HB 1451 Collaborative Management Program

YEAR 4 STATEWIDE EVALUATION FINDINGS

Colorado Department of Human Services
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Colorado Department of Human Services
Division of Child Welfare Services
Colorado Management Program

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February 24, 2014

TO: Julie Krow
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FROM: Collaborative Management Program (CMP) Evaluation Subcommittee

On behalf of the Collaborative Management Program's Evaluation Subcommittee, we are pleased to submit the FY 2013 CMP Evaluation Report. The Evaluation Subcommittee is composed of representatives from CMP counties, state agency partners, a family-driven organization and the contracted evaluation firm. The Committee's work over the over the past 20 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.

Key highlights from the 2013 CMP Evaluation Report include:

- 20,584 (duplicated) children and youth were served by CMP partner agencies across the 32 CMPs and 8,716 participated in Individualized Service and Support Team (ISST) services
- Family representatives in local governance groups increased from 60% (FY11) to 72% (FY13)
- CMPs delivered integrated services to multi-system children, youth, and families:
    - 92% of ISST cases had multiple agencies involved in service planning (up from 83% in FY12)
    - 88% of ISST cases had an integrated plan developed (up from 86% in FY12)
    - Family participation in ISSTs increased from 79% (FY12) to 85% (FY13)
    - CMPs increased implementation of evidence-informed programs: Team Decision Making (20 CMPs), High Fidelity Wraparound (15 CMPs), and the Crossover Youth Practice Model (9 CMPs)
- CMPs impacted outcomes for multi-system children, youth, and families:
    - Child Welfare outcomes
        - 53% had no new child welfare involvements
        - 93% had no substantiated abuse or neglect
        - Of those in out-of-home care, 76% had two or less placements
        - Of those discharged, 74% were to a permanent home

    - Juvenile Justice outcomes
        - 75% did not become involved with probation system
        - For children and youth who terminated probation:
            - 56% successfully terminated
            - 32% had probation revoked due to technical violation
            - 13% had probation revoked due to pre-release recidivism
    - CMPs piloted new outcomes measures in the areas of Education and Health/Mental Health
- Local CMPs reported $15 million in partner-provided in-kind funds, $3.4 million in CMP partner line-item contributions to support CMP efforts, and approximately $2.5 million from local, state and federal grants

Demonstrating program effectiveness is an important goal of the Colorado Department of Human Services. The development of evaluation infrastructure, including an online client-level data system, common data collection tools, and data sharing agreements with Trails and ICON/Eclipse to support analysis of CMP statewide outcomes, has enabled the evaluation to provide evidence of the positive impacts CMP is having on multi-system children, youth, and families across the state. The report concludes with recommendations that assist in stronger measurement of both CMP processes and outcomes to further illustrate program effectiveness, including:

1. Implement a mechanism to capture CMP-served cases within CDHS Trails
2. Explore the alignment of CMP child welfare outcomes with C-Stat measures
3. Focus statewide evaluation efforts primarily on families served through ISSTs
4. Expand state-level participation of other identified initiative partners

CMP continues to be the strongest vehicle in the state for breaking down silos at the local level, giving voice to involved families, and improving outcomes for children, youth, 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

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CMP Statewide Evaluation Year 4 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, youth, and families in the child welfare system.

As outlined in 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, designed to answer the following questions:

- To what extent is the CMP meeting legislative intent in key population, systems, services, and outcome components?
- Does the CMP result in positive outcomes for multi-system children and youth?
- Which CMP models/components are most effective?
- How are CMPs realizing systems improvements?

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)

The Year 4 Evaluation Report is organized to provide a comprehensive analysis of these questions utilizing data collected through a CMP online client-level database, the Annual Report, state agency databases (i.e., Trails, ICON/Eclipse), and IOG member surveys. This Executive Summary presents selected findings organized according to statutory reporting requirements (24-1.9-103, a-e), which primarily focus on system, service, and child and family outcome improvements stemming from ISST efforts.

(a) Individualized Service and Support Team (ISST) population, services, and outcomes

Numbers served by ISSTs. Since 2004, the program has grown from 6 to 35 counties comprising 32 CMPs in FY 2013. In FY 2013, CMPs reported serving 8,716 children and youth through ISST models; 5,263 of these cases were newly enrolled and 3,259 (79%) are represented in the CMP database. When factoring in those served through IOG partner agency programs, the number grows to about 20,500 individuals.

Data reveal the following regarding demographics and service needs of ISST-served children and youth:

Demographic characteristics	•56% were pre-adolescents or adolescents •57% were male, 43% were female •76% were White/Caucasian; 43% indicated Hispanic/Latino ethnicity •All percentages were similar to the ISST-served population in FY 2012.
Service needs	•55% of children or youth reported involvement with two or more agencies at ISST intake; a slightly lower percentage than in FY 2012 (60%) •The most common systems involvements in FY2013 and FY 2012 were child welfare open involvements (73% vs. 77%) and mental health services (35% vs. 38%, respectively)

Outcomes of services provided. As evidenced by the following indicators, CMPs successfully:

- **Delivered integrated services**
  - 92% of ISST cases had multiple agencies involved in service planning (up from 83% in FY 2012)
  - 88% of ISST cases had an integrated plan developed (up from 86% in FY 2012)
- **Reduced duplication and fragmentation** through streamlining services and improving experiences for families
  - 72% of CMPs utilized cross-agency consents
  - 100% of CMPs reported significant reduction in conflicting treatment requirements
  - 56% of CMPs reported using common client assessments shared across agencies
- **Improved quality of services**
  - Increased implementation of evidence-informed programs: Team Decision Making (20 CMPs), High Fidelity Wraparound (15 CMPs), and Crossover Youth Practice Model (9 CMPs)
  - 72% of CMPs reported implementing new programs that specifically target a population and service need/gap identified by their IOG (up from 61% in FY12)
  - 53% of CMPs reported implementing or enhancing existing services to be more culturally appropriate/culturally competent (up from 43% in FY12)

Improvements in family-centered service delivery systems

CMPs have made considerable progress integrating family perspectives in their efforts:

- Family representation in IOGs rose from 60% of CMPs in FY 2011 to 72% in FY 2013 (with a peak of 89% in FY 2012). Of those with current family representatives, 96% grant voting rights and 78% attend more than half of the meetings.
- CMPs reported increases in caregiver involvement in ISST meetings in FY 2013 (85% of ISST cases vs. 79% in FY 2012).

The evaluation team also successfully launched a validated measure to collect family feedback on CMP service delivery and perceived family outcomes, which will inform quality improvements.

Outcomes for children, youth, and families. The ultimate goal of CMP is to achieve positive outcomes that improve the lives of multi-systems-involved children, youth and families. Outcomes are assessed cross-site (standard statewide indicators) and within CMPs (locally defined performance measures).

The following reflect cross-site outcomes from Trails and ICON/Eclipse state data systems for the 12-month period following the start of ISST-services [matched to data from the Efforts to Outcomes (ETO)™ CMP database], for those youth who had the indicator selected as the targeted goal.

Child welfare outcomes

- 53% had no new child welfare involvements
- 93% had no substantiated abuse or neglect
- Of those in out-of-home care, 76% had two or fewer placements
- Of those in out-of-home care and discharged, 74% were to a permanent home

Juvenile justice outcomes

- 75% did not become involved with probation system
- For youth who terminated probation:
  - 56% were successfully terminated
  - 32% had probation revoked due to technical violation
  - 13% had probation revoked due to pre-release recidivism

In general, rates of occurrence were about the same or lower than annual CDHS and State Judicial reports on similar indicators. Over half (56%) of ISST-served children and youth terminating from probation were successful, which is lower than the state-reported rates from FY 2012 (75%).[1] Rates of revocation of probation for technical violations (31.7%) and pre-release recidivism (12.7%) were higher than state-reported rates (18% and 8%, respectively).[2] Given that CMP ISST services are designed to serve children and youth at greatest risk who also are multi-system involved, the lower comparative rates of success still represents positive outcomes.

[1] Office of the State Court Administrator (2013). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2012 releases*. Retrieved on-line December 2013.

In FY 2013, a subset of CMPs agreed to pilot indicator measures in the remaining two domains: Education and Health/Mental Health. Education measures included: school attendance, disciplinary problem, academic performance, and school enrollment in education; and health/mental health measures included: mental health functioning, substance use treatment, and access to health care providers in health/mental health. However, participation was quite low, with less than 8% of ISST-served youth in FY 2013 with any data entered. Results are not presented as they are unlikely to be representative of statewide performance. However, CMPs were able to access performance rates for local monitoring. The pilot will continue in FY 2014, and the CMP evaluation team will expand efforts to engage partners and address data collection challenges in these domains. In addition, recent changes in the tracking of student educational data for children and youth involved in the child welfare system in Trails may present an opportunity for additional monitoring of educational outcomes among a subset of CMP-served children and youth.

Performance on locally selected, defined, and reported measures by CMPs showed that:

- 94% of the 128 performance target goals across the 32 CMPs were met in FY 2013 (the same as reported in FY 2012, and up from 78% in FY 2011)
- Many noted considerable community-level child/family impacts as a result of CMP, including:
    - Lower juvenile criminal filings, fewer youth committed to DYC
    - Decreased number of children and youth in residential care and in out-of-home placement

(b) and (c) Implementation costs, cost-shifting and savings, and reinvestment of funds

The CMP approach assumes that reductions in duplication and greater integration of services across systems will lead to better family outcomes and net cost-savings over time. Cost savings recovered at the local level as a result of interagency cost sharing are required to be reinvested to improve or expand services.

Implementation costs. CMPs reported expending about $4.1 million of their available incentive funding. This total exceeds the $2.6 million earned incentives distribution fund in FY 2013 because CMPs called upon carryover funds to put previously planned programs into place. In FY 2013, CMPs reported an additional $15 million in CMP partner in-kind funds and $3.4 million in CMP partner line-item contributions to support CMP efforts.

Cost-shifting and cost-savings. Assessing actual service cost reductions and cost savings of CMP services remains challenging. Although information is limited, the following indicators suggest that CMPs are engaging in significant cost-sharing and are realizing local cost savings.

- 97% of CMPs indicated that agencies participating in ISSTs jointly agree on who will pay for interventions (e.g., blending and braiding), up from 81% in FY 2012
- CMPs realized cost efficiencies in service delivery: average cost of initial ISST meetings has gone down from $323 in FY 2011 to $286 in FY 2013

- Four CMPs reported quantified cost savings at program-level: Total cost savings reported was $432K (range was $28K - $168K)
- Many CMP IOGs have cost measurements as a specified objective in FY 2014

CMPs were successful in obtaining external funding to support efforts: 17 CMPs received approximately $2.5 million from local, state and federal grants (up from a total of approximately $1 million for 11 CMPs in FY 2012).[2]

Approximately $5.8 million of locally reserved funds will be reinvested in FY 2014. A greater percentage of CMPs (93%) plan to reinvest funds directly into new or expanded family-centered services, and into flexible spending accounts to provide for family needs (48%), compared to FY 2012.

Plans for reinvested savings	FY 2012: Number of CMPs (%)*	FY 2013: Number of CMPs (%)**	Examples
Support programs and services	16 (64%)	27 (93%)	Sustain or expand existing services, develop new programs, provide grants to programs with emergency needs
Support families directly	9 (36%)	14 (48%)	Retain flexible funds for families in need of respite care, emergency services, etc.
Support personnel costs	5 (20%)	14 (48%)	Contribute to CMP coordinator salary
Training and technical assistance	3 (12%)	4 (14%)	Support symposium, cross-site meetings
Hold funds in reserve	6 (24%)	3 (10%)	Retain funds to apply to planned programs or services
Support local evaluation	-- ----	5 (27%)	Engage evaluators to conduct local performance measure analysis

**Note: n = 25; **Note: n=29.*

(d) Identified barriers to provide effective services

Despite advances in FY 2012, there remain a number of challenges that the program continues to address collaboratively in order to fully respond to legislative requirements and goals:

- There is a diminishing amount of performance-based earned incentive funds for distribution among CMPs, at a time when CMPs also report that the current economic challenges 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 17% of ISST cases had a family advocate/facilitator in their initial planning meeting.
- Facilitation of efficient, comprehensive client-level data sharing across agencies and systems, at both the local and state level. Locally, about one-third of CMPs stated that they do not have multi-agency consents in place to share information among service providers.
- CMPs report some competing efforts across multiple state initiatives (e.g., IV-E Waiver, Trauma-Informed Systems of Care). Although there are shared components and goals across these programs, implementation and monitoring processes differ which can result in duplication.

[2] Totals for FY 2013 may include funds applied in prior year, as grant cycles vary.

(e) Other information relevant to improving the delivery of services

Key achievements were noted in evaluation findings, in the following three areas:

Strong collaboration at the community level	•IOGs observed that since implementing CMP, service approaches are more holistic and family-centered •IOGs also note that there is increased understanding of services and communication across agencies •IOG members consistently rate their collaborative processes as highly effective on annual survey (approximate ratings of 5 on a 6 point scale)
Implementation improvements	•Enhanced focus on implementation of CMP model components
Effective infrastructure to monitor impacts	•Expanded online client-level data collection and reporting •Local and state data reports to support program management •Case match with state datasets to analyze outcomes •Pre- and post-service education and health/mental health measures to gather standardized data in these domains •Roll out of standardized, validated family feedback measure for FY 2014 •Improved local performance outcome measurement and utilization: 96% of CMPs report reviewing data with IOGs; 47% distribute written summaries regularly

Future directions for the statewide 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 2014 are focused in the following areas:

- Promote expansion of client-level and cross-system data to:
  - More precisely measure CMP population, services, and outcomes
  - Analyze impacts longitudinally
  - Facilitate local efforts to identify quality improvements and monitor outcomes
  - Improve ability to measure costs and benefits
  - Align outcome measurement with CDHS C-Stat objectives
  - Capture CMP cases within other state data systems (e.g., Trails)
- Promote use of consent/authorization to release information in standard format across systems
- Promote learning within and across CMP sites to encourage model refinement

"[As a result of CMP] human service agencies, charitable organizations, schools, and governmental entities work in closer collaboration than before… staff members network monthly at community meetings and client staffings, and are more aware of what each other is doing. The "silo" mentality has changed. *(Pueblo CMP)*

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I. The Collaborative Management Program (CMP)

In 2004, the Colorado General Assembly passed House Bill 04-1451 (referred to as HB 1451) to establish collaborative management programs that would improve outcomes for children, youth, and families involved with multiple agencies at the county level. Specifically, the General Assembly determined that the "development of a uniform system of collaborative management is necessary for agencies at the state and county levels to effectively and efficiently collaborate to share resources or to manage and integrate the treatment and services provided to children and families who benefit from multi-agency services."[i] The legislative intent of HB 1451 was to address the increasing number of families served by more than one agency or system (e.g., juvenile justice, child welfare, mental health, education), which has placed significant demands on agencies' resources.[ii]

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

At the state level, the CMP has multiple state agency partners. The Department of Human Services, Division of Child Welfare Services is the lead administrative agency and other state partners include Department of Human Services, Division of Youth Corrections and Office of Behavioral Health, Department of Public Health and Environment, Office of the State Court Administrator judicial department, Department of Public Safety, Division of Criminal Justice, Department of Education, and Department of Health Care Policy and Financing. Directors of these key partnering agencies meet yearly to discuss program progress and help to address program challenges related to state level infrastructure or policy.

The specific goals of the legislation are as follows:

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

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

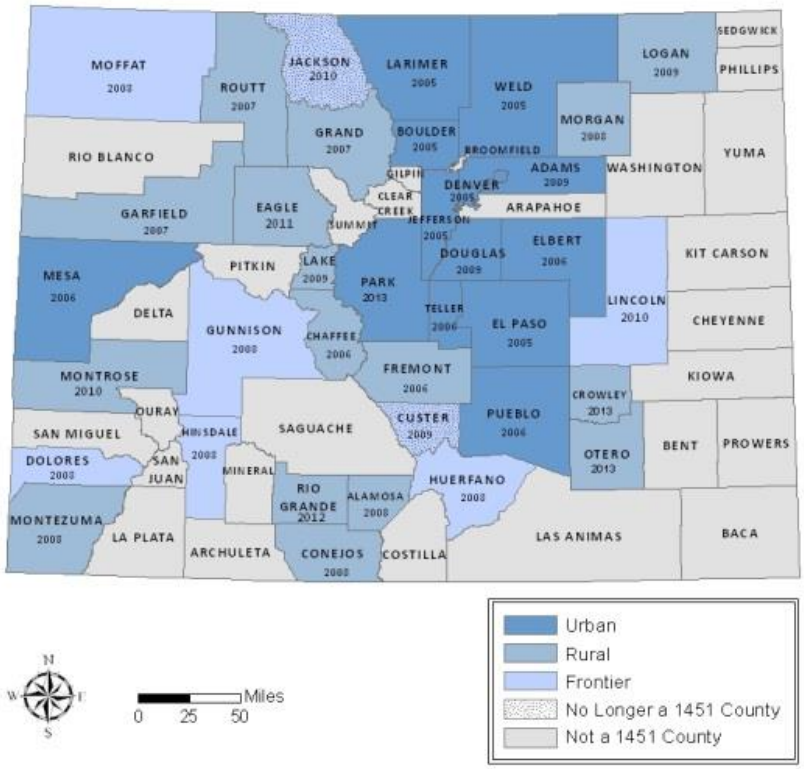
- Increased probability of improvement in child, youth, and family outcomes
- Maximization of available resources for the provision of services
- Increased coordination within and among service delivery systems
- Shared responsibility across systems and service providers[iii]

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

> *"**Collaboration**...has been seen as a means by which complex problems with interrelated causes can be addressed, a strategy for maximizing the efficient use of limited resources, a way of reducing the fragmentation within and between bureaucracies, [and] a means of engaging citizens in a democratic process of decision-making."*
>
> Emshoff et al., 2007, *American Journal of Community Psychology*

County participation in the CMP has increased significantly since it was established, growing from 6 counties in its first year to 35 counties (representing 32 CMPs) in the 2012-13 fiscal year. Figure 1 on the following page illustrates the distribution of participating counties across the state and by population density.

Figure 1: Map of participating CMP counties (2005-2013)



At the state-level, a CMP State Steering Committee composed of representatives from organizations that are mandatory CMP signatories, family advocacy organizations, and participating counties, provides on-going program oversight and works to advance CMP systems reform goals. See Appendix A for a diagram of the CMP oversight and implementation structure and Appendix B for a detailed timeline of key milestones over the course of the CMP.

The CMP Evaluation

In 2008, House Bill 08-1005 outlined specific reporting requirements for local CMPs and authorized an annual external evaluation of the CMP. The legislation requires that local sites report on the following common elements:

- 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
- Information relevant to improving the delivery of services to persons who would benefit from multi-agency services

In implementing this legislative requirement, CDHS issued a Request for Proposals for a statewide evaluation, outlining the expectation that the evaluation focus on building both local evaluation capacity and data collection infrastructure to support cross-site comparisons among CMP counties.

CDHS sought an evaluation with both "participatory" and "standardized" components. CDHS awarded OMNI Institute (OMNI) the statewide evaluation contract in October 2009.

Cross-site evaluations typically require an initial phase of information gathering in order to develop an evaluation plan that accommodates individual variations across sites while ensuring a common framework for measuring processes and outcomes. OMNI implemented the CMP evaluation plan in multiple phases in order to ensure that evaluation reflected both participatory and standardized qualities. Table 1, below, summarizes each of these phases (please refer to Appendix C for details on the phases of the statewide evaluation and Appendix D for a list of the reporting requirements from HB 04-1451 legislation).

Table 1: Phases of the evaluation

Year	Evaluation phase
Year 1 (FY10)	• Document and describe the range of efforts and outcomes of local CMPs
Year 2 (FY11)	• Refine common process and outcome measures and develop systems to collect data to evaluate legislative goals across sites
Year 3 (FY12)	• Establish statewide infrastructure for the systematic collection of process and outcome data for clients served by CMPs, including demographics, services, and outcomes • Match CMP data with outcome data available through Child Welfare (Trails) and Judicial (ICON/Eclipse) • Identify statewide outcome indicators in the domains of education and health/mental health
Year 4 (FY13)	• Expand statewide standard data collection and multi-year analyses of process/outcome data • Pilot education and health/mental health indicator measures

The evaluation is designed to answer the following key questions:

- To what extent is the CMP meeting legislative intent in key population, systems, services, and outcome components? (See Sections I-V, IX-X, and Appendix E for detailed information reported by county)
- Does the CMP result in positive outcomes for multi-system children and youth? (See Sections VI and VII)
- Which CMP models/components are most effective? (See Section VI)
- How are CMPs realizing systems improvements? (See Section VIII-X)

A related question of interest is whether the CMP is more effective than other programs that are focused on similar outcomes. Currently, no data collection system (other than the CMP database developed specifically for the statewide evaluation) captures data about multi-system involved children, youth, and families; this makes it difficult to identify an appropriate comparison group of similar youth not receiving CMP services. However, the evaluation infrastructure developed for the statewide evaluation (i.e., CMP database, data sharing agreements with Trails and ICON/Eclipse to obtain relevant outcome data) has moved the initiative closer to being able to address the question of whether CMP is more effective than other programs.

About This Report

The statewide evaluation developed infrastructure to gather data about systems change, service delivery and client outcomes through multiple sources including:

- Client-level service data from the Efforts to Outcomes (ETO)™ database through which CMPs collect data about children and youth served through Individualized Service and Support Teams (ISSTs) implemented by local communities (data available for 6577 youth for FY 2012 and FY 2013)
- Client-level outcome data matched to Trails and ICON/Eclipse (e.g., juvenile probation) systems (available for all of the 6577 youth for FY 2012 and FY 2013)
- Annual Report data about systems improvements and local services (available for all 32 CMPs)
- Collaborative survey data gathered annually via an online survey administered with local IOG members (available for 30 CMPs in FY 2013)[v]

Findings from these sources are presented throughout this report. Data from multiple years are included where relevant and available. Appendix F describes the data sources in greater depth. Endnotes and appendices are included throughout the report to provide additional detailed information.[3] This 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 Five (FY 2014).

[3] See Appendix G for a list of additional products resulting from statewide evaluation activities in Years 1 – 4.

II. CMP Infrastructure: Interagency Oversight Groups (IOGs)

Local stakeholders participate in the CMP through membership on an Interagency Oversight Group (IOG) and by implementing local service models aligned with CMP goals. CMPs are then eligible to receive earned incentive funding in support of their work. While the specific form of IOGs and services vary, as discussed below, the state requires all IOGs to meet a core set of common elements:

a. Inclusion of all nine mandatory partners enumerated in the CDHS Memorandum of Understanding for the program
b. Establishment of collaborative processes that "address risk sharing, resource pooling, performance expectations, outcome monitoring, and staff training" in support of CMP legislative goals
c. Implementation of Individualized Service and Support Teams (ISSTs) through which integrated services are delivered to "children and families who would benefit from integrated multi-agency services"

This report section addresses item "a" by describing IOG membership and attendance, and also highlights key IOG focus areas. The remaining two elements, development of collaborative processes that support systems change related to CMP legislative goals and ISST implementation, are discussed in Sections VIII and X, and IV, respectively.

What is the Multi-System Representation of IOGs?

Table 2 below lists the 19 most common agencies and individuals represented on IOGs. While all CMPs have the 9 mandated partners as signatories on their MOUs, participation in IOG efforts varies. With regard to mandated partners, IOG membership remained consistent between FY 2012 and FY 2013. All IOGs indicated participation from members from 4 of the 9 mandated partners and the majority had active members from the remaining (5) mandated partners. With regard to attendance of mandated partners at IOG meetings, fewer IOGs reported regular attendance of domestic violence service providers this year than last (20 CMPs in FY 13, 26 in FY 12).

As in past years, many CMPs actively involved non-mandated partners in their governance activities (e.g., Senate Bill 94 stakeholders sit on 88% of IOGs). Notably, representation of "family voice" on IOGs is strongly encouraged but not mandated. In FY 2013, less than half (41%) of CMPs included a family member, and only one-fifth had a family advocate/navigator/facilitator or youth representative on their IOG. See Section IX for additional details about "family voice" in CMP.

Table 2: IOG membership and attendance in FY 2013

Agency or individuals represented through membership on IOG (n=32)	Number of CMPs reporting participating IOG member (%)		Number of CMPs reporting IOG member attending at least 50% of IOG meetings (%)	
County Department of Human and Social Services	**32**	**(100%)**	**32**	**(100%)**
County Health Department	**32**	**(100%)**	**28**	**(88%)**
Division of Youth Corrections	**32**	**(100%)**	**28**	**(88%)**
Probation	**32**	**(100%)**	**32**	**(100%)**
Domestic violence service provider	**31**	**(97%)**	**20**	**(63%)**
School Representative	**31**	**(97%)**	**29**	**(91%)**
Behavioral health organization representative	**30**	**(94%)**	**20**	**(67%)**
Mental health service provider center	**30**	**(94%)**	**27**	**(84%)**
Substance abuse service provider	**29**	**(91%)**	**24**	**(75%)**
Senate Bill 94 representative	28	(88%)	26	(81%)
Local courts/judicial	**27**	**(84%)**	**25**	**(78%)**
Family member	13	(41%)	10	(31%)
Law enforcement	13	(41%)	10	(31%)
Diversion	12	(38%)	11	(34%)
Family Driven Organization	12	(38%)	9	(28%)
Elected official	9	(28%)	5	(16%)
Family advocate/facilitator/navigator	7	(22%)	5	(16%)
Youth representative	7	(22%)	2	(6%)
Local health services provider	6	(19%)	6	(19%)
Business or Chamber of Commerce	2	(6%)	2	(6%)
Other*	24	(75%)	--	--

*Note: Legislatively mandated partners are shown in **bold** text above. There are ten partners in bold text because probation and judicial were given unique rows.*
**Attendance of other members cannot be reported as some CMPs reported multiple "Other" IOG members.*

Twenty four CMPs reported active IOG members in categories other than those listed in the table above. These individuals were commonly from early childhood and faith-based organizations, and a variety of non-profits (e.g., Boys & Girls Club, family resource centers).

While not typically a voting IOG member, all CMPs have a full-time (53%) or part-time (47%) coordinator who plays a role on the IOG. In nearly all CMPs (81% to 94%), coordinators serve as agency liaisons and document key IOG decision-making processes and outcomes (see Appendix H for additional information about coordinator roles). Of note, CMP coordinators have increasingly played a leadership role on local IOGs, with 25 CMPs reporting that their coordinator provides leadership within the IOG (up from 24 CMPs in FY 2012 and 19 in FY 2011).

What Are the Common Areas of Focus for IOGs?

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. The figure below describes the four most common IOG focus areas in FY 2013, along with a CMP-reported example for each.

Figure 2: Most common IOG focus areas

Improving quality of service delivery (23 CMPs)	•Boulder County: *"[Our CMP] is in the midst of a large Services Continuum project, intended to improve outcomes for youth and families and to ensure long-term sustainability. The project is focused on appropriately matching youth to high-fidelity evidence-based and evidence-informed services..."*
Strengthening collaborative relationships (22 CMPs)	•Garfield County: *"[Our] CMP has strengthened its relationship with our existing partners, as well as reached out to new members. A representative from each of the school districts now attends the IOG meeting on a very regular basis. A family representative is a new addition to our collaborative, as well as a new early childhood representative..."*
Addressing CMP sustainability (13 CMPs)	•El Paso County: *"[Our CMP] agreed that CMP dollars are for system improvement/change and [we would] financially support direct services only during a development period and that the new strategy must become self-sustaining...evaluation and impact measures are being developed for more accurate and compelling evidence of the impact of CMP..."*
Refining IOG structure, processes, and protocols (21 CMPs)	•Montrose County: *"Strategic planning sessions conducted throughout the year have enabled the IOG to fine-tune its mandates. In addition, an ISST handbook was developed, outlining the mandates, protocols, expectations and processes of the ISST which created an additional level of confidence in the IOG structure among members."*

In addition to these common focus areas, a number of CMPs reported activities in two emerging areas – early childhood and transition-age youth.[vi] Figure 3 displays the number of CMPs that reported focusing efforts in these areas as well as common activities in which they engaged in FY 2013. Numbers are similar to FY 2012, when 20 of 29 CMPs reported early childhood as a focus area of their IOG and 11 of 29 CMPs reported transition-age youth as a focus area.

