Peer Review Team Report on the
Miami-Dade Child Welfare System of Care

July 2017
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I. Introduction

In April 2017, Florida Department of Children and Families’ (department) Secretary Mike Carroll convened a Peer Review Team (team) to the department’s Southern Region to conduct an assessment of current operations and develop recommendations to improve the child welfare system of care in Miami-Dade County. Our Kids is the community-based care (CBC) lead agency in Miami-Dade and Monroe counties. See Exhibit 1 for more details on the local system of care.

Earlier in the year, a Critical Incident Rapid Response Team (CIRRT) was deployed in response to a tragic child fatality in Miami that initiated some of the work around evaluation of the local system of care. The CIRRT made several findings, the following of which became the focus of the Peer Review Team:

- Service provision was fragmented and information sharing between various providers was insufficient.
- There is a shortage of specialized therapeutic foster care homes (STFC).
- Services available do not meet the needs of some highly traumatized children.
II. Background

In 2014, Secretary Carroll convened a Peer Consultation Team that focused on out-of-home care placements, foster care recruitment, and the implementation of Florida’s Child Welfare Practice Model. The summary identified strengths such as, the community strived for high quality, an Our Kids Board that supported the vision of community-based care, Our Kids’ use of technology to support the work, and a strong history of implementing evidence-based practice initiatives and programs.

The 2014 Peer Consultation Team made 25 specific recommendations to improve the child welfare system in Miami-Dade County, with a focus on the following eight areas:

- Community engagement
- Foster home capacity
- Reducing children in out-of-home care
- Case management accountability
- Full Case Management Agency stability
- Department workforce
- Florida child welfare practice implementation
- Leadership

A significant issue facing Our Kids and the Miami-Dade County child welfare system in 2014 was the financial stability of the overall system. A significant contributor to the financial stress was directly related to the increase in the number of children coming into care and the decrease in the rate of children exiting the system to permanency. At the time, Our Kids was projected to run out of funds in six weeks; all of the Full Case Management Agencies (FCMA) were in various states of financial stress and bankruptcy was a possibility for some. The department worked with Our Kids to ensure adequate cash flow through priority processing of invoices for payments to Our Kids and sought approval of additional budget authority from the Legislative Budget Commission. One FCMA closed and its work was absorbed by the remaining agencies. See Exhibit 2 for supporting financial and placement data.

The 2014 team cited the quality and number of foster homes as another major issue. In response, Our Kids brought recruitment and licensing in-house. Although the total number of foster homes has only grown slightly, Our Kids believes the quality has vastly improved, and the capacity issue has been mitigated by a reduction in out-of-home care and a shift to kinship care. The in-house recruiting of foster parents contributed to the FCMA’s feeling a loss of ownership as they have historically recruited and licensed their own foster parents, which generated a closer relationship between the foster parents and case managers. However, positive outcomes include more consistency in training, less artificial competition that adversely impacted board rates, and the elimination of potential conflict of interest by the FCMA’s in placement decisions.
Most of the recommendations from 2014 were successfully implemented. While the department/Our Kids relationship has strengthened, other parts of the system continue to experience frictional relationships. The FCMAs, the provider network, and foster parents remain generally discontent with Our Kids. The following issues identified in 2014 continue to be a problem in the Miami-Dade County system of care:

- The need for enhanced partnerships and a higher level of trust
- The need for more transparency, primarily by Our Kids and its Board, as reported consistently across stakeholder groups
- An inexperienced workforce due to high staff turnover rates in the department’s Children’s Legal Services (CLS) and FCMAs
- Gaps in the service array, specifically services to effectively support children at home and prevent removals
- A frustrated judiciary that lacks confidence in the overall system
III. Approach

In order to provide continuity, the team included some members of the 2014 peer review, as well as a previous Interim Executive Director for Our Kids. Team members included:

- E. Lee Kaywork, CEO of Family Support Services of North Florida, Lead
- Vicki Abrams, DCF Assistant Secretary for Operations
- Dr. Neil W. Boris, Division Chief of Behavioral Health at Nemours Children’s Hospital
- Skye Cleek, Program Manager at Henderson Behavioral Health
- Rebecca Kapusta, DCF General Counsel
- Kelly McGrath, DCF Assistant General Counsel
- April May, DCF SunCoast Substance Abuse and Mental Health Program Supervisor
- Steven Murphy, Executive Director of Devereux Florida
- Frank Prado, Director of Operations of Florida Statewide Guardian ad Litem Office
- Gertrude Petkovich, Foster Parent Consultant
- Lorita Shirley, CEO of Eckerd Kids
- Dr. Joyce Taylor, Consultant and Former Interim CEO of Our Kids Miami-Dade, Monroe

The team was divided into subgroups to each focus on one of three key areas:

- Relationships and Communication
- Services Information Sharing
- Adequate Behavioral Health Treatment

Each subgroup developed questions specific to its key area and identified individuals to interview. Prior to conducting interviews, each team member was provided background data and reports to familiarize themselves with the culture and history in the child welfare system in Miami-Dade County, including a report on the results of the 2014 peer review. The composition of the individual subgroups focused on their areas of expertise. Since two of the three areas centered on behavioral health, the membership of these subgroups was comprised of individuals with expertise in this area. To assist in understanding the relationship and communication issues, subgroup membership included CBC executives, the Guardian ad Litem (GAL) program, foster parents, and DCF operations leadership and the general counsel.

Each subgroup identified specific issues to be addressed:

Relationships and Communication
1. What are the key friction points?
2. Where are there mutual areas of agreement?
3. Is there empathy among the child welfare participants?
4. What is the conflict resolution process?
5. What are the recommendations for moving forward?

