

# **Michigan Title IV-E Waiver Child Welfare Demonstration Project**

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Administration for Children and Families, July 2012



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## I. Michigan's IV-E Waiver

### Purpose

Michigan seeks a waiver from the Department of Health and Human Services to utilize title IV-E funds to conduct a five-year child welfare demonstration project. The waiver will help DHS expand services needed to enhance safety and explicitly improve well-being outcomes for children and families in their own communities. It will better align services and resources to produce positive outcomes for all children, regardless of title IV-E eligibility, in a timely and least intrusive manner.

For the past three years, Michigan has fallen short of the national average on key measures related to child safety. The Child and Family Services Review, or CFSR, identified challenges with Children's Protective Services' ongoing cases and noted that Michigan needed to improve in the area of repeat maltreatment and services to protect children in the home. The CFSR concluded that Michigan's lack of prevention services contributed to recurrent maltreatment. It also noted that children remaining in their own homes continued to be at risk either because services were not provided or the services provided did not target key safety concerns.

After conducting a year-long examination of all parts of Michigan's child welfare system, Michigan's 85-member Child Welfare Improvement Task Force issued a final report in April 2009. The task force found consistently insufficient state appropriations for preventive, early intervention, and transitional services for children, youth, and families who come into contact with the child welfare system.<sup>1</sup> The report recommended:

***"Michigan's current child welfare array of services is weighted heavily toward out-of-home placement options. The array of early intervention, family preservation, post-placement and youth transition services is insufficient, both in terms of availability and the range of services."*** – CWITF, 2009

- Creating a seamless array of services to meet the needs of children and families in a respectful way with emphasis on prevention and early intervention,
- Planning and providing services guided by timely comprehensive screening and assessment of the child and family and their needs, and
- Securing greater funding and using it more flexibly to achieve structural, system, and service reforms.<sup>2</sup>

<sup>1</sup>Michigan CFSP 2010-2014.

<sup>2</sup> Improving Michigan's Child Welfare System: Our Children. Our Future. Our Responsibility. Child Welfare Improvement Task Force, April 2009.



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In 2012, Children's Protective Services (CPS) and Department of Human Services (DHS) management staff were surveyed about gaps in the child welfare continuum and frequently reported:

- Families at high risk for maltreatment need longer term services – intensive short-term services are often inadequate to support and sustain progress and prevent the need for removal.
- The array of services and intensity of intervention and family contact must be flexible to address a wide range of family needs.

Michigan's existing prevention and preservation continuum is insufficient to address these gaps. For example, Families First of Michigan, the state's premiere family preservation program, is funded through TANF and provides four weeks of intensive crisis intervention to families at high or intensive risk. However, its brief service intervention limits a family who may require longer engagement and support. Another program, Family Group Decision Making, provided up to a year of intervention with families with confirmed maltreatment, but its funding was eliminated in 2008. The Families Together Building Solutions program, initially considered for use as both a prevention and follow-up service to more intensive programs, is title IV-B2 funded. It provides three – six months of solution focused and skill-based intervention to families.

The Children's Trust Fund in Michigan administers a number of prevention initiatives and a grant program that funds local councils to develop services and programs to meet the child abuse and neglect prevention needs in their communities. However, declining state revenues led to diminution of prevention services. In 2011, Michigan's Zero-to-Three Secondary Prevention Initiative was discontinued.<sup>3</sup> In place for 13 years, this initiative was a statewide, evidence-based community collaborative whose purpose was to prevent child abuse and neglect. The initiative integrated a comprehensive system of services for Michigan's expectant families and those with children ages 0-3. The legislature withheld funding approval despite the program's positive results in preventing abuse/neglect, improving parenting, and reducing risk to infants and toddlers.<sup>4</sup> Michigan has received federal funds for home visiting for young children, birth to age 5 and their families. In the FY 2013 budget, the state maintained funding

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<sup>3</sup> Zero to Three programs were supported by interagency funding through the Departments of Human Services, and Community Health's budgets as well as an appropriation in the State School Aid Act.

<sup>4</sup> Child Abuse and Neglect Prevention Outcomes and Return on Investment Fiscal Year 2009 Report.



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to the Department of Community Health for Nurse-Family Partnership programs, but the Governor vetoed \$1 million in expanded funding for the program.<sup>5</sup>

At the request of DHS, the Child Welfare Resource Center at Michigan State University conducted a needs assessment of the Michigan child welfare system and issued its final report in May 2009. The needs assessment was intended to assist decision-makers in developing those services and programs that are essential to improving the safety, permanency, and well-being of children in the state's child welfare system.<sup>6</sup>

***“Expansion of home-based services that can be accessed in a timely manner to prevent removal to foster care, with a particular focus on effective parenting skills training, supportive counseling, and concrete needs such as employment, housing, and transportation, will support the goals of the settlement agreement and the Michigan Child Welfare Philosophy.” – MSU Report, 2009***

***“Prevention and preservation services are needed in Michigan that are effective in supporting families and reducing the need for removal from the home.” – MSU Report, 2009***

The final report identified Families First of Michigan, Family Group Decision Making, Team Decision Making, parent and in-home services, and Wraparound as being important and effective preservation services in Michigan. However, survey and focus group participants identified additional needs and gaps related to regional availability, insufficient number of openings, and inconsistency among DHS worker expectations.

The report noted a clear need to decrease the wait times for enrollment and to increase accessibility to services. Excessive wait times were identified for physical, mental and behavioral health related services. Mental health providers expressed the need for services to enhance a parent's understanding and ability to manage their children's development.<sup>7</sup>

<sup>5</sup> Nurse-Family Partnership is an evidence-based community health model that provides in-home nurse visits to families from pregnancy to age 2. [www.nursefamilypartnership.org](http://www.nursefamilypartnership.org) The program operates in Berrien, Kalamazoo, Kent, and Oakland counties.

<sup>6</sup> Michigan Child Welfare Needs Assessment. Child Welfare Resource Center, School of Social Work, Michigan State University, May 2009.

<sup>7</sup> Michigan Child Welfare Needs Assessment. Child Welfare Resource Center, School of Social Work, Michigan State University, May 2009.



### **Project Overview**

Michigan's waiver will expand its secondary and tertiary prevention service array provided to families with young children determined by CPS to be at high and intensive risk for maltreatment. DHS will contract with private agencies in three demonstration sites to coordinate services and engage with families in their own homes to prevent the need for removal.

Michigan's waiver project incorporates unique features that distinguish it from the current menu of preservation services. It is designed to work in collaboration with existing family support, strength-based initiatives, such as MiTEAM, Parent Partners, Circle of Parents, and local family resource centers, among others. It is also designed to incorporate evidence-based interventions that have demonstrated positive outcomes, such as Nurse-Family Partnerships, Early Head Start, Healthy Families America, Trauma-Focused Cognitive Behavioral Therapy, among others. Because the waiver utilizes a performance based payment strategy, payments to private agency contractors will be tied to a family's progress, including the absence of recurrent maltreatment and entry into foster care, and improvement on measures of child wellbeing.

Consistent with feedback from DHS field staff, Michigan's waiver project will fill a service gap for families that require longer-term, more risk specific intervention to prevent maltreatment and removal of children from home. The intensity and duration of family engagement will be based on the family's needs and progress as determined by risk and safety re-assessments, progress reports from treatment providers, and a concrete measure of improved functioning.

Michigan's proposed model includes screening for risk factors known to be precursors to child abuse and neglect such as domestic violence, substance abuse, and mental health issues. By identifying parents' strengths and needs in key areas of functioning at the onset of engagement, parents can be quickly connected to appropriate treatment, interventions, and supports. By utilizing early screening in combination with supportive preservation services, Michigan will test its ability to replicate the success reported by Los Angeles County, California through its use of "Up Front Assessments."

Michigan's waiver will leverage resources to promote the social and emotional wellbeing of children and families. It utilizes the protective factors framework when intervening with families to identify and build on family strengths and promote optimal family development and



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wellbeing while reducing risk of abuse and neglect. In addition, private agency contractors will be required to administer a trauma screening tool and, when indicated, refer children and families for comprehensive trauma assessments and interventions such as Parent-Infant Psychotherapy, among others. By identifying and addressing the underlying reasons for a child's behavior, workers and clinicians can intervene therapeutically with children and help parents understand and respond appropriately to their children's behavior.

### Goals and Hypothesis

Michigan's waiver demonstration will test the hypothesis that an array of intensive and innovative home-based preservation services tailored to the needs of individual families will 1) prevent child abuse and neglect and decrease entry of children into foster care, and 2) increase positive outcomes for children and families in their homes and communities and improve the safety and wellbeing of children. Over the life of the waiver, we expect a reduction in foster care maintenance expenditures and a commensurate increase in spending for services to safely maintain children in their own homes.

### Theory of Change

Family preservation services will be delivered by a team of clinicians and trained case workers to families at high risk for maltreatment and out of home placement.

The duration and intensity of engagement and service intervention will be based on a family's identified needs and progress as determined by measures of safety and wellbeing.

Agencies will receive a monetary reward when a family makes progress as determined by established measures. Payment incentives will motivate agencies to effectively engage with families, coordinate meaningful services, and develop community relationships to ensure availability and accessibility of services to meet families' needs.

