HB 1451 Collaborative Management Program

YEAR 3 STATEWIDE EVALUATION FINDINGS

Colorado Department of Human Services
people who help people
Colorado Department of Human Services
Division of Child Welfare Services
Colorado Management Program

Last revised: August 6, 2013

For more information, please contact:

Norman Kirsch, LCSW

norman.kirsch@state.co.us

303-866-5936

Collaborative Management Program Administrator

Colorado Department of Human Services, Division of Child Welfare Services

Erin Ingoldsby, PhD

eingoldsby@omni.org

303-839-9422 ext. 116

Laura Landry, PhD

llandry@omni.org

303-839-9422 ext. 170

OMNI Institute

Acknowledgements: The Collaborative Management Program (CMP) statewide evaluation project is funded by the Colorado Department of Human Services (CDHS). Special thanks to the CMP Statewide Evaluation Subcommittee for informing the design and implementation of the evaluation, and for contributing to the review and submission of the final report.

OMNI Institute

899 Logan Street, Suite 600

Denver, CO 80203

www.omni.org

STATE OF COLORADO

CHILDREN, YOUTH AND FAMILIES
George J. Kennedy, Deputy Executive Director

Division of Child Welfare Services
Lloyd D. Malone, M.P.A., Director

1575 Sherman Street, 2nd Floor
Denver, Colorado 80203-1714
Phone 303.866.5932 Fax 303.866.5563
www.cdhs.state.co.us/childwelfare

John Hickenlooper
Governor

Reggie Bicha
Executive Director

December 11, 2012

TO: Julie Krow
Dee Martinez
Reggie Bicha

FROM: Collaborative Management Program (CMP) Evaluation Subcommittee

On behalf of the Collaborative Management Program's Evaluation Subcommittee, we are pleased to submit the 2012 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 18 months has been reviewed and approved by the CMP State Steering Committee.

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 elegant service delivery which is having positive effects on the lives of Colorado families. A significant change in this year's evaluation report is the inclusion of client-level data, obtained through implementation of newly developed evaluation infrastructure including an online data system, common data collection tools, and data sharing agreements with Trails and ICON/Eclipse to support analysis of CMP statewide outcomes. The results from data gathered through these standard data collection mechanisms, in conjunction with CMPs' self-reported local achievements, provide emerging evidence of the positive impacts CMP is having on multi-system youth and families across the state.

As the initiative matures, we will more broadly capture service episode data, 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 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 multiple systems of care.

We look forward to continuing to partner with CMP stakeholders in advancing the program's vision for Colorado families.

Sincerely,

Members of the CMP State Evaluation Subcommittee

Evaluation Subcommittee Members

Norman Kirsch
Administrator, Collaborative Management Program
Colorado Department of Human Services

Terri Anderson
El Paso County CMP

Susan Colling
Colorado Office of the State Court Administrator

Margie Grimsley
Federation of Families for Children's Mental Health – Colorado Chapter

Norm Kirsch
Colorado Department of Human Services, Division of Child Welfare Services

Carl Larson
University of Denver

Chris Meyer
Douglas County CMP

Kelly Schramm
Weld County CMP

Quincy Senele
Larimer County CMP

Meg Williams
Colorado Department of Public Safety, Division of Criminal Justice

OMNI Institute Lead Staff to the Evaluation

Jim Adams-Berger

Laura Landry

Erin Ingoldsby

Contents

Executive Summary i

The Collaborative Management Program (CMP) initiative 1

A. Evolution of CMP 3

Developing and disseminating information about implementation practices 3

Establishing evaluation infrastructure and performance measurement 3

I. CMP infrastructure, population, and service delivery 5

A. Interagency Oversight Groups (IOGs) 6

IOG Membership 6

IOG Focus Areas 8

B. Populations eligible for CMP services 9

ISST structures and processes 10

Primary ISSTs and ISST meetings 12

II. Outcomes 18

A. Impacts assessed by statewide indicators 18

B. Impacts assessed at the local level 24

III. CMP implementation results in systems improvements 27

A. Systems change at the governance level 27

B. Systems change at the service level 28

ISST integrated service planning enables streamlined service provision 28

Coordination of information gathering simplifies processes for families 31

C. Systems change in family involvement 32

The initiative has developed strong infrastructure to support family involvement 33

CMPs involve families at the governance level 33

ISSTs engage families as well as family representatives in planning processes 35

CMPs evaluate involvement of families and utilize finding to improve processes 36

D. Systems change in cost sharing and cost savings 37

IOGs implement best practices to collaboratively finance CMP efforts 37

Agencies involved in CMP collaboratively finance CMP efforts 39

IV. Conclusions and considerations 41

V. Year four evaluation directions 47

Endnotes 49

Appendices ... 50
Appendix 1. Structure of state management of CMP ... 51
Appendix 2. Phases of the evaluation ... 52
Appendix 3. CMP coordinators ... 54
Appendix 4. Eligible population ... 55
Appendix 5. Served population ... 56
Appendix 6. Primary ISST summary data ... 57
Appendix 7. Description of data collection, management, and cleaning processes for client-level tracking information ... 58
Appendix 8. Larimer County CMP data summary for FAPT clients ... 63
Appendix 9. Process to select and define process and outcome data indicators ... 68
Appendix 10. CMP ISST-served population ... 73
Appendix 11. CMP MOU performance goals ... 74
Appendix 12. External funding ... 84
Appendix 13. Common assessments ... 85
Appendix 14. CMP statewide database sample reports ... 86

CMP Statewide Evaluation Year 3 Executive Summary

Colorado's commitment to improving social service delivery systems gave rise to the Collaborative Management Program (CMP) administered by the Department of Human Services' Division of Child Welfare. As specified in House Bill 04-1451, the program promotes the adoption of collaborative management structures at local (county) and state levels to achieve a variety of goals including family involvement in service decisions, reduced duplication and fragmentation of services, greater service quality, more effective use of resources, and better outcomes for children and families in the child welfare system.

As outlined in legislative statute CRS 24-1.9-102, local CMPs are encouraged to implement system reforms and service improvements through the development of interagency oversight groups (IOGs) and individualized service and support teams (ISSTs). ISSTs consist of providers and family representatives who share responsibilities, resources, and costs to provide highly coordinated and tailored intervention planning and services to identified families.

Since 2009, OMNI Institute, the Statewide Evaluation Committee, and the CMP State Steering Committee have collaborated in the development and implementation of a multi-phase evaluation effort to assess variation in CMP processes and outcomes. Data are collected through a CMP on-line client-level database, the Annual Report, state-agency databases (i.e., Trails, ICON/Eclipse), and IOG member surveys. Selected findings are presented below.

Legislative Goals of the Collaborative Management Program (CMP)

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

Colorado Revised Statute, Title 24, Article 1.9 (2010)

CMP serves Colorado's multi-system involved families. Since 2004, the program has grown from 6 to 32 counties comprising 30 CMPs in FY 2012. CMPs report serving over 7,300 children through ISST models and programs, with approximately 3,100 represented in the CMP database. When factoring in those served through IOG partner agency programs, the number grows to about 20,800 individuals. Yet, there is still a great need for expanded CMP resources, as the total estimated eligible population (as defined by each CMP) approaches 70,000 across the 32 counties.

- 60% of children report involvement with two or more agencies at ISST intake.
- Out-of-home placement and mental health issues are common presenting problems/risks.
- 59% are pre-adolescents or adolescents, 59% are male, and 68% are White/Caucasian.

CMP outcomes demonstrate positive impacts for children and families. The ultimate goals are to achieve better outcomes and improve the lives of multi-systems-involved children and families. In FY 2012, all 30 CMPs collected and reported standard client-level service data, including identifiers to facilitate matching to child welfare and juvenile justice statewide databases.

The table below summarizes baseline performance on child welfare and juvenile justice outcomes for children for whom the indicator was relevant. As FY 2012 is the first year these outcomes have been calculated, interpretation of CMP performance is limited. However, in FY 2013 and beyond, yearly performance can be compared to monitor trends. In general, relatively low rates of occurrence of poor outcomes and high rates of positive outcomes were demonstrated, when considered in light of annual reporting on similar indicators provided by CDHS and State Judicial. [i,ii] For example, 92% of CMP ISST-served youth who were in out-of-home placement with case closure during FY 2012 were reunified or placed in a permanent home; this is similar to the state level indicator tracked for closed cases within a 12-month period (91%). [i] While indicators align with state-tracked outcomes, rates are not directly comparable due to slightly different definitions of cohort and time periods.

Outcome	Statewide indicator	% of ISST cases where indicator was deemed relevant	Indicator rate for relevant cases
Safety and stability for children in child welfare	New involvements in child welfare system after initial ISST meeting	45%	6%
	Substantiated abuse or neglect finding within 6 months of their initial ISST meeting	31%	5%
	Of those in out-of-home placement, two or more moves in out-of-home placement during FY 2012	24%	13%
	Of those in out-of-home placement who were discharged, were discharged to a permanent home after their initial ISST meeting	21%	92%
Successful intervention for youth on probation	Of those entering probation within 6 months of initial ISST meeting, successful completion of probation after initial ISST meeting	17%	17%
	Of those entering probation within 6 months of ISST meeting, probation revocation due to technical violations after ISST meeting	29%	10%
	Of those entering probation within 6 months of ISST meeting: pre-release recidivism after ISST meeting	29%	4%

CMPs also report on locally defined (and measured) outcomes. Sites reported successfully meeting 93% of their targeted performance goals, which represents an increase from FY 2010 (75%) and FY 2011 (78%). This rate reflects achievements on 158 locally-defined indicators across 30 CMPs.

Finally, 21 CMPS piloted measures of education and health/mental health outcomes. Indicators include: school attendance, disciplinary actions, and performance and stability; and mental health problem severity/functioning, inpatient and substance use treatment, and access to health care providers. Findings from this pilot will be reported in FY 2013.

CMPs improve service quality and reduce duplication and fragmentation. These outcomes result from CMP system improvements at the *governance (IOG)* and *service* level that are designed to establish effective, integrated service delivery models (ISSTs). Key findings include:

- IOGs were effective in actively engaging mandated and non-mandated partners. IOG partners perceived authentic collaborative processes that result in mutually beneficial services.
- More IOGs implemented evidence-informed programs that integrate and streamline service planning and delivery for families (23 in FY 2012 vs. 20 in FY 2011). These models include High Fidelity Wraparound, Team/Family Decision Making, and the Crossover Youth Practice Model.
- IOGs made significant progress integrating family representatives in their efforts. Family participation rose from 60% of CMPs in FY 2011 to 89% in FY 2012. CMPs reported frequent caregiver involvement in ISST meetings (in 84% of CMPs and 83% of ISST cases).
- Local programs demonstrated strong collaboration in service efforts. 83% of ISST-served families had two or more systems involved in their integrated planning process and 86% received an integrated plan at the initial ISST. 73% of plans included interventions to be delivered by two or more agencies.

CMP partners collaborate to finance efforts and share costs. Although the number of CMPs has increased, the total spending authority has remained stable, at around $3.2 million. In FY 2012, the CMP distributed earned incentive funds to 28 sites (per site funds ranged from $28,000 to $226,000). While incentive funds support costs, they do not fully finance each CMP's comprehensive local efforts. All CMPs must implement additional cost-sharing strategies. Findings related to collaborative financing include:

- The majority of CMPs (81%) indicated that during ISST meetings, agencies jointly agree on who will pay for intervention services (an example of blending and braiding funds).
- 17 CMPs reported spending just over $1 million of their incentive funds on services provided directly to children and families (45% of annual expended funds; an increase from 29% in FY 2011), in addition to considerable in-kind donations to service provision by partner agencies.
- 11 CMPs obtained a total of over $1 million in external grant funds to support services.

CMPs collaborate to save costs and reinvest cost savings. CMPs continue to report that they are attaining cost savings from their more efficient, integrated "ways of doing business." Savings are then reinvested to serve more families. The table below shows areas of reinvestment reported by 25 CMPs. In addition, in three years of survey data, IOG members consistently report perceived success in this area.

Plans for Reinvested Savings	Number of CMPs (%)	Examples
Support programs and services	16 (64%)	Sustain or expand services, develop new programs, provide "emergency" grants to programs
Support families directly	9 (36%)	Retain flexible funds for families in need of respite care, emergency services, etc.
Support personnel costs	5 (20%)	Contribute to CMP coordinator salary
Training and TA	3 (12%)	Support symposium, cross-site meetings
Hold funds in reserve	6 (24%)	Apply funds in future when there are budget shortfalls

CMPs continue to experience implementation barriers. Despite advancements realized in FY 2012, there remain a number of limitations that the program continues to address collaboratively in order to fully respond to legislative requirements and goals:

- CMPs report that the current economic downturn and reduced agency budgets and resources have led to lower capacity to provide the level of services needed for multi-system families.
- Many CMPs report challenges in effectively involving family advocates at the ISST-level. Only 10%-14% of ISST cases had a family advocate/facilitator in their initial planning meeting.
- Data sharing barriers present challenges at the state- and local-level. State-level data sharing was achieved with two agencies (Child Welfare, Judicial); this may prove difficult with others (Education, Behavioral Health) partly due to federal regulatory issues. Locally, about one-third of CMPs stated that they do not have multi-agency consents in place to share information among service providers.
- There continues to be variation, and among some CMPs, low participation in client-level data collection for ISST-served families. In FY 2012, client-level data is available on only 56% of all children served by ISSTs.
- There is on-going need to expand and improve standard measurement across CMPs, to support alignment with other improvement efforts within Colorado (e.g., Trauma-informed Systems of Care, Colorado Practice Model, C-Stat) and to address key CMP goals. In addition, the Incentive Committee is exploring the inclusion of standard process indicators in the incentive formula to support an equitable distribution of incentive funds.

Enhancements in the 2013 evaluation. The State Evaluation Subcommittee will continue to seek a balance between meeting the needs of local programs while providing more rigorous evidence of the program's successes and challenges. Evaluation efforts in FY 2013 will focus in the following areas:

- Collection and analysis of standard education and health/mental health outcomes;
- Expansion of data elements in the online system to include evaluation areas of interest to local sites;
- Creation of customized reporting for local programs within the evaluation system to facilitate real-time tracking of client data and improve the management of ISST efforts;
- Expanded evaluation technical assistance to improve data quality and completeness;
- Support in the refinement and implementation of incentive formula elements (e.g., further incorporation of CMP measures and outcomes, as applicable);
- Improvements in the ability to statistically examine links between populations served, services provided, and achieved outcomes based on more uniform data collection; and
- Development of viable strategies for cost measurement based on improved standardization of client outcomes and more uniform data collection.

> *"[As a result of CMP] our county has a 'big picture' view of how collaboration on the policy level improves service delivery and reduces costs as well as a sense from our families that our work has more meaning to them on a personal level than ever before."* *(Elbert CMP)*

[i] *CDHS Division of Child Welfare Scorecard* (provided to OMNI by CDHS).

[ii] Office of the State Court Administrator (2011). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2010 releases*. Retrieved on-line October 2012.

The Collaborative Management Program (CMP)

The Collaborative Management Program (CMP), as specified in Colorado House Bill 04-1451(2004), pursues 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.

Participation in the CMP has increased significantly since it was established, growing from six counties in its first year to 32 in the 2011-12 fiscal year. Figure 1 illustrates the distribution of participating counties across the state and by population density, and Figure 2 below presents key milestones achieved across years. (See Appendix 1 for a diagram of the CMP oversight and implementation structure.)

Figure 1: Map of participating CMP counties (2005-2012)

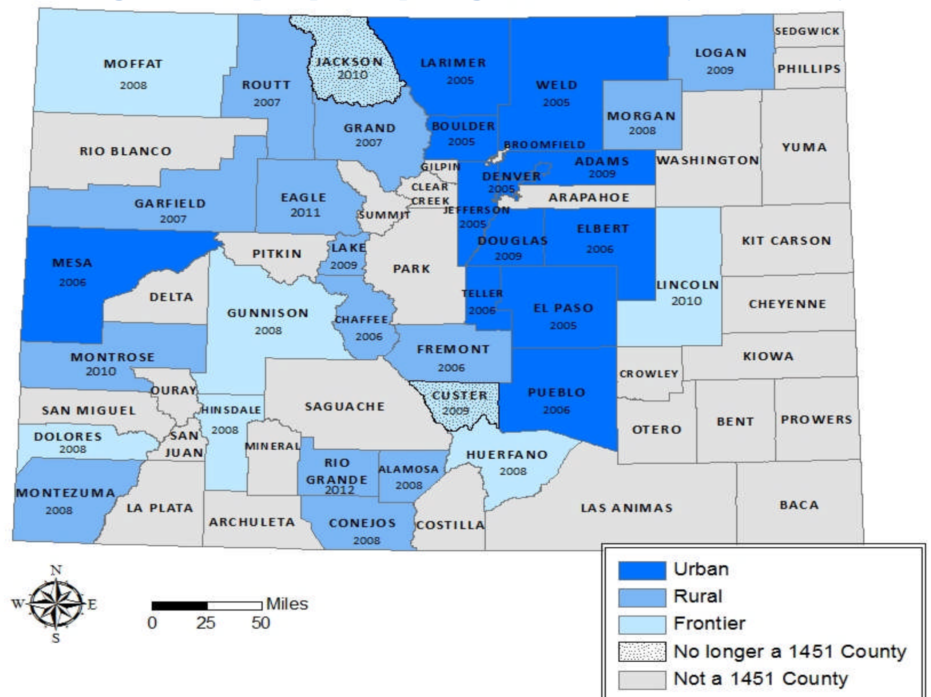


Figure 2: Collaborative Management Program timeline (2004-2012)

2004
- House Bill 04-1451 passes, establishing CMP

2005
- CMP begins
- CMP State Steering Committee (SSC) forms to provide oversight and direction for the program
- CDHS establishes CMP Program Director position
- SSC establishes outcome domains for the program:
  - Child Welfare
  - Juvenile Justice
  - Education
  - Health/Mental Health

2006
- Earned incentive formula developed in conjunction with state and county partners
- First annual report to executive directors of each department and agency party to MOU

2007
- Colorado Children and Youth Information Sharing Collaborative (CCYIS) forms
- CMP SSC Family Voice and Choice Subcommittee forms

2008
- House Bill 08-1005 authorizes an external evaluation of the CMP

2009
- CDHS hires OMNI Institute as external evaluator
- CMP SSC Evaluation Subcommittee forms

2010

2011
- CMP SSC Communications/ Sustainability Subcommittee forms

2012
- CMP Coordinator's Handbook released

Number of counties participating in the CMP

FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
6	12	15	24	29	31	30	32

A. Evolution of CMP

CMP stakeholders including state and local agencies, family advocacy groups and related key partners, continue to refine and build the program based on learning, collaborative efforts and ongoing use of evaluation findings. A number of achievements were realized in the past year related to the development and dissemination of information about effective practices within the program, and toward building critical evaluation infrastructure and systems to measure performance.

Developing and disseminating information about implementation practices

In FY 2012, CMP stakeholders undertook a number of efforts to further the program with respect to clarifying CMP approaches; advancing the use of high quality processes, programs and services; and establishing shared expectations about the core components of CMP activities. These include:

- Development and distribution of a detailed **CMP Handbook** that describes the origins, philosophy, goals, and activities of the program and serves as a "how to" tool for new CMPs as well as a tool to support the development of innovative practices in established CMPs;
- Strategic planning by the State Steering Committee which resulted in the formation of the **CMP Communications Subcommittee** tasked with identifying communication strategies to help sustain the program;
- Formation of the **CMP Incentive Committee** tasked with identifying common standards for implementation by which CMPs can be assessed for purposes of the incentive fund allocation process[1];
- Development and implementation of a **Collaborative Effectiveness Discussion Guide** to support IOG member reflection on the quality of their collaborative efforts;
- Exploration of the relationship between the nationwide Systems of Care movement and Colorado's Collaborative Management Program; and
- Active sharing of information related to best practices among CMP stakeholders via the CMP portal, subcommittee activities, and CMP regional meetings.

Establishing evaluation infrastructure and performance measurement

House Bill 08-1005 authorized an annual external evaluation of the CMP. 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.

The CMP statewide evaluation has been designed with these requirements in mind.

[1] To date, performance-based incentive dollars have been distributed to CMPs based on a demonstrated achievement of outcomes and in accordance with a formula approved by the State Board of Human Services.

While the CMP statewide evaluation began in 2009, it was necessary to phase-in evaluation requirements over time in order to achieve buy-in from local projects and to minimize disruption to established practices (refer to Appendix 2 for details on the phases of the statewide evaluation). In general, the first year of the evaluation concentrated on documenting and describing the range of local efforts and outcomes of local CMPs while the second year focused on refining common process and outcome measures and developing systems to collect data to evaluate legislative goals. In this past year, the evaluation achieved significant progress in advancing the systematic collection of process and outcome data to support improved analyses. This included:

- Initiating standardized local tracking of client level data including demographics, services, and outcomes;
- Developing data sharing agreements and processes between OMNI and analysts at Child Welfare (Trails) and Judicial (ICON/Eclipse) to obtain outcome data for CMP-served clients;
- Establishing analytic processes that match locally collected data with state databases to measure progress on legislative goals;
- Identifying additional statewide outcome indicators in the domains of education and health/mental health through interviews and focus groups with CMP stakeholders;
- Refining data collection systems, auditing data for quality assurance, and refining and administering data collection tools (*Collaboration and Success Survey*, CMP Annual Report).

This is the first report that incorporates client-level data from multiple sources. This includes process data from the CMP Annual Report and the CMP Statewide Evaluation Database (implemented in ETO; Efforts to Outcomes©) as well as outcome data from the Trails and ICON/Eclipse systems. Table 1 describes information gathered through the two process data reporting methods.

Table 1: Methods of reporting about individuals served by CMPs

Method	Description		Level
CMP Annual Report	Who?	All children served by any ISST provided by each CMP.	Aggregate data summarized at CMP level (CMP children as a whole)
	What?	General information about ISST-served children.	
	Who?	All children served by the "primary ISST." CMPs with more than one ISST report on the ISST serving the most children.	
	What?	Information about the number of children served by the ISST, and key information about the processes used by that ISST.	
CMP Database	Who?	Children served by ISST(s) designated by CMPs. To accommodate local-level information sharing protocols and staffing capacity, individual CMPs designate the ISST(s) and individuals to be entered into CMP database. Some CMPs do not enter all ISST-served children into this database.	Client-level data (specific to individual children served by CMPs)
	What?	Detailed, client-level information about children served through an ISST process, including agencies and family members participating in ISST meetings, services identified, and outcomes relevant to the child.	

The statewide evaluation obtained aggregate process data from 28 of 30 CMPs through the Annual Report (2 CMPs submitted reports after the analysis deadline and were not included in analyses)[2] and client-level process data from 29 of 30 CMPs primarily through the CMP database (1 CMP joined the program in FY 2012 and did not submit client-level data in its first year). The statewide evaluation also gathered data on the quality of collaborative processes and perceived success from IOG members in all 30 CMPs through the *Collaboration and Success Survey.*

The following table summarizes the statewide outcomes, indicators, and data sources that were selected for tracking of state-level outcomes. Client identifiers collected from the process dataset were shared with state agency data analysts, who then matched cases and provided variables needed to conduct the outcome analysis to the evaluators.

Statewide Outcomes	Indicators	Data source
Increase stability: Prevent new involvements in child welfare system	Number (rate) of new involvements in CW system after ISST services begin	CDHS Trails database
Increase safety: Prevent abuse	Number (rate) of substantiated abuse findings within 6 months of when ISST services begin	
Increase stability: Reduce number of moves while in placement	Number (rate) of two or more moves in out-of-home placement after ISST services begin	
Increase stability: Discharge to a permanent home	Number (rate) of discharges to a permanent home	
Increase successful intervention: Increase rates of successful completion of probation	Number (rate) of successful completion of probation	State Judicial ICON/ Eclipse database
Increase successful intervention: Decrease rates of probation revocations	Number (rate) of probation revocation due to technical violations among youth on probation	
Increase successful intervention: Decrease rates of pre-release recidivism	Number (rate) of probation revocation due to pre-release recidivism among youth on probation	

A total of 4092 unduplicated cases were entered into the CMP database or otherwise provided to the evaluator; this cohort served as the matching dataset for the outcome analyses. One CMP's client-level data (n=950) was not included due to differences in data collection and data entry. This resulted in a sample size of 3142 cases for the final client-level service and outcome analysis.

About this report

Findings presented in this report do not reflect the full scope of evaluation products; additional reports and deliverables have been produced during the course of the year and additional materials, based on year three data will be forthcoming. The report begins with a description of local CMP infrastructure followed by several sections highlighting the impact of CMP on outcomes and systems change benefitting multi-system families. The report closes with a discussion of conclusions and considerations, as well as next steps for the evaluation in year four.

[2] Due to missing data, n's for annual report results aggregated across CMPs range from 26 to 28. N's are included in tables only when they deviate from the total number of CMPs (28) with submitted data.