Services Information Sharing
1. What Memorandums of Understanding (MOUs) or similar documents exist to address expectations for sharing information?
2. Is the current level of shared information adequate to plan and provide services for children and families served?
3. What are the barriers to sharing information?
4. How does the Managing Entity (ME) facilitate information sharing?
Adequate Behavioral Health Services
   1. Do the services meet the needs of traumatized teens in the child welfare system?
   2. How does financial reimbursement impact service delivery?
   3. What roles do Medicaid and the ME play in the delivery of services?
   4. What evidence-based services are used to treat teens in child welfare?
   5. What challenges exist for providers in hiring and retaining qualified staff?
   6. How can behavioral health services be improved?

The subgroups created an exhaustive list of stakeholders to be interviewed, either individually or in groups, such as teens/youth, biological parents, relatives, foster parents, case managers, leaders from FCMAs, department child protective investigators and supervisors, school personnel, behavioral health providers, group care providers, staff and leaders of the ME, members of the CBC Alliance, members of the Our Kids Board of Directors, judges, attorneys, GAL, and members of the Department of Juvenile Justice.
IV. Findings

Secretary Carroll launched the team’s work during a meeting with the community and stakeholders on May 1, 2017. All team members attended and each subgroup remained in Miami through May 4, 2017, to conduct interviews. At the conclusion of each day, the team met as a whole to discuss findings.

One theme that arose through the process was a low level of trust among all professional groups involved in the system of care in Miami-Dade County, which is driven by a need for more transparency and accountability. Most stakeholders interviewed identified Our Kids as the entity most resistant to transparency.

A. Relationships and Communication

The subgroup interviewed judges, CLS attorneys, case managers and case manager supervisors, GALs, and foster parents. The focus of the interviews involved the identification of key friction points, areas of mutual agreement, assessing the level of empathy for others in the system, identifying the conflict resolution process, and guidance for moving forward.

There was a common understanding and belief that everyone in the system truly has the best interest of the child at the forefront. There is a real sense of pride in the child welfare system in Miami-Dade County and a genuine belief that the system is full of strengths, including a very resource-rich community.

Throughout the interviews and focus groups conducted by the team, participants identified many stressors in the system of care. Even though caseloads have gone down in number, the workload expectations have increased. These increased expectations include more paperwork, more transportation, more complex cases, and more information sharing among a larger group of professionals. These factors have contributed to making the process more time consuming and confusing. Additional expectations and time demands, coupled with high turnover, often lead to inexperienced staff and frequent case transfers.

How the judiciary, the CBC, and the department communicate and interact directly affects the overall system. Although there are numerous meetings held between the various professional groups within the child welfare system, there does not seem to be a venue for open discussion.

Subgroup Findings

Our Kids
- Our Kids leadership and its Board need more transparency.
- The relationship between Our Kids leadership and FCMAs is strained.
- Our Kids needs to take a more active leadership role in building/managing a system of care in the community.
- Case managers need more tools to perform their duties.
Judiciary
- The judiciary’s frustration is a source of tension in the system.
- Inconsistent approaches in the handling of cases, docket, and scheduling creates inefficiencies in the system.

GAL
- The GAL views its role as investigatory in nature rather than as an advocate.

Department
- CLS attorneys often fill the role of social worker and dictate what should be done rather than advise on the legal requirements.

Case Management
- Case management often abdicates its role to other professionals.
- Case managers anticipate what a judge wants rather than determining what is needed to meet the needs of the child.

Our Kids
Our Kids contracts with three FCMAs to carry out child welfare service delivery. See Exhibit 1 for details. The subgroups identified multiple stressors in the system. These include little information being shared between providers and case management, insufficient placement options, insufficient resource utilization, inefficiencies in day-to-day case management operations, a strained relationship between Our Kids and the courts, and strained relationships between Our Kids and other community stakeholders.

One source of tension posed by those interviewed is that the Our Kids’ board members are able to serve, and many have, without term limits. While there are no statutorily-prescribed term limits for board members (see section 409.987, Florida Statutes), many voiced concerns. Stakeholders interviewed indicated that the lack of term limits for board governance creates a sense of ownership by some board members that is viewed as not healthy for the local child welfare system. Term limits may or may not address this issue, depending on the make-up of new board members.

Our Kids prides itself on being technologically-innovative and advanced, however, deficiencies with its website were identified. For example, it contains minimal performance data, minimal financial data outside the 990s, insufficient board meeting minutes, and ultimately does not meet the community’s need for accountability. Although Our Kids has implemented excellent data systems, the insufficiencies in sharing this information contribute to the need for more transparency.

The Our Kids management has experienced significant changes in the past few years. In 2014, Jackie Gonzales was appointed as the CEO. Ms. Gonzales inherited a CBC that was on the brink of bankruptcy and FCMAs in similar circumstances. She brought a no-nonsense management style to Our Kids and, with the department’s assistance, worked to ensure adequate cash flow through priority processing of invoices for payments to Our Kids. Under her leadership, Our Kids amended its contracts, created financial accountability for the system, implemented data-driven processes, and restructured many aspects of the system with a focus on positive outcomes for the children. Additionally, out-of-home care was reduced by 19 percent, FCMAs became more financially stable, contract measurements improved, the Florida Child Welfare Practice Model was implemented, and the friction between the department and
Our Kids was eliminated. As a result, several federal measures for child outcomes has improved in Miami-Dade County. See Exhibit 3 for specific data.

This success came with unintended consequences. Old perceptions about the system continue to exist and have been exasperated by management’s approach. Our Kids continues to be seen, by some, as aggressive. Its cost-driven approach is viewed as necessary but also in some cases as punitive. The perception is that Our Kids makes decisions in isolation and does not engage its FCMAs. Most meetings with Our Kids are directive rather than inclusive. Our Kids presents new metrics, performance measures, and policy or processes without much two-way communication and conflicts are often aired in the public, which contributes to a tense environment.