Figure 3: IOG activities in the areas of early childhood and transition-age children and youth

Early childhood (19 CMPs)	•The most common activities in this area include engaging local experts, particularly members of local Early Childhood Councils, in their IOG/ISST meetings and integrating existing early childhood programs/interventions, such as Nurse Family Partnership, Incredible Years, Home Instruction for Parents of Preschool Youngsters, and the Nurturing Parenting Program, into CMP models.
Transition-age youth (13 CMPs)	•Activities in this area include referring youth to community based programs positioned to support these youth; consulting with community members to identify creative solutions to issues of particular importance to this population; and leveraging additional funding streams focused on transition age youth [e.g., the Supportive Services for Rural and Homeless Youth (RRHY) Federal Demonstration Grant.]

III. CMP Populations

Interagency Oversight Groups (IOGs) are required to define specific target populations that are eligible for services within Memorandums of Understanding with CDHS. This report section describes the target population agreed upon by CMPs as well as the total number of children, youth, and families served by CMPs at multiple levels of service delivery (see Appendix I for detailed information reported by county).

What is the CMP Target Population?

In FY 2013, the CMP State Steering Committee participated in a collaborative process to develop a standard definition of the CMP target population and, separately, engaged in discussions to reach consensus on what it means to be served by an Individualized Service and Support Team (ISST). Adopted definitions (see box to the right) provide some consistency across sites, yet also allow flexibility for local CMPs to define their own populations and service models. As such, CMPs continued to vary widely in the number of people served and the types of services provided.

Definitions Adopted for FY 2013

The **CMP target population** consists of at-risk children and youth, age birth through 21 years of age and their families, who would benefit from a multi-system integrated service plan.[vii]

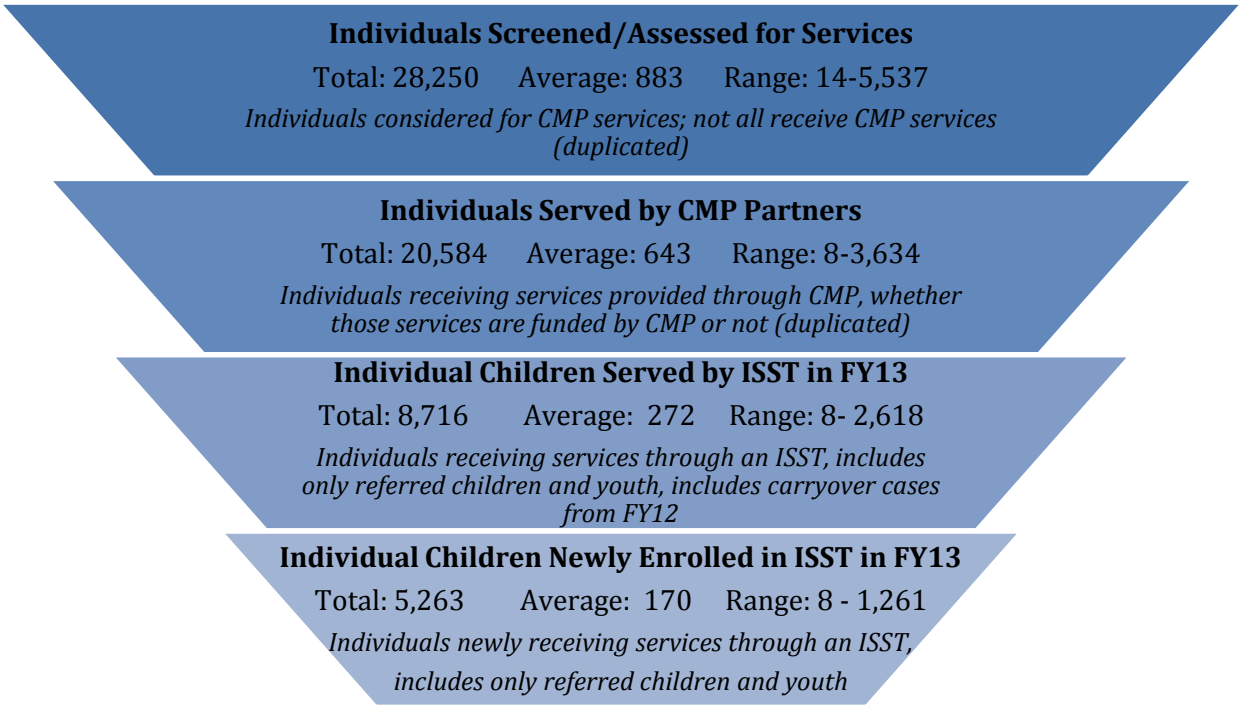
A **CMP ISST-served case** involves children, youth, and families where an integrated service plan was developed through a process that included the family and two or more agencies.[viii]

How Many Children, Youth, and Families Receive CMP Services?

Figure 4 on the following page describes the population screened or assessed by CMPs as well as children and youth served by ISSTs, including the total reported statewide, and the average and range across CMPs.[4] For some CMPs, most or all of the individuals and families served participate in a legislatively required ISST. Specifically, about 1 in 5 CMPs (21%) reported that three quarters or more of their population was served through an ISST. For other CMPs, a large proportion of referred children, youth, and their families receive services without first participating in an ISST and instead receive direct programs and services that are either financially supported by CMP dollars or provided by partnering MOU agencies. For example, 32% of CMPs indicated that less than a quarter of their target population is served through an ISST.

[4] Totals displayed in Figure 4 include estimated counts provided by CMPs; counts include some duplication.

Figure 4: Individuals screened and served by CMPs in FY 2013



Direct comparisons of the number of individuals screened or assessed for services and individuals served by CMP partners in FY 2012 and FY 2013 are not possible, as these data are duplicated within as well as across years. However, regarding individual children and youth served by an ISST, it is interesting to note that more children and youth were served by ISSTs in FY 2013 (8,716) than in FY 2012 (7,333), though the number of CMPs also increased from 29 to 32 during this time period. (Please see Table 3 in Appendix I for a comparison of the number of children and youth that were served by each CMP in FY 2012 and FY 2013.) The majority of CMPs (n=18; 56%) served more children and youth in FY 2013 than in FY 2012. Data on individual children and youth newly enrolled in an ISST staffing, displayed at the bottom of Figure 4 above, were gathered for the first time in FY 2013 to enable differentiation between children and youth continuing in services and children and youth newly beginning services in a given fiscal year.

The next section describes key features of ISST services for multi-system children and youth which is followed in Section V by a discussion of process outcomes for ISST services.

IV. Individualized Service and Support Team (ISST) Services

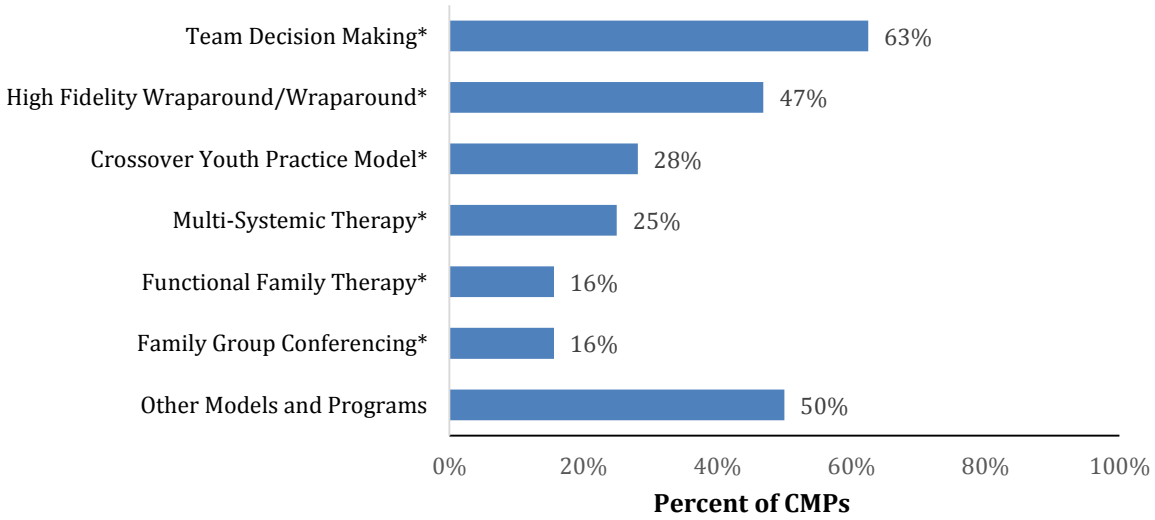
As noted above, Interagency Oversight Groups (IOGs) are required to implement Individualized Service and Support Teams (ISSTs) that support integrated service delivery to "children and families who would benefit from integrated multi-agency services." This section describes core elements of CMP ISST implementation, including the models, programs, and practices reported by CMPs in FY 2013.

What ISST Models and Programs Are CMPs Implementing?

There is wide variation in the types of integrated service models and programs selected by CMPs. Many have utilized "evidence-informed" programs, a term that is used throughout this report to describe evidence-based[ix] and promising[x] programs and practices for which some stronger evidence of effectiveness exists. These CMPs have adopted evidence-informed programs and practices that are specifically focused on cross-agency collaboration and service integration. Other CMPs have strategies in place that are informed by or which use elements of evidence-informed programs and practices with modifications made, as needed, for local settings.

Figure 5 below displays the percentage of CMPs utilizing the most commonly mentioned practice models and programs as part of their ISST process.

Figure 5: Common ISST programs and practice models implemented by CMPs[5]



[5] Programs and practices with some established research are denoted with an asterisk. "Other models and programs" encompasses other responses from CMPs; some examples include Wayfinder, Check and Connect, LifeSkills Training, and Cognitive Behavioral Therapy.

ISST Practices and Programs: A Snapshot

Through annual reporting, some CMPs described ISST practices and programs that were implemented in FY 2013 in detail, taking care to highlight the ways that collaboration has been beneficial for children and families served.

Eagle *"Wayfinder case management provides an internal and external accountability structure for both the case manager and the service providers. It fully engages families in the process and works to empower each family member."*

Douglas *"The Crossover Youth Practice Model (CYPM) has been adopted as a more effective ISST structure than the prior ISST model. This model focused on earlier identification, coordinated care by CW and JJ workers, and service delivery."*

Chaffee *"The implementation of High Fidelity Wraparound has provided an integrated family service model for high risk families and children. There has been a successful collaborative effort in the blending and braiding of resources and funding."*

What Are Some Key Features of ISST Implementation?

This section provides information about how CMPs have implemented their Individualized Service and Support Team (ISST) processes at the local level. Key components of ISSTs are discussed below.

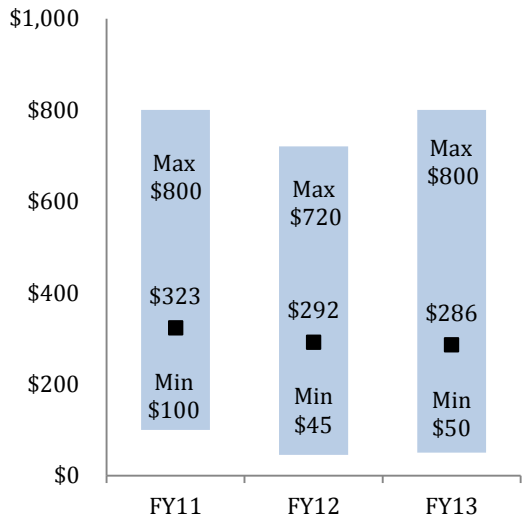
Number of ISSTs. There is substantial variation in the number of ISSTs implemented by CMPs. A total of 12 CMPs reported having only one ISST, 8 reported two, and the remaining 12 reported having three or more ISSTs. The largest number of ISSTs in a CMP is 10. Within CMPs, ISSTs are distinct from one another in various ways—some of the determining factors include domain or issue area (e.g., domestic violence, truancy, or substance abuse); complexity of need or level of risk presented by youth; age of youth served; or lead agency (e.g., local DHS or Probation).

Structure of ISSTs. Table 4 describes various structural elements of CMPs' "primary" ISST (typically the ISST serving the largest number of children and youth when CMPs have multiple ISSTs).[xi]

Table 4: Key features of ISSTs

ISST areas of focus	The most commonly indicated areas of focus for ISSTs were child welfare (88%), mental health (84%), and juvenile justice (81%).
Length of ISST meetings	CMPs most commonly reported spending one hour per family, per ISST meeting. However, meetings ranged from 15 minutes to 2 hours per family, consistent with reporting from FY 2012.
ISST meetings per family	The majority of CMPs (65%) reported that between one and two ISST meetings are held per family, on average.
Tailoring ISSTs according to child or youth needs	41% of CMPs reported that decisions about which partners participate in ISSTs are based on family needs; another 44% indicated that while a core group of partners attend all ISST meetings, additional attendees are invited based on family needs.

Figure 6: Range of estimated costs of a typical ISST meeting, FY 2011 – FY 2013



ISST service costs. Just as ISST structures are implemented in diverse ways across CMPs, there is also a wide range of estimated service costs. This is largely due to the varying ISST models and services in place, as well as efforts to adapt ISST meetings to the needs of each individual family. Since FY2011, CMPs have been asked to report the average estimated costs of ISST meetings. Figure 6 details the range of ISST meeting costs, indicated by the bars, and the average ISST meeting cost across CMPs, indicated by the bolded dollar amount.[xii] Average costs have generally decreased, though range widely in all three reporting periods. It is important to note that while there was between-CMP variation in how costs were computed (e.g., whether they summed hourly rates of participating staff, included funds provided to families for services or operational costs, etc), methods of calculation within-CMP were similar each year, allowing for comparison of mean costs across CMPs and years for statewide evaluation purposes.

V. Outcomes for ISST-Served Populations: Process Indicators

Coordinated service provision through Individualized Service and Support Teams (ISSTs) is a key feature of the CMP initiative and is one of the primary methods by which local CMPs respond to HB1451 legislative goals. This report section utilizes process indicators gathered through the CMP database to describe the characteristics of children and youth served through CMP ISSTs as well as important aspects of the ISST process, including the systems involved and development of an integrated service plan. FY 2013 reflects the second year that CMPs have tracked ISST-served children and youth at the client level, resulting in a total of 6577 unduplicated cases entered into the CMP database.[xiii] Tables and figures in this section summarize key population and ISST services information for cases tracked in the CMP database.[6]

Cases Served By ISSTs (unduplicated)

- **3318 in FY 2012**
- **3259 in FY 2013**

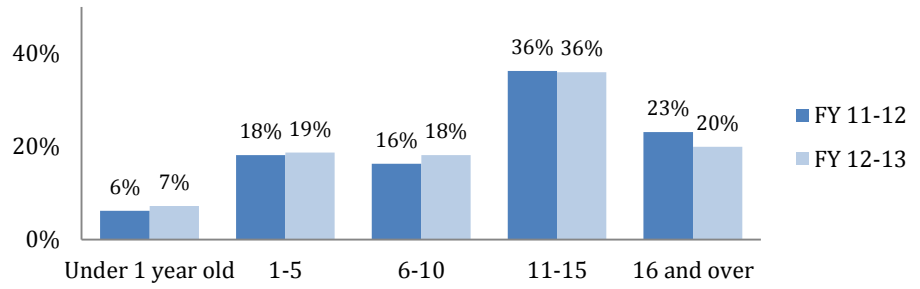
Who Was Served Through the ISST Process?

The tables and figures below describe the characteristics of ISST-served children and youth in terms of their demographics, the agencies/organizations from which they were referred to the ISST, and the systems with which they were involved at the time of their initial ISST meeting.

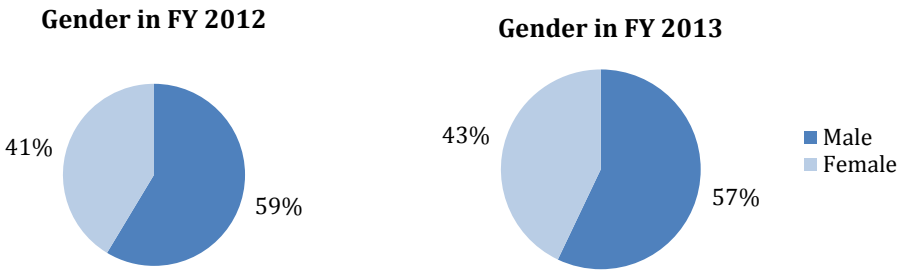
As shown in Table 5 below and Table 6 on the following page, demographic characteristics of ISST-served youth have remained stable over time.

Table 5: Age and gender of individuals served by ISSTs

Age

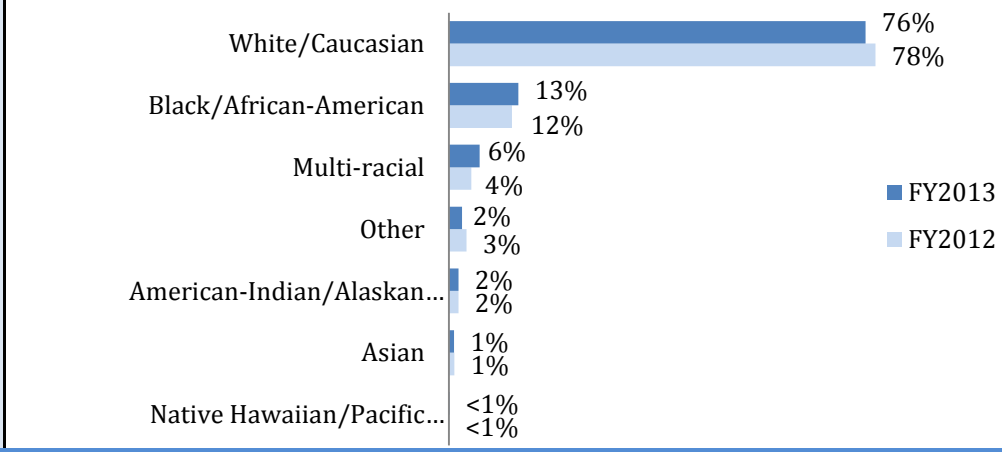


Gender



[6] While some cases are entered multiple times into the CMP database to correspond to each ISST staffing, data presented in Section V are based only on the initial ISST meeting to generate an unduplicated count. Please see Appendix J for more details on the data collection, auditing, and analysis process.

Table 6: Race and ethnicity of individuals served by ISSTs

Race	
Ethnicity	43% indicated Hispanic/Latino ethnicity in FY2013, similar to 41% in FY 2012.

Client-level data indicate that ISST referrals most commonly come from DHS, Judicial/probation, and/or schools. Moreover, the proportion of referrals from these various sources remained stable over time; no more than 7% of referrals came from any other single source over the last two years. Table 7 below lists all ISST referral sources reported by CMPs for ISST-served cases.

Table 7: ISST referral sources

	Number of cases (%)[xiv]			
Referral Source	**FY 2012**		**FY 2013**	
DHS Child Welfare	2105	(68%)	1988	(63%)
School	406	(13%)	551	(17%)
Judicial and/or probation	474	(15%)	347	(11%)
Self/parent	82	(3%)	219	(7%)
Other	212	(7%)	213	(7%)
Mental health/Behavioral health organization	159	(5%)	182	(6%)
SB-94 program	177	(6%)	143	(5%)
Law enforcement	120	(4%)	113	(4%)
DYC	15	(<1%)	15	(<1%)
Diversion	33	(1%)	14	(<1%)
Domestic violence	20	(1%)	10	(<1%)
Juvenile Assessment Center	--		4	(<1%)
Health Department	0	(0%)	0	(0%)

Note: Dashes (--) indicate items that could not be analyzed due to unavailability of response options in FY12.

Families involved in more than one system are the intended target population, as stipulated in the CMP legislation. In FY 2013, 55% of ISST-served youth were involved with two or more systems at

enrollment; this percentage is a slight decrease from FY 2012 (60%). For the majority of CMPs (27, or 84%) at least half of their ISST-served youth were involved in two or more systems at ISST intake.

Table 8 details system involvement at the time of ISST enrollment. The data suggest that being at risk for or being in an out-of-home placement and mental health needs remain the most commonly presented issues over the last two years.

Table 8: Systems involved at ISST enrollment

System, agency, or organization	Number of cases (%)[xi]			
	FY 2012		FY 2013	
DHS with CW open involvement	2408	(77%)	2297	(73%)
Mental/Behavioral Health Organization or Services	1194	(38%)	1096	(35%)
Judicial/Probation	738	(23%)	576	(18%)
Counseling/At-Risk Services	311	(10%)	364	(12%)
Special Education/IEP	462	(15%)	345	(11%)
Other System or Organization	229	(7%)	265	(8%)
Truancy Program	206	(7%)	239	(8%)
Other School-Based Program	239	(8%)	186	(6%)
Other Health Program	97	(3%)	157	(5%)
SB-94 Program	177	(6%)	143	(5%)
Other DHS CW program	110	(3%)	120	(4%)
DYC - Detention/Commitment	60	(2%)	90	(3%)
Health Department Program	97	(3%)	73	(2%)
Other Juvenile Justice Program	72	(2%)	68	(2%)
Domestic violence program	55	(2%)	40	(1%)
Diversion Program	57	(2%)	29	(1%)
DYC- Parole	9	(<1%)	10	(<1%)
Juvenile Assessment Center	--		6	(<1%)

Note: Dashes (--) indicate items that could not be analyzed due to unavailability of response options in FY12.

What Systems Were Involved With the ISST Planning Process?

As outlined in the legislation, ISSTs reflect multi-agency participation in developing a coordinated service plan with family engagement as a central goal. Over the last two years, CMPs have increased the involvement of multiple agencies in ISST processes: 83% of ISST-served cases involved more than one agency in ISST planning in FY 2012, rising to 92% in FY 2013 (see Figure 7 on the following page).

Figure 7: Number of systems or providers involved in ISST planning

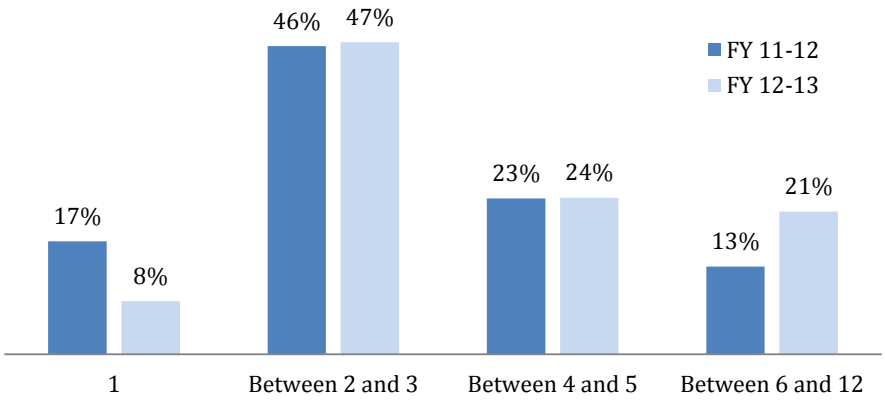


Table 9 outlines the various systems and providers that participated in ISST planning efforts. The data suggest heavy involvement from local DHS departments, as well as mental and behavioral health providers.

Table 9: Categories of systems or providers involved in ISST planning

	FY 2012		FY 2013	
System or provider involved in ISST planning process[xv]	**Number of cases (%)**	**Cases where system/ provider is newly involved (%)**	**Number of cases (%)**	**Cases where system/ provider is newly involved (%)**
DHS Child Welfare	2769 (91%)	(12%)	2786 (88%)	(13%)
ISST Facilitator	--	--	1719 (55%)	--
Mental Health/Behavioral Health Organization	1522 (50%)	(19%)	1544 (49%)	(22%)
Other	1356 (44%)	--	1196 (38%)	--
Judicial and/or Probation	1081 (35%)	(16%)	1171 (37%)	(22%)
School	966 (32%)	(12%)	1068 (34%)	(11%)
Family advocate/family facilitator	296 (10%)	--	531 (17%)	--
Other family support person/friend for family/youth	420 (14%)	--	523 (17%)	--
SB-94 program	536 (18%)	(11%)	521 (17%)	(12%)
Health Department	343 (11%)	(9%)	365 (12%)	(22%)
Division of Youth Corrections	232 (8%)	(6%)	154 (5%)	(4%)
Diversion	207 (7%)	(5%)	88 (3%)	(2%)
Juvenile Assessment Center	--	--	23 (1%)	(1%)

Note: Dashes (--) indicate items that could not be analyzed due to unavailability of response options in FY12.

Table 10 shows the percentage of cases where the system or provider is newly involved, meaning that CMPs worked to engage additional systems or providers even though they were not initially involved with the child or youth. The introduction of new service providers after the ISST process

begins is an indication of the degree to which CMPs are working to tailor services to child, youth, and family needs as they are identified.

In addition to involving multiple systems or providers in case planning, CMPs also involve families in case planning. In 85% of ISST-served cases, CMPs included a family member in the initial ISST meeting in FY 2013, up from 79% in FY 2012. The most common family members participating in ISST planning appear in Table 10 below.

Table 10: Family members involved in ISST planning

Family members attending ISST meeting	Number of cases (%)[xi]			
	FY 2012		FY 2013	
Mother	2016	(63%)	2223	(68%)
Father	1004	(31%)	1044	(32%)
Youth	663	(21%)	812	(25%)
Grandparent	510	(16%)	634	(20%)
Other family member	433	(13%)	484	(15%)
Sibling	202	(6%)	234	(7%)
Foster parent	187	(6%)	116	(4%)
Legal guardian	85	(3%)	89	(3%)
No family members present	*685*	*(21%)*	*493*	*(15%)*

Note: Dashes (--) indicate items that could not be analyzed due to unavailability of response options in FY12.

How Were ISST Services Provided, and What Was Involved in Initial ISST Service Provision?

An integrated service plan was developed in the majority of cases

- **86% in FY 2012**
- **88% in FY 2013**

For most cases across the two year period, ISST meetings resulted in an integrated service plan; this was the case for 86% of ISST-served children and youth in FY 2012 and 88% of ISST-served children and youth in FY 2013. CMPs have shown growth in ensuring multiple providers are included in the service plan, as 76% of all cases have more than one system/provider as part of the plan in FY 2013, up from 73% in FY 2012. Consistent with data suggesting high need in the areas of out-of-home placement and mental health, DHS Child Welfare and mental/behavioral health providers rank high among the systems or providers that were designated to provide services in the plan (see Table 11 on the following page).

Table 11: Systems, agencies, or providers designated to provide services in the plan

System, agency, or organization designated to provide services in integrated plan	Number of cases (%)[xi]			
	FY 2012		FY 2013	
DHS Child Welfare	2268	(74%)	2269	(72%)
Mental Health/Behavioral Health Organization	1633	(53%)	1701	(54%)
Other	901	(29%)	1088	(35%)
School	1000	(33%)	1020	(32%)
Judicial and/or probation	804	(26%)	735	(23%)
ISST Facilitator	--		408	(13%)
SB-94 program	202	(7%)	136	(4%)
Health Department	163	(5%)	130	(4%)
Division of Youth Corrections	90	(3%)	58	(2%)
Diversion	46	(1%)	29	(1%)
Juvenile Assessment Center	--		13	(<1%)

Note: Dashes (--) indicate items that could not be analyzed due to unavailability of response options in FY12.

VI. Outcomes among ISST Served Populations: Statewide Indicators

The ultimate goal of the CMP program, as outlined in the legislation, is to improve outcomes for children and families who require services from multiple agencies. As such, CMPs are required to report on outcomes of the children, youth, and families served by Individualized Service and Support Teams (ISSTs). As noted earlier in this report, in FY 2012 the statewide evaluation implemented processes for the collection of client-level ISST service data and selected child welfare and juvenile justice outcomes (referred to as "statewide indicators"). Additionally, in FY 2013, a subset of CMPs participated in a pilot study to collect a standard set of education and health/mental health outcomes.

The statewide indicators are designed to address the following key questions: for children and youth served by ISSTs, what are their outcomes with regards to:

- Child safety and stability/permanency;
- Probation outcomes/recidivism;
- School attendance, enrollment status, disciplinary problems, and performance; and
- Access to health care providers, mental health functioning, need for inpatient care, and completion of substance use treatment?

Indicators were selected by CMP stakeholders to align with outcome priorities identified by state- and county-level partners (e.g., C-Stat, Child Welfare Scorecard Reports) and to capitalize on commonly assessed measures at the local level. Additional information on the selection process and definition of statewide indicators is in Appendix J and has been summarized in prior CMP evaluation reports.[xvi]

This section of the report describes analyses designed to address two of the guiding questions of the statewide evaluation: Does the CMP result in positive outcomes for multi-system involved children and youth, and which CMP models/components are most effective? The first question is addressed through calculation of performance on the statewide outcome indicators; the second is explored through multilevel modeling that capitalizes on the accumulated client-level service and statewide indicator outcome data now available from FY 2012 and FY 2013 data collection efforts.

