requires that local projects report on the following:

- The number of children and families served through their individualized service and support teams and the outcomes of the services provided;
- Estimated costs and cost-shifting or cost-saving related to CMP efforts; and
- Information relevant to improving the delivery of services to persons who would benefit from multi-agency services.

In July of 2009, CDHS hired OMNI Institute (OMNI) to conduct the statewide evaluation of the CMP. The first year of the evaluation focused on documenting and describing the range of local efforts and outcomes of funded projects. The second year focused on the following efforts:

1. *Refinement of CMP process and outcome measurement:* A workgroup was formed to select common variables and develop standardized measurement processes for the Child Welfare and Juvenile Justice domains;
2. *Refinement of systems to evaluate and share progress on legislative goals, including:*
 - Revision and administration of CMP annual reports to improve content and usability.
 - Revision and administration of CMP collaborative effectiveness survey.
 - Administration and analysis of family advocacy surveys.
 - Refinements and technical support of the web-based CMP portal.

LEGISLATIVE GOALS AND EVALUATION FINDINGS

Goal I: Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent or family advocacy organizations.

Interagency Oversight Groups and Interagency Service and Support Teams

House Bill 04-1451 mandated participation of specific agencies, encouraged family involvement and required the establishment of two primary structures: an Interagency Oversight Group (IOG) to facilitate communication and resource sharing and an Individualized Service and Support Team (ISST) to plan and coordinate the delivery of services for multi-agency involved families.

Shown in the table, membership data reflect substantial participation by mandated IOG partners:

Agency or Individuals Represented through Membership on IOG (n=28)	Number of CMPs Reporting IOG Member (%)	Number of CMPs Reporting IOG Member Attending at Least 50% of IOG Meetings (%)
County Department of Human and Social Services	28 (100%)	27 (96%)
School representative	28 (100%)	27 (96%)
Probation	28 (100%)	27 (96%)
Mental health service provider center	27 (96%)	25 (93%)
Substance abuse service provider	27 (96%)	24 (89%)
Division of Youth Corrections	27 (96%)	23 (85%)
Domestic violence service provider	27 (96%)	23 (85%)
County Health Department	26 (93%)	22 (85%)
Senate Bill 94 representative	25 (89%)	22 (88%)
Behavioral health organization representative	24 (86%)	20 (83%)
Local courts/judicial	20 (71%)	13 (65%)
Diversion	13 (46%)	12 (92%)
Family advocacy organization	12 (43%)	10 (83%)
Law enforcement	12 (43%)	7 (58%)
Family representative	9 (32%)	0 (0%)
Local health services provider	6 (21%)	6 (100%)
Elected official	6 (21%)	0 (0%)
Youth representative	4 (14%)	4 (100%)
Business or Chamber of Commerce	3 (11%)	2 (67%)
Other	17 (61%)	16 (94%)

Note: Legislatively mandated partners are shown in **bold** text above.

IOGs identified a common set of core activities related to legislative goals. The five most common focus areas include:

- Improving quality of service delivery for children and families
- Establishing and/or refining IOG structure, processes, and protocols
- Strengthening collaborative relationships with new and existing partners
- Enhancing CMP personnel resources
- Addressing CMP sustainability

ISSTs plan and coordinate services for youth in families with the participation of multiple agencies to develop an integrated service plan. The following highlights findings related to ISST activities:

- On average, sites reported having two ISSTs, with sites ranging from 1 to 16. ISST types include those serving all families, a specialized ISST within one broad service area (e.g., Juvenile Justice), and those focused on a specific outcome area (e.g. truancy ISST).
- Youth and families are typically referred to an ISST through a CMP partner agency. The two most common referral sources are county

CMP impact on staffing teams

"We've always had good collaboration, but it has gone to a different level since becoming a part of the CMP. We are more effective in our staffing. We used to overwhelm families with too many people in the room. Thanks to ISST and wrap, we have refined our process. We have the right people in the room at the right time. We've brought in more funding opportunities and programming as a result of our collaboration. And lastly, the role of the family in their own case planning is clearer and more effective."

departments of human services and school districts, respectively. Other sources include domestic violence providers, primary care physicians (pediatricians), Senate Bill 94 staff, and early childhood education providers.

- Twenty-six CMPs indicated that at least four agencies typically attended staffing, with thirteen indicating participation of seven or more agencies.
- On average, CMPs hold five ISST meetings per family, though this varies widely, from a minimum of one to a maximum of thirty.

The Quality of Collaborative Processes

Overall, IOG members perceive their collaboratives to have strong and productive structures and processes in place. On average, IOG members indicated that their CMP’s efforts were characterized by high quality experiences in terms of strong leadership, authentic processes, and possessing structural integrity, with survey scale scores exceeding the 4.25 marker of collaborative effectiveness (out of a 6 point scale, with 6 indicating greater effectiveness).

CMPs shared evidence of the effectiveness of their collaborative efforts by describing key achievements at the IOG and ISST levels in FY2010-11, summarized in the table below:

Areas of Collaborative Effectiveness	Example Achievements
Improved processes within the IOG	Establishment of subcommittees, leading to more efficient use of IOG meetings <ul style="list-style-type: none"> • a steering committee to oversee "day-to-day" operational activities • an outcomes committee to specify local evaluation measures and goals
	Full partner participation in strategic planning sessions
	Creation of youth advisory board
	Establishment of a "virtual voting" process within a rural IOG to increase active participation in decision-making
Development of new programs or enhancement of existing service delivery	Roll-out of new programs targeting areas such as pregnancy, mentoring, youth service learning
	Increases in the number of families receiving specific services
	Increases in the number of referrals, indicating greater community awareness of effectiveness of service delivery
	Decreased time between referral and enrollment in intervention services
Supporting sustainability	Funded successful grant writing efforts
	Blended or braided funding identified for specific services leading to more integration and streamlined services among partner agencies
	Establishment of process to grant seed funds to new programs

CMPs continue to struggle with some common challenges in their collaborative efforts. These include:

- *Participation and buy-in from partners.* CMPs experience difficulty in getting participation from specific partners, and having partners fail to follow through on plans.
- *CMP staffing.* CMPs reported that inadequate staffing and turnover (lack of a coordinator, ISST facilitators) has impacted CMP administration and service delivery.
- *Financial stability/sustainability.* CMPs reported challenges associated with a general shortage of funding, largely attributed to the economic downturn. The CMP has increased from 6 counties in 2005-06 to 31 counties in 2011-12, while the available earned incentive funds have not increased.
- *Information sharing.* Some CMPs have struggled with establishing partner agreement regarding confidentiality requirements and consent processes/documents to share client information.

However, the Colorado Child and Youth Information Sharing committee was established as part of a CMP strategic plan and is engaged in promoting cross system information sharing and data sharing (see <http://collaboration.omni.org/sites/1451/SitePages/Home.aspx> for more information).

- *Shared CMP mission.* A few CMPs (3) cited difficulty ensuring clear and common understanding of collaborative goals, activities, and practices among partners, which has been compounded by turnover in the IOG and partner agencies.

Family Participation

The legislation strongly encourages CMPs to engage family representatives to ensure that systems are responsive to the families they serve. Families can be involved at both the IOG and ISST levels.

- *IOG level.* Over 40% of CMPs reported at least one family member on their IOG, about 40% reported at least one family advocate, and about 20% reported at least one youth member.
- *ISST level.* Nearly half of CMPs (12 CMPs, 46%) reported that family members are always viewed as partners in service planning for other families, and the vast majority (85%) of CMPs reported that family members are seen in this way at least “sometimes.”
- *Participation in service planning.* The majority (63%, 17 CMPs) of CMPs indicated involving families immediately after being determined eligible for ISST services and nearly one-third (30%, 8 CMPs) reported that families are first contacted prior to a decision regarding ISST eligibility. CMPs (96%) reported that primary caregivers participate in the ISST either frequently or always; the majority (77%) reported that important decisions about services are rarely or never made without the family present; and the vast majority (89%) reported that the family frequently or always participates in the process of developing and writing service plans, and is then given a copy of that plan (93%).

CMPs identified a number of barriers believed to limit effective engagement of families in their structures and processes. The most frequently cited barrier was identifying families appropriate for IOG participation (64%), followed by a lack of family knowledge or experience about CMP processes (39%) and confidentiality concerns (39%). Projects cited efforts to recruit, train, and retain family representatives as ways to overcome these barriers. The Family Voice and Choice Committee has been integral to facilitating local efforts.

Goal II: Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi-agency services.

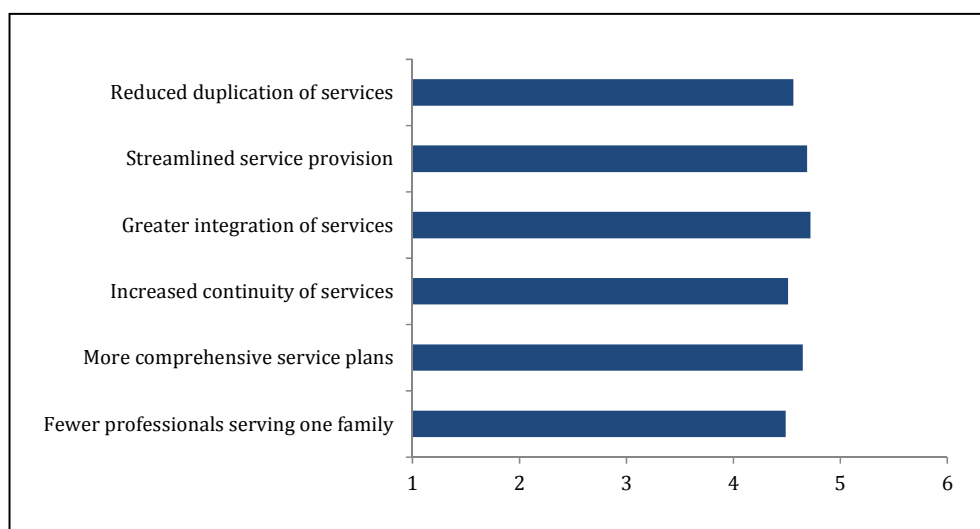
CMPs reported addressing duplication and fragmentation of service delivery by implementing strategies in four key areas: 1) coordination of client consents and assessments; 2) integrated service planning; 3) arranging payment for and provision of services; and 4) information sharing across agencies.

- The majority of CMPs (74%) use a common consent form, meaning that the individual or family need sign only one consent document to enable intervention-relevant information to be shared across all agencies involved in a given case.

- About half of CMPs (14) reported using a common client assessment or sharing assessment results across agencies (e.g., Colorado Juvenile Risk Assessment).
- While nearly all CMPs reported ISST service plans as being integrated (92.5%) and individualized to family needs (78%), only half (13) indicated sharing a single comprehensive service plan. Some sites described that partnering agencies agree upon service components yet create multiple (i.e., agency-specific) plans.
- Over 80% of CMPs share service delivery costs on a case-by-case basis, with individual agencies designated to pay for particular components of each individual service plan.
- Less than half of CMPs have formal data sharing agreements (46%) and processes in place for partner agencies to access data systems for service delivery (32%) or evaluation purposes (21%).

Effectiveness of efforts to reduce duplication and fragmentation

As survey results show, IOG members perceive CMP efforts as effectively addressing this legislative goal, with average scale scores exceeding the 4.25 benchmark (out of a 6 point scale, with 6 indicating greater effectiveness).



Despite progress in these areas, the following barriers were reported by multiple CMPs:

- The lack of connection between different state-level databases (e.g., Trails, Eclipse) makes it difficult to obtain complete information about youth being served across systems. This impedes identification of the youth with highest need for integrated planning.
- Many CMPs experience challenges in accessing data in specific systems (e.g., schools, private providers) and ensuring access for key personnel (e.g., enabling ISST facilitators to access Trails data), which slows down service delivery.
- One-quarter of CMPs have not yet developed a common release of information; some cite difficulties in meeting all federal and state laws as well as the policies of partner agencies.
- The economic downturn has resulted in high staff turnover in partner agencies, leading to delays and gaps in service coordination.

Goal III: Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services.

CMPs continue to identify and implement services meeting high standards of quality, while also ensuring that those services are well matched to the strengths and needs of the youth and families being served.

- Seventeen CMPs cited improvements in service quality as a primary achievement resulting from their IOG efforts in the past year. Noted indicators included newly established or enhanced ISST models, rollout of new programs targeting service gaps for specified populations, processes to ensure early case contact, and increased monitoring and follow-up with families.
- IOG members indicated strong “commitment to evidence-based/informed models,” rating this survey item at 5 out of a 6 point scale. This is reflected in the growing number of CMPs implementing the High Fidelity Wraparound modelⁱⁱ (7 CMPs).
- While widespread use of these models reflects positively on the quality of service provision, only about one-third (35%) of these sites measure quality of their implementation efforts (i.e., fidelity).
- Nineteen CMPs support the use of other evidence-informed preventive interventions (e.g., Multi-Systemic Therapy, Functional Family Therapy, Life Skills Training, Incredible Years).ⁱⁱⁱ

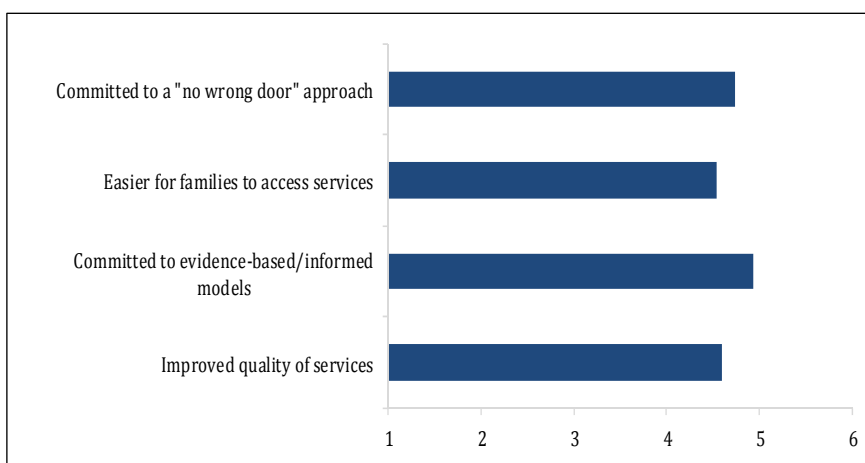
The majority of CMPs implemented at least one of the strategies specified in the table below to increase the appropriateness of their service delivery in the last year.

CMP strategies to enhance appropriateness of services	Number of CMPs (%)	
Identified service area that is currently not being addressed through <u>informal</u> needs assessment with CMP partners (n=27)	24	(89%)
Identified service area that is currently not being addressed through <u>formal</u> needs assessment with CMP partners (n=27)	16	(59%)
Implemented a new program/model that specifically targets the population and service need/gap that was identified by IOG (n=27)	20	(74%)
Implemented/enhanced services to be more culturally appropriate (n=27)	11	(41%)

*“Because of the CMP, we are seeing systems beginning to recognize what is not working in their process and wanting to address it. Instead of pointing fingers, we’re having more conversations with a win/win attitude. **Youth are not being labeled as “Your Problem”, rather the community as a whole is embracing their needs collectively.** This is a tremendous step in the right direction. Trust is growing and systems realize no one is out to tear them down for their mistakes. Rather the IOG is here to help each other succeed for the best interest of the youth.”*

Achievements related to CMP efforts to increase effectiveness

Overall, IOG members reported that their CMPs implement practices that result in more effective service delivery and improved program outcomes. Average ratings of relevant survey items exceeded the 4.25 effectiveness benchmark out of a 6 point scale, with 6 indicating greater effectiveness.



Goal IV: Encourage cost sharing among service providers that leads to cost-reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado.

The legislation assumes that effective interagency service coordination, decreases in duplication, and prevention of deeper and more costly family involvement in social service systems, should lead to better family outcomes and net cost-savings over time. Testing the cost-savings hypothesis implied in this legislative goal at an initiative level is complicated given the range and diversity of existing projects, processes and outcomes. However, local CMPs have developed processes to share costs. In addition, CMPs have successfully leveraged their collaborative efforts to obtain additional funding and re-invest savings to sustain and/or grow their programs and services.

- IOG partners frequently or always jointly paid for staffing (20 CMPs) and administrative costs (25 CMPs), by pooling funds to support salaries of IOG coordinators or program personnel, and contributing in-kind resources such as office space and trainings.
- As noted earlier, CMPs regularly share costs of intervention services. As a complement to cost-sharing, seventeen CMPs reported allocating nearly \$714,000 of their FY2010-11 incentive funds (approximately 29% of their total funds) to pay for direct family services.
- Ten of the 29 CMPs (34%) reported receiving competitive funds from federal and state agencies and private foundations. Together, these efforts leveraged at least \$1,084,776 in additional funding. Many CMPs also received non-competitive funds.

Cost-sharing: Use of blended and braided funds

"[Our CMP] continues to increase the frequency of blended/braided funding for the purchase of specifically identified services for youth/families which has increased effectiveness of the integrated plans for clients, as well as increased the strategic use of multiple funding streams, and reducing fragmentation of services between agencies. It has also elevated some discussions and informal agreements around who pays for what and when as it relates to a systemic approach rather than agency-specific. There is increased cooperation on projects between partner agencies when it comes to the pursuit or involvement in grants, which has also supported more cross-system training of staff in certain areas."

Cost savings associated with CMP efforts

The legislation supports CMPs in re-investing realized cost savings in local efforts. However, measurement of cost savings is challenging, as it requires a calculated estimate of the potential costs for a given individual or family had CMP efforts not been provided. In addition, while outcomes may be improved, it is difficult to determine whether these were achieved at lower cost, and some may argue that effectively serving multi-systems involved families may actually increase costs, at least in the short-term.

- Only 3 CMPs reported having a formal process to measure actual cost savings, although 12 CMPs provided monetary estimates of perceived savings. Example measures of savings include: reductions in the average number and length of time CMP-served children were in foster care and other placements; comparison of costs of services families received prior to, and following CMP services; and reduced use of emergency housing assistance and TANF funds.