Our Kids does not share in this view of its organization. As a lead agency, Our Kids takes pride in striving to be the best, to use evidence-based practices to achieve better outcomes for the children and their families, and to be a leader in child welfare. They delegate to the FCMAs and expect high performance. As such, its leadership believes it is unfairly criticized, particularly by the judiciary.

Judiciary/CLS
In general, the judiciary sees its role as setting the standard to ensure the children and their families receive the highest level of service. The judiciary views itself as being required to step into an oversight role of case management organizations due to the need for more direct oversight and leadership by Our Kids. The judges believe that Our Kids makes little attempt to manage the FCMAs to ensure quality work. It is not uncommon for a judge to call on leadership of the case management organization, Our Kids, or the department in open court to express dissatisfaction over quality of work.

While the judiciary has adopted strategic tactics to drive outcomes, they are not without consequences. The methods of scheduling court appearances have created what is perceived as a chaotic system and contribute to an inefficient use of time for CLS attorneys and case managers, who have to balance already relatively high caseloads. Workers, families, and children often devote idle hours waiting for their cases to be called, which limits a case manager's ability to see other children. This issue is sometimes exacerbated by delays in travel to and from court as dependency issues are only heard in one centralized location. These issues, coupled with frequent orders to show cause and expectations that are not consistent with other circuits in the state, have also contributed to tension within the system of care. This in turn contributes to an ongoing turnover of child welfare professionals.

There have been several circumstances in which pleadings have been filed with the court containing incorrect information, contributing to the judiciary’s skepticism of the reliability of the system. CLS is obligated to notify the court of any errors as soon as they are discovered, however, this has not happened on occasion. While no evidence was found to indicate this conduct was intentional, several contributing factors were identified that led to the breakdown of information, including an informal communication style and the statutory framework in which the system is designed.

Court hearings are sometimes set informally and without official notice and parties have become accustomed to communicating through judicial assistants and emails. While e-mail is common and acceptable for some communication, it seems to have spilled over to more formal issues that should be handled through the filing of a proper pleading with the court and copies to all parties. This relaxed form of communication has brought a level of informality and uncertainty to
the expectations in a court setting, which should be adherent to the rules governing the proceedings.

The department is the sole entity with statutory authority to remove a child from his or her home. Chapter 39 requires that all petitions and other pleadings on behalf of the State be filed by an attorney that represents the department’s position in court. However, Chapter 409 creates the Community-Based Care system and sub-contracted case management agencies actually provide the services and work directly with the families that are in the system. The delineation of roles in the child welfare system and the judiciary’s responsibility to make decisions based on the department’s statutory authority contribute to shifts in accountability for certain decisions. This feeds into the judiciary’s perception that there is a need for more accountability. The department has expressed strong disagreement with case management’s use of this tactic to shift accountability as it is essential that all entities of the child welfare system take responsibility and be held accountable for their individual roles, as well as collectively as a part of a larger system of care.

Community Alliance
The Community Alliance is a statutorily-created group designed to engage the community with the CBC. The Community Alliance is chaired by Judge Cindy Lederman. In Miami-Dade County, the interface between Our Kids and the Community Alliance also results in tension.

Recently, the Community Alliance publicly expressed its frustration with the need for more transparency by the Our Kids board and the qualifications of the board members. Although there are numerous meetings held between the various parties of the child welfare system, there does not seem to be a venue for open discussion.

Core to the Alliance’s frustration with Our Kids is the lack of consistent and detailed information and data regarding system performance, acknowledgement and analysis of system challenges, and updates based on improvement.

Department of Children and Families
Almost unanimously, professionals interviewed expressed that the department has been able to maintain a positive relationship with all of the parties in the system. The judiciary, Our Kids, and case management organizations have a positive view of DCF and its leadership. The Regional Managing Director is viewed as a resource for helping work through the various issues and maintains an ongoing dialog with the judiciary. The judges feel she is accessible. She and Our Kids’ leadership have been able to rebuild a fractured relationship.

Some expressed frustration with CLS due to a need for stronger leadership and management within the office. This could be attributed to ongoing role confusion between CLS and case management.

It is difficult to determine how much responsibility the deterioration of the relationships between Our Kids and the other organizations falls on the department. Since 2014, the department’s emphasis has been on stabilizing the financial viability of all the parties, including Our Kids, implementing the Child Welfare Practice Model, and mending the department/Our Kids relationship.
Assessment of Empathy
Most of the focus group interviewed shared a common appreciation of the hard work and tremendous challenges faced by case managers. They appreciate the complexity of the work and understand the logistical challenges of transporting children to and from medical appointments, court hearings, school, and visitations, which impacts work being done for other families on the case manager’s case load. Case managers also face deficiencies with the tools provided to perform the work. For example, case managers are not given unlimited data plans for their electronics and have had to pay for data overage charges from their own personal funds. This can become an issue when case managers are waiting for court hearings to proceed and must use data to work as Wi-Fi is not always available. Case managers are sympathetic toward and respected by one another. However, case managers generally expressed a feeling of being underappreciated and devalued in the system.

Likewise, each focus group seemed to have an appreciation for the frustrations encountered by the judiciary. Case managers, CPIs, and CLS all expressed the need to improve the quality of the work being filed with the courts.

The local court system seems to have little awareness for the stress that the unpredictable nature of scheduling and frequency of orders to show cause places on the system. Almost every focus group interviewed recognized these stressors as a root cause to turnover. One Judge stated that there should be a forum for open and honest dialogue. However, there remains a high level of tension within the system of care which limits all parties in engaging in open dialogue.