Families will demonstrate increased capacity to safely care for their children, experience improved social and emotional wellbeing, and will be less likely to experience subsequent maltreatment or out-of-home care.

Fewer children will be placed in out-of-home care, expenditures for costs related to out-of-home care will decrease while programs, services, and expenditures for supportive efforts to maintain children in their own homes will increase.

### Waiver Interventions

Intensive in-home intervention with waiver families will include each of the components listed below.



### **Protective Factors framework**

Numerous environmental factors can contribute to child neglect including poverty, community characteristics, and access to social supports. Since the majority of maltreated children in Michigan experience neglect, interventions to mitigate the factors that correlate with neglect are needed. Studies on social isolation and child neglect have compared parents who maltreat their children with parents who do not and found that parents who maltreat their children report greater isolation and loneliness and have less social support and fewer social networks.<sup>8</sup> Although child welfare intervention may not be able to solve a family's economic situation, using the protective factors approach with families will build their resiliency, parenting insight, and social connections to more effectively manage the stress caused by their situation.

Taken from the Strengthening Families Initiative and developed by the Center for the Study of Social Policy, protective factors consist of parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, social and emotional competence of children, and nurturing and attachment. The following concrete strategies that build protective factors will be utilized during waiver intervention:

- 1) Value and support parenting.
- 2) Strengthen parenting skills.
- 3) Facilitate friendships and mutual support.
- 4) Respond to family crisis.
- 5) Link families to services and opportunities.
- 6) Facilitate children's social and emotional development.
- 7) Observe and respond to early warning signs of abuse and neglect.

The Protective Factors Survey (PFS) was designed to be used with caregivers receiving child maltreatment prevention services.<sup>9</sup> The survey will be administered to the caregivers before, during, and after service intervention. The case plan developed with the family will identify specific strategies to build protective factors based on the survey. Parents and children will be linked with informal and community supports and services to build on family strengths based on the PFS. Case plans will uniformly address strategies to improve a family's economic success and stable housing. Private agency contractors will be responsible for establishing priority linkages to home visiting programs for families and identifying specific evidence-based resources and strategies that will be used to build each protective factor. The private agency contractor will be responsible for developing relationships with the local CMH and Medicaid

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<sup>8</sup> DePanfilis, Diane, Office of Child Abuse and Neglect, Children's Bureau. Child Neglect: A Guide for Prevention, Assessment, and Intervention, 2006.

<sup>9</sup> The PFS was developed by the FRIENDS Network in collaboration with the University of Kansas Institute for Educational Research and Public Service.



Health Plan providers to facilitate the referral and timely acceptance of waiver families for services. Medicaid should be utilized when available to cover the cost of services.

### **Child trauma screening and trauma-informed practice**

Failure to provide for basic needs is seen as a trauma by infants or young children because they depend on adults for survival.<sup>10</sup> Exposure to chronic, prolonged traumatic experiences during early childhood, including neglect of basic needs, has the potential to alter children's brains, which may cause longer-term effects in critical areas such as emotional regulation, physical health, cognition, and behavioral control.<sup>11</sup>

#### *Trauma can negatively affect a child's:*

- *Brain development*
- *Sense of personal safety*
- *Ability to trust others*
- *Sense of the future*
- *Behavior and social relationships*
- *Ability to navigate life changes*
- *Learning and school performance*

Children in foster care have experienced high rates of trauma, mainly due to attachment/caregiver type issues, such as poor attachment, caregiving issues, and traumatic loss. By screening for symptoms related to trauma, caseworkers can convey to parents the underlying reasons for their child's behavior and provide effective ways to respond. Screening can also be used in case planning to inform decisions about the appropriateness of services.

The Trauma Screening Checklist<sup>12</sup> developed by the Southwest Michigan's Children's Trauma

Assessment Center at Western Michigan University will be used to screen for trauma in children referred to the waiver. The checklist, developed for children ages 0-5, will be administered to parents(s) within the first 30 days of the family's referral into the waiver. The tool may be re-administered at any time during waiver intervention with the family if additional concerns are presented regarding the child's behavior, or if the child has experienced additional environmental factors that may affect behavior, such as multiple moves, domestic violence, and separation from the primary caregiver.

Evidence-based trauma-informed therapy will be provided to eligible children and strategies will be provided to caregivers to increase positive parenting experiences and decrease abusive

<sup>10</sup> Information in the insert on this page also taken from Tullberg, E. (2012). *Addressing trauma in the child welfare system* (Teleconference). Presented November 16, 2011 by the National Resource Center for Permanency and Family Connections [http://www.nrcpfc.org/teleconferences/2011-1116/Addressing\\_Trauma\\_in\\_the\\_CW\\_System.pdf](http://www.nrcpfc.org/teleconferences/2011-1116/Addressing_Trauma_in_the_CW_System.pdf).

<sup>11</sup> Cook, A., Spinazzola, P., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., et al. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390-398.

<sup>12</sup> Henry, Black-Pond & Richardson, 2008



or neglectful responses to their child's behavior. For children ages 0-3 with a positive history of exposure to trauma, the worker will assist the parent in contacting the local Early On provider to schedule a comprehensive developmental assessment and a referral to their local Community Mental Health office for home-based services using Parent-Infant Psychotherapy delivered by a clinical staff person endorsed by Michigan Association for Infant Mental Health.

For children ages 3-5 with a positive history of exposure to trauma as identified on the Trauma Screening Checklist, a referral will be provided for the child to undergo an evidence-based Trauma Symptom Checklist for Young Children (TSC-YC).<sup>13</sup> The TSC-YC is a 90-item caretaker-report instrument developed for the assessment of trauma-related symptoms in children ages 3 to 12. It is normed separately for boys and girls within separate age groups (3-4 and 5-9) and can be administered by the local Community Mental Health (CMH) or specialized Children's Trauma Assessment Center.

Following assessment, the clinician will determine whether intervention, such as evidence-based Trauma-Focused Cognitive Behavioral Therapy or Parent-Child Interaction Therapy, would be appropriate for the child age 3 and older.<sup>14</sup> In consultation with the parent, the worker will assess referrals to other appropriate interventions, such as HeadStart, evidence-based Parent-Infant Psychotherapy delivered by clinical staff endorsed by The Michigan Association for Infant Mental Health.

### **Screening for domestic violence, substance abuse, and mental health**

Research in the past several decades has identified four common co-occurring issues—parental substance abuse, parental mental illness, domestic violence, and child conduct problems—that are related to parenting and may lead to child abuse/neglect.<sup>15</sup> Families that come to the attention of CPS have often experienced these issues singularly or in combination. According to published studies, in 30 to 60 percent of families where spouse abuse takes place, child maltreatment also occurs.<sup>16</sup> In 2011, Michigan had 3,229 confirmed cases of child abuse/neglect in which domestic violence was a contributing factor.<sup>17</sup> In that year, roughly 12 percent of removals from home involved domestic violence as a contributing factor.<sup>18</sup>

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<sup>13</sup> Briere, John

<sup>14</sup> Parent-Child Interaction Therapy is available in Kalamazoo County, one of the three demonstration sites.

<sup>15</sup> Barth, Richard P. (2009) Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities. *Future of Children* Vol.19/No.2/Fall 2009. [www.futureofchildren.org](http://www.futureofchildren.org)

<sup>16</sup> Edelson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, 5(2), 134-154; Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology*, 12(4), 578-599.

<sup>17</sup> DHS Data Management Unit

<sup>18</sup> DHS Data Management Unit



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Substance abuse can interfere with a parent's intellectual functioning, judgment, and protective factors.<sup>19</sup> Michigan has seen a significant upward trend in methamphetamine abuse associated with child abuse and neglect, mostly in the rural to mid-sized counties in the southwest part of the state. In 2009, 250 children were confirmed victims of abuse or neglect due to methamphetamine exposure. That number jumped by 69 percent to 364 in 2011.<sup>20</sup>

Parental mental illness can compromise parenting and affect parent-child attachment patterns.<sup>21</sup> One in nine, or 11 percent of infants living in poverty have a mother suffering from severe depression; and more than half of all infants living in poverty are raised by mothers with depression ranging from mild to moderate.<sup>22</sup> Infants living in poverty with severely depressed mothers are more likely than their peers to have mothers who also experience domestic violence or substance abuse.<sup>23</sup>

The presence of substance abuse, domestic violence, and/or untreated parental mental health issues may render an environment unsafe for a child or negatively impact child wellbeing. CPS investigations may not necessarily identify these issues resulting in missed opportunities to quickly link a family to services and avert the need for removal. Private agency contractors with a MSW, MA in psychology or counseling degree who possess experience providing treatment to families with multiple co-occurring risk factors will administer a screening tool to the parent(s) in the family's home within 72 hours of referral to the waiver program. If domestic violence is a factor, arrangements will be made to meet and screen parents separately. Based upon the screening results, immediate referrals and appointments will be made to appropriate community service providers utilizing the latest in evidence-based practices with substance abusing populations.