I. CMP infrastructure, population, and service delivery

Colorado Revised Statute (24-1.9-102.5) states that the Colorado Department of Human Services (CDHS), with input from the counties, involved state agencies, participating stakeholders, and participating parent or family advocacy organizations will develop the criteria and components of an external evaluation. CDHS, in collaboration with these identified partners participating on the State Steering Committee, determined that CMPs must report on the following:

a) number of children and families served through the individualized service and support teams and the outcomes of the services provided;
b) estimated costs as well as cost-shifting or savings related to CMP implementation; and
c) information relevant to improving the delivery of services to persons who would benefit from multi-agency services.

The following section addresses aspects of items “a” and “c” above by describing how CMPs have implemented two key components of the legislation – Interagency Oversight Groups (IOGs) and Individualized Service and Support Teams (ISSTs) – as well as who is receiving CMP services, and the evidence-informed programs being implemented. Service outcomes, estimated costs and cost-shifting/savings, as well as additional efforts related to improving service delivery are discussed in Sections II and III.

A. Interagency Oversight Groups (IOGs)

While CMPs are required to establish local IOGs, and though many possess common characteristics, the size, meeting schedule, and composition of individual IOGs vary significantly across CMPs.

Characteristics of IOGs across CMPs
• The average number of IOG members was 19, with a range of 7 to 34 members. • The average number of voting members was 15. • Two-thirds of CMP IOGs (68%) meet monthly. • Almost all IOGs had a quorum at 76% or more of their meetings.

IOG Membership

Table 2 below lists the 19 most common agencies or individuals represented on IOGs. Legislatively mandated partners were generally well represented at IOG meetings, with all CMPS reporting members from county departments of human or social services, schools, probation, Division of Youth Corrections, and a domestic violence service provider. The vast majority of CMPs (90% or more) also reported IOG members from mental health service providers and county health departments. CMPs also have actively involved non-mandated partners in their governance activities (e.g., Senate Bill 94 stakeholders attend in over 90% of CMPs). This level of participation is consistent with reports from FY 2011. Of note, representation of “family voice,” which is strongly encouraged but not mandated, increased from FY 2011 (see Section III for additional details).

Nineteen CMPs reported active IOG members in categories other than those specifically listed in Table 2, most commonly from early childhood organizations, local attorneys, faith-based organizations, and other non-profit and foundation partners (e.g., Boys & Girls Club, Goodwill Industries, and United Way).

Table 2: IOG member agencies and percent where member attended 50% or more meetings

Agency or Individuals Represented through Membership on IOG	Number of CMPs with Member (%)		Member Attends 50%+ of Meetings (%)	
County Department of Human and Social Services	**28**	**(100%)**	**28**	**(100%)**
School Representative	**28**	**(100%)**	**27**	**(96%)**
Probation	**28**	**(100%)**	**27**	**(96%)**
Division of Youth Corrections	**28**	**(100%)**	**26**	**(93%)**
Domestic violence service provider	**28**	**(100%)**	**26**	**(93%)**
Mental health service provider center	**27**	**(96%)**	**26**	**(96%)**
County Health Department	**27**	**(96%)**	**25**	**(93%)**
Senate Bill 94 representative	26	(93%)	25	(96%)
Substance abuse service provider	**24**	**(86%)**	**19**	**(79%)**
Behavioral health organization representative	**23**	**(82%)**	**17**	**(74%)**
Local courts/judicial	**23**	**(82%)**	**16**	**(70%)**
Family representative	19	(68%)	13	(68%)
Diversion	13	(46%)	11	(85%)
Law enforcement	11	(39%)	8	(73%)
Family advocacy organization	9	(32%)	5	(56%)
Elected official	9	(32%)	5	(56%)
Youth representative	8	(29%)	4	(50%)
Local health services provider	7	(25%)	6	(86%)
Business or Chamber of Commerce	3	(11%)	1	(33%)
Other	19	(68%)	19	(100%)

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

While not typically a voting member, all CMPs have a full-time (68%) or part-time (32%) coordinator who plays a role on the IOG. In nearly all CMPs (86% to 93%), coordinators disseminate information and serve as liaisons among partners, and document key IOG decision-making processes and outcomes. CMPs reported coordinators played similar roles in FY 2011, although in FY 2012 more coordinators participated in IOG leadership (24 CMPs in FY 2012 vs. 19 CMPs in FY 2011) and managed funds and budgets (23 in FY 2012 vs. 18 in FY 2011). See Appendix 3 for additional details.

IOG Focus Areas

IOGs are expected to conduct oversight in several areas, including improving communication and resource sharing across partner agencies. They are also granted considerable discretion in defining their own priorities. In FY 2011 IOGs identified a common set of core activities that align closely with the legislative goals. Table 3 presents the number and proportion of CMPs indicating that they conducted work in each area in FY 2012. Selected activities associated with each priority area also are listed. The types of activities CMPs reported conducting in these core priority areas in FY 2012 are similar to those reported in FY 2011.

Table 3: IOG priority areas and activities in the 2011-12 fiscal year

Priority Areas and Supporting Activities	Number of CMPs	(%)
Improving quality of service delivery for children and families	26	(93%)
Introducing new services (e.g., mentoring)		
Hosting cross-agency trainings		
Increasing awareness about services within the community		
Refining ISST models		
Strengthening collaborative relationships with new and existing partners	23	(82%)
Recruitment of new partners (e.g., family representative, early childhood, mental health treatment, domestic violence, substance use treatment , justice system)		
Establishing and/or refining IOG structure, processes, and protocols	21	(75%)
Development and/or revision of IOG bylaws		
Expanding voting rights among IOG members		
Establishing new IOG subcommittees		
Addressing CMP sustainability	10	(36%)
Establishing dedicated committee/subcommittee on sustainability		
Pursuing grant funding		
Funding local service providers associated with the CMP		
Strategic planning		
Enhancing CMP personnel resources	9	(32%)
Hiring of new personnel (e.g., family representative, new CMP coordinator, Wraparound Facilitator, Family Support Partner, Systems Navigator)		
Modification of staff roles and responsibilities		

Emerging IOG Focus Area: Prevention of Multi-Systems Involvement in Early Childhood

Twenty CMPs described how their IOGs have expressed a growing interest in prevention and early childhood and are exploring how efforts in these areas may integrate with CMP. Indicators include:

- growing presence of early childhood stakeholders on CMP IOGs;
- increased partnership with local prevention efforts, including representation from prevention partners (e.g., early childhood councils, prevention coalitions) on the local IOG and/or ISST;
- establishment of dedicated prevention-oriented committees; and
- a general increase in coordination of CMP work with prevention efforts through blending funds, establishing joint committees, and outreach among stakeholders.

B. Populations eligible for CMP services

IOGs are required to define specific target populations that are eligible for services, which differ by site. Consistent with the legislation and the four CMP target outcome domains, the largest number of eligible children across the program were those being served by mental health providers (25,297 across CMPs), open child welfare involvement (22,442 across CMPs), demonstrating truancy issues (9,672 across CMPs), and on probation or in the Division of Youth Corrections (DYC) detention (4,249 and 3,178 across CMPs, respectively). The estimated eligible population in FY 2012 (the sum of the numbers eligible or served among all CMP partner agencies and containing known duplication), is 70,000 individuals, consistent with the eligible population reported in FY 2011.

Data reported about the individuals considered eligible for CMP services (i.e., the five categories mentioned above and additional twelve presented in Appendix 4) illustrate significant variation in target populations across CMPs. Specifically:

- not a single category of eligible children was selected by all 28 reporting CMPs;
- only four categories were selected by more than half of reporting CMPs; and
- the total number of eligible children in each category varies widely across CMPs (e.g., from 1 to 11,750 for youth served by partnering mental health providers).

Populations Served by CMPs

CMPs share a commitment to fostering cross-agency collaboration with the desired goal of improving outcomes for the children and families they serve. As required by legislation, all CMPs have an IOG that provides oversight and guidance for the collaborative process and a locally specified target population. However, in part driven by differing target populations, the form and focus of CMP work varies significantly. Figure 3 describes the population served by CMPs, including the total, average, and minimum and maximum number reported across CMPs, at the different levels of participation (all totals include duplicated cases).

Figure 3: Individuals served by CMPs

Individuals Screened/Assessed for Services

Total: 38,327 Average: 1,369 Range: 7-11,895

Individuals considered for CMP services; not all receive CMP services

Individuals Served by CMP Partners

Total: 20,799 Average: 743 Range: 7-5,583

Individuals receiving services provided through CMP, whether those services are funded by CMP or not

Individual Children/Youth Served by an ISST

Total: 7,333 Average: 262 Range: 7-2,068

Individuals receiving services through an ISST, includes only referred youth

For some CMPs, the legislatively required ISST is the focal point for service delivery, such that individuals and families served through an ISST comprise the vast majority, in some cases the entirety, of the population served by the CMP. For example, 21% (6) of CMPs reported that three-quarters or more of their population was served through an ISST. For other CMPs, however, a large proportion of individuals and families receive services outside of an ISST; that is provided by local partners and supported by the CMP. Here, 32% (9) of CMPs indicated that less than a quarter of their target population is served through an ISST (see Appendix 5 for more information).

ISST structures and processes

The CMP statewide evaluation has implemented multiple methods for collecting information about the youth and families served through an ISST, as well as the processes by which ISST services take place (See Table 1 in Introduction). The following section presents first a summary of information regarding ISSTs taken from local CMP Annual Reports, followed by a summary of data entered into the CMP statewide evaluation client-level database.

The number of ISSTs varies by CMP

Half (14) of CMPs reported having one ISST. Among those with multiple ISSTs, two reported two ISSTs, eight reported three ISSTs, and four reported four ISSTs. The factors that CMPs commonly use to differentiate among multiple ISSTs are summarized in Table 4 below.

Table 4: Factors distinguishing multiple ISSTs per CMP

Factor	Description
Subject or domain	Some CMPs with multiple ISSTs dedicate these to serve youth/families in a focused issue area, such as developmental delay, domestic violence, truancy, or substance use.
Complexity of need/ level of risk	Some CMPs with multiple ISSTs differentiate these based on case complexity or level of risk among the target population, and may include multi-level or tiered ISSTs. In this model, multiple ISSTs work together to provide services based on the family's level of need. For example, one ISST might focus on prevention and/or early intervention efforts, another might work with families with moderate needs, and a third would work specifically with families facing more complex issues.
Age of children served	In some instances, CMPs use multiple ISSTs to serve children/youth of different ages, with individual ISSTs focusing on smaller age ranges (e.g., children 0-5 served by one ISST; children ages 10-18 served by another).
Lead agency	CMPs may also establish multiple ISSTs when more than one agency is responsible for leading the ISST process. For instance, one CMP described one ISST hosted by the Department of Human Services and another by Probation.

Many CMPs implement evidence-informed interagency service models

Several CMPs have adopted evidence-based (EBP) and/or promising programs and practices (PP) specifically focused on cross-agency collaboration and service integration. In general, both EBPs and PPs are those programs or practices for which some systematic evidence of effectiveness exists. As there is not general consensus about the specific criteria required for a program to be considered evidence-based and/or promising, these are referred to as "evidence-informed" in this report.

Defining Features of Evidence-based Program/Practices (EBP)

- Effectiveness established through rigorous research, often through randomized controlled trial of quasi-experimental design with a comparison group
- Programs are implemented in a highly structured manner, with strict adherence or "fidelity" to the model

Defining Features of Promising Program/Practices (PP)

- Emerging evidence of efficacy, through less rigorous research designs (e.g., differences in pre-post comparisons within served sample)
- Is often adapted to meet local needs (lower threshold for fidelity)

Twenty-three CMPs (82%) reported implementing a total of 41 distinct evidence-informed programs or practices (79 instances). These are typically delivered directly through an ISST (e.g., High Fidelity Wraparound) or by CMP partner agencies to youth/families outside of an ISST. Table 5 highlights the most commonly reported evidence-informed programs. Of note, five of the seven most common programs specifically focus on cross-agency collaboration and/or service integration (denoted with an asterisk * in Table 5). Specifically, High Fidelity Wraparound or Wraparound, Team Decision Making/Family Group Conferencing, and Case Management each center around interagency staffing processes intended to coordinate and integrate service delivery. Additionally, Functional Family Therapy (FFT) and Multi-systemic Therapy (MST) emphasize interagency integrated plans in which families are collaborators in planning, though they typically do not involve interagency staffing meetings. The number of CMPs reporting implementation of evidence-informed programs has increased over time (20 CMPs in FY 2011; 23 CMPs in FY 2012).

Table 5: Most common evidence-informed programs and practices reported by CMPs

Evidence-informed Program or Practice	Number of Instances	Number of CMPs (%)
High Fidelity Wraparound or Wraparound*	15	13 (46%)
Team Decision Making/Family Group Conferencing*	6	6 (21%)
Case Management*	5	3 (11%)
Functional Family Therapy (FFT)*	4	4 (14%)
Mentoring	4	4 (14%)
Dialectical Behavior Therapy (DBT)	3	3 (11%)
Multi-systemic Therapy (MST)*	3	3 (11%)

CMPs also reported developing systems to enable monitoring of implementation fidelity, which suggests a strong emphasis on quality. Specifically, CMPs indicated that they monitor fidelity for 28 of the 79 (35%) evidence-informed programs/practices reported. When implemented with fidelity, CMPs can be confident that the evidence-informed strategies will result in positive outcomes.

In addition to the specific programs and practices identified above, CMPs report implementing a number of strategies that indicate they are engaged in ongoing learning and demonstrate incremental improvements to service delivery, including:

- Education of CMP partners on evidence-informed programs and practices through trainings/presentations from program experts;
- Internal research into practices and assessment tools;
- Implementation of evidence-based assessment tools;
- Exploration of fidelity measures; and
- More global refinement of the CMP target population or program/service delivery model.

Evidence-informed model highlight: Crossover Youth Practice Model

A number of CMPs are in the process of adopting the Georgetown University Center for Juvenile Justice Reform Crossover Youth Practice Model, one of which reported that the model "*will be our primary ISST method for youth active with Child Welfare and crossing over into the delinquency system (Court). This evidence based practice will improve the coordinated assessment process, family team meetings, joint treatment planning and joint supervision to help reduce conflicting requirements for family and the duplication of serving youth and families dually involved in these systems.*"

Bringing together research and applied learning about serving youth engaged in both the child welfare and juvenile justice systems, the model emphasizes "*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*)

Primary ISSTs and ISST meetings

Table 6 summarizes key information provided by CMPs in annual reports regarding service delivery within their "primary" ISSTs[3], as well as estimates of typical ISST meeting characteristics (i.e., aggregated across multiple ISSTs where relevant). These data reflect service provision among the population of children that CMPs reported serving served CMP descriptions of primary ISST structures and processes are relatively consistent from FY 2011; notable changes are indicated in Tables 6 and 7. Detailed information is presented in Appendix 6.

[3] CMPs with multiple ISSTs were asked to designate the one serving the most children for reporting purposes.

Table 6: CMP descriptions of primary ISSTs and typical ISST meetings (per annual reports)

<table>
<tr><td>How many children are served through the primary ISST?</td><td>In FY 2012, primary ISSTs served an average of 177 individual children and a total of 4,957. The number of individual children served by a primary ISST varied from 11 to 1,748.</td></tr>
<tr><td>How are families referred to ISSTs?</td><td>Families are referred to ISSTs through a variety of avenues, and the specific referral sources vary by CMP. However, the ISST referral sources reported by the greatest number of CMPs appear below. From FY 2011 to FY 2012, the three most common referral sources were the same, although there were more probation referrals than school district referrals in FY 2012.
<table>
<tr><th rowspan="2">Source</th><th colspan="2">Number of CMPs Reporting</th><th colspan="2">Average Share of Referrals</th></tr>
<tr><th>FY 11</th><th>FY 12</th><th>FY 11</th><th>FY 12</th></tr>
<tr><td>Department of Human Services</td><td>27</td><td>23</td><td>40%</td><td>42%</td></tr>
<tr><td>Probation</td><td>22</td><td>23</td><td>15%</td><td>30%</td></tr>
<tr><td>School district(s)</td><td>26</td><td>22</td><td>24%</td><td>9%</td></tr>
</table></td></tr>
<tr><td>How many families are addressed during a single ISST meeting?[4]</td><td>
<table>
<tr><th></th><th>FY 11</th><th>FY 12</th></tr>
<tr><td>One child/family per meeting</td><td>42%</td><td>61%</td></tr>
<tr><td>Multiple children (from different families) per meeting</td><td>46%</td><td>32%</td></tr>
</table></td></tr>
<tr><td>How much time is spent per family in each ISST meeting?</td><td>CMPs most commonly reported spending 1 hour per family per ISST meeting. However, they ranged from 20 minutes to 4 hours per family. These rates are similar to those reported in FY 2011.</td></tr>
<tr><td>How many ISST meetings are held per family?[5]</td><td>The majority (62%; 16) of CMPs reported that between 1 and 2 ISST meetings are held per family in FY 2012, representing a slight increase from FY 2011.
<table>
<tr><th></th><th>FY 11</th><th>FY 12</th></tr>
<tr><td>1-2 meetings</td><td>52%</td><td>62%</td></tr>
<tr><td>3-5 meetings</td><td>17%</td><td>15%</td></tr>
<tr><td>6-10 meetings</td><td>22%</td><td>15%</td></tr>
<tr><td>> 10 meetings</td><td>9%</td><td>2%</td></tr>
</table></td></tr>
</table>

[4] Percentages do not sum to 100% due to missing or other responses.
[5] Valid percents; in FY 2011, n=23; in FY 2012, n=26.

Table 6: CMP descriptions of primary ISSTs and typical ISST meetings (per annual reports)

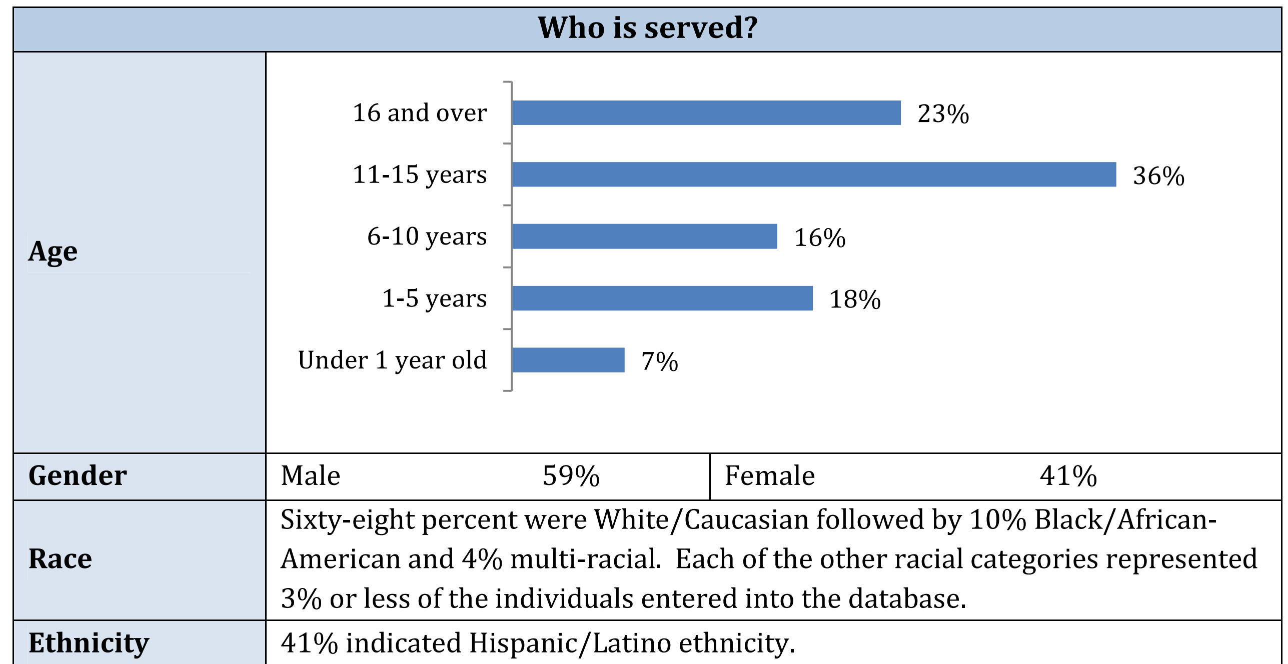
<table>
<tr><td rowspan="1">How many agencies are involved in the ISST meeting?</td><td colspan="3">57%
50%
32% 29%
FY 11
FY 12
14%
11%
4%
4%
2 to 3 | 4 to 6 | 7 to 10 | > 10

In FY 2012, 25 CMPs reported that at least four agencies were typically in attendance and 9 indicated participation of seven or more agencies. This was similar to FY 2011, when 26 CMPs indicated at least four agencies, and 13 reported seven or more agencies, attended ISSTs.</td></tr>
<tr><td rowspan="5">How are ISST members selected?</td><td rowspan="2"></td><td colspan="2">Number (%)</td></tr>
<tr><td>FY 11</td><td>FY 12</td></tr>
<tr><td>A set group of attendees participates in all ISST meetings</td><td>3 (12%)</td><td>3 (11%)</td></tr>
<tr><td>A core group of attendees attend all ISSTs, plus additional attendees based on individual child/family.</td><td>16 (62%)</td><td>12 (44%)</td></tr>
<tr><td>Attendees are selected based entirely on individual child/family needs.</td><td>7 (27%)</td><td>10 (37%)</td></tr>
</table>

Tables 7 through 10 summarize key population and ISST services information at the client level, as entered by CMPs into the CMP database. This is the first time the CMP can report on data at the client level. While some cases are entered multiple times into the CMP database to correspond to each ISST staffing, data presented below are based only on the initial ISST meeting to generate an unduplicated count (n = 3142; see Appendix 7 for more details on the data collection, auditing, and analysis process). For one county, client-level data were collected in a local database that resulted in slight variations in data items. A small subset (n=17) had equivalent data items but was identified after aggregate analysis was complete; thus, these data were analyzed separately and are presented in Appendix 8.

Table 7 shows that over half of ISST-served clients (59%) were pre-adolescents and adolescents, with one-quarter of clients under the age of five (25%). More than half (59%) of clients were male, and more Caucasian (68%) clients were served than individuals in any other racial category.

Table 7: Children, youth and families served by CMP ISSTs (per CMP database)



Who is served?				
Age	16 and over: 23% 11-15 years: 36% 6-10 years: 16% 1-5 years: 18% Under 1 year old: 7%			
Gender	Male	59%	Female	41%
Race	Sixty-eight percent were White/Caucasian followed by 10% Black/African-American and 4% multi-racial. Each of the other racial categories represented 3% or less of the individuals entered into the database.			
Ethnicity	41% indicated Hispanic/Latino ethnicity.			

Tables 8 and 9 summarize information pertaining to the agencies that families were involved with at the first ISST meeting. Three-fifths (60%) of all ISST-served children were involved in more than one system as they entered services; these families represent a targeted population in CMP legislation. The data suggest that risk for or existing out-of-home placement and mental health issues are the most common presenting issues.

Table 8: Systems involvement at referral and enrollment (per CMP database)

Characteristics of ISST-served children, youth and families at enrollment			
How were families referred to ISSTs?	Consistent with annual reporting, client-level data indicate that ISST referrals most commonly come from DHS, Judicial/probation, and/or schools. No more than 6% of referrals came from any other single source.		
	Referral Source	**Number of Cases (%)**	
	Local DHS/Child welfare	1,966	(67%)
	Judicial and/or probation	453	(15%)
	School	404	(14%)

Table 9: Systems involvement at referral and enrollment (per CMP database)

Characteristics of ISST-served children, youth and families at enrollment			
	System, Agency, or Organization	**Number of Cases (%)**	
What systems were clients involved with at ISST enrollment?	Local DHS with child welfare open involvement	2235	(75%)
	Mental health/Behavioral health program	1,122	(38%)
	Judicial/probation	707	(23%)
	Counseling/At-risk services	293	(10%)
	Other school-based program	233	(8%)
	Other system or organization	220	(7%)
	Truancy program	191	(6%)
	SB-94 program	173	(6%)
	Other DHS CW program	103	(3%)
	DYC - Detention/commitment	58	(2%)
	Other juvenile justice program	58	(2%)
	Domestic violence program	49	(2%)
How many systems were involved at enrollment?	In 60% of ISST-served cases, clients were involved with two or more systems at enrollment. In 40% of ISST-served cases, clients were involved with one system at enrollment.		

As outlined in the legislation, ISSTs reflect multi-agency participation in developing a coordinated service plan, with engagement by families a central goal. The data in Tables 10 and 11 show that in general, CMPs involved multiple agencies (83%) and engaged family members (83%) in initial ISST meetings; in the large majority of cases, these meetings resulted in an integrated plan (86%) where multiple agencies were designated to provide services (73%).