Focus groups widely cited the tension in the work environment as significantly contributing to staff turnover. Turnover contributes to a lack of continuity and knowledge of particular families being served, which feeds back into the initial poor case work concerns and oversight needs of the judiciary.

Conflict Resolution
Within the local system of care, there is little room to resolve conflict. CPIs expressed the use of a conflict resolution process and were satisfied with the process. CLS has a built-in escalation process to elevate a case within its own chain of command; however, there was no defined time-frame for when to seek the guidance of the Regional Managing Director.

B. Services Information Sharing
It is common for families to receive services from multiple providers with different areas of expertise. However, the providers must share information regarding the services or treatment being provided with others serving the same family. Without the information being shared, it seems that the services are limited to one symptom rather than treating the parent, child, or family as a whole. The subgroup dedicated to information sharing was tasked with identifying solutions and barriers to these issues. Specifically, the group looked at:

- What MOUs or similar documents exist to address information-sharing expectations?
- Is the current level of shared information adequate to plan and provide services for children and families?
- What are the barriers to sharing information?
- How does the ME facilitate information sharing?
Subgroup Findings

1. There is no integrated system of information accessible by all professionals that contains the history of a child or family for providers to rely on in providing care or treatment in the system.
2. Some service providers are not compensated for non-billable services that are required for children in the child welfare system (i.e. court hearings, case staffings, reports).
3. Foster parents report they are sometimes not provided all information they believe they need regarding the child(ren) in their care.
4. The inability to obtain information has steered case managers toward using only a select group of providers they know will provide the necessary information.
5. Most providers cite HIPAA as the reason for not providing information.
6. Orders issued by the courts requiring information to be provided do not always satisfy the providers’ requirements for protection from HIPAA issues.
7. There are MOUs for information sharing; however, implementation and follow-up is inconsistent.

Integrated Information

In order to provide the most effective services for children and families, there must be more information sharing. There are integration meetings held monthly, but they are not well-attended. Information is not provided to CPIs or FCMAs and the issues are not being elevated to Our Kids or the ME. There are multiple systems that contain information, however, none of them are accessible by all and none cross-populate the information. Court orders are obtained in order to retrieve information from medical providers; however, some providers are resistant to release the information and note that the orders are insufficient to meet their criteria for release under HIPAA. Case managers and CPIs are only using providers from whom they can obtain necessary assessment information and progress reports. This practice diminishes the adequacy and capacity of providers in the system. This also creates wait lists, and ultimately a barrier to permanency for children in the system.

There is inconsistent information sharing by providers. One of the largest providers in the area expressed ease in obtaining and sharing information. However, they never physically meet the parent or child for whom the treatment is being provided.

Additionally, in some circumstances, there is a lack of information at the inception of cases. While the family may not be new to the system, there is little ability to obtain the records for services previously provided.

Children are often transported to their appointments by a transporter working for the FCMA or a case manager who does not have daily involvement in the child’s life. This practice presents additional challenges to the provider to obtain information from a person with knowledge of how the child is adjusting from a mental health, medical, or other standpoint.

When providers are treating parents, they are often faced with no options for obtaining historical information except for what is self-reported by the parent. This self-reporting method for obtaining treatment history is inadequate as parents may be poor historians.

Foster Parents

Foster parents expressed frustration regarding the lack of information they believe needs to be available to them at time of placement. Children are often transported without the required historical information and without supplies to care for the child. The information issue was expressed multiple times and, as such, foster parents have become accustomed to taking
children in their care to specific providers they know will provide treatment despite not having all the documentation necessary.

Using transporters in lieu of foster parents to take children to treatment appointments creates additional information-sharing problems. The transporters have limited information with respect to the child, which makes it difficult to determine progress or understand the complexities of the child’s issues. This was expressed by therapists and psychiatrists.

**Provider Barriers**

Miami-Dade County has a wide range of providers that creates an additional layer of complexity for the child welfare system. Each provider has their own referral process, forms, and guidelines for information sharing, and policies for services to be provided. It is difficult for CPIs and case managers to keep up with who provides what services, how information can be obtained, who has a wait list, and what service is best to meet the needs of the family or child.

This creates delays in service delivery, receipts of reports, backlogs, waitlists, and favoritism in provider selection. Case managers tend to refer to those providers they are most familiar with, regardless of the appropriateness for the needs of the client. This is compounded by the high turnover rate of workers and the loss of system knowledge.

Providers expressed that a lack of compensation for non-billable services, such as additional reports or court appearances, is an underlying cause for the information sharing. The complexities of the issues presented by the families, coupled with ongoing court hearings, meetings with other professionals in the systems, and detailed reports to be generated, make it cost-prohibitive for providers to serve this population.

Most providers cited HIPAA as a barrier for sharing information. In an attempt to satisfy the provider and comply with HIPAA, the ME created a universal consent form. However, parents were encouraged by their lawyers not to sign the consents and case managers became unable to obtain the information.

Providers voiced concern that the courts often order information to be provided to the court that is inconsistent with HIPAA guidelines, creating conflicts for the providers. Providers often refuse to comply with information requests, making it difficult to properly assess whether a family has made adequate behavioral changes to satisfy the safety concerns initially identified, impacting permanency for the child.

C. Behavioral Health Services

The Southern Region has numerous behavioral health treatment providers rendering services to families in the child welfare system. This review focused on treatment services specifically for children ages 13 through 17, with special attention to the behavioral needs of children with a history of trauma and other complex situations. Specifically, this subgroup addressed the following questions:

- Do the services meet the needs of traumatized teens in the child welfare system?
- How does financial reimbursement impact service delivery?
- What role does Medicaid/ME play in the delivery of services?
- What evidence-based services are used to treat teens in child welfare?
- What challenges exist for providers in hiring and retaining qualified staff?
- How can behavioral health services be improved?
Subgroup Findings

1. The region has an array of services designed to meet the needs of teens in the child welfare system, however, these programs are available in certain pockets based on special initiatives or program capabilities and are not uniformly available throughout the region. Also, there is not a system in place to assure that CPIs and FCMA's have access to the most appropriate services for teens.