Statewide indicator results

This section begins with a description of the data sources and analytic approach, followed by a presentation of the outcomes calculated for ISST-served cases, aggregated across CMPs, for child welfare and juvenile justice outcomes.[xvii] Where possible, outcome rates on similar indicators from other state-level sources are presented to provide a comparison for interpreting findings. However, because indicator definitions differ across sources, it is not appropriate to draw direct comparisons between CMP data and other state sources.

It is important to note that because CMP ISST services are designed to serve the children and youth most at-risk and those who are multi-system involved, lower rates of success may still represent relatively positive outcomes. That is, CMP services may have prevented these high-risk children and

youth from potential further progression into social service systems and poorer outcomes in the absence of CMP, although this is impossible to know. To test this hypotheses, however, would require implementation of a controlled comparison evaluation design.

The section concludes with descriptive information regarding participation in the education and health/mental health pilot study. As is noted below, participation in pilot data collection in these areas was very low, thus indicator rates are not reported as they are unlikely to be representative of statewide CMP performance.

Child Welfare and Juvenile Justice Statewide Indicators: Method and Data Considerations

ISST-served child and youth case data were extracted from the CMP ETO database and then matched to outcome data from CDHS Trails and State Judicial ICON/Eclipse systems.

Case data were examined for children and youth with initial ISST meetings occurring between July 1, 2011 and June 30, 2013. Because these outcomes are inherently more meaningfully assessed over time, results were calculated for cases where at least one year had elapsed since the initial ISST meeting. Further, the analysis calculated the number and rate of outcomes occurring in the 12 months following the initial ISST meeting. This allowed for a sample of cases where the time period under examination was standard (one year post ISST meeting). The sample sizes for this analysis approach ranged from 4210 to 4579, depending upon the indicator. The analytic plan was reviewed and approved by CDHS and State Judicial analysts.

Further, performance on each indicator reported below was calculated on the subset of the ISST-served population where the outcome was specified as a target goal for the child or youth and family's intervention services. Thus, performance is examined for those cases where the outcome was specified as relevant, which serves as a proxy for the determination of risk (e.g., family would be considered at risk for the outcome if services were not provided).

Performance on indicators was also calculated for all ISST-served cases with one year follow-up data available in the year post-ISST, regardless of whether the indicator was designated as a target goal for services; see Appendix K for these results.

Child Welfare: What Are the Child Stability/Permanency and Safety Outcomes for Children, Youth, and Families Served by ISSTs?

The tables below present data for indicators in four areas relevant to child stability/permanency and safety for families served by CMP ISSTs:

- Preventing new/re-involvements in child welfare system
- Minimizing the number of moves while in out-of-home placements
- Increasing discharges to a permanent home
- Preventing child abuse and neglect

Results in each area are presented in a summary table, including the focus of the indicators, the number of children and youth for whom the indicator is relevant, and the results achieved by CMPs. Comparisons with similar data reported by state entities are included, where relevant data are available.

Table 12: Preventing new/re-involvements in child welfare

Purpose of the indicator(s): Assess the extent to which ISST-served children and youth avoided involvement or re-involvement in the child welfare system.	
Number of CMP cases who had preventing child welfare involvement as a target goal: 2141	
Indicator	**Results**
How many cases had **no open involvements** that occurred in the year following their initial ISST meeting?	Number: 1140 Rate: 53%
How many cases who had a closed involvement prior to ISST services had **no new/re-involvements** in the year following their initial ISST meeting?	Number: 47 Rate: 35%
Interpretation: For CMP-served cases who entered ISST services and for whom preventing child welfare involvement was a target goal, 53% were successfully averted from open involvement in the year after their initial ISST meeting. For those cases with a prior history of involvements, 35% were prevented from re-involvement in the year following ISST services.	

Table 13: Minimizing the number of moves while in out-of-home placement

Purpose of the indicator(s): Assess the extent to which ISST-served children and youth were placed out of the home, as well as the number of moves they experienced while placed outside of the home.	
Number of CMP children and youth in out-of-home placement who had reducing the number of moves as a target goal: 427	
Indicator	**Results**
How many of these children and youth experienced two or fewer moves?	Number: 323 Rate: 76%
Interpretation: Three-quarters (76%) of cases who were in out-of-home placement and at-risk for additional moves, experienced two or fewer moves in the year after their initial ISST meeting.	

Table 14: Increasing discharges to a permanent home

Purpose of the Indicator(s): Assess the rate at which ISST-served children and youth who were discharged from out-of-home placement were placed in a permanent home in the year following their initial ISST meeting.[xviii]	
Number of CMP children and youth who were in placement and discharged, and had discharge to a permanent home as a target goal: 400	
Indicator	**Results**
How many of these children and youth were discharged to a permanent home?	Number: 297 Rate: 74%
Interpretation: Approximately 74% of CMP ISST-served children and youth who were in out-of-home placement with case closure were reunified or placed in a permanent home.	
Comparison to state-wide child welfare data: This is lower than the similar indicator tracked for FY 2012 for all closed cases within a 12-month period at the state level (92%).[xix]	

Table 15: Preventing child abuse and neglect

Purpose of the indicator(s): Assess the extent to which ISST-served families successfully averted abuse and neglect, indicated by the absence of a substantiated abuse/neglect finding during the year following their initial ISST meeting.	
Number of CMP children and youth with preventing abuse/neglect as a target goal: 1518	
Indicator	**Results**
How many children and youth did not have a substantiated abuse/neglect finding in the year following their ISST meeting?	Number: 1410 Rate: 93%
Interpretation: In general, abuse/neglect findings among CMP ISST-served children and youth appear to be rare, with 93% of ISST-served children and youth with no substantiated reports in the year after their initial ISST meeting.	
Comparison to statewide child welfare data: Results provided by CDHS for all Colorado children and youth for FY 2012 reveals a similar pattern, with 97% of cases reflecting absence of abuse/neglect within 12 months of case closure.[xvii]	

Juvenile Justice: What Are the Probation Outcomes of ISST-served Children and Youth?

The tables below present data for indicators in areas relevant to juvenile justice involvement for children and youth served by CMP ISSTs:

- Preventing involvement with juvenile probation
- Successful termination of probation
- Unsuccessful termination of probation, due to:
  - Revocation due to technical violation
  - Revocation due to pre-release recidivism (new felony or misdemeanor offense)

Results in each area are presented in a summary table, including the focus of the indicators, the number of youth for whom the indicator is relevant, and rates achieved by CMPs. Comparisons with similar data reported by state entities are included, where relevant data are available.

Table 16. Preventing involvements/new involvements

Purpose of the indicator(s): Assess the extent to which ISST-served cases who had prevention of involvement or additional involvement with the juvenile justice system as a target goal, avoided involvement with the juvenile probation system in the year after starting ISST services.	
Number of CMP children and youth with preventing involvement/new involvements with the juvenile justice system as a target goal: 1039	
Indicator	**Results**
How many children and youth did not start probation within one year of their initial ISST meeting?	Number: 777 Rate: 75%
Interpretation: Three-quarters of the children and youth (75%) who were deemed at risk for juvenile justice involvement were successfully diverted from entering probation in the year following ISST services.	

Table 17: Successful and unsuccessful termination of probation

Purpose of the indicator(s): Assess the outcome status of those ISST-served children and youth who were adjudicated to probation shortly before or after the time of their round the time of their initial ISST meeting (within the six-month period before or in the year after their ISST[xx]) and terminated probation in the year following their initial ISST meeting.	
Number of CMP children and youth who were recently adjudicated and sentenced to probation and terminated probation in the year following their initial ISST meeting, with successful termination as a target goal: 237	
Indicator	**Results**
How many of these children and youth terminated successfully in the year following their initial ISST meeting?	Number: 132 Rate: 56%
How many of these children and youth were terminated with a revocation due to a technical violation?	Number: 75 Rate: 32%
How many of these children and youth were terminated with a revocation due to pre-release recidivism (new felony or misdemeanor offense)?	Number: 30 Rate: 13%
Interpretation: Among CMP served children and youth who entered ISST services with recently initiated probation services and where successful termination was a target goal, over half (56%) successfully terminated after their initial ISST meeting, and about a third (32%) were revoked for technical violations, with the rest revoked for pre-release recidivism (13%).	
Comparison to statewide child welfare data: Successful termination for CMP-served children and youth was lower than the state-reported rates among all terminated probations from FY 2012 (75%). Rates of revocation of probation were higher for CMP-served children and youth than state-reported rates among terminated juvenile probationers from FY 2012 (18% for technical violations and 8% for pre-release recidivism, respectively).[xxi]	

It is important to note that in State Judicial reports, these indicators are calculated using the same definition for the numerators, but the denominators include the entire state population of terminated probationers, thus including children and youth at all levels of risk for delinquency. As is noted above, the lower comparative rates of success for CMP youth may still represent relatively positive outcomes, if these high-risk children and youth were headed for deeper involvement in delinquency and crime without the intervention of CMP services.

Education and Health/Mental Health Indicators Pilot Study: Method and Data Considerations

During FY 2012, the evaluation engaged local and state-level stakeholders in a process to identify a select set of education and health/mental health indicators. During this process, it emerged that opportunities to leverage existing statewide data systems were substantially limited. In the education domain, no appropriate state data system with client-level data collection exists, and in the health/mental health domain, two systems with limited relevant client-level information were identified (Colorado Client Assessment Record, CCAR; Drug/Alcohol Coordinated Data System, DACODS). Therefore, in FY 2013, additional measures to collect client-level information to assess performance on education and health/mental health indicators among ISST-served children and

youth were introduced, and CMPs were voluntarily asked to participate in pilot data collection. Many of these indicators require pre/post data collection, while some require only post-ISST services data collection.

Despite initial strong interest from CMPs (21 agreed to participate at the start of FY 2013), the numbers of children and youth with completed education and health/mental health data were quite low. Overall, less than 8% of all ISST-served children and youth in FY 2013 had any data entered; and between 1-2% of all ISST-served cases had pre- and post-data available for analysis of outcomes on any specific indicator. Thus, results on these indicators are not reported, as they are unlikely to be representative of actual outcome rates.[xxii]

The pilot data collection period will continue through FY 2014. The low level of participation in the pilot illustrates some of the challenges or barriers related to collecting education and health/mental health data. These difficulties may hint at the potential resource burden of additional data collection, as well as issues related to meeting federal standards for data sharing and confidentiality of education and mental health information [e.g., *Family Educational Rights and Privacy Act (FERPA); 42 CFR Part II*].

Below, tables are presented to describe each outcome area, indicators that were selected for statewide tracking,[7] measurement strategies, number of cases with available data, and the number of CMPs that entered data into the CMP database, for all cases entered.

Education: What Are the Educational Outcomes of ISST-served Children and Youth?

The tables below present the definitions, measurement details, and extent of pilot participation for indicators relevant to educational outcomes for children and youth served by CMP ISSTs:

- Improving school attendance
- Reducing disciplinary problems at school
- Improving school performance
- Maintaining enrollment in school

[7] In the following tables in this section, "indicator" reflects the specified statewide indicator, which is defined in terms of number and rate of cases meeting criteria for the outcome. Note that because of low participation in pilot data collection, the indicators (numbers and rates) were not calculated; only the number of cases for which the indicator data was collected and entered are reported ("Total n").

Table 18. Improving school attendance

Purpose of the indicator(s): Assess the extent to which ISST-served children and youth improved their school attendance during the period in which they received ISST services.	
Description of measure(s): CMPs track the attendance rate (%) during one of the following periods of time (week, month, trimester, semester, or other-specified) preceding the initial ISST (pre measure) and preceding the exit date or selected post-ISST period (post measure).	
Indicator	**Total n (# of CMPs)**
Number (rate) of children and youth who demonstrate improved attendance during or for a period after ISST services are completed	259 cases (9 CMPs)

Table 19. Reducing disciplinary problems at school

Purpose of the indicator(s): Assess whether ISST-served children and youth had disciplinary actions during the period in which they received ISST services.	
Description of measure(s): CMPs track the number of times each of the following disciplinary actions occurred for the time period in which they received ISST services: in-school suspensions, out-of-school suspensions, school referrals to law enforcement, and expulsions (post measure).	
Indicator	**Total n (# of CMPs)**
Number (rate) who have no disciplinary actions at school during ISST services; average number of disciplinary actions during ISST services	27 cases (5 CMPs)

Table 20. Improving school performance (academic achievement)

Purpose of the indicator(s): Assess the extent to which ISST-served children and youth improved their school performance during the period in which they received ISST services.	
Description of measure(s): CMPs track the grade point average and/or test score preceding the initial ISST (pre measure) and at ISST-exit (post measure).	
Indicator	**Total n (# of CMPs)**
Number (rate) who demonstrate improved grade point averages or academic achievement scores during or for a period after ISST services	64 cases (3 CMPs)

Table 21. Maintaining enrollment in school

Purpose of the indicator(s): Assess whether ISST-served children and youth continued to be enrolled in school during the period in which they received ISST services.	
Description of measure(s): CMPs track the number of times children and youth moved from one school to another while they were served by an ISST (post measure).	
Indicator	**Total n (# of CMPs)**
Number (rate) 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	72 cases (4 CMPs)

Health/Mental Health: What Are the Physical and Behavioral Health Outcomes of ISST-served Children and Youth?

The tables below present the definitions, measurement details, and extent of pilot participation for indicators relevant to health and mental health outcomes for children and youth served by CMP ISSTs:

- Improving mental health functioning
- Decreasing need for inpatient care
- Improving completion of substance use treatment
- Increasing access to health care providers

Table 22. Improving mental health functioning

Purpose of the indicator(s): Assess the extent to which ISST-served children and youth decreased their problem severity or increased their level of functioning as determined by CCAR score data during the period in which they received ISST services.	
Description of measure(s): CMPs track CCAR scores (symptom severity rating and level of functioning rating) that occurred closest to the initial ISST (pre measure) and exit date (post measure).	
Indicator	**Total n (# of CMPs)**
Number (rate) with improved symptom severity and level of functioning as determined by CCAR during or for a period after ISST services	21 cases (2 CMPs)

Table 23. Decreasing need for inpatient care

Purpose of the indicator(s): Assess the number of ISST-served children and youth placed in inpatient mental health care and the total number of days spent in placement during the period in which they received ISST services.	
Description of measure(s): CMPs track the number of times children and youth were placed in inpatient mental health care and the total number of days spent in placement for the time period in which child or youth received ISST services (post measure).	
Indicator	**Total n (# of CMPs)**
Number (rate) 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	20 cases (1 CMP)

Table 24. Improving completion of substance use treatment

Purpose of the indicator(s): Assess the successful completion of substance use treatment, among children and youth who are receiving substance use treatment during ISST services.	
Description of measure(s): CMPs track data for up to three substance use treatment admissions per child or youth that occurred while they were receiving ISST services. Tracked data include start-date, end-date, and discharge reason at the end of treatment (transferred, treatment completed/no referral, treatment completed/follow-up, client died, client initiated termination, administratively terminated, DYC discharge, or still in treatment at ISST exit/post).	
Indicator	**Total n* (# of CMPs)**
Number (rate) who successfully complete substance use treatment during or for a period after ISST intake	3 cases (1 CMP)

Table 25. Increasing access to health care providers

Purpose of the indicator(s): Assess the extent to which ISST-served children and youth increased their access to the health care system or to healthcare provider(s) during the period in which they received ISST services.	
Description of measure(s): CMPs track whether or not the child or youth has the following at the initial ISST (pre measure) and at ISST exit (post measure): primary care provider, mental health provider, substance use treatment provider, and health insurance (and whether their insurance is public or private).	
Indicator	**Total n* (# of CMPs)**
Number (rate) with established providers of primary care, mental health, and/or substance use, and/or health insurance, as appropriate, during ISST services	214 cases (8 CMPs)

Given low levels of involvement, the evaluation team, in partnership with the State Evaluation Subcommittee and with input from the State Steering Committee, will work to identify strategies to assist in addressing data collection challenges in the outcome domains of education and health/mental health during FY 2014.

Exploratory analysis of relationships between CMP models/components and outcomes

As noted earlier in the report, a key area of interest to the CMP is identifying which CMP models/components are most effective in achieving positive outcomes for children, youth, and families, in order to better target CMP resources and inform expansion/replication efforts. The client-level service data collected in the CMP ETO database, and the matched outcome data from child welfare and state judicial systems, were utilized to begin to explore this question through the use of advanced analytic models. Descriptions of possible analytic approaches and some preliminary results of exploratory analyses conducted in FY 2013 are detailed on the following page.

There are two ways to answer questions related to effective service models; each suggesting a different analytic modeling approach:

1. Which service delivery models implemented by CMPs lead to more positive outcomes? This approach involves a comparative design, where outcomes associated with cases served by specific types of service delivery models are compared (e.g., High Fidelity Wrap vs. Team Decision Making). In order to conduct this type of analysis, it is necessary to ensure that there is sufficient specification of service models (i.e., it is clear which services each case received), and high standardization of service delivery across cases served within particular models (i.e., all High Fidelity Wraparound cases receive similar service components implemented with high fidelity).

2. Which components of CMP service delivery lead to more positive outcomes? This approach involves examining the predictive relationships between structural or service components that are central to CMP efforts across service types (e.g., presence of family members, development of an integrated plan) and child, youth, and family outcomes, to identify which factors are the most critical to implement to ensure positive outcomes.

In FY 2013, the evaluation team reviewed these approaches in light of the available data and identified that model approach #2 could be examined with exploratory analysis. The team determined that there are limitations that interfere with the ability to conduct the analysis for model approach #1, including lack of standardization and fidelity monitoring in service models across CMPs, as well as challenges in identifying specific service types for cases currently entered into the CMP ETO database. Modifications to the data collection for FY 2014 will facilitate examination of model approach #1 and a more exact examination of model approach #2 in future years.

Exploratory analysis: Service predictors of child, youth, and family outcomes
Question #2 was further specified as follows: *Are key CMP service components and collaborative effectiveness rated by CMPs predictive of child welfare and juvenile justice outcomes, after accounting for demographic characteristics and for variation associated with being served within a particular CMP? Which components are most critical, for which outcomes?*

The team identified the following service components as likely factors to predict child, youth, and family success, given research on similar evidence-informed models[xxiii]: a) family was present at the first meeting, b) multiple agencies were involved in the first meeting, and c) a service plan was created at the first meeting. Two-level multi-level statistical modeling (hierarchical linear modeling) was conducted to evaluate the three service factors listed above at level 1[xxiv] and community level factors at level 2 (CMP, IOG mean score on collaborative process from FY 2013 Collaborative Effectiveness Survey administration). Models controlled for child/family characteristics, which included gender, race, ethnicity, age, and whether the family was involved in multiple systems at the time of the initial ISST. Child and youth outcomes were the four child welfare statewide indicators (lack of child welfare involvement, two or fewer moves, discharge to a

permanent home, no substantiated abuse/neglect) and the four juvenile justice statewide indicators (status at termination of probation: successful, revocation due to technical violations, revocation due to pre-release recidivism); models were tested in the overall sample and in the subset with the outcome designated as a target goal of services. Two-way interactions were explored in order to further understand how these components may work in tandem to explain outcomes.

While most of the exploratory models converged revealing some significant predictors, in general findings were complex and difficult to interpret, as is often the case with initial exploratory analyses. Some models revealed significant predictors in unexpected directions. Some notable findings and examples of the complexity include:

- Children/youth with two or more systems/agencies involved in the initial ISST planning were:
    - 54% less likely to have a substantiated abuse finding
    - 79% less likely to move more than two times while in placement, relative to those without multiple agencies involved
- Children/youth who had an integrated service plan developed at the initial ISST were:
    - 32% more likely to report an open involvement
        - The effect of having a service plan on open involvements varied across CMPs at a trend level
- Children/youth with a service plan created at the initial meeting were:
    - 36% less likely to recidivate with a new felony or misdemeanor offense than children and youth without a service plan

It is important to note that models are exploratory and results are preliminary. The models may be impacted at this time by relatively small sample sizes within some CMPs and relatively low variability in a few key factors (e.g., over 85% of cases had a family member present and had integrated plans). In addition, the current models include a diverse set of cases in terms of CMP population characteristics (e.g., 0 to 21 years of age), which may also obscure underlying patterns. At this time, it was only possible to group cases by CMP, and not by service model within CMP (which are both important factors to consider as contributors to variation in outcomes). More rigorous measurement is needed to move from exploration to a stronger analytic model. In future years of the evaluation, the accruing of additional cases in the CMP ETO database and the collection of service model information will help to facilitate a more robust analysis of the data. The exploratory models conducted this year confirmed that this analytic method is capable of revealing important predictors of outcomes, but future analysis will require increased sample size and more nuanced examination of quality data on service components and population factors.

VII. Outcomes: Local and Community Outcomes of CMP

Since the program's inception and per statute, each CMP proposes locally-defined performance measures and target goals in their annual Memorandums of Understanding (MOUs). It is a hallmark of the CMP that communities have the flexibility to define their own populations, implement service models matched to local needs, and utilize local measures to assess progress. Through annual reporting, CMPs provide detailed information about their local achievements on these performance measures, as well as descriptions of positive outcomes experienced at the community-level. These measures provide additional sources of data to address the question of CMP impact on child, youth, and family outcomes. Information gathered from these sources is described below.

To What Extent Are CMPs Meeting Target Goals in Locally-Defined Outcomes?

Since FY 2012, CMPs have designated a single performance measure in each of the four outcome domains. Information from these measures is then incorporated into the current incentive formula (referred to as "primary incentivized outcomes"). The selection and definition of primary incentivized outcomes, and proposed target goals, are at the discretion of the local IOGs; they are tailored to outcomes that have been prioritized by each collaborative. As such, CMPs vary widely in their defined indicators. Despite some common outcome areas, local CMP performance measures focus on different aspects of outcomes (e.g., within the outcome area "improve child stability," target goals might include reducing number of moves while in out-of-home placement, achieving shorter average duration in out-of-home placement, etc.) and use varying measures and methods, which precludes state-level aggregate analysis of effects. In addition, the majority of local performance measures and goals have been modified from year to year; thus, it is difficult to assess the extent to which CMPs are showing progress in specific outcomes over time, even within a single CMP.

Appendix L lists the 128 different local performance measures assessed by the 32 CMPs in FY 2013 and the corresponding local performance measures assessed by CMPs in FY 2012. Measures and goals for both years are listed in order to illustrate the diverse target goals and the extensive tailoring of measures to local programs and identified needs. The table also highlights complex issues presented by the variation in measures which prevent cross-site aggregation of data. Summarized information for FY 2013 outcomes is presented below.

Method and Data Considerations

Data were extracted from Local Performance Measures tables, where CMPs reported: indicator with target goal as listed in MOU, domain, the number of individuals assessed by the indicator, performance or success rate in FY 2012 and in FY 2013, data source/measurement and calculation, whether the CMP met their target goal, and brief comments (optional).

Performance on the majority of local measures was calculated and self-reported by CMPs and therefore results cannot be verified by the evaluators. A small number of indicators (n=8 of 128) were aligned with the statewide indicators (i.e., the local CMP designated the statewide indicator as their local measure); performance on these indicators were calculated by the OMNI evaluation team.

To provide descriptive findings, data submitted for each indicator were reviewed and coded according to the following 5 goal attainment categories:

- Yes, met goal
- No, did not meet goal
- Unclear, not enough information provided to determine whether goal was met
- Not applicable (e.g., CMP was newly enrolled in FY 2013)
- Missing (no performance data were submitted)

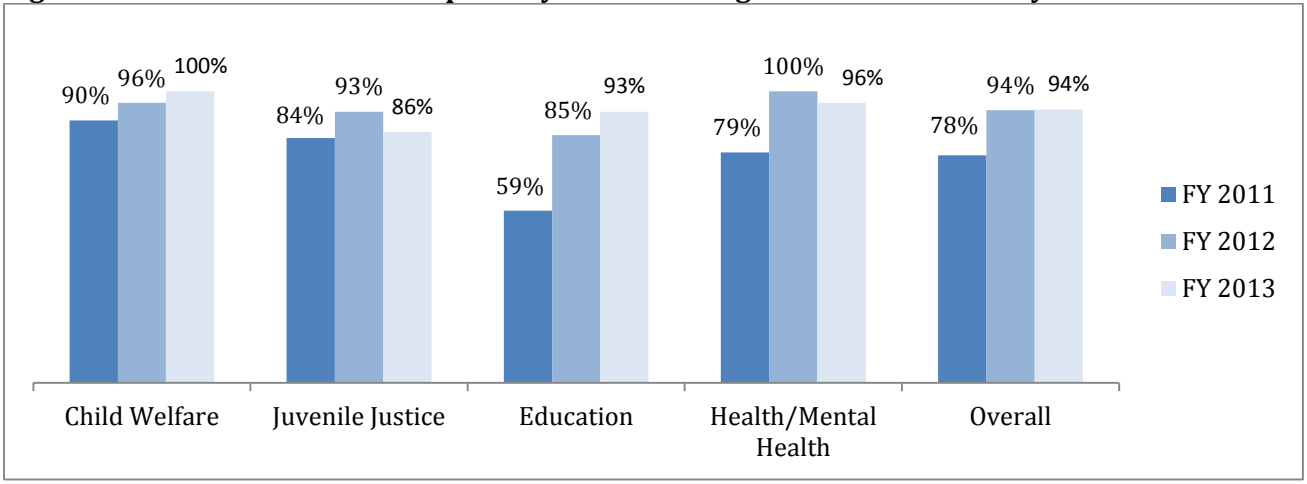
Descriptive data were categorized and analyzed in Excel software.

Of the 128 outcomes submitted in the 32 MOUs, 91% assessed child and family level outcomes and 9% assessed process outcomes (e.g., improvements in service delivery). Performance information was available for 88% of the 128 stated outcomes.

Overall, CMPs reported achieving 94% of their target goals on their locally-defined performance measures.

Overall, CMPs reported achieving 94% of their target goals. As shown in Figure 8, the percent of locally-defined target goals met across CMPs ranged from a high of 100% for the child welfare domain to a low of 86% in juvenile justice domain in FY 2013.

Figure 8: Percent of CMPs where primary incentivized goals were achieved by domain



Results indicate that overall, CMPs are increasingly meeting their target goals in locally-specified focal outcomes over time. The overall percent of target goals met has increased over the past three years, although direct comparisons are limited because required data collection for statewide analysis beginning in FY 2012 centered on primary incentivized outcomes only (4 per CMP), while prior years' results included varying numbers of performance goals per CMP. It is important to note that performance goals are set and measured by each CMP, so it is not possible in the statewide evaluation to verify that CMPs are actually showing quantifiable improvements in specific outcome areas from these local performance measures.

What Has Changed for Communities as a Result of Implementing CMP?

The CMP is designed to affect lasting change in social service systems and ultimately, in community-level outcomes for children and families. Twenty-two CMPs responded to the optional question "what has changed in your county since implementing CMP?" in their annual reports. The most frequently mentioned areas of impact are described in the figure below, along with illustrative examples.

Figure 9: Community-level impacts associated with CMP implementation

Improved collaboration and communication across agencies and service providers (17 CMPs)	•Gunnison-Hinsdale: *Overall deeper understanding of all agency and system roles within the community and understanding of processes and barriers.* •Pueblo: *Human service agencies, charitable organizations, schools, and governmental entities work in closer collaboration than before. Their staff members network monthly at community meetings and client staffings, and are more aware of what each other is doing. The "silo" mentality has changed.*
High quality services that address local community needs and gaps (12 CMPs)	•Adams: *Families and children with very specific needs are being served consistently. This has been due to the CMP realizing gaps in services and finding ways to fund these services to make them possible.* •Gunnison-Hinsdale: *[Greater] ability to fill the gaps in services within the community and better meet the needs of the community through flexible resources.*
Holistic, integrated approaches to delivering family services (8 CMPs)	•Huerfano: *Having an official process [*for collaboration*] has allowed more seamless service provision for families.* •Chaffee: *The implementation of High Fidelity Wraparound has provided an integrated family service model for high risk families and children.* •Montrose: *Plans are becoming more creative and individualized, increasing the chances of success for the families following them.*
Improved community-level child and family outcomes (7 CMPs)	•Douglas: *Reduced number of dually involved (child welfare and juvenile justice) youth being detained in detention* •Boulder: *Lower juvenile criminal filings, fewer youth placed out of home or committed to DYC* •Denver: *Decreased numbers of youth going into RCCF level of care or committed to DYC* •Gunnison-Hinsdale: *Overall reduction in probation cases and technical violations, overall reduction in open child welfare cases, noticeable decrease in number of juvenile cases seen by the District Attorney* •Teller: *Lower number of placements for older children* •Lake: *Successful closing of dependency and neglect cases and prevention of out of home placements*

VIII. Systems Improvements in Reducing Duplication, Eliminating Fragmentation, and Improving Quality of Services

Systems improvements that result in streamlined, coordinated, and high-quality services for families are at the heart of the CMP approach. Given the complexity of systems and the variation in local approaches, statewide progress in these areas can be difficult to quantify. The evaluation gathers proxy indicators for systems change through the annual report, CMP database, and an IOG collaboration survey. This report section describes how CMPs are progressing on these proxy indicators, indicating key ways CMPs are reducing duplication, eliminating fragmentation, and improving the quality of services. These data are used to address the question of whether CMPs are affecting positive changes throughout their social service delivery systems. Please see Appendix E for a snapshot of these indicators by CMP.