**The potential negative impact of parental depression on children, combined with the high prevalence of depression among parents, indicates that large numbers of children are at risk if steps are not taken to identify and treat parental depression. – Hendrick and Daly, 2000.**

<sup>19</sup> A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice. Author(s): Office of Child Abuse and Neglect, Children's Bureau. Goldman, J., Salus, M.K., Wolcott, D., Kennedy, K.Y. Year Published 2003

<sup>20</sup>DHS Children's Protective Services 2011 Trends Report Summary.

<sup>21</sup>Hendrick V. and K. Daly, *Parental Mental Illness*, in N Halfon, E Shulman, M Hochstein and M Shannon, eds., *Building Community Systems for Young Children*, UCLA Center for Healthier Children, Families and Communities, 2000.

<sup>22</sup> Vericker, T., Macomber, J., and Golden, O. "Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve." August 2010.

<sup>23</sup>Ibid.



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Los Angeles County, California utilized “Up Front Assessments” in its waiver from 2007- 2010 and experienced positive outcomes including reduced removals and shorter lengths of stay in care. Benefits also included: 1) provision of more in-depth information about a family’s needs and severity of issues that affect child safety, 2) motivated families who were more willing to open up and work with a service provider rather than CPS, especially if it means their children remain in the home, 3) streamlined and targeted services linking the family with immediate and appropriate services.<sup>24</sup>

### **Immediate needs and short-term stressors**

Environmental stressors impede learning and the effectiveness of meaningful interventions. Taking steps to alleviate everyday stresses in the lives of families will be an important part of waiver service delivery. Flexible funds will be available to help alleviate crisis and address short-term issues that cause stress for the family, such as transportation costs, respite care, housing assistance, legal fees, and beds and other essential household needs.

### **Safety planning**

Safety planning will occur as needed, but at a minimum, safety will be addressed each time the worker has an in-person contact with the family. Strategies to address immediate child safety will be discussed with the family and included in the written case plan developed with the family. Child safety will be documented and measured using the Structured Decision Making re-assessment tool at designated intervals throughout the intervention.

### **Performance-based contracts**

Michigan’s waiver will utilize performance based contracting that incentivizes achievement of identified outcomes related to child safety and wellbeing. Although the details have not been finalized, the following strategy is being considered. An hourly unit rate will be established for waiver intervention performed by contracted private agencies. The agencies will be paid roughly 75% of their billable costs according to a billing/payment schedule with the remainder of payment held in abeyance. Twelve months after the family was referred for waiver services, the contractor will be eligible for 50% of the amount held in abeyance if the family does not experience confirmed maltreatment or entry into foster care. At 15 months, the contractor will be eligible for the remaining 50% of the amount held in abeyance if the family does not experience confirmed maltreatment or entry into foster care, and the children exhibit increased wellbeing as determined by an established measurement tool.

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<sup>24</sup> Casey Family Programs: “Stories of Practice Change: What Flexible Funding means to the Children and Families of Los Angeles County.” February 2009.

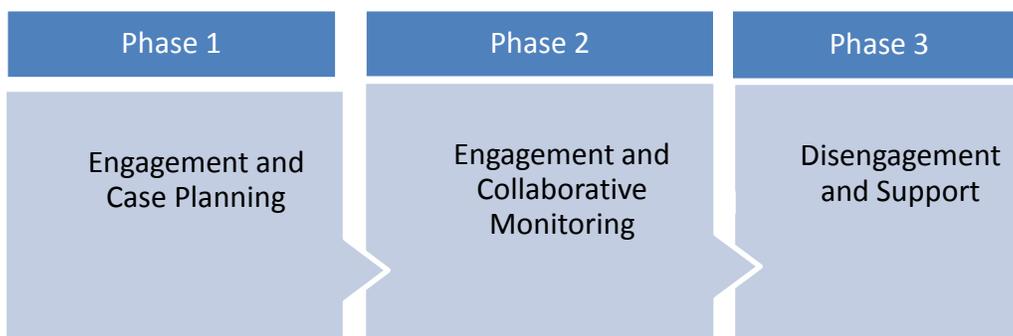


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## Service Delivery Model

For families in the waiver, the array of services provided and the frequency and intensity of worker engagement will be based on the family's individual needs and progress. Some families may require frequent worker contact, coordination of multiple services, and more intensive support for a longer period of time. While others may experience less frequent contact, fewer service referrals, and earlier worker disengagement. All families in the waiver will be offered supportive services for a period of 15 months, which will be defined by three separate phases.

With variation in duration and intensity of contact and service provision, each waiver family will experience a period of engagement and case planning, followed by continued engagement and collaborative monitoring while the family participates in community services, followed by a final phase of aftercare characterized by periodic support and decreased worker contact.



## Geographic Area

Michigan's waiver will focus on three demonstration sites during the first year of implementation: Kalamazoo, Muskegon, and Macomb counties. These counties were selected based on their numbers of Category II and IV cases, high rates of maltreatment recurrence, availability of community support services, upward trend in foster care population for children 0-5, and strong agency leadership and interagency collaboration. See page 20 for a description of each Category disposition.

## Target Population

Given the identified goals of Michigan's waiver demonstration, DHS will include families most likely to experience recurrent maltreatment and out-of-home placement. The waiver will focus on families with very young children regardless of income or IV-E eligibility. To be eligible for the waiver experimental or control groups, the following criteria must be met:



### Waiver Eligibility Criteria

- The family was investigated by CPS and either a Category II disposition or a Category IV disposition with “high/intensive” risk was assigned. (See page 20 for category descriptions).
- At least one child age 0-5 resides in the home.
- The family resides in a county or area designated as a demonstration site and agrees to participate in the waiver.

The following rationale was used for selecting the waiver target population:

#### ***Children 0-5 are victimized at a higher rate than other children.***

In 2010, there were 32,504 confirmed victims of child abuse/neglect in Michigan. Of those, 16,598 or 51% were ages 0-5. Very young children are victimized at a rate of 22.4 per 1,000.<sup>25</sup>

#### ***Cases with high/intensive risk are most likely to experience recidivism.***

According to Michigan’s validated Structured Decision Making (SDM) risk assessment tool, families in Category II cases are at high or intensive risk of experiencing future maltreatment. A portion of Category IV cases are assessed on the SDM Risk Assessment tool to also have a high or intensive risk of future maltreatment. National SDM validity research found that recurrence of maltreatment was not related to whether abuse or neglect was confirmed, but rather the level of risk.<sup>26</sup> Families in Category II and Category IV cases with “high/intensive” risk typically have one or more safety factors that, if left unaddressed, may result in future maltreatment or out-of-home placement. Timely and effective engagement of families in these categories will provide the best opportunity to prevent subsequent child abuse or neglect and safely reduce the rate of entry into foster care.

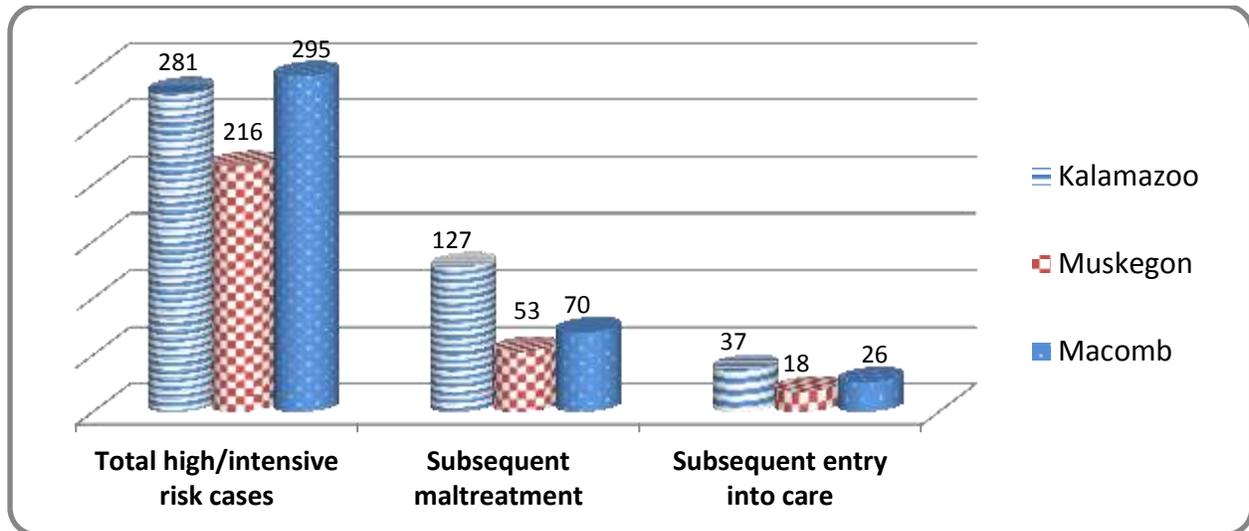
When considering the three demonstration sites (Kalamazoo, Muskegon, and Macomb counties), the chart below shows that on average 32% of children ages 0-5 in Category II and IV high risk cases experienced subsequent maltreatment. For the same group, the average rate of subsequent entry into care was 10%.