2. The methods of financial reimbursement do not promote a collaborative, team-based service delivery.

3. Additional services for children and families in the child welfare system are needed in the region, and the role of funding through Medicaid and the ME needs to be addressed.

4. Evidence-based practices are provided throughout the region, however, these treatment modalities may be provider-based and not consistently provided throughout the region.

5. Behavioral health providers are required by contract with the ME to measure fidelity to the practice. The providers are then monitored by the ME to assure that these actions are completed. Hiring and retaining staff in the behavioral health treatment organizations is a challenge due to rate structures and demands of the job.

6. The region, in conjunction with Our Kids and the ME, has worked hard to develop and provide behavioral health services to children in the child welfare system. However, there are system issues impacting the effectiveness of these services.

The Southern Region has developed several special programs to meet the needs of teens who have been exposed to trauma, victims of human trafficking, those with problematic sexual behaviors, those who have experienced sexual abuse, and those who have serious mental health or substance use disorders that require professional attention. The subgroup found that although the ME has concentrated on assuring that the behavioral health providers have training in evidence-based practices, there is a need for additional trained therapists available to meet the needs of the population. Additionally, there is a need for treatment for substance use disorders for females.

Although not a formal treatment service, the need for foster placements for teens was mentioned as a serious issue for the region. The lack of homes for these teens and the multiple placements experienced by a portion of the population may exacerbate existing behavioral health conditions. It should be noted that Our Kids endeavors to place teens in home environments.

Due to the number of behavioral health providers in Miami-Dade County, the CPIs and FCMA case managers are unable to stay current on the type of services available from different providers. Additionally, there are three main funding sources for services: Our Kids, the South Florida Behavioral Health Network ME, and Medicaid Managed Medical Assistance plans. Each payer type has their own network of behavioral health providers, which is another complicating factor. Our Kids’ intake department is very knowledgeable about the array of services and can, when requested, provide some assistance to CPIs, but the assistance is limited and not provided through a well-organized protocol. Each of the FCMA’s are expected to navigate the complex array of services and manage the referrals from their organizations. Each behavioral health provider has their own procedures and forms for making the referral. The case managers report that there is no centralized mechanism to assist them when determining which provider is a good match for the child’s needs and how to make the referral. Case managers often make referrals to providers they know will communicate with them or to behavioral health therapists in their own organization.
In addition, there are safety management services available, such as the Children’s Crisis Response Team, in some areas of the region that could help stabilize the child’s behavioral health condition and home environment; however, CPIs need training on available services.

Some methods of financial reimbursement do not promote collaborative, team-based service delivery. Providers are most frequently paid through fee-for-service units, which only compensates for services rendered directly with the client or family. The behavioral health provider does not receive payment for time spent completing reports, discussing the cases with other team members, appearing in court, or attending staffings. When therapists work for large organizations, the organization may absorb the cost of some of these activities. In many cases, therapists in Miami-Dade County work as contracted providers and only receive payment for billable services, not the additional activities required for child welfare cases. Therapists must serve a specific number of persons per week to cover their operating costs. Therapists are carrying high caseloads and working long hours in order to meet the demand and cover costs. The workload can lead to significant therapist turn over, as reported by behavioral health organizations in Miami-Dade County.

Funding services through a team-based approach is an effective payment structure to promote good practices. Payment is structured based on the cost of the team positions, other included services, and possible incidental costs, and is received on a periodic schedule based on certain performance and outcome requirements. Children and families with complex needs often work with several different organizations. Sometimes more than one therapist is working with the child and family, a GAL, case managers, school personnel, etc. In multi-risk situations, individuals involved with the child’s treatment may not agree on an approach, may be working with different assumptions, and toward different and possibly inconsistent goals. One of the tenets of children’s mental health best practices is collaboration across all involved parties. Using a team-based model is an effective way to achieve coordinated and integrated care.

Florida has several successful team-based models including the Florida Assertive Community Teams, Family Intensive Treatment Teams, and Community Action Teams (CAT). In these models, therapists and other team members are paid for activities that promote joint communication and shared information. The team models are strengthened when the therapists are trained in and provide evidence-based therapeutic interventions. The original intent of the CAT program was to provide services sufficient to keep kids stabilized in their homes and avoid coming into out-of-home care. The admission criteria around the CAT program has been clarified so that it is be available to some children in out-of-home care who meet certain criteria. The region has also developed an additional team-based approach through a system-of-care grant that serves children in foster care. In addition to the two CAT teams, two teams designed under the grant are currently operating and available to children in the child welfare system and are paid for through the ME. Throughout this review, interviewees stated that more team-based programs are needed in Miami-Dade County.

Medicaid currently funds a great deal of services for children in child welfare, including access to the individual and family therapy and Therapeutic Behavioral Health Onsite services. However, there is a need for additional Specialized Therapeutic Foster Care (STFC), Therapeutic Group Care (TGC), and Statewide Inpatient Psychiatric Programs (SIPP). There are waiting lists for STFC and TGC with reported delays to accessing care. Suitability assessments are completed by third party assessors. The interviewees stated that the findings do not always reflect the needs of the child, sometimes denying placement if the child already received treatment in a SIPP. Although Targeted Case Management is provided by the
managed care agencies, the number of authorized service units are reportedly often too few to address the needs of the children.

The ME also provides services to this population. The ME states that those involved in the child welfare system are a priority population and has funded specific services, such as the team-based level of care designed through the system-of-care grant. The ME also funds an Integration Specialist to work with Our Kids, the department, and other system partners to improve coordination of services.