How Are CMPs Achieving Reductions in Service Duplication and Fragmentation?

CMPs report that the single largest effort that effectively impacts duplication and fragmentation is the implementation of Individualized Service and Support Teams (ISSTs). Although ISST programs and models vary across CMPs, they are all implemented to achieve coordinated service delivery through interagency service planning involving family members and streamlined information sharing among service providers, culminating in integrated, well-specified plans for each family served. Multi-year findings for several indicators presented below suggest that CMPs are increasingly meeting these goals.

CMPs ensure multi-agency participation in initial service planning and service delivery. Client-level data collected at initial ISST meetings show that CMPs have expanded the extent to which initial planning meetings include multiple providers.[8]

Table 26. Multi-agency participation in service planning

Indicator	FY 2012	FY 2013
Percentage of initial ISST meetings where two or more systems/agencies were included	83%	92%
Percentage (number) of CMPs where 70% or more of initial ISST meetings had two or more systems/agencies included	86% (25)	94% (30)

[8] For all results reported in this section, the total number of CMPs with available data was 32 for FY 2013, and ranged from 28 to 29 in FY 2012.

Moreover, these data also reveal that in general, the "right" agencies and organizations are at the table when it comes to service planning. Table 26 shows the percentage of FY 2013 cases where the systems that the child or youth was involved with at the time of enrollment in ISST services, were also represented in the initial planning process (e.g., for 97% of cases where the child or youth was involved in child welfare at intake, a child welfare provider was involved in the ISST meeting). Child welfare, education, mental health and juvenile justice providers were particularly well-represented at meetings where the child or youth was noted as involved in those services at intake.

Table 27: Match of systems involvement at ISST meeting

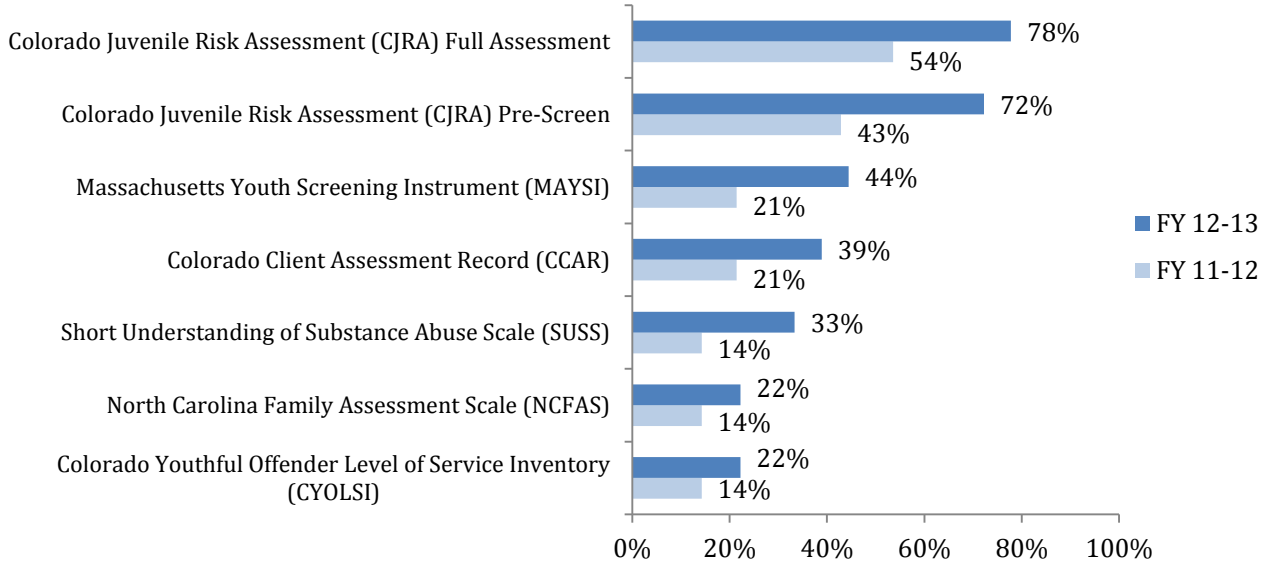
System/provider	% of youth
Child welfare	97%
Education	90%
Health/mental health	82%
Division of Youth Corrections	79%
Judicial and/or Probation	75%
SB-94 Program	74%
Diversion	60%
Health department	40%

CMPs actively share information to simplify and streamline service experiences for families and providers. CMPs report implementation of two key strategies aimed at streamlining and simplifying the experiences of children, youth, and families seeking services, as well as gathering information consistently across partners. Table 28 reports the extent to which CMPs utilize these two key strategies of common consents and client assessments across agencies. Figure 10 shows the most common shared assessments, and highlights that the percentages of CMPs reporting their use increased from FY 2012 to FY 2013 for all assessments.

Table 28: Methods of sharing information

Indicator	FY 2012	FY 2013
Percentage (number) of CMPs utilizing common consent across multiple agencies	68% (19)	72% (23)
Percentage (number) of CMPs using common client assessments/screening tools that are shared across multiple agencies	61% (17)	56% (18)

Figure 10: CMP reports of use of common assessments/screening tools across agencies



Multi-agency participation and streamlined processes are resulting in integrated service plans. Multiple indicators, from client-level data and annual reporting, suggest that CMPs are coordinating services in a detailed plan, with shared accountability across agencies and clear designation of service provision and payment responsibilities (see Table 29, and Section X for more details). In FY 2014, additional data collection will allow for reporting of the specific agencies/providers that are designated to provide intervention services as part of the plan.

Table 29. Components of service plans

Indicator	FY 2012	FY 2013
Percentage of initial ISST meetings where an integrated plan was developed	86%	88%
Percentage of initial ISST meetings where multiple systems/agencies were designated in the plan to provide services	73%	76%
Percentage (number) of CMPs reporting that they "often" or "always" designate which partners will provide services included in the plan	100% (28)	100% (32)
Percentage (number) of CMPs reporting that they "often" or "always" identify who will pay for specific components of the service plan	81% (22)	88% (28)

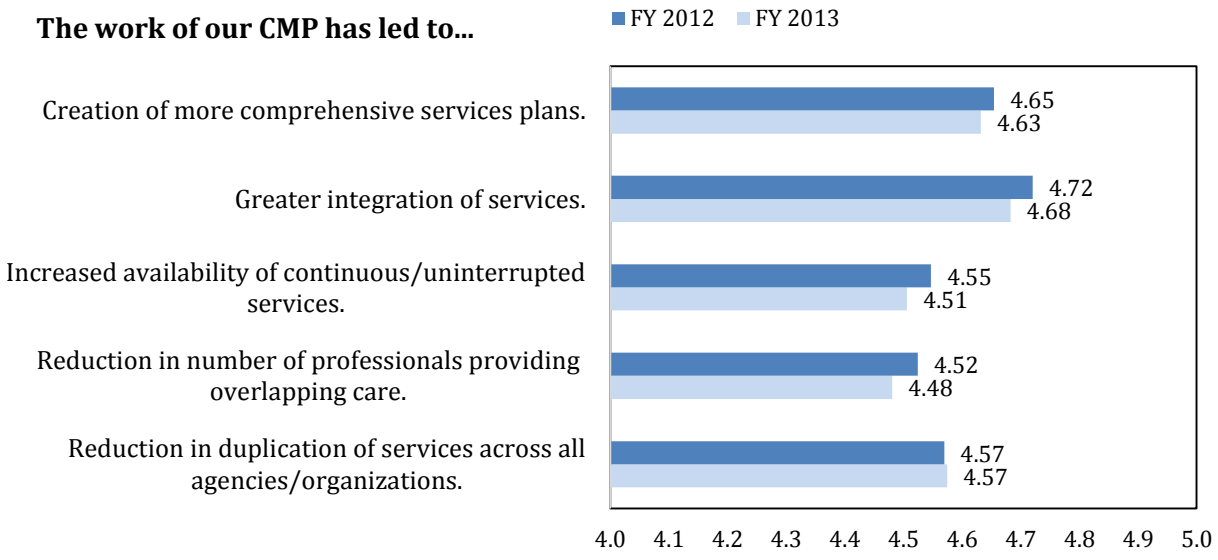
A critical systems improvement that flows from the development of a detailed coordinated plan is the reduction or elimination of conflicting intervention directives for families. Without integration across systems, families may experience different guidance from providers regarding the same issue, or may even be mandated to participate in intervention services with varying requirements that can create confusion and/or apathy for families. In FY 2013, progress was reported by CMPs in this area, with 100% (32 CMPs) reporting that they have significantly reduced conflicting mandates

or treatment requirements across multiple provider agencies, as compared to 85% (24 CMPs) in FY 2012.

CMP Practice Example: Montezuma/Dolores: "*The CMP has developed a case plan worksheet that is completed by the CMP coordinator at every [ISST] meeting for the families. A copy…also goes into the file for the family. The worksheet outlines what agencies have a role in the plan, a contact for that agency and a brief description and name of what needs to be accomplished through that agency. This has substantially impacted case planning and monitoring in a positive way, and has increased agencies' ability to share information and resources.*"

CMP stakeholders perceive significant achievements in their efforts to reduce duplication and eliminate fragmentation. Figure 11 below summarizes the responses from IOG members on five relevant items on the annually administered Collaborative Effectiveness Survey. IOG members generally indicated that their CMP's efforts were characterized by high quality efforts in each of five key areas reflecting reductions in duplication and fragmentation for individual youth and families and also for system partners. CMPs with sufficient survey data received average (mean) ratings of 4.5 or more on a 6-point scale on each item. Overall, mean ratings on items were slightly lower in FY 2013 relative to FY 2012. However, as noted in past evaluation reports, survey results have remained highly stable across years, with little statistically significant variation in ratings across years.[xxv]

Figure 11: Collaborative Effectiveness Survey results: CMP achievements regarding duplication and fragmentation[xxvi]



**Mean score on item, aggregated within CMP and averaged across CMPs.*

Despite significant achievements in these areas, CMPs did report some notable challenges in their efforts to reduce duplication and fragmentation. Two of the more commonly cited challenges were:

- **Data sharing among partners**: Alamosa, Conejos, Rio Grande: *"One challenge…was the level of understanding and compliance around sharing the appropriate data with the appropriate partners - and no others…we must be very diligent about ensuring that information is shared on a need-to-know basis only and that ROIs are reviewed before discussions."*

- **Sharing/coordination of resources and funding among partners**: El Paso: *"Multiple initiatives and funding opportunities continue to arise which are not clearly aligned with one another, crossing different geographical boundaries, excluding important partners, and do not take existing efforts or competing efforts into account. Funding fragmentation fuels continued competing interests and duplicative, confusing outcomes. Efforts to "blend", "braid", or "pool" funding at a local level do not occur naturally in absence of individual systems interests. The complexity of the patchwork of resources used to address needs and fund services creates the necessary use of less effective, or even counterproductive, services."*

How Are CMPs Improving the Quality and Effectiveness of Services?

In addition to achievements in reducing duplication and fragmentation, CMPs also reported efforts and achievements focused on enhancing the quality of services in FY 2013.

CMPs are addressing the specific service needs of their communities. Performance on indicators listed below in Table 30 indicates that CMPs are continuing to expand and enhance their services to meet the needs of their local communities and to provide a continuum of high-quality service options.

Table 30: Enhancements to service quality and appropriateness

Indicator	FY 2012	FY 2013
Percentage (number) of CMPs that implemented a new program or model locally that specifically targets a population and service need/gap identified by IOG	61% (17)	72% (23)
Percentage (number) of CMPs that implemented or enhanced existing services to be more culturally appropriate/ culturally competent	43% (12)	53% (17)

Table 31. Fidelity monitoring in commonly implemented ISST models

Evidence-informed program/practice	Number of CMPs	Fidelity measures
Team Decision Making	20	5 (25%)
High Fidelity Wraparound or Wraparound	15	8 (53%)
Crossover Youth Practice Model	9	4 (44%)

CMPs are increasingly implementing service models/programs with proven efficacy. As noted earlier in this report, CMPs reported the use of a variety of evidence-based and/or evidence-informed models (see page 11 for the most commonly implemented programs). Though collection of information about the use of evidence-informed programs and practices has evolved over the course of the evaluation, it appears that their use has been growing among CMPs. As of FY 2013, approximately two-thirds of CMPs utilize Team Decision Making (20 CMPs), half implement High Fidelity Wraparound/Wraparound (15 CMPs), and the Crossover Youth Practice Model has grown, with 9 CMPs now implementing the program. Some CMPs reported efforts to collect data about implementation fidelity; for example, 8 of the 15 CMPs implementing High Fidelity Wraparound report monitoring the fidelity of their implementation of the model (see Table 31).

CMPs are refining and expanding their use of performance measure and client-level data to improve practice. Despite the continued variation in local performance measurement, there are indications that CMPs are more frequently and effectively utilizing data in their efforts to improve local service delivery. FY 2013 saw increased data collection of client-level service and outcome data through expanded use of the CMP ETO database and greater utilization of customized CMP ETO data reports by local communities. In addition, supported by evaluation technical assistance efforts, CMPs more precisely defined local indicators, with an increased focus on assessing outcomes among ISST-served children and youth.

Additionally, almost all CMPs (96%) report monitoring service quality and outcomes through regular review of evaluation data to assess effectiveness of services and identify areas for improvement. The most common strategies are summarized in the table below. Strategies other than those listed in the table included coordinator review, annual reporting to IOGs, and annual reporting by external local evaluators to IOG.

Table 32. Strategies for integration of evaluation into CMP activities

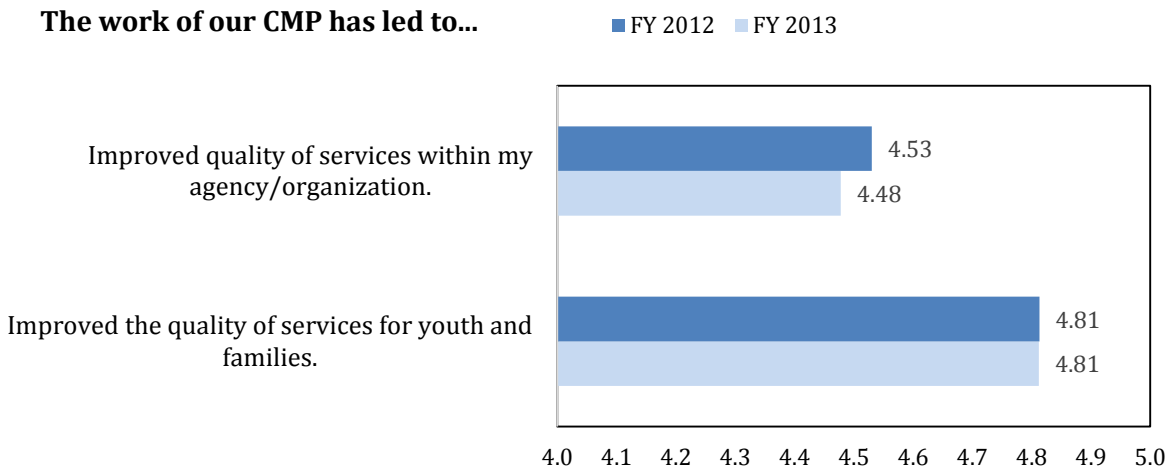
Strategy*	FY 2012: Number of CMPs (%)		FY 2013: Number of CMPs (%)	
Our full IOG regularly reviews evaluation/outcome monitoring processes and results.	--	--	13	(41%)
Our IOG has formed a data sub-committee or working group that meets regularly to review evaluation/outcome data.	4	(14%)	3	(9%)
Our coordinator or other CMP stakeholder distributes written summaries of evaluation/outcome data on a regular basis.	14	(50%)	15	(47%)
Other strategy	11	(39%)	7	(22%)

Note: – denotes item not collected in FY 2012.

CMP Practice Example: *"Garfield County IOG has as a standing agenda item, an ISST update that is presented by the ISST coordinator. This update often includes outcome data…[the] CMP has focused on researching and moving towards the adoption of an assessment tool to be used with all FACET and JET clients. The data…will lead our IOG toward evaluating our programs and services."*

CMP stakeholders perceive significant achievements in their efforts to improve quality of service. IOG members reported that CMP activities have resulted in improved quality of services, as shown in Figure 12.[xxvii]

Figure 12: Collaborative Effectiveness Survey results: CMP achievements regarding service quality[xxviii]



**Mean score on item, aggregated within CMP and averaged across CMPs.*

IX. Systems Improvements: Family Involvement

The integration of family involvement and family-centered service at all levels of implementation is central to the CMP approach. Family representatives who are involved in CMP governance and service delivery processes:

- Contribute unique perspectives related to policy
- Share valuable input on the content and delivery of services
- Identify potential challenges for families in service plans or policies

Moreover, when families are involved in identifying their own needs and goals, and in the design of services that will best meet these needs, they are more likely to achieve positive outcomes.[xxix]

CMPs have maintained improvements in family involvement demonstrated in earlier years of the evaluation. The information presented below demonstrates the ways in which CMP and local sites partner with families and family representatives to improve services and outcomes. The data inform the evaluation question regarding the extent to which CMPs are realizing positive systems changes in this area. Please see Appendix E for information reported by CMP.

How Has CMP Developed State-Level Infrastructure to Support Family Involvement?

A concerted effort has been made to integrate family perspectives at the state level. Activities and achievements to support family involvement in CMP in FY 2013 included:

- Active involvement of a representative from Federation of Families for Children's Mental Health (FOF) as a member of the CMP State Steering Committee
- Continued efforts from the Family Voice and Choice (FV&C) subcommittee to support local CMPs in increasing family engagement
- Through partnership with FOF Statewide Family Network project, dissemination of resources and trainings designed to assist CMPs in identifying family partners for IOG and ISST processes and to share methods to mentor and support family partners in these roles

In FY 2013, the CMP Executive Leadership voted to support a recommendation for a statutory change to make family representation, with voting capacity, mandatory for CMP IOGs.

How Are CMPs Ensuring Family Involvement at The Local Governance Level?

CMPs involve family representatives to help inform systems and service planning within IOGs. Although the level of family involvement has slightly decreased from 89% in FY 2012 to 72% in FY 2013, a majority of CMPs (23) reported that they currently have at least one family driven organization representative, family advocate, family member, or youth member on their FY 2013 IOG. Of these 23 CMPs, 22 (or 96%) of them designate voting rights to family representatives, and 18 (or 78%) of them have family representatives who attend more than half of all IOG meetings.

State-Adopted Definitions of Family Involvement

The following definitions are summarized; please see http://www.cbhc.org/news/wp-content/uploads/2012/03/Colorado-Definitions.pdf for exact legislative language.

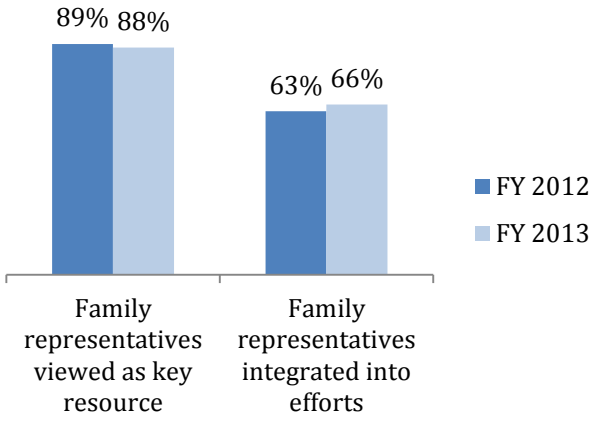
A **family member representative** is a person who is raising or has raised a child, youth, or adolescent with special physical, mental, emotional, behavioral, substance use, developmental, or educational needs. As a family member they experienced working with many of the agencies and providers in their community.

A **family-driven organization** has the explicit purpose to serve families who have a child with special needs as describe above. It is governed by a board of directors and comprised of a majority of individuals who are family members.

A **family advocate** is a parent or primary caregiver who has: 1) been trained in SOC approach, 2) raised or cared for child with needs, and 3) has worked with multiple agencies/systems. A **family systems navigator** meets criteria 1) and 3).

A **youth representative** is an adolescent with any needs as listed in family member representative description above.

Figure 13: Integration of family partners in IOGs



Although the percentages of CMPs who rated family representatives as being "sometimes," "often," or "always" key resources and integrated into the work of the IOG remained steady as compared to FY 2012 (see Figure 13), the number of CMPs actually increased for both items. There were 28 CMPs who rated family representatives as key resources in FY 2013, up from 24 in FY 2012; and there were 21 CMPs who reported that family representatives were integrated into IOG efforts in FY 2013, up from 17 in FY 2012. This is 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."[xxx]

Despite success in increasing family engagement overall, many CMPs continue to encounter challenges in effectively involving family representatives (see Table 33). Barriers experienced by CMPs appear to be stable from FY 2012 to FY 2013, with the notable exception of confidentiality issues (increased), lack of funding for compensation (decreased), and other barriers (decreased).

Family involvement at the IOG level: Making it official

CMPs report that they are finding ways to institutionalize family involvement through creating policies to mandate family involvement, hiring family support partners, and setting aside funds to compensate families for their IOG involvement.

- **Elbert:** *"The IOG has had regular committed participation by a community family partner for three years. She is compensated for her time but participates due to her personal commitment to the cause and the relationships among partners."*
- **Alamosa:** *"We created a Family Engagement workgroup [that] hired our first Family Support Partner and created processes and protocols for adding three Family Representatives to the Joint IOG (one for each county). They have all signed the [FY14] MOU."*
- **Lake:** *"Our CMP added a family representative to the IOG beginning June 2013. In addition we are in the process of hiring a part-time family support partner. We also continue to receive in-kind staff hours from a partner family organization to have family representatives and family advocates at ISSTs."*

Table 33: Challenges experienced by CMPs in involving families in IOGs[9]

Barrier description	FY 2012	FY 2013
Issues identifying appropriate families for IOG participation	54%	56%
Time constraints/scheduling	43%	44%
Confidentiality issues	14%	28%
Lack of knowledge/experience of family or youth recruited about CMP processes	32%	25%
Lack of commitment among recruited youth and families	25%	25%
Geography/Distance	11%	13%
Lack of funding to compensate family and youth members	18%	9%
Personnel turnover	11%	9%
Lack of IOG buy-in regarding family involvement	4%	3%
Other Barriers	32%	22%

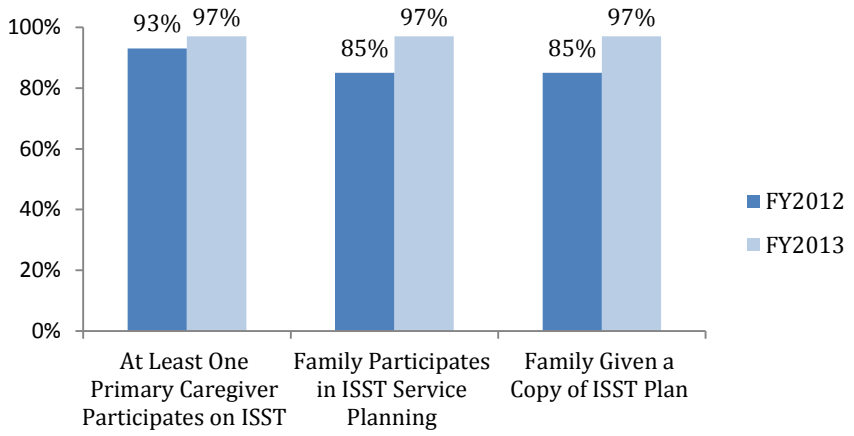
How Do CMPs Engage Families/Family Representatives in the ISST Process?

CMPs are growing in their efforts to involve families in their own service planning and/or engage family representatives to participate on behalf of other families, although this latter role is not as consistently present across CMPs.

CMPs are committed to ensuring that family members are integrally involved in treatment planning. Almost all CMPs reported that caregivers "frequently" or "always" participate in ISSTs, participate in ISST service planning, and receive copies of the plan (see Figure 14).

[9] For all figures and tables in section IX unless otherwise noted, n in FY2012 = 28; n in FY 2013 = 32. Totals sum to greater than the reported n's of CMPs and 100% because CMPs could select up to 3 barriers.

Figure 14: Family involvement in ISST



Family Involvement in ISST Services: Meeting families where they are at

CMPs have shown that success in family engagement can be achieved by setting up services to be as convenient and individualized as possible.

- **Grand:** *"We always schedule the Family-Team Meetings around the families—the day, time, and location. We try to meet families where they are at—both where it is most convenient for them to meet and in what are they most interested in making changes."*
- **Denver:** *"We do everything possible to ensure their participation, including phone conference if necessary."*
- **Huerfano:** *"The Family Services Coordinator works diligently to make sure family members…understand all that is happening."*

Eleven (38%) CMPs report that family representatives are viewed as partners in service to other families (down from 14 in FY 2012), and 28 (87%) report that family advocates or family friends participate in treatment planning meetings in a supportive role at least "sometimes," "frequently," or "always" (roughly the same as FY 2012). Among the children and youth served by ISSTs that are represented in the CMP database, 17% had a family advocate or facilitator involved in the initial service planning meeting in FY 2013. While this may appear to be a low rate, this is an increase from 10% in FY 2012; additionally, CMPs that report no involvement by family advocates or facilitators in the initial ISST meeting may routinely include them in subsequent meetings so this finding may underrepresent involvement at this level. Similarly, a family support person or family friend attended the initial ISST meeting in 17% of the cases in FY 2013, up from 14% in FY 2012.

Currently, of the 25 CMPs who reported having family partners with roles in CMP service activities, a total of 11 (44%) indicated that they have mentoring or other methods of supporting families in CMP governance and service delivery. The Family Voice and Choice subcommittee continues to explore methods to support local CMPs to effectively integrate family representatives specifically in ISST processes.

How Do CMPs Assess and Refine Processes to Involve Families?

A total of 19 CMPs (59%, down from the 24 CMPs that reported doing so in FY 2012) indicate that they implement measures or methods to track family involvement at the local level. Among those CMPs that track family involvement, there has been an increase in the number using most of the strategies listed in Table 34 from FY 2012.

Table 34: Methods of assessing family involvement

	Number of CMPs reporting "yes" (%)			
Family involvement measurement strategy	**FY 2012**		**FY 2013**	
Family survey about satisfaction with services	19	(68%)	16	(84%)
Tracking of family participation in ISST meetings	19	(68%)	13	(68%)
Family survey about cultural responsiveness	7	(25%)	9	(47%)
Other type of family survey	1	(4%)	0	(0%)
Tracking of family representative participation in IOG meetings	15	(54%)	--	--
Other method	0	(0%)	2	(11%)

Note: n = 24 for FY 2012; n = 19 for FY 2013. "--" denotes items not included in FY 2013 data collection.

In addition, a variety of family-related measurement tools are shared across CMP sites, including family satisfaction surveys, pre-ISST family assessments, fidelity checklists, local-level process evaluation surveys, and family functioning assessments. Some CMPs also supplemented their surveys by using qualitative methods to refine family involvement strategies. One CMP coordinator noted that they "hired a part-time family representative consultant to conduct 6 focus groups across the [counties] with families that had gone through multi-system involvement." These data were used to inform the CMP's strategic plan and were shared among IOG members.

CMPs that do utilize strategies to measure family involvement or gather family feedback report using this information in a number of ways. One CMP reports that they "collect all family satisfaction [surveys] and then track overall ISST satisfaction and families' response rate," where the information is then "distributed to all partners on a quarterly basis." Other CMPs use this information to improve their processes; one CMP in particular "discovered by using these forms that a few families [did] not understand the reason for the meeting and [were] unclear on the meeting expectations." The CMP responded to this information by working with referral sources to ensure youth and families were educated on what they could expect during a meeting. Since then, the CMP "has seen an improvement in regards to this issue within the last few months."