Table 10: Systems and family involvement in ISST intervention planning (per CMP Database)

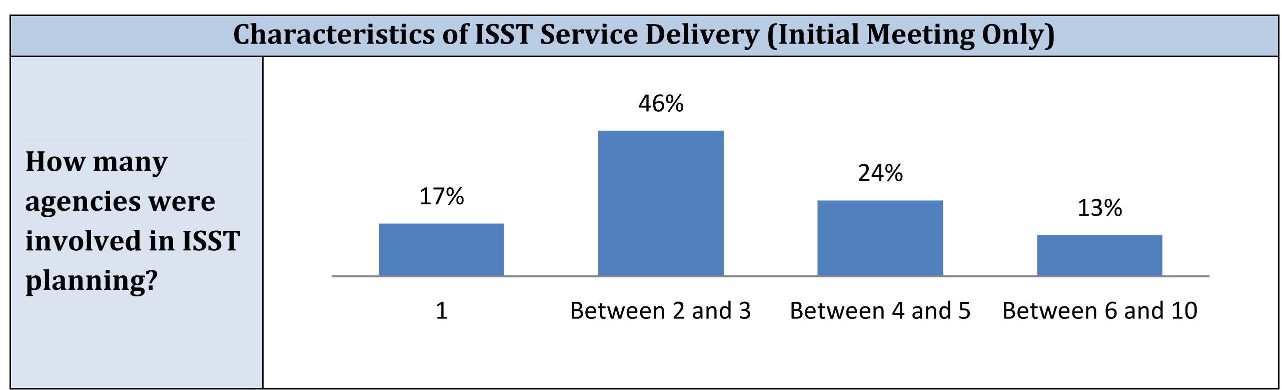


Table 11: Systems and family involvement in ISST intervention planning (per CMP Database)

<table>
<tr><th colspan="3">Characteristics of ISST Service Delivery (Initial Meeting Only)</th></tr>
<tr><td>How were families involved in ISST planning?</td><td colspan="2">At least one family member was involved in the vast majority (83%) of ISST meetings entered into the CMP database; 56% included multiple family members in the ISST meeting. The most common family members participating in an ISST meeting appear below.
Mother 66%
Father 33%
Youth 22%
Grandparent 17%
Sibling 7%</td></tr>
<tr><td>Was an integrated service plan developed?</td><td colspan="2">Yes 86%
No 14%</td></tr>
<tr><td rowspan="6">What systems, agencies, or providers were designated to provide services in the plan?</td><td colspan="2">Consistent with the legislation, 73% of cases resulted in a service plan including services from more than one agency; more than one-third (40%) of those involved more than two agencies. The most common agencies/organizations providing services in the plan appear below.</td></tr>
<tr><td>System, agency, or organization designated to provide services in integrated plan</td><td>Number of Cases (%)</td></tr>
<tr><td>DHS Child Welfare</td><td>2,099 (73%)</td></tr>
<tr><td>Mental Health/Behavioral Health Organization</td><td>1,504 (53%)</td></tr>
<tr><td>School</td><td>960 (33%)</td></tr>
<tr><td>Judicial and/or Probation</td><td>767 (27%)</td></tr>
</table>

II. Outcomes

The ultimate goal of the program, as outlined in Legislative Goal V, is to improve outcomes for children and families who require services from multiple agencies. The underlying program theory suggests that interagency system improvements resulting in more efficient and effective service delivery will lead to more successful outcomes for children and families. To that end, the program has focused significant attention on building evaluation infrastructure and systems; reporting on CMP performance relative to statewide and local indicators; assessing IOG member perceptions of the impact of CMP efforts on children and families; and more systematic utilization of evaluation data to inform work at both the local and state-levels.

In FY 2012 the statewide evaluation established processes for the collection of client-level service data and the analysis of selected child welfare and juvenile justice outcomes. In addition, CMPs continued to report on their success in meeting target goals on locally-defined performance measures, supplemented by anecdotal evidence of their positive impact. The discussion below first presents results as reflected in client-level data followed by results based upon locally-defined performance measures and reporting.

A. Impacts assessed by statewide indicators

The program successfully developed infrastructure and implemented processes to uniformly measure key child and family outcomes

In FY 2012 the program designed and implemented cross-CMP and cross-systems data collection, management, and analysis protocols to calculate performance on a set of uniformly measured outcome indicators. Indicators were carefully selected by CMP stakeholders to align with key outcome priorities identified by state agencies (i.e., CDHS and State Judicial) and to capitalize on commonly assessed child welfare and juvenile justice measures at the local level. Additional information on the selection process and definition of statewide indicators is in Appendix 9.

Key FY 2012 markers of success in this area include:

- Launch of the CMP on-line data management system.
- Implementation of a common client-tracking form used by all 30 CMPs to collect uniform information about client services and outcomes.
- Establishment of local processes and protocols to collect and share client-level data items across all 30 CMPs.[6]
- Creation of a statewide dataset comprising 3,456 ISST client tracking form entries and representing an unduplicated total of 3,142 children with FY 2012 ISST service and outcome data.[7] (See Appendix 11 for total numbers of clients by CMP.)

[6] Client-level data were entered directly into the CMP ETO data system by 26 CMPs; locally-collected datasets were provided to the evaluator by 3 CMPs (2 were able to be uploaded into the system); and 1 CMP in its initial year has processes in place to enter client-level data in FY 2013.

- Creation of aggregate reporting functions in the CMP on-line system, allowing CMPs to generate summary reports of their own client demographic and service data, to be used for service tracking, program improvement, and local evaluation purposes.
- Success in linking case data to two statewide databases (Trails and ICON/Eclipse). This accomplishment resulted from considerable efforts to develop partnerships and cross-agency data sharing agreements. For example, the Evaluation Subcommittee successfully petitioned the Colorado Public Access Committee to obtain permission to access juvenile probation data through the State Judicial Planning and Analysis office. CMP evaluators met on multiple occasions with data analysts from CDHS and State Judicial to define appropriate indicators and ensure accurate analytic approaches to calculating outcomes.
- Standardization of on-going data collection, data sharing, and analysis processes to track state-level performance on selected indicators among CMP youth over time.

Child welfare and juvenile justice outcomes: Baseline rates for the selected statewide indicators were established

Due to the selection of common measures, implementation of a local data collection system and granted access to state databases, this is the first time that performance on a standard set of child and family outcome indicators can be assessed for the program overall. Tables 13 and 14 below present the selected child welfare and juvenile justice outcomes, the indicator selected to measure the outcome, and the baseline performance for FY 2012.

Performance on each of the indicators was calculated at two levels of the CMP population:

1) All children served through an ISST (i.e., with data entered for an initial ISST meeting that occurred between July 1, 2011 and June 30, 2012);
2) The subset of children in (1) with the indicator selected as a target goal for intervention services (see Table 12 for the number and percent of relevant cases).

Table 12. Clients where statewide indicator was selected as ISST intervention goal

Statewide Indicator	Number of Cases (%)	
Prevent new involvements in CW system	1291	(45%)
Prevent abuse	1088	(38%)
Reduce number of moves in out-of-home placement	701	(24%)
Discharge from out-of-home placement to permanent home	615	(21%)
Successful completion of probation	499	(17%)
Prevent juvenile justice involvement/ additional involvement	823	(29%)
No target outcomes chosen	261	(9%)

Note: 255 cases were missing data. Successful completion of parole was a response option but was not measured in FY 2012 (n=36, 1% of ISST-served youth).

---

[7] One county submitted a dataset with 950 unduplicated cases; however, due to variation in items resulting in incomparable data, results of individual analyses of a subset of these data are found in Appendix 8.

Given that FY2012 is the first year for which statewide client-level data is available, the numbers and rates presented in Tables 13 and 14 below represent baseline performance. Thus, interpretation of performance in FY 2012 is limited. In FY 2013 and beyond, yearly performance on these indicators can be compared to monitor trends.

As mentioned earlier, the CMP statewide indicators were selected in part because they assess outcomes that have been a focus of improvement efforts within Colorado state agencies. For example, CDHS has implemented C-Stat, a performance-based analysis strategy whereby select indicators are reported on an on-going basis, and utilized to address needed service improvements. CMP indicators were defined, to the extent possible, to align with indicators that are consistently tracked and reported by a) CDHS on the population of children referred to the Division of Child Welfare;[i] and b) State Judicial on the population of youth receiving probation services.[ii] State agency indicators primarily are assessed on cases where services have ended, or are calculated for the prior year's cohort, in order to allow enough time to have passed for key outcome events to have occurred or to meet federal reporting standards. For CMP calculations, the base cohort is children who began services during FY 2012, and in most cases less than one year of follow up data is available for tracking of outcomes. For these reasons, performance rates for CMP indicators and state-agency indicators are not directly comparable. However, in future years, cumulative data collection will allow for greater alignment with state-reported indicators.

Analyses indicate that approximately two-thirds (63%) of CMP ISST-served youth had a case involvement opened with child welfare at some point during FY 2012. However, only 6-7% had an involvement open up between ISST service enrollment and the end of the fiscal year; this may indicate that the ISST approach positively addresses safety and risk by providing additional supports to prevent immediate need for out-of-home placement. In general, calculated indicators regarding abuse/neglect findings and moves in out-of-home placement among CMP ISST-served youth show low rates of occurrence, although interpretation of these rates is limited until there are multiple years of data to explore trends. Approximately 94% of CMP ISST-served youth who were in out-of-home placement with case closure during FY 2012 were reunified or placed in a permanent home; this is similar to the indicator tracked for all closed cases within a 12-month period at the state level (91%).[iii]

Among CMP served youth who entered ISST services with recently initiated probation services and where successful termination was a target goal, 17% successfully terminated after their initial ISST meeting. This rate of success is likely affected by the varying and short amount of time represented in the follow up time period (i.e., not enough time passed between ISST dates and the end of the fiscal year for this event to occur). Rates of revocation of probation for technical violations (10%) and pre-release recidivism (4%) were generally in line with state-reported rates among terminated juvenile probationers from FY 2010 (20% and 7%, respectively).[iv]

Table 13. Performance on Child Welfare CMP Statewide Indicators

Outcome	Statewide Indicator	Assessed with all CMP youth			Assessed for CMP youth with indicator as a relevant target goal	
		n	Rate		n	Rate
Number served	How many CMP youth had an initial ISST meeting in FY2012?	3128[a]				
Number of CMP youth with open involvements	How many of all CMP youth who had an initial ISST meeting in FY 2012 had an open involvement with Child Welfare during FY 2012?	1956				
Increase stability of children: Prevent new involvements	How many of all CMP ISST-served youth in FY 2012 had an open involvement that occurred after their initial ISST meeting (new involvements)?	204	7%		74	6%[b]
Increase safety of children: Prevent abuse and neglect	How many of all CMP ISST-served youth in FY 2012 had a substantiated abuse/neglect finding within 6 months of their initial ISST meeting?	97	3%		55	5%[c]
Number of CMP youth in out-of-home placement	How many CMP ISST-served youth were in out-of-home placement at some point during FY 2012?	1091			429	
Increase stability of children: Reduce number of moves while in placement	How many of these CMP ISST-served youth who were in out-of-home placement during FY 2012 experienced two or more moves after their initial ISST meeting?	111	10%		56	13%
Increase stability of children: Discharge from placement to permanent home	How many of these CMP ISST-served youth who were in out-of-home placement during FY 2012 were discharged to a permanent home?	407	94%[d]		157	92%[e]

[a] Total n's for ISST-served cohorts vary slightly from data shown elsewhere in this report, due to matched dataset differences and missing data patterns.
[b] Denominator was 1282 CMP ISST served youth during FY 2012 who had selected this indicator as a target goal.
[c] Denominator was 1081 CMP ISST served youth during FY 2012 who had selected this indicator as a target goal.
[d] Denominator was 434 CMP ISST served youth who were in out-of-home placement and had a completed discharge in FY 2012.
[e] Denominator was 170 CMP ISST served youth who were in out-of-home placement, had a completed discharge, and selected indicator as a target goal.

Table 14. Performance on Juvenile Justice CMP Statewide Indicators

Outcome	Statewide indicator	Assessed with all CMP youth			Assessed for CMP youth with indicator as a relevant target goal	
		n	Rate		n	Rate
Number of CMP youth who are on probation	How many CMP ISST-served youth were on probation at some point during FY 2012?	604				
Number of youth who started probation after ISST services	How many CMP ISST-served youth started probation after their initial ISST meeting?	357				
Number of CMP youth who came into ISST services already on probation	How many CMP ISST-served youth started probation within 6 months prior to their initial ISST meeting date?	294				
Increase successful intervention for youth with justice involvement: Increase or maintain success rates for youth on probation	How many of these CMP ISST-served youth who started probation within 6 months prior to their initial ISST meeting date successfully completed probation (where it may be assumed that the ISST process may have positively affected successful completion)?	42	14%		23	17%[b]
Increase successful intervention for youth with justice involvement: Decrease rates of youth with probation revocation due to technical violation	How many of these CMP ISST-served youth who started probation within 6 months prior to their initial ISST meeting date had probation revoked due to a technical violation?	38	13%		17	10%[c]
Increase successful intervention for youth with justice involvement: Prevent additional justice involvement for youth on probation	How many of these CMP ISST-served youth who started probation within 6 months prior to their initial ISST meeting data had probation revoked due to recidivism?	9	3%		7	4%[c]

[a] Total n's for ISST-served cohorts vary slightly from data shown elsewhere in this report, due to matched dataset differences and missing data patterns.
[b] Denominator was 134 ISST served youth who started probation within 6 months prior to ISST meeting who had selected this indicator as a target goal.
[c] Denominator was 164 ISST served youth who started probation within 6 months prior to ISST meeting who had selected this indicator as a target goal.

Education and health/mental health outcomes: Indicators and measures were developed for pilot implementation in FY 2013

During FY 2012, the statewide evaluation identified additional measures to assess performance in education and health/mental health domains at the client-level through CMP stakeholder interviews and focus groups (see Appendix 9 for more information). The goal of this process was to develop uniform measurement of outcome indicators in these domains that could be aggregated for statewide analysis. Measures were designed to allow calculation of indicators listed in Table 15. Many of these indicators require pre/post data collection, while some require collection only at post. Twenty-one CMPs began to pilot these measures in FY 2013.

Table 15. Indicators assessed in FY 2013 in education and health/mental health domains

Outcome	Indicator
Education Domain	
Improve school attendance (pre/post)	Number (rate) of children who demonstrate improved attendance during or for a period after ISST services are completed
Reducing disciplinary problems at school (post only)	Number (rate) of children who have no disciplinary actions at school during ISST services ; average number of disciplinary actions during ISST services
Improving school performance (pre/post)	Number (rate) of children who demonstrate improved grade point averages or academic achievement scores during or for a period after ISST services
Maintain enrollment in school (post only)	Number (rate) of children who continue to be enrolled in school during, or in the same academic year as, ISST services; average number of school moves during ISST services
Health and Mental Health Domain	
Decrease problem severity/ increase mental health functioning (pre/post)	Number (percent) of children with improved symptom severity and level of functioning as determined by CCAR during or for a period after ISST services
Reduce rates of inpatient mental health care (post only)	Number (percent) of children placed into inpatient mental health care during or for a period after ISST services; average number of (and average number of days in) hospitalizations for mental health services, and average days spent under hospitalization for mental health
Successful completion of substance use treatment (post only)	Number (percent) of children who successfully complete substance use treatment during or for a period after ISST intake
Increase access to health care system/providers (pre/post)	Number (percent) of children with established primary care provider, mental health provider, substance use provider, and/or health insurance, as appropriate, during ISST services.

Due to concerns from some CMPs about the potential resource burden of collecting pre/post data, and barriers related to data sharing and confidentiality [e.g., *Family Educational Rights and Privacy Act (FERPA)*], a pilot phase was designed for FY 2013. The pilot process will allow the program to

better assess the implications of these barriers and identify strategies to address them in anticipation of statewide implementation at a future date. Baseline rates will be established in these areas during FY 2013, and progress on indicators will be tracked in future years.

B. Impacts assessed at the local level

Since the program's inception, CMPs have proposed locally-defined performance measures and target goals in their MOUs. Each CMP reports on local achievements in Annual Reports submitted to CDHS. Performance on these measures is factored into incentive funding decisions. In FY 2012, CMPs were instructed to select a single performance measure in each of the four outcome domains, to serve as their primary outcomes, to be assessed in the current incentive formula (referred to as *primary incentivized outcomes*). CMPs also may track their performance on optional *secondary outcomes*. In total, 169 different primary and secondary performance measures and target goals were proposed by 30 local CMPs in their MOUs, and 158 were submitted in annual reports in FY 2012 (see Appendix 11 for a list of measures). The total number of locally-defined measures was similarly diverse in FY 2011 (198 indicators across 28 CMPs) and FY 2010 (155 indicators across 27 CMPs). It is important to note that performance on these local measures is calculated and self-reported by CMPs and therefore results cannot be verified by the statewide evaluators.

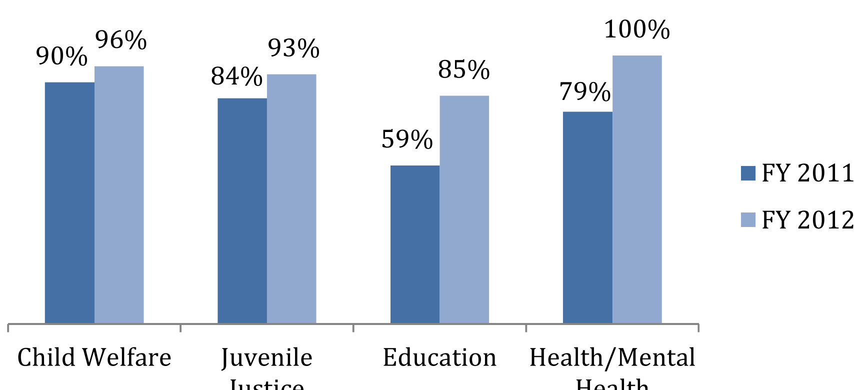
Key findings from review of primary incentivized outcomes

- *Number of indicators*. Performance data for 112 primary incentivized outcomes were submitted in annual reports from 28 CMPs (2 CMPs submitted data after analysis was completed).
- *Process versus population-level indicators.* The majority (85%) of stated goals involved population-level indicators (e.g., assessing child and family outcomes), while 15% 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 the entire county versus children served through the ISST).
- *Data sources.* Common data sources include the CDHS Trails database, ICON/Eclipse state judicial database, local school district databases, DBH and Colorado Client Assessment Records, and measures assessed within specific IOG partner agencies or programs.

CMPs reported achieving 93% of their target goals on locally-defined performance measures

CMPs indicated that they are achieving positive impacts for children and families as a result of their efforts. Figure 4 shows that the percent of locally-defined target goals met for primary incentivized outcomes across CMPs ranged from a high of 100% for the health/mental health domain to a low of 85% of education domain in FY 2012. The percentages of goals achieved were lower in FY 2011, particularly for outcomes in the education and health/mental health domains.

Figure 4. Percent of CMPs where primary incentivized goals were achieved by domain



Results support the notion that CMPs are increasing their achievements of locally-specified focal outcomes over time. The overall percent of target goals met has increased from FY 2010 (75%)[8] and FY 2011 (78%), although direct comparisons are limited because required data collection for statewide analysis in FY 2012 centered on primary incentivized outcomes only (4 per CMP) while prior years' results included varying numbers of performance goals per CMP.

CMPs perceive positive impacts on child and family outcomes

Anecdotal reports of family successes suggest that CMPs have observed positive outcomes for children and families and their communities.

Positive Impacts of Collaborative Service Delivery on Children and Families

"We worked with a family that had many complex needs. There was a family with 8 children in the home ranging in age from 1-16 years old. When we began with this family the identified risks were legal involvement, child safety, permanency, school success, medical, mental health, and financial stability. ***At one point this family was receiving a multitude of services from 9 various agencies and community partners with very high related costs.*** *Through our collaborative management process this family has stabilized, reduced the level of involvement to one agency and school and the children are all now in safe and stable environments working toward permanency, thriving in school and out of legal trouble.* ***Professional services needed have been reduced dramatically and there are no outside costs associated.*** *The success of this family is a direct reflection of collaboration through a multidisciplinary team and family engagement! The guardian now has the skill set to manage a complex household on her own, has a stable job and is reaching out for additional supports as needed (i.e. learning to read and volunteering at a local fitness center.)" (Gunnison-Hinsdale CMP)*

"[A social service organization] referred a family to ISST. The family was trying to obtain out of state custody of their son. ***There were 13 agencies involved in the case****. Family went through the Wraparound process. They* ***successfully completed process and have 2 agencies involved*** *with their family currently. The youth's* ***stepmother became our Family Support Partner****."*

(Montrose CMP)

[8] FY2010 rate was recalculated for this report to match other year's criteria.

CMPs refine processes to define and utilize local performance measures to improve practice

Despite the continued variation in local performance measures, there is emerging evidence that CMPs are increasingly becoming more sophisticated in their appreciation and utilization of data. As discussed below, indicators of this shift include more precisely defined and focused local indicators, and reports of expanded monitoring and application of data to improve local service delivery.

First, in FY 2011, standard local performance measures templates were instituted as part of the MOU submission, which required IOGs to clearly and comprehensively describe for each measure:

- the target population;
- desired outcome and indicator to assess performance in relation to the outcome;
- projected target goal and rationale for its' selection (e.g., baseline performance); and
- data collection process, data source, and analysis methods.

The statewide evaluation prepared and disseminated a detailed technical assistance manual, with step-by-step considerations to support IOG's collaborative processes for selecting indicators. As a result, local performance measures have been more clearly defined and sites have reported that there is greater clarity and focus on their collaborative's goals.

Additionally, some CMPs are assessing service quality and monitoring outcomes through regular review of evaluation data, providing systematic opportunities to assess effectiveness of services and identify areas for improvement. The most common strategies are summarized below.

Table 16: Strategies for integration of evaluation into CMP activities

Evaluation strategy	Number of CMPs (%)
Evaluation/outcome data is a standing agenda item on all IOG meetings.	6 (21%)
Our IOG has formed a data sub-committee or working group that meets regularly to review evaluation/outcome data.	4 (14%)
Our full IOG holds regular meetings dedicated specifically to evaluation/outcome monitoring.	3 (11%)
Our coordinator or other CMP stakeholder distributes written summaries of evaluation/outcome data on a regular basis.	14 (50%)

"Our community has also grown to appreciate the value and importance in properly evaluating programs and reporting their outcomes. This has also helped us to see the benefits of investing in evidence based or evidence informed programs, treatments and services. If we place our resources in programs, treatments or services with proven outcomes, it is more likely that we will see similar successes in the lives of our clients!"

(Weld CMP)

III. CMP implementation results in systems improvements

To realize the CMP goal of improving systems and services to achieve better outcomes for multi-system children and families, local CMPs target system improvements at the governance level, service level, in family engagement, and in cost sharing and cost savings. This section highlights indicators of systems improvements in these four areas, including:

- Systems change at the governance level, including effective IOG collaboration with key partners and leveraging of resources to apply for additional funding to support CMP sustainability;
- Systems change at the service level, including ISST integrated planning involving multiple providers, development of integrated service plans for families, and coordination of information gathering;
- Systems change in family involvement at all levels of CMP; and
- Systems change in cost sharing and cost savings, including combining funds across local systems, agencies giving in-kind/direct support to CMP, perceived cost reductions, and reinvestment of cost savings into services.

A. Systems change at the governance level

CMPs target systems improvements at the governance level by forming Interagency Oversight Groups (IOGs) of key leaders who work together to reduce duplication and eliminate fragmentation in services, and collaborate on ways to obtain funds to sustain efforts.

IOGs create systems change through effective collaboration with key partners

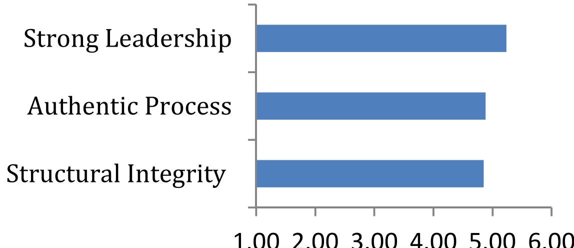
As described in Section I, IOGs have recruited leaders from numerous agencies involved in human service provision to make systems improvements that impact CMP-targeted outcome domains (child welfare, juvenile justice, education, and health/mental health). Results from the *Collaboration and Success Survey* administered with all CMP IOG members indicate that IOG members perceive their collaboratives to have strong and productive structures and processes in place. The survey includes 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.[v]
- 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 4.25 on a 6-point scale, with

higher ratings indicating greater collaboration.[vi] In general, there was little variability in the average scores in these areas across CMPs. Further, analyses of data collected with this survey in FY 2010, FY 2011, and FY 2012 reveal little variation in scores across time or across CMPs, suggesting that CMP IOG structures and processes are perceived to be consistently effective.

Figure 5: Rating of the quality of collaboration



Note: n = 283 from 30 IOGs, with response rates ranging from 25% - 92% across IOGs

Agencies collaborate to obtain additional external funding to support sustainability

IOG partners share grant writing resources to pursue external funding to promote sustainability of interagency collaborative work. In FY2012, 11 CMPs (39%) reported receiving funds from federal agencies, state agencies, block grants, and private foundations (see Appendix 12 for detailed information). Together, 21 external grants totaled over $1 million dollars in additional funding, a similar amount as reported in FY2011.