<sup>25</sup> 2010, DHS Data Management Unit and produced by the Michigan League for Human Services: Kids Count

<sup>26</sup> Patricia L. Kohl, Melissa Jonson-Reid and Brett Drake. Time to Leave Substantiation Behind: Findings From A National Probability Study. Child Maltreat 2009 14: 17 originally published online 29 October 2008



## Maltreatment Recidivism in Demonstration Sites for Children 0-5, FY 09- 5/31/12



### **Children 0-5 make up the greatest share of the foster care population.**

In 2010, there were 6,027 children ages 0-5 in foster care in Michigan, representing nearly 40% of the state’s foster care population. While the 0-5 foster care population has declined in Michigan, the decline has been modest when compared to Michigan’s decline in overall foster care population. Children in 14 of Michigan’s 83 counties (known as the Big-14 and listed in the chart below) make up more than three-quarters of the state’s child welfare caseload. Contrary to the statewide trend, several of the Big-14 counties, including the three demonstration sites, experienced *increases* in their 0-5 foster care population since 2005. These data indicate more needs to be done to effectively intervene with families with young children to prevent abuse/neglect and entry into foster care.

FC Population <sup>27</sup>	FY 05	FY 10	Difference
0-17 Michigan	19,599	15,446	- 21%
0-5 Michigan	6,237	6,027	- 3%
0-5 Wayne	1,943	1,492	- 23%
0-5 Genesee	551	461	- 16%
0-5 Oakland	507	286	- 44%
0-5 Macomb	290	454	+ 36%
0-5 Kent	258	367	+ 30%
0-5 Ingham	192	241	+ 20%
0-5 Muskegon	139	189	+ 26%

<sup>27</sup> 2010, DHS Data Management Unit and produced by the Michigan League for Human Services: Kids Count.



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0-5 Kalamazoo	208	240	+ 13%
0-5 Berrien	149	165	+ 10%
0-5 St. Clair	99	156	+ 37%
0-5 Washtenaw	78	90	+ 13%
0-5 Saginaw	186	128	- 31%
0-5 Jackson	136	74	- 46%
0-5 Calhoun	128	115	- 10%

### ***Intervening with families of young children may have the highest payoff***

Developmental changes, such as cognitive, social, emotional, and language development occur most rapidly during infancy and early childhood. Developmental delays, motor deficits, and poor neurodevelopment are some of the potential impairments that make this a stage of extreme vulnerability.<sup>28</sup> The experiences of early childhood shape a child's brain development in critical ways. Early brain development lays the foundation for all future development, impacting the rest of the child's life. Reducing children's exposure to violent, chaotic, or neglectful environments and helping parents develop positive, attentive and nurturing relationships with their young children will increase the likelihood of optimal childhood experiences and improve long-term outcomes for children.

### **Estimate of Families Served**

Although not finalized, it is projected that 100 families will be served each year in each of the three demonstration sites for a total of 300 families served every year during waiver implementation. The final decision will be contingent on cost-neutrality requirements. It is projected that roughly 37% of the families served will be title IV-E eligible.

### **Time Period of Waiver Implementation**

Taking into consideration activities that must occur during pre-implementation, implementation is expected to begin on October 1, 2013 and end on September 30, 2018.

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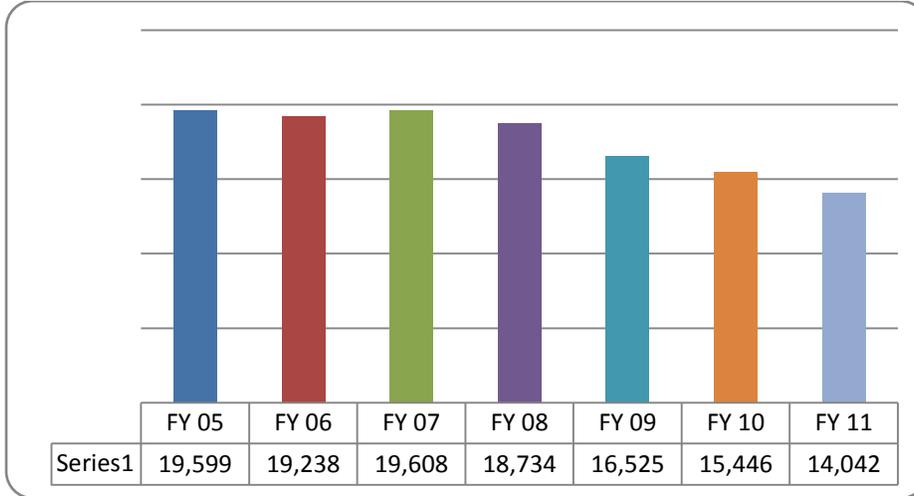
<sup>28</sup> Lou, Christine; Anthony, Elizabeth; Stone, Susan; Vu, Catherine; Austin, Michael. Assessing Child and Youth Well-Being: Implications for Child Welfare Practice. Bay Area Social Services Consortium School of Social Welfare University of California, Berkeley, September 2006.





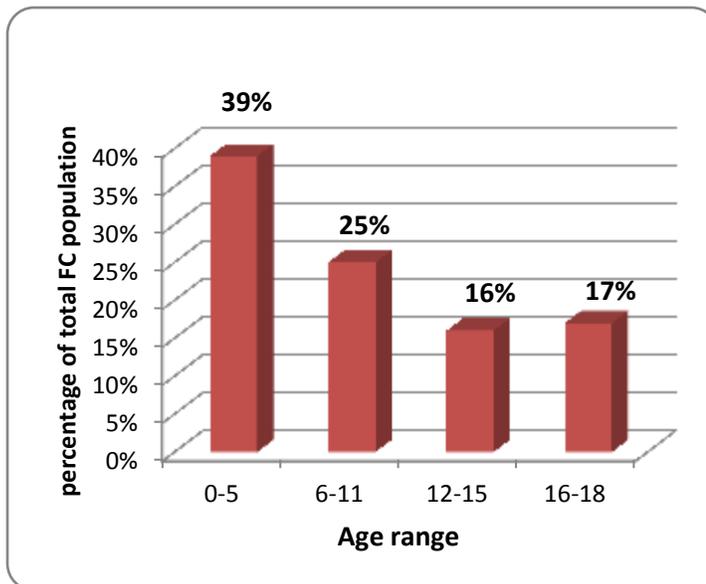
# Department of Human Services

## Children ages 0-17 in Foster Care, 2005-2011



The rate of decline in the foster care population for children ages 0-5 was not as steep. In 2005, there were 6,237 children ages 0-5 in foster care compared to 6,027 in 2010, a decrease of only 3%.<sup>35</sup>

## Age Range of Children in Foster Care, 2011<sup>36</sup>



When compared to children in all other age groups, children ages 0-5 make up the greatest share of Michigan children in foster care.<sup>37</sup>

<sup>34</sup> AFCARS data, produced by Data Advocacy, Casey Family Programs.

<sup>35</sup> DHS Data Management Unit and produced by Michigan League for Human Services.

<sup>36</sup> DHS Data Management Unit, Strategic Planning. "Facts About Children in Foster Care in Michigan," 3/23/11.

<sup>37</sup> DHS Data Management Unit.

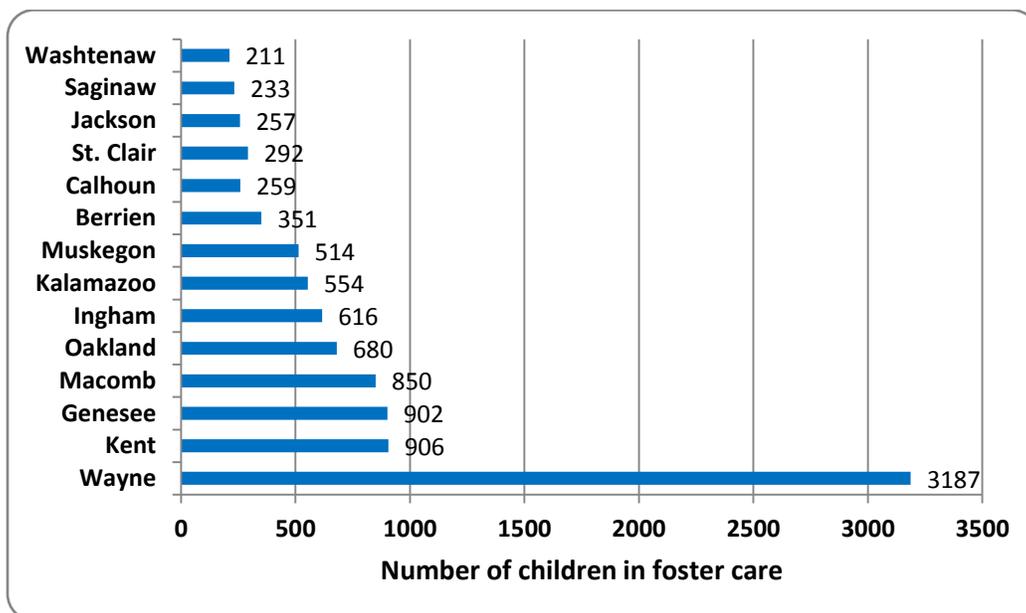


## Department of Human Services

### In Michigan:

- 28% of the foster care population is in Wayne County, where Detroit is the largest city.
- Roughly 60% is in the six largest urban counties: Wayne, Kent, Macomb, Genesee, Oakland, and Ingham.
- About 75% of the caseload is in the “Big-14” which includes the six urban counties plus: Berrien, Calhoun, Jackson, Kalamazoo, Muskegon, Saginaw, St. Clair and Washtenaw counties.
- Twenty-four percent is in the remainder of the state.<sup>38</sup>

### **0-17 in Foster Care in Michigan’s Big-14 counties, April 2012.<sup>39</sup>**



In the past five years, Michigan’s number and rate of Children’s Protective Services’ (CPS) complaints *assigned* for investigation have steadily climbed. In 2007, CPS assigned 67,756 complaints for investigation or roughly 55 percent of total complaints received that year. In 2011, there were 83,512 CPS complaints investigated or 66 percent of total complaints received.<sup>40</sup>

<sup>38</sup> DHS Child and Family Service Plan 2010-2014. 2010 Annual Progress and Services Report.