A CMP statewide resource: The Family Feedback Measure

During FY 2013, the CMP statewide evaluation team developed the CMP Family Feedback Form, a measure that assesses family perceptions of service delivery. The goal of this data collection effort is to enable local CMP sites and CDHS to demonstrate that CMPs are addressing the needs of their served families and to identify areas for service improvements. Originally offered as an optional measure for FY 2014, the CMP Family Feedback Form has been endorsed by CMP state administration and recommended for implementation by all CMPs beginning in January, 2014.

Two data collection methods were employed; 1) a non-anonymous method whereby the measure is entered into the CMP ETO database and linked to other case data; and 2) an anonymous method whereby families enter data directly into an online survey site where no identifying information is tracked other than CMP name. Items included in the measure have been drawn from the Youth Services Survey for Families (YSSF), a validated instrument that has been utilized in multiple state and local level programs. Items from this measure also align with those included in the SAMHSA Systems of Care evaluation.[iii] The non-anonymous method of data collection allows for multiple administrations and monitoring of family perceptions of key components over time.

X. Systems Improvements: Cost Sharing and Cost Savings

The CMP approach assumes that reductions in duplication and greater integration of services across systems will lead to better family outcomes and net cost-savings over time. Cost savings recovered at the local level as a result of interagency cost sharing are required to be reinvested to improve or expand services. Annually, CMPs are required to submit descriptions of:

- Costs and cost-sharing involved in CMP implementation
- Cost-savings realized as a result of ISSTs
- How funds are reinvested

Information in this section addresses how CMPs are responding to related legislative goals and working to affect key systems improvements in cost sharing and cost savings. This section first summarizes the strategies that CMPs are using to fund their efforts and then describes how CMPs are realizing cost savings and reinvesting these funds. It concludes by describing the challenges and possibilities associated with measuring cost savings across CMPs. (Please see Appendix H for information noted by CMP.)

How Are CMPs Funding Their Efforts?

CMPs employ a number of strategies to finance their efforts, including pooling, blending, and braiding funds. Interagency governance groups are encouraged to find innovative ways to "cross funding streams" to break down barriers that impede coordinated funding (see box on this page for common practices). As such, local funding structures are diverse and varied.

Financing strategy[xxxi]	Description
Create new structures to pool/blend/braid funding	Collapse and streamline funds from multiple systems for services that target relevant cross-system outcomes; cost savings are reinvested
Redeployment of existing dollars	With few "new dollars," funds are redirected from high costs/poor outcome areas into targeted services
Strategic use of earned incentive funds	Ensure performance measures are met to maximize incentive funds, carry over funds to address year-to-year fluctuations in agency budgets
Raise new revenue	Identify opportunities to generate new funds; e.g., through advocacy with state legislators and taxpayer referenda at the state level, and seek external grants or donations at the local level

CMPs report on funds derived from three primary sources: earned incentive funding from the state legislature; in-kind contributions from MOU partner agencies; and leveraged external sources (e.g., grants, waivers, etc.) (See Appendices M and N for detailed information regarding funding sources and expenditures and for listing of funding sources by county.)

Earned incentive funds: In FY 2013, the total earned incentive fund available for distribution to the 32 CMPs was approximately $2.6 million. The total funding available has stayed relatively consistent while the number of CMPs has increased, resulting in less money distributed to each site over time. In FY 2013, CMPs reported expending about $4.1 million of their available incentive funding. This total exceeds the FY 2013 earned incentives distribution fund, as CMPs called upon carryover funds from prior years to address budget shortfalls and to implement previously planned programs. The majority of expenditures funded programs and services for families, and covered personnel and other administrative costs.

About half of CMPs (46%) applied incentive funds to compensate family facilitators/navigators.

In-kind contributions: In total, CMPs reported an estimated $15 million provided in goods and services by partner agencies (see Appendix N for a list of categories of in-kind contributions by partner agency). In many cases, contributions came from non-mandated partners, indicating widespread support for collaborative services within communities.

External grants: 17 CMPs received an estimated total of $2.5 million in funds from local, state and federal grants to support and expand service delivery (See Appendix O for more details).

How Are CMPs Sharing Costs?

In addition to the primary funding sources listed above, CMPs engage in cost sharing both at the governance (IOG) level and at the ISST services level to finance CMP efforts. Shared contributions are largely in three areas:

- Operational costs**:** The majority of CMPs report that partner agencies and organizations contribute directly (69%) or in-kind (84%) at least "sometimes" for staffing and administrative needs
- Development and implementation of new programs: 91% of CMPs indicated that they contribute funds across agencies to build new programs at least "sometimes"
- ISST services: 97% of CMPs indicated that during ISST meetings, agencies jointly agree on who will pay for intervention services

"Denver [CMP] continues to increase the frequency of blended/braided funding for the purchase of specifically identified services for youth/families which has increased effectiveness of the integrated plans for clients, as well as increased the strategic use of

How Are CMPs Realizing Cost Savings and Reinvesting Funds?

> ***multiple funding streams, and reducing fragmentation of services between agencies."***

An underlying assumption of CMP is that collaborative efforts to blend and braid funds will result in overall 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 are largely not tracked locally and data from CMPs that do track the costs of their services have not been provided to CMP management or the statewide evaluation team. While outcomes may be improved for the youth served by the CMP, it is challenging to determine whether these were achieved at lower cost. However, there is indication that:

- Although information is limited, some CMPs are realizing local cost savings
- Many have plans in place to reinvest funds to expand service delivery

> ***"With the addition of Rio Grande County to the Joint IOG, our expenses are now being split three ways (Conejos, Alamosa and Rio Grande), significantly leveraging our incentive funds. We believe that by reinvesting these funds into universal system improvements such as the screening tool, evaluation of which services are working and which are not, and personnel such as a Family Support Partner and IOG Family Representatives, we are maximizing the funds to their greatest potential. We continue to look for grants to help fund specific programming needs, and recognize that as system-level cost savings become more directly connected to the work of the CMP (through effective data collection and evaluation), these saved funds can be redirected towards CMP services and supports."***

Cost savings

None of the 32 CMPs reported that they had a process in place to measure specific cost savings directly associated with collaborative management of multi-agency services. However, four CMPs provided some information regarding estimated cost savings associated with specific partner programs or outcomes/local performance measures (see Table 35 below). Five other CMPs indicated that their IOGs have cost savings measurement as a specified objective for FY 2014.

Table 35: Cost savings reported by CMPs

CMP	Program or service	Savings in FY 2013	Data source or method
El Paso	DHS Wraparound	$168K	Comparison of service costs of 101 served youth before and during/after Wraparound intervention
Fremont	Family Treatment Drug Court	$116K	Review of cases; comparison of estimated cost of in home services with estimated costs of foster care (averages)
Gunnison-Hinsdale	Not specified	$70K	Comparison of total cost of youth served compared to institutional cost for one year

Larimer	Not specified	$50K	Estimated costs of the reduction in residential care from previous year (Average Daily Placement), based on average cost of care
		$28K	Estimated costs of the reduction in out-of-home care from previous year (Average Daily Placement), based on average cost of placement

Reinvestment of funds

Of the 29 CMPs that reported on reinvesting funds in FY 2013, almost all (27, or 93%) noted that they plan to reinvest funds carrying over into FY 2014 directly into new or expanded family-centered services, as compared to 16 in FY 2012. Almost half of CMPs (14) plan to apply funds to develop a flexible spending account to provide for family needs, up from one-third in FY 2012. See Table 36 for additional reinvestment categories.

Table 36: CMP reported plans for reinvesting savings realized in FY 2012 and FY 2013

Plans for reinvested savings	FY 2012: Number of CMPs (%)*	FY 2013: Number of CMPs (%)**	Examples
Support programs and services	16 (64%)	27 (93%)	Sustain or expand existing services, develop new programs, provide grants to programs with emergency needs
Support families directly	9 (36%)	14 (48%)	Retain flexible funds for families in need of respite care, emergency services, etc.
Support personnel costs	5 (20%)	14 (48%)	Contribute to CMP coordinator salary
Training and technical assistance	3 (12%)	4 (14%)	Support symposium, cross-site meetings
Hold funds in reserve	6 (24%)	3 (10%)	Retain funds to apply to planned programs or services
Support local evaluation	-- ----	5 (27%)	Engage evaluators to conduct local performance measure analysis

**Note: n = 25; **Note: n=29.*

"The greatest collaborative level success [for Grand County] is the creation of the Day Treatment Alternative Program for both East and West Grand School Districts…the collaborative work that has been done by Northwest Colorado BOCES, Colorado West Regional Mental Health, Grand County Dept. of Social Services, both school districts, The Grand County Juvenile Services Department and the CMP to set up the program has involved cost sharing as well as true collaborative planning. Funding both cash and in-kind from the CMP, DSS, JSD, Colorado West, NW BOCES and the school districts has been pooled to start the program. We are excited to see what the implementation phase brings."

What Are the Challenges and Possibilities for Measuring Costs?

Testing the cost-savings hypothesis assumed in the legislation is complicated given the range and diversity of existing programs, processes and outcomes. This section outlines some of the specific challenges associated with quantifying costs and benefits for CMP efforts and concludes with a discussion of opportunities moving forward.

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

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

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

- Greater adoption of a precise and standard program model
- Increased implementation fidelity
- Agreement on corresponding outcomes

However, before moving in this direction, the initiative would need to consider some important trade-offs. Specifically, the CMP effort places a high value on local decision making and the diversity of approaches is one of its strengths. While the promise of a rigorous cost-benefit approach may seem like the ideal evaluation model, implementing required changes would necessitate greater standardization across sites, and may come at the expense of local investment and support for the CMP.

There are several options the evaluation could explore in FY 2014 to move the initiative a step closer to measuring costs savings. For example, the evaluation could pilot with a subset of CMP sites with clear service models actual measurement of service costs and outcomes. In addition, with multiple years of statewide indicator data available in Year 5, the evaluation will be positioned to analyze change from year to year in a select set of indicators (e.g., out-of-home placements) in order to provide estimated costs associated with identified changes. Finally, the evaluation could provide technical assistance regarding cost measurement to CMPs interested in exploring measurement options for their selected ISST model. With continued evaluation efforts in this area, it is hoped that over time, there will be an opportunity to specify a cost model and conduct related analyses.

XI. Evaluation Recommendations

The CMP evaluation plan was developed in response to language set forth in the enabling legislation and design requirements specified within the original CMP evaluation Request for Proposals (RFP, 2009). Specifically, the RFP required a focus on several key areas, including:

- Assessing and reporting the degree to which counties are meeting legislated components
- Designing and implementing strategies for comparing performance based measures across counties
- Designing and implementing strategies for comparing collaborative management practices and processes across counties
- Analyzing the relationships between collaborative practices/processes and performance based measures

Over the past four years, the evaluation has expanded to include data collection related to all key legislative components of the program, including efforts to reduce duplication and fragmentation of services, improving the quality and effectiveness of delivered services, cost sharing and cost reductions, and child and family outcomes.

Providing answers to the other evaluation areas above requires some degree of standardization in service delivery and outcome measures across sites. That is, it is not possible to "compare performance based measures across counties" or "the relationship between collaborative practices/processes and performance based measures" without at least some shared process and outcome measurement. Consistently, Colorado Department of Human Services has asked for more and improved outcome data in order to demonstrate program effectiveness. The following section provides recommendations that might assist in stronger measurement of both CMP processes and outcomes.

1. **Implement a way to capture CMP-served cases within Trails.** Currently, there is no way to identify the full set of CMP-served cases through the use of a single state data system. In response, OMNI implemented ETO, an online management information system, in order to collect data that could be used to count and describe children and families served by the program. However, many CMP cases are not entered into ETO and sites also serve non-open child welfare cases through their CMP efforts that would not be captured in Trails. These considerable data challenges make it impossible to generate an accurate count of CMP served cases.

   Changes to Trails through the addition of Program Area 3 (PA3) screens provide an opportunity to capture CMP-served cases within a state system, assuming the addition of a related selection box for designating CMP cases. Moreover, this would hold the added benefit of connecting PA3 services to CMP families, allowing for these data to be used in

evaluation efforts. Using the PA3 entry form, however, would require that all CMP cases are entered into the system, even if PA3 services are not provided. Describing these cases would also require corresponding entry into the CMP ETO system, since key process indicator data related to CMP efforts would not be contained within the PA3 screens. While not the most elegant solution, this at least provides an opportunity to collect more complete data on cases served through the program.

2. **Explore the alignment of CMP child welfare outcomes with C-Stat measures.** By design, the CMP is to include outcomes in four domains: child welfare, juvenile justice, health/mental health, and education. Because specific outcomes are not identified within legislation, it is possible for participating agencies to focus on the set of outcomes that best relate to the larger aims of the program and service delivery approaches. The Colorado Department of Human Services has implemented the C-Stat process which selects sets of outcome measures for programs across the agency. While some of the child welfare statewide indicators selected for CMP are similar to C-Stat indicators, they are not fully aligned in terms of definition and measurement.

   It may be reasonably hypothesized that CMP has the ability to impact cases in more lasting ways than typical care, given multi-agency involvement and the development of integrated case plans. Thus, CMP efforts may be seen as helping to meet C-Stat goals, which can be demonstrated to the extent that the program shares these performance measures. To this end, it may be beneficial for CMP to adopt some or all of the relevant C-Stat indicators in order to measure the contribution these efforts make to meeting county and statewide goals. From an evaluation standpoint, this also provides the opportunity to assess differences in outcomes given what might be considered typical service provision versus a CMP approach. While CMPs could continue to identify site-specific outcomes, the adoption of C-Stat measures would provide some base of comparability across all projects within the child welfare domain.

3. **Focus statewide evaluation efforts on families served through ISSTs.** Currently, the annual evaluation report includes the organization of site-reported data on local performance achievement. These data include a wide array of outcomes and service approaches, not all of which include case planning within an ISST process. While CMP funds may be used to support a variety of service needs, case planning through an ISST that includes two or more agencies may be seen as key defining elements of the collaborative management process.

   Moving forward, it may be most useful to perform a more focused test of the efficacy of differing ISST approaches, since these vary across sites in terms of structure and process. This would support the exploration and identification of model practices that might benefit all CMP sites. The evaluation design could also be expanded to consider ISST practices

within program models (e.g., High Fidelity Wraparound) to explore the relationship between ISST practices, service models and outcomes. Such an approach, however, would require a greater degree of rigor in implementation efforts and shared outcomes than presently observed across sites.

4. **Expand state-level participation of other identified initiative partners.** State-level leaders from child welfare and juvenile justice have played a critical role in helping to shape and support the Collaborative Management Program. This is demonstrated through active participation in both the State Steering and State Evaluation Committees, interest in outcomes that relate to their respective systems and ongoing efforts to strengthen the larger initiative. The legislation also identifies additional key parties from education, health, behavioral health and domestic violence that, at a minimum, are to be involved in local efforts. While CMPs have had success working with many of these partners at the local level, particularly education and behavioral health, there is no clear involvement by state-level representative in these areas.

   In the coming year, it may be useful to explore whether there is benefit in seeking the participation of state leaders from other systems identified in the legislation. As the CMP is designed to improve efficiency (i.e., reduced duplication and fragmentation) and effectiveness (i.e., integrated case plans and comprehensive service delivery) within a multi-system context, it can be argued that the other named systems benefit from the initiative and might also play a critical role in shaping its direction. Such participation could help improve cross-system communication regarding the CMP, promote alignment between state and local objectives, develop additional support for CMP goals, and ultimately improve outcomes for all system partners.

Endnotes

[i] Colorado Revised Statute, Title 24, Article 1.9. (2010). Retrieved from http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp.
[ii] Goerge, R. M., Smithgall, C., Seshadri, R. & Ballard, P. (2010). Illinois families and their use of multiple service systems. *Chapin Hall Issue Brief.*
[iii] California Department of Education. (2007). Handbook on developing and evaluating interagency collaboration in early childhood special education programs. Retrieved June 1st, 2010 from http://www.cde.ca.gov/sp/se/fp/documents/eciacolbrtn.pdf.
[iv] U.S. Department of Health and Human Services. (2010). Guiding principles of systems of care. Retrieved June 1st, 2010 from http://www.childwelfare.gov/pubs/soc/socc.cfm.
[v] 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 are available on the CMP portal (http://collaboration.omni.org/sites/1451). A summary of products resulting from statewide evaluation activities in the four years of evaluation appears in Appendix G.
[vi] This was an optional item on the Annual Report; totals may underrepresent CMP efforts in these areas.
[vii] Definition was determined utilizing the Codigital collaborative decision-making online tool. http://www.codigital.com/.
[viii] Definition was developed at the March 26, 2013 Steering Committee.
[ix] Evidence-based programs include programs that have established their effectiveness through rigorous research, and are implemented in a highly structured manner with strict adherence or "fidelity" to the model.
[x] Promising programs include programs for which there is emerging evidence of efficacy through less rigorous research designs. These programs are often adapted to meet local needs, meaning that there is a lower threshold for fidelity.
[xi] CMPs with multiple ISSTs were asked to designate a primary ISST, the ISST serving the largest number of youth, for reporting purposes. Data in this section reflect information about each CMP's primary ISST.
[xii] One outlier response was removed prior to mean calculations in each of the three fiscal years (one CMP reported a total cost that was more than twice the next largest reported cost, each year).
[xiii] The total number of children and youth whose information is entered into the CMP database is an underestimation of the actual number of children and youth served by ISSTs, as four CMPs indicated that they do not enter all of their ISST-served cases in the CMP database. For the total number of cases served by an ISST as reported by CMPs in FY 2013, see Figure 4 in Section III of this report.
[xiv] About 6% of cases (n = 203) in FY2012 and 3% of cases (n = 91) in FY2013 entered into the CMP database did not complete this item and were therefore excluded from the analysis.
[xv] About 8% of cases (n = 266) in FY2012 and 3% of cases (n = 109) in FY2013 entered into the CMP database did not complete this item and were therefore excluded from the analysis.
[xvi] Please see the CMP Portal to view previous CMP evaluation reports: http://collaboration.omni.org/sites/1451
[xvii] Each CMP receives an individualized report of their local performance on statewide indicators.
[xviii] Permanent home designations include adoption, emancipation, guardianship, reunion with relatives, or placement with other relatives; per instructions from CDHS data analyst consultants.
[xix] *CDHS Division of Child Welfare Scorecard Report* (provided to OMNI by CDHS).
[xx] Entry into juvenile probation in the 6 month time period prior to the initial ISST was selected as sample criteria in order to allow for the reasonable assumption that the ISST process may have been initiated due to recent probation involvement, and that the ISST process may have some impact on the probation outcome. This decision was reviewed and approved by State Judicial analyst consultants.
[xxi] Office of the State Court Administrator (2013). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2012 releases*. Retrieved on-line December 2013.

[xxii] Performance data on pilot education and health/mental health indicators are available to each CMP through the customized report function in ETO.

[xxiii] Grimes, K. E., Kapunan, P.E., & Mullin, B. (2006). Children's Health Services in a "System of Care": Patterns of Mental Health, Primary and Specialty Use. *Public Health Reports, 121*, 311-323.

[xxiv] The Collaborative Effectiveness Survey is administered to all IOG members each spring. The survey results in several scale scores; for multi-level modeling, the Overall Process Quality score (mean score by CMP) was utilized to reflect general perceptions of CMP collaboration success. As two CMPs were new and did not serve many youth with ISSTs in FY 2013, models were computed with 30 CMPs.

[xxv] Differences in Collaborative Effectiveness Survey Duplication of Services and Fragmentation of Services mean scale scores across FY 12 and FY 13 are not large enough to attain statistical significance.

[xxvi] Responses for FY 2012 and FY 2013 are as follows: In FY 2012, n = 306 respondents in 29 CMPs, in FY 2013, n = 265 respondents in 30 CMPs. Ratings reflect agreement with statements rated on a 6 point scale, with higher means indicating more positive responses.

[xxvii] Differences in Collaborative Effectiveness Survey Quality of Services mean scale scores across FY 12 and FY 13 are not large enough to attain statistical significance.

[xxviii] Responses for FY 2012 and FY 2013 are as follows: In FY 2012, n = 306 respondents in 29 CMPs, in FY 2013, n = 265 respondents in 30 CMPs. Ratings reflect agreement with statements rated on a 6 point scale, with higher means indicating more positive responses.

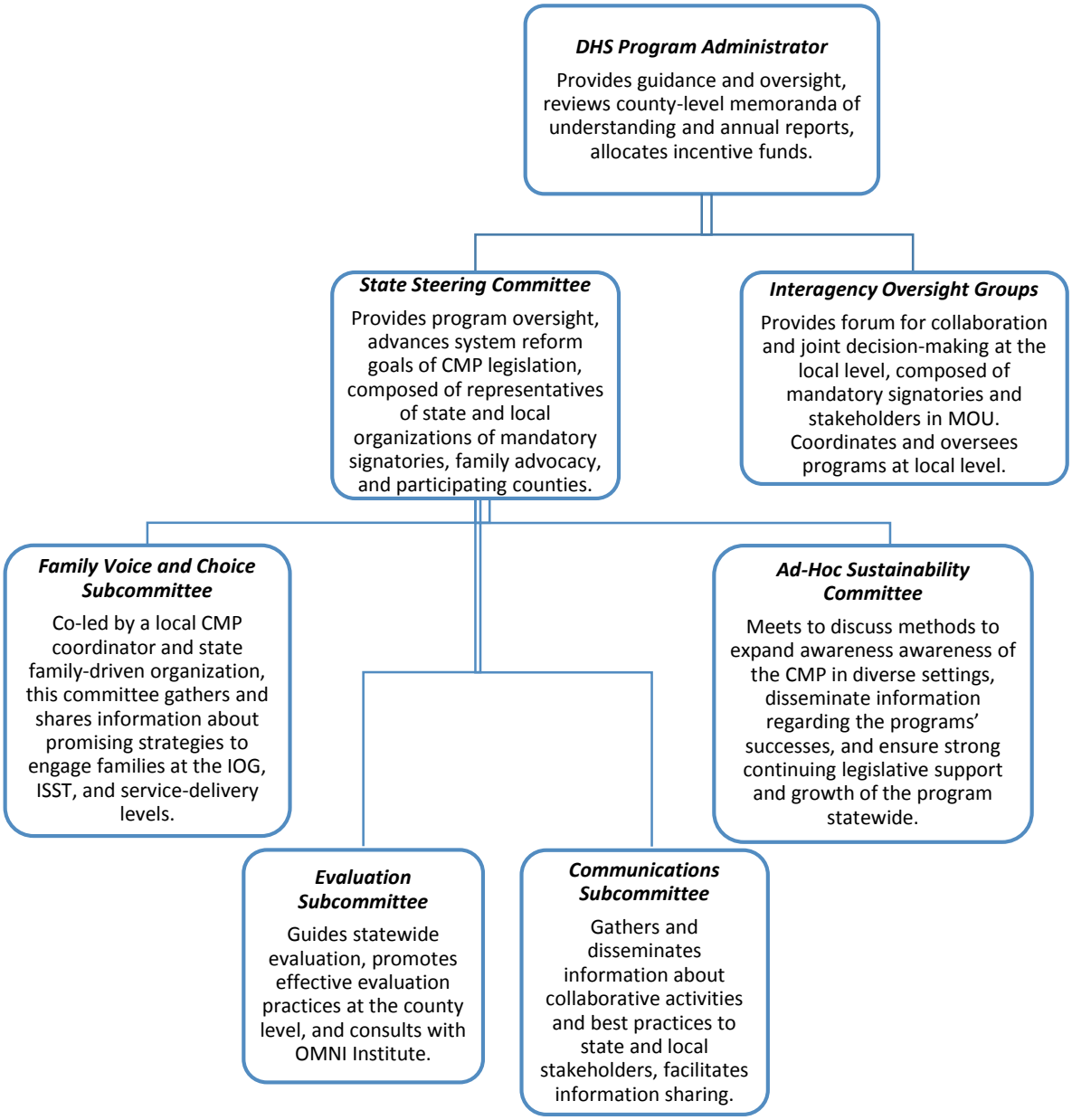
[xxix] U.S. Department of Health and Human Services, Administration for Children and Families. *Family Involvement in the Improving Child Welfare Outcomes through Systems of Care Initiative*. (Washington, DC: U.S. Government Printing Office, 2010).

[xxx] 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.

[xxxi] Adapted from Pires, S. (2002). Building Systems of Care: A Primer. Washington: DC: National Technical Assistance Center for Children's Mental Health, Georgetown University. Online: http://gucchd.georgetown.edu/72377.html.

Appendices

Appendix A. CMP Oversight and Implementation Structure



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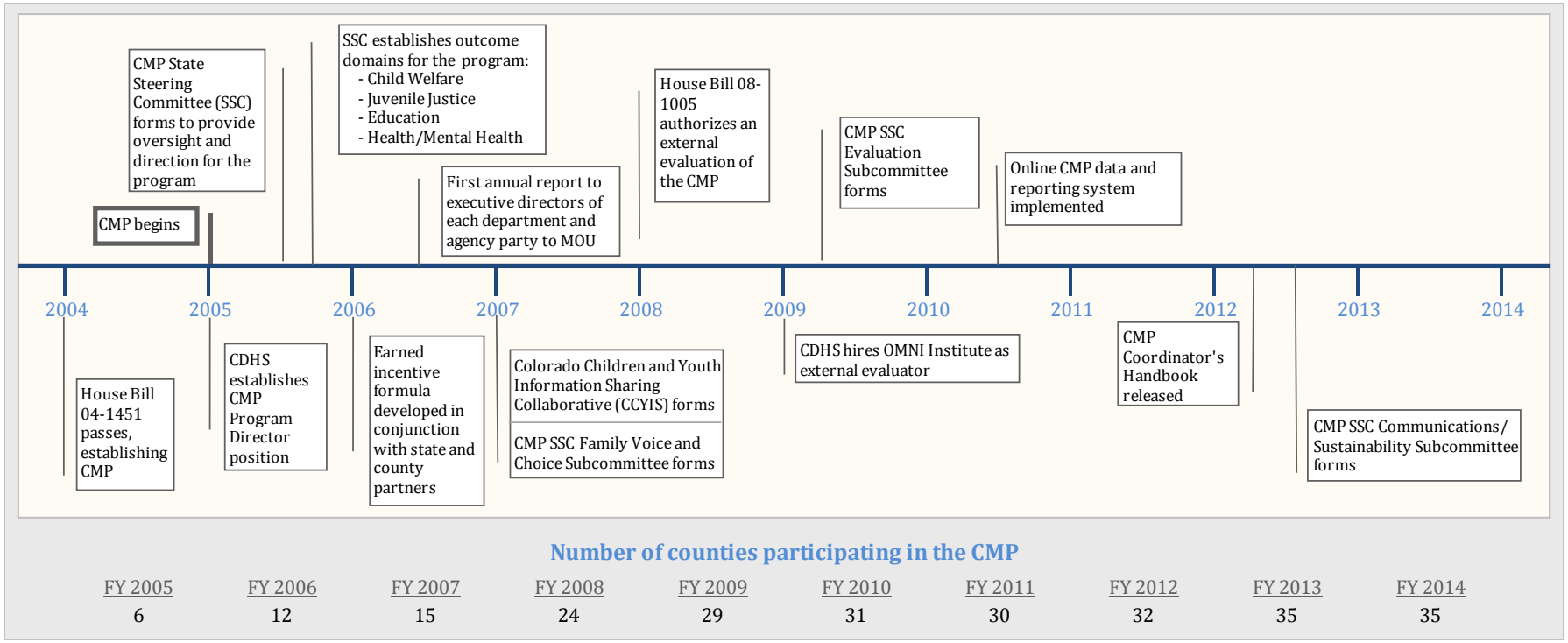
Appendix B. Key Milestones of the CMP Initiative

The following figure below details the key milestones reached from 2004 to 2013.