- These CMPs reported a total of \$5.9 million that were reinvested in CMP efforts. CMPs utilized these funds most often to purchase additional services or to serve more families with existing services (16 CMPs). Other frequently mentioned uses of reinvested funds included: contributing to coordinator salaries (4 CMPs), infrastructure building (e.g., database development), family “emergency” assistance, and contributing to local evaluation costs (2-3 CMPs).
- CMPs described other sources of perceived cost reductions, but were unable to quantify associated cost savings. These include: fewer families entering the child welfare system; lower truancy rates (leading to presumed lower education costs and increased school revenues); reductions in the length of mental health treatment and inpatient stays; improvements in coordination and access to needed care and funding sources such as Medicaid and CHP+; and prevention of costly services through targeted programs, including pregnancy prevention.

Goal V: Lead to better outcomes and cost-reduction for services provided to children and families in the child welfare system, including the foster care system, in Colorado.

CMPs provided estimates of eligible and served populations and performance on locally-defined goals, including child and family outcomes.

- *Eligible population.* Currently, it is difficult to obtain precise numbers, as there is no standard definition of eligibility, youth may be represented more than once (duplicated cases), and CMPs take varying approaches to calculate the total. Thus, the counts are likely overestimated.
 - In FY2010-11, 70,000 individuals were considered eligible for CMP services. About half (30,000) of that population was reportedly screened for CMP services.
- *Served population.* The total served were calculated at different levels of service delivery (all include duplicated cases):
 - 19,600 individuals participated in local services or efforts that were associated with their CMP (e.g., paid by incentive funds, donated in-kind, provided by partnering agencies).
 - 7,000 individuals received services through the local ISST process.
 - 5,300 individuals received services that were funded, at least in part, by CMP incentive funds (among 19 CMPs where their IOG financially supported specific programs).

Because CMPs employ a variety of service models that are targeted to individual and diverse community needs, local sites tend to track their performance in many outcomes, utilizing multiple indicators within outcomes. In FY2010-11, the review of indicators revealed:

- The 28 CMPs with at least one year of data tracked a combined 198 performance indicators.
- Two-thirds (134) measured population-level outcomes (e.g., child and family), while 64 measured process (e.g., service delivery improvements). Performance was measured at different levels (i.e., rate for county versus youth served through the ISST).
- On average, each CMP tracked 7 indicators, although a few CMPs measured twenty or more.
- Common data sources include CDHS Trails, Eclipse/ICON, school district data, and DBH/CCAR.

In terms of performance:

- CMPs reported meeting 78% of the 198 performance indicator goals. Success in meeting goals was high in three domains, with less success seen in the education domain.
- Performance on indicators reflecting the most commonly measured outcomes is summarized in the table below. The majority of performance goals targeting outcomes in the child welfare and juvenile justice domains were met, with more variable performance on outcomes in education and health/mental health domains.

Domain	Common Outcome	% Goals Met FY2010-11
Child Welfare	Enhance stability of out-of-home placements	88%
	Prevent out-of-home placement/increase reunification	80%
Juvenile Justice	Successful completion of probation	69%
	Low or reduced usage of commitment/detention facilities	86%
	Reduce or maintain low rates of re-offense/recidivism	88%
Education	Increase attendance/reduce truancy	44%
	Increase or improve student achievement	60%
Health/Mental Health	Improved level of functioning and decrease in problem severity	60%
	Increase prevention and treatment for substance use/abuse*	100%
	Decrease or maintain low rates of hospitalization/inpatient services	57%

*Note: Only one performance measure was assessed in this outcome area in FY10-11.

Although CMPs reported on indicators related to common outcomes, the target populations and specific performance indicators for those outcomes were defined and measured differently across CMPs. Thus, data could not be meaningfully analyzed across sites to obtain a precise estimate of impact in these outcomes across the state because direct comparison is neither possible nor appropriate.

Plan for common measurement across CMPs in evaluation year 3

The diversity of measures across CMPs led to the specification of a standard measurement plan. In July 2011, sites began uniform measurement of a select set of process and outcome indicators, which will be aggregated at the state level.

The process indicators will facilitate an accurate count and description of the CMP-targeted population and track progress on core ISST service components. These include:

- Number of children/families referred to ISSTs
- Number and type of agencies or systems that: families are involved in at the time of enrollment; participate in the family's service planning; and provide services to families as a result of the ISST
- Number of cases where family members participated in service planning
- Number of cases in which an integrated service plan was developed

The outcome indicators will measure core expected outcomes in the child welfare and juvenile justice domains, utilizing the Trails and ICON/Eclipse statewide databases. These include:

- Number (rate) of CMP-served youth: with new open involvements in Trails after CMP services began, with no substantiated abuse finding, discharged to a permanent home; and number of moves experienced when in out-of-home placement

- Number (rate) of CMP-served youth who: successfully complete probation and/or parole; recidivate; and experience revocations by technical violations

A measurement tool and online client level database (ETO ©) was created to support CMP data collection. In Year 3, indicators in the education and health/mental health domains will be selected.

FUTURE EVALUATION DIRECTIONS

In year two, the evaluation centered on identifying standard data collection opportunities across CMPs and establishing measurement systems, and informing CMP best practices and program models through ongoing process and formative evaluation efforts. Year three evaluation activities are intended to increase capacity and enhance data quality in ways that will allow for an examination of CMP outcomes. The shift from formative evaluation and infrastructure building to a summative design will require local adjustments in data collection practices to ensure consistent and rigorous measurement statewide, which may be challenging to some sites. OMNI, CDHS, and the Evaluation Subcommittee have proposed the following year three evaluation activities:

1. *Continue to develop and implement systems to collect and analyze well-defined uniform measures of:*
 - a. *Outcomes across CMPs on CMP-targeted populations.* OMNI will continue to support local CMPs in their data collection of standard and local outcome measures. Mechanisms to measure standard outcomes in education and health/mental health domains will be collaboratively developed and implemented in FY12-2013.
 - b. *Output and process measures.* OMNI will work with local CMPs to further refine and develop additional measurement strategies in collaborative processes, family involvement, service duplication and fragmentation, quality, effectiveness, and appropriateness of services, and costs and estimates of cost savings. The on-line statewide measurement data collection system provides a structure and mechanism by which local CMPs could develop additional uniform measures of CMP processes.
2. *Monitor and track trends in statewide measures of key CMP outcomes.* OMNI and the EC will develop an on-line platform to display data trends over time in the four CMP outcome domains at local and state levels, which will raise awareness of the initiative among state leaders and community members.
3. *Continue to define and support dissemination of information on effective IOG, ISST, and collaborative practices.* OMNI evaluators are leading or participating in efforts to review CMP-relevant research and disseminate best practices. These activities include:
 - a. *Development of a “Systems Facilitation Guide”* summarizing research and learning on systems collaboration and CMP core components (family involvement, integrated service planning).
 - b. *Brief evaluation and research reports on key topics.* These quarterly reports will explore topics relevant to state and local CMP stakeholders, such as measurement of cost savings.

- c. *CMP Handbook development.* The handbook will orient new CMPs and new stakeholders to the initiative, the establishing legislation, SSC policies and procedures, local evaluation and measurement processes, and collective learning regarding effective implementation of IOG and ISST structures and processes.
- d. *CMP community networking.* OMNI will continue to support CMP information sharing through maintaining the CMP SharePoint portal (an on-line information sharing tool) and attending and/or facilitating locally-initiated regional meetings.
- e. *Family involvement technical assistance.* OMNI will continue to support the Family Voice and Choice Committee's efforts to examine evaluation findings to identify technical assistance needs related to family involvement across the initiative.
- f. *Incentive funding.* OMNI will facilitate the SSC's discussions regarding the development of new methods to determine performance based incentive funding allocations.

Moving forward, the evaluation will focus on continued development of measurement infrastructure to create a solid foundation for summative evaluation of CMP efforts statewide. OMNI will continue to ground the evaluation in a participatory approach, working in close collaboration with the CMP State Steering Committee and the Evaluation Sub-committee, in an effort to ensure that results are well aligned with the needs and interests of the initiative and its stakeholders.

ⁱ Colorado Revised Statute, Title 24, Article 1.9. (2010). Retrieved from <http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp>.
<http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp>.

ⁱⁱ Bruns EJ, Sather A, Stambaugh L. (2008). National trends in implementing wraparound: Results from the State Wraparound Survey, 2007. In: Bruns, E.J. & Walker, J.S., (Eds.), *Resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

ⁱⁱⁱ SAMHSA: A Pocket Guide to Evidence-Based Programs. (2011). Retrieved from http://www.samhsa.gov/ebpwebguide/appendixA_Schools.asp

The Collaborative Management Program (CMP) initiative

In 2004, the Colorado General Assembly passed House Bill 04-1451 (referred to as HB 1451) to establish collaborative management programs designed to improve outcomes for children and families involved with multiple county agencies. The General Assembly determined that “development of a uniform system of collaborative management is necessary for agencies at the state and county levels to effectively and efficiently collaborate, share resources, or manage and integrate the treatment and services provided to children and families who benefit from multi-agency services.”ⁱ

The resulting Collaborative Management Program (CMP) is designed to improve both the quality and cost-effectiveness of interventions for Colorado children and families involved with multiple governmental programs and community agencies stemming from health, education, child welfare, and juvenile justice system contact. The legislation calls for the development of local collaborative management structures and processes that bring together agencies and services for at-risk, high systems-use children and families. Partners in local CMPs include county departments of human/social services, local judicial districts, health departments, school districts, community mental health centers and Behavioral Health Organizations, parent or family advocacy groups, and community agencies.

The specific goals of the legislation are as follows:

1. Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent advocacy or family advocacy organizations
2. Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi-agency services
3. Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services
4. Encourage cost sharing among service providers
5. Lead to better outcomes and cost-reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado.

The larger goal of the initiative is to improve outcomes for multi-system involved youth and families through cross-system service planning and coordination. Research has demonstrated that these collaborative practices yield important benefits including:

- Increased probability of improvement in child and family outcomes
- Maximization of available resources for the provision of services
- Increased coordination within and among service delivery systems
- Shared responsibility across systems and service providersⁱⁱ

Importantly, the legislation reflects a long history of system reform in Colorado based on Systems of Care principles. Core elements include community collaboration, family involvement in service planning and delivery, and culturally competent services tailored to the unique needs of different populations.ⁱⁱⁱ These elements are used to engage stakeholders outside state and local government in consensus-oriented efforts to manage public resources and collectively solve problems. In part, community collaboration has become a hallmark of social services reform in Colorado due to research indicating its effectiveness in engaging diverse disciplines to address issues that have multiple causes and solutions.^{iv}

“Collaboration...has been seen as a means by which complex problems with interrelated causes can be addressed, a strategy for maximizing the efficient use of limited resources, a way of reducing the fragmentation within and between bureaucracies, [and] a means of engaging citizens in a democratic process of decision-making.”

Emshoff et al., 2007, *American Journal of Community Psychology*

A. The CMP state initiative

The CMP initiative was first implemented in six counties in 2005-2006, with additional counties added annually (see Table 1 below). In the 2011-2012 fiscal year, there are 29 local CMPs participating in the initiative, two of which are multi-county partnerships.

Table 1. Number of counties participating in the CMP initiative

Year	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
Number of Participating Counties	6	12	15	24	29	31	30	31

Participating counties vary in size, population density, collaborative structure, service delivery approach, and stated outcomes. Figure 1 provides a statewide map of participating counties by geographic type.

To reward community efforts, performance-based incentive dollars are distributed based on achievement of outcomes in these four areas and in accordance with a formula approved by the State Board of Human Services. CMPs are required to set specific goals in all four outcome areas and to describe how these will be met. CMPs use incentive funds to support the costs of collaborative processes (e.g., coordinator salary) and service delivery (e.g., existing and new programs). Projects may also request waivers of rules and opt to reinvest any general fund savings into additional services to families that would benefit from multi-agency services.

B. CMP statewide program evaluation

In 2008, House Bill 08-1005 authorized an annual external evaluation of the CMP initiative. Specifically, Colorado Revised Statute (24-1.9-102.5) states that the Department of Human Services, with input from the counties, involved state agencies, participating stakeholders, and family advocacy organizations will develop the criteria and components of the external evaluation. The legislation requires that local projects report on the following:

1. the number of children and families served through their individualized service and support teams and the outcomes of the services provided;
2. estimated costs, as well as cost-shifting or cost-saving, related to implementing the CMP approach; and
3. information relevant to improving the delivery of services to persons who would benefit from multi-agency services.

In July of 2009, CDHS hired OMNI Institute (OMNI) to conduct the statewide evaluation. OMNI is a non-profit, social science research, evaluation and technical assistance firm based in Denver, Colorado established in 1976 (formerly OMNI Research and Training, Inc.). In October of 2009, OMNI began working in partnership with the SSC and the Program Director at CDHS to develop the evaluation design and an Evaluation Subcommittee (EC) was created to guide evaluation efforts. Membership in the EC is open to CMP partners and current members include IOG coordinators from four counties; the Program Director at CDHS; representatives from the Department of Criminal Justice and the State Judicial Branch; representative from a state family-driven organization; OMNI staff; and researchers from the University of Denver.

i. Phases of the evaluation

The overarching focus of the evaluation is on examining the effectiveness of CMP efforts in achieving the legislative goals of HB 1451 (e.g., increased family involvement; reduced duplication and fragmentation; increased quality, effectiveness and appropriateness of

services; greater cost and resource sharing across agencies; and improved child and family outcomes). Because the project had been operational for several years before commencing the evaluation, the design is being implemented in multiple phases. These include formative evaluation to service and describe current practices, infrastructure development to lay the foundation for standard data collection, and summative efforts to assess individual and cross-site effects. Each of these phases is described below.

Phase I – Formative assessment. Formative efforts collect data intended to help identify and refine program activities. The focus of data collection is to examine implementation, identifying barriers, observed successes, and other qualitative information, in order to gain an understanding of the program. Information gathered can be used to develop strategies to strengthen the program. Formative evaluation methods help to surface program needs to be addressed in the second phase of infrastructure building.

Phase II – Infrastructure building. The second phase of the evaluation seeks to lay the foundation for standard evaluation practices across sites. Evaluation efforts focus on the development of measurement strategies, implementation of data collection systems, and building the capacity of local projects to participate in the evaluation. Formative evaluation techniques are also used in this phase to further inform program implementation and support improvement efforts.

Phase III - Summative. Summative evaluations examine cumulative outcomes of a program or initiative. In this phase, evaluation efforts focus on analyzing data to examine variation in performance outcomes as a function of differences in practices and processes. Using this type of analytic approach, the evaluation can determine project effects as well as reflect on performance efforts to identify effective practices and opportunities for further program refinement.

The CMP statewide evaluation is currently in phase two. Phase I was completed in the first year in order to document and describe the range of local efforts and selected outcomes. This work helped to illuminate a wide variation in defined target populations, service models, and measured outcomes. Such diversity poses significant challenges for the specification and application of a uniform measurement strategy and related outcome analysis. To address these challenges, OMNI recommended that the project develop uniform output measures (e.g., clients served, services provided), a small set of common outcome measures, and a basic data management system to support local collection efforts. This effort to build evaluation infrastructure began in the second year (2010-2011) of the evaluation, with the EC and CMP stakeholders working to establish standard measurement and data systems to support future evaluation activities. Infrastructure building will continue and summative evaluation efforts will begin in the upcoming year.

It should be noted that the move toward more rigorous, cross-site data collection processes that support uniform measurement of efforts and outcomes has resulted in concerns being voiced by a subset of CMP communities. This is to be expected as sites in prior years have been able to submit data in ways that do not conform to standard or rigorous data collection standards or methods, and which cannot be verified. Thus, the request to participate in a statewide evaluation requiring some additional data collection may be perceived by some as an unwelcome burden. OMNI, the EC, CMP Coordinators, in conjunction with the project director, have worked carefully to develop a data collection process that involves a very small set of variables for this purpose. OMNI staff will continue to work with sites to support collection efforts, while also creating data reporting tools that will help coordinators and local ISSTs use collected information to support service and management activities.

ii. Year two evaluation methods

The following description outlines the evaluation effort employed in year two.

1. Refine CMP measurement processes

In October 2010, the Evaluation Subcommittee (EC) proposed the formation of a temporary workgroup to help select variables and refine CMP measurement processes. Accordingly, an Outcomes Workgroup, comprised of key CMP stakeholders, was assembled to explore the benefits of implementing uniform measurement processes; examine key assumptions and intentions of the legislation to select critical measurement areas; identify a set of common indicators; and develop a standard measurement approach to be implemented statewide. Led by OMNI and with guidance from the EC, the workgroup met three times for half-day retreats in November 2010, January 2011, and February 2011.

The specific tasks completed by the Outcomes Workgroup included the following:

- Identified ways to improve measurement processes that are beneficial to the initiative, both locally and at the state level
- Explored key assumptions of the CMP legislation and identified evaluation and measurement targets that are central to the initiative
- Developed a measurement approach to be implemented across all CMPs
- Selected and defined process and outcome indicators in the Child Welfare and Juvenile Justice domains to be measured in the 2011-12 fiscal year (and began exploring a process for later selection and definition of Education and Health/Mental Health indicators)
- Surfaced issues and challenges related to data collection and measurement, and identified opportunities to address these problems

- Developed a plan to disseminate information to State Steering Committee in March, 2011 and made refinements based upon feedback
- Facilitated implementation in time for integration of the plan into MOUs for the 2011-12 fiscal year

The efforts of the Outcomes Workgroup led to the specification of a statewide measurement plan adopted by the SSC and rolled out in July 2011. OMNI identified relevant measures to support data collection and developed protocols for data entry into a web-based management system. The plan is further described in the final section of this report.

2. *Refine and maintain infrastructure to evaluate and share progress on legislative goals*

The evaluation established and continued systems to document and share CMP progress:

- Revision and administration of CMP annual reports. OMNI further refined the structure and content of the CMP mid-year and annual reports to make reporting easier for CMP coordinators and enhance the usefulness of data collected. Evaluators used both quantitative and qualitative approaches to analyze data from these reports.
- Revision and administration of CMP collaborative effectiveness survey. On-line surveys assessed IOG members' perceptions of the quality and effectiveness of their local collaborative practices. Select scales from the first year administration were re-administered in the 2010-2011 fiscal year to explore changes in collaborative effectiveness over time. OMNI provided local results to individual CMPs and analyzed data aggregated across CMPs to assess collaborative effectiveness statewide.
- Administration of family advocacy surveys. In collaboration with the Family Voice and Choice Committee and a family engagement researcher from Walden University, OMNI administered two surveys in Spring 2011. OMNI compiled these data, conducted aggregate analyses, and provided a report to the Family Voice and Choice Committee to inform future efforts.
- Refinements and technical support of the web-based CMP portal. Established in the 2009-2010 fiscal year, the CMP Portal is a web-based system designed to facilitate communication and information sharing within the initiative, providing access to common documents, calendars, and resources in a centralized location. Based on feedback received from CMP stakeholders, evaluators made further revisions to the content and structure of the CMP portal in the 2010-2011 fiscal year.