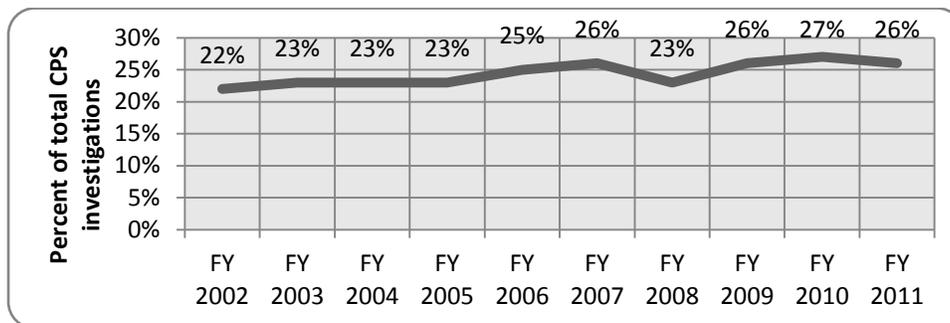
<sup>39</sup> DHS Data Management Unit.



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Michigan’s number and rate of *confirmed* cases of child abuse/neglect have also increased. There were 16,424 or 22% of investigations confirmed in 2002 compared to 22,069 or 26% of investigations confirmed in 2011.<sup>41</sup>

**Percent of CPS Investigations that were confirmed, 2002-2012**



In 2010, there were 35,497 child victims of abuse or neglect in Michigan. Of those, 91.8% were neglected, 23.1% were physically abused, and 3.6% were sexually abused.<sup>42</sup> Michigan’s rate of victimization per 1,000 children ages 0-17 was 13.8 placing it in the bottom ten states for that measure.<sup>43</sup> Michigan’s rate of victimization per 1,000 children ages 0-5 was 22.4.<sup>44</sup>

**Number of Confirmed Victims of Abuse and/or Neglect, Ages 0-5 in Big-14 Counties, 2010<sup>45</sup>**

Wayne	Kent	Genesee	Kalamazoo	Macomb	Ingham	Oakland	Saginaw	Muskegon	Berrien
2,327	1,342	1,260	1,001	840	839	825	616	492	427
			Washtenaw	Saint Clair	Jackson	Calhoun			
			360	347	346	301			

Since July 1, 1999, CPS has assigned a disposition category to each completed investigation. Five disposition categories are determined by a combination of evidence and risk to the child. As is consistently the case from year to year, a majority of complaints were not confirmed and were classified Category IV.

<sup>40</sup> DHS – Children’s Protective Services Program Office.

<sup>41</sup> CPS Program Office, Department of Human Services.

<sup>42</sup> Child Welfare League of America, “At A Glance” statistics.

<sup>43</sup> NCANDS, produced by Data Advocacy, Casey Family Programs.

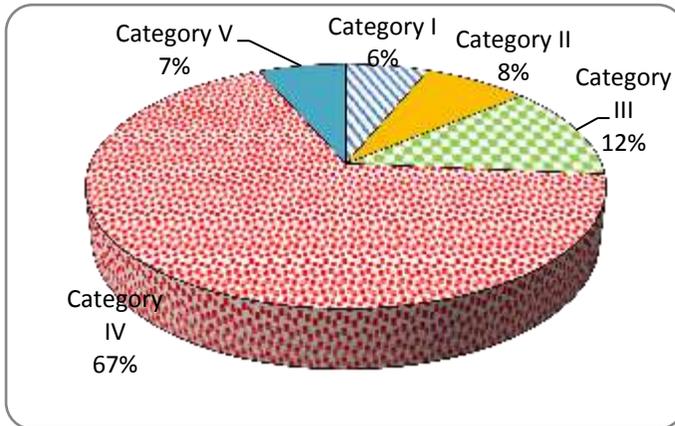
<sup>44</sup> 2010, DHS Data Management Unit and produced by the Michigan League for Human Services.

<sup>45</sup> 2010, DHS Data Management Unit and produced by the Michigan League for Human Services.



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## CPS Complaint Disposition by Category, 2011<sup>46</sup>



**Category I:** A court petition is required because a child is unsafe, a petition is mandated or a court order is needed to compel cooperation or compliance.

**Category II:** A preponderance of evidence shows that abuse or neglect occurred and the risk level is high or intensive. CPS must open a services case.

**Category III:** A preponderance of evidence shows that abuse or neglect

occurred and the risk level is low or moderate. CPS must refer the family to community-based services.

**Category IV:** A preponderance of evidence does not show that abuse or neglect occurred. However, the risk level may range from low to high/intensive. CPS must refer the family to community-based services, commensurate with the risk level.

**Category V:** There is no evidence that abuse or neglect occurred (a false complaint; no basis in fact). No further action is required by CPS.

## Category Dispositions in Big-14 Counties for Children 0-5, from 10/1/11 – 5/31/12

County	Complaint Category Code					
	1	2	3	4	5	NA
Berrien	36	42	145	530	29	
Calhoun	57	75	74	529	10	
Genesee	162	259	345	1809	67	
Ingham	157	143	222	847	62	
Jackson	54	57	150	639	17	
Kalamazoo	170	148	266	904	125	1
Kent	173	339	281	1818	66	2
Macomb	105	153	201	1221	94	2
Muskegon	112	139	89	530	62	
Oakland	89	85	327	1410	48	1

<sup>46</sup> DHS Children's Protective Services, 2011 Trends Report Summary.



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Saginaw	49	96	100	694	53	
St. Clair	58	80	104	691	78	1
Washtenaw	48	46	125	587	40	1
Wayne	305	384	831	3928	397	7
<b>Big-14 Totals</b>	<b>1578</b>	<b>2046</b>	<b>3260</b>	<b>16137</b>	<b>1148</b>	<b>15</b>

In 2005, 95.4% of children did not experience repeat maltreatment within 6 months. In 2010, the percentage worsened to 91.7%.<sup>47</sup> From 2008 – 2010, Michigan’s ability to prevent recurrent maltreatment did not improve, making it one of the worst ten performing states on that outcome.<sup>48</sup>

### Michigan scored below national standard in preventing recurrent maltreatment, 2008 – 2010

National Data Standards – Safety	National Standard	Michigan FY 2008	Michigan FY 2009	Michigan FY 2010
Absence of maltreatment recurrence	94.6+	92.9%	93.3%	91.7%

### Child Welfare Reforms

Over the past five years, DHS has undertaken significant organizational and programmatic reforms. These reforms were precipitated in part by Michigan’s severe economic and fiscal problems that resulted in serious state budget deficits and spending restraints across state departments. From 2001-2006, Michigan’s average monthly caseload of IV-E eligible children declined by 47 percent,<sup>49</sup> which put greater strain on state and county budgets. In 2010, the state’s percent of children claiming title IV-E funding was 29.5%.<sup>50</sup> As of April 2012, Michigan has increased its share of IV-E funding eligibility to 37%.<sup>51</sup> Reforms in the state’s child welfare system were also hastened by enforced conformity with federal requirements established by the Child and Family Services Review. Finally, substantial organizational and programmatic changes have occurred since Michigan was placed under a court enforced settlement agreement after a federal lawsuit was brought against the state in 2006 by Children’s Rights Inc.

DHS implemented several reform strategies to deal with budget challenges. In children’s services, privatization of foster care and adoption services was expanded and efforts were made to increase title IV-E funding by licensing more relative caregivers and strengthening the state’s eligibility determination process. DHS implemented subsidized guardianship to reduce foster care expenditures by moving older children out of foster care to permanency. The

<sup>47</sup> Taken from AFCARS and NCANDS; produced by Casey Family Programs.

<sup>48</sup> Taken from AFCARS and NCANDS; produced by Casey Family Programs.

<sup>49</sup> Overview of Child Welfare Services in Michigan State, Pew Issue Brief, October 2007.

<sup>50</sup> Data from AFCARS and NCANDS and produced by Casey Family Programs.

<sup>51</sup> DHS financial services.



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department averted unnecessary placement of children in costly residential settings through enhanced approval and oversight procedures when residential placements are considered for a child removed from home. DHS also entered into a partnership with the Michigan Department of Community Health to address the needs of foster children with serious emotional disturbances in the community. Through a waiver, Medicaid funds are used for home and community-based services for foster children with serious emotional disturbances who meet the criteria for admission to the state inpatient psychiatric hospital and are at risk of hospitalization without waiver services.