Number of counties participating in the CMP

FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
6	12	15	24	29	31	30	32	35	35

Appendix C. Statewide Evaluation Phases

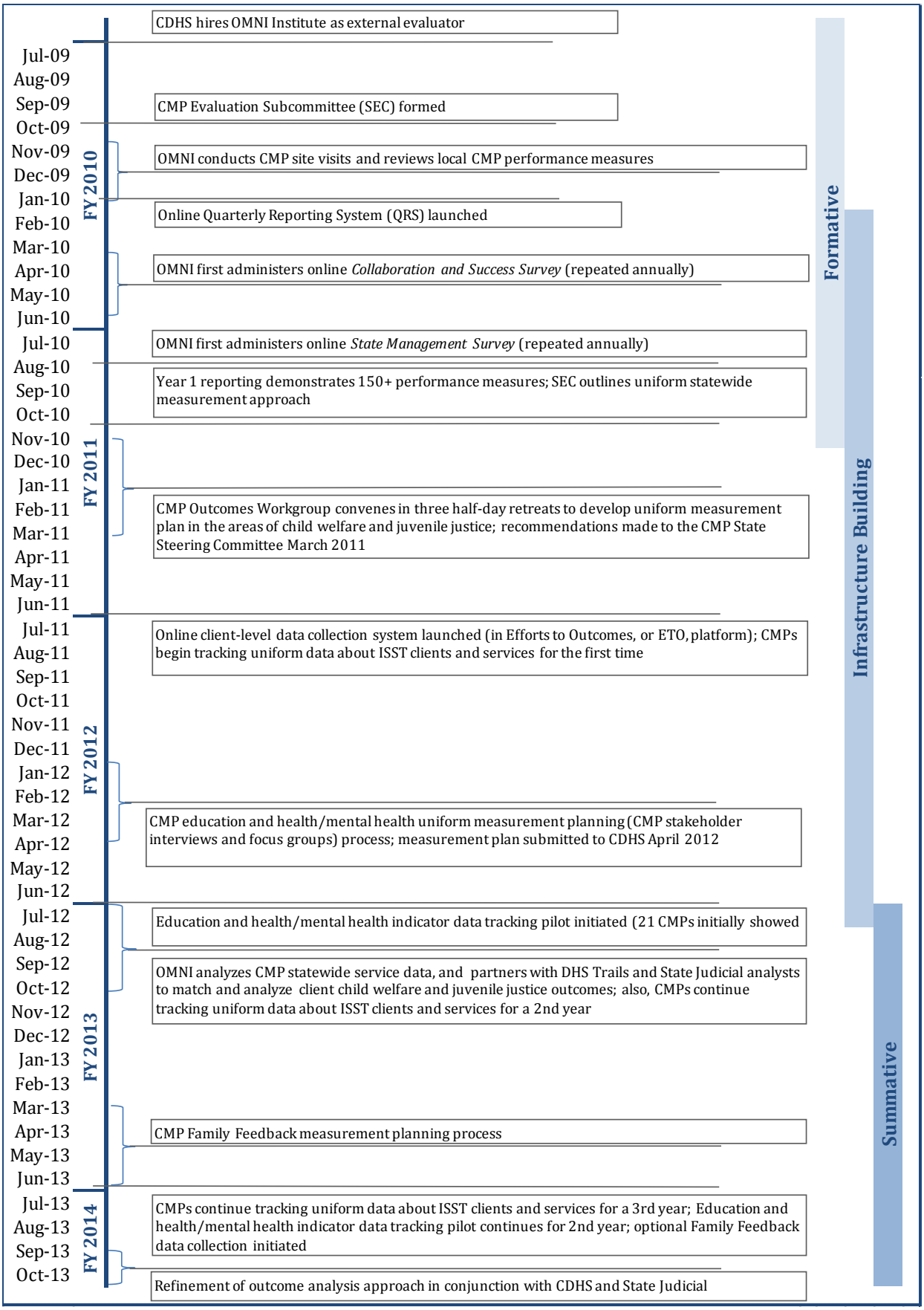
The overarching focus of the evaluation is on examining the effectiveness of CMP efforts in achieving the legislative goals of HB 04-1451 (e.g., increased family involvement; reduced duplication and fragmentation; increased quality, effectiveness and appropriateness of services; greater cost and resource sharing across agencies; and improved child and family outcomes). As is common with cross-site evaluations, as well as evaluations that commence some time after a project has been operational, 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 continued in this area through FY 2013.

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 reflects efforts to build upon the summative evaluation activities that commenced in FY 2012 and continued into FY2013. 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 III, though the infrastructure building efforts conducted during Phase II are still underway for some evaluation components.


CDHS hires OMNI Institute as external evaluator
Jul-09
Aug-09
Sep-09
CMP Evaluation Subcommittee (SEC) formed
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
FY 2010
OMNI conducts CMP site visits and reviews local CMP performance measures
Online Quarterly Reporting System (QRS) launched
OMNI first administers online Collaboration and Success Survey (repeated annually)
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
FY 2011
OMNI first administers online State Management Survey (repeated annually)
Year 1 reporting demonstrates 150+ performance measures; SEC outlines uniform statewide measurement approach
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
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
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
CMP education and health/mental health uniform measurement planning (CMP stakeholder interviews and focus groups) process; measurement plan submitted to CDHS April 2012
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
FY 2013
Education and health/mental health indicator data tracking pilot initiated (21 CMPs initially showed
OMNI analyzes CMP statewide service data, and partners with DHS Trails and State Judicial analysts to match and analyze client child welfare and juvenile justice outcomes; also, CMPs continue tracking uniform data about ISST clients and services for a 2nd year
CMP Family Feedback measurement planning process
Jul-13
Aug-13
Sep-13
Oct-13
FY 2014
CMPs continue tracking uniform data about ISST clients and services for a 3rd year; Education and health/mental health indicator data tracking pilot continues for 2nd year; optional Family Feedback data collection initiated
Refinement of outcome analysis approach in conjunction with CDHS and State Judicial
Formative
Infrastructure Building
Summative

Appendix D. Collaborative Management Program Evaluation and Reporting Requirements from HB1451 Statute

24-1.9-102.5. Evaluation.
The department of human services is authorized to utilize moneys in the performance-based collaborative management incentive cash fund created in section 24-1.9-104 for ongoing external evaluations of the counties participating in memorandums of understanding pursuant to section 24-1.9-102, also known as the collaborative management program, as well as those counties that opted to not participate in the collaborative management program. The external evaluation shall include an evaluation that may be required in connection with a waiver authorized pursuant to section 24-1.9-102 (4).

The department of human services, with input from the counties, agencies as listed in section 24-1.9-102 (1) (a) and (1) (a.5), the division of youth corrections in the department of human services, participating stakeholders in the private and nonprofit sector, and participating parent or family advocacy organizations that represent family members or caregivers of children who would benefit from multi-agency services participating in the collaborative management program, shall develop the criteria and components of the external evaluation.

Each county participating in the collaborative management program shall participate fully in the annual external evaluation. The department of human services is authorized to perform an evaluation pursuant to this section on an ongoing basis as needed, as determined by the department of human services and subject to available appropriations.

24-1.9-103. Reports - executive director review.

(1) Commencing January 1, 2007, and on or before each January 1 thereafter, each interagency oversight group shall provide a report to the executive director of each department and agency that is a party to any memorandum of understanding entered into that includes:

(a) The number of children and families served through the local-level individualized service and support teams and the outcomes of the services provided, including a description of any reduction in duplication or fragmentation of services provided and a description of any significant improvement in outcomes for children and families;

(b) A description of estimated costs of implementing the collaborative management approach and any estimated cost-shifting or cost-savings that may have occurred by collaboratively managing the multi-agency services provided through the individualized service and support teams;

(c) An accounting of moneys that were reinvested in additional services provided to children or families who would benefit from integrated multi-agency services due to cost-savings that may have resulted or due to meeting or exceeding performance measures specified by the department of human services and elements of collaborative management established by rule of the state board;

(d) A description of any identified barriers to the ability of the state and county to provide effective services to persons who received multi-agency services; and

(e) Any other information relevant to improving the delivery of services to persons who would benefit from multi-agency services.

Appendix E. Indicators Reflecting Key Program Components by CMP

Table 1 that follows details each CMP's reported responses related to specific indicators and/or characteristics that align with components referred to in the CMP legislation (HB 04-1451) in FY 2013. Checkmarks in the table indicate that the CMP reported responses that meet the definitions as listed below for each indicator, as described below. The data source is included in parentheses. It is important to note that although guidance was provided to CMPs for responding to each item, response options may have been differently interpreted by CMPs.

Maintained all nine mandated IOG partners. A checkmark signals that the CMP has all nine mandated partners on their IOG. In FY 2013, those who did not have a checkmark had eight of the nine partners in place; none had less than eight (Annual Report MOU partner table).

Maintained family representation on IOG. A checkmark signals that the CMP has a family representative on their IOG, which includes family advocacy organization representative, a family advocate/systems navigator/advocate, family member, or youth member (Annual Report MOU partner table).

Implemented common assessments/Implementing common consents/Sharing client-level data at ISST meetings. A checkmark in these areas signals that the CMP implements each of these practices as part of their efforts to reduce duplication in services (Annual Report, Common Consents/Assessments section, Yes to Item 2 (consents), Yes to Item 1 (assessments/screens); and Data/Information Sharing section, Yes to Item 1b (share information about individual youth at ISST meetings)).

Developed an integrated plan. A checkmark in this area is an indication that the CMP employs the practice of developing a single plan that is shared with multiple providers (Annual Report, ISST section, Item 7, response option 1). In FY 2013, the CMPs that did not have a checkmark indicated that they implement a practice where multiple plans can be developed, but that services are coordinated with multiple providers.

Applied evidence informed models and services. A checkmark in this area signals that the CMP has indicated that they utilize evidence informed practice models as part of their ISST services or that they offer evidence based services as part of their programming. This was assessed as all CMPs indicating "yes" to Practice Models section, list of models in Item 1 table. These include High Fidelity Wraparound/Wraparound, Multi-Systemic Therapy, Team Decision Making, Family Group Conferencing, Functional Family Therapy, Crossover Youth Practice Model, or other programs with established evidence.

Involved families in service provision to other families/Involved families in development of plan/Provided families with copies of the plan. A checkmark in these areas signals that the CMP indicated that they either "frequently" or "always" have these practices in place (Annual Report, Family Involvement - Involvement in Services section - Item 2 response 2 (involve families in service provision), response 4 (involve families in service plan), response 5 (families given copy of plan)). Those who do not have a checkmark indicated that they "sometimes" or otherwise less frequently implement these practices.

Measured family involvement. A checkmark in this area signals that a CMP indicated that they either have a method in place to measure family involvement or that they described some way that their CMP measures family involvement (Annual Report, Evaluation and Measurement of Family Involvement, Yes to Item 1).

Share staffing costs/Share administrative costs/Share new program costs. A checkmark in this area signals that the CMP indicated that they either "frequently" or "always" have these practices in place (Annual Report, Cost Sharing, Item 1, responses 1, 3, and 5). Those who do not have a checkmark indicated that they "sometimes" or otherwise less frequently implement these practices.

Obtained external funding. A checkmark signals that the CMP reported that they have been able to secure external funding for their CMP (Annual Report, Costs – Leveraging of State Incentive Dollars, Yes to Item 1).

Measured cost savings. A checkmark signals that the CMP reported some quantified cost savings realized as a result of their CMP efforts, programs, or partner programs (Annual Report, Costs Tables Template, multiple source items were reviewed to identify quantified savings). Note that no CMPs indicated that they measure cost savings specifically in relation to their collaborative management efforts (Annual Report, Cost Savings section, Item 1).

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Table 1. Indicators reflecting key CMP components, by CMP

CMP name	IOG representation		Processes to reduce duplication in services				Use of EBPs	Promotion of family engagement				Support for cost shifting, cost sharing, & cost savings				
	Maintained all nine mandated IOG partners	Maintained family representation on IOG	Implemented common assessments	Implemented common consents	Shared client-level data at ISST meetings	Developed integrated plans	Applied evidence informed ISST models and services	Involved families in service provision to other families	Involved families in development of plans	Provided families with copies of plans	Measured family involvement	Shared staffing costs	Shared administrative costs	Shared new program costs	Obtained external funding	Measured cost savings in ISST or partner program
Adams		✓	✓		✓	✓	✓	✓	✓	✓	✓					
Alamosa		✓			✓	✓	✓		✓	✓	✓				✓	
Boulder	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	
Chaffee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Conejos					✓		✓		✓	✓	✓			✓	✓	
Crowley/Otero			✓	✓	✓	✓	✓		✓	✓	✓					
Denver	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓					
Douglas	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Eagle	✓		✓	✓	✓	✓	✓		✓	✓	✓				✓	
El Paso	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Elbert		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					
Fremont		✓	✓		✓	✓	✓	✓	✓	✓		✓	✓			✓
Garfield	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓		
Grand	✓	✓		✓	✓		✓		✓	✓	✓	✓		✓	✓	
Gunnison/Hinsdale	✓		✓	✓	✓		✓		✓	✓	✓				✓	✓
Huerfano	✓	✓			✓		✓	✓	✓	✓	✓			✓	✓	

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CMP name	IOG representation		Processes to reduce duplication in services				Use of EBPs	Promotion of family engagement				Support for cost shifting, cost sharing, & cost savings				
	Maintained all nine mandated IOG partners	Maintained family representation on IOG	Implemented common assessments	Implemented common consents	Shared client-level data at ISST meetings	Developed integrated plans	Applied evidence informed ISST models and services	Involved families in service provision to other families	Involved families in development of plans	Provided families with copies of plans	Measured family involvement	Shared staffing costs	Shared administrative costs	Shared new program costs	Obtained external funding	Measured cost savings in ISST or partner program
Jefferson		✓	✓		✓	✓	✓	✓	✓	✓	✓					
Lake		✓		✓	✓	✓	✓	✓	✓	✓		✓				
Larimer	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓					✓
Lincoln			✓	✓	✓	✓	✓	✓	✓	✓	✓					
Logan	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓				
Mesa	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	
Moffat		✓		✓	✓	✓	✓		✓	✓		✓	✓	✓		
Montezuma/Dolores	✓	✓	✓	✓	✓		✓	✓		✓			✓	✓		
Montrose	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Morgan	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Park	✓	✓		✓	✓	✓	✓		✓	✓	✓					
Pueblo		✓			✓	✓	✓		✓			✓	✓		✓	
Rio Grande					✓		✓		✓	✓	✓			✓	✓	
Routt	✓			✓	✓	✓	✓	✓	✓	✓	✓					
Teller	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓				✓	
Weld	✓		✓	✓	✓		✓	✓	✓	✓	✓			✓	✓	

Appendix F. Data Sources

Table 1 below provides details regarding data sources for information included in the FY 2013 Evaluation Report.

Table 1. Data sources utilized in the FY 2013 evaluation report

Data source	Description	Type of data collected	Total sample size
Annual Report	The Annual Report is developed in partnership with the Evaluation Subcommittee of the Statewide Steering Committee and is designed to collect data to meet state reporting requirements. It is administered to all counties at the end of each fiscal year. CMP coordinators report data aggregated across their local programs and services.	The Annual Report is divided into the following sections: • Members • Population • Legislative Process Goals • Collaborative Structures and Process • Family Involvement • Costs • Local Performance Goals (Incentivized Outcomes) • Costs	32 CMPs representing 35 counties submitted a FY12-13 Annual Report
CMP on-line client-level database [Efforts to Outcomes (ETO)]	CMPs complete a Client-Tracking Form at the initial ISST meeting for every served youth. The data collected on these forms are then entered into Efforts to Outcomes (ETO)™, an on-line client-level database, which is managed by OMNI Institute, or an approved local database. Data entered into a local database are uploaded into ETO at the end of each fiscal year and included in the statewide evaluation. Summary reports can be run at the state- and/or CMP-level by authorized users.	Data collected from the Client-Tracking Form include the following: • Client demographics • Youth involvement in systems/organizations at ISST enrollment • Referral source • Systems/organization/agencies involved in ISST meeting • Family involvement • Agencies or providers with role in delivering services • Agencies or providers with role in paying for services • Potential target outcome/treatment goals for family • Exit information, if applicable New for FY 2014: • Commonly-reported planning models applied during initial ISST meeting	Number of unduplicated ISST Client-Tracking forms entered into ETO during FY 2013 for all CMPs: 3,259

Data source	Description	Type of data collected	Total sample size
State-agency databases (e.g., Trails, ICON/Eclipse)	CMPs locate and record child identifier numbers (e.g., Trails ID or ML number) when youth are involved in child welfare or the judicial system in the Client Tracking Form and enter these into ETO. During the statewide data auditing and analyses process, these identifiers are cross-walked with data from state-agency databases, including Trails from Child Welfare and ICON/Eclipse from Judicial, and CMPs are contacted regarding mismatched data. The identifiers are then used to pull outcome data at client level to facilitate calculation of child welfare and juvenile justice statewide indicators for inclusion in the year-end evaluation report.	The following outcomes are calculated by using state-agency data: *CDHS Trails database* • Increase stability: prevent new involvements in child welfare system • Increase safety: prevent abuse • Increase stability: low number of moves while in placement • Increase stability: discharge to a permanent home *State Judicial ICON/Eclipse database* • Prevent juvenile justice involvement: prevent involvement with probation • Increase successful intervention: increase rates of successful completion of probation • Increase successful intervention: decrease rates of probation revocations • Increase successful intervention: decrease rates of pre-release recidivism	All unduplicated cases are matched to state databases. For FY 2013, the total number of unduplicated cases included in outcome analysis was 3,259.
Collaborative and Effectiveness Survey	Each spring, OMNI works with CMP coordinators to administer the Collaboration and Success Survey to IOG members. The survey assesses their perceptions of their CMP structure, collaborative processes, and outcomes. CMPs that achieve a large enough participating sample (n=7) receive scale averages for the years in which their CMP completed the survey.	The Collaborative and Effectiveness Survey results in mean scale scores in the following areas: • Collaboration: structural integrity, authenticity, overall quality process, strong leadership, structure, and members • Overall success: general success, community involvement & collaboration, quality of services, duplication of services, fragmentation of services, outcomes, costs, and family involvement	Number of counties that received a Collaboration Effectiveness Report in FY 2013: 22 (8 counties did not receive a report because they did not achieve a large enough sample size, and 2 new CMP counties chose not to participate in this effort)

Appendix G. Resources and Products from Statewide Evaluation

Below is a list and brief descriptions of select reports and other resources developed during the course of the CMP statewide evaluation to date. These documents can be accessed using the following link to the CMP portal: http://collaboration.omni.org/sites/1451/SitePages/Home.aspx

Category	Report(s)	Description
Annual Evaluation Reports	Year 1 – FY 2010 Year 2 – FY 2011 Year 3 – FY 2012 Year 4 – FY 2013	These reports describe statewide evaluation goals and methods, and present findings from qualitative and quantitative analysis of data submitted in annual reports and other data collection efforts, including client-level data beginning in Year 3. Each report addresses legislative reporting requirements, including numbers served and statewide and local-level outcomes of ISST-served children and families, progress in reducing duplication and fragmentation, quality and effectiveness of services, cost-sharing and cost-savings, and implementation barriers.
State Management Survey Findings	FY 2010 FY 2011 FY 2012 FY 2013	Each fall, State Steering Committee members and IOG Coordinators complete the State Management Survey, an online survey designed to elicit feedback regarding CMP management, progress, and areas for further development. Reports present results from the survey, which includes items that assess progress and functioning of the State Management Office, the State Steering Committee, the Family Voice & Choice Subcommittee, the Evaluation Subcommittee, and the overall HB 1451 Program.
Collaboration and Overall Success Survey	Initial Data Summary: 2010 County-level Reports: 2010, 2011, 2012, 2013	The surveys assess IOG members' perceptions of their CMP's collaborative processes, as well as the perceived success of their collaborative efforts on several goals of the state legislation. The initial report provides a summary of findings from surveys administered to IOG members in spring of 2010, and includes analysis of the psychometric properties and factor structures of the scale scores. Each subsequent spring, the survey has been re-administered and county-level reports have been distributed to provide assessment of progress in collaborative processes and outcomes. Beginning in 2012, a Collaboration Guide has been disseminated with county-level reports to support local quality improvement efforts.
Collaborative Successes/ Practices	Collaborative Processes and Emerging Best Practices (2010)	This report summarizes the results of in-depth interviews conducted with a sample of CMP stakeholders (local IOG members) and responses to open-ended questions from a survey on the qualities of collaboration efforts. The report provides a discussion of the major themes that reflect findings, along with a brief presentation of potential best practices.

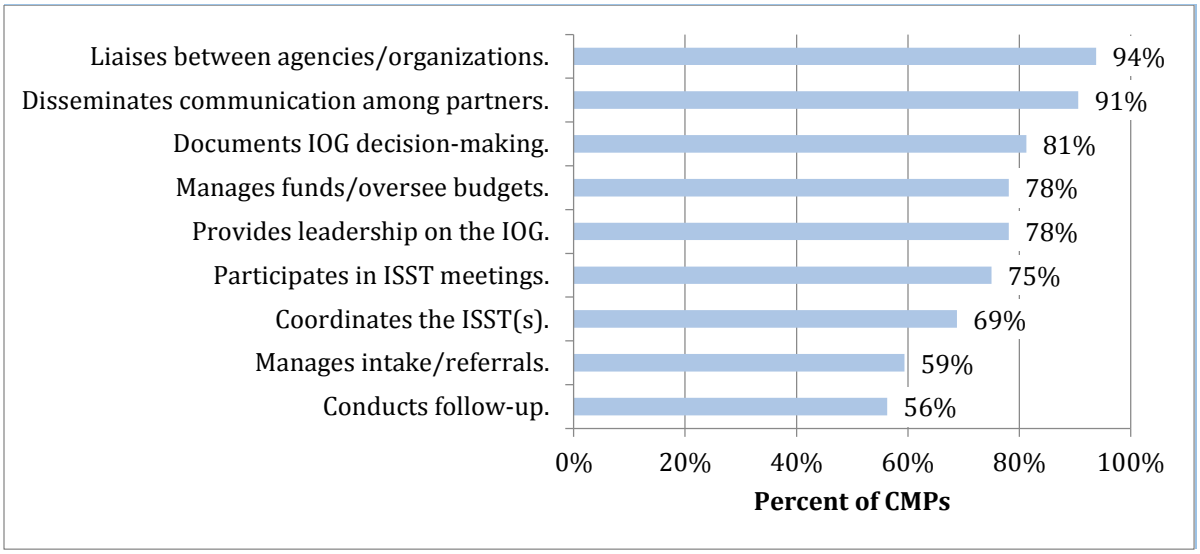
Category	Report(s)	Description
Child Welfare Data Indicators by County	Summary of Select Child Welfare Data Indicators by County (2010)	This report presents county-level "snapshots" of performance on six child welfare data indicators for the time period of 2003 to 2009 (represented in averages across years), as defined by the U.S. Department of Health and Human Services and reported to the Colorado Department of Human Services through the Trails database. This report also provides general background information on the available county-level statewide data related to CMP efforts.
Brief Report: Support for CMP Models	Emerging Evidence Supporting Collaborative Management Programs (2010)	OMNI Institute prepared a brief document in Summer 2010 detailing evidence that supports the success of community collaboratives to meet legislation goals. The document includes a summary of the Systems of Care (SOC) philosophy and highlights the High Fidelity Wraparound approach as one model to implement collaborative care practices to improve child and family outcomes.
State Evaluation and Measurement Plan	Year 2 Progress Report: Outcomes Workgroup (2011) State Measurement Plan Phase I: Brief Summary for CMP Coordinators and IOGs (2011) & PowerPoint Presentation for IOGs (2011) State Measurement Plan Phase II: Brief Summary on Education/Health Mental Health Indicators (2012)	This report summarizes the results and recommendations of the Outcomes Workgroup, which was convened to focus measurement on a small set of well-defined, uniformly measured outcomes, including child welfare and juvenile justice outcome indicators. It presents the measurement plan that emerged from this process. OMNI developed a brief summary of the state measurement plan for dissemination among CMP coordinators and for their IOGs. The purpose of this summary was to detail the rationale, objectives, data indicators, data collection strategies, and next steps for the implementation of the state measurement plan. The Phase II report describes the collaborative process that followed the Outcomes Workgroup efforts, that was designed to identify, select, and design measurement strategies for collecting standard outcome data in the education and health/mental health domains.
Brief Report: Prevention programs in child welfare	Current Practices in the Prevention of Child Abuse and Neglect (2011)	This brief report provides an overview of evidence-based programs and interventions most widely recognized in the area of child abuse prevention. Also included are discussions about the theoretical frameworks that provide the basis for these evidence-based practices, as well as links to more information about additional promising programs.

Category	Report(s)	Description
Family Involvement	Family Involvement Survey Report (2011)	In Summer 2011, the Family Voice and Choice Committee collected data related to CMP family involvement in order to understand family advocacy activity as implemented among CMP counties. This report highlights preliminary findings from data collection efforts, including an overview of current family advocacy activities, as well as a discussion for resource development and training opportunities for CMP counties.
CMP ETO Measures and Reports	CMP ETO Users' Manual CMP ETO Reports Manual ISST Client Tracking Form and Tutorial Education Indicators Tracking Form and Tutorial Health/Mental Health Indicators Tracking Form and Tutorial ISST Aggregate Report Education and Health/Mental Health Indicators Report (2012, 2013)	These measures and corresponding manuals and reports, are designed to support CMPs in collecting, entering, and generating summary reports of select process and outcome indicators reflecting their ISST-served children and families, in a dynamic online data system (ETO). Process measures include: client identifiers used to match to child welfare and juvenile justice state data systems, client demographics, development of an integrated plan, target outcomes, participation of family in planning meetings, and number and type of systems: families are involved in at intake; participating in planning meetings; providing services as part of the plan; and paying for services provided in the plan. Outcome measures collected and reported through the CMP ETO database include school attendance, enrollment, and achievement; and mental health functioning, substance use treatment, and access to health care providers.
Family Feedback	Family Feedback Form – anonymous and non-anonymous versions and reports (2013)	This measure, adapted from the nationally-validated Youth Services Survey for Families, assesses family perceptions of service delivery. Two methods of data collection and reporting were developed: 1) a non-anonymous method whereby the measure is entered into the CMP ETO database and linked to other case data; and 2) an anonymous method whereby families enter data directly into an online survey site where no identifying information is tracked other than CMP name. Items from this measure align with those included in the SAMHSA Systems of Care evaluation. The non-anonymous method of data collection allows for multiple administrations and monitoring of family perceptions of key components over time.

Appendix H. CMP Coordinator Roles

The figure below shows the percent of CMPs who reported that the CMP coordinator fulfilled each specified role.

Figure 1. Roles of CMP coordinators in FY 2013



Appendix I. Eligible and Served Populations

Who is eligible for CMP services?

Specific target populations that are eligible for CMP services are defined by IOGs at the local level, leading to a variety of ways that eligibility is defined across the state. In FY2013, CMPs provided the estimated numbers of total eligible youth by service system/type (see Table 1 below), which totaled 102,797 youth across the state; however, these reports contain known but unquantifiable duplication as youth are represented in multiple systems of care. This total is larger than the 70,000 total number of youth reported as eligible for CMP services in FY2012.[10] All totals of eligible populations provided by CMPs through annual reporting should be subject to some caution when interpreting totals, as multiple CMPs have indicated that these totals contain estimates as well as known duplication.

Table 1. Number of youth eligible for CMP services by partner/provider, FY 2013

Categories of eligible youth	Number of CMPs reporting	Range of eligible populations	Mean	Total across CMPs
Youth with open child welfare involvement	31	(0 - 5,304)	630	19,536
Youth served by public health department programs	25	(0 - 6,500)	574	14,356
Youth with school IEPs	29	(0 - 6,124)	408	11,839
Youth served by partnering mental health providers	31	(0 - 1,370)	219	6,804
Youth receiving counseling services at school	27	(0 - 2,578)	201	5,426
Youth served by domestic violence organizations	28	(0 - 2,193)	156	4,364
Youth served by partnering Behavioral Health Organizations	28	(0 - 1,278)	149	4,166
Youth on probation	30	(0 - 630)	116	3,478
Youth served by SB-94	31	(0 - 941)	103	3,192
Youth in DYC Detention	27	(0 - 1,093)	111	2,989
Youth served by juvenile assessment centers (JACs)	28	(0 - 1,737)	101	2,841
Youth considered Habitually Truant (per state definition)[11]	25	(0 - 738)	105	2,631
Youth on diversion	31	(0 - 300)	33	1,028
Youth in DYC Commitment	29	(0 - 201)	11	322
Youth on parole	29	(0 - 115)	5	157

[10] It is possible that the larger number reported in FY 2013 is due to more complete reporting; many CMPs reported in FY 2012 that they were unable to obtain estimated or actual numbers of eligible youth in some systems/agencies.

[11] 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)).

Data reported about the individuals considered eligible for CMP services illustrate the variation in eligible populations across CMPs. The largest groups of eligible children across the CMPs were those being served by child welfare agencies through open involvement, by public health department programs, and by school IEPs (see Table 1 above for more details). The total number of eligible children in each category varies widely across CMPs; for example, the eligible number of youth served by public health department programs ranges from 0 to 6,500.

How many youth were reported as served by CMPs, by level and type of service delivery?