Evidence-based practices are provided in the region, however, these treatment modalities may be provider based and not consistently provided throughout the region. Regardless of the funding source, additional services are needed for teens with multi-risk and challenging behaviors. Reportedly, providers are reluctant to provide treatment for some populations, especially those involved with the juvenile justice system, and those with severe conduct disorders.

The ME requires that behavioral health providers render evidence-based and evidence-supported practices. A long list of such practices were mentioned by the interviewees, including Trauma-Based Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, high fidelity wrap-around services, Problem Sexual Behaviors Therapy at Kristi House, Motivational Interviewing, Functional Family Therapy, Alternatives for Families – Cognitive Behavioral Therapy, and others. Although these practices are available with certain behavioral health providers and in specific parts of the region, services are not consistently available to children in each part of the region. Providers are reluctant to provide treatment for some populations, especially those involved in the juvenile justice system and those with severe conduct disorders. Also, it should be noted that team-based services are strengthened when paired with evidence-based and evidence-supported treatment.

Behavioral health providers are required by contract with the ME to measure fidelity to the practice. The providers are then monitored by the ME to assure that these actions are completed. Hiring and retaining staff in the behavioral health treatment organizations is a challenge due to rate structures and demands of the job. Publicly-funded behavioral health organizations face workforce issues. The needs of the population receiving services in these settings can be intense. The challenges in serving children with long histories of trauma, difficult life experiences, and often multiple home disruptions can be significant. Also, therapists face pressures to provide quality services at a high volume. The ME has re-negotiated reimbursement rates in some areas to try to assure that their rates cover more of the costs.

The region, in conjunction with Our Kids and the ME, has worked hard to develop and provide behavioral health services to children in the child welfare system. However, as reported above under the information sharing section, there is a lack of sharing of information by the behavioral health treatment providers. Concerns regarding confidentiality have created a system where valuable information is not provided at times. CPIs, case managers, and others entitled to this information have a very difficult time receiving information from behavioral health providers, even with properly executed release of information forms. Delays range from a number of weeks to up to 60 days. Treatment progress reports are also difficult to obtain, leaving the case managers and the court without information on the child’s and/or parents’ progress and level of need. The lack of information sharing also occurs among providers. If multiple providers are working with a family, the providers are not likely to share information regarding the family’s treatment and progress.
Lack of quality information also impacts the completion of assessments and psychiatric evaluations. Often children arrive for an evaluation without an informed adult to provide valuable information about the child’s history and status. The assessments and evaluation are completed without benefit of this important information and the assessors’ or psychiatrists’ observations and findings are often not shared with the parents and caregivers. Psychiatrists stated that they have difficulty monitoring the impact of treatment because they are not able to talk to an adult who has observed the child’s functioning. Unless the psychiatrist works at the same organization, such as in a Federally-Qualified Health Care Center, the psychiatrist may not be well integrated with the child’s treatment team.

Assessing the needs for behavioral health services is the first step in quality care. CPIs and case managers are not equipped, nor should they be expected, to assess a child’s need for behavioral health services. Within the region, there are two key components to address this issue. First, Subject Matter Experts (SME) are funded by the ME and placed in each of the three departmental hubs where the CPIs are located. The SME’s role is defined as a consultant to the CPIs. The SME is expected to help the CPI understand the possible issues that they may face on a case and offer suggestions as to how to address behavioral health concerns. The defined role and function of the SME may be too limited to meet the needs of the CPI. The SMEs do not accompany the CPIs into the field or meet with children and families directly. The CPIs believe that these functions are critical and necessary to provide CPIs with needed information.

Secondly, Comprehensive Behavioral Health Assessments (CBHA)/Level of Care Assessments are obtained for all children entering out-of-home care. Our Kids and the case managers believe that these assessments are well done and provide the basis for service delivery. In fact, the CBHA findings are included in the case plans. However, there are mixed reviews on the quality of the CBHAs, with CLS having some concerns about their overall quality and effectiveness.
V. Recommendations

Relationships and Communication
1. FCMAs need a more robust oversight model of its service delivery system and compliance with court orders. The Our Kids CEO must engage a team to conduct a full review of its internal and external structures and service delivery system. This review should also include a focus on improving information sharing, particularly with and among behavioral health service providers serving children with significant behavioral issues and medication needs.

2. Our Kids and its Board of Directors should foster a culture of inclusion by developing an action plan to change how Our Kids and its Board interfaces with the community, partners, and the judiciary. This plan should include a strategic engagement process, a revamping of the website to include all relevant data and financial information, an open door policy to allow open discussion and disagreement, and a proactive senior management initiative to work through conflicts and perceived injustices with all members of the child welfare system.

3. Our Kids should review their Board of Directors policy on the term limits for members. There was general consensus among stakeholders around limiting terms to between six and eight years. This can be done through setting appointments to two, three, or four years, and then limiting the number of reappointments. This allows for board members to become familiar with the organization over a period of time, develop leadership, and provide continuity through staggered terms. Members who have a dedication to the mission of Our Kids can remain engaged through philanthropic or volunteer work.

4. Our Kids should move past monitoring contract compliance and proactively work to improve the child welfare system. A lead agency has responsibilities beyond contracting with the FCMA. Although the FCMA has contractual responsibilities and should be held accountable for meeting those obligations, Our Kids ultimately shares the ownership of the issue. If there are problems with the quality of the case work, it is Our Kids’ responsibility to ensure there is improvement. If services are not being met or programs are not being implemented, Our Kids needs to make sure there is resolution. They need to support case managers, engage with the courts, help with the delivery of services, and provide community leadership and accountability.

5. Case management agencies should embrace accountability for its work with families and its responsibilities with respect to the courts and fulfilling all court orders.