### Child and Family Services Review (CFSR)

Michigan's initial CFSR occurred in 2002 and its first Program Improvement Plan (PIP) was approved in 2004. In its 2009 CFSR, Michigan achieved substantial conformity with several *systemic factors* including staff and provider training, agency responsiveness to the community, and foster and adoptive parent licensing recruitment and retention. However, Michigan did not achieve substantial conformity with any of the seven CFSR *outcomes*. The state's low performance on the assessed outcomes may be attributed in part to state budget cuts that have had a negative impact on the ability to serve children and families, particularly in-home service cases.

The CFSR identified challenges with Children's Protective Services (CPS) ongoing cases and Michigan achieved the rating of *area needing improvement* for the following items related to safety:

Outcomes and Items	% Required for Substantial Conformity	% Michigan Achieved 2009
<b>Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.</b>	95.0%	61.5%
Item 1. Timeliness of investigations	90.0%	69%
Item 2. Repeat maltreatment	90.0%	85%
<b>Safety Outcome 2: Children are safely maintained in their homes when possible and appropriate.</b>	95.0%	64.6%
Item 3. Services to protect children in home.	90.0%	69.0%
Item 4. Risk of harm.	90.0%	65.0%

Michigan's PIP was approved in June 2011 and lasts two years. It outlines the strategies the state will use to address identified weaknesses and to improve its child welfare system. Implementation of the strategies is a joint effort among state, federal and private agency



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partners. Failure to achieve the outcomes articulated in the plan within the two-year timeframe can result in federal penalties.

### **Settlement Agreement**

In response to a class action lawsuit filed against the state in 2006, DHS reached an out-of-court agreement with Children's Rights Inc. in July 2008 to implement numerous key reforms in its child welfare system.

Among other things, the agreement called for reduced caseload levels, increased resources to achieve permanency, increased capacity to license relative and non-relative providers, increased training for children's service staff, creation of a quality assurance unit and data management unit, development of an improved system of monitoring purchase of service contracts, and the implementation of performance-based contracting.

In January 2011, Governor Snyder appointed Maura D. Corrigan to the position of DHS director. As a former Michigan Supreme Court Justice, Director Corrigan was involved in Michigan's CFSR and spearheaded Michigan's plan to increase permanency for foster youth. In July 2011, DHS and Children's Rights agreed to a modified settlement agreement that demonstrated the department's commitment toward continuing progress already begun in critical areas of child welfare reform.

See page 32 for waiver impacts on the settlement agreement.



## III. Evaluation

### Outcomes

Michigan’s waiver demonstration will consistently monitor and address child safety and include ongoing standardized assessments of improved parental capacity and child well-being as a result of service delivery. Where feasible, comparisons will occur between experimental and control groups on the following expected outcomes.

	<b>Testable Hypothesis</b>	<b>Data Source(s)</b>
<b>Safety</b>	Children in the waiver demonstration will not experience subsequent maltreatment in the 15 months following acceptance into the waiver, as determined by the absence of a confirmed CPS complaint investigation (Category I, II, or III).	MiSACWIS – Investigation Summary Disposition
	Children in the waiver demonstration will remain safe in their homes 15 months following acceptance into the waiver, as determined by a “safe” or “safe with services” designation on the Safety Re-assessment.	MiSACWIS – CPS Safety Re-Assessment
	The risk of future maltreatment for children in the waiver will be reduced to low or moderate and will not elevate in the 15 months following acceptance into the waiver, as determined by the SDM Risk Re-assessment.	MiSACWIS – SDM Risk Re-Assessment
<b>Wellbeing</b>	Parents and or caregivers in the waiver demonstration will make positive changes in protective factors as determined by the Protective Factors Survey completed before, during and after waiver intervention.	FRIENDS PSF – FRIENDS data collection and tracking systems
	Children in the waiver will demonstrate improved wellbeing as determined by a functional assessment that measures infant/young child functioning on the social and emotional wellbeing domains.	Family Map of the Parenting Environment of Infants and Toddlers is being considered, along with Child & Adolescent Needs & Strengths.
<b>Permanency</b>	Children in the waiver group will remain in their homes throughout waiver intervention and 15 months following acceptance into the waiver, as determined by the absence of a court-order authorizing the children to be taken into protective custody.	MiSACWIS



## Methodology

The evaluation will consist of random assignment to experimental and control groups. Although not finalized, consideration is being given to a 2:1 ratio of families in the experimental and control groups. After the DHS supervisor approves the disposition and the case meets all eligibility criteria, the case will be designated in the MiSACWIS system as a waiver experimental or control. Families in both groups will be tracked throughout the demonstration period via DHS data available through MiSACWIS and data collected by private agency contractors.

MiSACWIS is Michigan's system tracking federal SACWIS requirements. See page 32 for waiver impacts on MiSACWIS.

The control group will be provided "services as usual." Services as usual for Category II cases will require the case to be opened and services coordinated by CPS until the risk level is reduced. PSM policy 714-1 states:

*"For Category II cases, the role of the worker may vary depending upon the resources and the other agencies in the community. If resources are limited, the worker may be more directly involved in the provision of services. If more resources and agencies are available, the worker may act as a case manager by coordinating the services provided directly by the worker with the delivery of various services provided by others. Regardless of whether services are provided directly or purchased, the worker must monitor the child's safety."*

Services as usual for a high/intensive risk Category IV case is closure of the CPS case following disposition. PSM policy 714-2 states:

*"For Category IV cases, the worker must provide the family with information on available community resources commensurate with the risk to the child..."*

## Process

The evaluation will examine how the waiver demonstration was implemented, including the policies and procedures that were put in place, the type and amount of services delivered and the characteristics of the population served. The evaluation will measure service delivery for both experimental and control groups, so that interventions that had the greatest impact on placement prevention and improvement in family and child wellbeing can be identified. Measures will be taken at designated intervals during waiver implementation to assess whether the demonstration proceeded as intended.



	Interpretation	Data Source(s)
<b>Organizational Aspects</b>	Interim and final reports will examine organizational issues such as: planning process, staffing structure, level of knowledge and acceptance of project by field staff, and methods of project implementation at various organizational levels, including ongoing monitoring, oversight, and problem resolution.	Interviews and agency documentation
<b>Service Aspects</b>	Model fidelity – delivery of services as intended - will be examined. The types and duration of services provided to families will be evaluated, in addition to the timeliness and accessibility of services.	Agency billing records
<b>Contextual Factors</b>	The evaluation will examine social, economic, and political factors that may have influenced the implementation or effectiveness of the demonstration.	Interviews, surveys and administrative reports
<b>Participant Satisfaction</b>	The evaluation will include participant satisfaction with programs, services, and interventions.	Survey during and after waiver intervention

### Cost Analysis and Cost Benefit

The evaluation will consider differences between the control and experimental groups in resources, services, costs, activities, staffing, among other things. It will include a cost-benefit analysis that will seek to determine whether the costs of the demonstration are matched or exceeded by the benefits produced. Data for the cost-benefit analysis will derive from administrative and case records.



### IV. Financial, Statutory, Regulatory

#### Social Security Act Waivers

The following sections of title IV-E of the Social Security Act would need to be waived to implement Michigan's proposed demonstration project.

1. Section 471(a) (3): Waive the requirement that programs operated by the state be available on a statewide basis. Michigan will be conducting its demonstration in selected counties only.
2. Section 471(a) (1), 472(a) (b) (e) and (h), 472(a) and 477(a) (2): Waive the requirements associated with title IV-E eligibility factors. Michigan's demonstration model is designed to serve any child who experiences a high level of risk for abuse/neglect. Michigan is seeking to waive title IV-E eligibility factors for children and families who would not be eligible.
3. Section 474(a)(3)(E) and 45 CFR 1356.60(c)(3): Expend title IV-E funds for services rather than for out-of-home care. Michigan's demonstration project is seeking to keep children safely in their homes and communities through the provision of enhanced services. Michigan is seeking to expend title IV-E for a full service array to achieve these goals rather than moving the child out-of home or return the child to their parental home more quickly.

#### Cost Neutrality

Based on the waiver demonstration research design, Michigan anticipates using a cost-per-case cost neutrality model. Under this model, Michigan will identify the control group cases and the accompanying title IV-E claims for the group. These claims will largely be driven by out-of-home care maintenance costs for those children entering care. Using the number of children assigned to the control group, Michigan will calculate a title IV-E amount per case to be used in support of the experimental group. The title IV-E amount per case will be multiplied by the number of children assigned to the experimental group to determine the maximum amount of IV-E funding to support the offered services.

Michigan anticipates some challenge in meeting the cost-neutrality requirements associated with this waiver proposal based on two major factors.

- (1) The state's title IV-E eligibility rate is at 37%. At this rate, Michigan would have to work to maximize IV-E eligibility to have a sufficient amount of IV-E claims in the control group to support the additional costs in the experimental group for the expanded family preservation services.