Table 2 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 2. Estimated CMP served population counts

Served population (N=32 CMPs)	Number of individuals served		
	Average	(Min. - Max.)	Total
Individuals Screened/Assessed for Services	883	(14 - 5537)	28250
Individuals Served by CMP Services	643	(8 - 3634)	20584
Individuals Served by an ISST	272	(8 - 2618)	8716
Individual Children/Youth Served by an ISST	170	(8 - 1261)	5263

Table 3 shows the number of youth served by ISSTs in FY 2012 compared to FY 2013 by county. These totals include newly enrolled cases as well as carryover cases from the previous fiscal year. As shown, the total number of youth served by ISSTs has increased from 7,333 cases in FY 2012 to 8,716 cases in FY 2013.

Table 3. Number of youth served by ISSTs in FY 2012 and FY 2013 including newly enrolled and carryover cases

CMP Name	FY2012		FY2013	
Adams	600	(8%)	365	(4%)
Alamosa	49	(0.7%)	75	(1%)
Boulder	171	(2%)	160	(2%)
Chaffee	59	(0.8%)	26	(0.3%)
Conejos	80	(1%)	65	(0.7%)
Crowley/Otero	--	--	12	(0.1%)
Denver	2068	(28%)	2618	(30%)
Douglas	19	(0.3%)	97	(1%)
Eagle	--	--	32	(0.4%)
El Paso	149	(2%)	277	(3%)
Elbert	18	(0.2%)	28	(0.3%)
Fremont	145	(2%)	362	(4%)
Garfield	118	(2%)	115	(1.3%)
Grand	20	(0.3%)	19	(0.2%)
Gunnison/Hinsdale	37	(0.5%)	31	(0.4%)
Huerfano	95	(1%)	77	(0.9%)
Jefferson	585	(8%)	1029	(12%)

CMP Name	FY2012		FY2013	
Lake	--	--	35	(0.4%)
Larimer	1935	(26%)	1412	(16%)
Lincoln	7	(0.1%)	10	(0.1%)
Logan	54	(0.7%)	83	(1%)
Mesa	143	(2%)	155	(2%)
Moffat	16	(0.2%)	19	(0.2%)
Montezuma-Dolores	20	(0.3%)	23	(0.3%)
Montrose	56	(0.8%)	62	(0.7%)
Morgan	124	(2%)	138	(2%)
Park	--	--	8	(0.1%)
Pueblo	18	(0.2%)	49	(0.6%)
Rio Grande	29	(0.4%)	31	(0.4%)
Routt	21	(0.3%)	20	(0.2%)
Teller	41	(0.6%)	184	(2%)
Weld	656	(9%)	1099	(13%)
TOTAL	**7333**	**(100%)**	**8716**	**(100%)**

As detailed in the body of the report, the total number of individual youth who were newly enrolled in FY 2013 and served by ISSTs is 5,263, per CMP responses as part of their annual reporting.[12] The following table shows this total displayed by each individual CMP.

Table 4. Number of youth served by ISSTs in FY2013 by CMP

CMP name	Youth served by ISSTs (newly enrolled in FY 2013)	
Adams	365	(7%)
Alamosa	63	(1%)
Boulder	160	(3%)
Chaffee	21	(0.4%)
Conejos	65	(1%)
Crowley/Otero	12	(0.2%)
Denver	318	(6%)
Douglas	84	(2%)
Eagle	32	(1%)
Elbert	28	(1%)
El Paso	Not reported	(0%)
Fremont	362	(7%)
Garfield	79	(2%)
Grand	10	(0.2%)
Gunnison/Hinsdale	18	(0.3%)
Huerfano	55	(1%)

[12] As noted in the body of the report, the total number of youth whose information is entered into the CMP database is an underestimation of the actual number of youth served by ISSTs, as four CMPs indicated that they do not enter all of their ISST-served youth in the CMP database. The number of unduplicated youth served by ISSTs in FY 2013, per the CMP ETO database, is 3,259.

CMP name	Youth served by ISSTs (newly enrolled in FY 2013)	
Jefferson	1029	(20%)
Lake	52	(1%)
Larimer	1261	(24%)
Lincoln	10	(0.2%)
Logan	56	(1%)
Mesa	155	(3%)
Moffat	12	(0.2%)
Montezuma/Dolores	17	(0.3%)
Montrose	31	(1%)
Morgan	133	(3%)
Park	8	(0.2%)
Pueblo	28	(1%)
Rio Grande	31	(1%)
Routt	19	(0.4%)
Teller	180	(3%)
Weld	569	(11%)
TOTAL	**5263**	**(100%)**

Appendix J. Description of the Statewide Indicator Measurement Process

History of statewide indicator measurement

The first statewide evaluation year (FY 2010) of CMP services revealed considerable variation in local performance measures. A total of 155 local performance indicators representing 31 different outcome areas were identified across the 27 participating CMPs. It was determined that standardized performance measures were necessary to ensure continued legislative support and funding, improve service delivery and programs, support refinement of the incentive formula, and provide evidence that collaborative management approaches lead to improved outcomes for children, families, and systems of care.

In the second year of the statewide evaluation (FY 2011), an Outcomes Workgroup, comprised of key CMP stakeholders[13] and led by the CMP Evaluation Subcommittee (SEC) and OMNI Institute, was assembled and tasked with:

- exploring the benefits of implementing uniform measurement processes,
- examining key assumptions and intentions of the legislation in order to identify critical measurement areas,
- selecting a set of uniform indicators, and
- developing a standard measurement approach to be implemented statewide.

Throughout FY 2011 and FY 2012, the Outcomes Workgroup worked to identify a set of standard outcome measures that to the extent possible, were reflective of local CMP target goals and programs, were already defined with existing data sources selected, were already being collected at the individual client level, and could demonstrate change over a year-long period. For each indicator, members prioritized potential indicators based on identified benefits and drawbacks, available data sources, and issues for further consideration. The final statewide evaluation plan outlined the collection and analysis of a set of four client-level process and outcome indicators in both the child welfare and juvenile justice domains. The proposed indicators were submitted to and approved by the CMP Evaluation Committee in FY 2011. Data collection began shortly thereafter, in FY 2012.

Additional indicators for education and health/mental health were identified in FY 2012 through a process of collaboration between stakeholders, evaluators, and local experts. OMNI Institute conducted interviews and discussion groups to explore local outcomes, activities, and data collection processes and identified additional indicators in each of these two domains. The

[13] Over 30 stakeholders participated in three workgroup meetings; participants included 17 CMP coordinators and/or IOG representatives, 3 CDHS CMP program administrators, 4 CDHS data analyst consultants, 2 State Judicial data analyst consultants, 1 state agency representatives from Division of Criminal Justice, 1 judicial district probation specialist, 1 representative from the Federation of Families, and multiple OMNI evaluation team members.

education and health/mental health outcome indicators were approved by the State Steering Committee in May 2012, and data collection for these indicators began on a pilot basis in FY 2013.

All outcome indicators that were selected are described in Sections V and VI of the report, where the indicators and subsequent findings are outlined in greater detail.

Data collection for statewide indicator measurement

Processes to ensure standard data collection and management of statewide outcome indicator data as outlined by the newly approved statewide measurement plan were implemented and refined throughout FY 2012 and FY 2013. Because child welfare and juvenile justice outcome indicators were being collected on an ongoing basis through existing statewide databases (Trails and ICON/Eclipse), data collection for outcome indicators in these two domains was easily integrated with existing efforts related to gathering client-level process indicator data. Specifically, a two-page data collection form, the ISST Client Tracking Form, was created to collect items required for the measurement of CMP process indicators. The ISST Client Tracking form includes client demographics, information related to the ISST process at the client level, as well as state identifier numbers from Trails and ICON/Eclipse from local CMPs, which allowed OMNI Institute to supplement CMP collected data with information obtained from these respective state data sources.

The education and health/mental health indicators required data collection for individual youth at the local CMP level both pre- and post-CMP services. There is currently no viable existing statewide data source that meet these criteria. Instead, data related to education and health/mental health services had to be gathered by CMP coordinators and staff. Pre- and post-data collection tools for these indicators were implemented as a voluntary pilot during FY 2013 and FY 2014.

To support local- and state-level data tracking and analysis, an on-line client-level CMP database built into the Efforts to Outcomes (ETO)™ software platform was developed specifically for data collection efforts related to the CMP statewide evaluation. ETO is a well-established social service data tracking system that allows for easy integration of additional data items. Additionally, custom reports can be created so that local CMPs can track and report on service information throughout the year. The CMP database currently serves to house and manage process indicator data, state identifier numbers for Trails and ICON/Eclipse databases, and pilot data for education and health/mental health outcome indicators. Most CMPs 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.

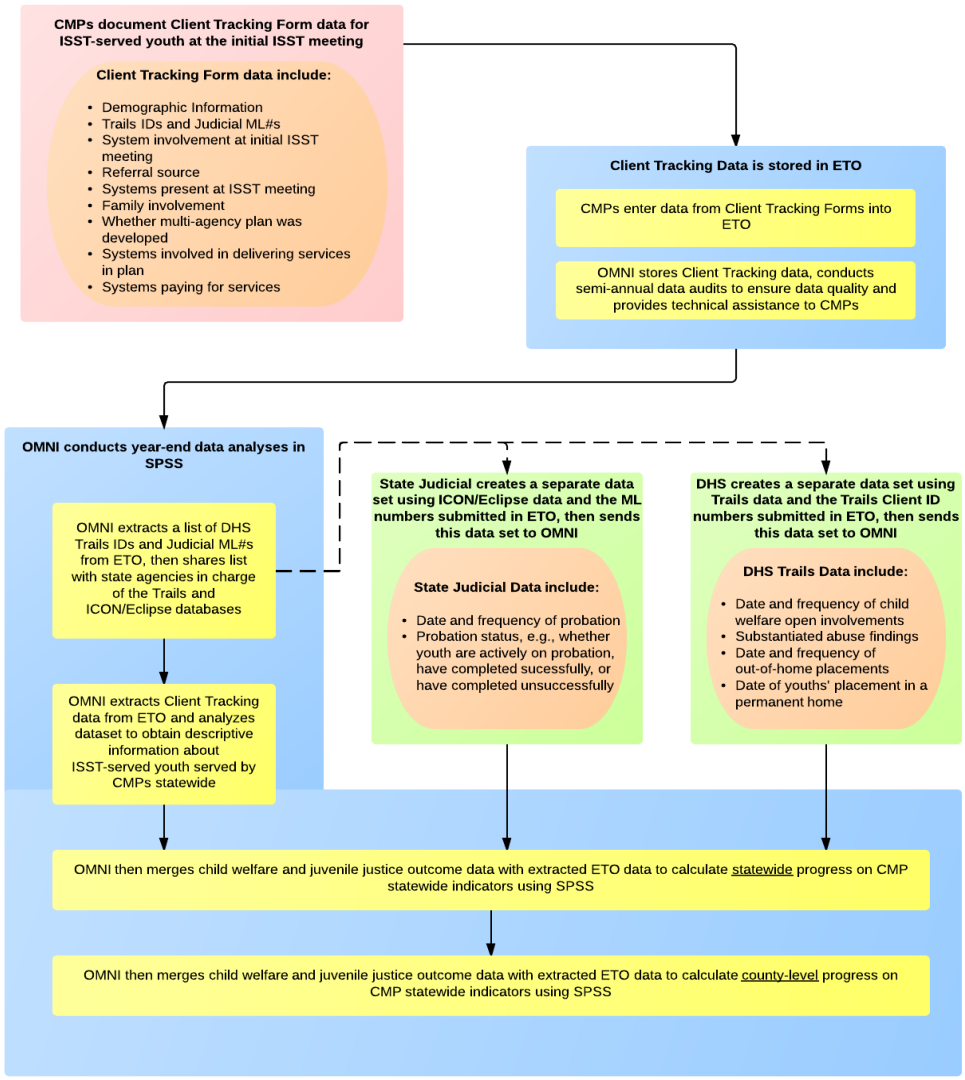
Preparation of statewide indicator data

All data related to child welfare and juvenile justice outcomes for ISST-served youth in FY 2012 and FY 2013 were extracted from the CMP ETO database, with the understanding that not all CMPs enter all of their ISST-served youth into the CMP database. The resulting dataset was sent to State Judicial and the Department of Human Services to match CMP youth records with existing Trails and ICON/Eclipse records on names, birthdates, and Trails ID/ML. All data transfers were conducted utilizing secure encryption software programs and processes.

The matched dataset containing data from the CMP database as well as Trails and ICON/Eclipse was reviewed for missing or inaccurate data related to Trails ID/ML numbers. OMNI Evaluation Liaisons then consulted with individual CMP coordinators to determine next steps for the affected

cases. 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. Once all CMP coordinators had the opportunity to provide feedback on the identified data issues, data were extracted from the CMP database a second time 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. The final dataset included records where the ISST meeting date was between July 1, 2011 and June 30, 2013.[14] Duplicate youth records were not included in the dataset. The record with the earliest ISST meeting date regardless of CMP was kept, while subsequent entries were dropped from the analysis. See figure 1 for additional details related to this process.

Figure 1. The CMP Data Collection and Analysis Process



[14] Records where ISST meeting dates were left blank were not included in the analysis.

Description of ISST process data collection tools and utilization

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 completed the data collection forms and were responsible for entering the information into the CMP database. Prior to implementation of data collection protocols, OMNI provided training and technical assistance for client-level data collection allowing for 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, other CMPs made different arrangements:

- **Adams, Morgan, and Weld**: Because of concern over sharing youths' names in the CMP database, staff entered youth information into the CMP database without including their names. Trails IDs and ML numbers were added to these records at the end of the fiscal year.
- **Boulder**: Because Boulder's CMP already uses a separate ETO site built to collect client-level data, OMNI collaborated with Boulder county CMP staff to extract data from their system and upload these data into the CMP database. OMNI reviews the data on a quarterly basis and uploads data into the CMP database on an annual basis.
- **Denver**: The Denver CMP tailored the standard CMP client tracking form for use with their CMP staff and partners.
- **Jefferson**: Jefferson CMP staff built additional data items into their locally-adapted Trails database to capture the statewide evaluation-specific information on youth served by their ISSTs. OMNI collaborated with Jefferson county CMP staff to extract data from their system and upload these data into the CMP database.
- **Larimer**: Larimer county staff worked with OMNI to revise their data collection efforts in Trails to more closely align with the process data elements that CMPs were collecting statewide. In FY 2012, data was transferred to OMNI for analysis. In FY 2013, Larimer's CMP began entering client-level data for one of their ISSTs directly into the CMP ETO database.
- **Mesa**: 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 through June 2012. In June 2012, OMNI worked with the CMP to data into the CMP database so that Mesa county staff could enter data directly into the CMP database.
- **Rio Grande**: Because this CMP was in its initial year in FY 2012, Rio Grande was not required to enter client-level data into the CMP database. Finalized processes to enter data into the CMP database occurred in FY 2013.
- **Boulder, Chaffee, Denver, Eagle, Fremont, Huerfano, Jefferson, Mesa, Morgan, Teller**: Ten CMPs elected to complete and enter multiple forms per client-level (for at least a subset of their cases) into the CMP database, for clients who had additional (follow-up) ISST meetings or who were participating in multiple ISST services or programs in FY 2012.

Child welfare and juvenile justice statewide indicator data analysis

Once child welfare and judicial data were matched to data extracted from the CMP database, analyses were conducted that reviewed the progress on the four CMP statewide indicators for the child welfare domain and the four indicators for the juvenile justice domain, as detailed in Table 1 below.

Table 1: Child welfare and juvenile justice statewide outcome indicators

Outcome	...as determined by:
Increase safety among children served by the CMP	Number (percent) of CMP youth with no substantiated abuse finding after CMP services began
Increase stability of children served by the CMP	Number (percent) of CMP youth with no open involvements/no re-involvements in Trails after CMP services began
	Number of CMP youth who experience two or fewer moves while in out of home placement
	Number (percent) of CMP youth discharged to a permanent home
Prevent involvement with the juvenile justice system	Number (percent) of CMP youth who did not get on probation after CMP services began
Increase successful intervention for children with juvenile justice involvement	Number (percent) of CMP youth who successfully complete probation Number (percent) of revocations by technical violations, resulting in unsuccessful completion of probation
	Number (percent) of CMP youth who recidivate, resulting in unsuccessful completion of probation

The methodology for the analysis of statewide outcome indicators for the child welfare and juvenile justice domains was revised for FY 2013 to accommodate the additional years' worth of data. Because very few youth who started ISST services in FY2013 had one years' worth of data, it was not possible to separate youth into two fiscal year cohorts based on ISST start date. These year-to-year comparisons will be possible in the future as the one-year follow-up period elapses for a larger number of youth. Additionally, outcomes were evaluated for the year following the ISST start date. Limiting the follow up to one year increases the likelihood that changes in outcome indicators are due to ISST service delivery rather than other services or events that may occur long after the ISST services. All methods used for analyzing child welfare and juvenile justice data were shared with and approved by representatives from CDHS and State Judicial.

All youth within the entire CMP-served population who had a CMP start date in FY 2012 or FY 2013 (i.e., July 1, 2011 to June 30, 2013) and who had one year of follow up data available were included in the analysis. The CMP evaluation team then examined outcomes experienced in the year after their CMP start date to measure progress. All outcome indicators were calculated for two samples:

1. All CMP ISST-served cases that meet the criteria outlined above (start data in FY 2012 or FY 2013, with one year of follow up data available)

2. All CMP ISST-served cases that meet the criteria outlined above (start data in FY 2012 or FY 2013, with one year of follow up data available), where the relevant indicator was identified by the ISST as being a target outcome for ISST intervention services.

The tables below (Table 2 and Table 3) outline the analysis conducted with each sample.

Table 2: Analyses conducted for child welfare outcome indicators

Indicator	Numerator: Of youth included in each denominator:	Denominator
Number (percent) of CMP youth with no substantiated abuse finding after CMP services began	Youth who did not have a substantiated abuse finding within one year after their CMP start date	Youth with a CMP start date in FY2012 or FY2013 who have one year of follow up data available
Number (percent) of CMP youth with no new open involvements in Trails after CMP services began	Youth who had no open involvement start date within one year after their CMP start date	
Number (percent) of CMP youth who experience two or fewer moves while in out of home placement	Youth who had been placed outside of the home at some point while receiving CMP services AND have experienced two or fewer legitimate moves within one year after their CMP start date	Youth with a CMP start date in FY2012 or FY2013 who have one year of follow up data available AND were placed out of the home at some point while receiving CMP services
Number (percent) of CMP youth discharged to a permanent home	Youth who had been placed outside of the home at some point while receiving CMP services AND had been placed in a permanent home within one year after their CMP start date as their final recorded move	Youth with a CMP start date in FY2012 or FY2013 who have one year of follow up data available AND were placed out of the home at some point while receiving CMP services AND had a completed discharge date recorded in Trails

Table 3: Analyses conducted for juvenile justice outcome indicators

Indicator	Numerator: Of youth included in each denominator:	Denominator
Number (percent) of CMP youth who did not get on probation after CMP services began	Youth who did not have a probation start date within one year after their CMP start date	Youth with a CMP start date in FY2012 or FY2013 who have one year of follow up data available
Number (percent) of CMP youth who successfully complete probation	Youth who successfully completed probation within one year after their CMP start date	Youth with a CMP start date in FY2012 or FY2013 who have one year of follow up data available AND were on probation within the last 6 months before their CMP start date AND have terminated their probation status
Number (percent) of revocations by technical violations, resulting in unsuccessful completion of probation	Youth who had their probation revoked due to a technical violation within one year after their CMP start date	
Number (percent) of CMP youth who recidivate, resulting in unsuccessful completion of probation	Youth who had their probation revoked due to re-offense within one year after their CMP start date	

The methodology described above does not include education and health/mental health outcome indicators, as data collection for these two domains is still on-going. To date, less than 8% of ISST-served cases have data entered for these indicators (see Section VI of this report for more details). Analysis of outcome indicators for these two domains will be conducted once the amount of data collected meets a threshold that would provide meaningful representation of CMP performance in cross-site analysis.

Appendix K. Outcomes among all CMP ISST-Served Cases: Statewide Indicators

Section VI of this report described CMP statewide progress on child welfare and juvenile justice outcomes calculated for ISST-served cases in the year following the initial ISST meeting. Performance on each indicator reported in that section was calculated on the subset of the ISST-served population where the outcome was specified as a target goal for the child and family's intervention services (i.e., where the outcome was specified as relevant, which serves as a proxy for the determination of risk for that outcome if services were not provided). This appendix describes performance on child welfare and juvenile justice indicators as calculated for the entire ISST-served population (all available cases with a year of follow up data available after the initial ISST meeting).

As previously mentioned, the statewide indicators are designed to address the following key questions: for children and youth served by ISSTs, what are their outcomes with regards to:

- Child safety and stability/permanency?
- Probation outcomes/recidivism?

For descriptive information about CMP progress on education and health/mental health statewide indicators, please see Section VI.

Child Welfare: What are the child stability/permanency and safety outcomes for all children and families served by ISSTs?

The tables below present data for indicators in the four key areas relevant to child stability/permanency and safety for families served by CMP ISSTs. Results in each of these areas are presented in a summary table, including the focus or purpose of the indicators, the number of youth for whom the indicator is relevant, and the results achieved by CMPs. Comparisons with similar data reported by state entities are included, where relevant data are available.

Table 1: Preventing new/re-involvements in child welfare

Purpose of the indicator(s): Assess the extent to which ISST-served youth avoided involvement or re-involvement in the child welfare system.	
Number of CMP youth with one year of data available post initial ISST: 4579	
Indicator	**Results**
How many youth had **no open involvements** that occurred in the year following their initial ISST meeting?	Number: 2643 Rate: 58%
How many youth who had a closed involvement prior to ISST services, had **no new/re-involvements** in the year following their initial ISST meeting?	Number: 64 Rate: 32%
Interpretation: Among all ISST-served youth who entered ISST services, 58% were successfully averted from open involvement in the year after their initial ISST meeting. For those youth who had a prior history of involvements, 32% were prevented from re-involvement in the year following their ISST meeting.	

Table 2: Minimizing the number of moves while in out-of-home placement

	Purpose of the indicator(s): Assess the extent to which ISST-served youth were placed out of the home, as well as the number of moves they experienced while placed outside of the home.	
	Number of CMP youth in out-of-home placement: 1169	
	Indicator	**Results**
	How many of these youth experienced two or fewer moves?	Number: 963 Rate: 82%
	Interpretation: Approximately 82% of all ISST-served youth who were in out of home placement after their initial ISST meeting experienced two or fewer moves in the year after their initial ISST meeting.	

Table 3: Increasing discharges to a permanent home

	Purpose of the Indicator(s): Assess the rate at which ISST-served youth who were discharged from out-of-home placement were placed in a permanent home in the year following their initial ISST meeting.[xxxii]	
	Number of CMP youth who were in placement and discharged: 1048	
	Indicator	**Results**
	How many of these youth were discharged to a permanent home?	Number: 781 Rate: 75%
	Interpretation: Approximately three-quarters (75%) of CMP ISST-served youth who were in out-of-home placement with case closure were reunified or placed in a permanent home.	
	Comparison to state-wide child welfare data: This is lower than the similar indicator tracked for FY 2012 for all closed cases within a 12-month period at the state level (92%).[15]	

[15] Permanent home designations include adoption, emancipation, guardianship, reunion with relatives, or placement with other relatives; per instructions from CDHS data analyst consultants.

Table 4: Preventing child abuse and neglect

Purpose of the indicator(s): Examine the extent to which ISST-served families successfully averted abuse and neglect, indicated by the absence of a substantiated abuse/neglect finding during the year following their initial ISST meeting.	
Number of CMP youth with one year of data available post initial ISST: 4579	
Indicator	**Results**
How many youth did not have a substantiated abuse/neglect finding in the year following their ISST meeting?	Number: 4379 Rate: 96%
Interpretation: In general, abuse/neglect findings among CMP ISST-served youth appear to be rare, with 96% of ISST-served youth with no substantiated reports in the year after their initial ISST meeting.	
Comparison to statewide child welfare data: Results provided by CDHS for all Colorado children and youth for FY2012 reveals a similar pattern, with 97% of cases reflecting absence of abuse/neglect within 12 months of case closure.[16]	

Juvenile Justice: What are the probation outcomes of children served by ISSTs?

The tables below present data for indicators in areas relevant to juvenile justice involvement for youth served by CMP ISSTs in the year following the ISST meeting. Results in each of these areas are presented in a summary table, including the focus or purpose of the indicators, the number of youth for whom the indicator is relevant, and the results achieved by CMPs. Comparisons with similar data reported by state entities are included, where relevant data are available.

Table 5. Preventing involvements/new involvements

Purpose of the indicator(s): Examine the extent to which ISST-served youth who avoided involvement with the juvenile probation system in the year after starting ISST services.	
Number of CMP youth with preventing involvement/new involvements with the juvenile justice system as a target goal: 4210	
Indicator	**Results**
How many youth did not start probation within one year of their initial ISST meeting?	Number: 3279 Rate: 89%
Interpretation: The large majority (89%) of CMP served cases were successfully diverted from entering probation in the year following their ISST services.	

[16] Entry into juvenile probation in the 6 month time period prior to the initial ISST was selected as a sample criteria in order to allow for the reasonable assumption that the ISST process may have been initiated due to recent probation involvement, and that the ISST process may have some impact on the probation outcome. This decision was reviewed and approved by State Judicial analyst consultants.

Table 6. Successful and unsuccessful termination of probation

	Purpose of the indicator(s): assess the outcome status of those ISST-served youth who were adjudicated to probation shortly before or after the time of their round the time of their initial ISST meeting (within the six-month period before or in the year after their ISST[xxxiii]) and terminated probation in the year following their initial ISST meeting.	
	Number of CMP youth who were recently adjudicated to probation and terminated probation in the year following their initial ISST meeting: 481	
	Indicator	**Results**
	How many of these youth terminated successfully in the year following their initial ISST meeting?	Number: 252 Rate: 52%
	How many of these youth were terminated with a revocation due to a technical violation?	Number: 161 Rate: 33%
	How many of these youth were terminated with revocation due to pre-release recidivism?	Number: 68 Rate: 14%
	Interpretation: Among CMP youth who entered ISST services with recently initiated probation services, half (52%) successfully terminated after their initial ISST meeting, and a third (33%) were revoked for technical violations, with the rest revoked for pre-release recidivism (14%).	
	Comparison to statewide child welfare data: Successful termination for CMP-served youth was lower than the state-reported rates among all terminated probations from FY 2012 (75%). Rates of revocation of probation were higher for CMP-served youth than state-reported rates among terminated juvenile probationers from FY 2012 (18% for technical violations and 8% for pre-release recidivism, respectively).[17]	

[17] Office of the State Court Administrator (2013). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2012 releases*. Retrieved on-line December 2013.

Appendix L. Local Performance Measures (Primary Incentivized Outcomes) for FY 2012 and FY 2013

Table 1 displays the local performance goals (primary incentivized outcomes) specified by CMPs in their FY 2012 MOUs (where goals were not specified, performance measures reported by CMPs in the FY 2012 annual reports were inserted) and in their FY 2013 annual reports. The first column lists the county, the second the domain (of the four CMP domains), and the third and fourth, the specified measure and target goal for each fiscal year as specified by CMPs. 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 not reported here.