> *"There has been an incredible increase in communication between the agencies and across the counties as a result of the CMP effort. Silos are melting away as common goals and visions are being embraced. There is also much more of a tendency to think of the youth as a whole person needing integrated care rather than a problem that needs to be fixed through separate issues and funding streams."*
>
> *[San Luis Valley (Alamosa, Conejos, and Rio Grande CMPs)]*

B. Systems change at the service level

CMPs target systems improvement at the service level by developing local Individualized Service and Support Teams (ISSTs) that coordinate service delivery through interagency service planning involving family members, develop integrated service plans for each family served, and coordinate information sharing as well as client assessments and consents. Data discussed below indicate that these collaborative processes are in place for most ISST-served cases, reducing duplication and eliminating fragmentation of services provided to the multi-system families served by CMP ISSTs.

ISST integrated service planning enables streamlined service provision

Although ISST structures and processes vary by CMP, they share the common purpose of bringing together providers from multiple agencies and, in most cases, family participants, to develop an integrated service plan. This interagency planning process represents a key systems improvement that helps to reduce duplication and eliminate fragmentation in services provided to multi-system families.

ISSTs convene agency representatives to collaboratively plan multi-system cases

Data gathered through the CMP database on the subset of ISST-served clients indicate that a majority of ISST-served cases (83%) involved two or more systems in the planning process, with 37% of cases involving as many as four or more systems (see figure in Table 10, pg. 16). Eighteen percent of ISST-served cases involved only one system or agency, which is the local DHS in 88% of these cases. This is the first year the statewide evaluation has obtained client-level data, through the new CMP database, to analyze patterns in ISST processes.

When the number of systems involved in planning is analyzed by CMP, the results show that 23 CMPs (85%) involved two or more systems in the ISST planning process in the vast majority (90-100%) of served cases. Two CMPs involved two or more systems in planning 70-89% of the time and the remaining three CMPs involved two or more systems in planning 50-69% of ISST-served cases.

Involvement of 2 or more systems in ISST planning	
Number of CMPs	**Percent of ISST-served cases**
23	90-100%
2	70-89%
3	50-69%

Table 17 displays the systems, agencies, and organizations involved in integrated service planning through ISSTs. Child welfare was involved in the most cases (91%), followed by mental health/behavioral health organizations (50%), judicial and/or probation (37%), and school representatives (33%).

Table 17. Systems involved in ISST planning process

System, agency, or organization involved in ISST planning process	Number of Cases (%)		*Newly involved (%)
DHS Child Welfare	2624	(91%)	(12%)
Mental Health/Behavioral Health Organization	1458	(50%)	(19%)
Health Department	346	(12%)	(9%)
School	941	(33%)	(13%)
Division of Youth Corrections	223	(8%)	(7%)
Judicial and/or probation	1058	(37%)	(16%)
Diversion	209	(7%)	(5%)
SB-94 program	534	(18%)	(12%)
Family advocate/family facilitator	276	(10%)	n/a
Other family support person/friend for family/youth	398	(14%)	n/a
Other	1302	(45%)	n/a

n=3142, 250 cases (8%) were missing data regarding systems involved in ISST planning
**Family was not involved in system at intake, but the system was represented in ISST planning process*

It was observed that agencies associated with the identified outcome domain for a given case (e.g., child welfare, juvenile justice) generally participated in the ISST process. For example, cases related to a juvenile justice issue would include representatives from Judicial and/or Probation and/or Division of Youth Corrections in the ISST planning process.

Through their integrated planning processes, ISSTs collaboratively determine which agencies will provide and pay for services so that families are not solely responsible for obtaining and coordinating services across multiple agencies. As shown in Table 18, ISSTs regularly designate the specific agencies responsible for providing services. Designation of the agencies responsible for paying for services occurs somewhat less regularly, though is still quite common across CMPs. The frequency of these activities was similar in FY 2011.

Outcome Domain	Corresponding system involvement
Child welfare	96%
Juvenile justice	82%
Health/mental health	74%
Education	55%

Table18: Designation of responsibility for provision of and payment for ISST services

Frequency	Number of CMPs (%)			
	Agency(ies) are designated to provide services		Agency(ies) are designated to pay for services	
Always	20	(71%)	16	(59%)
Often	8	(29%)	6	(22%)
Sometimes	0	(0%)	4	(15%)
Rarely	0	(0%)	0	(0%)
Never	0	(0%)	1	(4%)

**Note: n=27*

Integrated service planning can surface conflicting mandates or treatment requirements across agencies, allowing the IOG and ISST the opportunity to work together to reduce or eliminate these barriers for families receiving services. A majority of CMPs (65%) indicate CMP has reduced conflicting mandates or treatment requirements "a lot" or "completely."

Table 19. Reduction in conflicting mandates or treatment requirements

Extent to which CMP reduced conflicting mandates or treatment requirements across agencies	Number of CMPs (%)	
Completely	1	(4%)
A lot	17	(61%)
Somewhat	6	(21%)
A little	1	(4%)
Not at all	3	(11%)

ISSTs collaborate to develop integrated service plans for multi-system families

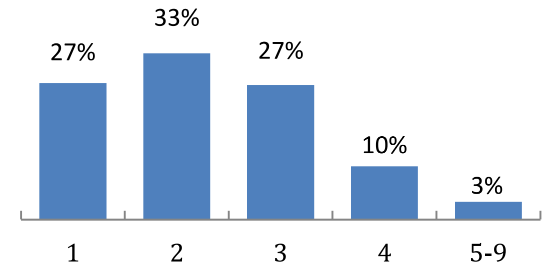
Through the annual report, all (28) CMPs reported that their ISST process results in an integrated family service plan, involving service provision from different providers with a clear plan for shared communication. This represents an increase from 2011, at which time 25 CMPs reported that their ISST process results in an integrated plan. In 2012, half (14) of CMPs reported that they develop a single integrated plan that is shared with multiple providers and half (14) of CMPs reported that they develop multiple plans, such that each agency has their own service plan but services are formally coordinated.

Client-level data collected through the CMP database on the subset of ISST-served families indicate that nearly all CMPs (26) developed an integrated plan in at least 50% of ISST-served cases. Nineteen CMPs developed an integrated plan in 90-100% of ISST-served cases and only two CMPs developed an integrated plan in less than 50% of ISST-served cases.

Integrated plan	
Number of CMPs	Percent of ISST-served cases
19	90-100%
3	70-89%
4	50-69%
2	43-49%

The importance of an integrated plan is underscored by results displayed in Figure 6, which show that a majority (73%) of integrated plans involve service provision from two or more systems. Without an integrated plan in place, families may experience conflicting treatment demands or duplication of services across agencies. Integrated service plans help to coordinate and streamline service provision across systems, reducing duplication and eliminating fragmentation of services.

Figure 6: Number of systems providing services in the integrated plan



Nearly all CMPs (27) involved two or more systems in ISST service delivery in at least 50% of ISST-served cases. Ten CMPs involved multiple systems in 90-100% of ISST-served cases and only one CMP involved multiple systems in less than 50% of ISST-served cases.

Extent of 2 or more systems delivering services from integrated plan	
Number of CMPs	Percent of ISST-served cases
10	90-100%
12	70-89%
5	50-69%
1	less than 50%

Coordination of information gathering simplifies processes for families

Another key systems improvement spearheaded by CMPs to reduce duplication and eliminate fragmentation is to coordinate client consent and assessments and engage in information sharing across agencies. ISSTs coordinate efforts in these areas to reduce the number of forms families are asked to complete, regardless of the number of agencies with which they are working. Nineteen CMPs (68%) reported having common consents that are shared across agencies, meaning that families need complete only one consent form in order to receive services from multiple providers. This number is similar to reports in FY 2011 (74%). Consents also commonly authorize sharing of youth/family information across agencies, thereby providing valuable information to service providers to inform service planning and delivery.

Table 20 summarizes some the strategies that CMPs use to share information about individual youth and families across approved agencies.

Table 20: Strategies used to share client-level information among agencies

Information Sharing Strategy	Number of CMPs (%)	
Individual agencies/organizations share aggregate data reports	8	(29%)
Individual agencies/organizations share data on individual youth/families (e.g., individual assessment results)	26	(93%)
Individuals from CMP partner agencies/organizations have direct access to data in other partners' data systems	4	(14%)
All or some CMP partners have access to a CMP-specific database with youth/family information	5	(18%)

CMPs also share information across agencies by utilizing common tools to assess strengths and needs for youth and families. Seventeen (61%) CMPs reported having a common client assessment form and process that is shared across agencies. In FY 2011, 14 CMPs reported having these practices in place, so this represents an increase in the number of CMPs implementing systems change in the assessment of multi-system youth and families. While the specific form varies, the most common assessments are those used within the juvenile justice system [e.g., Colorado Juvenile Risk Assessment (CJRA)]. Some of these assessments, like the CJRA, are extensive and have been widely adopted or are required by multiple programs in Colorado (e.g., SB94, probation, DYC); thus, sharing assessment data may reduce duplication in provider and family time and effort (see Appendix 13 for additional information).

C. Systems change in family involvement

A central tenet of the CMP approach is the integration of family involvement and family-centered service at all levels of implementation to ensure the system's responsiveness to the families it serves. Family representatives contribute unique perspectives not only to policy but also to the content and delivery of 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. Research has also shown that when families are actively involved in identifying their own needs and goals, and in collaboratively designing the services that will best meet those needs, they are more likely to follow through with interventions and achieve more positive outcomes.[vii]

The CMP and local CMPs have made great strides in increasing family involvement and developing partnerships with families, as demonstrated by the indicators discussed below. For many, this integration and central focus on families represents a fundamental shift in practice.

> *"Our county has a 'big picture' view of how collaboration on the policy level improves service delivery and reduces costs as well as a sense from our families that our work has more meaning to them on a personal level than ever before."* *(Elbert CMP)*

The program has developed strong infrastructure to support family involvement

Since its inception, CMP has demonstrated a strong commitment to the integration of family perspectives at the state level. For example, an active, founding member of the State Steering Committee is a representative from a state-level family advocacy organization (Federation of Families for Children's Mental Health – Colorado chapter). This representative co-leads the CMP Family Voice and Choice (FV&C) subcommittee, a collaborative group of CMP stakeholders who meet monthly to promote and support local CMPs in their efforts to successfully integrate family representatives and increase family engagement in services. Recent accomplishments of the subcommittee include:

- Administration and analysis, supported by the evaluators, of a survey of family advocacy efforts across all CMPs;
- Development of resources and training materials designed to:
    - Share evidence that supports the importance of family involvement in order to foster investment from IOGs and local community agencies
    - Increase CMP knowledge of state level legislation and advocacy activities that promote the expansion of family advocacy roles
    - Assist CMPs in identifying family partners for IOG and ISST processes and share methods to mentor and support family partners in these roles.

A primary focus of the FV&C subcommittee over the past few years has been to provide consultation to local CMPs who struggle to identify and engage family partners in their governance groups. These efforts have garnered some success, as demonstrated below.

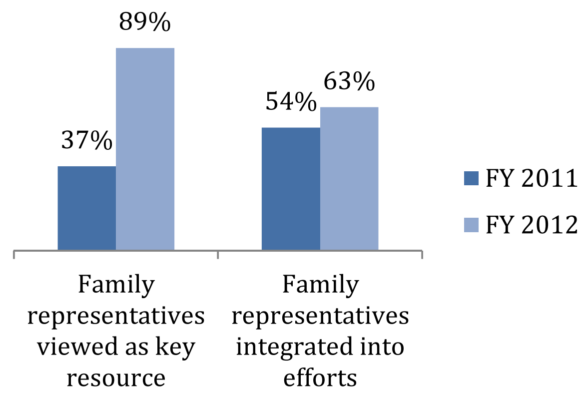
CMPs involve families at the governance level

CMPs involve family representatives to help inform systems and service planning within IOGs. Family involvement increased from 60% of CMPs in FY 2011 to 89% of CMPs in FY 2012. A majority of CMPs (25) reported that they currently have at least one family advocacy organization, family member, or youth member on their IOG; sixteen (64%) of these 25 CMPs designate voting rights to family representatives. Table 21 displays the types of family representation CMPs have on IOGs.

Table 21. Involvement of family voice in IOGs

Family Representation	FY2011		FY2012		FY2012	
	Number (%)		Number (%)		Proportional Change	
Family representatives/advocates	9	(32%)	19	(68%)	57%	⇧
Youth representative	4	(14%)	8	(29%)	50%	⇧
Family advocacy organization representative	12	(43%)	9	(32%)	25%	⇩

Figure 7. Integration of family partners in IOGs



CMPs also were more likely in FY 2012 to rate family representatives as being "sometimes" or "always" key resources and integrated into the work of the IOG, as compared to FY 2011 (Figure 7). Progress in this area is particularly notable, as "achieving a strong family-program partnership requires a culture that supports and honors reciprocal relationships, commitment from program leadership, a vision shared by staff and families, opportunities to develop the skills needed to engage in reciprocal relationships, and practices and policies that support meaningful family engagement."[viii]

CMPs described specific strategies used to increase family involvement in FY 2012. For example:

- 3 CMPs leveraged their participation in the SOC planning grant by consulting with the Family Involvement Task Force on methods to improve family engagement.
- 3 CMPs indicated that their IOGs engaged in strategic planning this year with a specific focus on increasing integration of family partners.
- 2 CMPs reported that they successfully engaged local family-based organizations to participate in IOG efforts and to assist in identifying family partners.

> *"In strategic planning the IOG agreed to increase the number of family representatives, to give a vote to each family representative, and to begin to provide a stipend to help cover the costs of participating (travel, child care, etc.). The new committee structure will also provide an opportunity for those family representatives not providing direct services to have practical input into program development and system integration improvement as well as CMP governance and evaluation/continuous quality improvement."* *(El Paso CMP)*

Despite success in increasing family engagement overall, many CMPs continue to encounter challenges in effectively involving family representatives (see Table 22). Fewer CMPs in FY 2012 reported experiencing these common barriers than in FY 2011, suggesting that improvement efforts may be gaining traction. Two exceptions were problems with scheduling and personnel turnover, which slightly increased.

Table 22. Challenges experienced by CMPs in involving families in IOGs

Barrier Description	FY2011	FY2012
Issues identifying appropriate families for IOG participation	64%	54%
Confidentiality issues	39%	14%
Lack of knowledge/experience of family or youth recruited about CMP processes	39%	32%
Time constraints/scheduling	25%	43%
Lack of commitment among recruited youth and families	21%	25%
Lack of funding to compensate family and youth members	21%	18%
Geography/Distance	11%	11%
Personnel turnover	4%	11%
Lack of IOG buy-in regarding family involvement	n/a	4%
Other Barriers	7%	32%

**Note: n in FY2011 = 29; n in FY 2012 =28. Totals sum to greater than the reported n's of CMPs and 100% because CMPs could select up to 3 barriers.*

ISSTs engage families as well as family representatives in planning processes

CMPs are also changing local practice to include family involvement within service planning through engaging families in their own service planning and/or engaging family representatives to participate on behalf of other families, although this latter role is not as consistently present across CMPs.

Figure 8. Family involvement in ISST

	FY2011	FY2012
At Least One Primary Caregiver Participates on ISST	96%	93%
Family Participates in ISST Service Planning	89%	85%
Family Given a Copy of ISST Plan	93%	85%

CMPs are committed to ensuring that family members are integrally involved in treatment planning. Over 84% of CMPs reported that caregivers "frequently" or "always" participate in ISSTs and receive copies of the plan (see Figure 8), although a larger percentage of CMPs involved families in treatment planning activities in FY2011.

Data collected through the CMP database on the subset of clients served through ISSTs show that 18 CMPs involved a family member or caregiver in the vast majority (90-100%) of ISST-served cases while seven CMPs involved a family member or caregiver in less than 50% of ISST-served cases.

Extent of Family Involvement in ISST planning	
Number of CMPs	**Percent of ISST-served cases**
18	90-100%
2	70-89%
1	50-69%
2	25-49%
5	less than 25%

CMPs consistently report that the result of involving families in their own service planning is more meaningful engagement in services. A coordinator described how "families are incredibly grateful and pleased

when their partner agencies gather in the same room to listen to them and create an integrated plan. They… often say it's the first time they have ever felt heard and honored in the process." Fourteen (50%) CMPs report that family representatives are viewed as partners in service to other families (down from 86% in FY 2011), and 24 (86%) CMPs report that family advocates or family friends participate in treatment planning meetings in a supportive role at least "sometimes," "frequently," or "always" (same as FY 2011). However, among the subset of youth served in CMP-defined ISSTs in FY 2012 (e.g., cases entered into the CMP database), only 10% of cases were marked as having a family advocate or family facilitator involved in the initial service planning meeting, and only 14% of cases indicated that a family support person or family friend attended. The percent varied by CMP; with 20 and 19 CMPs, respectively, indicating that less than 25% of their cases had family advocates or family support representation at this initial meeting.

Table 23. Family advocacy and support persons present at ISST meetings

Number of CMPs with Family Advocate	Number of CMPs with Family Support Person	Percent of ISST-served cases
2	1	75-100%
3	5	50-74%
3	3	25-49%
10	15	1-25%
10	4	0%

Currently, 43% of CMPs (12) indicated that they have mentoring or other methods of supporting families in CMP governance and service delivery, as compared to 22% (6 CMPs) in FY 2011. Recognizing this as an area for growth and improvement, the FV&C committee has as a stated goal for FY 2013 of developing training and support materials to assist local CMPs to effectively integrate family representatives specifically in ISST processes.

> *"Garfield County CMP has recently revised and adopted guiding principles… that states that the ISST will not conduct a meeting to develop a service plan without the family and youth being present. If the family is unable to attend, the meeting is rescheduled to a time when the family can be present."*

CMPs evaluate involvement of families and utilize findings to improve processes

Approximately two-thirds of CMPs (68%) indicate that they have implemented measures or methods to track family involvement at the local level (see Table 24 for CMP measurement strategies).

Table 24. Methods of assessing family involvement

Family Involvement Measurement Strategy	Number of CMPs (%)	
Family survey about satisfaction with services	19	(68%)
Family survey about cultural responsiveness	7	(25%)
Other type of family survey	1	(4%)
Tracking of family participation in ISST meetings	19	(68%)
Tracking of family representative participation in IOG meetings	15	(54%)

**Note: n=24*

D. Systems change in cost sharing and cost savings

The collaborative management approach assumes that decreases in service duplication combined with efforts to prevent deeper and more costly involvement in multiple social service systems will lead to better family outcomes and net cost-savings over time. Research has demonstrated that costs are driven higher by poorly coordinated delivery efforts.[ix] HB1451 legislative goals IV and V encourage cost sharing among service providers that leads to cost reduction. Cost savings recovered at the local level as a result of interagency cost sharing are required to be reinvested to improve or expand services. With more efficient and strategic use of resources across systems, sustainability of the CMP as well as local collaborative models and programs is improved.

Although the number of CMPs has increased steadily across the past few years, the total spending authority has remained stable, at approximately $3.2 million. When the program began in FY2006, six sites received from $240,625 to $765,625 in incentive funds. In FY2012, the CMP distributed earned incentive funds to 28 sites, with the total allocated per county ranging from $28,000 to $226,000. While incentive funds support costs of implementing ISSTs, they are not enough to finance each CMP's comprehensive local efforts. All CMPs must implement additional collaborative financing strategies to implement their models and programs. Below, select strategies and indicators reflecting systems improvements in sharing costs and cost savings are described.

IOGs implement best practices to collaboratively finance CMP efforts

While research demonstrating effective cost sharing strategies for interagency collaborations is sparse, some best practices for financing collaborative service models have been advanced within Systems of Care (SOC) publications (see Table 25).[x] The SOC financing framework emphasizes the importance of state and local interagency governance groups finding ways to "cross funding streams" to break down barriers that impede coordinated funding. This requires decision makers to understand the benefits of sharing funding across systems, which can be a challenging task as they are often concerned with protecting funds to meet needs within their own agencies.

Table 25. Best practices in financing complex systems service efforts

Financing Strategy	Description
Redeployment of existing dollars	With few "new dollars," funds must be redirected from high costs/poor outcome areas into targeted services
Creating new structures to pool/blend/braid funding	Collapsing and streamlining funds from multiple systems for services that target relevant cross-system outcomes; cost savings are reinvested
Raising new revenue	Identifying opportunities to generate new funds; e.g., through advocacy with state legislators and taxpayer referenda at the state level, and seeking external grants or donations at the local level
Refinancing to maximize matching dollars	Maximizing dollars from federal programs such as Medicaid or strategic application of Title IV-E allowable services/ activities

The CMP and local IOGs have explored and/or implemented these strategies, as highlighted in the examples and findings described below.

IOGs create structures and processes to combine funds to support cross-systems efforts

A core activity of IOGs is to develop effective processes to share and manage allocation of operational and service delivery costs among agency partners. CMPs vary in the ways they structure their finances. Each CMP outlines in their Memorandum of Understanding (MOU) a plan for financing CMP efforts. Although one partner agency typically serves as the fiscal agent (this is the local DHS in 82% of CMPs), allocation decisions are most often made collaboratively by the IOG or an IOG finance subcommittee. In half of CMPs (14), earned incentive funds are pooled together with funds dedicated from partner agencies in the MOU into a general CMP fund, from which allocations are distributed. The other half of CMPs (14) maintains separate accounts (e.g., line-item dedicated funds within agencies) but allocate funds through collaborative decision making.

IOG partners contribute direct and in-kind funds to support key cross-system processes

The designation of considerable in-kind contributions by CMP partners (particularly by non-mandated partners) highlights the high value placed on collaborative service delivery and their confidence that it will lead to positive outcomes. Shared contributions are largely in three areas:

- Operational costs**:** As seen in Table 26, many CMPs report that their partner agencies and organizations contribute at least "sometimes" to direct staffing costs (67%) as well as in-kind provision of administrative resources (89%).
- Development and implementation of new programs: 93% of CMPs indicated that they contribute funds across agencies to build new programs at least "sometimes."
- Direct services to children and families: As noted earlier, the majority of CMPs indicated that during ISST meetings, agencies jointly agree on who will pay for intervention services (an example of blending and braiding funds). Additionally, some CMPs allocate portions of their earned incentive funding to pay for individual or family services. The 17 CMPs with available data reported spending just over $1 million on services provided directly to

children and families, which represented 45% of their FY2012 expended funds. This amount represents an increase from FY2011, when CMPs report spending $714,000 (29% of expended funds) on services provided directly to children and families.

Table 26. Frequency of cost sharing among CMP partners across cost categories

Frequency	Extent to Which CMP Partners Share Costs - Number of CMPs (%)									
	Staffing Costs (n=27)		In-kind Staffing (n=26)		Administrative Costs (n=26)		In-kind Administrative Resources (n=27)		Costs of New Programs (n=28)	
Always	5	(19%)	11	(42%)	4	(15%)	7	(26%)	4	(14%)
Frequently	9	(33%)	14	(54%)	6	(23%)	9	(33%)	13	(46%)
Sometimes	4	(15%)	1	(4%)	6	(23%)	8	(30%)	9	(32%)
Rarely	0	(0%)	0	(0%)	4	(15%)	3	(11%)	2	(7%)
Never	9	(33%)	0	(0%)	6	(23%)	0	(0%)	0	(0%)

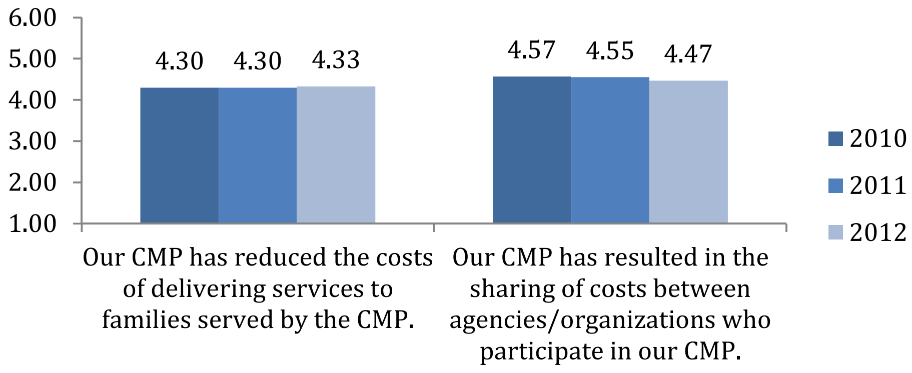
Agencies involved in CMP collaborate to save costs and reinvest cost savings

An underlying assumption of CMP is that collaborative efforts to blend and braid funds will result in service cost reductions, and thus cost savings. However, assessing actual cost reductions (e.g., in monetary terms) and cost benefits of CMP services remains challenging. Precise measurement of cost components is difficult, as it requires a calculated estimate of the potential costs for a given individual or family for comprehensive services (which are hard to quantify across systems and time), and costs of CMP services have not been provided. While outcomes may be improved, it is challenging to determine whether these were achieved at lower cost. However, several indicators suggest CMPs are implementing systems improvements to target service costs, including IOG-reported attainment of cost reductions and reinvestment of savings into expanded service delivery.

