

# HB 1451 Collaborative Management Program

## YEAR 5 STATEWIDE EVALUATION FINDINGS



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

For more information please contact:

Tiffany Sewell  
[tiffany.sewell@state.co.us](mailto:tiffany.sewell@state.co.us)

Erin Ingoldsby, PhD  
[eingoldsby@omni.org](mailto:eingoldsby@omni.org)

Laura Landry, PhD  
[llandry@omni.org](mailto:llandry@omni.org)

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OMNI

OMNI Institute  
899 Logan Street, Suite 600  
Denver, CO 80203  
[www.omni.org](http://www.omni.org)



# COLORADO

## Department of Human Services

TO: Julie Krow  
Robert Werthwein

FROM: Collaborative Management Program (CMP) Evaluation Subcommittee

On behalf of the Collaborative Management Program's Evaluation Subcommittee, we are pleased to submit the FY 2014 CMP Evaluation Report. This report presents key findings from five years of statewide evaluation.

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. Findings show that **CMP has led to more efficient, effective and elegant service delivery** which is having **positive effects** on the lives of Colorado families. Highlights include:

**CMPs serve Colorado's multi-system involved families.** The 32 CMPs report that their collaborative partners served over 24,000 (duplicated) children and youth. Nearly 12,000 of these cases participated in Individualized Service and Support Team (ISST) services. 56% of ISST-served cases were involved at multiple systems at intake.

**CMP outcomes demonstrate positive impacts for children and families.** Utilizing the most recent data available, rates calculated among FY12 and FY13 cases that were at risk for poor outcomes in the year after the initial ISST meeting showed:

<b>Child Welfare</b>	Fewer re-involvements in child welfare:	49% in FY12 vs. 30% in FY13
	Low rates of substantiated abuse/neglect:	7% in FY12 vs. 6% in FY13
	Two or fewer placements in out-of-home care:	74% in FY12 vs. 81% in FY13
<b>Juvenile Justice</b>	Low rates of involvement with probation:	22% in FY12 and 31% in FY13
	Successful termination of probation:	55% in FY12 and 53% in FY13

**The program has resulted in highly effective local interagency collaborations.** Survey and qualitative data indicate partner agencies' joint efforts have led to significant improvements in service delivery and increased capacity to address community needs.

**CMPs deliver integrated, high-quality services that reduce duplication and fragmentation.**

- 91% of ISST cases in FY14 had multiple agencies involved in service planning (up from 83% in FY12 and similar to 92% reported in FY13)
- 92% of ISST cases in FY 14 had an integrated plan developed (up from 86% in FY12 and 88% in FY13)
- CMPs implement evidence-informed ISST models: Team Decision Making (13 CMPs), High Fidelity Wraparound (15 CMPs), and the Crossover Youth Practice Model (8 CMPs)

**CMPs are achieving the objective of ensuring "family voice and choice."**

- Family representatives in local governance groups increased from 60% (FY11) to 94% (FY14)
- Family participation in ISSTs increased from 79% (FY12) to 85% (FY13) to 94% (FY14)
- Family survey data indicates high satisfaction with services and perceived positive outcomes

**CMPs effectively blend/braid funds, leverage resources, and realize cost efficiencies.**

- CMPs reported \$16 million in partner-provided in-kind funds, \$3.3 million in partner line-item contributions to support CMP efforts, and \$2.9 million from local, state and federal grants
- CMPs increasingly report cross-agency contributions to fund new programs (97% in FY14)

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. In FY 2014, pilot data assessing family feedback, education, and health and mental health outcomes showed potential for monitoring impact in these domains. The report concludes with a summary of major findings and information to support future evaluation efforts (pp. 52-53).

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. It is an exciting time as CMP stakeholders continue to advance the program's vision for Colorado families.

Sincerely,

Members of the CMP State Evaluation Subcommittee

FY 2013-2014 Evaluation Subcommittee Members

Norman Kirsch  
Administrator, Collaborative Management Program  
Division of Child Welfare  
Office of Children, Youth and Families  
Colorado Department of Human Services

José Esquibel  
Division of Child Welfare  
Office of Children, Youth and Families  
Colorado Department of Human Services

Terri Anderson  
El Paso County CMP

Susan Colling  
Colorado Office of the State Court Administrator

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

Serena Gonzales-Gutierrez  
Denver County CMP

Heather Harcourt  
Elbert/Lincoln Counties CMP

Carl Larson  
University of Denver

Chris Meyer  
Douglas County CMP

Kelly Schramm  
Weld County CMP

Amy Terry  
Jefferson County CMP

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

OMNI Institute Lead Staff to the Evaluation

Jim Adams-Berger

Laura Landry

Erin Ingoldsby

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## **CMP Statewide Evaluation Year 5 Executive Summary**

### **Background and Introduction**

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:

- Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent advocacy or family advocacy organizations
- Reduce duplication and eliminate fragmentation; and increase quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services
- Encourage cost sharing among service providers and cost-reduction for services
- Achieve positive outcomes for children and families, particularly in the child welfare system in Colorado

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

Since 2009, OMNI Institute, the CMP 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: 1) Is the CMP meeting legislative intent in regards to population, systems, services, and outcomes?; 2) Does the CMP result in positive outcomes for multi-system involved children and youth?; 3) Are CMPs' structures and processes improving local cross-agency collaboration?; 4) Which CMP models/components are most effective?; and 5) How are CMPs realizing systems improvements?

The Year 5 Evaluation Report provides a comprehensive analysis of these questions utilizing data collected through the Efforts to Outcomes (ETO)<sup>TM</sup> CMP online client-level database, Annual Reports, state agency databases (i.e., Trails, ICON), and IOG member surveys. This Executive Summary presents selected findings which primarily focus on system, service, and child and family outcome improvements stemming from ISST efforts.

### **Implementation of the Collaborative Management Program**

Since its inception in 2004, the program has grown from 6 to 35 counties comprising 32 CMPs in Fiscal Year (FY) 2014. The following data address the Individualized Service and Support Team (ISST) population and services implemented by the participating counties.

**Children and Families Served in FY 2014.** CMPs reported serving 11,874 children and youth through ISST models; 7,912 of these cases were newly enrolled and 4,795 (61%) are represented in the CMP database. The number served by ISSTs increased from FY 2013 (8,716). When factoring in those served through IOG partner agency programs, the number of children and family members receiving some level of CMP services grows to about 24,000 individuals (duplicated). Demographic characteristics indicate that approximately half were pre-adolescents or adolescents (48%) and 52% were under age 11. Over half (57%) were male. The majority were White/Caucasian (83%), with 39% indicating Hispanic/Latino ethnicity.

**Service Needs.** Just over half of children or youth reported involvement with two or more agencies at ISST intake (56%). The most common systems involvements in FY 2014 were child welfare open involvements

(80%), mental health services (38%), and judicial/probation services (16%). Children were most commonly referred to ISSTs from child welfare (74%), schools (11%), or judicial/probation providers (7%).

**Service Provision through ISSTs.** A total of 87 ISST programs were reported by CMPs. Among all ISST cases in FY 2014, the largest number of cases were served with Team Decision Making (59%), Family Group Conferencing (9%), and Crossover Youth Model (2%). In over two-thirds of cases (78%), DHS child welfare providers were designated to provide services in the plan; mental health service providers (55%) and ISST facilitators (33%) were also commonly identified for intervention involvement.

## **Outcomes of the Collaborative Management Program**

The overarching premise of CMP is that by facilitating cross-agency coordination and family partnership in intervention planning, service delivery systems will be improved and ultimately result in positive outcomes in the lives of multi-systems involved children, youth, and families. This report presents findings for statewide outcome indicators assessing service improvements tracked in annual reports, stakeholder surveys, and ISST-served case data entered into the CMP database; and on child and family outcomes in the four central domains of child welfare, juvenile justice, education, and health/mental health. Outcomes are assessed cross-site (standard statewide indicators selected to align with state-identified priorities) and within CMPs (locally defined performance measures).

### **Service Outcomes**

CMPs affect positive change throughout their service systems by streamlining, coordinating, and providing high-quality services for families. Statewide process indicators show positive impact in multiple areas:

**Reduced duplication and fragmentation.** All but one CMP reported significant reductions in families' experience of conflicting treatment requirements. CMPs streamlined services by using cross-agency consents to share client information (81% in FY 2014, up from 68% in FY 2012 and 72% in FY 2013) and increasingly sharing client assessments across agencies (65% in FY 2014, versus 61% in FY 2012 and 56% in FY 2013).

**Integrated service delivery.** In FY 2014, the majority (91%) of ISST cases had multiple agencies involved in service planning (up from 83% in FY 2012 and equal to 92% reported in FY 2013). Almost all ISST cases (92%) had an integrated service plan developed as part of the initial meeting, which represents a steady increase, from 86% in FY 2012 and 88% in FY 2013.

**Improved quality of services.** CMPs commonly implemented service models and programs with proven efficacy, with increasing efforts to track implementation fidelity. In FY 2014, 20 CMPs implemented Team Decision Making, about half implemented High Fidelity Wraparound (15 CMPs), and just under one-third apply the Crossover Youth Practice Model (9 CMPs). Over half of CMPs in FY 2014 (59%) also report implementing new programs that specifically target a population and service need/gap identified by their Interagency Oversight Group (IOG). About two-thirds (63%) of CMPs implemented or enhanced existing services to be more culturally appropriate and/or competent (up from 43% and 53% in the prior two fiscal years).

### **Outcomes for Children and Families**

The following findings reflect cross-site outcomes extracted from Trails and ICON/Eclipse state data systems for the 12-month period following the start of ISST-services matched to case data from the CMP database, for those youth served in FY 2012 and FY 2013 who had the indicator selected as the targeted goal (thus at risk for the outcome). FY 2012 and FY 2013 represent the most recent data available for this cohort analysis. Statistically significant differences across year/cohorts are noted.

**Child welfare statewide indicators.** Among ISST-served children identified at risk for involvement at intake in FY 2013, 57% had no new child welfare involvements in the year following their ISST meeting, a non-significant increase from FY 2012 (52%). Among those with closed involvements, there were statistically significantly fewer cases with re-involvement from FY 2013 (30%) than cases in FY 2012 (49%). CMPs successfully averted substantiated abuse or neglect in 94% of cases in FY 2013 (similar to 93% of cases in FY 2012). For children in out-of-home care, 81% of FY 2013 cases had two or fewer placements, an increase at a trend level from cases in FY 2012 (74%). Of those discharged from placement, 63% in FY 2013 were to a permanent home, a non-significant decrease from 68% for FY 2012 cases.

**Juvenile justice statewide indicators.** Among ISST-served cases at risk for involvement with probation, over two-thirds of FY 2013 cases (69%) did not become involved in the year following their ISST meeting, a significant decrease from FY 2012 cases (78%). For those terminated from probation, 53% of FY 2013 cases were successful (55% for FY 2012 cases), 33% had revocations due to technical violations (31% for FY 2012 cases), and 13% had pre-release recidivism (14% for FY 2012 cases).

**Education and health/mental health pilot indicators.** Despite strong interest and involvement in indicator selection, CMP participation in pilot data collection remained low in FY 2014. Rates on small subsets are presented in the body of report to demonstrate potential use of the pre-post measures; however, expanded data is needed to build capacity to ensure meaningful and representative results.

## Community-Level Outcomes

**Incentivized performance measures:** Locally defined incentivized outcomes reported by CMPs showed that 86% of all target goals were met in FY 2014 (slightly lower than 94% in FY 2013 and FY 2012, and up from 78% in FY 2011). Many CMPs 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.

**Collaborative effectiveness at the local level.** In each fiscal year of 2010 through 2013, IOG members in each CMP completed a survey designed to assess the extent and quality of collaborative efforts; how CMPs are working together to achieve the goals and outcomes outlined in legislation; to identify strengths and barriers to improve collaborations; and to examine changes in collaborations over time. IOG members consistently rated their collaborative processes as highly effective (> 5 on a 6 point scale); the high quality and extent of collaboration among CMP stakeholders is notable compared to similar collaborative efforts.<sup>1</sup>

## CMP Costs, Cost-Shifting and Savings, and Reinvestment

The CMP approach assumes that less 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 expand services.

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<sup>1</sup> Chrislip, D., Larson, C. (1994). *Collaborative leadership: How citizens and civic leaders can make a difference*. Jossey-Bass.

**Implementation costs.** CMPs reported expending about \$3.9 million of their available incentive funding, more than the \$1.6 million earned incentives distribution fund in FY 2013 as CMPs called upon carryover funds due to smaller incentive payouts. In FY 2014, CMPs reported an additional \$16 million in in-kind funds and \$3.3 million in CMP partner line-item contributions to support CMP efforts.

**Cost-shifting and cost-savings.** Information is limited, but indicators suggest that CMPs frequently share costs and are increasingly realizing local cost efficiencies. In all but one CMP, agencies participating in ISSTs blend/braid funds to pay for interventions. Average costs of initial ISST meetings decreased from \$323 in FY 2011 to \$292 in FY 2014. Five CMPs reported quantified cost savings at the program-level, totaling \$329K.

**Reinvestment of funds.** About \$5 million of locally reserved funds will be reinvested in FY 2015, with most CMPs (84%) planning to reinvest in new or expanded family programs and 68% in flexible spending accounts to provide for family needs. Twenty-two CMPs received a total of \$2.9 million in local, state, and federal grants to support efforts (up from \$1 million in FY 2012 and \$2.5 million in FY 2013).

## Identified Barriers

Despite significant advancements in recent years, CMPs continue to work collaboratively to address some barriers in order to fully respond to goals. The data below address identified barriers to provision of effective services.

- Diminishing funds for payout for earned incentives is placing stress on CMP partner agencies and lowering capacity to provide the level of services needed for multi-system families.
- Implementation and monitoring efforts in the context of multiple state initiatives (e.g., IV-E waiver, Systems of Care) is challenging and at times seems to create duplication in systems.
- Assessing actual service cost reductions and cost savings of CMP services remains challenging.

## Other Information Relevant to Improving the Delivery of Services

Two areas in which CMP has seen significant growth in the past few years are highlighted below.

**Family-centered service delivery systems.** “Family voice and choice” was adopted as a fundamental value of the CMP. The program has made significant progress integrating family perspectives in CMP efforts. Almost all CMPs (94%) reported having family representation on their IOGs in FY 2014, showing a steady increase from 60% in FY 2011. Family representatives are active, with 83% granted voting rights and 90% attending more than half of the meetings. CMPs also reported increases in caregiver involvement in ISST meetings in FY 2014 (94% of ISST cases, with 85% in FY 2013 and 79% in FY 2012). CMP also successfully launched a standardized, validated family feedback measure in FY 2014 to support on-going quality improvements. The CMP’s progress is supported in these efforts by a partnership with a state-level family advocacy organization and an active subcommittee of the State Steering stakeholder group.

**Evaluation infrastructure.** Since 2009, the evaluation team established critical infrastructure to enable examination of evaluation focus areas through a collaborative and participatory process that included:

- meeting monthly with an Evaluation Subcommittee of the State Steering Committee composed of local CMP Coordinators as well as state agency representatives to design and implement the evaluation
- traveling to each CMP to meet with local leaders to better understand their Individualized Service and Support Team (ISST) models and to develop aligned measurement strategies to collect client-level data
- convening local CMP stakeholder groups over time to identify common statewide indicators across four domains

- building foundational systems to collect standard data on efforts to reduce duplication and fragmentation of services, improving the quality and effectiveness of delivered services, cost sharing and cost reductions
- expanding the annual report to gather data about systems improvements and local services to capture information about diverse local models as well as to promote learning within and across CMP sites to encourage model refinement
- interviewing local Interagency Oversight Group (IOG) stakeholders, surveying IOG members over time to gather information about the quality and achievements of their collaborative processes, and providing feedback loops to facilitate collaborative quality improvements

**Implementation of a cross-systems online data collection and reporting system.** Given that there is no state system that captures data about multi-system involved children, youth, and families, the most critical evaluation infrastructure achievement was the successful implementation and expansion of an online data collection and reporting system to gather standard client-level service data for clients served through local CMP ISSTs. Since launching in 2011, over 11,000 cases from the 35 participating counties have been entered into the centralized system. Customized local and state-level reports to monitor ISST case data and standard process and outcome indicators in real-time are available. Measures to assess education, health/mental health, and family feedback indicators are integrated. Data sharing agreements and protocols were established with CDHS and State Judicial partners to facilitate case matching with state datasets (Trails, ICON/Eclipse) and analysis of child welfare and probation outcomes.

As a result of the statewide evaluation infrastructure, CMP has seen improved specification and utilization of local performance as well as statewide outcome data. Correspondingly, CMP now has an enhanced focus on implementation and measurement of best practices.

## Conclusions and Considerations

Based upon process and outcome analyses conducted over the course of the five-year evaluation, the following conclusions are drawn:

**CMPs are meeting and/or exceeding legislative goals regarding systems and service delivery improvements at the state- and local-level.** Interagency collaborative structures at governance and service levels are creating more uniform management of service delivery, successfully integrating family partners in service decisions, reducing duplication and fragmentation of services, improving service quality, and more effectively sharing and leveraging resources.

**CMP ISSTs serve as critical gateways to best practice interventions for Colorado’s multi-systems involved and at-risk children, youth and families.** CMPs are reaching the population of children and families indicated in the establishing legislation, with 56% of ISST-served cases involved in multiple systems of care at intake and 91% of cases with multiple system providers participating in integrated treatment planning. CMP programs and services touched an estimated 20,000 or more children and youth, with over 11,000 participating in integrated service planning. A large majority of cases received services with some proven efficacy, helping to ensure the best chances for improved functioning among Colorado’s children.

**CMPs are achieving positive outcomes for children, youth and families in the child welfare system and in other systems of care.** Overall, CMP children and youth, despite being deeply involved and at high-risk for poor outcomes at enrollment in ISST services, are being successfully diverted from involvement or re-involvement with the child welfare system, experience low rates of substantiated abuse or

neglect, are achieving permanency and reunification with families, and are maintaining stability when in out-of-home placement. Positive outcomes were also demonstrated for CMP youth involved with probation, with over one-half of CMP ISST-served relevant youth achieving successful termination. Moreover, CMPs demonstrated significant progress in “moving the needle” on some outcomes across yearly cohorts. CMPs also reported considerable progress on ISST- and community-level outcomes such as reducing residential placements and decreasing rates of youth detention.

**CMPs have significantly improved cross-agency collaboration.** Research has demonstrated that successful high-quality collaborative processes can lead to improvement in desired outcomes over time. The evaluation found that local CMP sites regard their collaborative structures, qualities and processes to be highly effective. The results, particularly considered in light of research with similar collaboration initiatives,<sup>1</sup> demonstrate that the CMP is achieving its goals of breaking down silos across agencies and promoting cross-agency solutions to address community needs.

**The CMP has made progress on, but will continue to need to address, balancing needs and resources of local programs while providing more rigorous evidence of the CMP’s effectiveness.** The evaluation infrastructure developed over the past five years is a strong foundation on which the CMP can continue to build and expand to:

- More precisely measure CMP population, services, and outcomes
- Analyze impacts longitudinally, across domains, and at multiple levels of influence
- 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, as desired
- Capture CMP cases within other state data systems (e.g., Trails)

The CMP can promote expansion of client-level and cross-system data in these areas to inform quality improvement, decision making, and model refinement efforts.

## **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.”<sup>1</sup> 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.<sup>2</sup>

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<sup>3</sup>

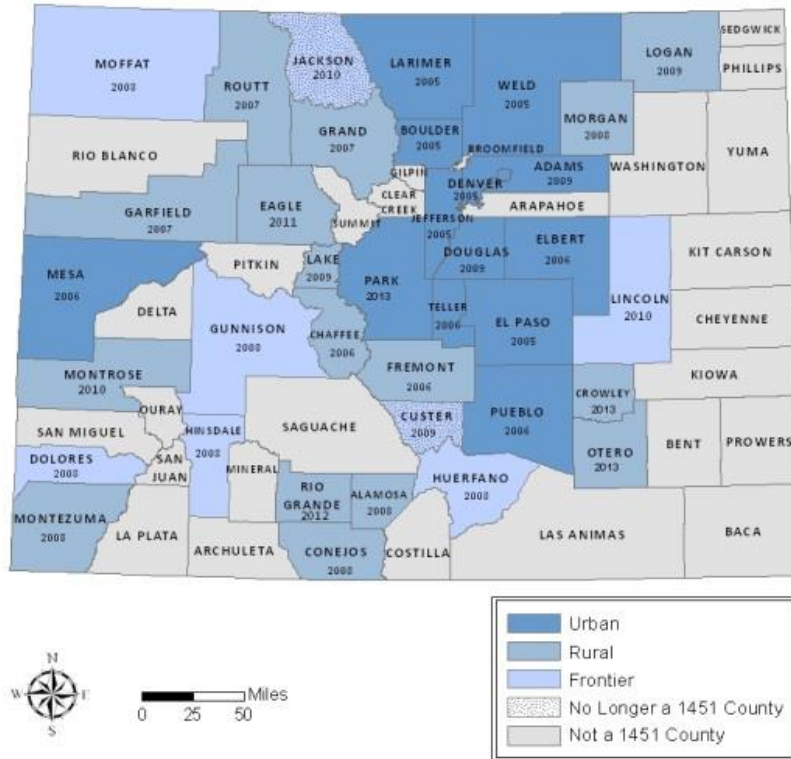
Importantly, the legislation reflects a long history of system reform in Colorado based on Systems of Care principles. Core elements include community collaboration, family involvement in service planning and delivery, and culturally competent services tailored to the unique needs of different populations. 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.<sup>4</sup>

*“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 2013-14 fiscal year. In September 2014, it was announced that 5 additional counties would be joining the CMP (one will join an existing regional CMP, the other four will create a regional CMP, bringing the total counties participating to 40, representing 33 CMPs). 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 (2005-2014)**



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

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
<b>Year 1 (FY10)</b>	<ul style="list-style-type: none"> <li>Document and describe the range of efforts and outcomes of local CMPs</li> </ul>
<b>Year 2 (FY11)</b>	<ul style="list-style-type: none"> <li>Refine common process and outcome measures and develop systems to collect data to evaluate legislative goals across sites</li> </ul>
<b>Year 3 (FY12)</b>	<ul style="list-style-type: none"> <li>Establish statewide infrastructure for the systematic collection of process and outcome data for clients served by CMPs, including demographics, services, and outcomes</li> <li>Match CMP data with outcome data available through Child Welfare (Trails) and Judicial (ICON/Eclipse)</li> <li>Identify statewide outcome indicators in the domains of education and health/mental health</li> </ul>
<b>Year 4 (FY13)</b>	<ul style="list-style-type: none"> <li>Expand statewide standard data collection and multi-year analyses of process/outcome data</li> <li>Pilot education and health/mental health indicator measures</li> </ul>
<b>Year 5 (FY14)</b>	<ul style="list-style-type: none"> <li>Continue to expand statewide standard data collection and multi-year analyses of process/outcome data</li> <li>Continue voluntary collection of education and health/mental health indicator measures</li> <li>Pilot family feedback measure</li> </ul>

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)
- To what extent are CMPs’ structures and processes improving cross-agency collaborations at the local level? (See Sections II, VIII)
- 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 V, 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)<sup>TM</sup> 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 3,303 youth for FY 2012, 3,333 youth in FY 2013, and 4,795 youth in FY 2014)
- Client-level outcome data matched to Trails and ICON/Eclipse (e.g., juvenile probation) systems (available for all 6,636 youth from FY 2012 and FY 2013)
- Annual Report data about systems improvements and local services (available for all 32 CMPs)
- Collaborative survey data gathered annually in the first four years of the evaluation via an online survey administered with local IOG members (available for 30 CMPs in FY 2013; survey not administered in FY 2014)<sup>5</sup>

Findings from these sources are presented throughout this report. Data from multiple years are included where relevant and available; thus the report represents a cumulative presentation of information gathered over the course of the statewide evaluation to date. Appendix F describes the data sources in greater depth. Endnotes and references to appendices are included throughout the report to provide additional detailed information. For a list of additional products resulting from statewide evaluation activities in Years 1 – 5, see Appendix G. 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 for future evaluation efforts.