Table 1. Primary incentivized outcomes for FY 2012 and FY 2013 by CMP

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Adams	JJ	Increase successful Truancy Court completion rates of youth referred to the Truancy Review Board	Decrease truancy court rates among children and youth referred to the Link and/ or ACTIT
Adams	HMH	Assess the need for Domestic Violence intervention/services to school aged children	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	Mapleton School District children will have improved overall grade average as a result of Boys and Girls club attendance.
Adams	CW	Increase school attendance of children exposed to Domestic Violence in their household in the last 30 days	10-20 families will receive individualized case management services
Alamosa	JJ	80% of probation youth served by the CMP will not have a revocation based on technical violations.	80% of the probation youth served by the CMP will not have a revocation based on a technical violation.
Alamosa	HMH	At least 85% of youth served by the collaborative Management Program will have required immunizations.	At least 85% of youth served by the CMP 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	75% of youth served by the CMP will not have an out-of-school suspension while receiving services
Alamosa	CW	≤ 25% of youth served by the CMP will have an OOH placement	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.
Boulder	JJ	Maintain current low commitment ADP with no more than a 20% variance in ADP.	Average Daily Population in DYC (Commitment). The goal will be to maintain current low commitment ADP with no more than a 20% variance in ADP.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Boulder	HMH	At least 65% of youth participating in intensive outpatient programs (ITOP & ISIS) to remain in treatment for 90 days or more.	Engagement in Treatment: at least 65% of youth participating in intensive outpatient programs 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.	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.	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	Successful Completion or Termination of Probation: 80% success rate among HB1451 referred juveniles in the justice system.	At least 75% of CMP youth will successfully complete probation and/or parole.
Chaffee	HMH	Improved Level of Functioning and Decrease in Problem Severity: Improvement by 10% in the Level of Functioning and Problem Severity of youth referred to HB1451.	Improvement by 10% in the Level of Functioning and Problem Severity of youth referred to HB 1451 as determined by the CCAR.
Chaffee	CW	Prevent Out-of Home Placement/ Increase Reunification: Chaffee County Department of Health & Human Services will have a 25% reduction in youth (1-2 youth) who have had 3 or more placements within 12 months of the latest removal from home.	At least 70 % of the CMP-served youth will have no substantiated abuse findings after CMP services begin.
Conejos	JJ	80% of the probation youth served by the ISST will not have a revocation based on technical violations.	80% of the probation youth served by the CMP will not have a revocation based on a technical violation.
Conejos	HMH	At least 85% of youth served by the CMP will have required immunizations.	At least 85% of youth served by the CMP 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.	75% of youth served by the CMP will not have an out-of-school suspension while receiving services.
Conejos	CW	≤ 25% of youth served by the CMP will have an OOH placement.	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.
Crowley Otero	JJ	n/a – new CMP	50% of CMP youth will successfully complete probation and/or parole.
Crowley Otero	HMH	n/a – new CMP	50% of CMP youth will successfully complete substance abuse treatment.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Crowley Otero	ED	n/a – new CMP	60% of CMP youth will remain enrolled in school while receiving ISST services.
Crowley Otero	CW	n/a – new CMP	75% of CMP youth with no substantiated abuse finding after CMP services begin.
Denver	JJ	50% of youth staffed through the DCP ISST's will complete probation and/or parole successfully.	52% 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.	70% of CMP youth/families that participate in TASC/CRAFT services will remain involved in services for a minimum of 90 days.
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.	Youth staffed through DCP ISST's will maintain a 90% "On Track to Graduate" rate in DPS for school year 12-13.
Denver	CW	90% of CMP youth will have no substantiated abuse finding after CMP services began.	90% of CMP youth will have no substantiated abuse finding after CMP services began.
Douglas	JJ	50% of CMP youth will successfully complete probation.	50% of CMP youth who will recidivate resulting in unsuccessful completion of probation.
Douglas	HMH	Reduce by 10% symptom severity as documented by the DLA-20 (GAF) generated by FREUD, for youth active with ADMHN.	80% of CMP youth with established: a) primary care provider, b) mental health provider, c) substance use provider, d) health insurance coverage, during ISST services.
Douglas	ED	Decrease number of missed class periods by 5% for youth served at ISST.	50% of youth demonstrating improved academic performance between ISST and end of school year.
Douglas	CW	25% or less of total CMP youth with new open involvements in Trails after CMP services began.	25% or less of CMP will have open involvements in Trails after CMP services start.
Eagle	JJ	Number (percent) of CMP youth who recidivate resulting in unsuccessful completion of probation and/or parole	Number 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	Number of youth identified as needing mental health services.
Eagle	ED	Number (percent) of students that miss >10% of student days in any grading period	Number 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	Number of CMP youth with new open involvements in Trails after CMP services begin.
El Paso	JJ	50% of youth on probation will not receive a new adjudication during participation in intervention.	50% of youth on probation will not receive a new adjudication during participation in intervention.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
El Paso	HMH	25% increase in level of functioning (determined by the CCAR).	25% increase in the level of functioning (as determined by CCAR).
El Paso	ED	50% decrease in incidents of suspension among participating youth.	50% decrease in youth with incidents of out of school suspensions or expulsions.
El Paso	CW	90% reduction in youth who have had 3 or more placements within 12 months of the latest removal from home.	90% reduction in youth who have had 3 or more placements within 12 months of the 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.	No more than 10% SRT youth will recidivate, resulting in unsuccessful completion of probation.
Elbert	HMH	Of the clients referred to MH services 90% will be enrolled and attending services at 90 day follow up.	95% of SRT youth with established providers: health, mental health, substance abuse, health insurance.
Elbert	ED	CMP served youth will have attendance rates within 10% of district average.	15% of youth served by SRT will have improved school attendance rate between first SRT meeting and end of year.
Elbert	CW	5% or fewer youth will have substantiated abuse finding entered in TRAILS after first ISST meeting.	95% of SRT youth will have no substantiated abuse findings after SRT services begin.
Fremont	ED	70% of the children referred to RE-1 & RE-2 truancy program will not be referred to Truancy Court	Improve school performance Improved school performance measure by a reduction in referrals for behavior or attendance problems for 80% of youth matched with a mentor.
Fremont	HMH	70% of youth enrolled in out-patient addictions services with RMBH will attend the program for more than 90 days	Increase mental health functioning of CMP youth- 40% of youth enrolled in additions services with RMBH will attend the program for 90 days or more.
Fremont	JJ	51% or more of the youth matched with a mentor will not become involved in the juvenile justice system	Prevent involvement in juvenile justice system -51% or more of the youth matched with a mentor will not become involved in JJ system during SFY 2013.
Fremont	CW	10% or less of the children served by ISST in foster care will experience 2 or more placement moves	Increase stability of children served by the CMP - 10% or less of the children in foster care will experience 2 or more placement moves.
Garfield	JJ	50% of youth who are on probation or parole and receive CMP services will successfully complete probation or parole.	60% of youth who receive CMP services will successfully complete probation and/or parole.
Garfield	CW	25% of children and youth involved with CMP will not have a new open involvement in TRAILS.	70% of youth who receive CMP services will not have new open involvement in TRAILS.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Garfield	ED	20% of CMP youth receiving services for school concerns will improve or maintain their school attendance after involvement with CMP.	80% of youth who receive CMP services will remain enrolled in school during the course of the ISST services.
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.	75% of youth who receive CMP services will improve problem severity scores and level of functioning determined by CCAR
Grand	JJ	Maintain the low level of DYC commitments of FST served youth.	60% of CMP youth will successfully complete probation and/or parole.
Grand	HMH	75% of eligible youth and families will receive CHP+ or Medicaid after enrollment in HB 1451	75% of eligible youth and families will receive CHP+ or Medicaid after Family Support Team (FST) services.
Grand	ED	75% of the youth referred to ISST will improve their school attendance after receiving FST services.	60% of CMP youth will show a reduction in disciplinary actions during the time of FST services.
Grand	CW	75% of FST served youth and families will not have any findings of substantiated abuse after 1451 services begin.	75% of FST served children and families will not have any findings of substantiated abuse after 1451/CMP services begin.
Gunnison/ Hinsdale	JJ	No more than 20% of CMP youth will terminate unsuccessfully due to revocations by technical violations.	No more than 20% of CMP youth will terminate unsuccessfully due to revocations by technical violations.
Gunnison/ Hinsdale	HMH	CMP served clients will be offered an appointment within 7 days of referral	CMP served clients will be offered an appointment within 7 days of referral.
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.	90% of CMP involved youth will have an attendance rate that will be no less than 80% (based on unexcused absences) who are enrolled at the end of the review period.
Gunnison/ Hinsdale	CW	75% of CMP youth will not have substantiated abuse findings after CMP services began.	75% of CMP youth will not have substantiated abuse findings after CMP services began.
Huerfano	JJ	20% of children receiving services through the CMP will not enter a detention facility. (approx. 4 youth)	20% of children receiving services through the CMP will not enter a detention facility. (approx. 4 youth)
Huerfano	HMH	Improvement by 10% in the Level of Functioning and Problem Severity of children/youth receiving services through the CMP. (approximately 8 youth)	10% of children/youth receiving services will have fewer problems/increased functioning. (approx. 8 youth)
Huerfano	ED	Increase by 10% the school attendance of children/youth receiving services through the CMP. (approximately 5 youth)	10% of children and youth receiving services through the CMP will have improved school attendance. (approx. 5 youth)

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Huerfano	CW	20% of children/youth receiving services through the Collaborative Management Program will successfully and safely remain in their own homes. (approximately 10 youth)	20% of children/youth receiving services will successfully/safely remain in their own homes. (approx. 20 youth)
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.	After 6 months of participation, a minimum of 50% of youth enrolled in HFW will show a decrease in a CJRA assessment.
Jefferson	CW	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.	Provide Safe Sleep education to 100 infant caregivers and provide assistance.
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.	10% of the students assessed at the JCJAC will show improvement in their attendance.
Jefferson	HMH	56% of Jefferson Center clients aged 0-21 as of April, 2011 did not have a primary care provider (PCP). This will be reduced to 55%.	40% of Jefferson Center clients, birth to 20 years, will have a primary care provider (PCP)
Lake	JJ	75% of Lake County youth will successfully complete probation.	Increase successful intervention for children with juvenile justice involvement. 70% 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	Decrease problem severity/increased level of functioning improvement by 10% in the level of functioning and problem severity of youth participating in High Fidelity Wraparound.
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.	Improve school performance (academic achievement); 70% of youth participating in CMP services demonstrated improved academic performance between ISST intake and case closure.
Lake	CW	60% of Lake County CMP youth will have no substantiated abuse findings after CMP services began.	Increase safety among children served by the CMP. 70% of CMP youth with no substantiated abuse findings after CMP High Fidelity Wraparound services began.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Larimer	JJ	Maintain successful probation termination among CMP served youth within a range of 55-65%.	Maintain successful termination of probation rate within a range of 55-65%.
Larimer	HMH	Maintain an ADP of 2 or less in PRTF and 25 or less in TRCCF/RCCF. Decrease overall use of PRTF and TRCCF/RCCF compared to FY11.	Maintain an average daily placement (ADP) of 15 or less for RCCF; ADP of 2 or less for PRTF.
Larimer	ED	Maintain school dropout rate within a range of 10-12%.	Maintain overall school dropout rate within a range of 12-16%.
Larimer	CW	Maintain reentry rate of CMP served youth into child welfare system within a range of 10-15%.	Maintain re-entry rate within a range of 10-15%.
Lincoln	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.	No more than 15% of CMP youth who recidivate, resulting in unsuccessful completion of probation and/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.	85% of CMP youth will have established health care and/or mental health providers during ISST services.
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.	75% of CMP youth will remain in school during the course of ISST services.
Lincoln	CW	5% or fewer CMP youth will have substantiated abuse finding entered in TRAILS after first Lincoln-Service Review Team meeting.	90% of youth will have no substantiated abuse findings after CMP services begin.
Logan	JJ	Have 100% of families served by our ISSTs with substance abuse issues involved with substance abuse treatment.	No more than 15% of CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.
Logan	HMH	20% of youth who have an ISST conference will receive follow up mental health and/or substance abuse services.	85% of CMP youth will have established health care and/or mental health providers during ISST services.
Logan	ED	20% of students whose families participate in ISST conferences will improve their school attendance so as not to be referred to Truancy Court.	75% of CMP youth will remain in school during the course of ISST services.
Logan	CW	90% of children served through ISSTs will have no substantiated abuse or neglect finding after CMP services have started.	90% of youth will have no substantiated abuse findings after CMP services begin

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Mesa	JJ	74% of CMP served youth will not recidivate pre-release resulting in unsuccessful discharge from Probation.	5% of revocations by technical violation where cases resulted in unsuccessful termination among CMP youth.
Mesa	HMH	90% of youth who do not have a medical provider as assessment will be referred to a medical provider during services.	85% of CMP uninsured youth who start FAP services without coverage will have established health care coverage during ISST services.
Mesa	ED	80% of youth served by FAP will have an increased attendance rate after services begin.	80% of CMP youth remain enrolled in school during the course of ISST services
Mesa	CW	At least 90% of youth served by FAP will not have a substantiated abuse finding after FAP services begin.	Increase stability of children served by CMP.
Moffat	JJ	Decrease further penetration into the juvenile justice system. Maintain the low level of DYC commitments by ISST served youth.	60% of CMP youth will successfully complete 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 discharge.	50% of youth with improved problem severity and level of functioning as determined by CCAR between ISST intake and case closure.
Moffat	ED	85% of youth in the wrap program will improve their school attendance after enrollment in wrap.	80% of CMP youth with improved school attendance rate between ISST intake and case closure.
Moffat	CW	50% of youth in out-of-home placement who are in custody of Moffat county Department of Social Services through a delinquency petition will be discharged to a permanent home.	80% of CMP youth will have no substantiated abuse finding after CMP services began.
Montezuma/ Dolores	JJ	Increase successful intervention for children with juvenile justice involvement.	85% of youth going to court on revocation will have been screened by CET.
Montezuma/ Dolores	HMH	90% of child and adolescent clients evaluated will not be hospitalized and will receive services in the community. Only the most complex cases will receive in-patient services.	90% of youth evaluated will not be hospitalized and will receive services in the community.
Montezuma/ Dolores	ED	Improve school attendance.	All youth in the Check & Connect program will be evaluated for referral to CET. 25% of Check & Connect students will show an improvement in school attendance. Youth referred to CET will demonstrate a reduction in alterable risk factors.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Montezuma/ Dolores	CW	Open child welfare assessments and cases will have an educational plan and be considered for the CET. Measurement: TRAILS documentation and/or review of individual case files, targeting 90% compliance.	85% of all CMP youth receiving CMP services will not experience any new substantiated abuse findings after CMP services begin.
Montrose	JJ	Number (percent) of revocations by technical violations where case resulted in unsuccessful termination among CMP youth. Achieve a percent of less than 12%.	Less than 12% of revocations by technical violations where case resulted in unsuccessful termination among CMP Youth.
Montrose	HMH	100% of youth referred to ISST that needs mental health services will be seen by the Center within 7 days of referral.	100% of CMP Youth in need of mental health services will be seen by the Center within 7 days of ISST referral.
Montrose	ED	Reduce the number of expulsions and the number of days youth are expelled. 80% of youth targeted by the school district as habitually disruptive will be referred to ISST.	75% of CMP Youth with improved school attendance between ISST intake and case closure.
Montrose	CW	Less than 25% of CMP youth will have new open involvements in Trails after CMP services begin.	Less than 25% of CMP Youth with new open involvement in Trails after CMP services began.
Morgan	JJ	There will be no more than 10 juveniles placed out of county due to probation revocation.	There will be no more than 10 juveniles placed out of county due to probation revocation.
Morgan	HMH	8 (or at least 9%) of youth who have had a FACT conference will receive follow up mental health and/or substance abuse services.	60% of CMP youth will have established: a) primary care provider; b) mental health provider; c) substance use provider; d) health insurance coverage during ISST services.
Morgan	ED	30% of youth who participate in FACT conferences will not be referred to Truancy Court in Morgan County.	35% of CMP Youth who were referred to "FACT" because of truancy and/or attendance concerns will not be filed for 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.	There will be no more than 21% of new assessments that result in open cases.
Park	JJ	n/a – new CMP	50% of youth will successfully complete probation or parole.
Park	HMH	n/a – new CMP	50% of youth will have established a primary care/mental health provider.

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Park	ED	n/a – new CMP	50% of youth will maintain school enrollment.
Park	CW	n/a – new CMP	50% of youth will be discharged to a permanent home.
Pueblo	JJ	Reach target success rate of 74% for juveniles under regular supervision.	74% success (completion) rate for juveniles under supervision in the 10th Judicial District.
Pueblo	HMH	5% of children show an increase in level of functioning	10% of the youth served by the school-based mental health program will have an increase in level of functioning.
Pueblo	ED	Youth at risk of or involved with truancy court will improve attendance by reducing days absent by 40%.	60% of youth at risk of Truancy Court will show increased school attendance.
Pueblo	CW	86.7% or more of the served youth in OOHP less than 12 months will have no more than 2 placement settings.	86.7% or more of youth in out-of-home placement will have no more than two (2) placements.
Rio Grande	JJ	80% of probation youth served by the CMP will not have a revocation based on technical violations.	80% of the probation youth served by the CMP will not have a revocation based on a technical violation.
Rio Grande	HMH	At least 85% of youth served by the Collaborative Management Program will have required immunizations.	At least 85% of youth served by the CMP will have required immunizations.
Rio Grande	ED	75% of CMP youth will improve their attendance by 10% or be within 5% of the school average or exceed it.	75% of youth served by the CMP will not have an out-of-school suspension while receiving services.
Rio Grande	CW	≤25% of youth served by the CMP will have an OOH placement.	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.
Routt	JJ	Decrease further penetration into the juvenile justice system. Maintain the low level of DYC commitments of ISST served youth.	Decrease further penetration into the juvenile justice system; Maintain the low level of DYC commitments of ISST served youth.
Routt	HMH	Improve access to substance abuse treatment. 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.	Increase access to health care system/ 80% of CMP youth will establish if needed: a)primary care provider; b)mental health care provider; c)substance use provider; d)health insurance coverage

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Routt	ED	Decrease truancy and dropout rates: 1. Provide assessment and individualized treatment and support to at least 40 students. Within the identified population, 80% will increase their attendance rate. 2. 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 education setting.	Improve School Attendance. 80% of CMP youth will show improved school attendance rates between ISST intake and case closure.
Routt	CW	Increase stability of children served by the CMP. 100% of the youth staffed with ISST will NOT have new open involvement in TRAILS.	Increase stability of children served by the CMP. 80% of youth will not have a new open involvement in TRAILS after CMP services begin.
Teller	CW	75% of CMP Youth served will not have substantiated abuse finding after CMP services begin.	75% of CMP Youth with no substantiated abuse finding after CMP services began.
Teller	JJ	75% of youth served through the CMP will have successful terminations of Probation.	75% of youth completing probation will be successful.
Teller	ED	Increase by 5% the attendance of youth enrolled in school receiving CMP Services.	Reduce number of referrals to the office by 10%
Teller	HMH	Improvement of at least 2 points on the final score for 80% of the clients as determined by the DLA-20.	75% of CMP Youth with improved problem severity and level of functioning as determined by CCAR between ISST intake and case closure (or specified date after ISST intake).
Weld	JJ	Maintain or decrease the rate of new adjudications (8%), across these service programs, (within 12 months of completing service*).	Maintain a similar rate of successful completion of probation for youth who are served by probation.
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).	Ensure 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).

County	Domain	Performance Goal (Fiscal Year 2012)	Performance Goal (Fiscal Year 2013)
Weld	ED	Maintain a rate of at least 78% of youth served by the TRIP program who have fewer unexcused absences after the intervention.	Maintain or improve the rate (between 49%-54%), and establish a baseline for future evaluation efforts, of youth served by TRIP who achieve a successful completion: increased school attendance after completion of TRIP services; high school graduation; obtaining their GED or equivalent degree; or having their case dismissed by the court or the school district due to their no longer being at-risk of truant behavior.
Weld	CW	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.	Maintain or improve the rate, and establish a baseline for future evaluation efforts, of the number of children who are in out-of-home foster care placement who have had 2 or fewer moves within the past 12 months.

Appendix M. CMP Expenditures at Local Level

The table below details funds and expenditures information provided by each CMP in the FY 2013 Annual Report Costs Tables. CMPs indicated that some of these totals are estimated.

The data below derive from the following items from the FY 2013 Annual Report Cost Table, and are reported by CMP County:

1. Please report the amount of CMP incentive funds that were remaining in reserve at the beginning of this fiscal year (i.e. carryover from the previous fiscal year)
2. Please report the total amount of CMP incentive funding you received in this fiscal year
3. Total CMP funds (combining #1 & #2 above)
4. Please report your CMP's total expenditures during this fiscal year (paid from funds listed in #3 above)
6. How much CMP earned incentive funding remains in reserve (Total CMP funds from #3 above minus Expended Funds outlined in Item #4 above)?

Table 1. Expenditures and funds in reserve as reported by CMPs

County	Carryover incentive funds from the previous FY 2012	Total amount of CMP incentive funding received in FY 2013	Total CMP funds (Fund from FY 2012 + Fund from FY 2013)	CMP's total expenditures during FY 2013	Amount of CMP earned incentive funding remains in reserve
Adams	$10,004	$97,854	$107,858	$101,101	$6,757
Alamosa	$155,032	$81,275	$236,301	$91,085	$145,222
Boulder	$207,407	$203,454		$261,963	
Chaffee	$71,971	$81,275	$153,246	$301,820	(-148,574.11)
Conejos	$177,973	$81,275	$259,248	$63,395	$195,853
Crowley-Otero	$0	$0	$0	$0	
Denver	$112,103	$203,454	$91,350	$251,783	$160,433
Douglas	$92,000	$30,000	$122,000	$67,427	$54,573
Eagle				$47,675	
El Paso	$769,739	$203,454	$973,193	$199,783	$798,762
Elbert	$117,391	$50,410	$167,801	$163,384	$4,417
Fremont	$492,475	$38,685	$531,160	$106,254	$424,906
Garfield	$55,762	$64,475	$120,237	$103,006	$17,231
Grand	$185,347	$83,048	$268,395	$82,195	$186,201

County	Carryover incentive funds from the previous FY 2012	Total amount of CMP incentive funding received in FY 2013	Total CMP funds (Fund from FY 2012 + Fund from FY 2013)	CMP's total expenditures during FY 2013	Amount of CMP earned incentive funding remains in reserve
Gunnison-Hinsdale	$188,469	$48,765	$237,234	$75,019	$164,295
Huerfano	$280,299	$81,275	$366,574	$95,370	$271,204
Jefferson	$749,024	$171,752	$920,776	$217,090	$703,686
Lake	$22,700	$61,535	$84,235	$13,571	$70,664
Larimer	$1,083,948	$150,669	$1,234,617	$841,568	$1,204,365
Lincoln	$14,244	$72,820	$87,064	$69,705	$17,359
Logan	$70,665	$47,675	$118,340	$27,213	$91,000
Mesa	$33,311	$80,254	$113,565	$81,901	$31,664
Moffat	$132,692	$31,965	$164,657	$12,986	$15,171
Montezuma-Dolores	$179,390	$81,275	$260,665	$75,333	$185,332
Montrose	$13,168	$72,968	$86,136	$71,810	$14,326
Morgan	$103,514	$81,275	$184,789	$55,795	$128,994
Park	N/A	N/A	N/A	$9,473	
Pueblo	$231,556	$80,353	$311,909	$99,578	$212,331
Rio Grande	N/A	$64,475	$64,475	$0	$64,475
Routt	$143,655	$81,275	$224,930	$68,758	$156,173
Teller	$615,492	$59,586	$675,078	$218,046	$457,032
Weld	$213,905	$203,432	$417,337	$254,177	$163,160

Appendix N. Direct and In-Kind Contributions

Table 1 and Table 2 below summarize the total dedicated and in-kind funds contributed to CMP efforts, reported by partner agency type (this page) and by CMP (see following page). CMPs indicated that some information was estimated, and some information was not available.

Table 1. Pooled and in-kind funds contributed by CMP partner agencies

CMP partner	Pooled funds - total	In-kind funds - total
County DSS	$846,606	$5,753,671
School district	$25,000	$2,485,801
Probation	$54,511	$1,150,385
Mental health services organization	$103,602	$608,100
Health dept.	$20,000	$390,890
Division of Youth Corrections	$1,349,674	$338,722
Domestic violence service organization	$0	$208,221
Local health services provider	$0	$204,430
Family-driven organization	$1,000	$169,901
Behavioral health organization	$189,000	$71,706
Diversion	$0	$68,306
SB94	$679,020	$59,510
Local courts/Judicial	$0	$57,821
Substance abuse service organization	$150,000	$35,517
Law enforcement	$0	$29,821
Elected official	$0	$26,462
Business or Chamber of Commerce	$0	$0
Other	$0	$2,847,172
Other (if CMP had additional agencies)	$0	$604,939
Total	**$3,418,413**	**$15,111,374**

Table 2. Pooled and in-kind funds contributed by CMP partner agencies, by CMP

County	Pooled funds - total $	Pooled funds - Count of CMP partner contributors	In-kind funds - total $	In-kind funds - Count of CMP partner contributors
Adams	$0	0	$557,685	3
Alamosa	$40,000	1	$70,745	10
Boulder	$2,106,732	5	$1,916,796	3
Chaffee	$332,041	1	$20,350	5
Conejos	$0	0	$82,695	9
Crowley-Otero	$0	0	$88,818	12
Denver	$30,971	3	$187,848	11
Douglas	$55,000	1	$149,635	8
Eagle	$0	0	$0	0
El Paso	$0	0	$0	0
Elbert	$0	0	$47,031	8
Fremont	$0	0	$704,825	10
Garfield	$20,000	2	$66,500	9
Grand	$56,081	1	$502,396	11
Gunnison-Hinsdale	$0	0	$3,960	3
Huerfano	$443,000	6	$89,000	7
Jefferson	$0	0	$731,772	9
Lake	$0	0	$99,462	7
Larimer	$0	0	$243,500	13
Lincoln	$0	0	$4,973,222	10
Logan	$0	0	$3,031,820	9
Mesa	$34,000	1	$218,217	11
Moffat	$0	0	$91,000	7
Montezuma-Dolores	$0	0	$132,046	8
Montrose	$0	0	$184,850	6
Morgan	$0	0	$105,490	14
Park	$10,473	2	$30,500	14
Pueblo	$134,000	1	$158,549	11
Rio Grande	$55,000	1	$69,432	10
Routt	$67,093	2	$121,200	7
Teller	$34,022	2	$247,601	10
Weld	$0	0	$184,430	13
Total	**$3,418,413**	**29**	**$15,111,374**	**268**

Appendix O. CMP External Funding Sources

The following table summarizes external funding (grants and other state and federal funding sources) reported by CMPs in FY 2013 Annual Reports.

Table 1. External funding sources for CMPs

Funding type	Source of funds	Description	Number of CMPs reporting	Amounts received
Federal	Juvenile Accountability Block Grant	Funds provided as block grants to states for programs promoting a greater accountability in the juvenile justice system	1	$27,500
	Supportive Services for Runaway and Homeless Youth grant*	The SSRHY funding comes out of the Rural Coalition for Homeless Youth (RCHY)	2	$18,000
	Communities of Excellence Planning or Implementation Grant through the Systems of Care**	Competitive funding to implement 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.	10	$800,000
	Promoting Safe and Stable Families***	Funds distributed by US HSS to states to grant services that address family support, family preservation, reunification, and adoption	4	$82,500
	Personal Responsibility Education Program	As part of the Affordable Care Act of 2010, PREP is a federal funding stream for programs that teach about abstinence, contraception for the prevention of pregnancy, and protection against sexually transmitted infections (STIs)	1	$155,000
	Bureau of Justice Assistance	Enhanced Assessment and Services Initiative	1	$100,000
State	Division of Criminal Justice Juvenile Assistance Grants (JAG)	Competitive funding for development of programs that prevent or reduce crime and delinquency using collaborative evidence-based and promising practices.	4	$170,417
	Senate Bill 94	Funds for local jurisdictions to cover a continuum of services to ensure that youth are incarcerated or supervised at a level that is commensurate with their risk to the community	2	$674,163

Funding type	Source of funds	Description	Number of CMPs reporting	Amounts received
	Division of Behavioral Health Prevention Block Grant	Funds for prevention programming	1	$100,000
	Truancy Reduction Planning Grant	Funds to reduce truant behavior, especially behavior that leads to adjudication, detention or placement of youth for contempt of a court order	1	$31,900
	The Expelled and At Risk Student Services Grant	The EARSS Grant is a grant from the Colorado legislature that supports the education of expelled students and those at-risk of suspension and expulsion	1	$122,311
	Invest in Kids	Tony Grampsas Youth Services grant that supports the implementation of the Incredible Years Parent Program	1	$6,930
Private Foundation /Other	Community Service Grant/Payment in Lieu of Taxes Fund****		1	$56,000
	Community Foundation of the Gunnison Valley	Flex funding for alternative and prevention programming for multi-system involved youth and families.	1	$1,500
	Pueblo County Department of Social Services	Unspent Child Welfare released to the Pueblo County CMP; the savings were possible due to best practices, case management, and efficient spending by the Pueblo County DSS Child Welfare staff.	1	$130,000
	Innovative and Student Services Budget	Funds provided to Eagle County Schools	1	$42,000

* One CMP did not provide the grant amount received.
** The total amount includes funding from FFY12 and FFY13 because funding overlaps fiscal years. Funding was granted to the San Luis Valley and was split between Alamosa, Rio Grande, and Conejos counties.
***Two CMPs did not provide the grant amount received.
****Additional information about this grant was unavailable.