IOGs perceive cost reductions and are establishing processes to monitor cost reductions

IOG members consistently perceive that their efforts have reduced the costs of delivering services to families served by the CMP. Figure 9 shows the average ratings (on a 6 point scale) for items on the *Collaboration and Success Survey* from administrations in FY 2010, FY 2011, and FY 2012.

Figure 9. Perceived success in cost outcomes



In FY 2011 and FY 2012, CMPs were asked to report average costs of ISST meetings, to begin to provide data that can be monitored for cost reductions over time. Estimated costs of average ISST meetings, based upon provider time and personnel costs, remained relatively stable from FY 2011 to FY 2012 (see Table 27). However, there is a large range of estimated service costs, given the diversity of ISST models and services. Sites not reporting indicated that it was difficult or unworkable to calculate a meaningful average cost, given that their planning meetings are adapted to the needs of each family.

Table 27. Estimated cost of a typical ISST meeting

	FY2011	FY2012
Number of CMPs with reported data	21	24
Estimated average cost of ISST staffing	$323	$292
Range of average costs	$100 to $800	$45 to $720

CMPs reinvest cost savings into family services and supporting family needs

Systems designers emphasize that it is critical that any cost savings realized from blending and braiding strategies must be reinvested into the cross-system structure.[vi] The HB1451 legislation proposed that savings generated from CMP could be reverted to local IOGs, for greater expansion of their efforts. Of the 25 CMPs that reported how they utilize these savings, approximately two-thirds (16) noted reinvesting the funds directly into new or expanded family-centered services. About one third of CMPs (9) applied funds to develop a flexible spending account to provide for family needs. See Table 28 for additional reinvestment categories.

Table 28. CMP reported plans for reinvesting savings realized in FY 2012

Plans for Reinvested Savings	Number of CMPs (%)		Examples
Support families directly	9	(36%)	Retain flexible funds for families in need of respite care, emergency services, etc.
Support programs and services	16	(64%)	Sustain or expand existing services, develop new programs, provide grants to programs with emergency needs
Support personnel costs	5	(20%)	Contribute to CMP coordinator salary
Training and technical assistance	3	(12%)	Support symposium, cross-site meetings
Hold funds in reserve	6	(24%)	

**Note: n = 25.*

IV. Conclusions and considerations

As it enters its eighth year, the Collaborative Management Program continues to develop and refine its core strategies. Stakeholders at all levels continue to help guide the program, pursuing deeper and more sophisticated forms of collaboration; drawing upon evidence informed programs and services; and bringing families more centrally into CMP oversight, service planning and delivery efforts. The 2011-12 fiscal year in particular was a critical year in the evolution of the program. Through the evaluation, critical infrastructure achievements were realized including:

- A shared data system was designed and launched to support uniform client-level data collection across CMPs;
- Uniform measurement of CMP population, ISST services, and key outcomes is now instituted; and
- The program established partnerships with key state-level agencies to support analysis of client-level outcomes in two core areas (child welfare and juvenile justice).

Additionally, a CMP Handbook was developed by coordinators, with support of the evaluation team, to provide guidance on CMP models, strategies, and expectations.

Progress was also made in obtaining new data sets which allows a more complete story to be told about who CMPs are serving; what systems changes are being accomplished; and with what impact on community collaborations, service delivery and child and family outcomes. Overall, evaluation data show that **CMPs are largely achieving the population, collaborative structures and service goals** outlined in the HB 1451 legislation. Further, emerging evidence from outcome analyses suggests that **CMP systems- and service-level changes are positively impacting children and family outcomes** in areas of priority for Colorado social service agencies.

Below, key findings are summarized and discussed in the context of CMP's progress over time along with considerations for how CMP might utilize the findings to strengthen the program and local implementation.

Legislative Goals of the Collaborative Management Program (CMP) Initiative

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

Colorado Revised Statute, Title 24, Article 1.9 (2010)

CMP population

CMPs report serving over 7,300 children through Individualized Service and Support Team (ISST) models and programs, and when factoring in Interagency Oversight Group (IOG) partner agency and organization's programs, the number served by CMP grows to approximately 20,800 individuals. However, there is greater need for services than there are CMP resources, as the total estimated eligible populations reported approaches 70,000 across the 32 participating counties.

The CMP-served population is largely comprised of children and families who are already involved in multiple systems of care, in alignment with the population targeted by the legislation (Legislative Goals II, III, and IV). Most (60%) ISST-served children were involved in at least two systems at the time of the initial ISST meeting, with most families interacting with local child welfare (75%), mental or behavioral health providers (38%), or probation services (23%). The high number of DHS involved children suggests that CMP services are targeted to those already in, or at risk for, the foster care system, which is the primary targeted population in the legislation.

Per statute, each CMP may define their target population; thus, there is some variation in who CMPs report they serve and what issues they are trying to address (e.g., subpopulations). However, all CMPs have at least one ISST model or program that is targeted or at least serves some of the "deep-end" children and families (i.e., those involved with different, and overlapping, social service agencies who are at-risk for poor outcomes). Half of CMPs (14) in FY 2012 have multiple ISST models in place, often targeting different issue areas (e.g., truancy, domestic violence), age groups, and levels of risk. In some cases, CMPs are focused on meeting needs in existing systems or agencies (e.g., contributing funds and efforts to existing service programs within local DHS), others build upon or develop new coordinated service approaches that cross one or more systems (e.g., the Crossover Youth Practice Model, serving children who have overlapping involvement in child welfare and juvenile justice), and still other CMPs seek a balance between meeting the service needs of "deep-end" children while also developing prevention programs to keep families from reaching that part of the system. This variation reflects the diverse array of needs for targeted integrated services at the local level, and demonstrates that CMPs are adapting the "CMP approach" to different needs in their communities.

CMP infrastructure and collaboration

Despite local variation, findings from multiple years of data collection show that there are a number of components in these locally-defined approaches that are similarly implemented across CMPs. This demonstrates progress towards developing a more uniform collaborative system across the state (Legislative Goal I). There is strong evidence that these collaborative systems, both at the governance and service level, are effectively meeting the needs of multi-systems involved families. For example, CMPs have been highly effective in actively engaging partners from multiple agencies and organizations, with wide representation from both mandated and non-mandated, youth-serving providers. IOGs report that they are bringing the "right people to the table" – key leaders

and decision-makers who are committed to collaborative planning and the delivery of effective, appropriate, high-quality services through their ISSTs (key objectives of Legislative Goals II and III).

- Three years of survey data show that IOG members perceive strong, authentic, collaborative processes that result in mutually beneficial relationships and positive impacts.
- IOGs have made great progress in integrating family representatives in their efforts, increasing from 60% of CMPs in FY 2011 to 89% of CMPs in FY 2012, and rating family participation more highly in FY 2012 than FY 2011.
- Non-mandated partners with similar service goals and target populations continue to join and actively participate in CMP efforts (e.g., SB94 representatives).

Similarly, IOGs have developed ISST structures and processes so that services are family-centered and the "right service providers are at the table."

- There is strong "family voice" in ISST meetings, with 84% of CMPs reporting frequent involvement of caregivers in the initial ISST meeting, and 83% of ISST-served cases with a primary caregiver in attendance.
- In the majority of individual cases (83%), providers from two or more agencies participated in the intervention planning process. These providers predominantly aligned with the family's presenting issues at enrollment (i.e., if involvement in a system was noted, a provider from that system participated in the meeting).
- In 86% of ISST-cases an integrated service plan was developed in the initial ISST meeting, and in the majority of cases (73%) multiple providers were designated to offer services to the family. Services were provided most often from DHS (73%) or mental/behavioral health agencies (53%), but schools (33%) and probation (27%) also engaged in service delivery.

Evaluation findings from the client-level data are somewhat limited, as data collection and analyses necessarily focused on information gathered at the initial ISST meeting only. At least 11 CMPs implement service models that involve multiple planning meetings and result in service provision that is responsive to family needs as they change over time. Unfortunately, some CMPs indicate that they do not have adequate resources to collect client-level data within at least some of their ISST structures. This results in the discrepancy seen between the reported total of ISST-served children in annual reporting relative to those included in the client-level database (i.e., 56% of all ISST-served children had client-level tracking information). Provision of technical assistance and expansion of local client-level tracking is a focus of the statewide evaluation in the upcoming year. It is critical to address data collection issues so that evaluation results reflect the full complement of CMP-served children, which will improve the ability to examine links between populations, services, and outcomes.

CMP services and strategies

Improvements in service integration realized by CMPs are leading to reductions in duplication and fragmentation (Legislative Goal II) and increases in quality of service (Legislative Goal III). Several indicators emerged across the three years of evaluation data to support these conclusions:

- An increasing number of CMPs (23 in FY 2012 vs. 20 in FY 2011) are implementing evidence-informed models and programs designed to streamline and integrate services. Examples include High Fidelity Wraparound, Team (or Family) Decision-Making, and the Crossover Youth Practice Model. However, CMPs report adapting program components to fit local resources and needs, which may inadvertently result in lower fidelity to the model. When models are delivered with fidelity, CMPs can expect established positive outcomes. It could benefit the program to engage CMPs in shared learning regarding implementation of evidence-informed models and in mentorship of CMPs considering these models.
- CMPs have established effective strategies to streamline their cross-agency processes, thus reducing duplication, fragmentation, and conflicting mandates that multi-systems involved families often experience. Examples specific to data and information sharing include:
    - Seventeen (61%) CMPs indicate that they administer assessments that are shared across agencies, thus reducing burden on families and staff data collection resources. This represents an increase from FY 2011 (14 CMPs).
    - Nineteen CMPs (68%) employ multi-agency service consents (similar rate to FY 2011). Other CMPs noted that this remains a challenge for their IOG. However, the efforts of the Colorado Child and Youth Information Sharing (CCYIS) workgroup, which grew out of CMP requests for guidance, will assist these CMPs in the upcoming year as a state-level common consent tool will be disseminated.
- CMPs are enhancing local evaluation measurement practices and using data to improve quality of service (Legislative Goal III). Supporting evidence includes:
    - Between 6 and 14 CMPs described processes to regularly review evaluation data, in IOG or subcommittee meetings and written dissemination.
    - Although CMPs continue to report a diverse number of local performance measures and goals (e.g., 169 in FY 2012, 198 in FY 2011, 155 in FY 2010), indicator templates and technical assistance from OMNI and the SEC shared in FY 2011 have resulted in clearer specification of intended outcomes and greater overlap in priority outcome areas (e.g., reducing out-of-home placement). CMPs indicated these resources add value and clarity to IOG discussions regarding target outcomes.
    - Two-thirds (68%) of CMPs use measures to track family satisfaction and input.
    - In FY 2013, the SEC will launch customized reporting functions in the CMP database that will allow for real-time tracking of client data to facilitate local data application and inform quality improvement efforts.

CMP cost sharing and cost savings

Legislative Goal IV encourages CMPs to establish cost-sharing among service providers. CMPs have implemented best practices to effectively share costs in multiple areas or levels of their work,

including blending/braiding funds and seeking external sources of support. For example, IOG partner agencies dedicate considerable direct and in-kind funding to CMPs to support operational costs, development of new and existing programs, and family services. To complement their cost sharing practices, CMPs collaborate to apply for grant funding and in FY 2012 eleven CMPs (39%) successfully obtained funds to support services through external grants, worth just over $1 million dollars (a similar amount was reported in FY 2011). Finally, as reported in previous years of the evaluation, the majority of CMPs (81%) continue to regularly designate the specific agencies responsible for payment of services.

An important end-goal of the CMP legislation, as outlined in Legislative Goal V, is to realize cost-reductions and cost savings that can be reinvested to serve more multi-systems involved families. CMPs continue to report that they are attaining cost savings from their more efficient, integrated "ways of doing business." IOG members consistently report perceived success in this area in three years of survey data. CMPs also consistently report reinvesting savings into expanded services; for example, two-thirds (16 CMPs) put savings towards supporting programs and one-third (9) created flexible funding accounts to utilize for immediate family needs. These areas of reinvestment were similar in FY 2011. Given the diversity of local service models, target populations, and outcomes, specification of a standard cost model is challenging. However, because this is a principal goal of CMP, the SEC adopted exploration of best practices and identification of possible strategies for cost measurement as a primary focus in FY 2013.

CMP outcomes

The ultimate, overarching goals of the CMP are to achieve better outcomes and improve the lives of children and families who are involved in multiple systems of care, with a specific focus on families in the child welfare and foster care system in Colorado (Legislative Goal V). In FY 2010 and FY 2011, the statewide evaluation necessarily relied on examining the extent to which local CMPs self-reported progress on achieving locally-defined target performance goals (reported on varying populations), and IOGs' perceived success on outcomes. In FY 2012, the statewide evaluation successfully established infrastructure and processes for the collection of client-level service and outcome data. All 30 CMPs enacted data protocols to collect client-level data (n=4092) and to provide key identifiers for their served population, to facilitate matching to statewide outcome databases, which resulted in the ability to calculate baseline estimates of outcome indicators in child welfare and juvenile justice domains. These results, in conjunction with CMPs' reports of success in meeting local target goals, provide emerging evidence of the positive impacts of CMP on child and family outcomes in FY 2012.

Table 29 provides a brief summary of baseline performance on the statewide indicators, calculated for children with the indicator noted as a target intervention goal (see Appendix 9 for detailed information regarding the definition and calculation of indicators). Most of the indicators below were assessed for outcome events occurring after the child's initial ISST meeting, thus reflecting proximal relation to CMP service delivery (i.e., possible impact of services). Interpretation of CMP baseline performance on these outcomes is limited; however, in FY 2013 and beyond, yearly performance can be compared to monitor trends. In general, relatively low rates of occurrence of

poor outcomes and relatively high rates of positive outcomes (e.g., discharge to a permanent home) were demonstrated, when considered in light of annual reporting on similar (but not the same) indicators provided by CDHS and State Judicial. While indicators were selected to align with state-tracked priority outcomes, rates are not directly comparable in FY 2012 due to slightly different definitions of cohort and time periods under assessment.

Table 29. Summary of baseline performance on statewide indicators

Statewide Indicators	Number (%) of Cases where Indicator is Relevant	Rate
New involvements in child welfare system	1291 (45%)	6%
Substantiated abuse or neglect	1088 (31%)	3%
Two or more moves in out-of-home placement	701 (24%)	13%
Discharge to a permanent home	615 (21%)	92%
Successful completion of probation	499 (17%)	17%
Decrease rates of youth with probation revocation due to technical violations	823 (29%)	10%
Prevent justice involvement/additional involvement (pre-release recidivism among youth on probation)	823 (29%)	4%

Note: Denominators vary; see Tables 13 and 14 for more information.

Another achievement in the statewide evaluation for FY 2012 was the development of additional indicators reflecting commonly assessed education and health/mental health outcomes, with implementation of pilot measures in 21 CMPs. Indicators include: school attendance, disciplinary actions, and school performance and stability in the education domain; and problem severity/functioning, inpatient and substance use treatment, and access to health care providers in the health/mental health domains.

CMPs indicated that they are achieving positive impacts for children and families as a result of their local efforts. For the past three years the statewide evaluation has tracked CMPs' self-reported performance on locally-defined measures and target goals. In FY 2012, 169 indicators were proposed in the 30 CMP MOUs, and achievement data were submitted on 158 of these indicators in annual reports. CMPs reported meeting 93% of their target goals in FY 2012, which represents an increase from FY 2010 (75%) and FY 2011 (78%).

V. Year four evaluation directions

This is an exciting time in the evaluation process, as infrastructure to support on-going standard data collection across CMPs is now in place, enabling a more comprehensive, objective state-level assessment of CMP processes and outcomes, including the examination of the key research questions presented in this report.

In FY 2013, Year 4 of the statewide evaluation, the CMP Evaluation Subcommittee (SEC) prioritized continued assessment of the impacts of CMP on integration of service delivery and on outcomes for children and families as well as capacity development within local CMPs and the larger CMP in the utilization of data to inform practice and support sustainability. Each of these priority areas is discussed below.

Refine and expand data collection and analysis of key outcome and service data demonstrating CMP effectiveness and addressing legislative goals

Evaluation efforts underway for FY 2013 will build upon the statewide measurement plan adopted by the State Steering Committee (SSC) in FY 2011 and implemented in FY 2012.

Continue to measure and track progress on a set of defined, uniformly measured outcomes across CMPs on CMP-served populations. The assessment of standard indicators among children and families served by ISSTs will enable the evaluation to draw direct links between CMP services and outcomes over time. To support this process, in collaboration with the SSC, the SEC will:

- Encourage CMPs to expand client-level data collection to reflect all ISST-served children and families. In FY 2012, the majority of CMPs provided client-level data on most, but not all of their ISST-served clients (i.e., 56%; see Appendix 11). With a larger sample of CMP-served individuals, the stability and accuracy of the estimates of CMP outcomes would be improved.
- Analyze impact of CMP on statewide child welfare and juvenile justice outcomes over time. In FY 2012, through data sharing processes with CDHS and State Judicial analysts, the evaluation established baseline cross-CMP outcomes in these domains. In Year 4, the evaluation will be able analyze and monitor annual progress in these areas among CMP-served populations. In addition, there is now opportunity to expand analysis to other standard measures collected in statewide systems. For example, the established CMP measurement plan could enable tracking of state-prioritized outcomes (e.g., C-Stat indicators) if there is a desire to align measurement.
- Establish baseline estimates of CMP impact on education and health/mental health outcomes among a subset of CMPs, and refine measures for broad dissemination in FY 2014. A majority (21) of CMPs agreed to pilot during FY 2013 measures designed to assess client-level improvements in school attendance, educational performance, and behavior; and in access to and utilization of health and mental health services and mental health functioning. The SEC will refine measures and protocols in advance of dissemination across all CMPs in FY 2014.

Continue to support, design, and implement standard process measures and data monitoring functions. In FY 2013, OMNI and the SEC will enhance the functionality of the Efforts-to-Outcomes (ETO) CMP database to support the provision of reports, collection of local data, and case management efforts, such as creation of online integrated service plans, and explore cost measurement. Specifically, OMNI and the SEC will:

- Launch customized reports that summarize client-level data entered into the CMP database. These reporting functions support local CMPs through dynamic (real-time) monitoring of their clients, informing service improvements, and local performance evaluation activities. OMNI will continue to provide technical assistance on data entry as well as data application.
- Develop measurement strategies to support the Incentive Committee's on-going efforts to develop a fair and equitable data-driven incentive formula process. The Incentive Committee is considering the inclusion of standard process indicators in the incentive formula, drawing upon data from the two sources below. The SEC will lead development and implementation of any new measures identified by the Incentive Committee and approved by the SSC.
    - CMP client-level database: Proposed indicators include family satisfaction with services; detailed documentation of integrated plan components (e.g., payment, service models).
    - Annual Reports: Proposed indicators include evidence of blended/braided service funding across partnering agencies; documentation of methods to assess cost savings.
- Continue to explore and develop standard measures of costs and cost savings. In collaboration with SSC members, the SEC will work to identify common components for which costs may be assigned (e.g., specific outcomes such as out-of-home placement), and develop methods to track costs and cost reductions associated with CMP service delivery, where possible.

Support and promote learning opportunities and capacity development within the program and among local CMPs to utilize data and support sustainability efforts

Disseminate key findings and promote participation in the evaluation process. With three years of data and the addition of client-level and statewide outcome information, the SEC is poised to more deeply explore links between CMP structures, services, and outcomes. This information can be utilized to raise awareness of CMP's positive impacts and to facilitate sustainability efforts. In order for the program to continue its growth, key decision-makers at both the local and state levels must be engaged in the evaluation process, informed of key findings, and have access to information to promote CMP with legislators and other funders.

In FY 2013, the following SEC activities will support this objective:

- Brief newsletters summarizing findings on specific topics. The evaluation team will create quarterly evaluation newsletters exploring topics relevant to state and local CMP stakeholders. This work will be done in collaboration with the SEC and the Communications Subcommittee, in order to align with the Communications Subcommittee 's marketing efforts.
- Collaborative meetings with key CMP stakeholders. Through the SEC, the evaluation has been grounded in a participatory approach, working in collaboration with agencies, committees, and workgroups across the state. Given the complicated nature of local- and systems-level data collection and synthesis, the SEC is currently reaching out to CMP stakeholder groups, including state agency directors, the Colorado Human Services Directors Association, and local IOGs. Also, in recognition of the growing interest in implementing state-level initiatives through the CMP structure (Systems of Care, Colorado Practice Model, C-Stat), SEC members are meeting with leaders of these efforts to identify opportunities to support these initiatives, through utilization of CMP data, alignment of data collection efforts, and shared learning.

Endnotes

[i] *CDHS Division of Child Welfare Scorecard* (provided to OMNI by CDHS).

[ii] Office of the State Court Administrator (2011). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2010 releases*. Retrieved on-line October 2012.

[iii] *CDHS Division of Child Welfare Scorecard* (provided to OMNI by CDHS).

[iv] Office of the State Court Administrator (2011). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2010 releases*. Retrieved on-line October 2012.

[v] Hicks, D., Larson, C., Nelson, C., Olds, D., & Johnston, E. (2008). The influence of collaboration on program outcomes: The Colorado Nurse Family Partnership. *Evaluation Review, 32*, 453-477.

[vi] Chrislip, D.D., Larson, C.E. (1994). *Collaborative leadership: How citizens and civic leaders can make a difference*. San Francisco: Jossey-Bass

[vii] U.S. Department of Health and Human Services, Administration for Children and Families. *Family Involvement in the Improving Child Welfare Outcomes through Systems of Care Initiative*. (Washington, DC: U.S. Government Printing Office, 2010).

[viii] Halgunseth, L.C., A. Peterson, D.R. Stark, S. Moodie. 2009. *Family Engagement, Diverse Families, and Early Childhood Education Programs: An Integrated Review of the Literature.* Washington, DC: NAEYC. Online: http://www.naeyc.org/files/naeyc/file/ecprofessional/EDF_Literature%20Review.pdf.

[ix] Goerge, R.M., Smithgall, C., Seshadri, R., & Ballard, P. (2010). *Illinois Families and Their Use of Multiple Service Systems*. Chicago: Chapin Hall at the University of Chicago.

[x] Pires, S. (2010). *Building systems of care: A primer (2nd Ed.).* Washington, D.C.: Human Service Collaborative.

Appendices

Appendix 1. Structure of state management of CMP

DHS Program Director
Provides guidance and oversight, reviews county-level memoranda of understanding and annual reports, allocates funds and incentive funds

State Steering Committee
Provides program oversight, advances system reform goals of CMP legislation, composed of representatives of organizations of mandatory signatories, family advocacy, and participating counties.

Family Voice and Choice Subcommittee
Co-led by a local CMP coordinator and state family-driven organization, this committee gathers and shares information about promising strategies to engage families at the IOG, ISST, and service-delivery levels.

Evaluation Subcommittee
Guides statewide evaluation, promotes effective evaluation practices at the county level, and consults with OMNI Institute

Communications Subcommittee
Gathers and disseminates information about collaborative activities and best practices to state and local stakeholders, facilitates information sharing

Appendix 2. 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 04-1451 (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 in 2009, the design is being implemented in multiple phases. These include formative evaluation to 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. Formative methods were the focus of the statewide evaluation in FY 2010.

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. The statewide evaluation began infrastructure building efforts in FY 2010 and has focused in this area in both FY 2011 and FY 2012.

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. This report represents the early stages of summative evaluation activities for the CMP statewide evaluation. Summative evaluation will represent the focus of statewide evaluation activities in the coming years, though infrastructure building and formative approaches will continue, as appropriate and necessary.

The CMP statewide evaluation is currently in Phase II. Phase I was completed in the first year in order to document and describe the range of local efforts and selected outcomes.

Month	Fiscal Year	Event
		CDHS hires OMNI Institute as external evaluator
Jul-09	FY 2010	
Aug-09	FY 2010	
Sep-09	FY 2010	CMP Evaluation Subcommittee (SEC) formed
Oct-09	FY 2010	
Nov-09 – Jan-10	FY 2010	OMNI conducts CMP site visits and reviews local CMP performance measures
Jan-10	FY 2010	Online Quarterly Reporting System (QRS) launched
Feb-10	FY 2010	
Mar-10 – Jun-10	FY 2010	OMNI first administers online *Collaboration and Success Survey* (repeated annually)
Jul-10	FY 2011	OMNI first administers online *State Management Survey* (repeated annually)
Aug-10 – Oct-10	FY 2011	Year 1 reporting demonstrates 150+ performance measures; SEC outlines uniform statewide measurement approach
Nov-10 – Mar-11	FY 2011	CMP Outcomes Workgroup convenes in three half-day retreats to develop uniform measurement plan in the areas of child welfare and juvenile justice; recommendations made to the CMP State Steering Committee March 2011
Apr-11	FY 2011	
May-11	FY 2011	
Jun-11	FY 2011	
Jul-11	FY 2012	Online client-level data collection system launched (in Efforts to Outcomes, or ETO, platform); CMPs begin tracking uniform data about ISST clients and services for the first time
Aug-11 – Dec-11	FY 2012	
Jan-12 – Apr-12	FY 2012	CMP education and health/mental health uniform measurement planning (CMP stakeholder interviews and focus groups) process; measurement plan submitted to CDHS April 2012
May-12	FY 2012	
Jun-12	FY 2012	
Jul-12	FY 2013	Education and health/mental health indicator data tracking pilot initiated (21 CMPs participating)
Aug-12 – Oct-12	FY 2013	OMNI analyzes CMP statewide service data, and partners with child welfare Trails and judicial analysts to match and analyze client child welfare and juvenile justice outcomes (baseline rates)

Phases: Formative (Jul-09 – Nov-10); Infrastructure Building (Feb-10 – Jul-12); Summative (Jun-12 – Oct-12)

Appendix 3. CMP coordinators

CMPs have emphasized the value of having a designated CMP coordinator, ideally dedicated to CMP activities on a full-time basis. All CMPs reported having a designated coordinator, with most (68%) serving in this role on a full-time basis. As seen in Table 1, about half of coordinators are hosted by the county DHS, followed by a mental health service provider, local schools, family/youth advocacy organizations, and probation. In the majority (61%) of sites, the coordinator position is funded fully with CMP incentive funds. Eight CMPs (29%) reported that their coordinator position is partially funded by CMP, and three (11%) reported that the position is supported entirely by other funds.