## 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. Item “b,” development of collaborative processes that support systems change related to CMP legislative goals and ISST implementation, are discussed in this section and in Sections VIII, IX, and X, respectively. Item “c” is discussed in Sections III, IV, and VIII.

### What is the Multi-System Representation of IOGs?

Table 2 on the following page 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 generally consistent between FY 2012 and FY 2014. All IOGs indicated participation from members from 3 of the 9 mandated partners and the majority had active members from the remaining (6) mandated partners.

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, yet membership and participation increased considerably from FY 2013. In FY 2014, over half (59%) of CMPs included a family member (41% in FY 2013) and/or a family advocate/navigator/facilitator (53%; 22% in FY 2013) on their IOG. See Section IX for additional details about “family voice” in CMP.

**Table 2: IOG membership and attendance in FY 2014**

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 (%)
<b>County Department of Human and Social Services</b>	<b>32 (100%)</b>	<b>32 (100%)</b>
<b>Division of Youth Corrections</b>	<b>32 (100%)</b>	<b>29 (91%)</b>
<b>Probation</b>	<b>32 (100%)</b>	<b>32 (100%)</b>
<b>School Representative</b>	<b>32 (100%)</b>	<b>32 (100%)</b>
<b>Behavioral health organization representative</b>	<b>31 (97%)</b>	<b>26 (81%)</b>
<b>Mental health service provider center</b>	<b>31 (97%)</b>	<b>30 (94%)</b>
<b>County Health Department</b>	<b>30 (94%)</b>	<b>26 (81%)</b>
<b>Domestic violence service provider</b>	<b>30 (94%)</b>	<b>22 (69%)</b>
<b>Substance abuse service provider</b>	<b>30 (94%)</b>	<b>24 (75%)</b>
Senate Bill 94 representative	28 (88%)	27 (84%)
<b>Local courts/judicial</b>	<b>27 (84%)</b>	<b>22 (69%)</b>
Family member	19 (59%)	16 (50%)
Family advocate/facilitator/navigator	17 (53%)	15 (47%)
Diversions	16 (51%)	13 (41%)
Law enforcement	14 (44%)	9 (28%)
Family Driven Organization	9 (28%)	9 (28%)
Elected official	8 (25%)	4 (13%)
Youth representative	6 (19%)	3 (9%)
Local health services provider	5 (16%)	5 (16%)
Business or Chamber of Commerce	4 (13%)	2 (6%)
Other*	26 (81%)	-- --

*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.*

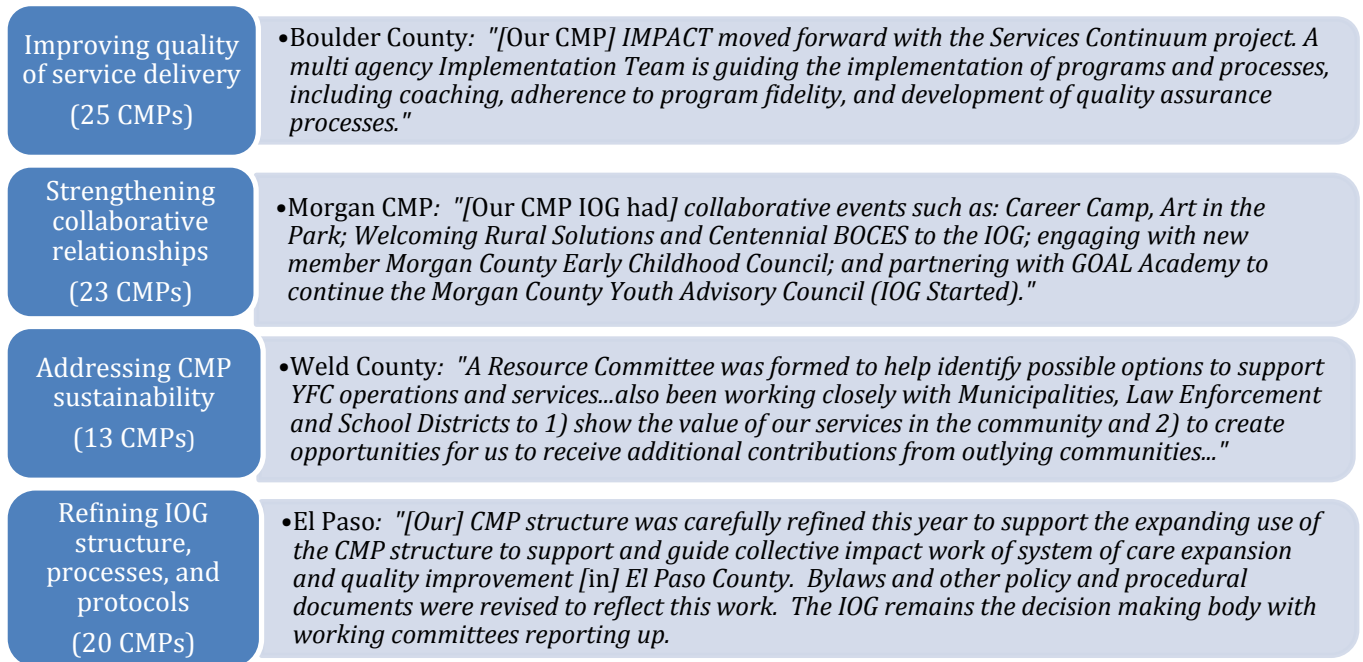
*\*Attendance of other members cannot be reported as some CMPs reported multiple "Other" IOG members.*

Twenty-six 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).

### What Are the Common Areas of Focus for IOGs?

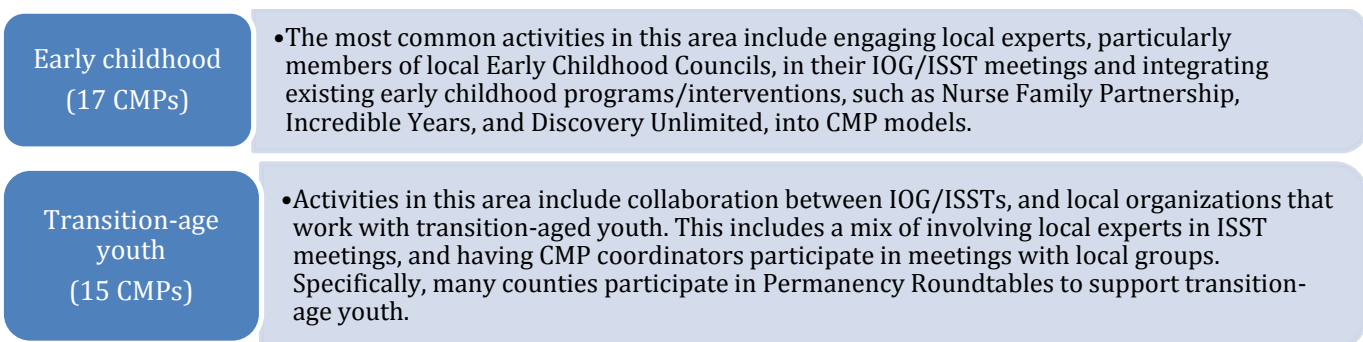
IOGs are expected to conduct oversight in several areas, including improving communication and resource sharing across partner agencies. They are also granted considerable discretion in defining their own priorities. The figure below describes the four most common IOG focus areas in FY 2014, along with a CMP-reported example for each. Focus areas were similar from FY 2013 to FY 2014.

**Figure 2: Most common IOG focus areas**



In addition to these common focus areas, a number of CMPs reported activities in two emerging areas – early childhood and transition-age youth.<sup>6</sup> 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 2014. Numbers are similar to FY 2013, when 19 of 32 CMPs reported early childhood as a focus area of their IOG and 13 of 32 CMPs reported transition-age youth as a focus area.

**Figure 3: FY 2014 IOG activities in the areas of early childhood and transition-age children and youth**



**To what extent are CMPs’ IOG structures and processes improving cross-agency collaboration?**

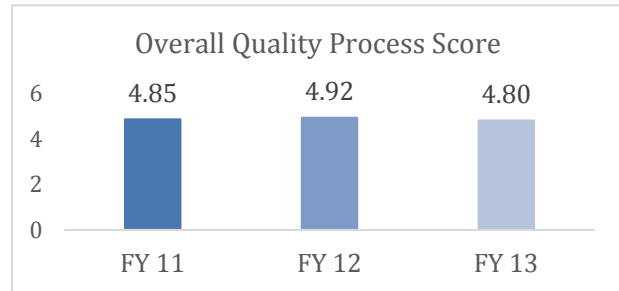
Evaluating collaborative structures, qualities and processes is a critical part of demonstrating the effectiveness of the CMP. Research has demonstrated that successful high-quality collaborative processes can lead to improvement in desired outcomes over time.<sup>7</sup> To achieve this, it is important

that the collaborative processes have not simply been implemented to fulfill a mandate, but rather that the credibility of the process justifies the investment of time and energy in it.

In each fiscal year of 2010 through 2013, OMNI worked with CMP coordinators to administer the Collaborative Effectiveness survey to all CMP counties.<sup>8</sup> The survey was designed to assess the extent and quality of collaborative efforts; how CMPs are working together to achieve the goals and outcomes outlined in legislation; to identify strengths and barriers to improve collaborations; and to examine changes in collaborations over time. Each CMPs’ IOG members were invited to participate in the survey to share their perceptions about their CMP structure, collaborative processes and outcomes. After each administration, CMPs received a report with mean scale scores on multiple items that measured different aspects of collaboration. In addition, in 2012, a Collaboration and Success Survey Toolkit was provided to CMPs in order to provide guidance on how to use the findings from the report to affect local quality improvements.

**Figure 4. Mean scores of CMP’s process quality ratings**

Figure 4 displays the aggregate Overall Quality Process score for all CMPs from FY 2011 through FY 2013. The Overall Quality Process score is a summary score assessing the concepts of structural integrity and authenticity of the collaborative process. IOG members responded to questions on a six point scale (from “strongly disagree” to “strongly agree”), and higher scale averages demonstrate greater perceived levels of collaboration. A high quality collaborative process is seen as open and credible by its members.



In general, mean scale scores have been consistently high across years—above “4” (“agree more than disagree”) and just below “5” (“agree”). The results, particularly considered in light of research with similar collaboration initiatives, demonstrate that the CMP is achieving its goals of breaking down silos across agencies and promoting cross-agency solutions to address community needs.<sup>8</sup> This interpretation of results is also supported by an in-depth qualitative analysis conducted in the first year of the evaluation, summarized in the *Collaborative Processes and Emerging Best Practices* (2010) report.<sup>9</sup> (See Section VI for qualitative data analysis and narrative examples of collaboration impacts, and Section VIII for additional results for key survey items.)

*Highlight from Weld CMP IOG member: “The most significant systems change that has resulted from the work of our CMP is...recognizing common goals and planning strategies to accomplish these goals; working together for the benefit of youth/families.”*

### 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, through the work of the IOGs. Twenty-six 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 following figure, along with illustrative examples.

**Figure 5: Community-level impacts associated with IOG efforts**



### 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 H 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. In FY 2014, the CMP State Steering Committee continued to discuss the definition of ISST-served cases, focusing on establishing clear, measurable parameters and the fit of local models/services within these parameters; this work is on-going in FY 2015.

#### Definitions Adopted in FY 2013

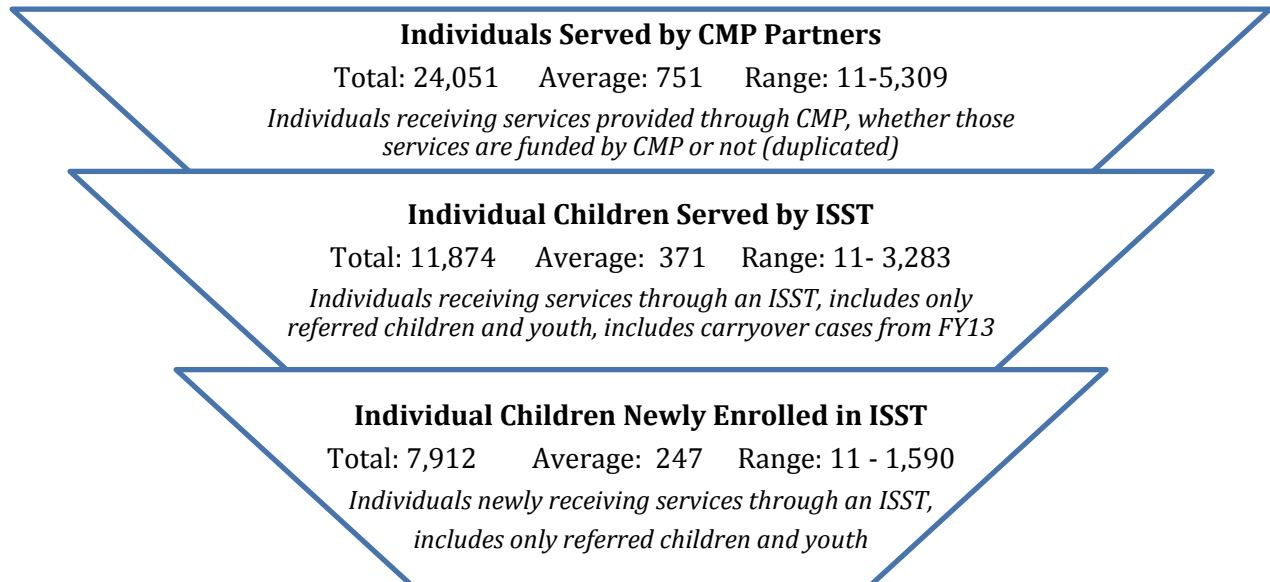
The **CMP target population** consists of at-risk children and youth, age birth through 21 years of age and their families, who would benefit from a multi-system integrated service plan.<sup>10</sup>

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.<sup>11</sup>

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

Figure 6 on the following page describes the population of children and youth served by ISSTs as reported in the annual report, including the total reported statewide, and the average and range across CMPs.<sup>12</sup> For some CMPs, most or all of the individuals and families served participate in a legislatively required ISST. Specifically, about half of CMPs (47%) 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, 19% of CMPs indicated that less than a quarter of their target population is served through an ISST.

**Figure 6: Individuals served by CMPs as reported in FY 2014 annual reports**



Direct comparisons of the number of individuals served by CMP partners in FY 2013 and FY 2014 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 reported to have been served by ISSTs in FY 2014 (11,874) than in FY 2013 (8,716), though the number of CMPs did not increase during this time period. (Please see Table 3 in Appendix H for a comparison of the number of children and youth that were served by each CMP in FY 2013 and FY 2014.) The majority of CMPs (n=21; 66%) reported serving more children and youth in FY 2014 than in FY 2013. Data on individual children and youth newly enrolled in an ISST staffing, displayed at the bottom of Figure 6 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. A similar pattern was noted; more children and youth were reported as newly enrolled in ISSTs in FY 2014 (7,912) than in FY 2013 (5,263).

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

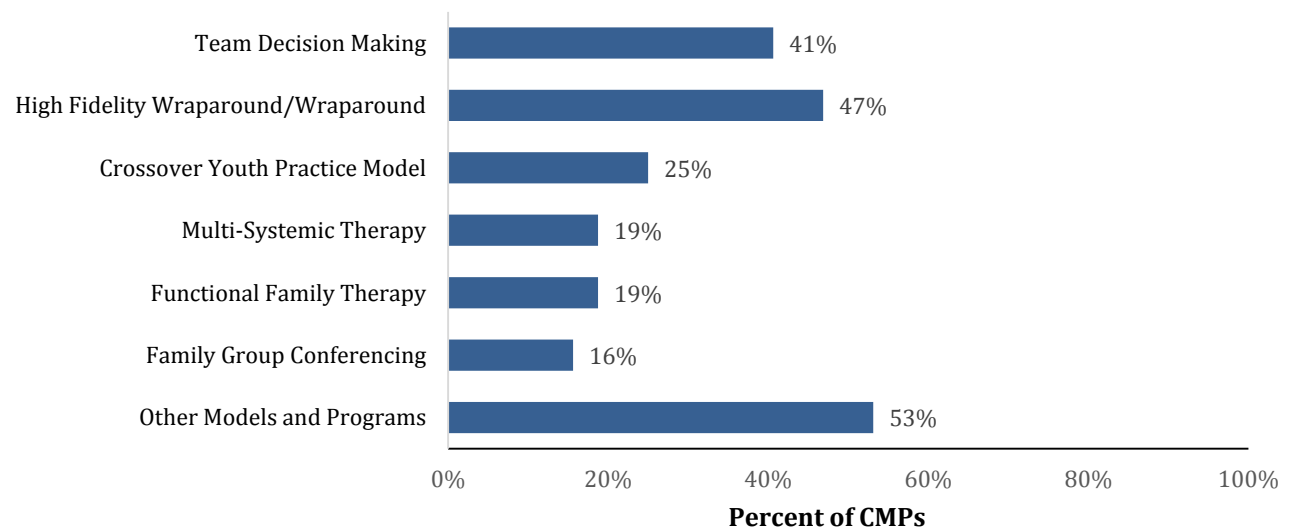
As noted above, Interagency Oversight Groups (IOGs) are required to implement Individualized Service and Support Teams (ISSTs) that support integrated service delivery to “children and families who would benefit from integrated multi-agency services.” This section describes core elements of CMP ISST implementation, including the models, programs, and practices reported by CMPs in FY 2014.

##### 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<sup>13</sup> and promising<sup>14</sup> 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 7 below displays the percentage of CMPs utilizing the most commonly mentioned practice models and programs as part of their ISST process.

**Figure 7: Common ISST programs and practice models implemented by CMPs<sup>15</sup>**



**ISST programs and practices.** Through annual reporting, some CMPs described ISST practices and programs that were implemented in FY 2014 in detail, taking care to highlight the ways that collaboration has been beneficial for children and families served. Qualitative data provide snapshots of the highly collaborative, integrated, and family-centered nature of ISST services:

- **Park CMP:** *During the intake process, each family is asked to describe informal and formal delivery systems with whom they would like to be a collaborative part of their own process. These persons/agencies are then contacted to participate in the ISST after a release has been signed by the parent/guardian. They then participate in the ISST with the targeted youth and any other family members deemed appropriate.*
- **Grand CMP:** *Our ISST meetings (known as the Family Support Team or FST in Grand County) are not where our integrated service plans are developed. Our process is the following: 1. Referral; 2. Intake Meeting with 1451 Coordinator and parent(s); 3. Family-Team Meeting - designed like a Team Decision Making meeting with attendees invited by both the family and the CMP Coordinator with input from the family - this is where the integrated family service plan is created. Agency representatives that are invited are almost always current members of the Family Support Team; 4. On-going case management by coordinator and monthly updates on families' progress at FST meetings (without families present). However, decisions are not made without families. Caseload updates to the FST provide a think tank atmosphere to bring other ideas back to families...If we find that a family has been experiencing multiple barriers and/or if new issues have arisen, then the team will suggest we hold another Family Team Meeting and revise our action plan.*
- **Teller CMP:** *Teller County ISST is attended by not only the Wraparound Facilitator, Coach and Family Support Partner, but also the following: Project Respect Coordinators, CASA, Teller County Sheriff's Department (Diversion), The Department of Social Services, Permanency Roundtable Coordinator, The Department of Public Health, School personnel and the HB 1451 Coordinator. When a case is referred for Wraparound the above members meet at the weekly Team Meeting to discuss if it is appropriate for Wraparound. Once a case has been accepted, the assigned Facilitator meets with the child and family to begin the Wraparound Process; building a team, completing a Strengths, Needs, Cultural Discovery and working regularly, meeting with the family to develop a family plan with goals unique for the family's situation. Both Wraparound and Project Respect are voluntary programs.*

## 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 14 CMPs reported having only one ISST, 5 reported two, and the remaining 13 reported having three or more ISSTs. The largest number of ISSTs in a CMP is 9. 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 3 describes various structural elements of CMPs’ “primary” ISST (typically the ISST serving the largest number of children and youth when CMPs have multiple ISSTs).<sup>16</sup>

**Table 3: Key features of ISSTs**

ISST areas of focus	The most commonly indicated areas of focus for ISSTs were child welfare (94%), mental health (97%), and juvenile justice (94%) (CMPs could select more than one area.)
Length of ISST meetings	CMPs most commonly reported spending one hour per family, per ISST meeting. However, meetings ranged from 30 minutes to 3 hours per family, consistent with reporting from FY 2013.
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	31% of CMPs reported that decisions about which partners participate in ISSTs are based on family needs; another 60% indicated that while a core group of partners attend all ISST meetings, additional attendees are invited based on family needs.

**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. Table 4 details the range of ISST meeting costs, indicated by the bars, and the average ISST meeting cost across CMPs.<sup>17</sup> Average costs have generally remained consistent after a decrease from FY 2011 to FY 2012, though range considerably in all four 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.

**Table 4. Range of estimated costs of a typical ISST meeting, FY 2011 – FY 2014**

	FY 2011	FY 2012	FY 2013	FY 2014
Average cost of typical ISST meeting*	\$323	\$292	\$286	\$292
Range (min – max)	\$100 - \$800	\$45 - \$720	\$50 - \$800	\$90 - \$800

## 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 2014 reflects the third year that CMPs have tracked ISST-served children and youth at the client level, resulting in a total of 11,431 unduplicated cases entered into the CMP database.<sup>19</sup> Tables and figures in this section summarize key population and ISST services information for cases tracked in the CMP database.<sup>20</sup>

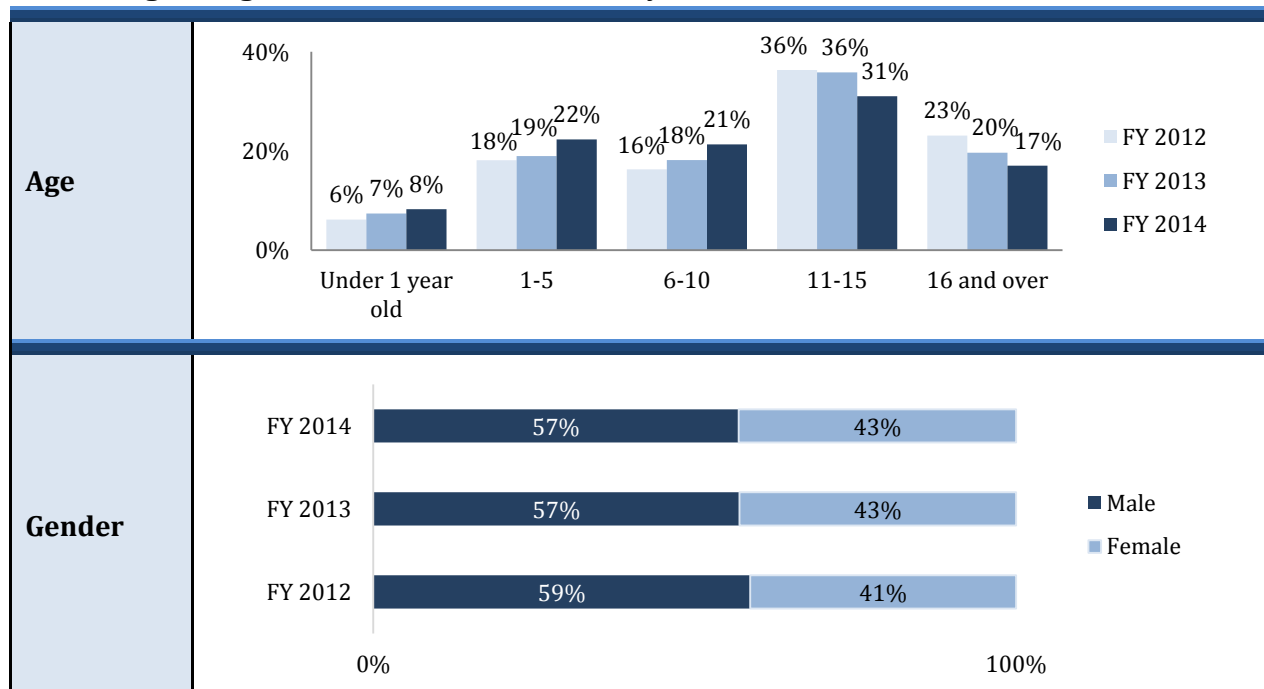
**Cases Served By ISSTs (unduplicated)<sup>18</sup>**

- 3303 in FY 2012
- 3333 in FY 2013
- 4795 in FY 2014

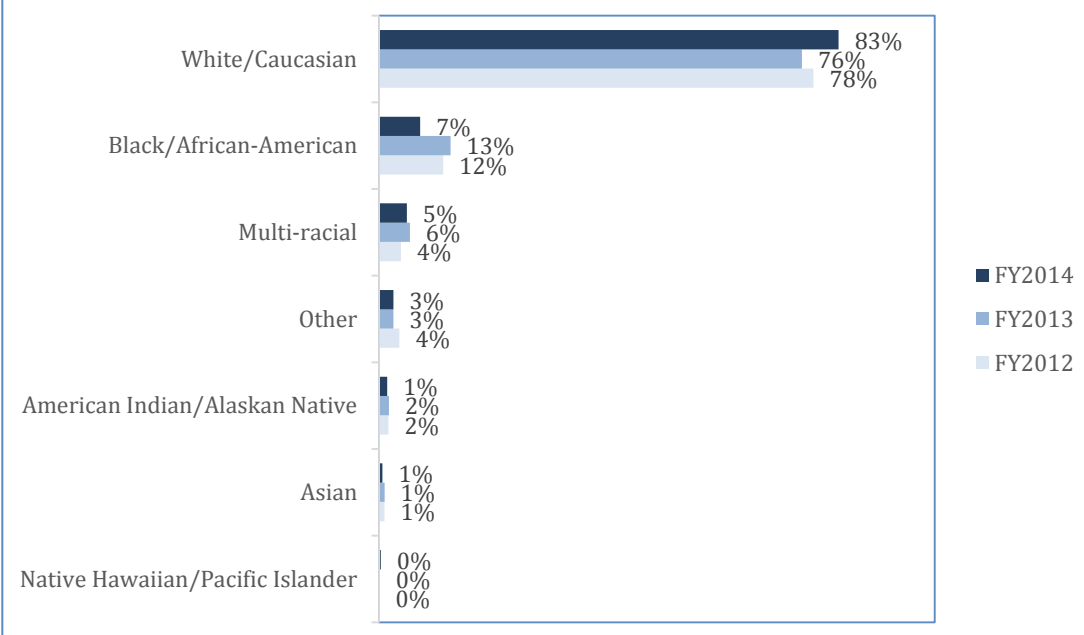
### Who Was Served Through the ISST Process?