6. The local court system should streamline the judicial process where possible. Judges should create a uniform set of expectations for case work and court requirements and a more efficient scheduling process should be considered to reduce conflicts for hearings and help alleviate long waits by all parties to allow for more effective use of court time. Alternate hearing sites should be considered to reduce travel time to and from the courts from outlying areas where possible and an electronic notification system should be considered so all parties can be more effectively noticed. Circuit meetings should be held regularly to discuss issues and processes to keep conflicts at a minimum.

7. The local participants in the system of care should develop a conflict resolution process. Senior members of the department, Our Kids, FCMAs, the judiciary, and other key players should meet on a regular basis to discuss process issues, resolve conflicts, and provide the system with a predictable process for escalating issues. These meetings should be facilitated and utilize a specific framework, such as Results Based Facilitation.

8. The department should provide more robust management and leadership within CLS. Additionally, CLS should regularly address problematic cases with the Regional Managing Director or designee to ensure department operations staff is fully informed of any
potential or ongoing issues.
9. All stakeholder groups need to be more vigilant in creating a work environment that facilitates open, two-way communication and promotes quality services and outcomes for the families served through the system of care.

Information Sharing
1. Although there is no integrated system of information accessible by all professionals in the system, the ME and Our Kids should develop a limited scope release and centralized clearing process for providers to use for information sharing.
2. The department should initiate a quality management process to ensure that CPIs provide foster parents with the statutorily-required “Blue Book” with all known medical information on children being placed with a foster parent or kinship provider. Our Kids should develop a process to validate whether the information has been provided and ensure that subsequent information is current and communicated with all placements.
3. Case managers should be provided with the information necessary to satisfy the needs of the families, children, and courts. This should eliminate selectively choosing providers, accepting waitlists, and completing case plans to satisfy the judicial review.
4. Our Kids, in concert with their FCMAs, should review the impact that provider waitlist, inadequate information, and the failure to coordinate services is having on permanency rates.
5. The ME should provide HIPPA training to the judges to minimize orders that place providers in conflicting positions between court orders and federal privacy requirements.

Behavioral Health Services
1. An array-of-service analysis should be completed to determine what services are needed for the children in care, including evidence-based and supported services, and determine specific gaps in services using the three regional offices as the geographical basis for determining and measuring need.
2. The need for additional Medicaid-funded services should be addressed directly with the Medicaid managed care health plans.
3. Our Kids should work with the ME to develop a clinically-informed centralized information and referral system to aid CPIs and case managers in making appropriate referrals to behavioral health providers.
4. Confidentiality issues must be addressed and mechanisms put in place to allow the sharing of information with CPIs, case managers, and other allowable stakeholders within a reasonable time frame.
5. Team-based services should continue to be used and expanded as a financial reimbursement method to ensure full integration of key ancillary and support services, such as completing progress reports, court appearances, attendance in staffings, and other team-based activities.
6. The expansion of funding for team-based and wrap-around services should be explored with the MEs and Medicaid managed care.
7. The Southern Region should work with Our Kids, the ME, and Medicaid managed care plans to establish and implement expectations for aligned planning and teamwork for behavioral health providers, CPIs, case managers, GAL, CLS, and other partners.
8. The rates and frequency, duration, and intensity of services should be examined to determine the needs of teens are met in the child welfare system. Rate reviews should be conducted by Our Kids, the ME, and Medicaid managed care health plans.
9. Practices regarding children attending assessments and psychiatric appointments without an informed adult should be examined and modified. Information transmission from the assessor and the psychiatrist should also be addressed.
10. There should be a mechanism in place to allow providers to gather information from other appropriate community partners that may have information relevant to creating an effective treatment plan for children and families.
11. The effectiveness and optimal use of the SMEs should be examined.
I. Exhibits

Exhibit 1

<table>
<thead>
<tr>
<th>DCF Region</th>
<th>Southern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counties</td>
<td>Miami-Dade and Monroe</td>
</tr>
<tr>
<td>Judicial Circuits</td>
<td>11 and 16</td>
</tr>
<tr>
<td>Community-Based Care Lead Agency</td>
<td>Our Kids, since April 2005</td>
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<tr>
<td>Financial Viability Plan Required</td>
<td>Yes</td>
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<tr>
<td>CPA Audit Exemption</td>
<td>No</td>
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<tr>
<td>Child Protective Investigations Entity</td>
<td>DCF</td>
</tr>
<tr>
<td>Children's Legal Services Entity</td>
<td>DCF</td>
</tr>
<tr>
<td>Case Management Agencies</td>
<td>Center for Family and Child Enrichment, Children's Home Society, Family Resource Center, Wesley House Family Services</td>
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</table>
## Exhibit 2