Evaluation methods to date have relied on collecting and analyzing information about CMP stakeholders' perceptions and other self-reported data due to the absence of uniform process and measurement strategies across CMPs. Thus, findings must be interpreted with

caution as they may be influenced by stakeholder biases. As discussed above, implementation of data standards in year two will support analysis between and across sites beginning in year three.

iii. Year two findings

Information provided below describes local CMP efforts to target the legislative goals of HB 1451 and summarizes findings from the second year of the statewide evaluation. Findings presented in this report are not exhaustive; additional reports and deliverables have been produced during the course of the year. The legislative goals provide the structure for the presentation of findings throughout this report, with each goal discussed in turn. In general, each report section first describes CMP efforts to address the respective goal; explores evidence about the perceived effectiveness of those efforts to date; and concludes with on-going challenges or barriers encountered and opportunities for continued improvement. The report concludes with a discussion of next steps and directions for evaluation efforts in year three.

Legislative Goal I: Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent advocacy or family advocacy organizations.

The first legislative goal of the Collaborative Management Program sets forth several expectations regarding local implementation of a collaborative management system. It mandates that the multiple agencies addressing the needs of Colorado families, youth and children develop a more uniform, interagency system of service management. It further encourages collaborative management systems to engage parents or family advocacy groups to ensure the system's responsiveness to the families it serves.

The following section examines the degree to which local CMP efforts have contributed to creating greater uniformity in the county systems addressing the needs of families, youth and children; more effective working relationships between agencies; and stronger involvement of individuals and organizations that advocate on behalf of families served by these agencies. We first describe the mandated components of local CMPs and then explore the extent of variation among projects in key areas. This discussion is followed by a presentation of the evidence of overall CMP effectiveness and identified challenges or barriers. Finally, we conclude this section with a discussion of CMP efforts to involve families in their work. Data and information presented throughout this section were collected from CMP annual reports and survey data on collaborative effectiveness from the 2010-2011 fiscal year.

A. Mandated components of CMPs

Per the legislation, county departments of human/social services, health departments, judicial districts (probation), school districts, and community mental health and behavioral health organizations are mandated to participate in local CMP efforts. CMPs also are strongly encouraged to involve family advocacy groups and other community agencies with related missions and service populations.

The legislation also stipulates that two organizational structures are to be created to support collaborative efforts: an Interagency Oversight Group (IOG) to facilitate communication and resource sharing across agencies; and an Individualized Service and Support Team (ISST) to plan and coordinate the delivery of services for multi-agency involved families. Additionally, CMPs are required to establish processes that facilitate effective partnerships, including methods for making collective decisions and implementing procedural change across agencies.

Finally, counties must submit Memoranda of Understanding (MOU) with participating partners addressing the following areas:

- Definition of the population to be served
- Services and funding sources
- Creation of an Interagency Oversight Group (IOG)
- Development of collaborative management processes
- Development of Individualized Service and Support Teams (ISST)
- Clear authorization to contribute resources and funding
- Description of the process to reinvest monies saved
- Performance based measures
- Confidentiality protections and requirements.

B. Local adaptation

As would be expected, CMPs share in common many characteristics, including IOG and ISST collaborative structures, an emphasis on resource allocation and reinvestment, and similar definitions of local performance measures. However, CMPs also reflect a considerable amount of variation in key areas including:

- Patterns of IOG membership, attendance, and areas of focus;
- Individualized Service and Support Team (ISST) models and processes; and
- CMP coordinator roles and responsibilities.

Each of these areas is described further below.

i. IOG membership, attendance, and areas of focus

Information collected in the first year of the evaluation revealed that the composition and activities of IOGs varied considerably among CMPs. Year two data collection also addressed IOG attributes, including IOG membership, attendance, meeting frequency, and areas of focus during the 2010-2011 fiscal year. Analysis of these data showed that in general, both mandated and non-mandated partners are engaged in collaborative efforts and that there exist many common areas of focus among IOGs.

a) IOG membership and attendance

In year one of the evaluation, CMPs frequently cited challenges to obtaining buy-in and participation from various key stakeholders, most notably, families/parents, schools, and law enforcement officials. As shown in Table 2, however, membership data for the current evaluation year reflect relatively substantial IOG participation of many of these same stakeholders, particularly local schools. In general, legislatively mandated partners were

well represented on IOGs, both in terms of IOG membership and frequency of meeting attendance. In fact, all (28) CMPs reported IOG members from county departments of human or social services, schools, and probation, with the vast majority (96%) attending at least half of the IOG meetings in the year. Of note, Senate Bill 94 stakeholders are included in 25 (89%) IOGs though their participation is not required.

Inclusion of non-mandated partners on IOG

CMPs often described the presence of non-mandated partners on their IOGs:

- Nearly all (89%) CMPs include Senate Bill 94 staff on their IOGs.
- Four CMPs specifically cited the inclusion of non-mandated IOG partners as one of their primary successes. Such partners include local law enforcement officials, higher education staff, local tribal leaders, and other community partners.

Table 2. IOG member agencies and attendance

Agency or Individuals Represented through Membership on IOG (n=28)	Number of CMPs Reporting IOG Member (%)	Number of CMPs Reporting IOG Member Attending at Least 50% of IOG Meetings (%)
County Department of Human and Social Services	28 (100%)	27 (96%)
School Representative	28 (100%)	27 (96%)
Probation	28 (100%)	27 (96%)
Mental health service provider center	27 (96%)	25 (93%)
Substance abuse service provider	27 (96%)	24 (89%)
Division of Youth Corrections	27 (96%)	23 (85%)
Domestic violence service provider	27 (96%)	23 (85%)
County Health Department	26 (93%)	22 (85%)
Senate Bill 94 representative	25 (89%)	22 (88%)
Behavioral health organization representative	24 (86%)	20 (83%)
Local courts/judicial	20 (71%)	13 (65%)
Diversion	13 (46%)	12 (92%)
Family advocacy organization*	12 (43%)	10 (83%)
Law enforcement	12 (43%)	7 (58%)
Family representative*	9 (32%)	0 (0%)
Local health services provider	6 (21%)	6 (100%)
Elected official	6 (21%)	0 (0%)
Youth representative*	4 (14%)	4 (100%)
Business or Chamber of Commerce	3 (11%)	2 (67%)
Other	17 (61%)	16 (94%)

Note: Legislatively mandated partners are shown in **bold** text above.

*In some instances, CMPs provided inconsistent responses to similar items within the Annual Report. As such, counts of members reflected above may differ from similar figures presented elsewhere in this report.

Additionally, overall IOG composition reflects the legislative expectation of multi-agency membership reasonably well. On average, IOGs include members from about 12 of the 19

systems listed in Table 2, with a minimum of 9 and a maximum of 16 systems represented per IOG. Finally, nearly all (27) IOGs meet at least quarterly, with about half (15) meeting on a monthly basis, and only one meeting less than quarterly.

b) IOG areas of focus

IOGs are expected to conduct oversight in several areas, including improving communication and resource sharing across partner agencies. They are also granted significant discretion in defining their own priorities. In the 2010-2011 fiscal year, IOGs identified a common set of core activities that aligned closely with the legislative goals. The five most common priority areas reported are presented in Table 3 below, in order of frequency. Specific activities associated with each priority area also are listed.

Table 3. IOG priority areas and activities in the 2010-2011 fiscal year

Priority Area	Activities
Improving quality of service delivery for children and families	Introducing new services
	Ensuring early contact between providers and families
	Refining ISST models
Establishing and/or refining IOG structure, processes, and protocols	Development of IOG bylaws, clear policies, and procedures distribution of earned incentive funds
	Formation of targeted IOG sub-committees
	Clarification of IOG member roles and responsibilities
Strengthening collaborative relationships with new and existing partners	Recruitment of new partners (law enforcement, domestic violence, tribal communities)
	Creating opportunities for IOG partners to learn more about each other and the CMP initiative
Enhancing CMP personnel resources	Hiring new staff (coordinators, facilitators)
	Providing training and professional development opportunities
Addressing CMP sustainability	Strategic planning
	Pursued grant funding

ii. Individualized Service and Support Team (ISST) models and processes

The ISST is a service planning and coordinating body that brings together providers from multiple agencies and, in some cases, family participants, to develop an integrated service plan. ISST models of service delivery varied significantly across CMPs. Year two of the evaluation explored ISST models and processes by examining the number of ISST’s implemented per CMP, ISST referral sources, and agency and family involvement during ISSTs¹. Findings in each of these areas are presented below.

¹ Some CMPs reported more than one ISST model or structure. These collaboratives were asked to focus on one “primary” ISST for the purposes of responding to subsequent questions about ISST characteristics.

a) Number of ISSTs and referrals to ISSTs

On average, sites reported having two ISSTs, with sixteen reporting having one and one site reporting utilizing six separate models. The variation in number and the existence of multiple ISSTs within a single CMP reflects the ISST model(s) being used. Specifically, ISSTs typically take one of three forms:

- a general ISST that serves all families;
- a specialized ISST within one broad service arena (e.g., Juvenile Justice) that serves only families receiving related services; or
- an ISST specific to an outcome area (e.g. truancy ISST) that serves only families targeting the specific outcome.

CMPs with multiple ISSTs usually have at least one that focuses on a specific issue or population.

Table 4. ISST referral sources

Referral Source (N varies by referral source)	Number of CMPs Reporting (%)	Average % of Referrals (Min.-Max.)
Department of Human Services	27 (96%)	40% (1% - 80%)
School district	26 (93%)	24% (1% - 66%)
Probation	22 (79%)	15% (2% - 45%)
Mental/behavioral health	19 (68%)	9% (2% - 25%)
Court/judicial	13 (46%)	14% (4% - 50%)
Law enforcement	10 (36%)	2% (1% - 4%)
Department of Public Health	9 (32%)	6% (1% - 22%)
Self/parent	9 (32%)	11% (3% - 25%)
Diversion	7 (25%)	10% (5% - 17%)
Division of Youth Corrections	7 (25%)	5% (1% - 8%)
Other	14 (50%)	19% (3% - 48%)

Youth and families are typically referred to the local ISST through a CMP partner agency or other entity in the community. Table 4 (above) presents the most common referral sources, including the number of CMPs reporting each, as well as the average share of referrals made by each source. The two most common referral sources, both of which also made the largest share of referrals, are county departments of human services and school districts, respectively. Additionally, fourteen (14) counties indicated that they receive referrals from sources not listed above. These include domestic violence providers, primary care physicians (pediatricians), Senate Bill 94 staff, and early childhood education providers.

b) ISST structure and agency participation

Because ISSTs are designed to convene representatives from multiple agencies, CMPs were asked about the number of agencies participating in a typical ISST staffing. Twenty-six (26) indicated that at least four agencies were typically in attendance, with thirteen (13) indicating participation of seven or more agencies. The majority (59%) of CMPs reported that ISST participation is both standard and tailored to the needs of the individual youth being served; that is, they include a core set of common participants as well as additional attendees based on the specific issues presented. Just over one-quarter (26%) reported that ISST participation is determined solely on the needs of the individual youth.

CMP impact on staffing teams

“We’ve always had good collaboration, but it has gone to a different level since becoming a part of the CMP. We are more effective in our staffing. We used to overwhelm families with too many people in the room. Thanks to ISST and wrap, we have refined our process. We have the right people in the room at the right time. We’ve brought in more funding opportunities and programming as a result of our collaboration. And lastly, the role of the family in their own case planning is clearer and more effective.”

CMPs also described the typical structure of an ISST meeting, namely how many families are addressed during the course of a single meeting, how much time is spent per family, and how many meetings are held per family. Findings are as follows:

- Projects are nearly evenly divided between those addressing one family per meeting versus those addressing multiple families per meeting (42% and 46%, respectively).
- On average, CMPs dedicate about one hour per family per ISST, though this varied from about fifteen minutes to two hours.
- On average, CMPs hold five ISST meetings per family, though this varied widely, from a minimum of one to a maximum of thirty.²

iii. CMP coordinator roles and responsibilities

In year one of the evaluation, CMPs emphasized the value of having a designated CMP coordinator, ideally dedicated to CMP activities on a full-time basis. In year two, CMPs were asked to provide additional information about their coordinators, particularly about the characteristics and roles associated with this position. Nearly all (96%) of CMPs reported having a designated coordinator, with the majority (63%) serving in this role on a full-time basis. About half of CMP coordinators are hosted by the county Department of Human or Social Services. Less common host agencies include mental health centers, local family/youth advocacy organizations, the juvenile justice system, and local schools. Of note,

² When reporting the average amount of time spent in an ISST per family and the average number of ISST meetings per family, many CMPs provided ranges (e.g., between 1 and 3 hours; or between 10 and 15 meetings). In these instances, the mid-point of the estimated range was used for purposes of analysis.

about one-third of CMPs reported a joint coordinator host, often with one agency “housing” the coordinator and another serving as fiscal agent for the position. The coordinator position is funded fully with CMP incentive funds (i.e., the yearly funds allocated to each CMP by CDHS) in 14 programs. However, six (6) projects (22%) reported that their coordinator position is funded only partially by CMP incentive funds, and seven (7) counties (26%) reported that the position is supported entirely by other funds.

Table 5. CMP coordinator roles

Coordinator Role (N=27)	Number of CMPs Reporting "Yes" (%)	
Liaison between partners	27	(100%)
Disseminates communication	27	(100%)
Documents decision making	27	(100%)
ISST team member	20	(74%)
IOG leadership	19	(70%)
Manages funds and oversees budgets	18	(67%)
Coordinates ISST	17	(63%)
Manages intake and referrals	15	(56%)
Conducts follow up with families	13	(48%)
Provides direct service	10	(37%)
Other	12	(44%)

CMPs were also asked to identify the key roles and responsibilities of the coordinator position (see Table 5, above, for the most common responses). Coordinators most commonly provide support at the IOG-level, with all (100%) serving as liaisons among CMP partners, disseminating information, and documenting decision-making processes and outcomes. However, many coordinators also support service planning and delivery, including participating on and coordinating ISSTs, and managing intake, referrals, and follow-up with families served. Twelve (12; 44%) CMPs indicated that their coordinator has responsibilities other than those listed in the table, such as serving as a liaison with people and agencies outside of the local CMP (e.g., CMP State Steering Committee and sub-committees), managing data collection and reporting, and supporting fundraising efforts.

C. Effectiveness of the interagency collaboration established by CMPs

Evaluation efforts also examined the outcomes of CMP collaborative processes and structures. In the first year of the evaluation, OMNI worked with collaboration researchers at the University of Denver to employ two methods to gather information about collaborative effectiveness. First, they conducted key informant interviews with a sample of IOG coordinators and state-level stakeholders. Interviews examined processes used to establish and implement the CMP, reflections on inclusion and decision making, and

lessons learned. This work culminated in a report describing key practices and perceived indicators of collaborative effectiveness (see Appendix B for a link to the full report).

Second, to gather a broader perspective on collaborative effectiveness and further explore themes from stakeholder interviews, evaluators developed a survey for IOG members. The *Collaboration Survey* and *Overall Success Survey* were administered to 235 IOG members in 22 CMPs in the 2009-2010 fiscal year, and a revised version integrating select scales from the two surveys was completed by 276 IOG members in 27 CMPs in the 2010-2011 fiscal year (see Appendix B for a link to reports describing the surveys in further detail). The survey measures several dimensions of collaborative effectiveness that, overall, reflect a) perceived quality of the collaborative process, and b) perceived impact of CMPs in reaching both legislative and other goals. Although the measure relies upon IOG members' perceptions of effectiveness, survey items assessing the collaborative process have been found to be predictive of positive outcomes that public health collaboratives are designed to achieve.^v

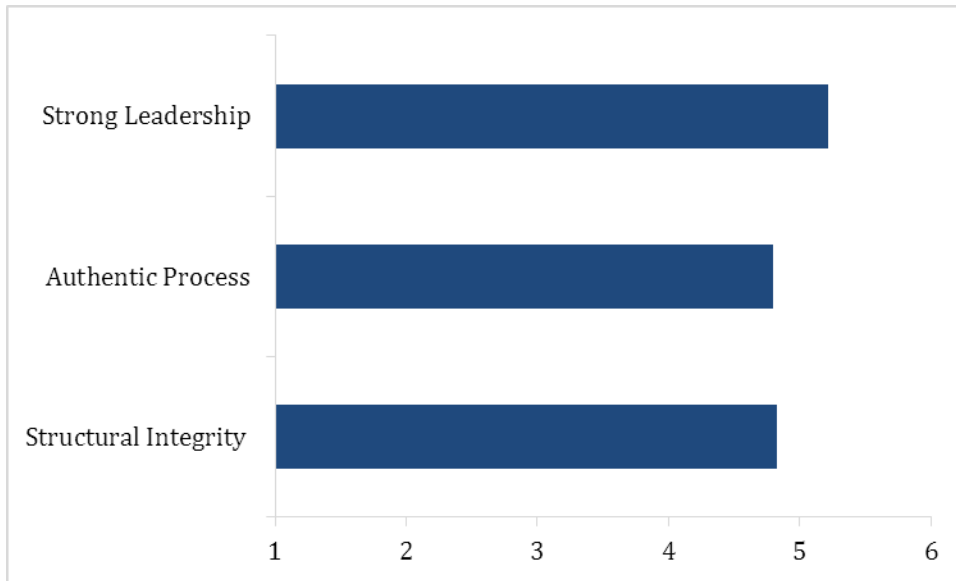
i. Quality of collaborative processes

Overall, IOG members perceive their collaboratives to have strong and productive structures and processes in place. The survey included three key scales assessing the quality of the collaborative process:

- Structural integrity, which occurs when the process is perceived as “fair.” The process allows for sufficient opportunity for stakeholders to challenge and revise decisions, but in a context in which all partners feel equally heard and respected
- Authentic process, which results when collaborative partners perceive the decision-making process as “open and credible,” because they see themselves as having real power to both formulate and make binding decisions^{vi}
- Strong leadership, which reflects the perception that efforts of collaborative partners are led by dedicated and effective coordinators.