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<sup>18</sup>**



**Table 6: Race and ethnicity of individuals served by ISSTs<sup>18</sup>**

<b>Race</b>	 <table border="1"> <thead> <tr> <th>Race</th> <th>FY2014</th> <th>FY2013</th> <th>FY2012</th> </tr> </thead> <tbody> <tr> <td>White/Caucasian</td> <td>83%</td> <td>76%</td> <td>78%</td> </tr> <tr> <td>Black/African-American</td> <td>7%</td> <td>13%</td> <td>12%</td> </tr> <tr> <td>Multi-racial</td> <td>5%</td> <td>6%</td> <td>4%</td> </tr> <tr> <td>Other</td> <td>3%</td> <td>3%</td> <td>4%</td> </tr> <tr> <td>American Indian/Alaskan Native</td> <td>1%</td> <td>2%</td> <td>2%</td> </tr> <tr> <td>Asian</td> <td>1%</td> <td>1%</td> <td>1%</td> </tr> <tr> <td>Native Hawaiian/Pacific Islander</td> <td>0%</td> <td>0%</td> <td>0%</td> </tr> </tbody> </table>	Race	FY2014	FY2013	FY2012	White/Caucasian	83%	76%	78%	Black/African-American	7%	13%	12%	Multi-racial	5%	6%	4%	Other	3%	3%	4%	American Indian/Alaskan Native	1%	2%	2%	Asian	1%	1%	1%	Native Hawaiian/Pacific Islander	0%	0%	0%
	Race	FY2014	FY2013	FY2012																													
	White/Caucasian	83%	76%	78%																													
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Asian	1%	1%	1%																														
Native Hawaiian/Pacific Islander	0%	0%	0%																														
<b>Ethnicity</b>	39% indicated Hispanic/Latino ethnicity in FY2014, similar to 44% in FY 2013 and 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 three years. Table 7 lists all ISST referral sources reported by CMPs for ISST-served cases.<sup>21</sup>

**Table 7: ISST referral sources<sup>18</sup>**

Referral Source	Number of Cases (%)		
	FY 2012	FY 2013	FY 2014
DHS Child Welfare	2097 (67%)	2035 (63%)	3545 (74%)
School	412 (13%)	556 (17%)	534 (11%)
Judicial and/or probation	471 (15%)	349 (11%)	316 (7%)
SB-94 program	181 (6%)	153 (5%)	311 (7%)
Other	213 (7%)	221 (7%)	271 (6%)
Mental Health/Behavioral Health Organization	157 (5%)	181 (6%)	246 (5%)
Self/Parent	82 (3%)	219 (7%)	86 (2%)
Law enforcement	118 (4%)	112 (3%)	36 (1%)
Diversion	33 (1%)	14 (<1%)	27 (1%)
Domestic violence	20 (1%)	11 (<1%)	25 (1%)
Juvenile Assessment Center	--	5 (<1%)	14 (<1%)
DYC	15 (<1%)	16 (<1%)	12 (<1%)
Health Department	0 (0%)	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 2014, 56% of ISST-served youth were involved with two or more systems at enrollment; this percentage is a slight decrease from FY 2012 (60%) and similar to FY 2013 (55%). For the majority of CMPs (28, or 88%) 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 three years.

**Table 8: Systems involved at ISST enrollment<sup>18</sup>**

System, Agency, or Organization	Number of cases (%)					
	FY 2012		FY 2013		FY 2014	
DHS with CW open involvement	2437	(78%)	2400	(74%)	3761	(80%)
Mental Health/Behavioral Health Organization or Services	1192	(38%)	1116	(35%)	1777	(38%)
Judicial/Probation	735	(23%)	592	(18%)	744	(16%)
Counseling/At-Risk Services	313	(10%)	366	(11%)	468	(10%)
Special Education/IEP	462	(15%)	347	(11%)	451	(10%)
Truancy Program	206	(7%)	236	(7%)	323	(7%)
SB-94 Program	181	(6%)	153	(5%)	311	(7%)
Other School-Based Program	242	(8%)	193	(6%)	243	(5%)
Other System or Organization	231	(7%)	274	(8%)	226	(5%)
Other DHS CW program	109	(3%)	129	(4%)	186	(4%)
Other Health Program	100	(3%)	159	(5%)	122	(3%)
Health Department Program	97	(3%)	77	(2%)	104	(2%)
DYC - Detention/Commitment	61	(2%)	93	(3%)	83	(2%)
Domestic violence program	54	(2%)	42	(1%)	79	(2%)
Other Juvenile Justice Program	71	(2%)	64	(2%)	77	(2%)
Diversion Program	56	(2%)	36	(1%)	63	(1%)
Juvenile Assessment Center	--		6	(<1%)	32	(1%)
DYC- Parole	9	(1%)	12	(<1%)	14	(<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 three 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 and remaining at 92% in FY 2014 (see Figure 8 on the following page).

**Figure 8: Number of systems or providers involved in ISST planning<sup>18</sup>**

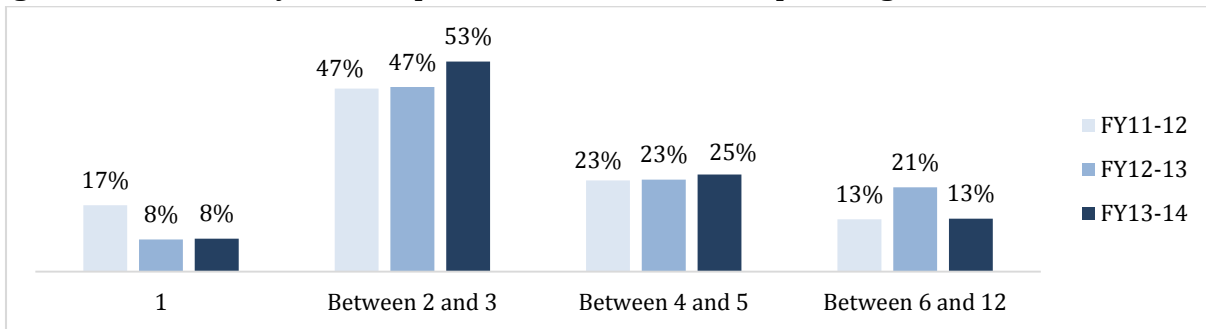


Table 9 outlines the various systems and providers that participated in ISST planning efforts. The data suggest frequent involvement from local DHS departments, as well as mental and behavioral health providers.

**Table 9: Categories of systems or providers involved in ISST planning<sup>18</sup>**

System, agency, or organization involved in ISST planning process	FY 2012			FY 2013			FY 2014		
	Number of Cases (%)	System is newly involved (%)		Number of Cases (%)	System is newly involved (%)		Number of Cases (%)	System is newly involved (%)	
DHS Child Welfare	2760 (91%)	(11%)		2862 (89%)	(13%)		4204 (89%)	(7%)	
Mental Health/Behavioral Health Organization	1516 (50%)	(19%)		1564 (49%)	(22%)		2077 (44%)	(18%)	
ISST Facilitator	22 (1%)	--		1771 (55%)	--		1833 (39%)	--	
Other	1355 (44%)	--		1218 (38%)	--		1781 (38%)	--	
Judicial/Probation	1076 (35%)	(16%)		1187 (37%)	(22%)		1431 (30%)	(16%)	
Family advocate/family facilitator	297 (10%)	--		551 (17%)	--		1281 (27%)	--	
Other family support person	419 (14%)	--		533 (17%)	--		1269 (27%)	--	
School	967 (32%)	(12%)		1089 (34%)	(11%)		1231 (26%)	(8%)	
SB-94 program	539 (18%)	(11%)		535 (17%)	(12%)		548 (12%)	(6%)	
Health Department	344 (11%)	(9%)		371 (12%)	(7%)		244 (5%)	(4%)	
Diversion	209 (7%)	(5%)		94 (3%)	(2%)		202 (4%)	(3%)	
Division of Youth Corrections	234 (8%)	(7%)		156 (5%)	(3%)		133 (3%)	(3%)	
Juvenile Assessment Center	0 (0%)	(0%)		23 (1%)	(1%)		78 (2%)	(1%)	

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

Table 9 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 94% of ISST-served cases, CMPs included a family member in the initial ISST meeting in FY 2014, up from 85% in FY 2013 and 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<sup>18</sup>**

Family Members at ISST Meeting	Number of Cases (%)					
	FY 2012		FY 2013		FY 2014	
Mother	2014	(63%)	2282	(69%)	3679	(77%)
Father	1000	(31%)	1074	(32%)	2056	(43%)
Youth	665	(21%)	826	(25%)	1489	(31%)
Grandparent	504	(16%)	647	(19%)	872	(18%)
Other family member	430	(13%)	505	(15%)	659	(14%)
Legal guardian	85	(3%)	93	(3%)	278	(6%)
Sibling	204	(6%)	238	(7%)	206	(4%)
Foster parent	189	(6%)	124	(4%)	128	(3%)
No family members present	680	(21%)	498	(15%)	311	(6%)

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

For most cases across the three year period, ISST meetings resulted in an integrated service plan; this was the case for 92% of ISST-served children and youth in FY 2014, 88% in FY 2013 and 86% in FY 2012. CMPs have shown growth in ensuring multiple providers are included in the service plan, as 86% of all cases have more than one system/provider as part of the plan in FY 2014, up from 76% in FY 2013 and 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).

**An integrated service plan was developed in the majority of cases<sup>18</sup>**

- 86% in FY 2012
- 88% in FY 2013
- 92% in FY 2014

**Table 11: Systems, agencies, or providers designated to provide services in the plan<sup>18</sup>**

System, agency, or organization designated to provide services in integrated plan	Number of cases (%)					
	FY 2012		FY 2013		FY 2014	
DHS Child Welfare	2261	(74%)	2330	(72%)	3406	(78%)
Mental Health/Behavioral Health Organization	1628	(53%)	1735	(54%)	2426	(55%)
Other	904	(29%)	1104	(34%)	2135	(49%)
ISST Facilitator	8	(<1%)	422	(13%)	1453	(33%)
School	999	(33%)	1033	(32%)	1169	(27%)
Judicial and/or probation	800	(26%)	724	(22%)	793	(18%)
Health Department	162	(5%)	134	(4%)	158	(4%)
SB-94 program	204	(7%)	140	(4%)	129	(3%)
Diversion	45	(1%)	30	(1%)	53	(1%)
Division of Youth Corrections	91	(3%)	60	(2%)	44	(1%)
Juvenile Assessment Center	--	--	14	(<1%)	42	(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 pilot study continued through FY 2014.

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 I and has been summarized in prior CMP evaluation reports.<sup>22</sup>

This section of the report describes analyses designed to address a primary question of the statewide evaluation: Does the CMP result in positive outcomes for multi-system involved children and youth? The question is addressed through calculation of performance on the statewide outcome indicators. The section concludes with a brief summary of the exploratory analyses that were conducted in early 2014 to begin to examine the question: Which CMP components are most effective? Analyses involved multilevel modeling, and the exploratory results illustrate how accumulated client-level service and statewide indicator outcome data may be applied in future evaluation efforts, when there is sufficient sample size and more specified data regarding service models, to answer key evaluation questions.

### **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.<sup>23</sup> Where possible, outcome rates on similar indicators from other state-level sources are presented to provide contextual information 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 data collection. As is noted below, participation in pilot data collection in these areas continued to be quite low. Indicator rates are reported for the small subset of cases with available data, for the purposes of demonstrating measurement capability. It is critical to note that the findings are unlikely to be representative of statewide CMP performance in these areas.

### **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. The analytic plan was reviewed and approved by CDHS and State Judicial analysts in FY 2013.

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). Thus, **results reflect the outcomes of children and youth with initial ISST meetings in two annual cohorts: FY 2012 (n = 3,303) and FY 2013 (n = 3,333); cases with initial ISST meetings in FY 2014 were not included as one year had not yet passed** for any of these cases.<sup>18</sup> Chi-square analyses were conducted to explore statistically significant differences in percentages in meeting outcomes across FY 2012 and FY 2013 cohorts; findings that reached significance are indicated in the tabled results below.

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 (i.e., 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 in FY 2012 and FY 2013 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 J for these results.

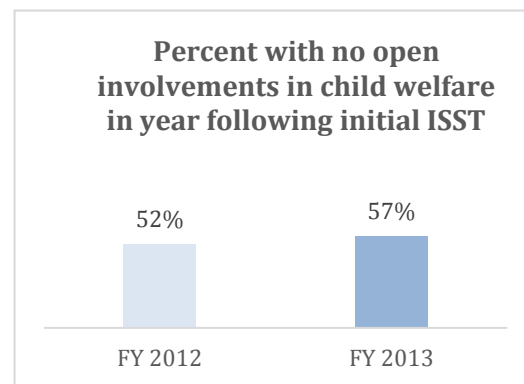
## Child Welfare: What Are the Child Stability/Permanency and Safety Outcomes for Children, Youth, and Families Served by ISSTs?

Below, indicator data in four areas relevant to child stability/permanency and safety for families served by CMP ISSTs are presented, utilizing the most recent available data (FY 2012 and FY 2013). The number of children and youth for whom the indicator is relevant, details regarding the calculation of the indicator (numerator and denominator), and the results achieved by CMPs are provided. Comparisons with similar data reported by state entities are included, where relevant data are available.

### Preventing new involvements in child welfare.

Among ISST served children, approximately 51% of the 3303 served in FY 2012 and 54% of the 3333 served in FY 2013 were deemed at risk of open involvement or re-involvement with the child welfare system.

Of these, over half of the FY 2012 cases (52%) and FY 2013 cases (57%) were successfully averted from open involvements in the year after their initial ISST meeting. The difference across cohort-years was not statistically significant.

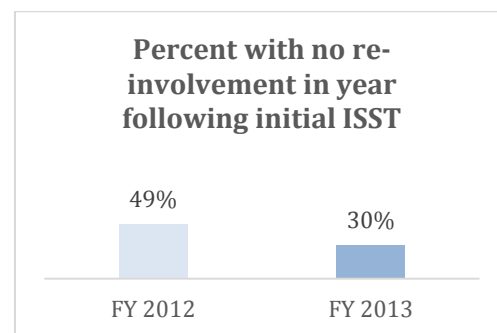


Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who had no new open involvements in year following ISST meeting	801	988
<i>Denominator:</i> CMP children who had prevent open involvements selected as a target goal	1548	1754

### Preventing re-involvements in child welfare

For those cases with a prior history of involvements and considered at risk, 49% of FY 2012 cases and 30% of FY 2013 cases were prevented from re-involvement in the year following ISST services.

The decrease from FY 2012 to FY 2013 was statistically significant ( $p < .01$ ).



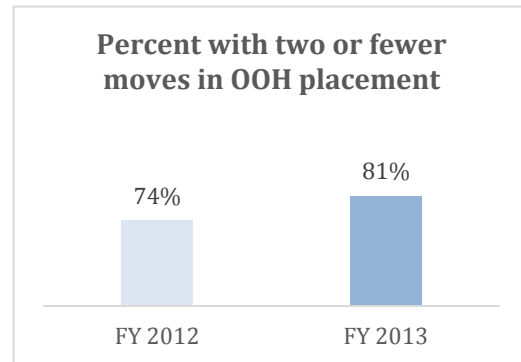
Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children with closed involvements who had no new open involvements in year after ISST meeting	71	35
<i>Denominator:</i> CMP children who had a history but no current open involvement at time of ISST, and had prevent open involvements selected as a target goal	145	118



### Minimizing the number of moves while in out-of-home placement

Approximately 24% of ISST served cases in FY 2012 and 26% in FY 2013 had minimizing number of moves while in out-of-home placement indicated as a target goal for services.

Results showed that 81% of FY 2013 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. This percentage was higher than what was demonstrated in the FY 2012 cohort (74%), at a trend level ( $p=.06$ ).



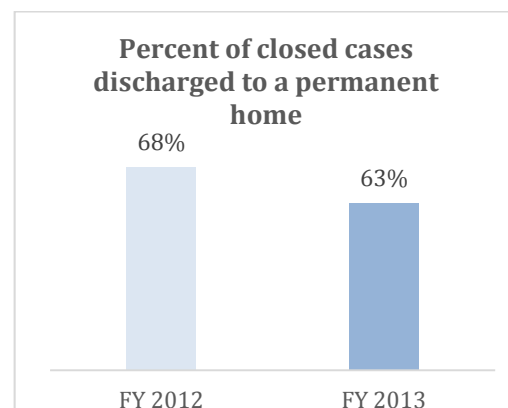
Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children in OOH placement with two or fewer moves in year following ISST meeting	200	154
<i>Denominator:</i> CMP children in OOH placement who had reducing number of moves as target goal	269	189

### Increasing discharges to a permanent home

Approximately 22% of FY 2012 and 20% of FY 2013 ISST served cases had discharge to a permanent home as a relevant target goal for services.

Results showed that 68% of FY 2012 and 63% of FY 2013 cases with this indicator as a goal who were in out-of-home placement with case closure were reunified or placed in a permanent home.

The difference across cohort-years was not statistically significant.



Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who were in OOH placement and discharged, discharged to a permanent home in year following ISST meeting	263	201
<i>Denominator:</i> CMP children who were in OOH placement and discharged, and had discharge to a permanent home selected as a target goal	387	321

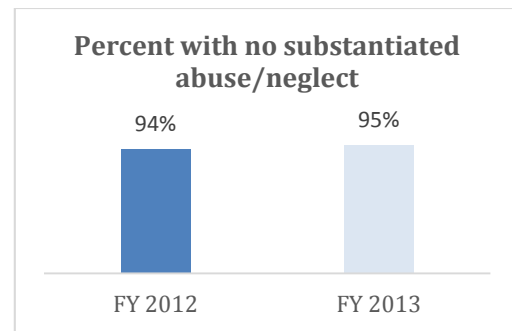
**Comparison to state-wide child welfare data:** These rates are lower than the similar indicator tracked for all closed cases within a 12-month period at the state level (76%).<sup>24</sup>



### Preventing child abuse and neglect

About 37% of children and youth served by ISSTs in FY 2012 and 40% in FY 2013 were deemed at risk for child abuse or neglect.

In general, abuse/neglect findings among CMP ISST-served children and youth appear to be rare, with 95% (FY 2012) and 96% (FY 2013) of ISST-served children and youth with no substantiated reports in the year after their initial ISST meeting.



The difference across cohort-years was not statistically significant.

Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who had a substantiated finding of abuse or neglect in year following ISST meeting	1050	1220
<i>Denominator:</i> CMP children who had preventing child abuse and neglect selected as a target goal	1127	1294

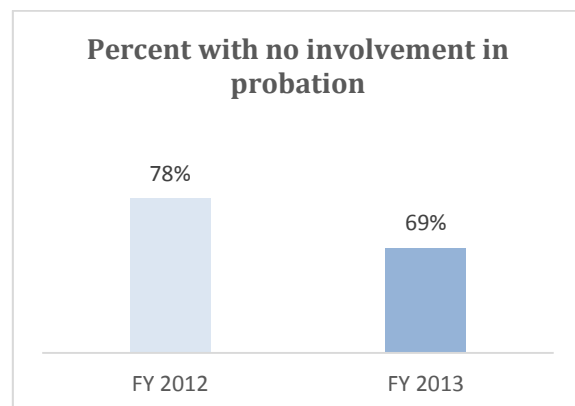
### Juvenile Justice: What Are the Probation Outcomes of ISST-served Children and Youth?

Below, indicator data for indicators in areas relevant to juvenile justice involvement for CMP ISST cases are presented, utilizing the most recent available data (FY 2012 and FY 2013). The number of cases for whom the indicator is relevant, details regarding the calculation of the indicator (numerator and denominator), and the results achieved by CMPs are provided. Comparisons with similar data reported by state entities are included, where relevant data are available.

#### Preventing involvements/re-involvements

Approximately 28% of the 3,303 served by ISSTs in FY 2012 and 23% of the 3,333 in FY 2013 were deemed at risk of involvement or re-involvement with the juvenile justice system.

About 78% of these cases in FY 2012 and 69% of FY 2013 cases were successfully averted from involvement with probation in the year following their ISST meeting. The decrease from FY 2012 to FY 2013 was statistically significant ( $p < .01$ ).



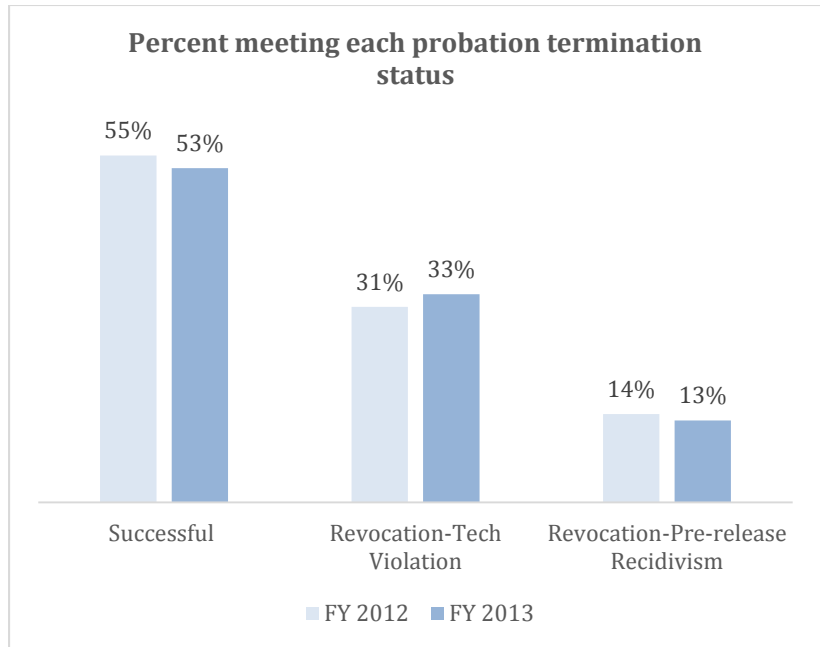
Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who did not become involved with probation in the year following their initial ISST meeting	661	513
<i>Denominator:</i> CMP children who had preventing involvement in juvenile justice system selected as a target goal	849	714



### Successful and unsuccessful termination of probation

For FY 2012 ISST-served cases, 17% had successful termination of probation as a target goal, with 14% of cases with the same designation in FY 2013.