### Total Our Kids Funding

<table>
<thead>
<tr>
<th>DCF Contract Funds Available (by Fiscal Year)</th>
<th>FY11-12</th>
<th>FY12-13</th>
<th>FY13-14</th>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
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<tbody>
<tr>
<td>Core Services Funding</td>
<td>$70,181,186</td>
<td>$70,136,696</td>
<td>$70,014,276</td>
<td>$70,053,264</td>
<td>$73,062,669</td>
<td>$73,366,913</td>
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<tr>
<td><strong>Subsequent Amendments to Initial Allocation</strong></td>
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<tr>
<td>Unfunded Core Funding Budget</td>
<td></td>
<td>$16,647</td>
<td>$47,321</td>
<td>$36,696</td>
<td>$78,516</td>
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<td>Prior Year Excess Federal Earnings</td>
<td>-$10,148</td>
<td>-$1,628</td>
<td>$36,696</td>
<td>$78,516</td>
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<td>Non-Recurring Budget approved by Legislative Budget Commission - March 2014 for a projected</td>
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<td></td>
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<td>$5,410,094</td>
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<td>Section 45 MAS from back of the Bill</td>
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<td>$349,052</td>
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<tr>
<td>Core Services Funding Adjusted</td>
<td>$70,197,833</td>
<td>$70,184,017</td>
<td>$70,040,824</td>
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<td>$75,540,246</td>
<td>$73,411,419</td>
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<td><strong>Funding not defined as Core Services Funding</strong></td>
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<td>Independent Living (IL) and Extended Foster Care</td>
<td>$7,724,386</td>
<td>$7,724,386</td>
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<td>Children’s Mental Health Services (Cat 100800/10800)</td>
<td>$1,559,624</td>
<td>$1,559,624</td>
<td>$1,559,624</td>
<td>$1,559,624</td>
<td>$1,559,624</td>
<td>$1,559,624</td>
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<tr>
<td>PI Training, Casey Foundation or other non-core services</td>
<td>$157,000</td>
<td></td>
<td>$528,704</td>
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<tr>
<td>Safety Management Services (Nonrecurring)</td>
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<td>$559,694</td>
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<td><strong>Total at Year End</strong></td>
<td>$79,638,843</td>
<td>$79,468,027</td>
<td>$79,853,538</td>
<td>$84,824,256</td>
<td>$82,695,429</td>
<td>$83,210,617</td>
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<td>Maintenance Adoption Subsidy (MAS)</td>
<td>$17,942,631</td>
<td>$18,149,766</td>
<td>$19,014,743</td>
<td>$19,814,743</td>
<td>$19,832,050</td>
<td>$20,533,933</td>
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<td>MAS Prior Year Deficit</td>
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<td>-$349,052</td>
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<tr>
<td>Carry Fwd Balance from Previous Years</td>
<td>$3,367,182</td>
<td>$2,590,340</td>
<td>$2,813,708</td>
<td>$906,032</td>
<td>$223,014</td>
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<tr>
<td><strong>Total Funds Available</strong></td>
<td>$100,948,656</td>
<td>$100,208,133</td>
<td>$101,681,989</td>
<td>$104,745,031</td>
<td>$102,401,441</td>
<td>$103,744,550</td>
</tr>
</tbody>
</table>
### Expenditures on Core Services and Administration

#### Reported Expenditures by Fiscal Year (Including Carry Forward)

<table>
<thead>
<tr>
<th>Category</th>
<th>FY11-12</th>
<th>FY12-13</th>
<th>FY13-14</th>
<th>FY14-15</th>
<th>FY15-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin Cost Rate (Exp as % of Total Allocations)</td>
<td>3.7%</td>
<td>3.6%</td>
<td>3.4%</td>
<td>2.7%</td>
<td>3.4%</td>
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<tr>
<td>Dependency Case Management</td>
<td>$36,547,420</td>
<td>$36,874,574</td>
<td>$35,099,652</td>
<td>$36,475,607</td>
<td>$38,227,492</td>
</tr>
<tr>
<td>Adoption Services Promotion &amp; Support</td>
<td>$2,458,736</td>
<td>$2,358,982</td>
<td>$1,976,651</td>
<td>$1,870,418</td>
<td>$427,700</td>
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<tr>
<td>Prevention/Family Support/Family Preservation</td>
<td>$6,079,640</td>
<td>$6,318,440</td>
<td>$6,297,599</td>
<td>$6,253,382</td>
<td>$2,765,108</td>
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<tr>
<td>Other Client Services</td>
<td>$6,945,024</td>
<td>$6,817,969</td>
<td>$9,046,572</td>
<td>$8,193,935</td>
<td>$4,921,967</td>
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<tr>
<td>Training - Staff and Adoptive/Foster Parent</td>
<td>$1,529,804</td>
<td>$1,393,501</td>
<td>$1,161,232</td>
<td>$348,868</td>
<td>$3,402,624</td>
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<tr>
<td>Licensed Family Foster Home Care</td>
<td>$6,202,833</td>
<td>$6,063,054</td>
<td>$7,416,014</td>
<td>$6,672,112</td>
<td>$5,951,080</td>
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<tr>
<td>Licensed Facility Based Care</td>
<td>$9,277,664</td>
<td>$9,286,083</td>
<td>$10,172,447</td>
<td>$15,064,529</td>
<td>$13,061,602</td>
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<td>Services for Victims of Sexual Exploitation</td>
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<td>$842,441</td>
<td>$937,099</td>
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<td>Other</td>
<td>$643,300</td>
<td>$645,370</td>
<td>$716,559</td>
<td>$484,419</td>
<td>$610,519</td>
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<tr>
<td><strong>Total Core Services</strong></td>
<td><strong>$69,684,421</strong></td>
<td><strong>$69,757,974</strong></td>
<td><strong>$71,886,726</strong></td>
<td><strong>$76,205,710</strong></td>
<td><strong>$70,305,190</strong></td>
</tr>
</tbody>
</table>

#### Core Services Expenditures by Category

![Core Services Expenditures by Category](image-url)
Children in Out-of-Home Care by Placement Setting

Removals, Discharges, and Children in Out-of-Home Care by Month
Exhibit 3

Miami-Dade County Federal Child Welfare Measures
Federal Child Welfare Indicator Trends

- M01 - Rate of Abuse per day in Foster Care
- M02 - Recurrence of Maltreatment
- M03 - % Exiting to Perm. Home in 12 Months
- M04 - % Exit to Perm. Home in Care 12 to 23 Months
- M05 - % Exit to Perm. Home in Care 24+ Months
- M06 - % Not Re-entering Care in 12 Months
- M07 - Placement Moves per 1,000 days in FC

Legend:
- Red: Not Meeting Standard
- Green: Meeting/Exceeding Standard

Last Updated: 7/11/2017