On average, IOG members indicated that their CMP's efforts were characterized by high quality experiences in each of these three areas, with average scores exceeding the 4.25 marker of collaborative effectiveness on a 6-point scale, with higher ratings indicating greater collaboration^{vii}. In general, there was little variability in the average scores in these areas across CMPs.

Figure 2. Ratings of the quality of collaborative process



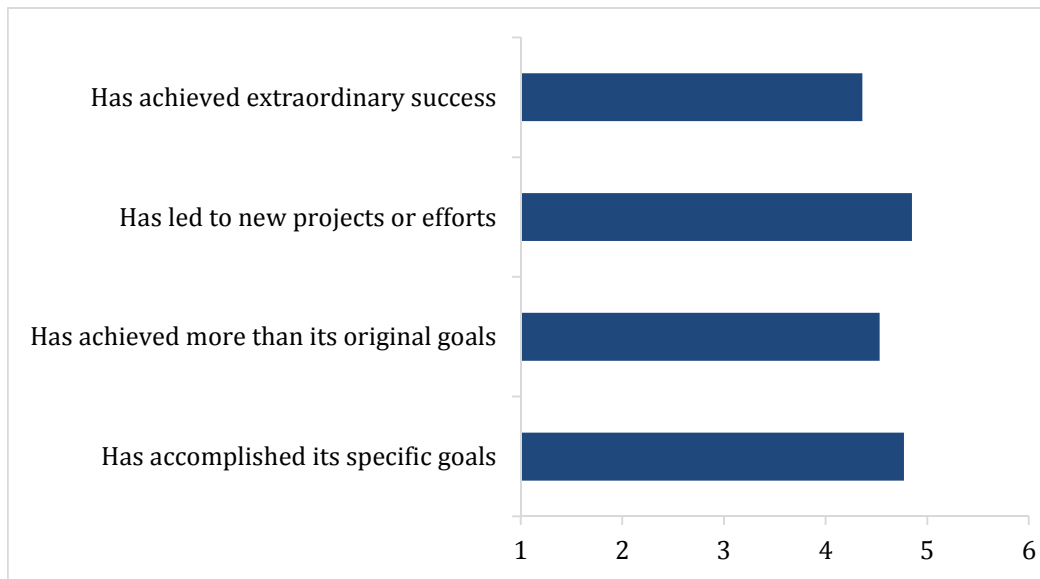
Note: Items are rated on a 6 point scale (1 = strongly disagree, 2 = disagree, 3 = disagree more than agree, 4 = agree more than disagree, 5 = agree, 6 = strongly agree). N = 276 respondents from 27 IOGs.

ii. Success of collaborative processes

IOG members also rated the extent to which their collaborative processes led to systems-level successes during the 2010-2011 fiscal year. As seen in Figure 3, on average, IOG members perceive a high level of general success, believing that their CMPs generally have accomplished or exceeded their yearly goals.

Additional evidence of collaborative effectiveness was gathered in annual reports, in which CMPs described significant successes realized as a result of their collaborative efforts during the 2010-2011 fiscal year. The most commonly mentioned areas of success (mentioned by more than five CMPs) appear in Table 6, along with examples of reported achievements in each area.

Figure 3. Item-level ratings of overall success of CMP during the FY2010-2011



Note: Items are rated on a 6 point scale (1 = strongly disagree, 2 = disagree, 3 = disagree more than agree, 4 = agree more than disagree, 5 = agree, 6 = strongly agree). N = 276 respondents from 27 IOGs.

Table 6. CMP-reported evidence of collaborative effectiveness

Areas of Collaborative Effectiveness	Example Achievements
Improved processes within the IOG	Establishment of subcommittees, leading to more efficient use of IOG meetings <ul style="list-style-type: none"> • a steering committee to oversee "day-to-day" operational activities • an outcomes committee to specify local evaluation measures and goals
	Full partner participation in strategic planning sessions
	Creation of youth advisory board
	Establishment of a "virtual voting" process within a rural IOG to increase active participation in decision-making
Development of new programs or enhancement of existing service delivery	Roll-out of new programs targeting areas such as pregnancy, mentoring, youth service learning
	Increases in the number of families receiving specific services
	Increases in the number of referrals, indicating greater community awareness of effectiveness of service delivery
	Decreased time between referral and enrollment in intervention services
Supporting sustainability	Funded successful grant writing efforts
	Blended or braided funding identified for specific services leading to more integration and streamlined services among partner agencies
	Establishment of process to grant seed funds to new programs

Positive community impacts as a result of CMP processes

CMPs were asked to reflect on “what has changed in your community since the initiation of CMP.”

*“One of the biggest impacts the CMP has had in [our county] is **increased communication** between agencies. The partner agencies are working more to collaborate, **share resources** and **reduce duplication of services**. As a small community, relationships already existed and have only been strengthened by their membership in the CMP...larger overarching issues get addressed...and specific plans to address areas of concern can more easily be collaborated upon...”*

*“There is **greater communication between the agencies**, namely the schools and DSS. In the past, there has been some contention between the two around who is responsible for helping this family and who will pay for it. For example, a youth would be truant, and instead of utilizing an RTI process, the school would punt the kid to DSS and ask them to file a D&N. This put the agencies at odds with each other. Because of the CMP, we are seeing systems beginning to recognize what is not working in their process and wanting to address it. Instead of pointing fingers, we’re having more conversations with a win/win attitude. **Youth are not being labeled as “Your Problem”, rather the community as a whole is embracing their needs collectively**. This is a tremendous step in the right direction. Trust is growing and systems realize no one is out to tear them down for their mistakes. Rather the IOG is here to help each other succeed for the best interest of the youth.”*

*“[Our] county’s Collaborative Management Program is embarking on its fifth year. Each year has shown **increased collaboration and effective service delivery** among youth-serving agencies as the model of collaboration supported by the CMP gradually has become more of a cultural norm within our community. The IOG anticipates that the CMP will continue to fine-tune its efforts and that its success will continue to grow.”*

*“Though agencies have always worked together, this effort has provided the resources (coordinator, funding for some services) that allow the agencies to step back and look into systems and know that there is a mechanism that will help solve issues that arise. **1451 has become a household word** among our agencies – people know what we are talking about when we say 1451. **Agencies know that 1451 is a good collaborative partner** in meeting the needs of high risk children and families.”*

*“Our county has experienced a **sense of unity and purpose** that is directly tied to the CMP. We are identifying weaknesses and feeling that **effective strategies will be found to solve local problems**.”*

iii. Challenges associated with CMP collaborative structures and processes

Taken together, the results above revealed that IOG members generally believe that they have established high-quality and effective collaborative partnerships. Despite these accomplishments, CMPs still struggle with some common issues. The most common challenges, along with strategies used to overcome them (if identified), include:

- *Participation and buy-in from partners.* Eight (8) CMPs cited difficulties obtaining buy-in from partners, both in CMP oversight and service delivery. Some of these CMPs indicated that engaging specific partners, such as schools, non-profits, and city government agencies, has been difficult. Others described situations in which IOG members agree upon a plan, but then may fail to communicate this to the specific staff members(s) responsible for implementation. CMPs indicated that they are working to address these issues by incorporating expectations about participation and internal communication into agency policies and county-level MOUs.
- *CMP staffing.* An equal number (8) of CMPs reported that inadequate staffing and turnover have impacted CMP administration and service delivery, citing difficulties resulting from the lack of a coordinator, ISST facilitator, or other staff. Some CMPs have contracted with private providers or agencies to address staffing needs.
- *Financial stability/sustainability.* Seven (7) CMPs specifically reported challenges associated with a general shortage of funding, largely attributed to the economic downturn. In order to address these challenges, CMPs indicated that they are undertaking additional efforts to obtain external funding.
- *Information sharing/confidentiality.* Barriers related to client-level information sharing were reported by six (6) CMPs. In most instances, CMPs described a lack of partner agreement regarding confidentiality requirements. Strategies intended to clarify these requirements include consultation with the Colorado Child and Youth Information Sharing Collaborative (CCYIS), as well as general discussion among partners.
- *Understanding and clarity of CMP mission.* Finally, three (3) CMPs cited difficulty ensuring clear and common understanding of collaborative goals, activities, and practices among partners. One factor contributing to this challenge appears to be turnover at the IOG-level, as well as at partner agencies. To address this challenge, some CMPs have conducted research on collaborative effectiveness, consulted with CMP coordinators in other communities, and held regular meetings to discuss these issues.

Overall, CMPs described their local collaborative structures and relationships as strong, and reported that joint efforts have led to significant improvements in service delivery systems and capacity to address community needs. Although CMPs continue to experience some barriers, they appear to be working together to identify solutions and innovations to overcome these.

D. Inclusion of the input, expertise, and active participation of parent or family advocacy organizations

The establishing legislation strongly encourages CMPs to engage parent or family advocacy groups to ensure that systems are responsive to the families they serve. Although the legislative language focuses on involvement of family representatives at the IOG level, the CMP State Steering Committee has encouraged CMPs to also incorporate family advocates and family members at the ISST level. A state family-driven organization, the Federation of Families for Children’s Mental Health, has been a strong proponent and facilitator of these efforts. Family representatives contribute unique perspectives not only to policy but also to the content and delivery of family services. For example, family representatives may identify potential challenges for families in service plans or policies, which can inform efforts to develop more integrated and streamlined processes that result in better family outcomes.

This section presents findings relating to family involvement in CMP activities, including strategies, evidence of effectiveness, and on-going barriers. We include information on the extent to which family and youth, as well as family advocates, are included in CMP activities and describe evidence of the effectiveness of family engagement strategies and common barriers encountered. This is reported at three levels:

- Involvement of family representatives in IOG efforts;
- Involvement of family representatives advocating for families in ISSTs; and
- Engagement of families in their own service delivery systems and processes.

i. Involvement of family representatives in IOG efforts

At the IOG level, family involvement is most readily reflected by the presence of family members, youth, and/or family representatives on the IOG itself. Table 7 below provides the number and proportion of CMPs reporting IOG members in each of these three categories.

Over 40% of CMPs reported at least one family member on their IOG, about 40% reported at least one family advocate, and about 20% reported at least one youth member.

Table 7. Family representation on IOGs

Number of Representatives on IOG	Number of CMPs Reporting		
	Family Member (%) (N=29)	Youth Member (%) (N=29)	Family Advocate (%) (N=29)
0	17 (59%)	23 (79%)	18 (62%)
1	8 (28%)	3 (10%)	5 (17%)
2	4 (14%)	2 (7%)	4 (14%)
3	0 (0%)	0 (0%)	1 (3%)
4	0 (0%)	0 (0%)	1 (3%)
5+	0 (0%)	1 (3%)	0 (0%)

The extent of family involvement in the IOG is reflected not only by the presence of these representatives but also in their role as a decision-maker. Only three (3) of the CMPs that do have family representatives on their IOGs include them as non-voting members.

**Local highlight:
IOG-level youth advisory boards**

Some CMPs described innovative strategies for including youth in CMP oversight activities. For example, one CMP reported the implementation of a Youth Advisory Board that works in collaboration with its IOG. The Board, which is comprised of 10 local youth, was established during the course of the 2010-2011 fiscal year and meets independently of the IOG, provides input on IOG activities, and votes on all official IOG issues.

ii. Involvement of family representatives advocating for families in ISSTs

Family involvement also occurs within service planning efforts on behalf of other families. Nearly half of CMPs (12 CMPs, 46%) reported that family members are always viewed as partners in service planning for other families, and the vast majority (85%) of CMPs reported that family members are seen in this way at least “sometimes.” While CMPs reported a significant degree of family member involvement for the benefit of other CMP families, few (22%) indicated that they have a process in place to support or mentor family members serving in this role. The six (6) CMPs that did report having such a process in place described the following types of support:

- orientation processes to clarify CMP mission and activities as well as the role of family partners;
- general supervision, coaching or mentoring provided by other CMP personnel; and
- assistance obtaining external training.

Less than half (42%) of CMPs employ paid or volunteer family advocates (also referred to as family systems navigators and family support partners) to work with families going through the ISST process.

Additional data were collected from CMPs this year to better understand the roles, training, background, and resource needs of family advocates; findings are summarized in the highlight box below.

Family Involvement Survey: Role of family advocates in service planning and delivery

Since 2007-2008, the Family Voice and Choice Committee (FV&C) has been collecting data about CMP family involvement. Previous years' data collection centered on family involvement at the IOG-level whereas this year's efforts focused on learning about family advocacy activities. Surveys were designed in partnership with the FV&C Committee, OMNI, and Dr. Donna Heretick, a family engagement researcher at Walden University, and administered in the spring of 2011. Twenty-four coordinators and 42 individuals serving in a family advocacy role completed surveys. Highlighted findings are as follows:

- Of 24 total coordinator survey participants, 42% (13) reported having family advocates involved in ISSTs.
- The majority of CMPs with family advocates reported that they are paid, most often by the local DHS, and about one-third (36%) devote more than 20 hours per week to this work.
- CMP family advocates reported a variety of roles and responsibilities, the most common of which were participating in IOG meetings; consulting with families about on-going issues; referring families to local services and supports; and assisting in family-level program or service design.
- Over half (55%) of advocates reported caseloads of 10 or less, and about one-third reported larger caseloads of anywhere between 11-30 families.
- Family advocate training most frequently involves informal and formal agency-based training, specialized workshops; and information-sharing among practitioners, both on- and off-the-job.
- When asked to describe the greatest challenges or resource needs for enhancing family advocacy work, the most common responses included:
 - Training on professional roles and responsibilities for Family Advocates (e.g., confidentiality protocols, communication practices);
 - Support and development of Family Advocates with personal experience with the CMP, namely previous CMP clients;
 - Development of a hiring manual and formal policies/procedures about Family Advocates for CMPs; and
 - Additional funding for advocate positions and associated costs.

iii. Engagement of families in their own service delivery systems and processes

A core value of the CMP initiative is meaningful involvement of family members in developing their own service plans. In general, CMPs reported a substantial degree of family engagement in explored areas including the timing of first contact with the family, ISST participation by a primary caregiver, and the frequency with which important decisions are made with the family present.

The majority (63%, 17 CMPs) of CMPs indicated involving families immediately after being determined eligible for ISST services and nearly one-third (30%, 8 CMPs) reported that families are first contacted prior to a decision regarding ISST eligibility. As shown in Table 8, nearly all CMPs (96%) reported that primary caregivers participate in the ISST either frequently or always; the majority (77%) reported that important decisions about services are rarely or never made without the family present; and the vast majority (89%) reported that the family frequently or always participates in the process of developing and writing service plans, and is then given a copy of that plan (93%).

Table 8. ISST-level family involvement practices

Frequency	Number of CMPs Reporting (%)				
	At Least One Primary Caregiver Participates on ISST (n=27)	Family, Friend, Advocate Other than Family on ISST (n=27)	Important Decisions Made Without Child or Family Present (n=26)	Family Participates in ISST Service Planning (n=27)	Family Given a Copy of ISST Plan (n=27)
Always	19 (70%)	6 (22%)	1 (4%)	19 (70%)	21 (78%)
Frequently	7 (26%)	6 (22%)	0 (0%)	5 (19%)	4 (15%)
Sometimes	0 (0%)	11 (41%)	5 (19%)	2 (7%)	2 (7%)
Rarely	1 (4%)	3 (11%)	11 (42%)	1 (4%)	0 (0%)
Never	0 (0%)	1 (4%)	9 (35%)	0 (0%)	0 (0%)

iv. Effectiveness of family involvement in CMP

To a large degree, the measure of effectiveness of this legislative goal is reflected by the numbers of CMPs with family members involved in IOGs and ISSTs, as well as the extent to which CMPs report that these members are valued as active partners in CMP service delivery. The findings presented above suggest that projects are making strides in this area, with approximately two-thirds of CMPs reporting active participation of family representatives in their IOGs and almost all CMPs indicating active involvement of families in ISST meetings. Additionally, some CMP stakeholders specifically highlighted achievements around family involvement, with one reporting that *“agencies are beginning to let go of certain agendas with youth and families and processing with the families to decide*

what they want to work on” and another that “systems [are] understanding families better, which creates better plans and outcomes based on the families` strengths and culture. More individualized goals and plans create better success.”

Some, but not all
CMPs (59%),
reported that they
have a structured or
formal on-going
process to gather
additional evidence
of effectiveness in
family involvement.
These CMPs most
commonly described
the collection of
family satisfaction

Local evaluation of family involvement efforts

Three sites highlighted information obtained via efforts to evaluate their family involvement efforts:

“The vast majority of families that have completed the survey feel that their voices were heard, their concerns and needs considered, and their children’s needs met through the CMP.”

“We have realized that when more family members are involved in the ISST process, they are more engaged in the process, the targeted youth is more supported and confident in the meeting, and they are more likely to continue to engage in follow up [ISST] conferences.”

“Family/youth post service surveys indicate families feel they were an equal part of the process, that the process was respectful, and that their perspectives were prioritized.”

surveys (69%), followed by tracking family participation in ISST meetings (63%), and tracking family representative participation in IOG meetings (38%). Some of the learnings from these efforts are highlighted above.

Further, many CMPs provided anecdotal evidence of the effectiveness of their efforts in this area via stories of how family engagement led directly to improvements in service delivery and positive outcomes for children and families. Some of these stories are shared on the following page.

Case examples of effective family involvement

“The [ISST] met with the child and family to discuss ways we could support the child to maintain an educational setting, in the delinquency system and at home. The family requested day treatment services, coaching (mentoring) services and in home therapy. [The ISST] funded all three services and continued to meet with the family on a monthly basis to address any concerns and help the family accomplish their identified goals. The child is now on a reduced school schedule and is getting homebound services through the school district. The family and child have successfully completed their in home family therapy program and the youth has not gotten any new charges since January of this year. DHS has closed their case as there are no longer any beyond control of parent issues.”

One CMP-served family “mentioned that they appreciated the fact we listened to them and helped them brainstorm ideas versus telling them what they should do. Using [the ISST], the Facilitator was able to coordinate with the school to let them know that the daughter was on new medication, the father received counseling through our mental health partner, and the family worked through the [ISST] process. School reports the daughter is doing much better in school; and dad is stable on his medication and continues with counseling, and the parents continue to co-parent the children.”

v. Challenges to family involvement

While the initiative has seen notable growth in the degree of family involvement overall, CMPs also identified a number of barriers believed to limit effective engagement of families. As illustrated in Table 9 below, the most frequently cited barrier was identifying families appropriate for IOG participation (64%), followed by a lack of family knowledge or experience about CMP processes and confidentiality concerns (39%; see Table 9).