Among those cases who entered ISST services recently on probation and where termination was a target goal, over half (55% in FY 2012 and 53% in FY 2013) successfully terminated after their initial ISST meeting, and about a third (31% and 33% respectively) were revoked for technical violations, with the rest revoked for pre-release recidivism (14% and 13%, respectively). The differences from FY 2012 to FY 2013 were not statistically significant.



Initial ISST in:	FY 2012	FY 2013
<i>Denominator:</i> 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	260	189
<i>Numerator:</i> CMP children who <b>successfully terminated</b> probation in the year after their initial ISST meeting	142	101
<i>Numerator:</i> CMP children who <b>unsuccessfully terminated</b> probation with <b>revocation due to technical violation</b> in the year following their initial ISST meeting	81	63
<i>Numerator:</i> CMP children who <b>unsuccessfully terminated</b> probation with <b>revocation due to pre-release recidivism</b> (new felony or misdemeanor offense) in the year following their initial ISST meeting	37	25

**Comparison to statewide judicial data:** It is important to note that in State Judicial reports of similar indicators for Colorado’s youth, 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.

The State Judicial report showed that among all youth who terminated probation during FY 2014, 73% were successfully terminated, 15% were revoked for technical violations, and 8% were revoked for pre-release recidivism.<sup>25</sup> Thus, successful termination for CMP-served children and youth was lower, and rates of revocation of probation were higher than state-reported rates.

### **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 in FY 2013 and remained low in FY 2014 (overall, less than 5% of ISST-served children and youth in the two fiscal years had any data entered into the CMP ETO database; and between 0.02-2% of all ISST-served cases had pre- and post-data available for analysis of outcomes on any specific indicator). For purposes of describing the indicators and demonstrating the potential for measurement in the future, results from the very small subset of cases with available data are reported. **However, the results should not be considered representative of the CMP population and should not be reported as evidence of impact at this time.**<sup>26</sup>

Given the small amount of available data for cases served in each fiscal year, overall rates reported below were calculated utilizing all available data (i.e., any case with pre-post or post-only measures among those served in initial ISSTs in FY 2013 or FY 2014, aggregated across fiscal years, without applying any restrictions on follow up periods for analysis or selecting only those cases for whom the outcome was selected as a target goal). Thus, the samples for education and mental health statewide indicators are not analogous to the samples reported for child welfare and juvenile justice statewide indicators in the previous section.

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*].

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

Below, the indicator, measurement details, extent of pilot participation and exploratory results for indicators relevant to educational outcomes for children and youth served by CMP ISSTs are described. As stated above, the results are calculated with all available data (aggregated across FY 2013 and FY 2014) and are not representative of the CMP population nor the subsample of children who may be considered at risk for these outcomes.

**Improved school attendance.** CMPs track the attendance rate (recorded as a percent) 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), in order to assess the number and rate who demonstrate improved attendance during or for a period after the ISST services are completed. Of the 123 cases in FY 2013 and FY 2014 from 10 CMPs with measures at both time points, 60 (49%) improved, 16 (13%) stayed the same, and 47 (38%) had decreased attendance by exit from ISST services.

**Reduced disciplinary problems at school.** 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). Data are used to calculate the number and rate of children and youth who have no disciplinary actions and the average number of disciplinary actions at school during ISST services. In FY 2014, items to assess these indicators were added to the pre measure per request of CMPs. The following were reported among cases served by 8 CMPs for FY 2013 and FY 2014 cases:

- **In school suspensions.** Of the 53 cases, 43 (81%) had no in school suspensions during ISST services. The average number of suspensions was 0.5 during ISST services.
- **Out-of-school suspensions.** Of the 52 cases, 43 (83%) had no out-of-school suspensions during ISST services, with an average number of 0.4 of out of school suspensions.
- **School referrals to law enforcement.** Of the 54 cases, 46 (85%) were not referred to law enforcement by school officials during ISST services. The average number of referrals was 0.26 during ISST services.
- **Expulsions.** Of the 53 cases, 51 (96%) were not expelled during ISST services. The average number of expulsions was 0.05.

**Improved school performance (academic achievement).** CMPs track the grade point average and/or test score preceding the initial ISST (pre measure) and at ISST-exit (post measure), in order to assess the number (rate) who demonstrate improved grade point averages or academic achievement scores during or for a period after ISST services. Of the 85 cases in FY 2013 and FY 2014 with GPA recorded at both time points, an equal number improved (35; 41%) as declined (35; 41%), with 15 (18%) cases with no change in GPA from baseline to exit of ISST services. The

average GPA at baseline was 1.82 and 2.43 at exit from ISST services. Among those who improved, the average amount of change from baseline to post measure was 1.2.

**Maintain enrollment in school.** CMPs track the number of times children and youth moved from one school to another while they were served by an ISST (post measure). Data are applied to calculate the number (rate) who continue to be enrolled in school during, or in the same academic year as, ISST services, as well as the average number of school moves during ISST services. Of the 295 cases in FY 2013 and FY 2014 from 14 CMPs, 255 (86%) were enrolled at exit from ISST services, 22 (7%) were not enrolled, and for 18 (6%) enrollment status was unknown. Approximately 26% (69) of those with post measures regarding number of school moves (265) experienced at least one move (range was 0 to 4). Among those who moved, the average number of change in schools was 1.2.

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

The indicator, measurement details, extent of pilot participation and exploratory results for indicators relevant to health and mental health outcomes for children and youth served by CMP ISSTs are described below. As stated above, the results are calculated with all available data (aggregated across FY 2013 and FY 2014) and are not representative of the CMP population nor the subsample of children who may be considered at risk for these outcomes.

**Improved mental health functioning.** 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), in order to assess the number (rate) of cases with improvements. In FY 2013 and FY 2014, only three cases from 2 CMPs had available data at both time points. Of the three cases, one showed improvements on both symptom severity and level of functioning; one remained stable on symptom severity and improved on level of functioning, and one case showed no change in either indicator from baseline to end of ISST services.

**Decreased need for inpatient mental health care.** 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). Data are used to calculate the 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. In FY 2013 and FY 2014, of the 94 cases with relevant data from 3 CMPs, 83 (88%) had no inpatient hospitalization placements, one had one placement (2%) and two (10%) had two placements during ISST services.

**Completion of substance use treatment.** CMPs track data for up to three substance use treatment admissions per 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, Division of Youth Corrections discharge, or still in treatment at ISST exit/post). Data are used to calculate the number (rate) who successfully

complete substance use treatment during or for a period after ISST intake. Five cases from two CMPs had pre- and post-measures available across the two fiscal years (2013 and 2014). Three of the five cases had successfully terminated treatment, while one was still in treatment at end of ISST services, and one had initiated an early termination.

**Increased access to health care providers.** 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). Data are used to assess the number (rate) of CMP children and youth with existing or newly established providers in these areas, as appropriate, during ISST services. The following results were obtained for cases with available data (pre and post measures) in FY 2013 and FY 2014 from 12 CMPs; results refer to status at exit of ISST services:

- **Primary care provider:** Of the 216 cases, 190 (88%) remained with a primary care provider, 4 (2%) remained unknown, and 22 (10%) cases had a newly established primary care provider arranged during ISST services
- **Mental health services provider:** Of the 208 cases that were deemed appropriately assessed at both time points for this outcome, 104 (50%) retained existing mental health providers, 63 (30%) had a newly established provider, 32 (15%) did not have mental health provider in place, and 9 (4%) were unknown.
- **Substance use treatment provider:** Of the 125 cases that were deemed appropriately assessed at both time points for this outcome, 67(54%) had a provider (50 were newly established during ISST services), 52 (42%) did not, and 6 (5%) were unknown.
- **Health insurance:** Of 425 with measures at both time points, by exit from ISST services, 262 (62%) had public insurance, 111 (26%) had private insurance, 3 (<1%) were in process of establishing insurance, 19 (4%) were unknown, and 6 (1%) had no insurance. Of the 21 with no insurance noted at the start of service, 19 had newly established insurance at the end of ISST services, with 3 others in the process.

Given low levels of involvement in the measurement of these outcomes, it will be important for the CMP State Evaluation Subcommittee and the CMP State Steering Committee to identify strategies to address data collection challenges in education and health/mental health domains in FY 2015.

### **Exploratory analysis of relationships between CMP components and outcomes**

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. In December 2013-January of 2014, as reported in the Year 4 Evaluation Report, the evaluation team conducted exploratory analyses in this area (see Appendix K for a more detailed description of these efforts and emerging results). The analyses were not repeated for the Year 5 Evaluation Report as relatively few additional cases were available to apply to the analysis; thus sample size would continue to be insufficient to provide definitive results at this time. However, a brief summary of these efforts are summarized here in order to demonstrate the potential of the method to answer key questions when sufficient data become available in future years.

Hierarchical linear models were run to examine the following question: *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?*

Models tested for significant predictors of each of the child welfare and juvenile justice statewide indicators; three service related variables (family present, multiple agencies involved, and service plan created), two community level factors (CMP, Process Quality score from IOG survey), and control variables reflecting demographic characteristics and systems involvement at time of initial ISST were entered. Two-way interactions were explored, and analyses were conducted on both the full sample and subset with the outcome as a target goal.

In general, findings were complex and difficult to interpret. 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 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

These results were preliminary. The models were impacted 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), and wide variability in other factors not fully accounted for in the models (e.g., diverse ages and service types, participation of CMP in other initiatives that may impact findings, such as Differential Response), leading the evaluation team to have limited confidence in the results. More rigorous measurement is needed to move from exploration to a stronger analytic model. The exploratory models conducted in 2014 confirmed that this method is capable of revealing important predictors of outcomes, but future analysis will require increased sample size and nuanced examination of 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. These measures provide additional sources of data to address the question of CMP impact on child, youth, and family outcomes.

### 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 incentive formula (referred to as "primary incentivized outcomes"). The selection and definition of 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 M lists the 128 different local performance measures assessed by the 32 CMPs in FY 2014 and the corresponding local performance measures assessed by CMPs in FY 2013. 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 appendix also highlights complex issues presented by the variation in measures which prevent cross-site aggregation of data. Summarized information for FY 2014 outcomes is presented below.

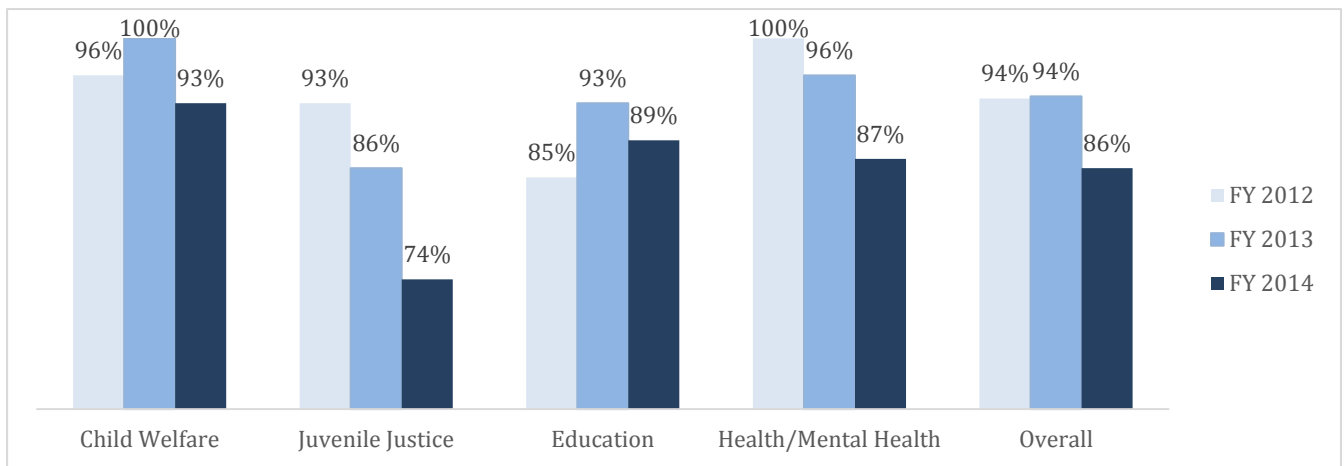
**Method and data considerations.** Data were extracted from Local Performance Measures tables, where CMPs reported: indicator with target goal as listed in MOU, domain, the number of individuals assessed by the indicator, performance or success rate in FY 2013 and in FY 2014, data source/measurement 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. 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., if CMP was newly enrolled); missing (no performance data were submitted). Descriptive data were categorized and analyzed in Excel software.

Of the 124 outcomes submitted from 31 CMPs (one CMP did not submit outcomes by the time of analysis) in FY 2014, 88% assessed child and family level outcomes and 12% assessed process outcomes (e.g., improvements in service delivery). Performance information was available for 87% of the 128 stated outcomes.

*Overall, CMPs reported achieving 86% of their target goals on their locally-defined performance measures.*

Overall, CMPs reported achieving 86% of their target goals. As shown in Figure 9, the percent of locally-defined target goals met across CMPs ranged from a high of 93% for the child welfare domain to a low of 74% in juvenile justice domain in FY 2014.

**Figure 9: Percent of CMPs where primary incentivized goals were achieved by domain**



Results indicate that overall, CMPs are consistently meeting their target goals in locally-specified focal outcomes over time. The overall percent of target goals met decreased in FY 2014 after an increase from FY 2012 to FY 2013. 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. A decrease in the percentage of goals met may reflect more stringent goal setting at the local level, as opposed to meaningful change; this is not currently able to be assessed.

## 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 has gathered 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.<sup>27</sup>

**Table 12. Multi-agency participation in service planning<sup>18</sup>**

Indicator	FY 2012	FY 2013	FY 2014
Percentage of initial ISST meetings where two or more systems/agencies were included	83%	92%	92%
Percentage (number) of CMPs where 70% or more of initial ISST meetings had two or more systems/agencies included	86% (25)	94% (30)	91% (29)

Moreover, these data also reveal that in general, the “right” agencies and organizations are at the table when it comes to service planning. Table 13 shows the percentage of FY 2014 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 98% 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, judicial justice providers, education, and mental health providers were particularly well-represented at meetings where the child or youth was noted as involved in those services at intake.

**Table 13: Match of systems involvement at ISST meeting in FY2014**

System/Provider	% of youth
Child welfare	(98%)
Judicial and/or Probation	(83%)
Juvenile Assessment Center	(75%)
Education	(70%)
SB-94 Program	(70%)
Health/mental health	(66%)
Diversion	(61%)
Health department	(34%)

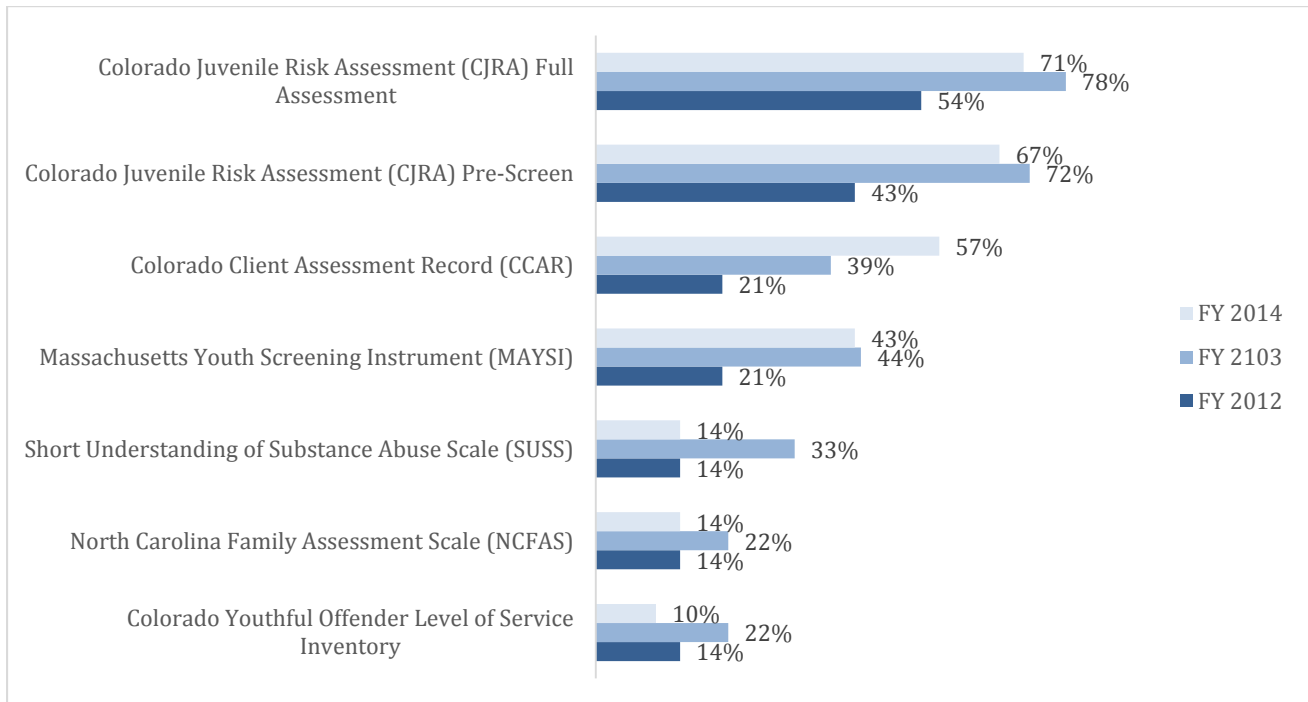
**CMPs actively share information to simplify and streamline service experiences for families and providers.** CMPs report implementation of two key strategies aimed at streamlining and simplifying the experiences of children, youth, and families seeking services, as well as gathering information consistently across partners. Table 14 reports the extent to which CMPs utilize these two key strategies of common consents and client assessments across agencies. Figure 10 on the following page shows the most common shared assessments, and highlights that the percentages of CMPs reporting their use showed similar patterns from FY 2012 to FY 2014, but with decreased use of some assessments in FY 2014.

**Table 14: Methods of sharing information**

Indicator	FY 2012	FY 2013	FY 2014
Percentage (number) of CMPs utilizing common consent across multiple agencies	68% (19)	72% (23)	81% (26)
Percentage (number) of CMPs using common client assessments/screening tools shared across multiple agencies	61% (17)	56% (18)	65% (21)

**CMP Practice Example: Mesa County** “...continues to utilize our secure online information sharing system, ‘Basecamp,’ for identifying current involvement and for notification of future system involvement. During FY13-14, service authorizations have been distributed to providers and partner agencies through Basecamp, in an effort to notify providers more swiftly, as well as keeping the designated team notified of the current status.”

**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 reports, suggest that CMPs coordinate services in a detailed plan, with shared accountability across agencies and clear designation of service provision and payment responsibilities (see Table 15 and Section X for details).

**Table 15. Components of service plans<sup>18</sup>**

Indicator	FY 2012	FY 2013	FY 2014
Percentage of initial ISST meetings where an integrated plan was developed	86%	88%	92%
Percentage of initial ISST meetings where multiple systems/agencies were designated in the plan to provide services	73%	76%	86%
Percentage (number) of CMPs reporting that they “often” or “always” designate which partners will provide services included in the plan	100% (28)	100% (32)	97% (31)
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)	97% (31)

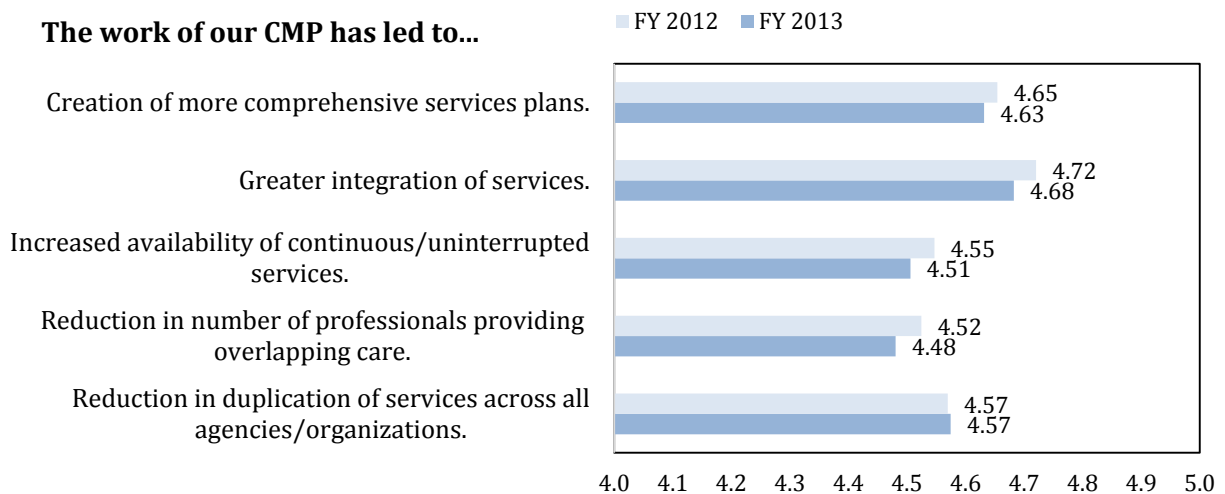
**CMP Practice Example: Gunnison-Hinsdale** “Our FAST collaborative reviews all family teams once a month, both written and verbally. Reports are given by each facilitator indicating # of ISST’s for the month, goals, progress, services, barriers and offers a unique format for brainstorming around needs. Everyone [who is] a part of the ISST is aware of all services being provided to the family as well as progress in service and outcome areas and potential risk of involvement in future services. In addition to attendance on support teams, there is a process in place to ensure all agencies involved with the family agree to adopt the integrated, family driven plan.”

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. Nearly all CMPs reported that they have significantly reduced conflicting mandates in FY 2014 (97%, 31 CMPs), similar to FY 2013 (100%; 32 CMPs) and up from FY 2012 (85%; 24 CMPs).

**CMP Practice Example: Alamosa** *“Duplication of services as well as fragmentation of services is reduced or eliminated altogether because all concerned parties are at the table at the same time making decisions, along with the juvenile and family, regarding the best interest of the juvenile. Within the past 12 months, the courts have designated one judge to handle all CYPM cases giving us a ‘One Judge/One Family’ model. [The judge] hears the child welfare D&N case as well as the juvenile justice case on the same day, at the same time. This eliminates the need for the family to appear one day for the child welfare case in front of one judge, and then appear again on another day in front of a different judge for the juvenile justice case. Because one judge handles both cases, she understands more aspects of the family dynamics. During the hearings, the SB94 Case Worker or Probation Officer, DSS Case Worker, County Attorney, Defense Counsel, District Attorney, GAL, parents and juvenile are all present. This assists the judge in hearing from all parties at the same hearing as well as assists the family in handling both cases at once.”*

**CMP stakeholders perceive significant achievements in their efforts to reduce duplication and eliminate fragmentation.** Figure 11 on the following page summarizes the responses from IOG members on five relevant items on recent administrations from fiscal years 2012 and 2013 Collaborative Effectiveness Survey (the survey was not administered in FY 2014). 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.<sup>28</sup>

**Figure 11: FY 2012 and FY 2013 Collaborative Effectiveness Survey results: CMP achievements regarding duplication and fragmentation<sup>29</sup>**



\*Mean score on item, aggregated within CMP, averaged across CMPs. Survey was not administered in FY 2014.