Table 1. Coordinators' host agency/organization

Host Agency/Organization	Number of CMPs (%)	
County Department of Human/Social Services	12	(43%)
Mental health service provider/center	8	(29%)
Behavioral health organization	0	(0%)
Local school/school district	3	(11%)
Courts/Judicial	0	(0%)
Probation	2	(7%)
Law enforcement agency	0	(0%)
Family/Youth Advocacy Organization	2	(7%)
Senate Bill 94	0	(0%)
Other*	10	(36%)

**Responses included youth-focused non-profit organizations, other county departments, and contract agencies.*

Coordinators serve in a number of important roles, as seen in Table 2. Most provide key liaison, communication, and support functions at the IOG-level. 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.

Table 2. CMP coordinator roles

Coordinator Role	Number of CMPs (%)	
Disseminates communication	27	(96%)
Liaison between partners	26	(93%)
Documents decision making	25	(89%)
IOG leadership	24	(86%)
Manages funds and oversees budgets	23	(82%)
ISST team member	22	(79%)
Coordinates ISST	18	(64%)
Manages intake and referrals	15	(54%)
Conducts follow up with families	12	(43%)
Provides direct service	8	(29%)
Other	16	(57%)

Local highlight: Role of CMP Coordinator

One CMP highlighted the impact of streamlining oversight and coordination across multiple ISSTs under one coordinator: "*The CMP has been working towards reducing duplication by implementing a plan to effectively integrate our 3 ISSTs. In the past, each ISST was led by a different coordinator. During this past fiscal year, one ISST coordinator has been managing all three ISSTs, which is providing more consistency throughout the program while also eliminating fragmentation and duplication of services.*" (Garfield CMP)

Appendix 4. Eligible population

Table 1 below presents the estimated number of children or youth who are considered eligible for CMP services, as reported by CMPs in annual reports.

Table 1. Estimated counts of children eligible for CMP services

Number of children:	Number of CMPs	Population Size (Min.-Max.)	Averag e	Total Across CMPs
Served by partnering mental health providers	25	(1 - 11,750)	1012	25,297
With open child welfare involvement	26	(2 - 5,304)	863	22,442
Considered habitually truant (per state definition)	21	(1 - 5,458)	461	9,672
On probation	24	(4 - 800)	177	4,249
In DYC Detention	13	(2 - 1,124)	244	3,178
Served by partnering Behavioral Health Organizations	13	(9 - 1,170)	239	3,104
Receiving counseling services at school	11	(4 - 2,265)	249	2,735
With school IEPs	16	(5 - 882)	142	2,270
Served by SB-94	20	(2 - 937)	111	2,213
On diversion	17	(1 - 339)	107	1,815
In DYC commitment	13	(1 - 240)	36	474
On parole	12	(1 - 156)	30	357

Note: The Colorado Revised Statute defines "habitual truant" as: A child who has attained the age of seven years and is under the age of seventeen years having four unexcused absences from public school in any one month or ten unexcused absences from public school during any school year. (C.R.S. 22-33-107 (3)(a)).
Note: Counts above often reflect duplicated counts, so that individual children may be counted more than once across categories in the table.

Appendix 5. Served population

Table 1 below provides the estimated counts of individuals who were considered served by CMPs, at multiple levels of possible involvement. CMPs vary widely in the total number of individuals who are screened or assessed, served by CMP partners, and/or participated in ISST services.

Table 1. Estimated CMP served population counts

Served Population	Number of Individuals Served		
	Average	(Min.-Max.)	Total
Individuals screened/assessed for services	1369	(7 - 11895)	38327
Individuals served by CMP services	743	(7 - 5583)	20799
Individuals served by an ISST	321	(7 - 2068)	8993
Individual children/youth served by an ISST	262	(7 - 2068)	7333

There is great variation among CMPs in terms of the degree to which their services are focused around an ISST[9] (see Figure 1). Specifically, about one-third (32%; 9) of CMPs indicated that the number of ISST-served individuals represents 25% or less of the total individuals served through the CMP; the majority of these individuals received services from the CMP outside of an ISST. In contrast, about one-fifth (21%; 6) of CMPs indicated that the number of ISST-served individuals represents more than 75% of the total CMP-served population. CMPs in this latter group concentrate the bulk of their service delivery efforts within their ISST(s).

Figure 1. Proportion of CMP-served population served through an ISST

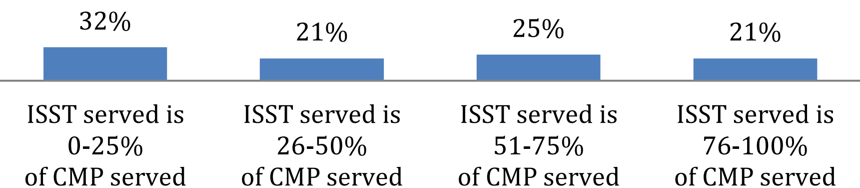
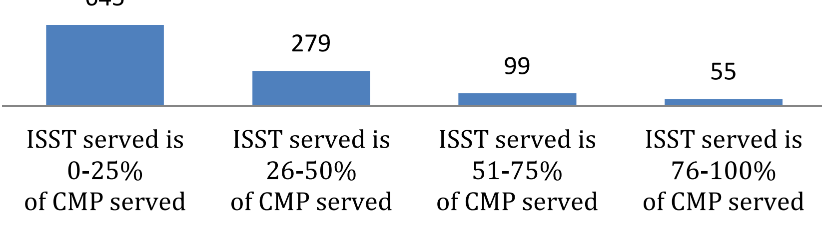


Figure 2 shows that the median number of individuals considered "CMP-served" is largest for those CMPs providing most services outside of an ISST, and smallest for those concentrating service delivery within an ISST.

Figure 2. Median number of individuals served, by proportion served through an ISST



[9] "CMP-served" refers to individuals served through all CMP supported services; "ISST-served" is used to refer to individuals served specifically through an ISST.

Appendix 6. Primary ISST summary data

Table 1 summarizes information regarding the sources of referrals to CMPs' designated primary ISST.

Table 1. Primary ISST referral sources

Referral Source	Number of CMPs (%)	Average % of Referrals (Min.-Max.)
Department of Human Services	23 (92%)	42% (1% - 99%)
School district	22 (88%)	30% (1% - 85%)
Probation	23 (92%)	9% (1% - 35%)
Mental/behavioral health	14 (56%)	6% (1% - 24%)
Court/judicial	15 (60%)	8% (1% - 65%)
Law enforcement	5 (20%)	8% (2% - 17%)
Department of Public Health	5 (20%)	10% (2% - 25%)
Self/parent	9 (36%)	6% (1% - 13%)
Diversion	7 (28%)	6% (2% - 12%)
Division of Youth Corrections	5 (20%)	2% (1% - 4%)
Other	15 (53%)	13% (1% - 66%)

Note: In reporting the proportion of referrals across sources, 3 CMPs reported proportions totaling significantly more or less than 100%. These 3 CMPs were excluded from calculations of the average and range of proportions by source.

Appendix 7: Description of data collection, management, and cleaning processes for client-level tracking information

This appendix describes data collection processes, strategies to ensure data quality, and data cleaning steps taken for the FY 2012 client-level data of the CMP statewide evaluation.

Description of process data collection tools and utilization

The statewide evaluation measurement plan, developed in FY 2011, outlined the collection and analysis of a set of client-level process and outcome indicators measured uniformly across CMPs and aggregated at the state level. Process indicators 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 families' 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 in child welfare, juvenile justice, education, and health/mental health domains, that are aligned with ISST-served cases

A two page data collection form was created to collect items needed to measure these indicators. The form also includes client 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 CMP database supported by Efforts to Outcomes (ETO) © software was developed specifically for the program. 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 service information throughout the year. Data collection forms are intended for completion by an ISST facilitator or case manager. However, some items on the form may require the assistance of other CMP partners for completion, such as DHS or Probation representatives who may have access to Trails or ICON/Eclipse identification numbers. Client-level data is collected only for youth who have been served by a CMP's ISST process. CMPs self-defined their ISST services; they indicated which met the definition of an ISST according to statute, and implemented processes for data to be collected within those services. Data are required to be collected only for each youth's initial ISST meeting.

Statewide implementation of process data collection

Most CMPs had established processes to collect and track client-level data by August 2011, and by January 2012, all CMPs were actively collecting data on at least a subset of ISST-served youth. Local CMP staff complete the data collection forms and are responsible for tracking the information. Most sites enter these data into the CMP database; the remaining sites track these data in a local database and provide OMNI with the data file during auditing or analysis periods, as necessary.

Prior to implementation of data collection protocols, OMNI provided training and technical assistance for client-level data collection. CMP coordinators and data entry staff attended training webinars hosted by OMNI in June 2011 to review the client tracking data collection form and the CMP database. OMNI evaluation staff also scheduled follow-up phone calls with each CMP coordinator to discuss client-level tracking implementation and individualized data collection steps. These implementation calls allowed CMPs to tailor data collection activities according to each partners' capacity and readiness to collect and enter CMP data. While most CMPs opted to collect client-level data on all youth who went through an ISST process and to enter their information into the CMP database, other CMPs made different arrangements:

- Adams, Morgan, Weld: Among these CMP's IOG partners, there was concern about sharing youths' names in the CMP database. As a result, a protocol was developed by which CMP staff enter youth information into the CMP database without including their names. At the end of the fiscal year, CMP staff are responsible for adding Trails IDs and ML numbers to these records to be used to match indicator data.
- Boulder: Because Boulder's CMP already uses a separate ETO site built to collect client-level data, OMNI collaborated with Boulder CMP staff and ETO representatives to allow Boulder to collect and enter data into their own ETO site, extract data from their system during data auditing and analysis periods, and allow OMNI to upload these data into the CMP database. Boulder's CMP has agreed to pull client records and assessments for OMNI to review on a quarterly basis and to perform a batch upload into the CMP database on an annual basis.
- Denver: While Denver enters client-level data into the CMP database like other CMPs, their CMP tailored the standard CMP client tracking form for use with their CMP staff and partners.
- Jefferson: Jefferson CMP staff built additional items into their locally-adapted Trails database to capture information on youth served by their ISSTs. Because their CMP was interested in utilizing the reporting features available in the CMP database without entering data directly, OMNI worked with Jefferson CMP staff to make arrangements for extracting Jefferson's data during auditing and analysis periods, and uploading the extracted data into the CMP database.
- Larimer: Larimer's CMP already utilized the Trails database to capture client-level data. As such, Larimer staff worked with OMNI to revise their data collection efforts to more closely align with the process data elements that CMPs were collecting statewide. Data was collected for four of Larimer's ISSTs, and transfers occurred to support year-end analyses.
- Mesa: Until June 2012, Mesa opted to collect client-level data in a local MS Access database using the process data elements that were detailed in the CMP client tracking form. In June 2012, the Mesa CMP decided to begin using the CMP database. OMNI then worked with the CMP to extract existing data and upload the information into the CMP database. From this point forward, Mesa's CMP staff entered client data directly into the CMP database.
- Rio Grande: Because this CMP was in its initial year, Rio Grande was not required to enter client-level data into the CMP database. This CMP collected client-tracking data on served cases in FY 2012 but did not finalize processes to enter data into the CMP database until FY 2013.

- Ten CMPs elected to complete and enter multiple client-level data collection forms per client into CMP database, for clients who had additional (follow-up) ISST meetings or who were participating in multiple ISST services or programs in FY 2012 (Boulder, Chaffee, Denver, Eagle, Fremont, Huerfano, Jefferson, Mesa, Morgan, Teller).

Implementation of client-level data collection included conducting data auditing procedures to ensure data quality, and working with local CMPs to identify and correct data entry errors. Additionally, because this was the first year of the statewide evaluation measurement plan's implementation, OMNI evaluators engaged in efforts with state-level data partners at the Department of Human Services and State Judicial to pilot the data transfer process to match outcome indicator data with process indicator data and to conduct outcome analyses. Data auditing and data transfer piloting were carried out at the same time in order to maximize resources. Data auditing included:

- Checking for duplicated entries in the CMP database that were neither a result of a youth exiting ISST services then returning for another ISST service after the initial exit nor a result of youth going through two or more separate ISST processes
- Missing data fields, including date of birth or date of ISST meeting
- Blank data fields that were expected to be completed, such as the ML number for youth who had been involved with the Probation system
- ML numbers or Trails ID numbers that were in the incorrect format.

When these issues were identified, OMNI Evaluation Liaisons worked collaboratively with individual CMP coordinators to resolve them. This effort reduced the amount of incorrect or missing data in the CMP database system and prevented cases that would otherwise not have been included in the analyses to be included.

Data Analysis Preparation Steps

The following steps were taken to prepare client-level data for analysis of child welfare and juvenile justice outcomes:

- All data for FY 2012 were extracted from the CMP database and merged in SPSS. The only CMP whose data were not entered or uploaded into the CMP database was Larimer; their data was submitted in MS Excel format and was then merged with other CMPs' data directly in the SPSS statewide dataset.
- The resulting dataset was cleaned, with missing data fields and duplicate entries identified and documented by CMP, so that OMNI Evaluation Liaisons could consult with individual CMP coordinators to determine next steps for the affected cases.
- Before CMP coordinators were consulted about missing data fields and duplicate entries, the dataset was sent to State Judicial and the Department of Human Services to match CMP youth records with existing Trails and ICON/Eclipse records. For both agencies, data partners used youth names, birthdates, and Trails ID/ML numbers to identify matching records. This round of record matching did not yield complete datasets; rather, it allowed for the CMP evaluation team to identify CMP database records that had incomplete or

inaccurate Trails ID/ML numbers that CMP coordinators could correct. All data transfers were conducted utilizing secure encryption software programs and processes.

- Once State Judicial and DHS staff completed their matching process, the resulting dataset was sent to OMNI for review. For instances where a case did not result in an expected match (i.e., the process data indicated open involvement in the child welfare system, but no Trails ID was documented), these issues were document by CMP and added to the list of existing data issues to be shared with individual CMP coordinators.
- OMNI Evaluation Liaisons then contacted CMP coordinators and reviewed the identified data issues. CMP coordinators worked with their staff to resolve data issues to the best of their ability, and the OMNI evaluation team made edits in the CMP database according to CMP coordinator feedback.
- Once all CMP coordinators had the opportunity to provide feedback on the identified data issues, data were extracted from the CMP database once again, cleaned, and sent to State Judicial and DHS for a second round of matching with Trails and ICON/Eclipse records.
- State Judicial and DHS partners, upon completion of data record matching, returned the full datasets to OMNI to prepare for analysis of child welfare and juvenile justice outcomes.

Additional considerations led to the following parameters for inclusion in the child welfare and juvenile justice outcome analysis dataset:

- Only records for which the ISST meeting date was between July 1, 2011 and June 30, 2012 were kept in the dataset. Records with missing ISST meeting dates also were kept.
- Inclusion in child welfare data analyses only occurred if a youth's CMP database data record was correctly matched with his or her data record in Trails; similarly, juvenile justice analyses only included youth whose CMP database records were accurately matched with ICON/Eclipse records.
- Duplicate records were included in the dataset only if the duplicate record consisted of a) a youth exiting from CMP services (as indicated by an exit date) then returning for another ISST meeting after the exit date, or b) a youth going through a different ISST group (as indicated by the "ISST Name" field).
    - A final duplicate check was conducted to identify youth who had been served by different CMP counties at different instances; for example, one youth may have been served by one CMP before moving to another county and being served by another CMP at a later date. The record with the earliest ISST meeting date was kept for the statewide analysis. However, both records will remain in the dataset for county-level analyses.
- For statewide analysis of aggregated process and outcome data, all duplicates were removed such that each youth was represented once in the dataset. The record with the earliest ISST meeting date was kept for the statewide analysis.
- Data provided from Larimer's CMP for one of the four defined ISSTs was separated from the dataset and analyzed in isolation from the other CMPs' data. Client-level data from the other three ISSTs were not included in the statewide analysis and reporting. This decision was made as a result of Larimer's unique data collection methods, where not all client tracking

items were completed in the same manner as other CMPs (e.g., not all response options on the client tracking form were represented in Larimer's data). The separate dataset representing client data from one of Larimer's ISSTs was included in an Appendix. These data were not included in the statewide aggregated dataset, because these data collection issues were very recently identified and the timing of the final analysis and deadline for submission of the report precluded the ability to reanalyze data with these cases included. However, summary results with Larimer's full client-level dataset were shared separately with Larimer's CMP to be used for service tracking, program improvement, and local evaluation purposes.

Appendix 8. Larimer County CMP data summary for FAPT clients

The following tables and figures summarize client demographic and key service components for clients served through the FAPT process in Larimer County. Larimer County CMP provided client-level data for three other multi-agency team services implemented through their local Department of Human Services (n=933); however, the local data collection process was sufficiently different from other CMPs that the data were not able to be aggregated in the statewide dataset. However, the majority of data items reported in the statewide analysis utilizing the CMP Client Level Tracking Form were collected on the subset of FAPT cases. These data were identified shortly after statewide analysis was completed; thus, the data are reported separately in this appendix.

Data Sample
There were 17 unduplicated children served by Larimer County FAPT ISSTs in FY 2012 in the dataset provided by Larimer County DHS, after data cleaning was complete. Data presented below summarize results of analysis of data collected at the child/youth's initial ISST meeting.

Key Demographics

Table 1: Age of FAPT-served children

Age Group	Number of Cases (%)
Under 1 year old	0 (0%)
1-5	0 (0%)
6-10	0 (0%)
11-15	9 (56%)
16 and over	7 (44%)

Table 2: Gender of FAPT-served children

Gender	Number of Cases (%)
Male	9 (53%)
Female	8 (47%)

Table 3: Race of FAPT-served children

Race	Number of Cases (%)
White	14 (82%)
Multi-Racial	2 (12%)
Black/African-American	1 (6%)
Asian	0 (0%)
Amerian Indian/Alaskan Native	0 (0%)

Table 4: Ethnicity of FAPT-served children

Ethnicity (Hispanic/Latino)	Number of Cases (%)
Yes	4 (24%)
No	13 (76%)

Key Service Data

Table 5: Systems involved at FAPT enrollment

Number of Systems Involved at ISST enrollment	Number of Cases (%)
1	9 (52.9%)
2	3 (17.6%)
3	3 (17.6%)
4	2 (11.8%)

Table 6: Systems working with family at FAPT intake

System, Agency, or Organization Family was Involved With at Intake	Number of Cases (%)
DHS with CW open involvement	17 (100%)
Other DHS CW program	0 (0%)
Mental Health/Behavioral Health Organization or Services	0 (0%)
Truancy Program	6 (35%)
Counseling/At-Risk Services	0 (0%)
Other School-Based Program	0 (0%)
DYC - Detention/Commitment	4 (24%)
SB-94 Program	0 (0%)
Other Juvenile Justice Program	0 (0%)
Domestic violence program	0 (0%)
Judicial/Probation Program	5 (29%)
Other System or Organization	0 (0%)

Table 7: FAPT referral source

Referral Source	Number of Cases (%)
DHS Child Welfare	10 (59%)
Mental Health/Behavioral Health Organization	4 (24%)
Health Department	0 (0%)
School	0 (0%)
DYC	0 (0%)
Judicial and/or Probation	7 (41%)
Diversion	0 (0%)
SB-94 Program	0 (0%)
Law Enforcement	0 (0%)
Domestic violence	0 (0%)
Self/Parent	0 (0%)
Other	0 (0%)

Table 8: FAPT referral source

System, agency, or organization involved in ISST planning process	Number of Cases (%)
DHS Child Welfare	17 (100%)
Mental Health/Behavioral Health Organization	17 (100%)
Health Department	1 (6%)
School	17 (100%)
Division of Youth Corrections	0 (0%)
Judicial and/or Probation	17 (100%)
Diversion	0 (0%)
SB-94 Program	1 (6%)
Family Advocate/Family Facilitator	17 (100%)
Other Family Support Person/Friend for Family/Youth	0 (0%)
Other	9 (53%)

Table 9: Number of systems involved in FAPT planning process

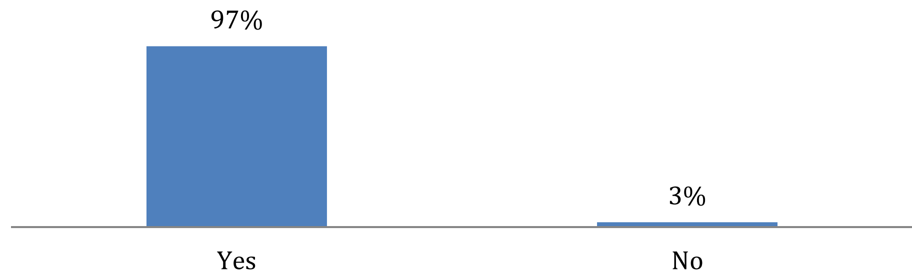
Number of Systems Involved in ISST planning process	Number of Cases (%)
4 or less	0 (0.0%)
5	8 (47.1%)
6	7 (41.2%)
7	2 (11.8%)

Family Involvement in Services

Table 10: Family members attending FAPT meeting

Family Members Attending ISST Meeting	Number of Cases (%)
Mother	17 (100%)
Father	4 (24%)
Youth	16 (94%)
Legal Guardian	0 (0%)
Grandparent	0 (0%)
Foster Parent	0 (0%)
Sibling	3 (18%)
Other Family Member	0 (0%)

Figure 1: Percent of cases where family was involved in ISST meeting



Service Planning

Figure 2: Percent of cases with an integrated plan

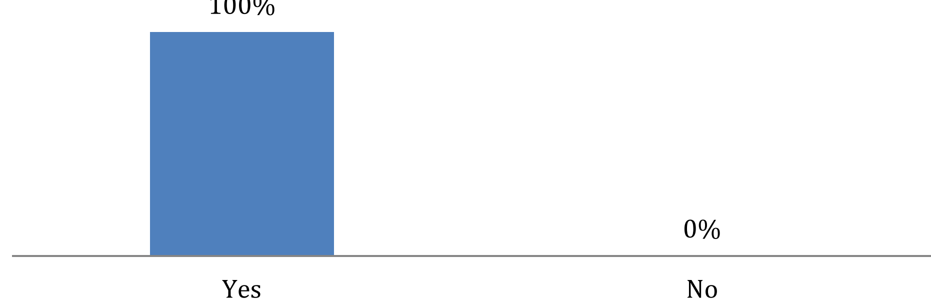


Table 11: Systems designated to provide services

System, agency, or organization designated to provide services in integrated plan	Number of Cases (%)	
DHS Child Welfare	9	(53%)
Mental Health/Behavioral Health Organization	12	(71%)
Health Department	1	(6%)
School	8	(47%)
Division of Youth Corrections	0	(0%)
Judicial and/or Probation	9	(53%)
Diversion	0	(0%)
SB-94 Program	1	(6%)
Other	9	(53%)

Figure 3: Number of systems providing services in the integrated plan

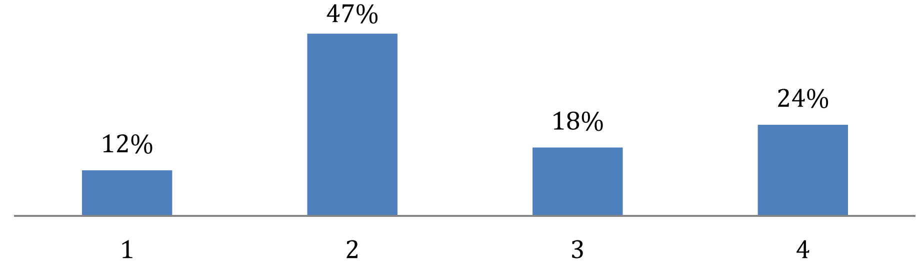
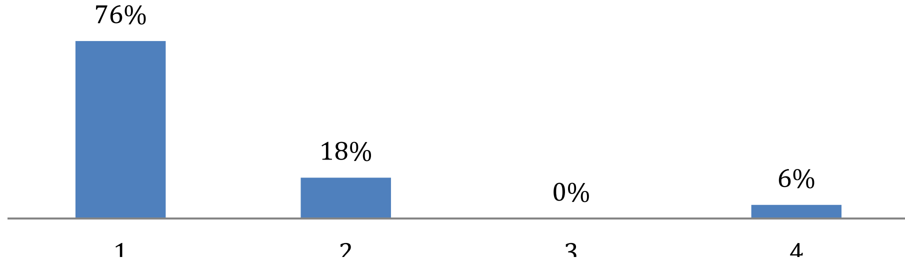


Table 12: Clients where statewide indicator was selected as ISST intervention goal

Statewide Indicator	Number of Cases (%)
Prevent new involvements in CW system	17 (100%)
Prevent abuse	17 (100%)
Reduce number of moves in out-of-home placement	1 (6%)
Discharge from out-of-home placement to permanent home	1 (6%)
Successful completion of probation	4 (24%)
Successful completion of parole	0 (0%)
Prevent juvenile justice involvement/prevention additional juvenile justice involvement	17 (100%)
No target outcomes chosen	0 (0%)

Figure 3: Number of statewide indicators selected as appropriate for family



Appendix 9: Process to select and define process and outcome data indicators

This appendix details the description of steps taken to select and define process and outcome indicators for the CMP statewide evaluation measurement plan, including decisions made in regards to the analysis of these indicators.