Table 9. CMP-reported barriers to family involvement

Barrier Description (N=29)	Number of CMPs Reporting (%)
Issues identifying appropriate families for IOG participation	18 (64%)
Confidentiality issues	11 (39%)
Lack of knowledge/experience of family or youth recruited about CMP processes	11 (39%)
Time constraints/scheduling	7 (25%)
Lack of commitment among recruited youth and families	6 (21%)
Lack of funding to compensate family and youth members	6 (21%)
Geography/distance	3 (11%)
Personnel turnover	1 (4%)
Other barriers	7 (25%)

Note: Totals sum to greater than 29 CMPs and 100% because CMPs could select up to 3 barriers.

CMPs described a variety of approaches to address these barriers. Select strategies are listed below and illustrate the wide range of methods being used to foster family involvement statewide:

- *Recruitment/retention.* Some CMPs described strategies focused on the recruitment of family members and representatives with appropriate knowledge of and experience with the CMP, including outreach to graduates from local programs, as well as providing financial compensation to family representatives in recognition of their contributions.
- *Training and development.* CMPs also described efforts to secure and provide financial support to enable family representatives to attend trainings deemed relevant to their roles and responsibilities within the IOG.
- *Planning.* Finally, some CMPs described strategies intended to formalize their focus on family involvement, including the creation of a Youth Advisory Council, which informs IOG processes and decision-making, as well as the development of formal planning of efforts to increase family involvement.

In summary, the 31 counties participating in the CMP initiative have addressed this legislative goal to promote greater uniformity in the systems serving Colorado families, children, and youth, by implementing specified organizational structures, such as IOGs and ISSTs, and processes such as family involvement, necessary to implement a system of collaborative management. Although legislation has set some common standards for CMPs, there has been considerable leeway for local sites to adapt their structures and processes. The evaluation revealed that IOGs across the state share similar prioritized goals, but set up diverse structures and activities to achieve goals (e.g., in terms of the membership and operations of their IOGs, ISSTs, and staffing). Overall, sites perceive their local collaborative structures and relationships to be strong and effectively resulting in improvements in their service delivery systems and capacity to address community needs. In particular, CMPs described significant progress toward increased and meaningful family involvement at all levels. Although CMPs continue to experience some barriers, they reported active efforts to continue to learn from and build upon their successes, as well as specific strategies intended to address barriers encountered to date.

Legislative Goal II: Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi-agency services.

The second legislative goal of the Collaborative Management Program is to integrate multi-agency services for families and children, such that the duplication and fragmentation in service delivery is reduced or eliminated. Service duplication refers to situations where families receive the same services from multiple agencies. Fragmentation reflects the condition of uncoordinated, conflicting, or unrelated service provision when these services are not managed or coordinated across agencies. Both issues can be addressed, at least in part, through the provision of interagency planning and service management efforts. Such efforts can result in the alignment of requirements for families, easing of multi-agency navigation, and the creation of cost efficiencies by eliminating unnecessary duplication of services.

CMPs report implementing a variety of strategies designed to impact duplication and fragmentation of service delivery. These include: a) coordination of client consents and assessments; b) integrated service planning; c) arranging payment for and provision of services; and d) information sharing across agencies. Activities in each of these areas are outlined below, followed by a discussion of their perceived effectiveness, and related barriers. Data about the strategies by which CMPs have worked to address both duplication and fragmentation were drawn from mid-year and annual reports and survey data on collaborative effectiveness.

A. Coordination of client consents and assessment

Project coordinators were asked whether they use common processes and data collection forms to obtain client consents and assessment information. A majority (74%) of CMPs use a common consent form that is shared across all agencies, meaning that the individual or family need sign only one consent form. Most often, this common release occurs at the ISST and enables the sharing of client-level information across all agencies involved in a given case. However, three (3) CMPs indicated that not all partner agencies are included as some agencies require additional consent from youth or families, and others elect not to use the common form. Two (2) CMPs indicated that, while they do have a common consent, individual youth or families are allowed to specify which agencies may and may not have access to their information or to revoke their consent at any time.

About half of CMPs (14) reported having a common client assessment form and process that is shared across agencies. While the specific form varies, the most common

assessments are those used within the juvenile justice system [e.g., Colorado Juvenile Risk Assessment (CJRA), Massachusetts Youth Screening Instrument (MAYSI)]. Some of these assessments are extensive (e.g., CJRA) and have been widely adopted or are required by multiple programs in Colorado (e.g., SB94, diversion programs); thus, sharing assessment data reduces duplication in provider and family time and effort. One CMP described the expected relationship between its common client assessment and efforts to reduce duplication and fragmentation in the following way: [all clients served by the ISST process] *“engage in a comprehensive assessment process. The information collected...is documented by the ISST’s coordinator and shared with all agencies who participate on the ISST in order to help avoid duplication of services and ensure the continuity of provided services.”*

B. Integration of service delivery planning

Another component of coordinated service planning and delivery is the development of an integrated service plan. The legislation requires ISSTs to develop service delivery plans for each staffed youth and/or family. While the structure of these plans is not dictated, the larger goals of the initiative (i.e., to foster integrated and appropriate service delivery, to reduce duplication and eliminate fragmentation of services) would suggest that a single, individualized plan be developed. CMPs were asked to describe the degree to which their ISST plans possess these two key characteristics and reported the following:

CMP impact on service planning and delivery

One CMP reported that *“initiating the CMP...has shifted the perspective of partnering organizations to that of a more collaborative focus on providing those services. As we develop and fully implement our ISST procedures, there will be a more evident impact on the actual delivery of direct services.”*

- All service plans developed during ISST processes are individualized at some level, with the majority (78%) indicating that plans are individualized to the *family* being served, and 22% indicating that plans are individualized to the *youth* being served.
- Additionally, nearly all (92.5%) of CMPs reported that ISST service plans are integrated. However, only half of these (13) indicated that a singular, integrated service plan is developed and shared among providers. Some sites described that partnering agencies agree upon service components yet create multiple (i.e., agency-specific) plans. While these plans may reflect some integration of services, the presence of a single, agreed-upon plan may signal to families a greater commitment among all agencies to true coordination and shared responsibility of services.

C. Coordination of payment for and provision of services to CMP youth

CMPs described strategies by which responsibility for costs and/or delivery of services to youth and families are shared among partner agencies. Over 80% of CMPs share the costs

of service delivery on a case-by-case basis, with individual agencies designated to pay for particular components of each individual service plan. Very few (7%) CMPs reported having a shared, general fund, from which services are paid.

CMPs also described the frequency with which partner agencies are expressly designated to either pay for and/or deliver services to the youth or families they serve. Nearly all sites indicated designating a specific agency with each of these responsibilities either often or always (see Table 10 below). Processes such as these serve to clarify agencies' roles in service delivery and may be viewed as indicators of collaboration and more efficient service delivery.

Table 10. CMP designation of agency service responsibilities

Frequency	Number of CMPs (%) (N=27)			
	Agency(ies) are designated to pay for services		Agency(ies) are designated to provide services	
Always	10	(37%)	19	(70%)
Often	15	(56%)	7	(26%)
Sometimes	1	(4%)	1	(4%)
Rarely	1	(4%)	0	(0%)
Never	0	(0%)	0	(0%)

CMPs also target conflicting mandates or treatment requirements across partner agencies in order to reduce duplication and fragmentation in their local systems. All 29 CMPs reported some reduction in this area and over half of the CMPs (15) indicated reducing duplication and fragmentation “a lot,” through efforts such as clarifying and simplifying policies and reducing conflicting requirements. An example reflected in a CMP MOU states that *“When an existing [ISST] case exists and placement decision is required, the discussion and decision will occur within the [ISST] meeting and will not also go through the [established local DHS placement team] process.”* This type of agreement streamlines processes and decision-making to better serve families in the county.

D. Information sharing practices

The creation of systems that facilitate the sharing of client data and related information across agencies represents another strategy that supports inter-agency coordination and service integration. Allowing staff from multiple systems to access a common set of client-level data creates opportunities to identify and address instances of service duplication and/or fragmentation. Some CMPs reported having established such systems both for the

purposes of sharing information generally, and for sharing information specifically about individual youth or families served by the collaborative. Each of the strategies listed in Table 11 (below) represent a method CMPs use to enhance more systematic access to data about collaborative activities and services provided to clients.

Table 11. CMP information sharing strategies

Information Sharing Strategy (n=28)	Number of CMPs Reporting (%)
Formal data sharing agreement in place.	13 (46%)
Cross-agency access to data for service delivery.	9 (32%)
Cross-agency access to data for measurement/ evaluation.	6 (21%)

The existence of a formal data sharing agreement indicates that, to some degree, CMP partners have been able to articulate and formally document their expectations of one another with respect to the handling and sharing of data about the collaborative and its clients. While thirteen (13) CMPs indicated having formal data sharing agreements in place, the degree of specificity, detail and breadth of these agreements varies significantly across these sites. In most instances, it appears that the agreements referenced by projects are embedded in other documents, such as releases of information or CMP Memoranda of Understanding with the state, that address a range of issues beyond data sharing. These materials do not typically address cross-agency data sharing with the degree of detail appropriate for sharing sensitive client-level information across CMP partners.

As shown in the table above, nine (9) CMPs indicated that they provide cross-agency access to data for purposes of service delivery. For example, one CMP reported that “*sharing information across agencies has been invaluable. We often are dealing with the same families and have no idea that they are asking for services from other agencies.*” Again, the structure and formality of these processes varies. In general, these processes rely on existing databases, maintained either by a local agency partner or a state-level agency. Most frequently, cross-agency data access is provided for specific individuals associated with the CMP (e.g., the CMP Coordinator or ISST staff) and for select data systems, most often Trails. Further, most CMPs described cross-agency access between two, rather than all, partner agencies.

Local highlight: Crossover Youth Practice Model

One CMP is implementing the Georgetown University Center for Juvenile Justice Reform Crossover Youth Practice Model, which it cites as a key approach in its efforts to reduce duplication and fragmentation. Specifically, the CMP reported that *“the Crossover Youth Practice Model is used to identify youth involved in the Child Welfare system as soon as they are arrested and screened by SB94. More formalized joint planning is conducted by the Juvenile Justice system and the Child Welfare system. Diversion also addresses Crossover cases and works to not duplicate expectations. The Court has been using the...ISST to assist in the development of management plans when youth are deemed incompetent. One ISST has increased the number of truancy youth staffed in order to reduce unnecessary referrals to [the Department of Human Services] when services can be provided by partner agencies or barriers can be problem-solved creatively with the family and assistance provided.”*

Per the Center website, the Crossover Youth Practice Model brings together research and practice learning about strategies to serve youth engaged in both the child welfare and juvenile justice systems. Consistent the CMP principles, the model emphasizes *“the following practices: the creation of a process for identifying crossover youth at the point of crossing over, ensuring that workers are exchanging information in a timely manner, including families in all decision-making aspects of the case...and maximizing the services utilized by each system to prevent crossover from occurring.”*

[\(<http://cjjr.georgetown.edu/pm/practicemodel.html>\)](http://cjjr.georgetown.edu/pm/practicemodel.html)

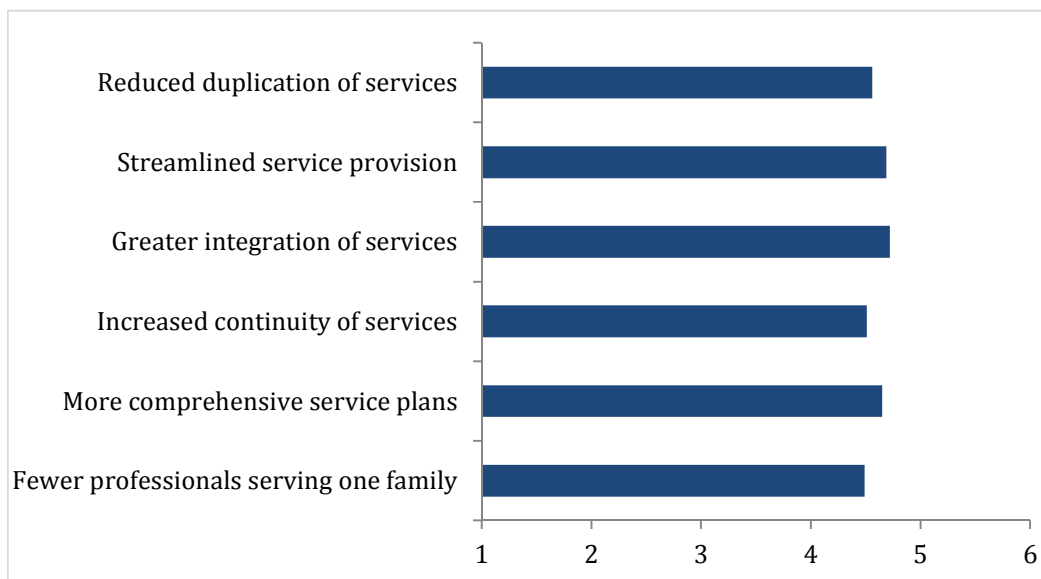
CMPs also described the systems and data they use to support program evaluation and measurement. These efforts and related data are likely to help support the assessment of performance and the identification of opportunities for improvement. Only about one-fifth of CMPs (6) reported processes that support cross-agency information sharing for this purpose. However, on-going work by the SSC and infrastructure developed as part of the statewide evaluation have created significant opportunities to expand the tracking and sharing of data to measure CMP performance, as discussed further in the description of the statewide measurement plan (page 55).

Finally, nearly all CMPs (27) reported informal methods of data and information sharing, such as telephone or email communication. While these methods play an important role in coordinated service planning and delivery, they may be insufficient to support all CMP data and information sharing needs, particularly given the complex and fast-paced nature of CMP work.

E. Effectiveness of CMPs in reducing duplication and eliminating fragmentation

The *Collaborative Success Survey* (see link to additional information in Appendix B) included multiple items to assess the effectiveness of CMP efforts to reduce both duplication and fragmentation. Survey data indicate that IOG members perceive their CMP collaborative to have led to reductions in duplication and fragmentation across all measurement areas, as shown in Figure 4. IOG members assigned an average rating of 4.5 or higher on each item, indicating high perceived success in streamlining and integrating services, and providing more comprehensive services that are delivered by fewer professionals, thus reducing duplication.

Figure 4. Effectiveness of efforts to reduce duplication and fragmentation



Note: Items are rated on a 6 point scale (1 = strongly disagree, 2 = disagree, 3 = disagree more than agree, 4 = agree more than disagree, 5 = agree, 6 = strongly agree).

F. Challenges associated with duplication and fragmentation

Despite progress toward reducing service duplication and fragmentation, many CMPs reported significant barriers that impede advancement in this area. First, some CMPs expressed frustration about the lack of connection between different state-level databases, such as Trails and Eclipse. Because client-level records cannot easily be linked across these databases, CMP and partner agency staff may struggle to obtain complete information about youth being served across systems. CMPs indicated that establishing connections across these databases could enable them to more effectively identify youth appropriate for CMP services, as well as assess instances in which integrated planning might be beneficial. CMPs also cited difficulties accessing data in specific systems (e.g., those maintained by

schools and private providers) and ensuring access to existing data for individual personnel (e.g., enabling ISST facilitators to access Trails data). Second, many CMPs described barriers around information sharing and confidentiality, specifically noting challenges in developing a common release of information that meets all federal and state laws as well as the policies of individual partner agencies. Finally, some CMPs indicated that the economic downturn has limited the resources available to support information sharing and resulted in staff turnover in partner agencies.

Whereas significant progress had been made by CMPs to reduce duplication and fragmentation of services across their local systems, further opportunities exist to target this legislative goal. Current strategies include development of shared forms and integrated service delivery plans, information and data sharing practices, and jointly-determined division of responsibilities for payment and service provision. Securing shared access to key data sources across agencies remains an important area for continued work at the local as well as state level in order to ensure integrated planning can occur. In addition, it will be important moving forward for all CMPs to develop multi-agency consent forms, if these are not already in place, as part of broad service management efforts as well as to ensure that client-level information can be shared across CMP partners. Finally, development of a singular, integrated service plan that can be shared among providers is another area for continued exploration in order to target reductions in duplication and fragmentation of services for multi-system families.

Legislative Goal III: Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services.

The third legislative goal of the initiative is to improve services provided to families engaged with multiple agencies. In response, CMPs have developed and implemented a number of strategies that are designed to impact service quality, appropriateness, and effectiveness for multi-system families. This section examines some specific approaches, including the use of evidence-based or evidence-informed models, and strategies to identify existing service gaps. We conclude the section with a discussion of the evidence of perceived effectiveness in this area. Data and information presented throughout this section were drawn from CMP annual reports and survey data on collaborative effectiveness from the 2010-2011 fiscal year.

A. Service quality

Year one evaluation findings indicated that stakeholders, by and large, believe that local CMPs had improved the quality and delivery of locally provided services. In the second year, CMPs continued to make progress in this area with 17 citing improvements in service quality as a primary success this year. Specifically, IOGs have undertaken efforts to establish or refine their ISST models, introduce new programs, focus efforts toward identified target populations, ensure early case contact, and provide ongoing monitoring and follow-up with families.

Within the ISST structure, CMPs have addressed service quality through the implementation of evidence-based, or evidence-informed (i.e., a federal agency is reviewing the evidence to determine if the program can be designated as evidence-based) service models. Year one evaluation results indicated that High Fidelity Wraparound^{viii} and Team/Family Decision Making^{ix} were two commonly implemented models. This year, CMPs were asked to provide additional information about their chosen evidence-based or evidenced-informed models.

CMP effect on services for youth and families

“Historically, small rural communities have had to rely on collaboration to make limited funding go a long way. By formalizing the process and adding funding, it has allowed many more services to stay in place that would have been eliminated due to the economic climate. These services are absolutely critical in low socio-economic areas where needy families are a large portion of the population.”

The CMP has led to “a focus on EBPs [Evidence-based Programs] as a system and starting to create a common language on what we are about and what we want to accomplish.”