Despite significant achievements in these areas, CMPs did report some notable challenges in their efforts to reduce duplication and fragmentation in FY 2014. Two of the more commonly cited challenges were:

- Data and information sharing among partners:** Jefferson County: *The committed use of the common release of information form within the County continues to be a goal of the CMP. Making the change to a single format has proven difficult for some agencies in regards to specific site policy and procedure. Despite the common release of information form including all confidentiality laws, some agencies are hesitant to make the switch. This has been addressed somewhat by collaborative agreements regarding information sharing across CMP members. In these circumstances, there is close attention to confidentiality and who needs to know the information.*
- Sharing/coordination of resources and funding among partners:** Morgan: *“Resource sharing, outside of in-kind contributions, is always a topic of conversation especially when beginning to discuss sustainability for the program into the future; however, this becomes very gray in regards to other agencies budgeting money to spend out to the IOG, finding grant funding that can be funneled towards IOG, and also [identifying] the individual benefit to their agency in order to offer funding to the collaborative.”*

### 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 2014.

**CMPs are addressing the specific service needs of their communities.** Performance on indicators listed in Table 16 on the following page 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 16: Enhancements to service quality and appropriateness**

Indicator	FY 2012	FY 2013	FY 2014
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)	59% (19)
Percentage (number) of CMPs that implemented or enhanced existing services to be more culturally appropriate/culturally competent	43% (12)	53% (17)	63% (20)

**CMP Practice Example: El Paso** “Two new programs were developed in the 2013-14 fiscal year. 1) The Reach Youth and Families Care Management Entity (Reach CME) to deliver quality integrated services through a wraparound model of care coordination while monitoring client impacts and resource utilization. The focus of this effort is to tailor services to individual youth and family needs, encourage and empower youth and families to advocate for themselves, and connect youth and families to community and natural resources for long term stability. Reach CME will be sustainable through Medicaid and blended and braided funding systems including the development of an at risk case rate model within two years. 2) Reach Schools to deliver similar services with a specific school point of entry in order to fill gaps of resources and service access between identification of need in the school setting and deeper system involvement. Reach Schools is integrated with Reach CME to provide a seamless support as families move between levels of system involvement.”

**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

12 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 generally grown across the past few years among CMPs. As of FY 2014 approximately half of CMPs utilize High Fidelity Wraparound or Wraparound (15 CMPs, same as in FY 2013) and Team Decision Making (13 CMPs, down from 20 in FY 2013), and the Crossover Youth Practice Model has remained at about one-fourth of all CMPs (8 CMPs). Efforts to collect data about implementation fidelity for these models have grown; for example, 9 of the 15 CMPs implementing High Fidelity Wraparound report monitoring the fidelity of their implementation of the model (see Table 17), up from 8 CMPs in FY 2013.

**Table 17. Fidelity monitoring in commonly implemented ISST models**

Evidence-informed program/practice	Number of CMPs	Fidelity measures
High Fidelity Wraparound or Wraparound	15	9 (60%)
Team Decision Making	13	5 (38%)
Crossover Youth Practice Model	8	3 (38%)

**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 2014 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, all CMPs (100%) 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 Table 18 included coordinator review, annual reporting to IOGs, and annual reporting by external local evaluators to IOG.

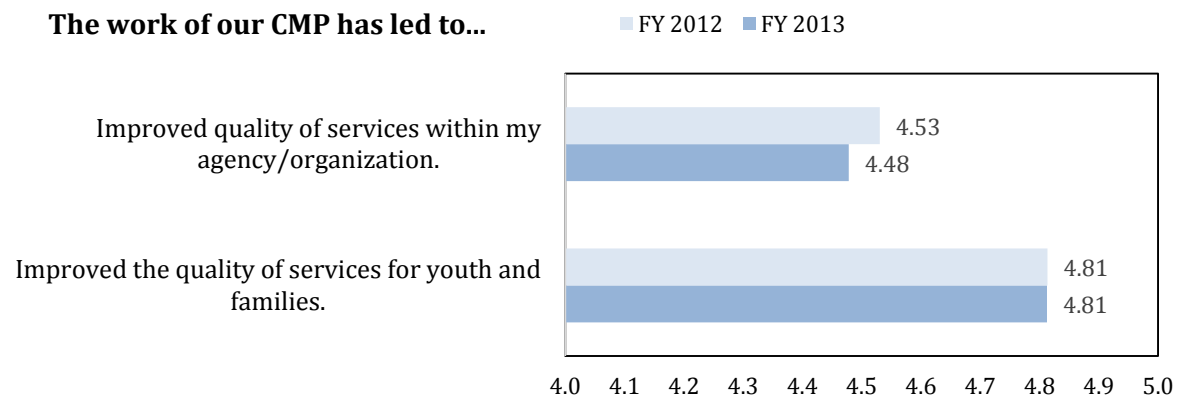
**Table 18. Strategies for integration of evaluation into CMP activities**

Strategy	FY 2012	FY 2013	FY 2014
Our full IOG regularly reviews evaluation/outcome monitoring processes and results	4 (14%)	13 (41%)	23 (72%)
Our IOG has formed a data sub-committee or working group that meets regularly to review evaluation/outcome data.	3 (11%)	3 (9%)	8 (25%)
Our coordinator or other CMP stakeholder distributes written summaries of evaluation/outcome data on a regular basis.	14 (50%)	15 (47%)	26 (81%)
Other strategy	11 (39%)	7 (22%)	2 (6%)

**CMP Practice Example: Fremont** *“Written updates for members are provided at each monthly meeting for the mentoring and mini-grant program, website, youth activities, family representation, family assistance program. Reports...share any activities related to the CMP and the numbers being served in each [program].”*

**CMP stakeholders perceive significant achievements in their efforts to improve quality of service.** IOG members reported in FY 2013 that CMP activities have resulted in improved quality of services, as shown in Figure 12.<sup>30</sup>

**Figure 12: FY 2012 and FY 2013 Collaborative Effectiveness Survey results: CMP achievements regarding service quality<sup>31</sup>**



\*Mean score on item, aggregated within CMP, averaged across CMPs. Survey was not administered in FY 2014.

## **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.<sup>32</sup>

In January 2014, a letter was sent by the director of the Office of Children Youth and Families in the Colorado Department of Human Services to directors of county human services departments “to strongly encourage the addition of a family organization or family member to the voting membership” of Interagency Oversight Groups (IOGs) of local Collaborative Management Programs. The letter specified that at the time of the original CMP legislation it was intended that the local IOGs would add a family organization or family members to the voting membership and that local CMPs would tangibly support family-driven practices. Please see Appendix E for information related to this request that are 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 2014 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 ensuring culturally competent family-centered services, and in best practices in collecting feedback on services from families

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

CMPs involve family representatives to help inform systems and service planning within IOGs. The level of family involvement has slightly increased from 89% in FY 2012 and 72% in FY 2013 to 94% in FY 2014. The majority of CMPs (30) reported that they currently have at least one family driven organization representative, family advocate, family member, or youth member on their FY 2014 IOG. Of these 30 CMPs, 25 (or 83%) of them designate voting rights to family representatives, and 27(or 90%) 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.

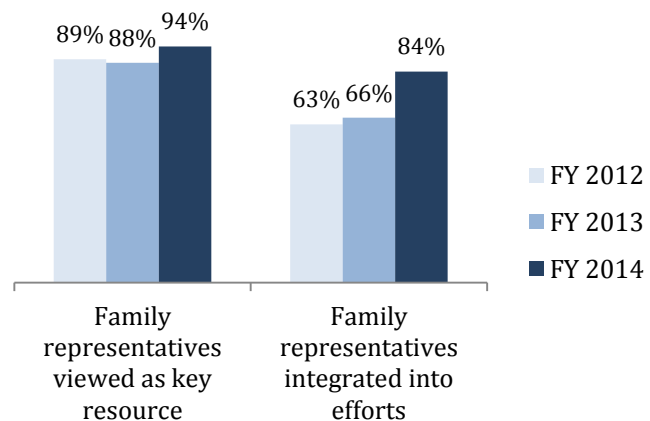
A **family-driven organization** has the explicit purpose to serve families who have a child with special needs as describe above. It is governed by a board of directors and comprised of a majority of individuals who are family members.

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<sup>33</sup>**

Perceptions of IOG family representatives' engagement in IOG activities has grown over the past three fiscal years. The percentages of CMPs who rated family representatives as being "sometimes," "often," or "always" key resources and integrated into the work of the IOG increased in FY 2014 (30 CMPs) as compared to FY 2012 (24 CMPs) and FY 2013 (28 CMPs; see Figure 13). There were 27 CMPs who reported that family representatives were integrated into IOG efforts in FY 2014, which was larger than the number of CMPs reporting this in FY 2013 (21 CMPs) and FY 2012 (17 CMPs).



Some CMPs described significant improvements in this area (see examples in highlight box in this section). However, other CMPs continue to encounter challenges in effectively involving family representatives (see Table 19 on the following page). Barriers experienced by CMPs appear to be stable from FY 2012 to FY 2014.



### Family involvement at the IOG level

CMPs report that they are finding ways to encourage and sustain family engagement in oversight and governance of their efforts.

- **Huerfano:** *“Family member involvement has been excellent at the ISST level.... Our work continues to get family members involved at the IOG level.”*
- **Douglas:** *“Our 1451 brought on our family representative in the 12-13 FY, so this is a newer role for our group. Our family representative is considered another partner at the table and not a token partner. We have included our family representative on our MOU as a voluntary voting member. We are not looking to change the person in this position and hope to create a long-term relationship.”*
- **Pueblo:** *“The Pueblo IOG Family Representative began conducting focus groups with client families late in the current fiscal year to gauge their level of satisfaction with access-to-services in Pueblo County. These focus groups will continue into the next fiscal year.”*

**Table 19: Challenges experienced by CMPs in involving families in IOGs<sup>34</sup>**

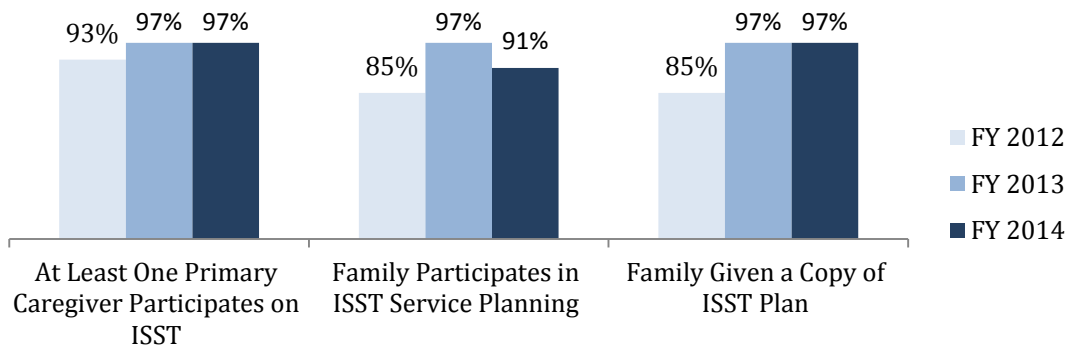
Barrier description	FY 2012	FY 2013	FY 2014
Issues identifying appropriate families for IOG participation	54%	56%	56%
Time constraints/scheduling	43%	44%	41%
Confidentiality issues	14%	28%	22%
Lack of knowledge/experience of family or youth recruited about CMP processes	32%	25%	19%
Lack of commitment among recruited youth and families	25%	25%	16%
Geography/Distance	11%	13%	16%
Lack of funding to compensate family and youth members	18%	9%	13%
Personnel turnover	11%	9%	9%
Lack of IOG buy-in regarding family involvement	4%	3%	0%
Other barriers	32%	22%	0%

### 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 on the following page).

**Figure 14: Family involvement in ISST**



### Family involvement in ISST Services: Tailoring services to meet families' needs

CMPs have indicated that family involvement is maintained when families are engaged and services are tailored to the individual.

- **Routt:** *"A lot of upfront time is spent in educating the families about the ISST process, in order to give them the opportunity to derive the most benefit from the meeting. Families are assisted in identifying potential needs, which then drive the services; this is a critical component to the process."*
- **Gunnison/Hinsdale:** *"We strive to ensure that services and plans are family-driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. We...provide individualized services which address the unique needs and potential of a child. We choose to think outside of the box and explore creative ways to support youth and families by asking 'What if?' and 'How could we?'"*

In FY 2014, nine (28%) CMPs report that family representatives are viewed as partners in service to other families (down from 14 in FY 2012 and 11 in FY 2013), and 29 (91%) report that family advocates or family friends participate in treatment planning meetings in a supportive role at least "sometimes," "frequently," or "always" (about the same as FY 2012 and FY 2013). Among the children and youth served by ISSTs that are represented in the CMP database, 27% had a family advocate or facilitator involved in the initial service planning meeting in FY 2014. While this may appear to be a low rate, this is an increase from 10% in FY 2012 and 17% in FY 2013; 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 27% of the cases in FY 2014, up from 14% in FY 2012 and 17% in FY 2013.

Of the 29 CMPs who reported having family partners with roles in CMP service activities in FY 2014, a total of 13 (45%) indicated that they have mentoring or other methods of supporting families in CMP governance and service delivery (same as FY 2013). 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 25 CMPs (78%, up from the 19 CMPs that reported doing so in FY 2013) indicate that they implement measures or methods to track family involvement at the local level. Among those CMPs that do so, there has been an increase in the number utilizing family surveys to assess satisfaction and decreases in tracking participating in ISST meetings, as compared to prior years (see Table 20).

**Table 20: Methods of assessing family involvement**

Family involvement measurement strategy	Number of CMPs reporting "yes" (%)					
	FY 2012		FY 2013		FY 2014	
Family survey about satisfaction with services	19	(68%)	16	(84%)	19	(76%)
Tracking of family participation in ISST meetings	19	(68%)	13	(68%)	0	(0%)
Family survey about cultural responsiveness	7	(25%)	9	(47%)	0	(0%)
Other type of family survey	1	(4%)	0	(0%)	19	(76%)
Tracking of family representative participation in IOG meetings	15	(54%)	--	--	--	--
Other method	0	(0%)	2	(11%)	2	(8%)

Note: n = 24 for FY 2012; n = 19 for FY 2013; n = 25 for FY 2014. "--"denotes items not collected.

In addition, a variety of family-related measurement tools have been shared across CMP sites, including family satisfaction surveys, pre-ISST family assessments, fidelity checklists, local-level process evaluation surveys, and family functioning assessments.

*“Garfield County tracks family participation in the CMP process. Our CMP continues to believe that family involvement is essential to the ISST process. Our families are invested from start to finish, which leads to a higher rate of success for the youth, since the families are more inclined to participate in direct services and therefore we see improved outcomes for children, youth and families.”*

**Statewide resource: Family Feedback Form.** 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. The *Family Feedback Form* was offered as an optional measure for FY 2014 and was officially launched in January 2014, with strong endorsement by CMP state administration.

The *Family Feedback Form* is available in English and Spanish. 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.<sup>4</sup> The non-anonymous method of data collection allows for multiple administrations and monitoring of family perceptions of key components over time.

Since launching the measure in January of 2014, 8 CMPs have collected and entered *Family Feedback Form* data (non-anonymous version) for a total of 40 ISST cases. Scale scores were calculated by averaging the relevant items scores (5 point scale, with higher ratings indicating greater satisfaction) according to methods outlined by Brunk (1999).<sup>35</sup> The following table presents the means for the five scale scores, and the percentage of cases where the mean scale score was over 3.5. Among this small subset of CMP cases, scores generally indicate that CMPs are quite effectively meeting the needs of families and children.

**Table 21: Mean scale scores for Family Feedback Form measure, with a higher rating on the five-point scale indicating greater satisfaction**

<b>Performance Indicator – Scale Score</b>	<b>Mean</b>	<b>% With Mean Over 3.5</b>
Access to Services	4.4	98%
Participation in Treatment	4.6	94%
Satisfaction with Services	4.5	92%
Cultural Sensitivity of Staff	4.7	100%
Perceived Outcome of Service	4.2	92%

## 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.

### 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.

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 L and M for detailed information regarding funding sources and expenditures and for listing of funding sources by county.)

Financing strategy <sup>36</sup>	Description
<b>Create new structures to pool/blend/braid funding</b>	Collapse and streamline funds from multiple systems for services that target relevant cross-system outcomes; cost savings are reinvested
<b>Redeployment of existing dollars</b>	With few “new dollars,” funds are redirected from high costs/poor outcome areas into targeted services
<b>Strategic use of earned incentive funds</b>	Ensure performance measures are met to maximize incentive funds, carry over funds to address year-to-year fluctuations in agency budgets
<b>Raise new revenue</b>	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

**Earned incentive funds:** For FY 2014, the total earned incentive fund distributed to the 35 counties was approximately \$1.6 million. In FY 2014, CDHS reviewed the incentive funding process and timing, and determined that adjustments were required in order to ensure that counties receive earned incentive dollars in the fiscal year in which their performance on incentive outcomes was assessed. In FY 2014, funds dispersed were based upon the cash balance at the end of FY 2014. Prior to FY 2014, total funding dispersed to CMPs had remained around \$2.6 million per year. The total funding available has stayed relatively consistent or has been reduced while the number of CMPs has increased, resulting in less money distributed to

each site over time. In FY 2014 CMPs reported expending about \$3.9 million of their available incentive funding, slightly lower than in FY 2013 (\$4.1 million). This total exceeds the FY 2014 earned incentives 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 personnel and administrative costs.

**In-kind contributions:** In total, CMPs reported an estimated \$16 million provided in goods and services by partners (see Appendix N for categories of in-kind contributions by partner agency); an increase from FY 2013 (\$15 million). In many cases, contributions came from non-mandated partners, indicating widespread support for collaborative services within communities.

**External grants:** 22 CMPs received an estimated total of \$2.9 million in funds from local, state and federal grants to support and expand service delivery, up from 17 CMPs with \$2.5 million reported in FY 2013 (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 (88%) or in-kind (97%) at least “sometimes” for staffing and administrative needs, similar to FY 2013
- **Development and implementation of new programs:** 97% of CMPs indicated that they contribute funds across agencies to build new programs at least “sometimes”, up from 91% in FY 2013
- **ISST services:** 97% of CMPs indicated that during ISST meetings, agencies jointly agree on who will pay for intervention services, same as in FY 2013

*“Two partner agencies [in Gunnison-Hinsdale County] have contributed dollars to the incentive fund directly to help support the family advocate and wraparound facilitator positions. We continue to successfully blend and braid funding across all child and family serving systems to support Wraparound facilitation and direct services to children and families.”*

### How Are CMPs Realizing Cost Savings and Reinvesting Funds?

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 multi-agency CMP services are largely not tracked locally and data from CMPs that do track the costs of their services have not been systematically 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:

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

*“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 multiple funding streams, and reducing fragmentation of services between agencies.”*

### 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, six CMPs (up from four in FY 2013) provided some information regarding estimated cost savings associated with specific partner programs or outcomes/local performance measures (see Table 22). Four other CMPs indicated that their IOGs have cost savings measurement as a specified objective for FY 2015.

**Table 22: Cost savings reported by CMPs**

CMP	Program or service	Savings in FY 2013	Data source or method
Crowley-Otero	ISST and Family Engagement Meetings	\$74K	Average cost per year of DYC commitment of \$65,404 and juvenile parole of \$8,614
	Family Engagement and Preventative Aftercare Services	\$57K	Average cost per day of out-of-home (OOH) placement; estimated cost based upon the likelihood of placement as estimated by one county DSS (5 youth averted) and DYC (one youth averted). Takes into consideration reduced lengths of stay for some already in placement and reduction in number of possible placements.
Fremont	Family Treatment Drug Court; efforts of IOG partners to reduce OOH placements	No amount reported	Reported measurement but not total amount saved. Each case was assessed to whether or not out-of-home placement would have happened, OOH shortened, adoption costs and subsidy avoided when compared to using the standard case services model.
Larimer	All CMP services contributed to impact	\$118K	Estimated costs of the reduction in out-of-home care from previous year, based on average cost of placement
Lake	High-Fidelity Wraparound	\$20K	Cost of one youth averted from residential substance use treatment for four months, utilizing one residential treatment program average costs per month
	Department of Human Services	\$45K	Costs associated with averting nine youth from OOH, estimated (conservative) cost of \$5K per youth
Pueblo	ISST/Family Support Team services	\$50K	Estimated costs of averting OOH, provided by DSS
Routt	Department of Human Services	\$12K	Estimated costs of averting one child from residential placement for one month (\$5K), and one child averted from foster care for seven months (\$7K)
	Mental health services	\$16K	Estimated costs of averting one child from psychiatric hospitalization (\$1K per day for 16-day stay).

### Reinvestment of funds

Of the 31 CMPs that reported on reinvesting funds in FY 2014, the majority (26, or 84%) noted that they plan to reinvest funds carrying over into FY 2015 directly into new or expanded family-centered services. Almost two-thirds of CMPs (21) plan to apply funds to develop a flexible spending account to provide for family needs or pay for services, up from one-third in FY 2012 and one-half in FY 2013. See Table 23 for additional reinvestment categories.

**Table 23: 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 (%)**	FY 2014: Number of CMPs (%)***	Examples
Support programs and services	16 (64%)	27 (93%)	26 (84%)	Sustain or expand existing services, develop new programs, provide grants to programs with emergency needs
Support families directly	9 (36%)	14 (48%)	21 (68%)	Retain flexible funds for families in need of respite care, emergency services, etc.
Support personnel costs	5 (20%)	14 (48%)	19 (61%)	Contribute to CMP coordinator salary
Training, technical assistance	3 (12%)	4 (14%)	5 (16%)	Support symposium, cross-site meetings
Hold funds in reserve	6 (24%)	3 (10%)	5 (16%)	Retain funds to apply to planned programs or services
Support local evaluation	-- ----	5 (27%)	3 (10%)	Engage evaluators to conduct local performance measure analysis

Note: \*n = 25; \*\* n=29; \*\*\*n=31.

**CMP Practice Example: El Paso** “The El Paso County CMP serves as a catalyst for the encouragement and support of best practice including the development of new efforts that are designed to become sustainable through common funding streams. The EP CMP’s goals are not to manage programs indefinitely but to establish them in the community supported through innovative use of existing funding streams for sustainability. This approach has been adopted by the IOG in order to support SOC wide system improvement and to impact the greatest number of youth and families. This is not accomplished through a typical granting of dollars but through collaborative, active development and analysis of efforts by the entire IOG.”

### 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. The challenges associated with cost analysis at the state level for CMP have been described in prior evaluation reports and are briefly summarized here. Currently, CMPs implement diverse (and multiple) program approaches. CMPs continue to define key program components and to specify the extent to which specific outcomes are realized as a result of program components. In many CMPs, models have not become standard enough or implemented with sufficient fidelity to enable accurate cost assignment to efforts or to

savings associated with achieving outcomes directly from those efforts. These factors impede the ability to aggregate cost information across sites.

There are options the evaluation could explore in FY 2015 to move the CMP a step closer to measuring costs savings related to some CMP efforts. 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 future years, 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 investment in model specification and aligned cost measurement through evaluation 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 Conclusions and Considerations**

### **Evaluation goals**

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 measures across counties
- Designing and implementing strategies for comparing collaborative management practices and processes across counties
- Analyzing relationships between collaborative practices/processes and performance measures

### **Evaluation selected efforts and achievements**

Over the past five years, the evaluation established infrastructure to enable examination of these focus areas through a collaborative and participatory process that included meeting monthly with an Evaluation Subcommittee of the State Steering Committee composed of local CMP Coordinators as well as state agency representatives to design and implement the evaluation, traveling to each CMP to meet with local leaders to better understand their ISST models, and convening local CMP stakeholder groups over time to identify common statewide indicators across four domains. Local Interagency Oversight Group (IOG) stakeholders were interviewed and surveyed over time to gather information about the quality of collaborative processes, a key element of the CMP model.

The evaluation built foundational systems to collect standard data on an annual basis on 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 as well as child and family outcomes in the domains of child welfare, juvenile justice, education, and health/mental health. Evaluators expanded the annual report to gather data about systems improvements and local services to capture information about diverse local models as well as to promote learning within and across CMP sites to encourage model refinement.

Given that there is no state system that captures data about multi-system involved children, youth, and families, the evaluation developed an online database to gather standard client-level service data for clients served through local CMP ISSTs as well as outcome data in the domains of education and health/mental health and family feedback on service provision. Evaluators established data sharing agreements to enable matching of client-level ISST service data with client-level outcome data available through Child Welfare (Trails) and Judicial (ICON/Eclipse).

As a result of these evaluation efforts and achievements, CMP has seen improved specification and utilization of local performance as well as statewide outcome data. Correspondingly, CMP now has an enhanced focus on implementation and measurement of best practices.