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- (2) The subsequent entry into care rate for the Category II and Category IV families targeted in this proposal average about 10% within 24 months. Because the cost-per-case calculated for the control group in the above methodology is largely driven by out-of-home care costs, the waiver structure presents a challenge in having sufficient funding available to support the experimental group.

Despite these challenges, DHS looks forward to working collaboratively with the federal government to identify potential solutions to allow Michigan to move forward with its demonstration project while meeting cost-neutrality requirements.

### Accounting of Child Welfare Investments

The waiver design builds on ongoing family preservation and abuse and neglect prevention services funded in Michigan. Its unique combination of services provided over a longer duration to families at high risk of maltreatment and out-of-home placement is not currently available in the state. As a proxy, the following provides total funding that supported existing interventions for the past two fiscal years.

#### State of Michigan – Fiscal Years 2010 and 2011

##### Total Spending – Family Preservation and Prevention Services

<u>Fiscal Year</u>	<u>Federal Funding</u>	<u>State Funding</u>	<u>Total Funding</u>
2010	\$44,267,800	\$0	\$44,267,800
2011	\$50,581,300	\$728,900	\$51,310,200



## V. Alignment and Assurances

### Impact on CFSR

Michigan's waiver project will not adversely affect implementation of the state's CFSR Program Improvement Plan (PIP), which is effective from 6/1/11 through 5/31/13. Services and supports offered through the demonstration project will bolster Michigan's efforts to improve safety, permanency and wellbeing of children and families identified at high risk. The strategies that will be used in the demonstration project compliment the activities of the PIP and focus on two key related goals: enhancing the service array and addressing declining performance in safety outcomes 1 and 2. Michigan's improvement plan to address these goals includes:

- Reassess and improve safety and risk assessments in child welfare policies and practices throughout the continuum of child welfare services with particular focus on children's protective services.
- Enhance the state's capacity to provide for children, families and caregivers by identifying needs, providing services and engaging families in the service planning process from initial contact with a family through the life of the case.
- Implement increased permanency efforts and concurrent permanency planning.
- Enhance accountability and workforce development.

### Alignment with the DHS Strategic Plan

Implementation of the title IV-E waiver is consistent with the mission of the Michigan DHS 2011-2012 Strategic Plan to improve *"the quality of life in Michigan by providing services to vulnerable children and adults that will strengthen the community and enable families and individuals to move toward independence."*

### Capacity to Use Waiver Authority

DHS will take the following steps during pre-implementation to effectively implement the waiver project:

- Training – DHS will develop training modules in cooperation with the Child Welfare Training Institute, university partners, professional experts, and/or contracted service providers. The training plan will include protective factors, child trauma, domestic violence, utilization of measurement tools, and other pertinent topics.



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- Contracts – DHS will follow the state bidding process to establish contracts with private agencies and an independent evaluator.
- Legislation – DHS will recommend language for inclusion in its budget bill that gives it authority for waiver expenditures.
- Policies and Procedures – DHS will develop policies, procedures, and forms to achieve waiver goals and requirements.
- Broad-based cooperation – DHS will inform its department child welfare staff and contract agency child welfare staff, statewide and local stakeholders, legislators, advocacy organizations, and community service providers about the waiver demonstration project and obtain recommendations for moving forward.

### **Impact on Existing Projects**

#### **Community-Based Child Abuse Prevention (CBCAP)**

CBCAP programs were established by title II of the Child Abuse Prevention and Treatment Act Amendments of 1996 and most recently reauthorized by the Keeping Children and Families Safe Act in 2003. They are authorized to fund local child abuse prevention programs that provide a multitude of services and supports, including:

- Comprehensive support for parents.
- Promote the development of parenting skills.
- Improve family access to formal and informal resources.
- Support needs of parents with disabilities through respite or other activities.
- Provide referrals for early health and development services.
- Promote meaningful parent leadership.

Macomb County, one of the demonstration sites, provides services using CBCAP funding. For fiscal years 2012-2015, CARE of Southeastern Michigan was awarded \$37,500 per year to provide in-home parent education for pregnant women and new mothers. The program uses the evidence-based nurturing skills curriculum and consists of a minimum of 12 home visits. The waiver is not expected to affect this program, but waiver families may use the nurturing skills program to address and build one or more of the protective factors.

#### **Family Resource Centers**

Michigan has 44 family resource centers operating statewide, including Muskegon, one of the demonstration sites. The resource centers offer a “one-stop shop” for family services located in or near a neighborhood school. DHS staff working in the family resource centers administer benefits to families including, cash assistance, food, clothing, shelter and prevention service referrals; Medicaid eligibility determination, emergency assistance for utility shut-off and rental



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eviction and other housing issues. They coordinate access to community-based mental health services, therapy and other services in agreement with local partners. Private agencies delivering waiver services will partner with Muskegon family resource centers as needed to assist families.

### **Children's Trauma Assessment Center (CTAC)**

Kalamazoo, one of the demonstration counties, has a CTAC, a National Child Traumatic Stress Network site. The waiver project will collaborate with the site at Western Michigan University to provide assessment, linking, and evidence-based services within a trauma-informed system of care.

### **Domestic violence shelter and support**

Among other things, the Michigan Domestic Violence and Sexual Assault Prevention and Treatment Board provides funding to community-based agencies for domestic violence prevention. Services provided under contracts with 44 non-profit domestic violence programs across the state include emergency shelter, emergency intervention (24-hour crisis lines and emergency response services), supportive counseling, community education and prevention services, personal and support advocacy with health care, criminal justice systems, housing location, financial assistance, transportation and child care and children's services and treatment. Each demonstration site has domestic violence programs and support services. The waiver project will require agencies to communicate and coordinate with local domestic violence programs to assist families as needed.

### **Family preservation**

Families First of Michigan (FFM) is a TANF funded four-week crisis intervention provided to families at imminent risk of removal from home. Families Together Building Solutions (FTBS) is a title IV-B (2) funded program provided to families for 90 days to prevent removal or re-entry into foster care. All three demonstration sites have FFM and two of the three have FTBS. The waiver project will not affect existing preservation services.

### **Child Protection Community Partners (CPCP)**

This collaborative effort requires DHS and community partners to plan for and provide services to at-risk children of families that meet specific eligibility of low to moderate risk of child abuse or neglect (Category III or IV CPS cases). Services purchased with CP/CP funds may include parenting classes, parent aide services, wraparound, counseling, and prevention case management. The goal of CP/CP funding is to support prevention and early intervention programs. The waiver will not affect this collaborative.



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### **Local Child Abuse and Neglect Councils**

Each county operates a local child abuse and neglect council that provides a variety of prevention services, information and supports to families. The waiver project will coordinate and cooperate with local councils as needed to efficiently meet the needs of waiver families.

### **Great Start Collaboratives (GSCs)**

GSCs are located across the state and operate in all three demonstration sites. They target families with children 0-5 and provide a continuum of services and supports ranging from parent education, child care, play groups, Early On, and specialized screening, assessment and intervention services to promote the social-emotional well-being of all infants and young children. Communication with GSCs will occur to determine how local GSC and the waiver project may work collaboratively to assist waiver families.

### **Impact on Michigan's State Automated Child Welfare Information System (MiSACWIS)**

Title IV-E mandates requirements and specific rules for the state's computer application. In October 2012, Michigan will pilot its statewide automated child welfare information system in Ingham County and seven private foster care agencies. Training, testing, and other implementation and scaling up activities will occur through full implementation in July 2013. MiSACWIS will be launched statewide prior to implementation of the waiver demonstration. Data collection capabilities of MiSACWIS will benefit tracking, data collection, and evaluation aspects of the waiver.

### **Impact on Settlement Agreement**

As the result of the class action suit *Dwayne B. v. Snyder*, commenced by Children's Rights, Inc., a modified settlement agreement was entered into by Children's Rights Inc. and DHS. Generally, the settlement was designed to compel DHS to implement programs that more successfully provide for the specific needs of individual children and families and for the safety of all children in the system, effectively reducing the number of incidents of maltreatment in placements. Further, the settlement stresses the need for DHS's programs to be centered on families and communities in order to support family reunification whenever possible, and ultimately, permanency in a child's placement. Moreover, the settlement was designed to require DHS to develop services to meet the unique needs of individual children and families. Each service and program is required to be based on its outcome, driven by data, and evaluated on a continuous basis.

The provisions of the settlement further provide for specific qualifications for both supervisors and subsidiary employees to ensure only qualified and specifically trained individuals are



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handling cases. For the same reason, the number of cases an individual caseworker can accept is limited. Additionally, as indicated above, the settlement requires DHS to provide measurable objectives with specific deadlines to attain certain goals. Such programs must then be reviewed by a court-appointed monitor to ensure the objectives of the settlement agreement and of the program are being met. In response to the evaluations by both the DHS Continuous Quality Improvement Division (as required by the settlement) and by the monitors, DHS is required to utilize the information to improve its programs and services.

**Bold text** indicates provisions of the settlement agreement, followed by enumerated provisions of the proposed project that work to meet the goals of the settlement agreement.