The Wraparound model continues to be one of the most commonly implemented evidence-based ISST approaches (reported by 20 CMPs) and is demonstrated effective in integrating service delivery and enhancing quality. Table 12 reflects the number and proportion of CMPs reporting the use of a Wraparound model, including whether they implemented High Fidelity Wraparound; whether their Wraparound model is offered to all or only select CMP youth or families; and whether they collect evaluative information reflecting the degree of implementation fidelity.

Table 12. CMP use of the wraparound model in service delivery

Wraparound Practices	Number of CMPs (%)	
CMPs Using Wraparound (n=27)	20	(74%)
CMPs Using High Fidelity Wraparound (n=20)	7	(35%)
CMPs Offering Wraparound to All Children (n=20)	14	(70%)
CMPs Collecting Data on Wraparound Implementation Quality (n=20)	7	(35%)

As noted above, the majority (74%) of CMPs reported using a Wraparound model, with about a third (35%) of those using the more highly structured High Fidelity Wraparound model. The majority (70%) of CMPs offering Wraparound do so for all youth or families served. In general, the six (6) CMPs not offering Wraparound to all youth or families indicated that they select youth or families for Wraparound based on the complexity of the case, with more complex cases receiving priority. While widespread use of a Wraparound model reflects positively on the quality of service provision, it is noteworthy that only about one-third (35%) of these counties track data on the quality of their implementation efforts (i.e., fidelity).

Community needs and the use of evidence-based services

“As a result of the CMP there has been a formal venue for IOG member agencies to meet, discuss issues and make collaborative plans to address issues related to children, youth and families who are high risk of increased involvement with the IOG member agencies. This coordination has also led to a dedication to collaboration that extends beyond the IOG and into the other arenas that our agencies intersect. There have been more protocols established that encourage collaboration and multi-agency assessment. The collaborative approach has also led to assessing community needs and developing programming and services to meet the needs of children, youth, and families that is evidence-based or evidence informed.”

Additionally, nineteen (19) CMPs reported the use of other evidence-informed programs and practices, and two (2) reported that use of such programs is a priority for the future. When they do not serve as the main ISST model, evidence-based or evidence-informed programs are frequently offered through one of the IOG partner agencies to families who

have participated in the ISST process (i.e., as a suggested intervention emerging from the integrated plan). Consistent with findings from last year, CMPs highlighted the use of nationally recognized preventive interventions such as Multi-Systemic Therapy^x or Functional Family Therapy^{xi}, while others implement prevention-focused programs such as Life Skills Training^{xii} or the Incredible Years curriculum.^{xiii}

B. Appropriateness of services

Appropriateness of services refers to the fit between the services provided and the individual family being served. Services can fail to be appropriate when they do not consider the full range of family circumstances or account for family interactions with other agencies and potentially competing demands. Meaningful efforts in the areas of family engagement, treatment matching, and service coordination have been shown in research to increase rates of treatment completion and to improve outcomes.^{xiv}

As described in the year one evaluation report, the adoption of ISSTs is a central strategy for promoting appropriateness of service delivery within a CMP, particularly when the ISST successfully engages families in intervention planning and service selection efforts. This year, CMPs were asked to further describe efforts to ensure the appropriateness of services for the youth and families they serve. Table 13 below presents a list of key strategies by which service appropriateness might be assessed and enhanced, along with the number and proportion of CMPs reporting each.

Table 13. CMP strategies to enhance appropriateness of services

Strategy	Number of CMPs (%)	
Identified service area that is currently not being addressed through informal needs assessment with CMP partners (n=27)	24	(89%)
Identified service area that is currently not being addressed through formal needs assessment with CMP partners (n=27)	16	(59%)
Implemented a new program or model that specifically targets the population and service need/gap that was identified by IOG (n=27)	20	(74%)
Implemented or enhanced services to be more culturally appropriate/culturally competent (n=27)	11	(41%)
Other (n=25)	5	(20%)

As reflected above, the vast majority (24; 89%) indicated using informal needs assessments, such as discussions of existing service gaps, as a means to ensuring service appropriateness. The next most common strategy, reported by 20 CMPs, was the implementation of new programs or models that are intended to fill an identified service gap. Specific programs vary among CMPs but included the creation of a new ISST, a new mentoring program, enhanced case management, and a young parent support group.

A different area of focus reflected efforts to improve the cultural fit of services to identified families. Eleven CMPs reported working toward improvements in this area and example strategies included utilization of translation services, support of local groups focused on cultural competency, and the provision of cultural competency trainings to staff, each of which was reported by 3 CMPs.

Case examples of efforts to enhance appropriateness of services

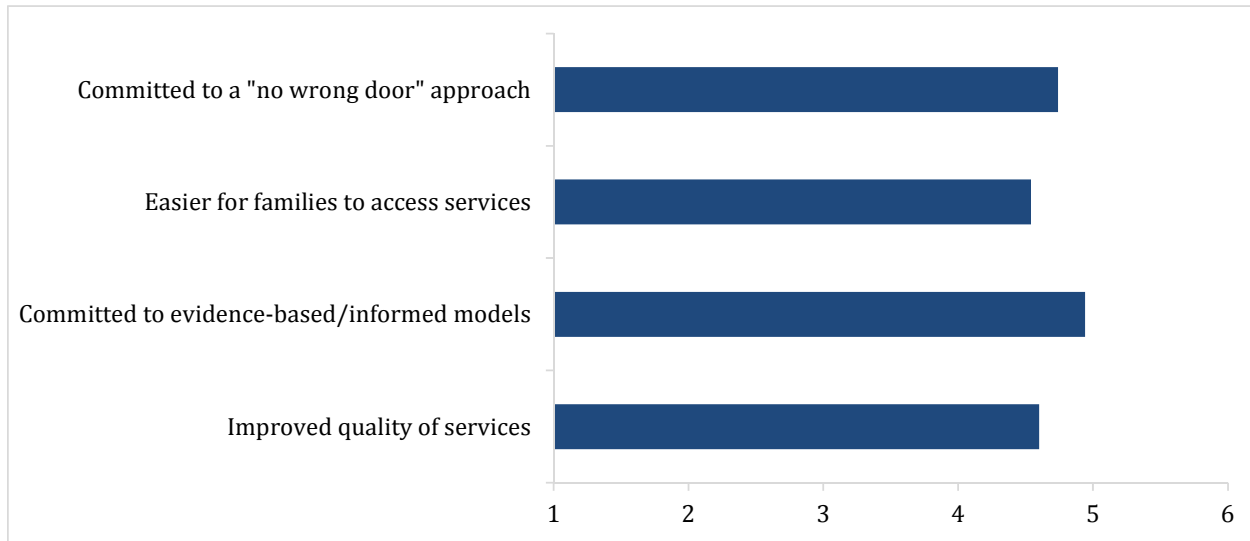
One CMP reported the recent completion of “a two-year review of the continuum of services, including quantitative and qualitative assessments, and a comprehensive and inclusive collaborative process. This resulted in the development of a new continuum of services model that will be implemented over the next 2-3 years.”

“[The CMP uses] a three-tiered model where each tier represents the level of referred client/family risk and then match that to the appropriate model, level of service, and funding allocation. The idea is to improve the appropriateness of services and to not flood low risk families with too many services and ensure we are using our incentive funding in the most appropriate manner.”

C. Effectiveness of services

The *Collaborative Success Survey*, described earlier (see Appendix B for further information), included a series of items related to service quality including commitment to the use of evidence-based or evidence-informed models, improvements in service quality within individual partner agencies, and ease of access to services. As shown in Figure 5, respondents reported that CMP implementation has had a positive effect on the overall quality of services provided to families, assigning an average rating of greater than 4.5 on a six-point scale on each of these items.

Figure 5. Effectiveness of efforts to enhance service quality and appropriateness



Note: Items are rated on a 6 point scale (1 = strongly disagree, 2 = disagree, 3 = disagree more than agree, 4 = agree more than disagree, 5 = agree, 6 = strongly agree).

CMPs continue to implement strategies focused on the identification and implementation of services meeting high standards of quality, while also ensuring that those services are well matched to the strengths and needs of the youth and families being served. Additionally, the SSC and CMP portal provide on-going opportunities for CMPs to learn about evidence-based programs being implemented throughout the state, as well as the strategies other communities are using to ensure the quality, appropriateness, and effectiveness of their services. Nonetheless, it will be valuable for CMP stakeholders to explore other services and programs that may be well-aligned with CMP goals. To that end, evaluation activities in year three will include continued efforts to identify best practices related to both collaboration and service delivery, drawing upon the extant research literature, as well as CMP practice to date.

Legislative Goal IV: Encourage cost sharing among service providers that leads to cost-reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado

The collaborative management approach assumes that decreases in service duplication combined with efforts to prevent deeper and more costly involvement in various social service systems will lead to better family outcomes and net cost-savings over time. In fact, research demonstrates that costs are driven higher by poorly coordinated delivery efforts.^{xv} The development of interagency processes that successfully integrate service delivery should reduce the need for, and the costs of, duplicated care.

This section outlines CMPs' approaches to cost- and resource-sharing, and reported perceptions of success. We first explore the extent to which sites allocate and share resources to support CMP operations and administrative needs; pay for existing and new services; and ensure sustainability of programs. We then examine reported cost savings and re-investment of funds. The section concludes with a discussion of the challenges related to cost-benefit analysis and the infrastructure necessary to specify cost models across the CMP initiative. Data presented in this section were derived from 2010-2011 fiscal year annual reports.

A. Cost-sharing approaches

The management of funds and the development of effective processes to share operational and service delivery costs among agency partners are core activities of IOGs. Although one partner agency typically serves as the fiscal agent (this is the local DHS in 69% of CMPs), allocation decisions are most often made collaboratively, by the IOG (72%) or an IOG subcommittee (24%). Specific methods of cost-sharing are described below and summarized below in Table 14.

Cost-sharing: Use of blended and braided funds

"[Our CMP] continues to increase the frequency of blended/braided funding for the purchase of specifically identified services for youth/families which has increased effectiveness of the integrated plans for clients, as well as increased the strategic use of multiple funding streams, and reducing fragmentation of services between agencies. It has also elevated some discussions and informal agreements around who pays for what and when as it relates to a systemic approach rather than agency-specific. There is increased cooperation on projects between partner agencies when it comes to the pursuit or involvement in grants, which has also supported more cross-system training of staff in certain areas."

i. Sharing costs of CMP operations

Sites reported that IOG partners “frequently” or “always” jointly paid for staffing and administrative costs (25 and 20 CMPs, respectively). This often is achieved through pooling funds to support salaries of IOG coordinators or program personnel, and contributing in-kind resources such as office space and trainings. Partner agencies also frequently share funding in order to develop new programs, thus expanding service capacity.

Table 14. Cost sharing among CMP partners

Frequency	Extent to Which CMP Partners Share Costs Number of CMPs (%)					
	Staffing Costs (n=26)		Administrative Costs (n=27)		Costs of New Programs (n=27)	
Always	12	(46%)	8	(30%)	3	(11%)
Frequently	13	(50%)	12	(44%)	11	(41%)
Sometimes	1	(4%)	6	(22%)	10	(37%)
Rarely	0	(0%)	1	(4%)	1	(4%)
Never	0	(0%)	0	(0%)	2	(7%)

ii. Sharing costs of services

CMPs emphasized that cost- and resource-sharing is an integral part of the ISST process. As noted earlier, the majority of CMPs indicated that during ISST meetings, agencies jointly agree on who will pay for services proposed in the intervention plan. Agencies may agree to share the cost of an expensive service, or negotiate to have each agency pay for separate services. As a complement to these cost-sharing processes, some CMPs allocate portions of their yearly incentive funding to pay for intervention services. The seventeen (17) CMPs with available data reported spending nearly \$714,000 on services provided directly to children or families, which represented 29% of their 2010-11 fiscal year incentive funds.

iii. Ensuring sustainability of services

Many CMPs are working to expand funding and promote program sustainability. To achieve this, IOG partner agencies often share grant writing resources in pursuit of external grant opportunities. In the 2010-2011 fiscal year, 10 of the 29 CMPs (34%) reported receiving competitive funds from federal agencies, state agencies and block grants, and private foundations (see Appendix C for detailed information). Together, these efforts garnered at least \$1,084,776 in additional funding.³ CMPs often are successful in these endeavors because of their strong collaborative relationships. The existing partnerships are attractive to funders because the foundation needed for effective implementation is

³ This total is underestimated due to missing data on total amounts received.

already present. The infrastructure built by the CMP initiative is recognized as being a key mechanism to implement programming across Colorado. For example, CMP communities are a focus of a statewide planning initiative to ensure that counties embrace the Systems of Care approach to serving children and families with serious emotional disturbances.

B. Cost reductions, potential cost savings, and reinvestment of funds

An underlying assumption of the initiative is that collaborative efforts will lead to cost reductions and thus cost savings, which may be re-invested in local CMP activities. However, precise measurement of these cost components is difficult, as it requires a calculated estimate of the potential costs for a given individual or family had CMP efforts not been provided. While outcomes may be improved, it is difficult to determine whether these were achieved at lower cost. Moreover the lack of standardized outcomes and measurement protocols across projects, as evidenced in the first two years of the evaluation, prevents the assignment of potential savings estimates.

In the 2010-2011 fiscal year, only three CMPs reported having a formal process to measure actual cost savings. Twelve (12) provided rough estimates of savings based upon their perceptions of the extent to which services may have led to reductions in the number of children, and the amount of time spent in out-of-home placements, including foster care, therapeutic residential and psychiatric care, and commitment and detention. These twelve CMPs reported a total of \$5.9 million of savings that were reinvested in CMP efforts.

CMPs described other sources of perceived cost reductions, but were unable to quantify the associated cost savings. These include:

- Fewer families entering the child welfare system
- Reductions in truancy rates (leading to presumed lower costs in education, child welfare, and juvenile justice programs, and increased revenues for schools)
- Reductions in the length of mental health treatment and inpatient stays
- Improvements in coordination and access to needed care and funding sources such as Medicaid and CHP+
- Successful prevention of costly services through targeted programs, including pregnancy prevention.

A recommendation from the year one evaluation was to work toward methods to track costs of CMP services more systematically. In the current year, CMPs based estimates of an ISST staffing on time spent by providers in an average meeting. Among the 21 CMPs that responded to this item, the average cost was \$323, with a range of \$110 to \$800. The large range of estimated service costs is to be expected, given the diversity of ISST models and services. That is, some CMPs structure their ISSTs such that brief, frequent meetings with smaller numbers of participating providers are held, while others may hold one long initial ISST planning meeting with a larger numbers of providers. Some sites indicated that it was difficult or unworkable to calculate a meaningful average cost, given that their service planning meetings are adapted to the need of each family.

Local highlight: Measurement of cost reductions

One CMP estimates cost savings using a pre- and post- service design. They collect data retrospectively on actual costs of services incurred by families during the one-year period prior to enrollment in their ISST. Baseline costs include any DHS Core Services, mental health treatment covered by Medicaid, NYC detention, and any day treatment costs. The total baseline costs are compared with the actual cost of implementing their Wraparound model services. This CMP reported estimated savings of \$236,000 this year. This method is noteworthy as it relies upon actual costs among families served by the CMP; thus, total savings, while still an estimate, could be reasonably attributed to CMP service delivery.

i. Reinvestment of funds

To the extent that CMPs do experience cost-savings, the legislation requires them to reinvest those funds into CMP-related operations. Twenty-one (84%) of the 25 CMPs reporting these data in the 2010-2011 fiscal year described their actual or planned reinvestment of funds. As reported, funds were frequently reinvested in the provision of additional support to existing or new services (16 CMPs), to support coordinator salaries (4 CMPs), and to build needed infrastructure (e.g., database development; 3 CMPs). Other less frequently mentioned uses included creating “emergency” accounts to assist families in paying for direct services or immediate needs and paying for external local evaluation services to assess performance on key outcomes.

C. Challenges related to measuring costs and benefits at the initiative level

Testing the cost-savings hypothesis assumed in legislation is complicated given the range and diversity of existing projects, processes and outcomes. Below, we outline key difficulties associated with quantifying costs and benefits for CMP efforts. We then describe

the supports needed to move toward the specification of one or more cost models for the initiative in the future.

In its simplest form, cost-benefit analysis sums the value of the benefits accruing from a set of actions and then subtracts from this, the sum of the costs associated with those actions. Thus, in order to conduct a cost-benefit analysis, it is necessary to assign monetary figures to both sides of this basic equation: costs and benefits. This is challenging for the CMP initiative for a variety of reasons. First, it is difficult to assign monetary values on the cost side of the equation as most CMP efforts do not have sufficiently clear program models and/or lack the required level of precision needed to specify costs. That is, models have not become standard enough or implemented with sufficient fidelity to enable accurate cost assignment to efforts. Because it is also critical to assign a standard cost regimen across multiple sites, this variability problem is compounded when several CMPs are considered for analysis.

The benefits side is somewhat more complicated. It is assumed that CMP efforts result in outcomes that are achieved at lower cost because without the CMP, services would have been more expensive due to service duplication, fragmentation, and a prolonged need for costly services. In order to assign monetary values to these benefits, one must hypothesize what would have happened without CMP services; that is, what the likely trajectory of negative outcomes from a given set of problems might have been without CMP intervention and what the associated costs would have been. If the total of these estimated costs exceeds the total cost of CMP collaborative processes plus provided services, then the CMP would be assumed to have had a net financial benefit. However, specification of these various hypothetical costs is very difficult because we do not have reliable methods of predicting long-term child and family outcomes.

Should the initiative seek to develop a cost-benefit model in the future, many of the barriers above would need to be addressed through the following:

- greater adoption of a precise and standard program model
- increased implementation fidelity
- agreement on corresponding outcomes

However, before moving in this direction, the initiative would need to consider some important trade-offs. Specifically, the CMP effort places a high value on local decision making and the diversity of approaches is one of its strengths. While the promise of a rigorous cost-benefit approach may seem like the ideal evaluation model, implementing

required changes would necessitate greater standardization across sites, and may come at the expense of local investment and support for the CMP.

The plan to uniformly measure a select set of service delivery and outcome indicators across all CMPs in the 2011-2012 fiscal year (mentioned above and discussed in detail in the following section) moves the initiative a step closer to measuring costs and benefits. With continued evaluation efforts in this area, it is hoped that over time, there will be an opportunity to specify a cost-benefit model and conduct related analyses.