### **Evaluation conclusions**

Through this infrastructure the evaluation was able to determine that CMPs are meeting legislated systems and service components and have high quality collaborative processes in place at the local

level to support CMP efforts. Specifically, interagency collaborative structures at governance and service levels are creating more uniform management of service delivery, successfully integrating family partners in service decisions, reducing duplication and fragmentation of services, improving service quality, and more effectively sharing and leveraging resources. CMPs are reaching the population of children and families indicated in the establishing legislation, with 56% of ISST-served cases involved in multiple systems of care at intake and 91% of cases with multiple system providers participating in integrated treatment planning. CMP programs and services touched an estimated 20,000 or more children and youth, with over 11,000 participating in integrated service planning. A large majority of cases received services with some proven efficacy, helping to ensure the best chances for improved functioning among Colorado's children.

In terms of performance based measures, CMPs are achieving positive outcomes for children, youth and families in the child welfare system and in other systems of care. Overall, CMP cases, despite being deeply involved and at high-risk for poor outcomes at enrollment in ISST services, are being successfully diverted from involvement or re-involvement with the child welfare system, have low rates of substantiated abuse or neglect, are achieving permanency and reunification with families, and are maintaining stability when in out-of-home placement. Positive outcomes were also demonstrated for CMP youth involved with probation, with over one-half of CMP ISST-served relevant youth successfully terminating. Moreover, CMPs demonstrated significant progress in "moving the needle" on some outcomes across cohorts. CMPs also reported considerable progress on ISST- and community-level outcomes such as reducing residential placements and decreasing rates of youth detention.

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 evaluation utilized client-level service data collected in the CMP database, and the matched outcome data from child welfare and state judicial systems, to begin exploring this question through the use of advanced analytic models, although sample sizes were too limited in this evaluation to have confidence in the findings. In future years when larger sample sizes are available, this focus area may be examined more thoroughly.

### **Evaluation considerations**

The evaluation infrastructure developed over the past five years is a strong foundation on which the CMP can continue to build and expand to:

- More precisely measure CMP population, services, and outcomes
- Analyze impacts longitudinally, across domains, and at multiple levels of influence
- 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, as desired
- Capture CMP cases within other state data systems (e.g., Trails)

The CMP can promote expansion of client-level and cross-system data in these areas to inform quality improvement, model refinement, and decision making efforts.

## Endnotes

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- <sup>1</sup> Colorado Revised Statute, Title 24, Article 1.9. (2010). Retrieved from <http://www.lexisnexis.com/hottopics/Colorado/>.
- <sup>2</sup> Goerge, R. M., Smithgall, C., Seshadri, R. & Ballard, P. (2010). Illinois families and their use of multiple service systems. *Chapin Hall Issue Brief*.
- <sup>3</sup> California Department of Education. (2007). Handbook on developing and evaluating interagency collaboration in early childhood special education programs. Retrieved June 1<sup>st</sup>, 2010 from <http://www.cde.ca.gov/sp/se/fp/documents/eciacolbrtn.pdf>.
- <sup>4</sup> U.S. Department of Health and Human Services. (2010). Guiding principles of systems of care. Retrieved June 1<sup>st</sup>, 2010 from <http://www.childwelfare.gov/pubs/soc/socc.cfm>.
- <sup>5</sup> 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 per request from the CMP Program Manager. A summary of products resulting from statewide evaluation activities in the four years of evaluation appears in Appendix G.
- <sup>6</sup> This was an optional item on the Annual Report; totals may underrepresent CMP efforts in these areas.
- <sup>7</sup> LaFasto, F., Larson, C. (2001). *When teams work best: 6,000 team members and leaders tell what it takes to succeed*. Sage Publications.
- <sup>8</sup> Chrislip, D., Larson, C. (1994). *Collaborative Leadership: How Citizens and Civic Leaders Can Make a Difference*. Jossey-Bass.
- <sup>9</sup> Available upon request to CDHS Program Administrator.
- <sup>10</sup> Definition was determined utilizing the Codigital collaborative decision-making online tool. <http://www.codigital.com/>.
- <sup>11</sup> Definition was developed at the March 26, 2013 Steering Committee.
- <sup>12</sup> Totals displayed in Figure 6 include estimated counts provided by CMPs in the FY 2014 Annual Report; counts include some duplication.
- <sup>13</sup> 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.
- <sup>14</sup> 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.
- <sup>15</sup> “Other models and programs” encompasses other responses from CMPs; some examples include Wayfinder, Check and Connect, LifeSkills Training, and Cognitive Behavioral Therapy.
- <sup>16</sup> 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.
- <sup>17</sup> 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).
- <sup>18</sup> Total number of cases and results for ISST case analysis differs from previous reports as case information is constantly updated in the CMP database; thus data from prior years/cohorts were re-analyzed and updated findings are presented throughout this report.
- <sup>19</sup> 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 2014, see Figure 5 in Section III of this report.

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<sup>20</sup> 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 I for more details on the data collection, auditing, and analysis process.

<sup>21</sup> In tables in this section, shading is used to demarcate groups by percentages, in ascending order.

<sup>22</sup> Please request previous CMP evaluation reports from the CMP Program Administrator (formerly available on the CMP Portal).

<sup>23</sup> Each CMP receives an individualized report of their local performance on statewide indicators.

<sup>24</sup> Retrieved from CDHS *Community Performance Center* Web page <http://www.cdhsdatamatters.org/index.html>.

Retrieved on-line October 2014.

<sup>25</sup> Office of the State Court Administrator (2014). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2014 releases*. Retrieved on-line October 2014.

<sup>26</sup> Performance data on pilot education and health/mental health indicators are available to each CMP through the customized report function in ETO.

<sup>27</sup> For all results reported in this section, the total number of CMPs with available annual report data was 32 for FY 2014 and FY 2013, and ranged from 28 to 29 in FY 2012. All available and updated ISST case data for FY 2012 through FY 2014 were utilized in analyses; thus, results may differ from prior reports.

<sup>28</sup> 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.

<sup>29</sup> 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.

<sup>30</sup> 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.

<sup>31</sup> 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.

<sup>32</sup> 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).

<sup>33</sup> For all figures and tables presenting results from annual reports in section IX unless otherwise noted, n in FY 2012 = 28; n in FY 2013 = 32; n in FY 2014 = 32.

<sup>34</sup> Totals sum to greater than the reported n's of CMPs and 100% because CMPs could select up to 3 barriers.

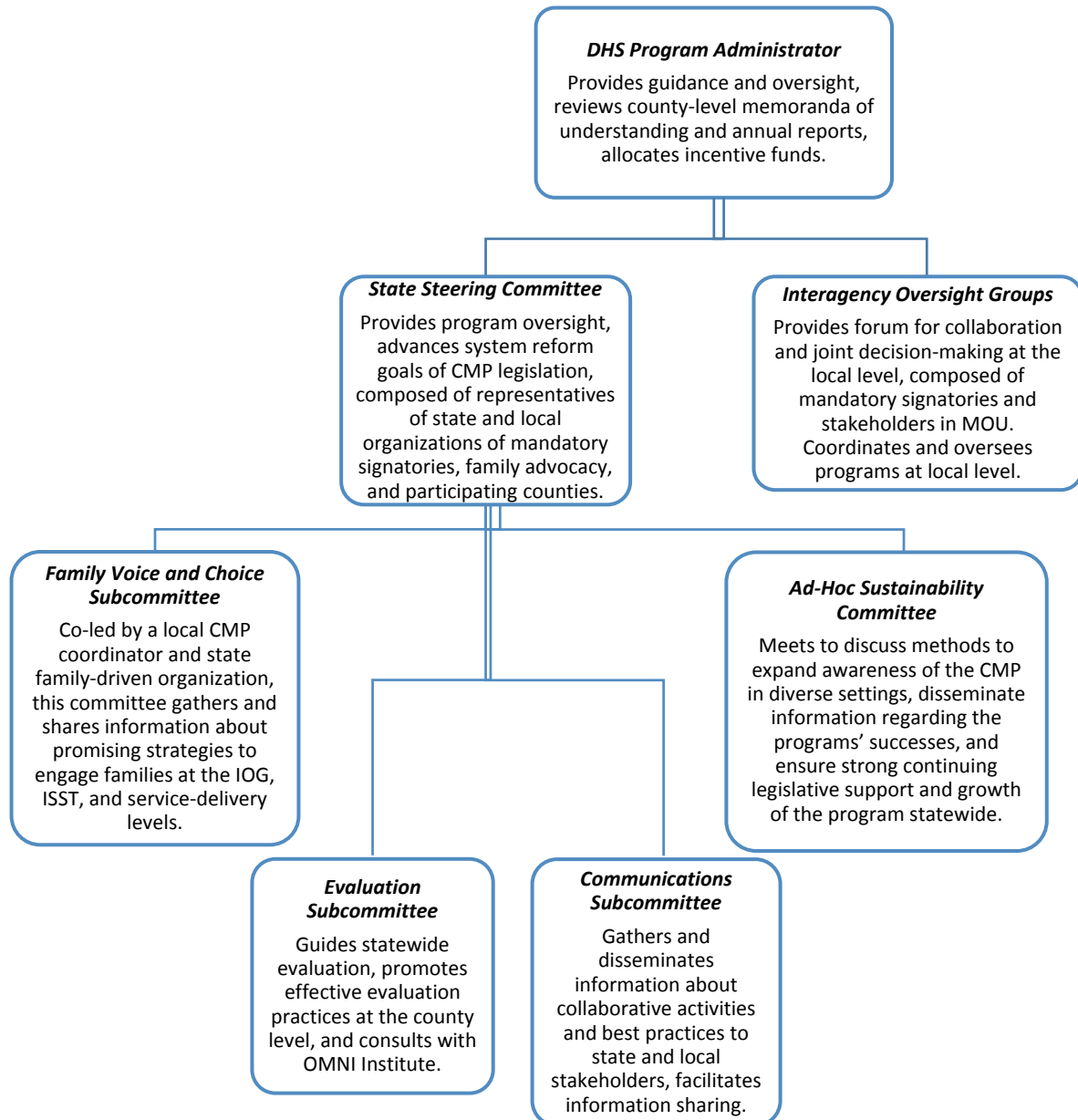
<sup>35</sup> Brunk, M. (1999). Youth Services Study and Youth Services Survey for Families. Mental Health Statistics Improvement Program.[On-line]. Available: [www.mhsip.org](http://www.mhsip.org).

<sup>36</sup> 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>.

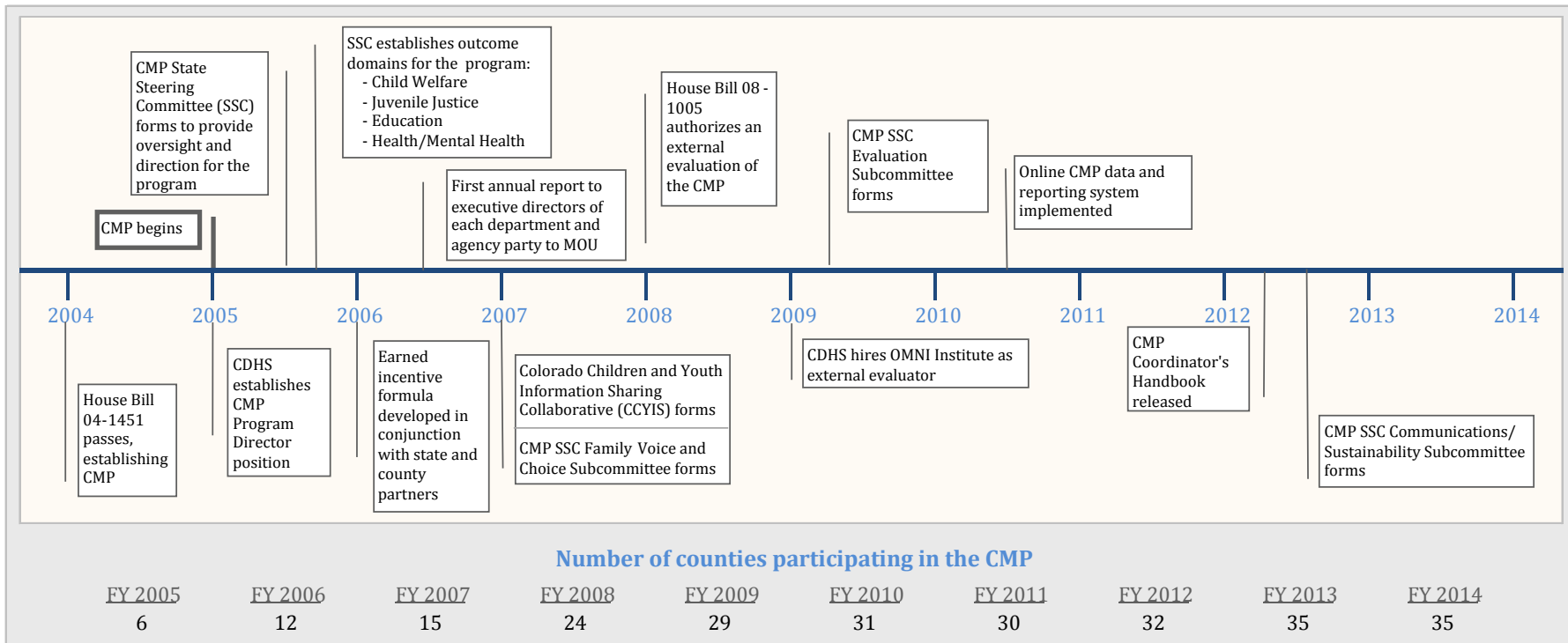
## Appendices

## Appendix A. CMP Oversight and Implementation Structure



## Appendix B. Key Milestones of the CMP Initiative

The following figure below details the key milestones reached from 2004 to 2014.



## 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 2014.

*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 FY 2014.

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	
FY 2010	CMP Evaluation Subcommittee (SEC) formed	Formative
	OMNI conducts CMP site visits and reviews local CMP performance measures	
	Online Quarterly Reporting System (QRS) launched	
	OMNI first administers online <i>Collaboration and Success Survey</i> (repeated annually)	
	OMNI first administers online <i>State Management Survey</i> (repeated annually)	
FY 2011	Year 1 reporting demonstrates 150+ performance measures; SEC outlines uniform statewide measurement approach	Infrastructure Building
	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	
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	Infrastructure Building
	CMP education and health/mental health uniform measurement planning (CMP stakeholder interviews and focus groups) process; measurement plan submitted to CDHS April 2012	
FY 2013	Education and health/mental health indicator data tracking pilot initiated (21 CMPs)	Summative
	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	
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	Summative
	Refinement of outcome analysis approach in conjunction with CDHS and State Judicial	

## **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 2014. 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 2014, 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.** 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)).

**Developed an integrated plan.** A checkmark in this area is an indication that the CMP reported that an integrated plan was developed in at least 80% of their ISST-served cases that were entered into the CMP ETO database (CMP ETO database, Client Tracking Form, Item "Was an integrated plan developed?," checked "Yes"). (Please note that this is a different measure than what was reported in the Year 4 Evaluation Report for this construct (the relevant item was removed from the FY 2014 Annual Report)).

**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))].

**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 or No to Item 1 but then marked a method of measurement elsewhere).

**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).

**Table 1. Indicators reflecting key CMP components, by CMP**

CMP name	IOG representation		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	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		✓		✓	✓	✓		✓	✓	✓					✓



CMP name	IOG representation		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	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
Garfield	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Grand	✓	✓		✓	✓	✓		✓	✓	✓	✓		✓	✓	
Gunnison/Hinsdale	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Huerfano	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓		
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 2014 Evaluation Report.

**Table 1. Data sources utilized in the FY 2014 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: <ul style="list-style-type: none"> <li>• Members</li> <li>• Population</li> <li>• Legislative Process Goals</li> <li>• Collaborative Structures and Process</li> <li>• Family Involvement</li> <li>• Costs</li> <li>• Local Performance Goals (Incentivized Outcomes)</li> <li>• Costs</li> </ul>	32 CMPs representing 35 counties submitted a FY 2014 Annual Report
CMP on-line client-level database [Efforts to Outcomes (ETO)]	<p>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)<sup>TM</sup>, 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.</p> <p>CMPs may also choose to complete Family Feedback Form, Education Pre-Post Indicator Form, Health/Mental Health Pre-Post Indicator Form (optional client-level measurement).</p>	<p>Data collected from the Client-Tracking Form include the following:</p> <ul style="list-style-type: none"> <li>• Client demographics</li> <li>• Youth involvement in systems/organizations at ISST enrollment</li> <li>• Referral source</li> <li>• Systems/organization/agencies involved in ISST meeting</li> <li>• Family involvement</li> <li>• Agencies or providers with role in delivering services</li> <li>• Agencies or providers with role in paying for services</li> <li>• Potential target outcome/treatment goals for family</li> <li>• Exit information, if applicable</li> </ul> <p>New for FY 2014:</p> <ul style="list-style-type: none"> <li>• Commonly-reported planning models applied during initial ISST meeting</li> </ul>	Number of unduplicated ISST Client-Tracking forms entered into ETO during FY 2014 for all CMPs: 4,795

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.	<p>The following outcomes are calculated by using state-agency data, assessed for ISST cases in the year following their initial ISST meeting.</p> <p><i>CDHS Trails database</i></p> <ul style="list-style-type: none"> <li>• Increase stability: prevent new involvements in child welfare system</li> <li>• Increase safety: prevent abuse</li> <li>• Increase stability: low number of moves while in placement</li> </ul> <p><i>State Judicial ICON/Eclipse database</i></p> <ul style="list-style-type: none"> <li>• Increase stability: discharge to a permanent home</li> <li>• Prevent juvenile justice involvement: prevent involvement with probation</li> <li>• Increase successful intervention: increase rates of successful completion of probation</li> <li>• Increase successful intervention: decrease rates of probation revocations</li> <li>• Increase successful intervention: decrease rates of pre-release recidivism</li> </ul>	All unduplicated cases are matched to state databases. Analysis calculates outcomes in year following the initial ISST. The total number of unduplicated cases included in outcome analysis was 3,303 (FY 12) and 3,333 (FY 13). FY 2014 cases were not included in outcome analysis as none would have one year of follow up data available at this time.
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.	<p>The Collaborative and Effectiveness Survey results in mean scale scores in the following areas:</p> <ul style="list-style-type: none"> <li>• Collaboration: structural integrity, authenticity, overall quality process, strong leadership, structure, and members</li> <li>• Overall success: general success, community involvement &amp; collaboration, quality of services, duplication of services, fragmentation of services, outcomes, costs, and family involvement</li> </ul>	Administered annually in FY 2010 through FY 2013. Not administered in FY 2014.

## 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 are publicly available; contact the Program Manager at CDHS with any requests.

Category	Report(s)	Description
Annual Evaluation Reports	Year 1 – FY 2010 Year 2 – FY 2011 Year 3 – FY 2012 Year 4 – FY 2013 Year 5 – FY 2014	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 FY 2014	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  Not administered in 2014	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.
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.

Category	Report(s)	Description
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	<p>Year 2 Progress Report: Outcomes Workgroup (2011)</p> <p>State Measurement Plan Phase I: Brief Summary for CMP Coordinators and IOGs (2011) &amp; PowerPoint Presentation for IOGs (2011)</p> <p>State Measurement Plan Phase II: Brief Summary on Education/Health Mental Health Indicators (2012)</p>	<p>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.</p> <p>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.</p> <p>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.</p>
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.
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	<p>CMP ETO Users' Manual</p> <p>CMP ETO Reports Manual</p> <p>ISST Client Tracking Form and Tutorial</p> <p>Education</p>	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



Category	Report(s)	Description
	<p>Indicators Tracking Form and Tutorial Health/Mental Health Indicators Tracking Form and Tutorial</p> <p>ISST Aggregate Report Education and Health/Mental Health Indicators Report (2012, 2013)</p>	<p>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.</p>
Family Feedback	Family Feedback Form – anonymous and non-anonymous versions and reports (2013)	<p>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.</p>

## Appendix H. 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 prior years, CMPs provided the estimated numbers of total eligible youth by service system/type; however, these reports contain known but unquantifiable duplication as youth are represented in multiple systems of care. In FY 2014, CMPs were asked to report only the number of children/youth with open child welfare involvement during FY 2014. This category was included because it represents the largest eligible population served by CMP and is available in published, verifiable reports through the state Trails data system. Prior years' reports are included for comparison purposes. It is important to note that this total number does not represent the entire eligible population for CMP services.

**Table 1. Number of youth eligible for CMP services as a result of open child welfare involvement, FY 2013-2014**

Number of youth with open child welfare involvement	Number of CMPs Reporting	Average Number of Population (Min.-Max.)	Mean	Total Across CMPs
FY 2014	30	(4 - 8,689)	775	23,237
FY 2013	31	(0 - 5,304)	630	19,536
FY 2012	26	(2 - 5,304)	863	22,442

The total number of eligible children as represented by open child welfare involvement varies widely across CMPs; for example, the totals reported by CMPs in FY 2014 ranged from 4 to 8,689.

### 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 in FY 2014. CMPs vary widely in the total number of individuals who are 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 Served by CMP Services	752	(11 - 5,309)	24,051
Individuals Served by an ISST	371	(11 - 3,283)	11,874
Individual Children/Youth Served by an ISST	247	(8 - 1590)	7,912



Table 3 shows the number of youth served by ISSTs in FY 2013 compared to FY 2014 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 8,716 cases in FY 2013 to 11,874 cases in FY 2014.

**Table 3. Number of youth served by ISSTs in FY 2013 and FY 2014 including newly enrolled and carryover cases**

<b>CMP Name</b>	<b>FY2013</b>	<b>FY2014</b>
Adams	365 (4%)	457 (3.8%)
Alamosa	75 (1%)	39 (0.3%)
Boulder	160 (2%)	119 (1.0%)
Chaffee	26 (0.3%)	27 (0.2%)
Conejos	65 (0.7%)	43 (0.4%)
Crowley/Otero	12 (0.1%)	35 (0.3%)
Denver	2618 (30%)	2396 (20.2%)
Douglas	97 (1%)	160 (1.3%)
Eagle	32 (0.4%)	45 (0.4%)
El Paso	277 (3%)	350 (2.9%)
Elbert	28 (0.3%)	31 (0.3%)
Fremont	362 (4%)	428 (3.6%)
Garfield	115 (1.3%)	123 (1.0%)
Grand	19 (0.2%)	18 (0.2%)
Gunnison/Hinsdale	31 (0.4%)	28 (0.2%)
Huerfano	77 (0.9%)	219 (1.8%)
Jefferson	1029 (12%)	1590 (13.4%)
Lake	35 (0.4%)	32 (0.3%)
Larimer	1412 (16%)	1480 (12.5%)
Lincoln	10 (0.1%)	11 (0.1%)
Logan	83 (1%)	152 (1.3%)
Mesa	155 (2%)	165 (1.4%)
Moffat	19 (0.2%)	32 (0.3%)
Montezuma-Dolores	23 (0.3%)	25 (0.2%)
Montrose	62 (0.7%)	53 (0.4%)
Morgan	138 (2%)	181 (1.5%)
Park	8 (0.1%)	12 (0.1%)
Pueblo	49 (0.6%)	148 (1.2%)
Rio Grande	31 (0.4%)	44 (0.4%)
Routt	20 (0.2%)	26 (0.2%)
Teller	184 (2%)	122 (1.0%)
Weld	1099 (13%)	3283 (27.6%)
<b>TOTAL</b>	<b>8716 (100%)</b>	<b>11874 (100%)</b>

As detailed in the body of the report, the total number of individual youth who were newly enrolled in FY 2014 and served by ISSTs is 7,912, per CMP responses as part of their annual reporting.<sup>2</sup> The following table shows this total displayed by each individual CMP.