Collaborative Planning for Indicator Selection

In October 2010, the Evaluation Subcommittee (EC) proposed the formation of a temporary workgroup to select variables and refine CMP measurement processes. Among other tasks related to the development of a statewide evaluation measurement plan, the Outcomes Workgroup was charged with identifying a set of common process and outcome indicators to be implemented across CMPs. The workgroup met three times for half-day retreats in November 2010, January 2011, and February 2011. During discussions held at these three retreats, the Outcomes Workgroup selected and defined process and outcome indicators in the Child Welfare and Juvenile Justice domains to be measured in FY 2012. The group also began exploring a process for later selection and definition of Education and Health/Mental Health indicators. Additionally, the group recommended the utilization a web-based data management system to collect these data for implementation in July 2011.

During FY 2012, the CMP sought to select and define outcome indicators for the Education and Health/Mental Health domains through a similarly collaborative process. OMNI evaluators conducted a series of interviews with CMP stakeholders who had varying perspectives on the measurement of education and health/mental health indicators. A summary of interview findings were reviewed with CMP coordinators during a focus group session. The feedback was synthesized and used to develop a list of proposed indicators and data collection strategies for each of the two domains. The proposed indicator list was reviewed and refined by the EC and approved by the SSC in Spring 2012 in time for inclusion in the FY 2013 MOU development process.

Process Indicator Data Collection

Discussions among the CMP Outcomes Workgroup during FY 2011 highlighted the importance of the CMP's ability to demonstrate success, as well as provide evidence that the CMP is meeting the requirements and goals of the legislation. By collecting process indicator data, the program would be better able to:

- Obtain a clear count of CMP participants served through ISSTs,
- Demonstrate the extent of family involvement in services and service planning, and
- Show evidence of multi-system involvement and multi-system service delivery and reductions in duplication and fragmentation of services.

The process indicators being collected for the CMP statewide evaluation are listed below:

- 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 was created to collect items needed to measure process indicators. The form also includes client demographic information and state identifier numbers from two statewide data systems (Trails, ICON/Eclipse). Additionally, an on-line client-level database supported by Efforts to Outcomes (ETO) © software was developed specifically for the program. The data collection form was designed to be completed at the time of a family's first ISST meeting. The form is to be completed on all youth within a family who are 1) multi-systems involved; and 2) will be receiving services that are specified in the ISST plan.

Outcome Indicator Data Collection

Through collaborative indicator selection processes in FY 2011 and FY 2012, key CMP stakeholders identified a set of indicators that reflect core expected outcomes of the CMP in all four domains relevant to the program: child welfare, juvenile justice, education, and health/mental health. For FY 2012, the child welfare and juvenile justice indicators were measured among youth who participate in ISSTs and analyzed utilizing the process outlined in Appendix 7 and the considerations outlined below. Using the client-level data collection form described above, CMPs indicated which of the statewide indicators align with each youth (i.e., which reflect intervention goals or represent potential outcomes relevant to the child being served). This information was used to identify subsets of CMP-served children to include in the analysis of each outcome.

Child Welfare and Juvenile Justice Indicators

Indicators in the first two domains (child welfare and juvenile justice) were selected for the initial rollout of the statewide measurement plan, given that they are currently collected through existing statewide databases (Trails and ICON/Eclipse). Tables 1 and 2 below list the indicators and provide detailed information regarding the calculation of the indicators. OMNI evaluators established processes with research staff in the state child welfare and judicial agencies to: a) define the indicators with greatest alignment to annually-reported state agency indicators (e.g., calculated for federal reporting and state-level monitoring); and b) conduct aggregated analyses of the selected outcomes. Using the state identifier numbers and client identifying information, research staff at these agencies matched client information with outcome data extracted from Trails and ICON/Eclipse systems. OMNI then calculated performance on these indicators, aggregated at local and state levels, and provide these results to the state child welfare and judicial agencies for confirmation of results. OMNI also analyzed the process data collected through ETO or extracted from existing local databases.

Table 1. Statewide indicators in child welfare domain

Outcome	Indicator	Numerator/Denominator	Additional Considerations
Number of CMP youth with open involvements in child welfare system	Number of CMP youth who have open involvements in Trails at any time during FY	Count: Number of CMP youth who have open involvements between 7/1/11 and 6/30/12	This count includes all youth with open involvements, even if involvements occurred prior to ISST meeting date.
Increase stability of children served by the CMP: Prevent new involvements in CW system	Number (rate) of CMP youth with new open involvements in Trails after CMP services began	Numerator: Number of youth with open involvements with a start date after their initial ISST meeting Denominator: Number of CMP youth with an initial ISST meeting between 7/1/11 and 6/30/12	If the date of open involvement and ISST meeting date are equivalent, this is counted as a new involvement.
Increase safety among children served by the CMP: Prevent abuse	Number (rate) of CMP youth with a substantiated abuse finding within 6 months after CMP services began	Numerator: Number of youth with substantiated abuse findings with a start date within 6 months after their initial ISST meeting Denominator: Number of CMP youth with an initial ISST meeting between 7/1/11 and 6/30/12	None.
Increase stability of children served by the CMP: Reduce number of moves in out-of-home placement	Number of CMP youth who experience multiple moves when in out-of-home placement	Numerator: Number of CMP youth who experience two or more moves after an initial ISST meeting between 7/1/11 and 6/30/12 Denominator: Number of CMP youth who have been placed outside of the home at any point during the fiscal year	Administrative changes, hospitalizations, psychiatric care, runaways, removal periods less than 2 days, and placement periods less than 8 days were not included as a move in this calculation.
Increase stability of children served by CMP: Discharge from out-of-home placement to permanent home	Number (rate) of CMP youth who were in out-of-home placement when entering CMP or were placed out-of-home after initiating CMP with a completed discharge, who were discharged to a permanent home	Numerator: Number of youth whose final removal status is placement in a permanent home; the date of this last removal status must be after their initial ISST meeting Denominator: Number of CMP youth who have placed outside of the home and had a completed discharge at any point during the fiscal year	Permanent home designations included adoption, emancipation, guardianship, reunion with relatives, or placement with other relatives for this calculation.

Table 2. Statewide indicators in juvenile justice domain

Outcome	Indicator	Numerator/Denominator	Additional Considerations
Number of CMP youth who have juvenile justice involvement (probation)	Number of CMP youth who are involved with probation services	Count: Number of CMP youth who are on probation at some point between 7/1/11 and 6/30/12	Dataset includes only case data pertaining to the most recent probation period. Thus, youth may have multiple probation periods (e.g., multiple filings or charges) that are not reflected in these outcome calculations.
	Number of CMP youth who began probation after initial ISST meeting	Count: Number of CMP youth who are on probation at or after an initial ISST meeting that is between 7/1/11 and 6/30/12	
	Number of CMP youth who were on probation prior to initial ISST meeting	Count: Number of CMP youth who start probation within 6 months prior to their ISST meeting date that is between 7/1/11 and 6/30/12	
Increase successful intervention for children with juvenile justice involvement: Increase/maintain success rate for juveniles on probation	Number (rate) of CMP youth who successfully complete probation	Numerator: Number of youth whose probation status at any point before 6/30/12 is "Completed successfully" Denominator: Number of CMP youth who start probation within 6 months prior to their ISST meeting date that is between 7/1/11 and 6/30/12	Successful completion for probation includes all cases whose termination status for the most recent completed probation is "successful" (TERMS or DUNS code)
Increase successful intervention for children with juvenile justice involvement: Decrease rate of probation revocations	Number (rate) of CMP youth who receive technical violations, resulting in unsuccessful completion of probation	Numerator: Number of youth whose probation status at any point before 6/30/12 is "Probation revoked due to technical violation" Denominator: Number of CMP youth who start probation within 6 months prior to their ISST meeting date that is between 7/1/11 and 6/30/12	Includes cases whose probation status code is RTEC. Does not include youth who are designated as having a change in venue, pending, or absconded with a warrant outstanding.
Decrease further penetration into the juvenile justice system: Prevent (additional) juvenile justice involvement	Number (rate) of CMP youth on probation who recidivate before successful completion of probation	Numerator: Number of youth whose probation status at any point before 6/30/12 is "Probation revoked due to pre-release recidivism" Denominator: Number of CMP youth who start probation within 6 months prior to their ISST meeting date that is between 7/1/11 and 6/30/12	Includes cases whose probation status code is RNOF or RNOM. Does not include youth who are designated as having a change in venue, pending, or absconded with a warrant outstanding.

Considerations for Child Welfare and Juvenile Justice Indicators Data Analysis for FY 2012

For all outcome indicator calculations, the following decisions guided the analysis:

- Outcomes were only calculated for youth who were matched with an existing record in the Trails or ICON/Eclipse database; matching occurred on the youth's name, date of birth, and Trails or ML number.
- For Probation indicators, it is possible that youth may have experienced more than one charge or filing resulting in multiple entries in the probation database within the fiscal year. However, for the FY 2012 analysis, State Judicial data analysts were able to only provide matched case data for the most recent probation period/event.

Education and Health/Mental Health Indicators

For indicators in the final two domains (education and health/mental health), the outcome selection process revealed that currently, there are no appropriate statewide database resources from which relevant outcome data could be extracted for aggregated analysis. For the education domain, there were no existing state-level data sources that could facilitate access to student-level data; and, while one statewide database exists for one of the chosen indicators in the health/mental health domain, alternative methods of gathering indicator data were recommended due to data quality and access issues. As a result, OMNI evaluators expanded data collection infrastructure to allow for local pre- and post-ISST services data collection for education and health/mental health indicators through the creation of additional data collection forms, as well as ETO system expansion. The indicators and corresponding measures are described in the body of the report (see Section III). These measures are undergoing pilot testing among 21 CMPs during FY 2013.

Appendix 10. CMP ISST-served population

Table 1 below presents the number of children (unduplicated cases), and the proportion of children with data entered into the CMP database relative to the total number reported in the annual reports in FY 2012. There was significant variation across CMPs in terms of how many of their ISST-served children were tracked at the client-level, from 16% to 100%, with one CMP tracking more children than the total reported in annual reporting. Approximately two-thirds of CMPs tracked client-level data on at least half of their ISST cases.

Table 1. Number and proportion of children served by ISSTs

	Total Individuals Served by all ISSTs (reported in Annual Report)	Total Individuals Entered in CMP Client-Level Database	Percent of ISST- Served Population with Client-Level Data
Adams	600	123	21%
Alamosa	49	19	39%
Boulder[c]	171	160	94%
Chaffee[c]	59	33	56%
Conejos	80	24	30%
Denver[c]	2068	913	44%
Douglas	19	19	100%
Eagle[c]	not reported[a]	25	not calculated
El Paso	149	89	60%
Elbert	18	13	72%
Fremont[c]	145	135	93%
Garfield	118	116	98%
Grand	20	14	70%
Gunnison-Hinsdale	37	23	62%
Huerfano[c]	95	123	129%
Jefferson[c]	585	491	84%
Larimer[c]	1935	950/17[b]	not calculated
Lincoln	7	6	86%
Logan	54	53	98%
Mesa[c]	143	234	164%
Moffat	16	16	100%
Montezuma-Dolores	20	20	100%
Montrose	56	35	63%
Morgan[c]	124	85	69%
Pueblo	18	13	72%
Rio Grande	29	n/a[d]	not calculated
Routt	21	19	90%
Teller[c]	41	26	63%
Weld	656	309	47%
Total	**7333**	**4086**	

[a]Eagle submitted their annual report after the statewide analysis deadline.

[b]Larimer CMP provided client-level data for 950 unduplicated youth; 17 had equivalent data items to statewide database and are reported in Appendix 8.

[c]Eleven CMPs entered additional client tracking forms to track information related to follow-up ISST meetings; these are not included in the total.

[d]Rio Grande is in its first year; this CMP began entering data into the CMP database in FY 13.

Appendix 11. CMP MOU performance goals

The table below displays the 169 performance goals specified by CMPs in their FY 2012 MOUs (where goals were not specified, performance measures from the FY 2012 annual reports were inserted). The first column lists the county, the second the domain (of the four CMP domains), and the third the specified measure and target goal. Note that CMPs are required to select four primary goals, one in each of the four domains; they may elect to include additional, secondary goals. As noted, the table below includes both primary and secondary goals, where appropriate.

County	Domain	Performance Goal (Primary & Secondary)
Adams	JJ	20% of all youth involved in Truancy court referred to the TRB, will successfully complete court with intervention/services.
Adams	JJ	Increase successful Truancy Court completion rates of youth referred to the Truancy Review Board.
Adams	HMH	90% of children identified will be assessed for services.
Adams	HMH	Assess the need for Domestic Violence intervention/services to school aged children.
Adams	ED	Maintain College for Life attendance at a minimum of 7 individuals.
Adams	CW	Increase attendance by 5% for each child identified in this pilot program.
Adams	CW	Increase school attendance of children exposed to Domestic Violence in their household in the last 30 days.
Adams	CW	Increase participation to 82% for children, youth and families referred to the TRB.
Alamosa	JJ	80% of probation youth served by the CMP will not have a revocation based on technical violations.
Alamosa	HMH	At least 85% of youth served by the collaborative Management Program will have required immunizations.
Alamosa	ED	75% of CMP youth will improve their attendance by 10% or be within 5% of the school average or exceed it.
Alamosa	ED	The drop-out rate for CMP youth will be 5% or less.
Alamosa	ED	CMP youth will have a GPA of 2.0 or the equivalent (elementary).
Alamosa	ED	75% of CMP youth who have had a former suspension will not have any further suspensions.
Alamosa	CW	< 25% of youth served by the CMP will have an OOH placement.
Boulder	JJ	Average Daily Population in DYC (Commitment). The goal will be to maintain current low commitment ADP with no more than 20% variance in ADP.

Boulder	HMH	Engagement in Treatment - research demonstrates significantly improved outcomes for clients that stay in substance abuse treatment at least 90 days. Therefore, the goal will be for at least 90 days. Therefore, the goal will be for at least 65% of youth participating in intensive outpatient programs (ITOP & ISIS) to remain in treatment for 90 days or more.
Boulder	ED	75% of children & youth enrolled in day treatment programs will remain in the community and avoid hospitalization, out-of home placement, or commitment.
Boulder	CW	65% of youth over age 16 years and 60 days (in placement) will have a comprehensive ILP that addresses all needs identified from a state approved assessment.
Chaffee	JJ	80% of the probation youth served by the ISST will not have a revocation based on technical violations.
Chaffee	HMH	Improvement by 10% in the level of functioning and problem severity of youth referred to HB1451.
Chaffee	ED	Increase attendance rates among targeted children by 1%.
Chaffee	CW	At least 70% of the CMP-served youth will have no substantiated abuse findings after CMP services began.
Conejos	JJ	80% of the probation youth served by the CMP will not have a revocation based on technical violations (80% success rate).
Conejos	HMH	At least 85% of youth served by the Collaborative Management Program will have required immunizations.
Conejos	ED	75% of CMP youth will improve their attendance by 10% or be within 5% of the school average or exceed it.
Conejos	ED	The drop-out rate for CMP youth will be 5% or less.
Conejos	ED	CMP youth will have a GPA of 2.0 or the equivalent (elementary).
Conejos	ED	75% of CMP youth who have had a former suspension will not have any further suspensions.
Conejos	CW	< 25% of youth served by the CMP will have an OOH placement.
Denver	JJ	50% of youth staffed through the DCP ISST's will complete probation and/or parole successfully.
Denver	HMH	83% of youth staffed through DCP will receive follow-up case management for referrals to mental health services in the community if recommended.
Denver	ED	Youth staffed through DCP ISST's will increase by 2 % their "On Track to Graduate" rate in DPS for school year 11-12.
Denver	CW	90% of CMP youth will have no substantiated abuse finding after CMP services began.
Douglas	JJ	During the time of service engagement a 50% will neither have probation revoked nor accumulate another charge.
Douglas	HMH	Reduce by 10% symptom severity as documented by the DLA-20 (GAF) generated by FREUD, for youth active with ADMHN.
Douglas	ED	Decrease the # of class periods missed (absent) by 5% for all students K-12.
Douglas	CW	Number (percent) of CMP youth with new open involvements in Trails after CMP services began, for youth served by FIRST.
Eagle	JJ	Number (percent) of CMP youth who recidivate resulting in unsuccessful completion of probation and/or parole.

Eagle	HMH	Number (percent) of youth identified through multi-agency Early Warning Indicator.
Eagle	ED	Number (percent) of students that miss >10% of student days in any grading period.
Eagle	CW	Number (percent) of CMP youth with new open involvements in Trails after CMP services begins.
El Paso	JJ	50% of youth on probation will not receive a new adjudication during participation in intervention.
El Paso	HMH	25% increase in level of functioning (determined by the CCAR among participating youth.
El Paso	ED	50% decrease in incidents of suspension among participating youth.
El Paso	CW	90% reduction in CMP youth who have 3 or more placements within 12 months of latest removal from home.
Elbert	JJ	CMP served youth will have 5% improvement in recidivism due to new convictions resulting in unsuccessful termination of probation measured from date of offense.
Elbert	HMH	CMP served youth will have a one point improvement on CCAR scores in 5 domains: family functioning, socialization, Overall level of functioning, role performance, activity involvement.
Elbert	ED	CMP served youth will have attendance rates within 10% of district average.
Elbert	CW	5% or fewer youth will have substantiated abuse finding entered in TRAILS after first Service Review Team meeting.
Fremont	ED	70% of the children referred to RE-1 & RE-2 truancy program will not be referred to Truancy Court.
Fremont	HMH	70% of youth enrolled in out-patient addictions services with RMBH will attend the program for more than 90 days.
Fremont	JJ	51% or more of the youth matched with a mentor will not become involved in the juvenile justice system.
Fremont	CW	10% or less of the children served by ISST in foster care will experience 2 or more placement moves.
Fremont	CW	Reducing the number and rate of children placed away from their birth families. – Trails.
Fremont	CW	Among children coming into foster care, increasing the number and rate at which children are placed in their own neighborhood or communities by remaining in their current school. – Trails.
Fremont	CW	Reducing the number of children served in institutional and group care and shifting resources from institutional and group care to kinship care, family foster care, and family-centered services. – Trails.
Fremont	CW	Decreasing the length of stay of children in placement. – Trails.
Fremont	CW	Increasing the number and rate of children reunified with their birth parents. – Trails.
Fremont	CW	Decreasing the number and rate of children re-entering placement. – Trails.
Fremont	CW	Reducing the number of placement moves children in care experience. – Trails.
Fremont	CW	Increasing the number and rate of siblings placed together. – Trails.

Fremont	JJ	Probation - Exceed by 6% the statewide percentage of the number of successful terminations of probation. – Probation.
Fremont	JJ	DYC - Increase by 10% above the baseline year SFY 06-07 the number of successful terminations of parole. – Trails/DYC.
Fremont	JJ	DYC - Ensure all youth returning to Fremont County on parole status under the jurisdiction of DYC shall have a community transition plan. (Goal added SFY 08-09) – Trails/DYC.
Garfield	CW	25% of children and youth involved with CMP will not have a new open involvement in TRAILS.
Garfield	JJ	50% of youth who are on probation or parole and receive CMP services will successfully complete probation or parole.
Garfield	ED	20% of CMP youth receiving services for school concerns will improve or maintain their school attendance after involvement with CMP.
Garfield	HMH	50% of youth referred to CMP for behavioral concerns will reduce problem severity score by 10% as measured on the CCAR pre and post test scores.
Grand	JJ	Maintain the low level of DYC commitments of FST served youth.
Grand	HMH	75% of eligible youth and families will receive CHP+ or Medicaid after enrollment in HB 1451.
Grand	ED	75% of the youth referred to ISST will improve their school attendance after receiving FST services.
Grand	CW	75% of FST (Family Support Team) served youth and families will not have any findings of substantiated abuse after 1451 services begin.
Gunnison/ Hinsdale	JJ	No more then 20% of CMP youth will terminate unsuccessfully due to revocations by technical violations.
Gunnison/ Hinsdale	JJ	90% of youth being discharged from a higher level of care (60 days or more) will have an aftercare transitional plan developed prior to discharge.
Gunnison/ Hinsdale	JJ	75% of sentenced youth receiving Senate Bill 94 and/or 1451 services will not go to long term placement (beyond 60 days).
Gunnison/ Hinsdale	JJ	75% of pre-adjudicated youth enrolled in Senate Bill 94 and/or 1451 services will not incur new charges intervention.
Gunnison/ Hinsdale	HMH	CMP served clients will be offered an appointment within 7 days of referral.
Gunnison/ Hinsdale	HMH	90% of youth being discharged from a higher level of care (60 days or more) will have an aftercare transitional plan developed prior to discharge.
Gunnison/ Hinsdale	HMH	Implement use of GAF score for CMP involved youth among all Behavioral Health Providers.
Gunnison/ Hinsdale	ED	90% of CMP involved youth will have an attendance rate that will be no less than 94% (based on unexcused absences) who are enrolled at the end of the review period.

Gunnison/ Hinsdale	ED	90% of youth being discharged from a higher level of care (60 days or more) will have an aftercare transitional plan developed prior to discharge.
Gunnison/ Hinsdale	CW	75% of CMP youth will not have substantiated abuse findings after CMP services began.
Gunnison/ Hinsdale	CW	90% of youth being discharged from a higher level of care (60 days or more) will have an aftercare transitional plan developed prior to discharge.
Huerfano	JJ	20% of children receiving services through the Collaborative Management Program will not enter a detention facility.
Huerfano	HMH	Improvement by 10% in the Level of Functioning and Problem Severity of children/youth receiving services through the Collaborative Management Program.
Huerfano	ED	Increase by 10% the school attendance of children/youth receiving services through the Collaborative Management Program.
Huerfano	CW	20% of children/youth receiving services through the Collaborative Management Program will successfully and safely remain in their own homes.
Jefferson	CW	Number of CMP youth with new open involvement in Trails after CMP services began. 10% of families (with children ages 0-5) who have been the subject of a substantiated child abuse or neglect incident with no open child welfare case and who have returned the Ages and Stages Questionnaires will access services.
Jefferson	JJ	After six months of their participation, a minimum of 50% of those who are actively enrolled in the High Fidelity Wraparound program will show a decrease in dynamic risk level (i.e., From Maximum to Medium or Minimum Risk levels) as measured by the CJRA.
Jefferson	ED	Ten percent or more of the students from the 5 middle schools in the 2011-2012 school year, assessed at the Jefferson County Juvenile Assessment Center will show an improvement in their attendance, post assessment.
Jefferson	HMH	Clients ages 0-21 years of Jefferson Center who do not have a physical health care provider and would like to obtain one, will receive a health care provider resource.
Lake	JJ	75% of Lake County youth will successfully complete probation.
Lake	HMH	Improvement by 10% in the Level of Functioning and Problem Severity of youth referred by the Lake County IOG.
Lake	ED	90% of students whole are participating in at least one of these Lake County school district programs: Educational Enhancement, Why Try, Smart Girls, Girls Circle, Link Leaders or Juntos, during the 2011-2012 school year will remain in school.
Lake	CW	60% of Lake County CMP youth will have no substantiated abuse findings after CMP services began.