**Services must be uniquely tailored to meet the needs of each family member:**

- Based on a family's individual needs as determined by assessments of risk, safety, and needs, the frequency and intensity of worker engagement with a waiver family will vary. Some families may require frequent worker contact, coordination of multiple services, and more intensive support for a longer period of time, while others may experience less frequent contact, fewer service referrals, and earlier worker disengagement.

**Reduction in maltreatment: Must meet or exceed 94.6% of foster children who were not the victims of recurring maltreatment within six months:** The waiver will have no effect on this settlement provision as it does not target children in foster care or their foster parents.

**The first priority is the safety of the child and the overall wellbeing of the child:**

- The goals of the waiver program are aligned with this provision.
- Goals addressing child safety will be included in the written case plan and will be documented using the Structured Decision Making risk assessment tool throughout the intervention.
- Specific safety planning will take place as needed throughout the intervention.
- Cases will remain open to CPS and be fully engaged in the waiver until risk is reduced to low or moderate.

**Services should be outcome-based, data-driven and continuously evaluated:**

- The waiver will include the use of evidence-based services in each demonstration site.
- An independent evaluation team will determine the effectiveness of the waiver project at designated intervals throughout the waiver. A final evaluation will be published and available to the public. The evaluation will involve a comparison group design in which families meeting demonstration eligibility criteria are randomly assigned to the experimental or control groups. The evaluation will include a process evaluation, cost-analysis, and will compare the experimental and control groups for significant differences on established outcomes.



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A Trauma Screening Checklist will be used to determine the child's exposure to prior trauma and whether services are needed to address trauma.

- The Protective Factors Survey will be used before, during and after waiver intervention to determine progress in building protective factors.
- Service provision will also be based on the use of early screenings for substance abuse, domestic violence and mental health concerns.

**The best placement is in the child's own home; however, if that is not possible, children must be placed in a safe, caring home as soon as possible, striving to "make the first placement the best and only placement":**

- The waiver works with intact families in their own homes and communities to improve family functioning and prevent entry into foster care.

**Contracts with private child placing agencies must be performance based:**

- Contracts will be performance based. Agencies will be eligible for incentive payments if they succeed in meeting the goals of the program.

**Families must be treated with dignity and respect, and, whenever possible, included in decisions that affect them and their children. (3) The Family Engagement Model must be finalized by March 2012. By March 2013 the Big 14 counties are required to implement a Family Team Meeting (FTM) model, which engages the children, parents, family, friends, service providers, LGALs, and others involved to collaborate in making important decisions regarding the care of the child. FTMs are required for all counties by December 2014. (Family involvement in the program and decision making is essential)**

- Family Team meetings will occur with the family to develop the case plan. The program is directed toward families that have been reunified to help increase the success of the families.
- The protective factors approach that will be used with the family builds on a family's strengths to increase resiliency, social connections, social and emotional wellbeing, and knowledge of child development.
- The plan to determine the level and duration of intervention will be developed with participation from the family.
- Trauma informed therapy is designed to provide strategies for parents to increase parental satisfaction and decrease abusive or neglectful responses to the child's behavior.



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**DHS must ensure families have access to sufficient services, DHS must assist the families in connecting to, engaging with, and making use of these services, and DHS must “monitor the provision of services to determine whether they are of appropriate quality and are having the intended effect.” In addition, “DHS must actively partner with communities to protect children and support families when determining the intervention plan for the child:”**

- The agency worker has a primary responsibility for engaging with the family, building trust, functioning as a liaison with community providers and assessing progress.
- Assigned workers will make appropriate referrals, coordinate services and monitor the family’s progress. A case plan will be developed by which effectiveness of service provision will be gauged.
- Before, during, and after engagement with waiver families, the Protective Factors Survey will be administered to determine progress and effectiveness of the intervention.

**Supervisors and staff must have program specific training:**

- Agency workers for this program must successfully complete training in using the protective factors approach, trauma informed practice, domestic violence, and safety planning.

**Entry level caseworkers must have a BSW or similar degree and have pre-service training or a University-Based Child Welfare certificate. Supervisors must have a MSW and three years of experience as a social worker or a bachelor’s with four years of experience, three of which are in child welfare, and the person must pass a competency based performance evaluation and training program.**

- Each family in the waiver will be assigned a worker and supervisor that meet the qualifications outlined in the settlement agreement. Each supervisor will supervise up to four workers.

### **Assurance of Health Insurance Coverage**

Adoption subsidy policy related to Medicaid coverage is based on Public Law 105-89; the Adoption and Safe Families Act of 1997 which includes a requirement that states provide health care coverage for children with medical or rehabilitative needs receiving an adoption support subsidy not funded by title IV-E.

Medicaid coverage through the adoption subsidy program can be found in Adoption Subsidy Manual (AAM) policies AAM 120 and AAM 230. Following are policy highlights:



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- The adoption subsidy office determines whether or not a child qualifies for Medicaid through the adoption support subsidy program.
- Children eligible for title IV-E adoption support subsidy are categorically eligible for Medicaid coverage.
- Children who are not eligible for title IV-E funded adoption support subsidy but are eligible for state funded adoption support subsidy may be eligible for Medicaid coverage if it is determined prior to the adoption that they have a physical, mental or emotional handicap or condition that requires medical or rehabilitative care.
- Medicaid coverage is available for children eligible for a non-title IV-E funded adoption support subsidy who meet all of the following:
  - Have a documented special need for medical, mental health or rehabilitative care.
  - Cannot be placed for adoption without medical assistance.
  - Are covered by a non-title IV-E adoption support subsidy and their adoption is finalized on or after December 1, 1997.
- The adoption subsidy office determines the presence of a special need for medical, mental health or rehabilitative care based on documentation provided by the adoption worker.
- The special need for medical, mental health or rehabilitative care must be documented prior to the final order of adoption.
- Children who do not qualify for Medicaid through the adoption support subsidy program may be eligible for other Medicaid programs. Adoptive parents may make application at the local DHS office.

To further assist adoptive children and their families, the State of Michigan is working with Michigan Department of Community Health to assess the feasibility of having all children who are eligible for adoption support subsidy categorically eligible for Medicaid, regardless of funding source.



### **Public Comment**

Michigan's waiver project is the result of input by DHS child welfare managers and administrators, external child welfare stakeholders, members of the CPS Advisory Committee, and county directors from the Big-14 counties. Planning meetings included staff representing Child Welfare Funding & Juvenile Programs, Child Welfare Programs, Continuous Quality Improvement, Field Operations, Communications, Executive office, Financial Services, Domestic Violence, Bureau of Technology and Project Services, and Center for Transformation, among others. Meetings with external stakeholders included the Office of Children's Ombudsman, the Michigan Federation for Children and Families, the Michigan Department of Community Health, the Michigan League for Human Services, the State Court Administrative Office, Children's Trust Fund, the Foster Care Review Board and private agencies.

Plans to obtain public comment include meetings in the fall of 2012 with foster parent associations, local child abuse and neglect councils, the Michigan Youth Opportunity Initiative youth boards and community partner board, Michigan Foster Care Review Board, Great Start Collaboratives, and various other citizen and advocacy organizations across the state and in the demonstration sites.

### **Child Welfare Program Improvement Policies**

To be considered for a title IV-E waiver, Michigan must demonstrate that it has implemented or plans to implement at least two child welfare program improvement policies from the list of options provided in section 1130(a)(3)(C) of the Social Security Act. One of the child welfare program improvement policies to be implemented must be a policy that Michigan has not previously implemented as of the date it submits the waiver application.

The DHS Bureau of Child Welfare within the Children's Services Administration is responsible to develop child welfare policy for the department. The Bureau of Child Welfare identified the following policies for implementation:

#### ***Increase Age Limit for Title IV-E programs***

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) includes an option for states to receive matching federal funds to extend foster care maintenance payments, through federal title IV-E funding, to eligible foster youth ages 18, 19, and 20. To implement this option, in 2011, Michigan passed the Young Adult Voluntary Foster Care Act (MCL 400.641 - 400.671), which offers 18, 19, and 20-year-olds who were in state-supervised foster care at the age of 18 or older the option of living in a licensed foster family home, a child care institution or an approved setting in which the individual is living



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independently, until age 21. Michigan Court Rule (MCR) 3.616 was also amended to allow judicial action under 2011 PA 225, the Young Adult Voluntary Foster Care Act.

On April 1, 2012, DHS issued corresponding statewide policy and procedures to child welfare field staff, which can be located at: <http://www.mfia.state.mi.us/olmweb/ex/fom/722-16.pdf>

On April 5, 2012, the Michigan State Court Administrative Office issued an administrative memorandum to help courts with implementation of the Young Adult Voluntary Foster Care Act and other recently signed acts that extend adoption support subsidy agreements and medical subsidy agreements to children who were adopted between the ages of 16 and 18, and who meet the eligibility requirements set out in the Young Adult Voluntary Foster Care Act, MCL 400.641 *et seq.*

### ***Foster Care Bill of Rights***

Michigan Department of Human Services has begun to develop a foster care bill of rights that clearly outlines protections for infants, children, and youth, such as assuring frequent visits with parents, siblings, and caseworkers and access to attorneys, participation in age-appropriate extracurricular activities, assurance of safety and provisions to meet their needs while placed in substitute care, and procedures for ensuring the protections are provided.