**Table 4. Number of youth newly served by ISSTs in FY 2013 and FY 2014 by CMP**

<b>CMP name</b>	<b>Youth served by ISSTs (newly enrolled in FY 2013)</b>		<b>Youth served by ISSTs (newly enrolled in FY 2014)</b>	
Adams	365	(6.9%)	457	(5.8%)
Alamosa	63	(1.2%)	27	(0.3%)
Boulder	160	(3.0%)	109	(1.4%)
Chaffee	21	(0.4%)	21	(0.3%)
Conejos	65	(1.2%)	34	(0.4%)
Crowley/Otero	12	(0.2%)	31	(0.4%)
Denver	318	(6.0%)	1355	(17.1%)
Douglas	84	(1.6%)	99	(1.3%)
Eagle	32	(0.6%)	39	(0.5%)
Elbert	28	(0.5%)	348	(4.4%)
El Paso	Not reported	(0%)	31	(0.4%)
Fremont	362	(6.9%)	252	(3.2%)
Garfield	79	(1.5%)	74	(0.9%)
Grand	10	(0.2%)	8	(0.1%)
Gunnison/Hinsdale	18	(0.3%)	14	(0.2%)
Huerfano	55	(1.0%)	145	(1.8%)
Jefferson	1029	(19.6%)	1590	(20.1%)
Lake	52	(1.0%)	29	(0.4%)
Larimer	1261	(24.0%)	1331	(16.8%)
Lincoln	10	(0.2%)	11	(0.1%)
Logan	56	(1.1%)	92	(1.2%)
Mesa	155	(2.9%)	158	(2.0%)
Moffat	12	(0.2%)	31	(0.4%)
Montezuma/Dolores	17	(0.3%)	23	(0.3%)
Montrose	31	(0.6%)	50	(0.6%)
Morgan	133	(2.5%)	174	(2.2%)
Park	8	(0.2%)	11	(0.1%)
Pueblo	28	(0.5%)	119	(1.5%)
Rio Grande	31	(0.6%)	39	(0.5%)
Routt	19	(0.4%)	21	(0.3%)
Teller	180	(3.4%)	88	(1.1%)
Weld	569	(10.8%)	1101	(13.9%)
<b>TOTAL</b>	<b>5263</b>	<b>(100%)</b>	<b>7912</b>	<b>(100%)</b>

<sup>2</sup> 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 2014, per the CMP ETO database, is 4,795.

## Appendix I. 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<sup>3</sup> 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 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.

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<sup>3</sup> 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.

### **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, FY 2013 and FY 2014. 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.

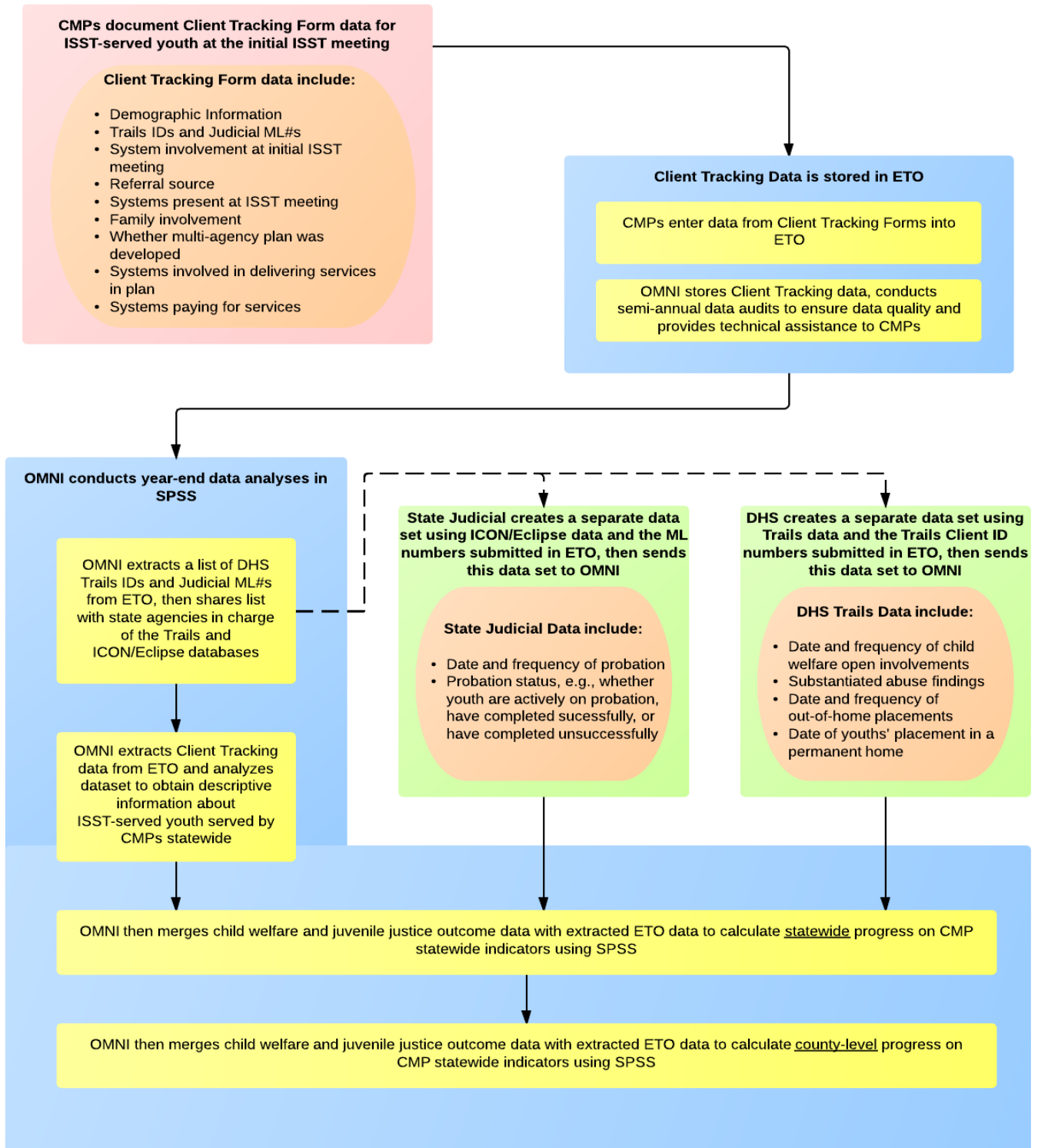
To support local- and state-level data tracking and analysis, an on-line client-level CMP database built into the Efforts to Outcomes (ETO)<sup>TM</sup> software platform was developed specifically for data collection efforts related to the CMP statewide evaluation. ETO is a well-established social service 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, FY 2013, and FY 2014 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, 2014. Records where ISST meeting dates were left blank were not included in the analysis. 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**



## 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. For FY 2013 and 2014, Larimer's CMP entered client-level data for one of their ISSTs directly into the CMP ETO database, and provided a dataset with all other cases to be merged with the CMP 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 transfer 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.

### 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 on the following page.

**Table 1: Child welfare and juvenile justice statewide outcome indicators**

<b>Outcome</b>	<b>...as determined by:</b>
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 best utilize information from multiple years of data collection. For the Year 4 Evaluation Report (FY 2013), because very few youth who started ISST services in FY 2013 had one year's worth of data, it was not possible to separate youth into two fiscal year cohorts based on ISST start date. In FY 2014, yearly cohort comparisons were possible as the one-year follow-up period elapsed for a larger number of youth. 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 thus 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 date in FY 2012 or FY 2013)
2. All CMP ISST-served cases that meet the criteria outlined above (start date in FY 2012 or FY 2013), where the relevant indicator was identified by the ISST as being a target outcome for ISST intervention services.

The tables on the following page (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	

### Education and health/mental health statewide indicator data analysis (pilot data)

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 5% of ISST-served cases have data entered for these indicators (see Section VI of this report for more details). Analysis of indicators was conducted, in order to demonstrate measurement and planned analysis approach. Results should not be interpreted or reported as CMP impacts, as participation and sample size are too low to provide meaningful and representative results.

Table 4 outlines the selected statewide indicators in these two domains.

**Table 4: Education and health/mental health statewide outcome indicators**

Outcome	...as determined by:
Improve school attendance of children served by CMP	Number (percent) of CMP youth with improved attendance during or immediately following ISST services
Reduce disciplinary problems at school of children served by CMP	Number (percent) of CMP youth with no disciplinary actions (in-school suspensions, out-of-school suspensions, school referrals to law enforcement, expulsions) during ISST services; average number of disciplinary actions
Improve academic achievement of children served by CMP	Number (percent) of CMP youth who demonstrate improved grade point averages or academic achievement scores during or for a period following ISST services
Maintain enrollment in school for children served by CMP	Number (percent) of CMP youth who continue to be enrolled in school during or for a period following ISST services; average number of changes in school setting
Improve mental health functioning of children served by CMP	Number (percent) with improved ratings on the CCAR in symptom severity and level of functioning during ISST services
Decreased need for inpatient mental health care for children served by CMP	Number (percent) of CMP youth placed in inpatient mental health care during or for a period following ISST services; average number of days spent under hospitalization
Successful completion of substance use treatment of children served by CMP	Number (percent) of CMP youth who successfully complete substance use treatment during ISST services
Increased access to health care provider for children served by CMP	Number (percent) of CMP youth with existing or newly established health providers (primary care, mental health, substance use treatment) and health insurance, during ISST services

For exploratory analysis of the pilot data in this Year 5 report, all youth within the entire CMP-served population who had a CMP start date in FY 2013 or FY 2014 (i.e., July 1, 2012 to June 30, 2014) were included in the analysis. The evaluation team utilized all available data; thus the number of youth in the denominator of each reported indicator was the total number of cases with available data for that indicator, and numerators matched the described indicators listed in the second column of Table 4. For more detailed description of the planned analysis for education and health/mental health data once there is sufficient sample size and representation of the CMP population to provide meaningful results, see *the State Measurement Plan Phase II: Brief Summary on Education/Health Mental Health Indicators (2012)* report and the indicator tracking form tutorials (available per request from CDHS CMP Administrator).

## Appendix J. Outcomes for all 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 after 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 all ISST-served cases in FY 2012 and FY 2013** (all cases with ISST data entered into the CMP ETO database).

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.

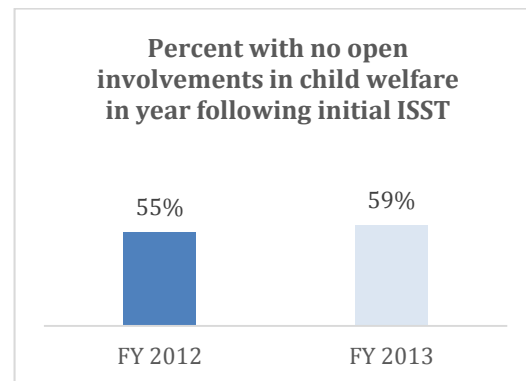
### Child Welfare: What are the child stability/permanency and safety outcomes for all children and families served by ISSTs?

Below, indicator data in four areas relevant to child stability/permanency and safety for families served by CMP ISSTs are presented. The number of children and youth for whom the indicator is relevant, details regarding the calculation of the indicator (numerator and denominator), and the results achieved by CMPs are provided.

#### Preventing new involvements in child welfare.

Among all ISST served children, over half of the FY 2012 cases (55%) and FY 2013 cases (59%) were successfully averted from open involvements in the year after their initial ISST meeting.

The increase across cohort-years was not statistically significant.

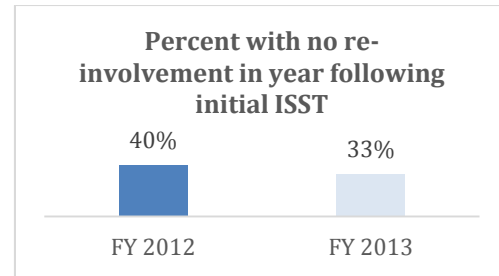


Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who had no new open involvements in year following ISST meeting	1828	1982
<i>Denominator:</i> CMP children who had prevent open involvements selected as a target goal	3303	3333

### Preventing re-involvements in child welfare

For those cases with a prior history of involvements and considered at risk, 40% of FY 2012 cases and 33% of FY 2013 cases were prevented from re-involvement in the year following ISST services.

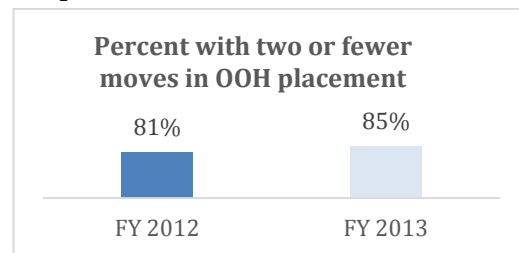
The decrease from FY 2012 to FY 2013 was not statistically significant.



Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children with closed involvements who had no new open involvements in year after ISST meeting	91	62
<i>Denominator:</i> CMP children who had a history but no current open involvement at time of ISST, and had prevent open involvements selected as a target goal	226	190

### Minimizing the number of moves while in out-of-home placement

Results showed that 85% of FY 2013 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. This percentage was statistically significantly higher than what was demonstrated in the FY 2012 cohort (81%;  $p < .05$ ).

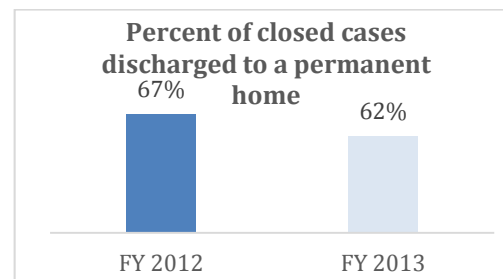


Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children in OOH placement with two or fewer moves in year following ISST meeting	550	459
<i>Denominator:</i> CMP children in OOH placement who had reducing number of moves as target goal	682	540

### Increasing discharges to a permanent home

Results showed that 67% of FY 2012 and 62% of FY 2013 cases who were in out-of-home placement with case closure were reunified or placed in a permanent home.

The decrease from FY 2012 to FY 2103 was statistically significant ( $p < .05$ ).

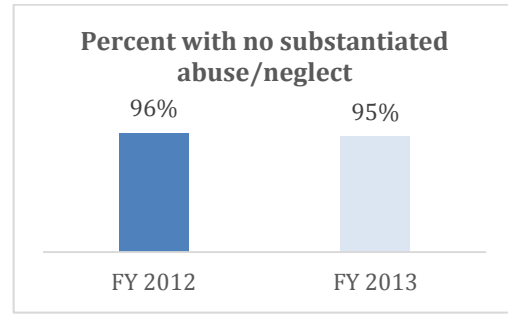


Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who were in OOH placement and discharged to a permanent home in year after ISST	759	559
<i>Denominator:</i> CMP children who were in OOH placement and discharged, and had discharge to a permanent home selected as a target goal	1137	908

**Comparison to state-wide child welfare data:** These rates are lower than the similar indicator tracked for all closed cases within a 12-month period at the state level (76%).<sup>xxxvii</sup>

### Preventing child abuse and neglect

In general, abuse/neglect findings among CMP ISST-served children and youth appear to be rare, with 96% (FY 2012) and 95% (FY 2013) of ISST-served children and youth with no substantiated reports in the year after their initial ISST meeting.



The difference across cohort-years was not statistically significant.

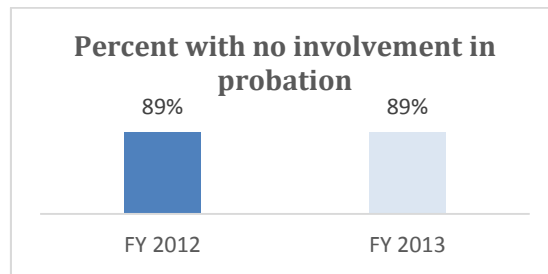
Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who had a substantiated finding of abuse or neglect in year following ISST meeting	3156	3177
<i>Denominator:</i> CMP children who had preventing child abuse and neglect selected as a target goal	3303	3333

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

Below, indicator data for indicators in areas relevant to juvenile justice involvement for children and youth served by CMP ISSTs are presented. The number of children and youth for whom the indicator is relevant, details regarding the calculation of the indicator (numerator and denominator), and the results achieved by CMPs are provided. Comparisons with similar data reported by state entities are included, where relevant data are available.

### Preventing involvements/re-involvements

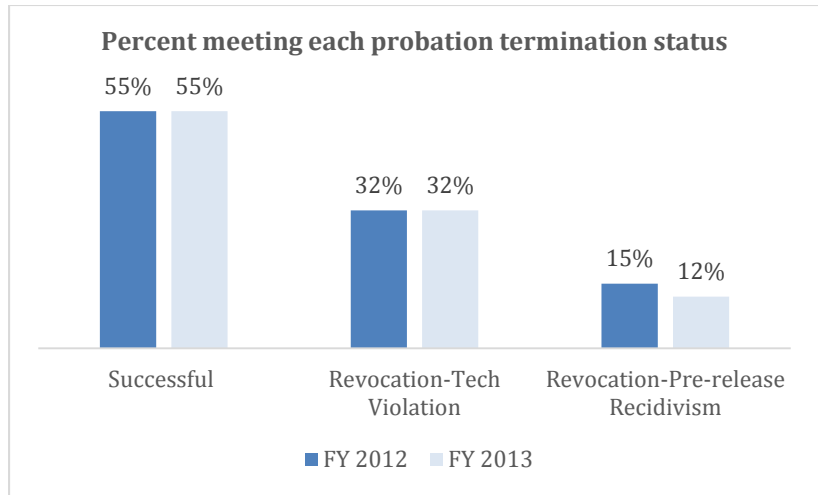
About 89% of all ISST-served children and youth in FY 2012 and FY 2013 were successfully averted from involvement with probation in the year following their ISST meeting, with no significant difference across cohort-years.



Initial ISST in:	FY 2012	FY 2013
<i>Numerator:</i> CMP children who did not become involved with probation in the year following their initial ISST meeting	2953	2978
<i>Denominator:</i> CMP children who had preventing involvement in juvenile justice system selected as a target goal	3303	3333

### Successful and unsuccessful termination of probation

Among those cases who entered ISST services with recently initiated probation services, over half (55% in FY 2012 and FY 2013) successfully terminated after their initial ISST meeting, and about a third (32% in both years) were revoked for technical violations, with the rest revoked for pre-release recidivism (15% and 12%, respectively). The differences from FY 2012 to FY 2013 were not statistically significant.



Initial ISST in:	FY 2012	FY 2013
<i>Denominator:</i> 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	542	331
<i>Numerator:</i> CMP children who <b>successfully terminated</b> probation in the year following their initial ISST meeting	282	183
<i>Numerator:</i> CMP children who <b>unsuccessfully terminated</b> probation with <b>revocation due to technical violation</b> in the year following their initial ISST meeting	178	107
<i>Numerator:</i> CMP children who <b>unsuccessfully terminated</b> probation with <b>revocation due to pre-release recidivism</b> (new felony or misdemeanor offense) in the year following their initial ISST meeting	82	41

**Comparison to state-wide juvenile probation data:** Successful termination for CMP-served children and youth was lower than the state-reported rates among all terminated probations reported in FY 2014 (73%). Rates of revocation of probation were similar for CMP-served children and youth than state-reported rates among terminated juvenile probationers from FY 2014 (15% for technical violations and 8% for pre-release recidivism, respectively).<sup>xxxviii</sup>

<sup>xxxvii</sup> CDHS Division of Child Welfare Scorecard Report (retrieved online at <http://www.cdhsdatamatters.org/index.html>, October, 2014).

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<sup>xxxviii</sup> Office of the State Court Administrator (2014). *Pre-release termination and post-release recidivism rates of Colorado's probationers: FY2014 releases*. Retrieved on-line October 2014.

## Appendix K. Exploratory Analysis of Relationships Between CMP Models/Components and Outcomes

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. In December 2013-January of 2014, as reported in the Year 4 Evaluation Report, the evaluation team identified two key research questions and possible analytic modeling approaches: Which ISST service delivery models implemented by CMPs lead to more positive outcomes (requiring comparative analysis by types of service models); and which components of CMP service delivery lead to more positive outcomes (requiring predictive analysis involving structural and service components central to CMP efforts). The evaluation team reviewed these approaches in light of the available data and identified the latter could be examined with exploratory analysis. In January 2014, 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 hierarchical linear modeling.

Details regarding the analytic approach and preliminary results of exploratory analyses conducted at that time are summarized below in order to demonstrate the potential of the method to answer key questions when sufficient data are available. The analyses were not repeated for the Year 5 Evaluation Report as relatively few additional cases were available to apply to the analysis; thus sample size would continue to be insufficient to provide definitive results at this time.

The analysis question 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<sup>4</sup>: 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<sup>5</sup> and two 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

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<sup>4</sup> 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.

<sup>5</sup> 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.

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 were exploratory and results were preliminary. The models were impacted 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), leading the evaluation team to have limited confidence in the results at this time. 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. In the exploratory analysis, 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 in 2014 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.

## Appendix L. Local Performance Measures (Primary Incentivized Outcomes) for FY 2013 and FY 2014

Table 1 displays the local performance goals (primary incentivized outcomes) specified by CMPs in their FY 2013 and FY 2014 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 2013 and FY 2014 by CMP**

County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Adams	JJ	Decrease truancy court rates among children and youth referred to the Link and/ or ACTIT	80% of youth will be provided supportive services to decrease truancy court involvement.
Adams	HMH	Assess the need for Domestic Violence Intervention/services to school aged children	A parent will participate in 80% of service planning meetings to prevent child welfare involvement or will engage in CW services.
Adams	ED	Mapleton School District children will have improved overall grade average as a result of Boys and Girls club attendance.	Parent/Caregiver will attend an FTM, ACT-IT, or Maplestar groups/meetings or KEEP services 80% of the time
Adams	CW	10-20 families will receive individualized case management services	Youth will participate in FTMs, ACT-IT, or Maplestar groups/meetings or KEEP services 80% of the time.
Alamosa	JJ	80% of the probation youth served by the CMP will not have a revocation based on a technical violation.	70% of CMP youth who complete Probation and/or Parole in 2013-2014 will complete successfully.
Alamosa	HMH	At least 85% of youth served by the CMP will have required immunizations.	85% will have health insurance at the completion of services
Alamosa	ED	75% of youth served by the CMP will not have an out-of-school suspension while receiving services	75% of youth ages 6-16 will be enrolled in school at the completion of CMP services.
Alamosa	CW	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.

County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Boulder	JJ	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.	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.
Boulder	HMH	Engagement in Treatment: at least 65% of youth participating in intensive outpatient programs to remain in treatment for 90 days or more.	Engagement in Treatment – research demonstrates significantly improved outcomes for clients that stay in substance abuse treatment at least 90 days. Therefore, the goal will be for at least 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	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	At least 75% of CMP youth will successfully complete probation and/or parole.	At least 75% of CMP youth will successfully complete probation and/or parole.
Chaffee	HMH	Improvement by 10% in the Level of Functioning and Problem Severity of youth referred to HB 1451 as determined by the CCAR.	Improvement by 10% in the Level of Functioning and Problem Severity of youth referred to HB 1451 as determined by the CCAR.
Chaffee	ED	Increase attendance rates among targeted children by 1%.	Increase attendance rates among targeted children by 1%.
Chaffee	CW	At least 70 % of the CMP-served youth will have no substantiated abuse findings after CMP services begin.	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 CMP will not have a revocation based on a technical violation.	70% of CMP youth who complete Probation and/or Parole in 2013-2014 will complete successfully.
Conejos	HMH	At least 85% of youth served by the CMP will have required immunizations.	85% will have health insurance at the completion of services
Conejos	ED	75% of youth served by the CMP will not have an out-of-school suspension while receiving services.	75% of youth ages 6-16 will be enrolled in school at the completion of CMP services.
Conejos	CW	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.

County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Crowley Otero	JJ	50% of CMP youth will successfully complete probation and/or parole.	No more than 50% of CMP youth on probation will be revoked as a result of technical violations while receiving ISST services
Crowley Otero	HMH	50% of CMP youth will successfully complete substance abuse treatment.	No more than 10% of CMP youth will be placed in inpatient mental health care while receiving ISST services.
Crowley Otero	ED	60% of CMP youth will remain enrolled in school while receiving ISST services.	75% of CMP youth will remain in school while receiving ISST services.
Crowley Otero	CW	75% of CMP youth with no substantiated abuse finding after CMP services begin.	75% of CMP youth with no substantiated abuse finding after CMP services begin
Denver	JJ	52% of youth staffed through the DCP ISST's will complete probation and/or parole successfully.	54% of youth staffed through the DCP ISST's will complete probation and/or parole successfully.
Denver	HMH	70% of CMP youth/families that participate in TASC/CRAFT services will remain involved in services for a minimum of 90 days.	76% 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 maintain a 90% "On Track to Graduate" rate in DPS for school year 12-13.	30% of CMP youth remaining enrolled in school during the course of ISST services.
Denver	CW	90% of CMP youth will have no substantiated abuse finding after CMP services began.	95.5% of CMP children and youth will have no substantiated abuse finding after CMP services began.
Douglas	JJ	50% of CMP youth who will recidivate resulting in unsuccessful completion of probation.	25% of CMP youth who will recidivate, resulting in unsuccessful completion of probation.
Douglas	HMH	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.	95% 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	50% of youth demonstrating improved academic performance between ISST and end of school year.	35% of CMP youth with improved academic performance between ISST intake and case closure (or at a specified date after ISST intake).
Douglas	CW	25% or less of CMP will have open involvements in Trails after CMP services start.	1% of CMP youth with new open involvements (re-entry) in trails after CMP services begin.