Larimer	JJ	Reduce the rate of recidivism. Evaluation: Because the population served in HB 1451 is higher risk than the general DHS population, we expect a higher re-entry rate for this population than for our general population. Also, new research from Chapin Hall indicates that County's which place less children in out of home placement have higher re-entry rates because the children who are placed are higher risk and are more likely to re-enter. Larimer County's out of home placement numbers have dropped 50% in the last four years and therefore, we would expect that our re-entry rate would be higher than in prior years. We expect to maintain our recidivism rate within the range of 10% to 15%. This range is consistent with the most recent HB 1451 research paper submitted by Colorado State University.
Larimer	JJ	Increase successful probation terminations in Judicial District 8. Evaluation: We expect to maintain a range of 55% to 65% for successful probation terminations. This range is consistent with the most recent HB 1451 research paper submitted by Colorado State University.
Larimer	JJ	Reduce the rate of new charges for youth. Evaluation: We expect to maintain a range of 20% to 25% of youth with new charges. This range is consistent with the most recent HB 1451 research paper submitted by Colorado State University.
Larimer	JJ	Maintain or decrease the rate of DYC commitments
Larimer	HMH	Decrease use of inpatient services including PRTF and TRCCF. Evaluation: Due to the restructuring of the RTC program in Colorado, we have changed this outcome from RTC placements to PRTF and TRCCF placements. We expect to maintain a daily average of 2 or less in PRTF for FY10. We expect to maintain a daily average of 25 or less in TRCCF for FY10.
Larimer	HMH	Protect youth from recurrence of abuse/neglect and institutional abuse. Evaluation: The percent of children who do not experience repeat maltreatment within 6 months of a confirmed report of abuse/neglect will be at or above 90%.
Larimer	HMH	Protect youth from recurrence of abuse/neglect and institutional abuse. Evaluation: The percent of children who do not experience founded abuse/neglect during or after the completion of services will be at or above 90%.
Larimer	HMH	Protect youth from recurrence of abuse/neglect and institutional abuse. Evaluation: The percent of children who do not experience maltreatment in out of home placement will be at or above 95%.
Larimer	ED	Decrease school dropout rate. Evaluation: We expect to maintain a range of 10% to 12% school drop-out rate for both Thompson and Poudre School Districts. This range is consistent with the most recent HB 1451 research paper submitted by Colorado State University.
Larimer	CW	Reduce the number of moves for youth in out of home placement. Evaluation: 81.5% or more of the youth who have been in out of home placements less than 12 months will have no more than two placement settings.

Larimer	CW	Achieve reunification in a shorter time period. Evaluation: 76% or more youth will be reunified with their parents in less than 12 months from the time of the latest removal from home.
Larimer	CW	Increase the percentage of children who Remain Home whose permanency goal was to Remain Home. Evaluation: By providing up front services and developing a safety/support plan with the family, we expect to maintain the percentage of youth who remain home at 90% or above.
Larimer	CW	Maintain reentry rate of CMP served youth into child welfare system within a range of 10-15%.
Lincoln	JJ	25% or fewer youth will recidivate after first L-SRT meeting, resulting in unsuccessful completion of probation or parole.
Lincoln	HMH	75% of youth served by the L-SRT will actively participate in mental health treatment recommended by the collaborative service plan. Increase adolescent treatment completion by 3%.
Lincoln	ED	75% of students with identified attendance concerns will improve school attendance OR 75% of students with identified behavioral concerns will have fewer documented incidents.
Lincoln	CW	5% or fewer youth will have substantiated abuse finding entered in TRAILS after first Lincoln-Service Review Team meeting.
Mesa	JJ	80% of youth served by FAP will have an increased attendance rate after services begin.
Mesa	HMH	90% of youth who do not have a medical provider as assessment will be referred to a medical provider during services.
Mesa	ED	At least 74% of youth served by FAP will not recidivate resulting in unsuccessful completion of pre or post adjudication intervention.
Mesa	CW	At least 90% of youth served by FAP will not have a substantiated abuse finding after FAP services begin.
Moffat	JJ	Number (percent) of CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.
Moffat	HMH	For those juveniles assessed with a CCAR, 50% will show an improvement in overall symptom and functioning scores between admission and either update or discharge.
Moffat	ED	85% of youth in the wrap program will improve their school attendance after enrollment in wrap.
Moffat	CW	Number (percent) of CMP youth discharged to a permanent home.
Montezuma/ Dolores	JJ	Improve positive terminations and compliance with supervision requirements by 5% for youth who are enrolled in SB94 services an referred to the CET; ensure that 95% of referred youth will be engaged in an educational program; 90% of all juvenile cases will have been referred to CET prior to a commitment or out-of-home placement.
Montezuma/ Dolores	HMH	90% of youth evaluated will not be hospitalized and will receive services in the community.
Montezuma/ Dolores	ED	All youth in the Check and Connect Program will be evaluated for referral to the CET, will show a 25% improvement in school attendance during the school year and youth referred to the CET will demonstrate a reduction in alterable risk factors.

Montezuma/ Dolores	CW	90% compliance of all individual cases will have a educational plan and will be considered for the CET.
Montrose	JJ	Number (percent) of revocations by technical violations where case resulted in unsuccessful termination among CMP youth/Set baseline at 12%. Achieve a percent of less than 12%.
Montrose	HMH	100% of youth referred to ISST that needs mental health services will be seen by the Center within 7 days of referral.
Montrose	ED	80% of youth targeted by the school district as habitually disruptive will be referred to ISST.
Montrose	CW	Number of CMP youth with new open involvements in Trails after CMP services begin/Less than 25% of CMP youth will have new open involvements in Trails after CMP services begin.
Morgan	Other (Domestic Violence)	200 families will receive Domestic Violence intervention services.
Morgan	Other (Domestic Violence)	36 women will attend support/education groups, and 56 children will attend children's groups.
Morgan	Other (Domestic Violence)	95 percent of adults who participate in groups at SHARE will complete a questionnaire evaluation and be able to determine 2 characteristics of potential abusers.
Morgan	Other (Domestic Violence)	95 percent of children who participate in groups at SHARE will demonstrate the ability to dial 911 and be able to verbalize a basic safety plan.
Morgan	Other (Sexual Assault Program)	100 families will receive sexual abuse/assault intervention services.
Morgan	Other (Sexual Assault Program)	At least 50 % of families who complete the "Darkness to Light" class will complete a pre/post questionnaire and be able to: 1.) Identify the dynamics of sexual abuse, and 2.) Identify the proper safety measures to prevent ongoing sexual abuse.
Morgan	JJ	There will be no more than 10 juveniles placed out of county due to probation revocation.
Morgan	HMH	8 (or at least 9 percent) of youth who have had a FACT conference will receive follow up mental health and /or substance abuse services.

Morgan	ED	30% of youth who participate in FACT conferences will not be referred to Truancy Court in Morgan County.
Morgan	CW	18 youth who are in out of home placement, and have participated in the FACT conference process will be discharged to a permanent home.
Pueblo	JJ	Reach target success rate of 74%for juveniles under regular supervision.
Pueblo	HMH	5% of children show an increase in level of functioning.
Pueblo	HMH	Improvement by 3% in drug & alcohol out-patient tx in a 90-day tx plan.
Pueblo	HMH	A minimum of 12 youth, age 6-18 will be sheltered with their mothers and provided supportive services.
Pueblo	HMH	Utilize the info obtained to develop a community plan to address the issue of teen pregnancy by June 2012.
Pueblo	ED	Improve attendance by reducing days absent by 40%.
Pueblo	CW	86.7% or more of the served youth in OOHP less than 12 months will have no more than 2 placement settings.
Rio Grande	JJ	80% of probation youth served by the CMP will not have a revocation based on technical violations.
Rio Grande	HMH	At least 85% of youth served by the Collaborative Management Program will have required immunizations.
Rio Grande	ED	The attendance of youth served by the CMP will either improve by 10% or be within 5% of the school average or exceed it.
Rio Grande	ED	The drop-out rate for CMP youth will be 5% or less.
Rio Grande	ED	CMP youth will have a GPA of 2.0 or the equivalent (elementary).
Rio Grande	ED	75% of CMP youth who have had a former suspension will not have any further suspensions.
Rio Grande	CW	</_ 25% of youth served by the CMP will have an OOH placement.
Routt	HMH	Assure substance abuse treatment interventions for 10% of children, youth and families in need of treatment and currently not able to access treatment in Routt County. Having increased and maintained the number of youth served to 120, the goal for this year will be to maintain a minimum of 120 youth able to access affordable substance abuse treatment.
Routt	ED	Provide assessment and individualized treatment and support to at least 40 students. Within the identified population, 80% will increase their attendance rate.
Routt	ED	Provide alternative education planning to at least 40 students to assist them in meeting graduation requirements. Within the above identified population, 80% will remain in school and/or an alternative educational setting.
Teller	CW	75% of CMP Youth served will not have substantiated abuse finding after CMP services begin.
Teller	JJ	Reach target success rate of 74% for juveniles under regular supervision.
Teller	ED	Youth at risk of or involved with truancy court will Improve attendance by reducing days absent by 40%.

Teller	ED	Increase by 5% the attendance of youth enrolled in school receiving CMP Services.
Teller	HMH	5% of children show an increase in level of functioning.
Teller	HMH	Improvement of at least 2 points on the final score for 80% of the clients as determined by the DLA-20.
Weld	JJ	Maintain or decrease the rate of new adjudications (8%), across these service programs, (within 12 months of completing service*).
Weld	JJ	Establish a baseline of success for youth (within 12 months of completing service*).
Weld	HMH	Insure that all MST outcome indicators remain in the "high range" of 77% or higher (showing an increase in socio-emotional, behavioral, developmental and/or cognitive functioning).
Weld	ED	Will maintain a rate of at least 78% of youth served by the TRIP program who have fewer unexcused absences after the intervention.
Weld	CW	Will maintain a 76% rate of the number of children who are in out-of-home placement who have returned home within 12 months* of the start of removal.
Weld	CW	Will maintain a 47% rate of the number of children who are in out-of-home placement who have had no moves in service placement.
Weld	CW	MYAT – Maintain or improve the rate at which youth who complete the MYAT program that are successfully diverted from involvement in child welfare services and/or the juvenile justice system within 12 months* after enrolling.

Appendix 12. External funding

The table below CMP reports about funding obtained from federal, state, and private/other sources in support of CMP work.

Source of funds	Description	Number of CMPs	Amount received
Federal and State Funding Sources			
Juvenile Accountability Block Grant	Block grants to states for programs promoting accountability in the juvenile justice system (federal)	2	$44,849
Supportive Services for Runaway and Homeless Youth Grant	Out of the Rural Coalition for Homeless Youth (RCHY) (federal)	1	$25,400
Communities of Excellence Planning Grant through the Systems of Care	Competitive funding to develop a comprehensive strategic plan for improving and expanding services provided by systems of care (SOC) for children and youth with serious emotional disturbances and their families (federal)	7*	$350,000
Promoting Safe and Stable Families	Funds distributed by US HSS to states for services that address family support, family preservation, reunification, and adoption (federal)	1	$32,500
FEMA Fire Grant: Juvenile Firesetter Intervention Program	Supports evaluations & risk assessments of individuals involved in firesetting behavior, follow-up education to prevent future behaviors (federal)	1	$34,472
Personal Responsibility Education Program	Programs that teach about abstinence, contraception, and protection against sexually transmitted infections (STIs) (federal)	1	$140,000
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 (state)	5	$289,366
Tony Grampas Youth Services Grant	Competitive funding to organizations that target youth and their families with programs designed to reduce youth crime and violence (state)	1	$9,873
The Expelled and At Risk Student Services Grant	Funding from the Colorado legislature that supports the education of expelled students and those at-risk of suspension and expulsion (state)	1	$8,000
Statewide Strategic Use Fund	Funds distributed for programs serving Colorado's most vulnerable families (state)	1	$200,000
Division of Behavioral Health Prevention Block Grant	Funds for prevention programming (state)	2	$153,787
Private Foundation/Other Funding Sources			
Ariel Clinical Services	Funding to help children and adults live and thrive in their communities and is a non-profit Child Placement Agency and Adult Service Agency.	1	$5,000
Hilltop Community Resources	Hilltop offers a wide-range of services, including B4 Babies and Beyond, job re-training, and Assisted/Retirement Living Communities.	1	$5,000
Community Foundation of the Gunnison Valley	The Foundation awards grants to programs that benefit Gunnison County citizens.	1	$2,950

**One of these SOC communities represents a joint effort of three CMPs (counted as one in this total).*

Appendix 13. Common assessments

CMPs were asked to report on whether or not they utilize common screening and/or assessment measures that are shared across agencies. Seventeen counties (60.7%) said that they utilized at least one common screen or assessment in FY 2012. CMPs most commonly indicated that they use two common screening tools or assessments. The minimum number of common screens or assessments selected by a single CMP was one, and the maximum was seven.

CMPs were also asked to indicate which screening tools or assessments they use, out of a list of seven options. Over half (54%; 15 CMPs) indicated that they use the Colorado Juvenile Risk Assessment (CJRA) full assessment, while 12 (43%) use the pre-screen version of the CJRA. Other commonly reported screening tools and assessments appear in the table below.

Table 1: Common screening tools or assessment measures used by CMPs

Assessment or Screening Tool	Brief description[a]	Number of CMPs (%)
Colorado Juvenile Risk Assessment (CJRA) Pre-Screen	A 23-item abbreviated version of the full CJRA. The CRA pre-screen is designed to predict probability of re-offense by designating youth as low, moderate, or high risk for engaging in future criminal activity.	12 (43%)
Colorado Juvenile Risk Assessment (CJRA) Full Assessment	A risk assessment instrument used to measure juvenile offender risk and protective factors in twelve domains. Clinical information obtained through a structured motivational interview produces an individualized scoring profile designed to depict dynamic and static criminogenic risk and protective factors that can be used for service plan development.	15 (54%)
Colorado Youthful Offender Level of Service Inventory (CYOLSI)*	An 84-item semi-structured, staff-guided risk/ needs assessment. Results provide an overall risk score that is predictive of recidivism, supervision failure and institutional misconduct. Results also assist in supervision needs and case management resources.	4 (14%)
Colorado Client Assessment Record (CCAR)	A clinical instrument designed to assess the behavioral health status of an individual in treatment. The tool can be used to identify current clinical issues and to measure progress during treatment. It includes questions related to daily functioning on 25 clinical domains.	6 (21%)
Short Understanding of Substance Abuse Scale (SUSS)	A 19-item screening tool to measure staff and patient beliefs about the etiology of substance abuse. The measure results in 3 scales: disease model, psychosocial model, and eclectic model.	4 (14%)
Massachusetts Youth Screening Instrument (MAYSI)	A 52-question self-report screening instrument that measures symptoms on 7 scales pertaining to areas of emotional, behavioral, or psychological disturbance. It is intended for use at any entry or transitional placement point in the juvenile justice system.	6 (21%)
North Carolina Family Assessment Scale (NCFAS)	The original NCFAS has 5 family functioning domains, each consisting of several factors that are rated for level of family functioning for each individual factor and for the overall domain. The more recently validated NCFAS-R has 7 domains (5 original and 2 others designed to predict successful reunification).	4 (14%)

Note: Other responses included: Child & Adolescent Needs & Strengths Assessment; ETO Intake/Exit Assessment & Family Centered Assessment; Strengths & Needs Cultural Assessment & CASII & ECASI; & The Outcome Tracking System.
*CJRA has replaced CYOLSI for youth assessed for probation services.
[a]Derived from the *Colorado Reference Guide, Juvenile Screening and Assessment Instruments, 2008*.

Appendix 14. CMP statewide database sample reports

The selection of common indicators and the use of a shared data system become even more powerful when paired with the reporting capabilities of the CMP statewide database, implemented through the Efforts-to-Outcomes (ETO) platform, which can produce customized, real-time reports for CMP stakeholders at both the state and local levels. This appendix includes select sections of the reports available through the CMP statewide database. The first two pages present indicator data in the education domain, while the second two present data for health/mental health. In addition to the summary presentations shown here, CMP stakeholders have the ability to run client-level reports to monitor progress for individual youth.

TARGET OUTCOMES: Education Indicators

Which education indicators were selected as potential target outcomes/treatment goals for CMP-served youth at their initial ISST meeting?

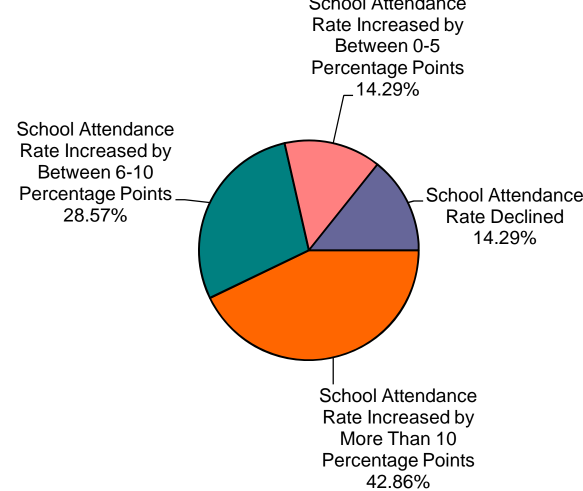
Education Outcome Area	Count of CMP Youth
Improve School Attendance	8
Improve School Performance (academic achievement)	9
Maintain Enrollment in School	6
No Education Outcome Selected	26
Reduce Disciplinary Problems at School	8
Total:	**57**

INDICATOR: Improve School Atttendance

Do CMP-served youth improve their school attendance after starting CMP services?

Change in School Attendance Between Pre and Post	Count of CMP Youth
School Attendance Rate Declined	1
School Attendance Rate Increased by Between 0-5 Percentage Points	1
School Attendance Rate Increased by Between 6-10 Percentage Points	2
School Attendance Rate Increased by More Than 10 Percentage Points	3
Total:	**7**

Note: Data above assume that the attendance rate was measured in the same unit (weekly, monthly, etc.) at pre and post for each individual youth, though the unit may vary across youth (e.g., attendance may be measured weekly for some youth and monthly for others). The "School Attendance Details" tab of this report provides additional detail about attendance measurement units by youth.



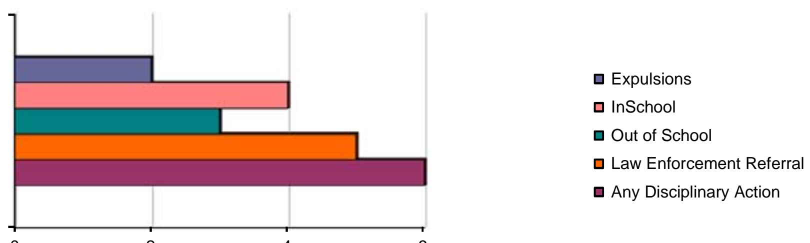
INDICATOR: Reduce Disciplinary Problems at School

How common are school disciplinary actions among CMP-served youth after starting CMP services?

Number of Youth with at Least One Expulsion	2
Number of Youth with at Least One In-school Suspension	4
Number of Youth with at Least One Out-of-school Suspension	3
Number of Youth with at Least One Law Enforcement Referral	5
Number of Youth with at Least One of the above Disciplinary Actions	6

Note: If a youth had disciplinary actions in multiple categories (e.g., both an In-school Suspension and an Out-of-school Suspension), s/he will be counted multiple times in this table (e.g., once on the In-school Suspension row and then again on the Out-of-school Suspension row), as well as the bar chart below.

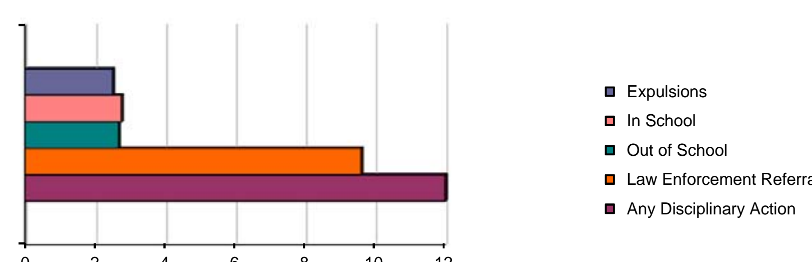
Number of Youth with at Least One Occurrence



Average Number of Expulsions Per Youth	2.5
Average Number of In-School Suspensions Per Youth	2.75
Average Number of Out-of-School Suspensions Per Youth	2.6667
Average Number of Law Enforcement Referrals Per Youth	9.6
Average Number of Disciplinary Actions (Overall) Per Youth	12

Note: Averages in the table above and chart below reflect only those youth with at least one disciplinary action.

Average Occurrences Per Youth



TARGET OUTCOMES: Health/Mental Health Indicators

Which health/mental health indicators were selected as potential target outcomes/treatment goals for CMP-served youth at their initial ISST meeting?

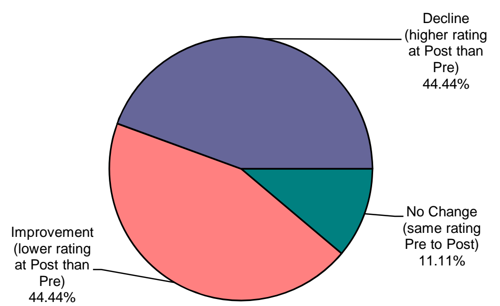
Health/Mental Health Outcomes	Count of CMP Youth
Decrease Problem Severity/Increased Level of Functioning	9
Increase Access to Health Care Systems/Providers	7
Reduce Hospitalization for Mental Health Services	9
Successful Completion of Substance Use Treatment	6
No Health/Mental Health Outcome Selected	24
Total:	**55**

INDICATOR: Decrease Problem Severity/Increase Level of Functioning

a) Do CMP-served youth show improved symptom severity (as measured by CCAR) after starting CMP services?

Change in CCAR Symptom Severity Rating Between Pre and Post	Count of CMP Youth
Decline (higher rating at Post than Pre)	4
Improvement (lower rating at Post than Pre)	4
No Change (same rating Pre to Post)	1
Total:	**9**

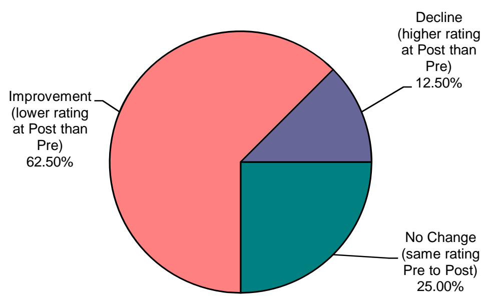
Note: DBH CCAR form provides a rating scale of 1-9, with the following anchors:
1 No symptoms are present for this person.
3 Symptoms may be intermittent or may persist at a low level.
5 Symptoms are present which require formal professional mental health intervention.
7 Significant symptoms affecting multiple domains exist, often requiring external intervention.
9 Symptoms are profound and potentially life-threatening.



b) Do CMP-served youth show improved level of functioning (as measured by CCAR) after starting CMP services?

Change in CCAR Level of Functioning Rating Between Pre and Post	Count of CMP Youth
Decline (higher rating at Post than Pre)	1
Improvement (lower rating at Post than Pre)	5
No Change (same rating Pre to Post)	2
Total:	**8**

Note: DBH CCAR form provides a rating scale of 1-9, with the following anchors:
1 No symptoms are present for this person.
3 Symptoms may be intermittent or may persist at a low level.
5 Symptoms are present which require formal professional mental health intervention.
7 Significant symptoms affecting multiple domains exist, often requiring external intervention.
9 Symptoms are profound and potentially life-threatening.



INDICATOR: Reduce Hospitalization for Mental Health Services

How common are hospitalizations for mental health services among CMP-served youth after starting CMP services?

Number of Hospitalizations for Mental Health Services	Count of CMP Youth	Percent
At Least One Hospitalization	4	17.4%
No Hospitalizations	19	82.6%
Total:	**23**	

Total Days Spent in Hospitalization for Mental Health Services	553
Total Number of Hospitalizations for Mental Health Services	27

Average Number of Hospitalizations (among children/youth with at least one hospitalization)	6.75
Average Number of Days Spent in Hospitalization for Mental Health Services (among children/youth with at least one)	110.6
Average Number of Hospitalizations(among all children/youth with data)	5.4

INDICATOR: Increase Access to Health Care System/Providers

Do CMP-served youth have and/or obtain healthcare supports after starting CMP services?

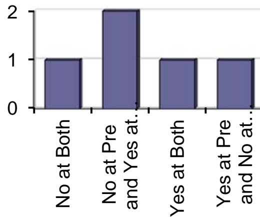
Primary Care Provider

Pre	Count of CMP Youth
No	5
Yes	2
Total:	**7**

Post	Count of CMP Youth
No	2
Yes	5
Total:	**7**

Pre/Post	Count of CMP Youth
No at Both	1
No at Pre and Yes at Post	2
Yes at Both	1
Yes at Pre and No at Post	1
Total:	**5**

Note: Youth for whom data about Primary Care Provider were not available are excluded from the above totals. As such, it is possible for total counts of youth to differ between Pre and Post (e.g., if data about the provider were not available at Pre but were available at Post).



Health Insurance Coverage

Pre	Count of CMP Youth
None	5
Private	1
Public	1

Post	Count of CMP Youth
None	2
Private	2
Public	2

Any Insurance Pre	2
Any Insurance Post	4
Any Insurance Both	1
No Insurance Both	1

Note: Youth for whom health insurance data were not available are excluded from the above totals. As such, it is possible for total counts of youth to differ between Pre and Post (e.g., if data about insurance coverage were not available at Pre but were available at Post).