In summary, the evaluation revealed that local partner agencies have developed clear processes to share costs of operations and services. In many cases, local CMPs have effectively leveraged their collaborative efforts to obtain additional funding to sustain and/or grow their programs and services. However, it is difficult to ascertain the extent to which CMP structures and processes have led to cost reductions and cost savings, given the difficulties in measurement. One site was highlighted for their method of accounting for pre- and post-intervention service costs in determining cost savings. However, the local resources needed to collect retrospective service data may be prohibitive for CMPs serving large numbers of children and families. Thus, while representing a promising strategy to more precisely assess cost savings at the local level, this method may not be feasible to apply across all CMPs. An important next step for the initiative will be to develop feasible methods to more specifically assess costs (e.g., cost templates). In addition, evaluation activities in year three will explore the development of uniform methods of measuring cost savings associated with specific CMP processes and, to the extent possible, specific outcomes.

Legislative Goal V: Lead to better outcomes and cost-reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado.

The fifth and final goal of the CMP initiative is to improve outcomes for children and families who require services from multiple agencies. It assumes that interagency system improvements resulting in more efficient and effective service delivery also should lead to more successful and permanent outcomes for children and families.

This section first describes the complex nature of CMP service population definitions and reports estimates of the number of children eligible for, and served by, CMPs. We then explore what the evaluation revealed about defining and measuring outcomes, and discuss current limitations in assessing the statewide impact of the CMP. We present findings from local CMP performance measures during the 2010-2011 fiscal year and, where appropriate, discuss these in light of findings from last year. This section concludes with a detailed outline of the updated evaluation plan which helps to address some of the identified limitations. Data sources for this section include mid-year and annual reports.

A. Defining CMP target populations

Currently, it is difficult to obtain precise numbers of individuals and families who are eligible for, and served by CMPs, both within and across sites. According to 24-1.9-102 (2)(c) CRS, each Memorandum of Understanding is supposed to include a functional definition of "children and families who would benefit from integrated multi-agency services." However, there is no standard definition of eligibility for CMP service efforts. As a result, CMPs have specified varying definitions of their eligible and served populations, which range in both breadth and specificity. Examples include: all children within the county; all children with open cases in their county's child welfare system; all children eligible for services in any of their partner agencies; all children receiving services in at least two partner agencies; and all children "at risk" for involvement with partner agencies. Additionally, methods used to identify, count and manage information on youth and families also vary. Few CMPs, for example, have data management systems that track individuals or families served through the program. Further, many CMPs rely on county-, district-, or state-level databases or partner agency data systems to obtain counts; however, these counts often include larger populations than those served through local CMP efforts. Finally, some CMPs count individuals, others count families and some count both as their units of measurement, and counts may be unduplicated (each individual or family counted once) or duplicated (each individual or family represented more than once)

in the total. The variation in how individuals and families are defined and counted at the local level makes it difficult to determine the extent to which local projects are serving the target population as outlined in the legislation (e.g., children and families involved in multiple systems of care). Taken together, the present counts of eligible and served populations discussed below should be interpreted with caution and are likely overestimated.

i. Estimates of CMP eligible and screened population

In the 2010-2011 fiscal year, there was an estimated 70,000 individuals considered eligible for CMP services and approximately half (30,000) of that population was reportedly screened for services across all CMPs.

CMPs estimated the following numbers of total individuals served, calculated at different levels of service delivery (all include duplicated cases):

- *19,600 individuals who participated in local services or efforts that were directly associated with their CMP.* These efforts reflect totals from all CMPs and could include services paid by CMP incentive funds, services donated in-kind or provided by partnering agencies, all those served by ISSTs, and any large-scale prevention or intervention efforts that were supported by their IOG.
- *7,000 individuals who received services through the local ISST process.* These reflect the individuals who participated in a multi-agency provider staffing meetings across all CMPs.
- *5,300 individuals who received services that were funded, at least in part, by CMP incentive funds.* This total number was calculated across 19 CMPs where individuals participated in programs which the IOG financially supported with incentive funds. Four CMPs indicated that no individuals received services supported by incentive funding (i.e., partner agencies provided in-kind services), and another four had not yet received incentive funding.

B. Defining CMP outcomes

Each year, local IOG partners describe their plan to assess progress on key outcomes in their MOUs. They specify components of their measurement plan, which are defined below:

- *Targeted outcome domain.* Local CMPs are required to assess performance in the four outcome domains (i.e., child welfare, juvenile justice, education, and health/mental health). Sites may also assess performance in other domains such as domestic violence.

- *Targeted outcomes.* CMPs indicate what general outcomes they are measuring within these domains (e.g., reduce truancy, increase stability of out-of-home placements).
- *Performance indicators/measures and goals.* For each outcome, sites define the indicator (specific measure) that they employ to assess progress on the outcome and state their annual target goal (e.g., increase the rate of CMP-served youth who remain in their homes after receiving CMP services by 2%).

At the beginning of the initiative, the Steering Committee specified a list of approximately 20 outcomes reflecting key goals of the CMP (e.g., reduce out-of-home placements, reduce recidivism). Over the past six years, however, the number and variety of outcomes and related performance indicators associated with these outcomes expanded greatly. As part of the formative evaluation, outcomes and performance indicators were examined each year to assess the extent of standardization across CMPs, as well as similarities in measurement and data sources. It was determined in year one of the evaluation that CMPs reported on over 150 different performance indicators and goals. In the second year, the review revealed the following:

- *Number of performance indicators/goals.* On average, each CMP assessed 7 goals, although a few CMPs measured twenty or more.
- *Goals by domain.* The 28 CMPs with at least one year of data proposed 198 performance goals, distributed almost evenly in child welfare (49), juvenile justice (49), education (49), and health/mental health domains (42). Nine goals were in other areas, including domestic violence.
- *Process versus population-level indicators.* Two-thirds (134) of stated goals involved population-level indicators (e.g., assessing child and family outcomes), while 64 involved process indicators (e.g., improvements in service delivery).
- *Definitions of performance indicators.* CMPs vary greatly in their defined indicators. Despite some common outcome areas, local CMPs measure very different aspects of these outcomes, which precluded any aggregate analysis of effects.
- *Population level.* Performance is measured at different population levels (i.e., rate for entire county versus youth served through the ISST).
- *Data sources.* Common data sources include the CDHS Trails database, Eclipse/ICON state judicial database, local school district databases, and DBH and Colorado Client Assessment Records (see Appendix D for a further description of data sources).

These summary findings show that in general, local sites tend to track their performance in many outcomes, utilizing multiple indicators within outcomes. This is expected to some

degree, given that CMPs employ a variety of service models that are targeted to local community needs, which are diverse. A wide-ranging measurement approach allows CMPs to demonstrate achievements on several fronts. However, it may also come at a cost, if local sites' attentions and resources are divided in terms of working on too many fronts or outcomes at once. The more CMPs are focused on a small set of central target goals and dedicating resources to developing strong indicators of these goals, the easier it is to demonstrate a clear and positive impact of efforts.

In addition, with 198 different performance indicators, all with varying definitions and methods of measurement, it is currently impossible to aggregate indicators to assess impact across multiple CMPs or at the state level. However, to facilitate development of a summary of achievements across the CMP initiative, performance indicators were categorized into the ten most frequently assessed (common) outcomes. These outcomes, examples of related indicators, and the number of CMPs selecting these in years one and two are presented in Table 15 on the following page.

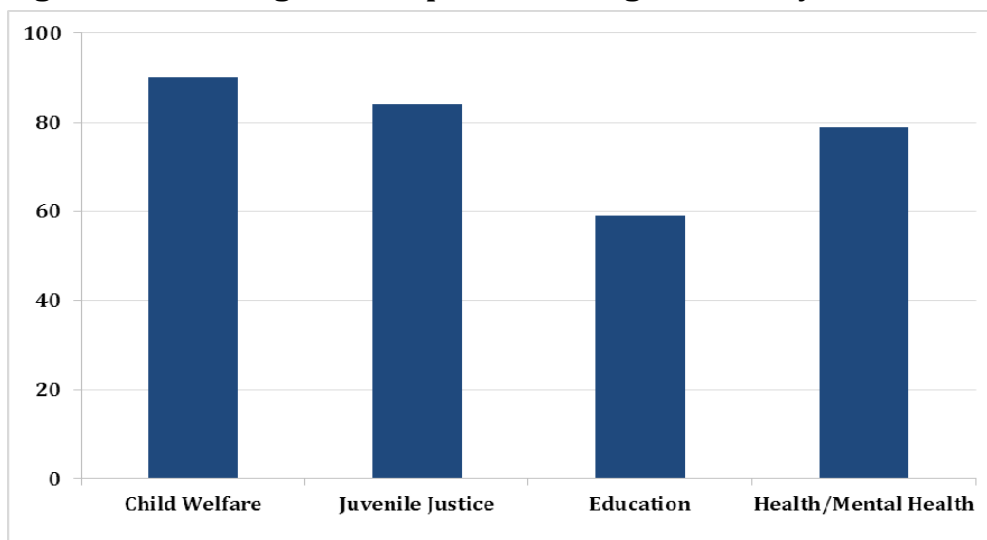
Table 15. The ten most commonly assessed outcomes

Domain	Common Outcome	Example Indicators	Number of CMPs assessing outcome	
			FY09-10	FY10-11
Child Welfare	Enhance stability of out-of-home placements	Reductions in the number of moves and length of time that children in out-of-home care settings experience	6	10
	Prevent out-of-home placement/increase reunification	Reductions in the rate of out-of-home placement, number of children served through the CMP who successfully remain in their homes, reductions in the average length of stay in foster care	13	13
Juvenile Justice	Successful completion of probation	Increasing positive discharges, decreasing probation revocations, and increasing the number of youth not violating court orders	17	16
	Low or reduced usage of commitment/detention facilities	Maintaining a low rate of Average Daily Placement (ADP) in detention and low rates of long-term placement	5	7
	Reduce or maintain low rates of re-offense/recidivism	Reducing the number of youth that reoffend or are adjudicated delinquent, or increasing the number of youth not incurring new charges while receiving CMP services	6	8
Education	Increase attendance/reduce truancy	Increasing youth attendance and decreasing truancy rates	18	25
	Increase or improve student achievement	Improvements in reading scores, grades, and standard achievement scores	7	4
Health/Mental Health	Improved level of functioning and decrease in problem severity	Improvements in the level of functioning or problem severity of individuals receiving mental health services	12	14
	Increase prevention and treatment for substance use/abuse	Improvement in number of youth remaining in treatment programs for a specific period of time	5	1
	Decrease or maintain low rates of hospitalization/inpatient services	Lower rates of inpatient care and therapeutic residential child care foster placements and fewer cases of admitting youth into higher levels of care	3	5

i. Overall performance

We first examined the percent of all performance goals measured across the initiative. CMPs reported meeting 78% of the 198 total performance goals. As shown in Figure 6 below, success in meeting goals was high in three of the four domains, with less success in the education domain.

Figure 6. Percentage of total performance goals met, by domain



Note: N = 198

ii. Performance in ten common outcome areas

In order to examine summary achievements in specific outcome areas, we detail performance on the 103 indicators reflecting the ten common outcomes, among 26 CMPs that have participated in the initiative for at least two years thus enabling assessment of progress from FY2009-10 to FY2010-11(see Table 16 below).

Table 16. Percent of performance goals met

Domain	Common Outcome	% Goals Met FY2010-11
Child Welfare	Enhance stability of out-of-home placements	88%
	Prevent out-of-home placement/increase reunification	80%
Juvenile Justice	Successful completion of probation	69%
	Low or reduced usage of commitment/detention facilities	86%
	Reduce or maintain low rates of re-offense/recidivism	88%
Education	Increase attendance/reduce truancy	44%
	Increase or improve student achievement	60%
Health/Mental Health	Improved level of functioning and decrease in problem severity	60%
	Increase prevention and treatment for substance use/abuse*	100%
	Decrease or maintain low rates of hospitalization/inpatient services	57%

*Note: Only one performance measure was assessed in this outcome area in FY10-11.

In general, the majority of the performance goals targeting outcomes in the child welfare and juvenile justice domains were met, with more variable performance on outcomes in education and health/mental health domains.

A few interesting differences in proposed measurement and performance between the two evaluation years were noted:

- *Prevent out-of-home placements/increase reunification.* The number of proposed goals for this outcome grew from 15 goals in the 2009-2010 fiscal year to 21 goals in the current (2010-2011) year, suggesting that this may be an area of growing interest and focus among local CMPs.
- *Successful completion or termination of probation.* CMPs may have targeted additional efforts in this area over the past year, as a larger share of these goals was met this year than last (69% and 44%, respectively). However, the significance of this shift is uncertain, as local CMPs may have set goals with lower expectations in response to last year's poorer performance.
- *Increase attendance/reduce truancy.* More performance goals (25) were measured in this area compared to last year (18), suggesting that there may be growing interest and/or need to provide multi-agency integrated services in this area.
- *Increase prevention and treatment for substance use/abuse.* Only one CMP measured a goal in this area this year, as compared to the five CMPs that did so in the previous year. This difference may have resulted from challenges with data collection, particularly in relation to timely calculation of outcomes for annual reporting.

In summary, CMP efforts resulted in reported improvements in locally-defined performance indicators during the fiscal year. CMPs met approximately three-quarters of their proposed goals, though success rates varied somewhat by outcome. Although CMPs reported data reflecting ten common outcomes, the target populations and specific performance indicators for those outcomes were defined and measured differently across CMPs. Thus, data could not be meaningfully analyzed across sites because direct comparison is neither possible nor appropriate. As discussed above, issues related to outcome measurement and analysis led to the creation of an Outcomes Workgroup, discussed below.

Improving youth outcomes

"The most significant change in our system has been the effective collaboration of partner agencies. The true beneficiaries of this has been our youth. Largely due to the partnership, we have reduced the number of youth committed to the Division of Youth Corrections, we've been able to reduce the number of youth on probation, placed in mental health hospitals or TRCCF level placements. These youth are being maintained in their own communities and with their respective families."

C. Plan for measurement of standard outcomes in evaluation year 3

The new statewide evaluation measurement plan was collaboratively developed by the Outcomes Workgroup, using the process outlined in the evaluation methods section (page 9) and further detailed in a comprehensive report (see Appendix B for a link to the full report). The measurement plan was adopted by the CMP State Steering Committee in March of 2011 and implementation began in July 2011. The plan centers on the collection and analysis of a select set of indicators measured uniformly across CMPs and aggregated at the state level. These indicators assess core CMP processes and outcomes, including the number of children served, the extent of service integration across agencies, and improvements in the functioning of children and families served by the CMP. Additional information about the specific indicators, data collection processes, selected outcomes, and data analysis associated with this plan is presented below.

i. Process measures and method of data collection

Process indicators were selected to obtain an accurate count and description of the CMP target population and to track progress on core service components. These process indicators are:

- Number of children/families referred to ISSTs
- Number and type of agencies or systems that:
 - Families are involved in at the time of enrollment
 - Participate in the family's service planning
 - Provide services to families as a result of the ISST
- Number of cases where family members participated in service planning
- Number of cases in which an integrated service plan was developed
- Number and type of outcomes, among a selection of outcomes in the child welfare and juvenile justice domains, that are aligned with ISST-served cases

A two page data collection form to collect items needed to measure the above listed indicators was created. The form also includes client identifying and demographic information and state identifier numbers from two statewide data systems (Trails, ICON/Eclipse).

To support local- and state-level data tracking and analysis, an on-line client-level database supported by Efforts to Outcomes (ETO) © software was developed specifically for the initiative. ETO was selected for a number of reasons: it is a well-established social service data tracking system; it is flexible so that additional data items can be easily integrated; and custom reports can be created so that local CMPs can track and report on their service information throughout the year. Each CMP has established processes to collect the data on

children and families participating in initial ISST meetings. Most sites will enter these data into the ETO system; the others will track these data items in their local database and provide OMNI with the data file. OMNI is providing training and technical assistance for these data collection systems and will be conducting quality control checks.

ii. Outcomes measures and method of data collection

The Outcomes Workgroup identified a set of indicators that reflect core expected outcomes of the CMP initiative in the child welfare and juvenile justice domains. Indicators in these two domains were selected for the initial rollout of the new plan, given that they are currently collected through existing statewide databases (Trails and ICON/Eclipse). All of these indicators will be measured among youth who participate in ISSTs. The selected set of indicators is:

- Number (rate) with new open involvements in Trails after CMP services began
- Number (rate) with no substantiated abuse finding after CMP services began
- Number of moves experienced when in out-of-home placement
- Number (rate) discharged to a permanent home
- Number (rate) who successfully complete probation and/or parole
- Number (rate) of revocations by technical violations where case resulted in unsuccessful termination
- Number (rate) who recidivate, resulting in unsuccessful completion of probation and/or parole

CMPs indicate which of the above-listed outcomes align with each case (i.e., which reflect intervention goals or represent potential outcomes relevant to the child being served). This information will be used to identify subsets of CMP-served children to include in the analysis of each outcome.

In the upcoming year, in conjunction with the SSC and EC, a collaborative process will be developed to create a standard measurement approach for indicators in the education and health/mental health domains.

iii. Proposed analysis

OMNI evaluators have established processes with research staff in the state child welfare and judicial agencies to conduct aggregated analyses of the selected outcomes. Using the state identifier numbers and client identifying information, research staff at these agencies will match client information with outcome data extracted from Trails and ICON/Eclipse systems. They will then calculate outcomes, aggregated at local and state levels, and

provide these results to OMNI. OMNI will then analyze the process data collected through ETO or extracted from existing local databases. Analysis of process data will result in an accounting of the total number of children served through ISSTs, array of referral sources, extent and patterns of multi-system involvement, families involved in service planning, and the types of outcomes ISST services are attempting to achieve. OMNI will share relevant results with each local CMP and in the statewide evaluation report.

The statewide measurement plan is one component of a multi-method approach to evaluating the CMP initiative and reporting on mandated legislative goals, as required by the legislation. Other data collection activities, including mid-year and end-of-year reporting and administration of surveys, will continue in order to inform the evaluation in other key areas and to comply with other legislative requirements.