County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Eagle	JJ	Number 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 is less than 10.
Eagle	HMH	Number of youth identified as needing mental health services.	Number of CMP youth with established mental health provider during ISST services is greater than 10.
Eagle	ED	Number of students that miss >10% of student days in any grading period.	Number of CMP youth with improved school attendance rate between ISST intake and case closure (or at specified date after ISST intake) is greater than 10.
Eagle	CW	Number of CMP youth with new open involvements in Trails after CMP services begin.	Number of CMP youth with new open involvements in Trails after CMP services begin is less than 10.
El Paso	JJ	50% of youth on probation will not receive a new adjudication during participation in intervention.	65% of CMP youth who successfully complete probation and/or parole.
El Paso	HMH	25% increase in the level of functioning (as determined by CCAR).	30% of CMP youth with improved a) problem severity and b) level of functioning as determined by CCAR between ISST intake and case closure (or at a specified date after ISST intake).
El Paso	ED	50% decrease in youth with incidents of out of school suspensions or expulsions.	60% of CMP youth with disciplinary actions (referrals, suspensions, or expulsion) occurring while receiving ISST services.
El Paso	CW	90% reduction in youth who have had 3 or more placements within 12 months of the latest removal from home.	90% of CMP youth will experience less than two moves while in out of home placement.
Elbert	JJ	No more than 10% SRT youth will recidivate, resulting in unsuccessful completion of probation.	No more than 10% CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.
Elbert	HMH	95% of SRT youth with established providers: health, mental health, substance abuse, health insurance.	95% of CMP youth with established: a) primary care provider; b) mental health provider; c) Substance use provider; d) health insurance
Elbert	ED	15% of youth served by SRT will have improved school attendance rate between first SRT meeting and end of year.	15% of CMP youth with improved school attendance rate between ISST intake and case closure (or at a specified date after ISST intake).
Elbert	CW	95% of SRT youth will have no substantiated abuse findings after SRT services begin.	95% of CMP youth with no substantiated abuse finding after CMP services began.



County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Fremont	ED	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.	51% or more of the youth matched with a mentor will not become involved with the juvenile justice system during the year
Fremont	HMH	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.	For Children & youth in wraparound, improve Global Assessment Functioning (GAF) score by 2 points in at least 809% of the cases
Fremont	JJ	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.	Improved school performance measured by a reduction in referrals for behavior or attendance problems for 80% of youth matched with a mentor
Fremont	CW	Increase stability of children served by the CMP - 10% or less of the children in foster care will experience 2 or more placement moves.	60% of siblings groups will be placed in the same foster home
Garfield	JJ	60% of youth who receive CMP services will successfully complete probation and/or parole.	70% of court involved youth who receive CMP services will not reoffend during the course of ISST services
Garfield	CW	70% of youth who receive CMP services will not have new open involvement in TRAILS.	78% of youth who receive CMP services will improve problem severity scores and level of functioning as determined on the CCAR
Garfield	ED	80% of youth who receive CMP services will remain enrolled in school during the course of the ISST services.	96% of youth who receive CMP services will remain enrolled in school during the course of the ISST services.
Garfield	HMH	75% of youth who receive CMP services will improve problem severity scores and level of functioning determined by CCAR	92.5% of youth who receive CMP services will not have new, open involvement in TRAILS.
Grand	JJ	60% of CMP youth will successfully complete probation and/or parole.	100% of juveniles ordered on Supervised Probation that assess as medium or high risk on CJRA will be staffed with the Family Support Team that could result in a Family-Team Meeting
Grand	HMH	75% of eligible youth and families will receive CHP+ or Medicaid after Family Support Team (FST) services.	75% of eligible youth and families will receive CHP+ or Medicaid after FST services
Grand	ED	60% of CMP youth will show a reduction in disciplinary actions during the time of FST services.	60% of CMP youth will show a reduction in absenteeism and/or office referrals during the time of FST services
Grand	CW	75% of FST served children and families will not have any findings of substantiated abuse after 1451/CMP services begin.	75% of FST (Family Support Team) served children and families will not have any findings of substantiated abuse after 1451/CMP services begin.

County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
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.	95% of 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 80% (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. 5 youth)
Huerfano	HMH	10% of children/youth receiving services will have fewer problems/increased functioning. (approx. 8 youth)	10% of children/youth receiving services will have fewer problems and increased functioning (approx. 9 youth)
Huerfano	ED	10% of children and youth receiving services through the CMP will have improved school attendance. (approx. 5 youth)	10% of children/youth receiving services through the CMP will have improved school attendance (approx. 7 youth)
Huerfano	CW	20% of children/youth receiving services will successfully/safely remain in their own homes. (approx. 20 youth)	20% of children/youth receiving services will successfully safely remain in their own homes (approx. 20 youth)
Jefferson	JJ	After 6 months of participation, a minimum of 50% of youth enrolled in HFW will show a decrease in a CJRA assessment.	Implement a validated assessment tool for 40 youth ages 10-12
Jefferson	CW	Provide Safe Sleep education to 100 infant caregivers and provide assistance.	65% of children, aged 0-20 years, served by Jefferson Center will have a PCP
Jefferson	ED	10% of the students assessed at the JCJAC will show improvement in their attendance.	10% of students assessed through this project will show improvement in their attendance
Jefferson	HMH	40% of Jefferson Center clients, birth to 20 years, will have a primary care provider (PCP)	Provide Safe Sleep education to 100 infant caregivers and provide assistance



County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Lake	JJ	Increase successful intervention for children with juvenile justice involvement. 70% of Lake County youth will successfully complete probation.	75% of Lake County youth served by CMP Wraparound who are involved with juvenile justice will successfully complete probation and/or diversion
Lake	HMH	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.	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	Improve school performance (academic achievement); 70% of youth participating in CMP services demonstrated improved academic performance between ISST intake and case closure.	80% of CMP youth involved in Wraparound will demonstrate improved academic performance between ISST intake and case closure (or at a specified date after ISST intake).
Lake	CW	Increase safety among children served by the CMP. 70% of CMP youth with no substantiated abuse findings after CMP High Fidelity Wraparound services began.	75% of Lake County Youth will have no substantiated abuse findings after CMP Wrap Around services begin.
Larimer	JJ	Maintain successful termination of probation rate within a range of 55-65%.	The number of youth who successfully complete probation will be within the range of 55-65% or higher.
Larimer	HMH	Maintain an average daily placement (ADP) of 15 or less for RCCF; ADP of 2 or less for PRTF.	The daily average of youth placed (ADP) in PRTF will be 2 or less and the daily average of youth placed (ADP) in RCCF will be 20 or less
Larimer	ED	Maintain overall school dropout rate within a range of 12-16%.	The percent of youth who drop out of either Thompson or Poudre School Districts will be within the range of 9-14%.
Larimer	CW	Maintain re-entry rate within a range of 10-15%.	The percent of youth who reunify within 12 months from out of home care will be within the range of 70-80%
Lincoln	JJ	No more than 15% of CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.	No more than 10% CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.
Lincoln	HMH	85% of CMP youth will have established health care and/or mental health providers during ISST services.	90% of CMP youth with established: a) primary care provider; b) mental health provider; c) Substance use provider; d) health insurance
Lincoln	ED	75% of CMP youth will remain in school during the course of ISST services.	15% of CMP youth with improved school attendance rate between ISST intake and case closure (or at a specified date after ISST intake).
Lincoln	CW	90% of youth will have no substantiated abuse findings after CMP services begin.	90% of CMP youth with no substantiated abuse finding after CMP services began.



County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Logan	JJ	No more than 15% of CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.	No more than 15% of CMP youth who recidivate, resulting in unsuccessful completion of probation and/or parole.
Logan	HMH	85% of CMP youth will have established health care and/or mental health providers during ISST services.	85% of CMP youth with established: primary care provider; mental health provider; substance use provider; health insurance coverage; during ISST services.
Logan	ED	75% of CMP youth will remain in school during the course of ISST services.	75% of CMP youth remaining enrolled in school during the course of ISST services.
Logan	CW	90% of youth will have no substantiated abuse findings after CMP services begin	90% of CMP youth with no substantiated abuse finding after CMP services began.
Mesa	JJ	5% of revocations by technical violation where cases resulted in unsuccessful termination among CMP youth.	5% of revocations by technical violations where case resulted in unsuccessful termination among CMP youth.
Mesa	HMH	85% of CMP uninsured youth who start FAP services without coverage will have established health care coverage during ISST services.	85% of CMP uninsured youth will have established and/or be in the process of obtaining health care coverage during ISST services.
Mesa	ED	80% of CMP youth remain enrolled in school during the course of ISST services	80% of CMP youth remaining enrolled in school during the course of ISST services
Mesa	CW	Increase stability of children served by CMP.	85% of CMP youth discharged to a permanent home.
Moffat	JJ	60% of CMP youth will successfully complete probation and/or parole.	60% of CMP youth will successfully complete Probation/Parole or maintain compliance with terms of Probation or Parole.
Moffat	HMH	50% of youth with improved problem severity and level of functioning as determined by CCAR between ISST intake and case closure.	50% of CMP youth served will have improved problem severity and level of functioning as determined by CCAR between ISST intake and case closure (or at a specified date after ISST intake.
Moffat	ED	80% of CMP youth with improved school attendance rate between ISST intake and case closure.	80% of CMP youth served will improve school attendance rate between ISST intake and case closure (or specified date after initial ISST).
Moffat	CW	80% of CMP youth will have no substantiated abuse finding after CMP services began.	80% of youth served will have no substantiated abuse finding after CMP services began.



County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Montezuma/ Dolores	JJ	85% of youth going to court on revocation will have been screened by CET.	85% of youth going to court on revocation will have been screened by CET
Montezuma/ Dolores	HMH	90% of youth evaluated will not be hospitalized and will receive services in the community.	75% of youth evaluated served by CET will receive a trauma assessment and be referred for trauma treatment when needed
Montezuma/ Dolores	ED	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.	All youth in the Check & Connect program will be evaluated for referral to the CET. 40% of Check & Connect students will show an improvement in school attendance.
Montezuma/ Dolores	CW	85% of all CMP youth receiving CMP services will not experience any new substantiated abuse findings after CMP services begin.	85% of youth receiving CMP services will not experience any new substantiated abuse findings after CMP services begin
Montrose	JJ	Less than 12% of revocations by technical violations where case resulted in unsuccessful termination among CMP Youth.	Less than 12% of CMP youth will receive a probation revocation by technical violation.
Montrose	HMH	100% of CMP Youth in need of mental health services will be seen by the Center within 7 days of ISST referral.	100% of CMP youth in need of mental health services will be seen within 7 days of referral.
Montrose	ED	75% of CMP Youth with improved school attendance between ISST intake and case closure.	90% of CMP youth will maintain enrollment in an approved educational program while receiving CMP services.
Montrose	CW	Less than 25% of CMP Youth with new open involvement in Trails after CMP services began.	Less than 25% of CMP youth will have new (involuntary) open involvements in Trails after CMP services begin.
Morgan	JJ	There will be no more than 10 juveniles placed out of county due to probation revocation.	50% of CMP youth who successfully complete probation and/or parole
Morgan	HMH	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.	60% of CMP youth with established: a) primary care provider; b) mental health provider; c) substance use provider, d) health insurance coverage during ISST services
Morgan	ED	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.	50% of CMP youth with improved school attendance rate between ISST intake and case closure (or at a specified date after ISST intake)
Morgan	CW	There will be no more than 21% of new assessments that result in open cases.	20 CMP youth discharged to a permanent home



County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Park	JJ	50% of youth will successfully complete probation or parole.	<i>No indicators submitted by time of reporting</i>
Park	HMH	50% of youth will have established a primary care/mental health provider.	<i>No indicators submitted by time of reporting</i>
Park	ED	50% of youth will maintain school enrollment.	<i>No indicators submitted by time of reporting</i>
Park	CW	50% of youth will be discharged to a permanent home.	<i>No indicators submitted by time of reporting</i>
Pueblo	JJ	74% success (completion) rate for juveniles under supervision in the 10th Judicial District.	76% of CMP youth on probation or parole successfully complete probation and / or parole
Pueblo	HMH	10% of the youth served by the school-based mental health program will have an increase in level of functioning.	30% of CMP youth will show decreased problem severity and increased level of functioning as determined by CCAR and GAF scores
Pueblo	ED	60% of youth at risk of Truancy Court will show increased school attendance.	75% of CMP youth will have improved school attendance rate between Family Support Team (ISST / FST) intake and case closure
Pueblo	CW	86.7% or more of youth in out-of-home placement will have no more than two (2) placements.	Less than 10% of CMP youth with new open involvements in TRAILS after CMP services began
Rio Grande	JJ	80% of the probation youth served by the CMP will not have a revocation based on a technical violation.	70% of CMP youth who complete Probation and/or Parole in 2013-2014 will complete successfully.
Rio Grande	HMH	At least 85% of youth served by the CMP will have required immunizations.	85% will have health insurance at the completion of services
Rio Grande	ED	75% of youth served by the CMP will not have an out-of-school suspension while receiving services.	75% of youth ages 6-16 will be enrolled in school at the completion of CMP services.
Rio Grande	CW	80% of youth served through the CMP will have less than 2 moves during the time they are receiving services.	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.	Increase successful intervention for children with Juvenile Justice involvement
Routt	HMH	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	Increase access to health care system



County	Domain	Performance Goal (Fiscal Year 2013)	Performance Goal (Fiscal Year 2014)
Routt	ED	Improve School Attendance. 80% of CMP youth will show improved school attendance rates between ISST intake and case closure.	Improve School attendance
Routt	CW	Increase stability of children served by the CMP. 80% of youth will not have a new open involvement in TRAILS after CMP services begin.	Increase stability of children served by the CMP
Teller	CW	75% of CMP Youth with no substantiated abuse finding after CMP services began.	75% of youths completing probation will be successful.
Teller	JJ	75% of youth completing probation will be successful.	75% of CMP Youth with improved a.) problem severity and b.) level of functioning as determined by CCAR between ISST intake and case closure (or specific date after ISST intake).
Teller	ED	Reduce number of referrals to the office by 10%	Reduce the number of referrals to the office by 10%.
Teller	HMH	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).	75% of CMP Youth with no substantiated abuse finding after CMP services began.
Weld	JJ	Maintain a similar rate of successful completion of probation for youth who are served by probation.	Meet the state established positive completion rate of 75%.
Weld	HMH	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).	Insure that all MST outcome indicators remain in the "high range" of 77% or higher (showing an increase in socio-emotional, behavioral, developmental and/or cognitive functioning).
Weld	ED	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.	Will maintain a similar average rate of 73% (within 3%) of youth served by the TRIP program who have increased school attendance, in a semester, after completion of TRIP services
Weld	CW	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.	To maintain the established baseline rate (within 3%), of the number of children who are in out-of-home placement who were returned home (reunified) within 12 months of the start of removal.

### Appendix M. CMP Expenditures at Local Level

The table below details funds and expenditures information provided by each CMP in the FY 2014 Annual Report Costs Tables. CMPs indicated that some of these totals are estimated.

The data below derive from the following items from the FY 2014 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 2013	Total amount of CMP incentive funding received in FY 2014	Total CMP funds (Fund from FY 2013 + Fund from FY 2014)	CMP's total expenditures during FY 2014	Amount of CMP earned incentive funding remains in reserve
Adams	\$10,004	\$89,405	\$99,409	\$98,065	\$1,344
Alamosa	\$145,221	\$36,702	\$181,923	\$67,026	\$114,897
Boulder	\$194,393	\$67,107	\$261,500	\$169,933	\$0
Chaffee	\$0	\$36,000	\$36,000	\$225,308	\$189,308
Conejos	\$207,484	\$81,275	\$211,176	\$0	\$0
Crowley-Otero	\$0	\$26,744	\$26,744	\$0	\$0
Denver	\$273,360	\$67,107	\$340,467	\$257,099	\$83,368
Douglas	\$71,539	\$27,989	\$99,528	\$75,527	\$24,001
Eagle	\$47,675	\$32,969	\$80,644	\$47,675	\$32,969
El Paso	\$840,524	\$67,107	\$907,631	\$150,975	\$756,656
Elbert	\$166,427	\$36,702	\$203,129	\$136,188	\$30,239



County	Carryover incentive funds from the previous FY 2013	Total amount of CMP incentive funding received in FY 2014	Total CMP funds (Fund from FY 2013 + Fund from FY 2014)	CMP's total expenditures during FY 2014	Amount of CMP earned incentive funding remains in reserve
Fremont	\$424,906	\$58,758	\$483,665	\$119,467	\$385,997
Garfield	\$17,231	\$32,968	\$50,199	\$50,199	\$0
Grand	\$242,282	\$113,297	\$355,561	\$112,248	\$243,313
Gunnison-Hinsdale	\$173,518	\$36,702	\$210,220	\$80,767	\$129,453
Huerfano	\$268,785	\$36,702	\$305,488	\$91,552	\$213,935
Jefferson	\$800,030	\$55,905	\$855,935	\$253,795	\$602,140
Lake	\$70,487	\$65,478	\$135,965	\$71,460	\$64,505
Larimer	\$1,203,498	\$0	\$1,203,498	\$793,510	\$663,024
Lincoln	\$14,244	\$36,702	\$50,946	\$27,854	\$23,092
Logan	\$71,930	\$48,304	\$120,234	\$44,039	\$76,195
Mesa	\$158,080	\$55,905	\$213,985	\$108,844	\$105,142
Moffat	\$155,098	\$26,745	\$181,842	\$51,579	\$130,264
Montezuma-Dolores	\$185,428	\$32,968	\$218,396	\$91,645	\$126,751
Montrose	\$32,880	\$59,654	\$92,534	\$45,968	\$46,567
Morgan	\$128,994	\$32,968	\$161,962	\$60,569	\$101,394
Park	\$0	\$32,000	\$32,000	\$923	\$31,077
Pueblo	\$212,331	\$40,968	\$253,299	\$145,955	\$107,344
Rio Grande	\$64,860	\$32,968	\$97,443	\$26,539	\$70,904
Routt	\$156,172	\$32,968	\$189,141	\$62,670	\$121,240
Teller	\$457,032	\$58,758	\$515,790	\$186,433	\$329,357
Weld	\$250,035	\$165,953	\$415,988	\$234,245	\$181,743

## 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), in the FY 13-14 Annual Reports. 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	\$554,621	\$6,381,391
School district	\$55,239	\$3,032,470
Probation	\$60,044	\$1,145,289
Mental health services organization	\$74,437	\$602,856
Health dept.	\$20,000	\$360,719
Division of Youth Corrections	\$1,302,971	\$274,022
Domestic violence service organization	\$1,000	\$175,042
Local health services provider	\$0	\$300
Family-driven organization	\$0	\$157,964
Behavioral health organization	\$305,000	\$88,897
Diversion	\$10,000	\$34,654
SB94	\$687,619	\$141,882
Local courts/Judicial	\$3,000	\$94,056
Substance abuse service organization	\$24,000	\$219,512
Law enforcement	\$5,000	\$51,321
Elected official	\$125,000	\$28,862
Business or Chamber of Commerce	\$35,000	\$0
Other	\$42,468	\$3,134,368
<b>Total</b>	<b>\$3,305,399</b>	<b>\$15,923,606</b>

**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	3	\$2,822,266	4
Alamosa	\$0	8	\$81,475	10
Boulder	\$1,975,420	3	\$2,105,060	3
Chaffee	\$0	4	\$17,150	5
Conejos	\$0	7	\$76,495	8
Crowley-Otero	\$0	7	\$600	10
Denver	\$136,558	2	\$498,565	2
Douglas	\$0	15	\$136,783	17
Eagle	\$125,000	11	\$272,329	13
El Paso	\$0	3	\$286,000	4
Elbert	\$48,316	7	\$2,462,168	8
Fremont	\$21,800	7	\$609,399	8
Garfield	\$18,766	8	\$35,500	9
Grand	\$32,510	10	\$502,396	11
Gunnison-Hinsdale	\$4,500	7	\$226,000	8
Huerfano	\$468,702	8	\$239,000	7
Jefferson	\$0	12	\$799,130	14
Lake	\$0	12	\$128,866	14
Larimer	\$258,036	12	\$259,500	13
Lincoln	\$0	7	\$2,282,692	9
Logan	\$0	10	\$592,307	12
Mesa	\$37,000	10	\$193,820	11
Moffat	\$0	7	\$124,160	9
Montezuma-Dolores	\$0	9	\$156,946	12
Montrose	\$35,000	4	\$149,850	5
Morgan	\$0	13	\$103,990	15
Park	\$16,000	12	\$102,900	12
Pueblo	\$72,000	8	\$162,859	10
Rio Grande	\$0	8	\$66,432	10
Routt	\$5,000	6	\$106,200	7
Teller	\$50,792	9	\$138,339	9
Weld	\$0	11	\$184,430	13
<b>Total</b>	<b>\$3,305,399</b>	<b>260</b>	<b>\$15,923,606</b>	<b>302</b>

## 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 2014 Annual Reports.

**Table 1. External funding sources for CMPs**

Funding type	Source of funds	Description	Number of CMPs Reporting	Amounts received
<b>Federal</b>	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.	17	\$870,000
	Promoting Safe and Stable Families	Funds distributed by US HSS to states to grant services that address family support, family preservation, reunification, and adoption	3	\$78,249
	CORE/Child Welfare/IV-E Waiver Funds**	Funds utilized to promote family engagement and treatment for families with domestic violence, substance abuse, mental health, developmental delays, and school attendance issues.	2	\$258,036
	Basic Center Program Grant	Funds provide services to youth ages 12-17 that are homeless, a runaway, or at-risk for either situation.	2	\$261,036
	Bureau of Justice Assistance	Enhanced Assessment and Services Initiative	1	\$100,000
	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
<b>State</b>	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	\$170,271
	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	3	\$702,916



Funding type	Source of funds	Description	Number of CMPs Reporting	Amounts received
		commensurate with their risk to the community		
	Office of Behavioral Health Prevention Block Grant	Funds for substance abuse prevention programming	1	\$100,000
	The Expelled and At Risk Student Services Grant	Funds from the Colorado legislature that supports the education of expelled students and those at-risk of suspension and expulsion	1	\$59,000
	Invest in Kids	Tony Grampas Youth Services grant that supports the implementation of the Incredible Years Parent Program	1	\$11,250
	Restorative Justice funds	Funding through the 10th Judicial District's District Attorney's Office	1	\$10,000
<b>Private Foundation/ Other</b>	Community Foundation of the Gunnison Valley	Flex funding for alternative and prevention programming for multi-system involved youth and families	1	\$3,000
	The Colorado Health Foundation (TCHF) through the Family Resource Center Association (FRCA) Parent Engagement grant	This grant is for engaging parents to help with grassroots efforts to work on health issues in the community.	1	\$13,000
	Community Foundation Collaborative Grant	Awarded to help support the Communities of Excellence/Systems of Care grant	1	\$4,000
	United Way of Weld County Community Impact Grant	Grant funds to support the Truancy Response and Intervention Program (TRIP) that is designed to help youth remain in school and graduate	1	\$35,948
	Eagle County Community Grant	Private grant from Eagle County Government	1	\$125,000

\* The total amount includes funding from FFY13 and FFY14 because funding overlaps fiscal years. These amounts reflect data provided by TISOC administrators rather than CMPs' reported amounts. Funding was granted to the San Luis Valley and was split between Alamosa, Rio Grande, and Conejos counties.

\*\* One CMP did not provide the grant amount received.