With the establishment of the statewide data management system and client-tracking processes, there is the opportunity moving forward for the initiative to identify additional relevant standard outcomes to track over time. Outcomes that are targets of statewide efforts could be assessed among CMP-served youth in order to explore the impact of the collaborative approach. For example, recommendations in an October 2011 Annie E. Casey Foundation report suggest that the Colorado Department of Human Services focus efforts on specific outcomes, including use of congregate care, family-based placements, and re-abuse rates. These outcomes align with CMP targets and goals, and could be integrated into the statewide measurement plan.

Year three evaluation directions

In the first year of evaluation, quantitative and qualitative research methods were employed to gather a baseline understanding of CMP core components, structures, and processes (i.e., phase I formative evaluation). The resulting findings informed a series of recommendations that were initiated in year two. Principally, these centered around two areas: 1) identify standard data collection opportunities across CMPs and establish measurement systems to support these efforts; and 2) continue to inform CMP best practices and program models through ongoing process and formative evaluation efforts.

Evaluation activities planned for the third year are intended to increase capacity and enhance data quality in ways that will allow for an examination of CMP outcomes (i.e., phase III summative evaluation). The shift away from formative evaluation and infrastructure building to a summative design will require local adjustments in data collection practices to ensure consistent measurement statewide. This may be challenging to some projects, and OMNI, CDHS, and the Evaluation Subcommittee are committed to supporting CMPs in making these changes. The following information outlines work that will occur in the third year of the evaluation to support more rigorous measurement of CMP outcomes.

A. Continue to develop and implement systems to collect and analyze uniform measures of CMP outcomes, outputs, and processes

1. *Continue efforts to focus outcome measurement on a small set of well defined, uniformly measured outcomes across CMPs on CMP-targeted populations.* The new statewide measurement system implemented for the 2011-2012 fiscal year facilitates the analysis of standard outcomes in the child welfare and juvenile justice domains. These data are measured on children and families served by local ISSTs, enabling us to draw a direct link between progress on outcomes over time and CMP programs. In the 2011-2012 fiscal year, mechanisms to measure standard outcomes in the education and health/mental health domain will be collaboratively developed, and implemented in fiscal year 2012-2013.
2. *Continue to develop standard output and process measures and measurement approaches to support improved data collection and analysis of progress on legislative goals, at the statewide and local levels.* The set of output and process indicators measured in the new statewide measurement system described in the section above inform efforts to assess reductions in duplication and fragmentation and the extent of family involvement in

service planning. In addition, the evaluation will continue to assess collaborative effectiveness, through stakeholder surveys and annual reporting. In the upcoming year, OMNI will work with local CMPs to further refine and develop additional measurement strategies in these areas, as well as improvements in quality, effectiveness, and appropriateness of services. Specifically, the on-line statewide measurement data collection system provides a structure and mechanism by which local CMPs could develop additional uniform measures of CMP processes. These could include the tracking of family engagement and satisfaction with services, types of intervention services, and other aspects of service delivery.

3. *Develop standard measures of cost and cost-savings to be implemented across CMPs.* Formative evaluation efforts have revealed significant difficulties in measuring local costs, cost reductions, and potential cost savings. Utilizing the information gathered, as well as evidence and examples from the field, OMNI's evaluation team will work to identify common CMP components for which costs can be assigned, and develop a set of standardized measures to assess costs and cost reductions associated with CMP service delivery. Measures will be refined in collaboration with the EC and CMP coordinators and then implemented across CMPs in future years.
4. *Monitor and track trends in statewide measures of key CMP outcomes.* OMNI, in partnership with the EC, will develop an on-line platform to display relevant data in order to bring awareness to CMP initiative efforts among leaders and community members throughout the state. This on-line data display will enable monitoring of trends over time in the four CMP outcome domains (child welfare, juvenile justice, education, and health/mental health) at the local- and state-level.

B. Continue to define and support dissemination of information on effective IOG, ISST, and collaborative practices

1. *Summarize research on best practices related to core CMP components.* OMNI evaluators are leading efforts to review research findings in the systems literature which will be shared with local CMPs and stakeholders in two publications to be developed in the 2011-2012 fiscal year. These include the following:
 - *"Systems Facilitation Guide."* This report will summarize the extant research literature on systems-level collaboration and the core components contributing to CMP structures and processes (e.g., family involvement, integrated service planning). The goal is to identify best practices.

- *Brief evaluation and research reports on key topics.* In the upcoming year, the evaluation team will create quarterly evaluation newsletters exploring topics relevant to state and local CMP stakeholders, such as measurement of cost savings.
2. *Support the CMP's broader efforts to define and disseminate best practices in local CMP implementation and operations.* OMNI staff will participate in a number of efforts related to disseminating best practices. These include the following:
- *CMP Handbook development.* OMNI will contribute to efforts being led by CMP coordinators to develop a CMP Handbook, which will include key information to orient new CMPs and new stakeholders to the initiative, the establishing legislation, SSC policies and procedures, local evaluation and measurement processes, and collective learnings regarding effective implementation of IOG and ISST structures and processes.
 - *CMP information sharing activities.* OMNI will continue to support CMP community networking activities, through maintaining the CMP SharePoint portal (an on-line information sharing tool) and attending and/or facilitating locally-initiated regional meetings focused on CMP implementation topics.
 - *Family involvement technical assistance.* OMNI will continue to support the Family Voice and Choice Committee's efforts to examine evaluation findings to identify technical assistance needs related to family involvement across the initiative.
 - *Incentive funding.* OMNI will facilitate the SSC's discussions regarding the development of new methods to determine performance based incentive funding allocations.

Moving forward, the evaluation will focus on continued development of measurement infrastructure to create a solid foundation for summative evaluation of CMP efforts statewide. OMNI will continue to ground the evaluation in a participatory approach, working in close collaboration with the CMP State Steering Committee and the Evaluation Sub-committee, in an effort to ensure that results are well aligned with the needs and interests of the initiative and its stakeholders.

Endnotes

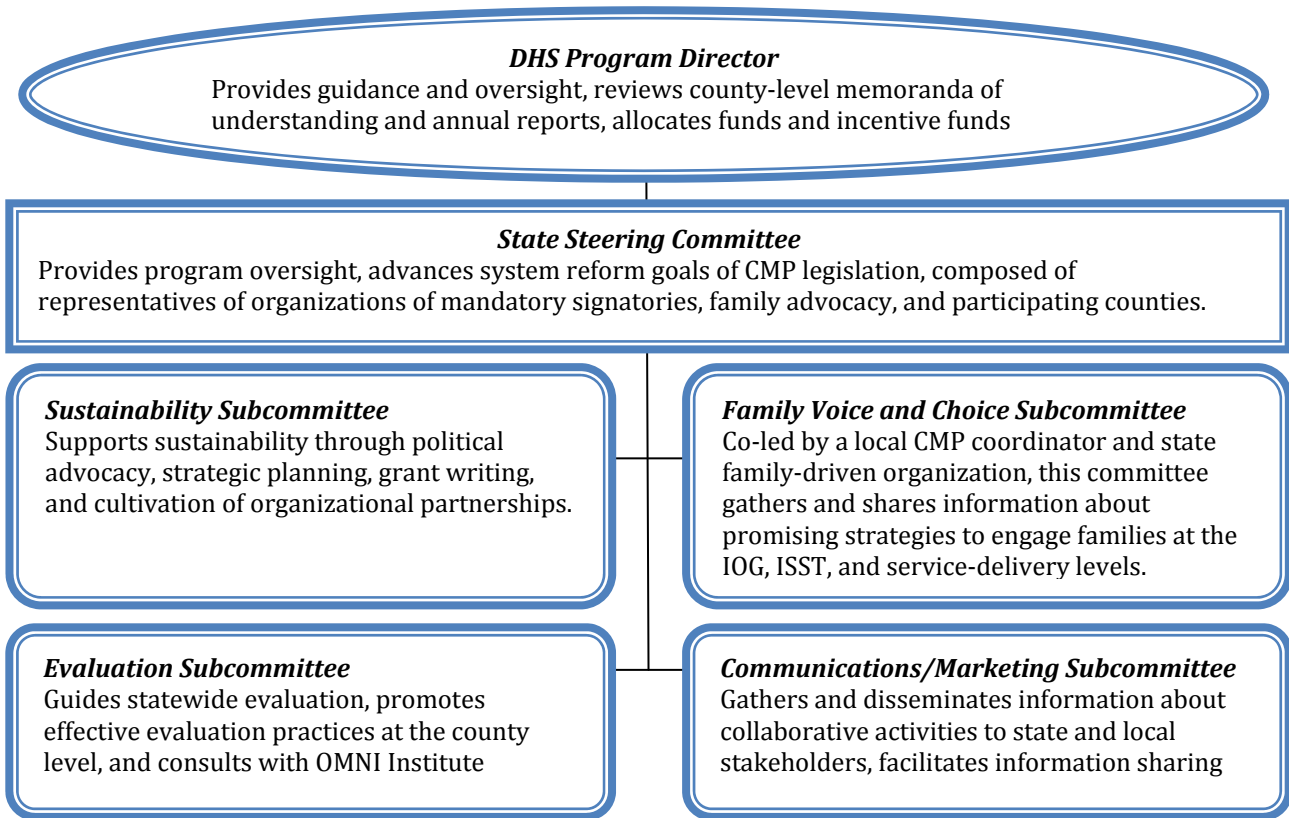
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Appendices

Appendix A. Structure of state management of the CMP



Appendix B: Additional reports and products

Below are descriptions of select additional reports and products developed during the course of the CMP statewide evaluation to date. These documents can be accessed using the following link to the CMP initiative portal (note that recent reports may still be under final review and thus may not be published on this site yet): <http://collaboration.omni.org/sites/1451/SitePages/Home.aspx>

Reports published in 2010

Report	Date	Description
Collaborative Management Program: Year 1 Evaluation Progress Report	February 2010	This report describes OMNI Institute’s qualitative and quantitative approach to statewide evaluation for the first year of evaluation. The report discusses initial formative findings, addressing topics such as barriers to CMP implementation, resource allocation conflicts, IOG performance issues, and observed success of local CMP implementation.
State Management Survey Findings	November 2010	In Fall 2010, a total of 29 State Steering Committee members and IOG Coordinators responded to the State Management Survey, an online survey designed to elicit feedback regarding CMP management, progress, and areas for further development. This report presents the results of the State Management Survey, which includes items that assess progress and functioning of the State Management Office, the State Steering Committee, the Family Voice & Choice Subcommittee, the Evaluation Subcommittee, and the overall HB 1451 initiative.
Collaboration and Overall Success Survey: Initial Data Summary	December 2010	This report provides a summary of initial findings from two surveys administered to IOG members in 22 CMPs in Spring 2010. The surveys assessed IOG members’ perceptions of their CMP’s collaborative processes, as well as the perceived success of their collaborative efforts on several goals of the state legislation. The findings provide an initial assessment of collaborative processes and outcomes, an important part of demonstrating the benefit of the CMP approach.
Summary of Select Child Welfare Data Indicators by County	June 2010	This report presents county-level “snapshots” of performance on six child welfare data indicators for the time period of 2003 to 2009 (represented in averages across years), as defined by the U.S. Department of Health and Human Services and reported to the Colorado Department of Human Services through the Trails database. This report also provides general background information on the available county-level statewide data related to CMP efforts.

Report	Date	Description
Emerging Evidence Supporting Collaborative Management Programs	July 2010	OMNI Institute prepared a brief document in Summer 2010 detailing evidence that supports the success of community collaboratives to meet legislation goals. The document includes a summary of the Systems of Care (SOC) philosophy and highlights the High Fidelity Wraparound approach as one possible way to implement collaborative care practices to improve child and family outcomes.
Collaborative Processes and Emerging Best Practices	August 2010	This report summarizes the results of in-depth interviews conducted with a sample of CMP stakeholders (local IOG members) and responses to open-ended questions from a survey on the qualities of collaboration efforts. The report provides a discussion of the major themes that reflect findings, along with a brief presentation of potential best practices.
Collaborative Management Program: Year 1 Statewide Evaluation Findings	October 2010	This report summarizes findings and learnings emerging from evaluation efforts over the first year of the statewide evaluation. The report details OMNI Institute's work to date on identifying common and unique components of CMP service and systems delivery models and implementation; measuring the quality of collaborative structures, relationships, and processes as well as the perceived effectiveness of the collaborative approach; building infrastructure and processes to assess progress on legislative goals in a standard way across CMPs; identifying how CMPs are measuring local program impacts by identifying each CMP's targeted populations and child/family outcomes, data indicators, and performance goals; and assessing the capacity to assess cross-CMP impacts on key population-level outcomes and providing recommendations and guidance in establishing infrastructure to move towards statewide outcome analyses.

Reports published in 2011

Report	Date	Description
Collaborative Management Program: Year 2 Evaluation Progress Report	February 2011	Building upon findings from Year 1, statewide evaluation efforts in Year 2 involved focusing measurement on a small set of well-defined, uniformly measured outcomes. This report summarizes the results and recommendations that led to this focus, resulting in the development of an Outcomes Workgroup; describes the Outcomes Workgroup process and progress; presents the measurement plan that emerged from this process; and details the proposed next steps in the process.
State Measurement Plan: Brief Summary for CMP Coordinators and IOGs	March 2011	OMNI developed a brief summary of the state measurement plan (see previous entry) for dissemination among CMP coordinators and for their IOGs. The purpose of this summary was to detail the rationale, objectives, data indicators, data collection strategies, and next steps for the implementation of the state measurement plan. This document was intended to present key content about the Outcomes Workgroup's efforts and the resulting state measurement plan in a format appropriate for wide distribution.
State Measurement Plan: PowerPoint Presentation for Coordinators	April 2011	In addition to the brief summary just described, this presentation was developed as a tool to assist CMP coordinators in their efforts to describe the state measurement plan to IOG members and discuss local CMP roles and responsibilities. Like the two preceding resources, the presentation provides a summary of the Outcomes Workgroup's efforts, the state measurement plan that emerged from the Workgroup's planning process, and next steps for implementing the state measurement plan.
Current Practices in the Prevention of Child Abuse and Neglect	April 2011	This brief report provides an overview of evidence-based programs and interventions most widely recognized in the area of child abuse prevention. Also included are discussions about the theoretical frameworks that provide the basis for these evidence-based practices, as well as links to more information about additional promising programs.
Collaboration and Overall Success Survey: Summary Table	June 2011	This brief document provides a summary table of aggregate Collaboration and Overall Success survey results from survey re-administration in Spring 2011 (see Collaboration and Overall Success Survey: Initial Data Summary – December 2010 above for details regarding the survey) . Data results for a number of survey domains were reported by fiscal year, by coordinator status, and by population density characteristics.

Report	Date	Description
Collaboration and Overall Success Survey: County-Level Survey Results	July 2011	These reports provide descriptive information regarding each county's IOG members' general perceptions of their CMP structure, collaborative processes, and emerging outcomes. The results in these reports reflect CMPs scores for two fiscal years (2009-10 and 2010-11).
Family Involvement Survey Report	August 2011	In Summer 2011, the Family Voice and Choice Committee collected data related to CMP family involvement in order to understand family advocacy activity as implemented among CMP counties. This report highlights preliminary findings from data collection efforts, including an overview of current family advocacy activities, as well as a discussion for resource development and training opportunities for CMP counties.

Appendix C. Sources of additional funding reported by CMPs

Funding Type	Source of Funds	Description	Number of CMPs reporting	Total Amounts Received
Federal	Juvenile Accountability Block Grant	Funds provided as block grants to states for programs promoting greater accountability in the juvenile justice system	1	unreported
	Bureau of Juvenile Assistance	Funds provided for programs aiming to improve criminal justice systems and services for crime victims	1	unreported
	Support Systems for Rural Homeless Youth	Funds awarded to Colorado to support programming for homeless youth and families	1	\$15,000
	Basic Center Program	Grant from Family and Youth Services Bureau to support organizations and shelters that serve and protect runaways, homeless, and street youth	1	\$15,000
	Promoting Safe and Stable Families	Funds distributed by US HHS to states to grant services that address family support, family preservation, reunification, and adoption	2	\$73,500
	Office of Juvenile Justice and Delinquency Prevention	Funds for juvenile justice programming	1	unreported
State	Division of Criminal Justice Juvenile Assistance Grants (JAG)	Competitive funding for development of programs that prevent or reduce crime and delinquency using collaborative evidence-based and promising practices	6	\$415,000*
	Tony Gramscas Youth Services Grant	Competitive funding to local organizations that target youth and their families with programs designed to reduce youth crime and violence	1	unreported
	Statewide Strategic Use Fund	Funds distributed for programs serving Colorado's most vulnerable families	2	\$382,489
	Division of Behavioral Health Prevention Block Grant	Funds for prevention programming	1	\$98,787
Private foundation/ other	United Way	Funds for social services	1	\$81,000
	Center for Juvenile Justice Reform Technical Assistance Grant	Provides technical assistance for implementing an evidence-based collaborative juvenile justice practice model	1	unreported
	El Pomar Foundation Build a Generation Grant	Funds for social programs	2	\$4,000

Appendix D. Frequently used data sources for measurement of CMP performance goals

Domain	Data Source	Description
Child Welfare	Trails	Trails is a statewide automated case management system detailing client information across youth corrections and child welfare populations. Trails is currently used by various divisions of the Colorado Department of Human Services.
Juvenile Justice	Eclipse/ICON	ICON/Eclipse is a statewide automated case management system for the district and county courts, and is used by trial courts and probation. ICON/Eclipse links to the Colorado Integrated Criminal Justice Information System (CICJIS) which is used by the Division of Youth Corrections and other law enforcement agencies to track offenses.
	Trails	See above
Education	Local school district records	Districts maintain local databases that track absences, tardiness, and other student-level data
	Web-based records management programs (PROSTAR, GoEdu.com and Infinite Campus)	Online data tracking systems to record attendance, grades, student information; with school, teacher, parent, and youth level access
	NWEA District Testing	Standardized measures of academic progress (MAP) tests implemented in district-wide testing
Health/Mental Health	CCAR/DMH	CDHS's Colorado Client Assessment Records (CCAR) is a multi-dimensional checklist and level of functioning measure that is consistently collected at intake and discharge in several mental health settings across the state, including inpatient and substance use programs.
	DACODS/DBH	DACODS is a client level data collection instrument used by the Division of Behavioral Health (DBH) to track substance use treatment and program implementation variables
	CHIPS/CMHC program	Centennial Mental Health Center's information system tracking client-level mental health service related data