

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

B.H., et al.,)	
)	
Plaintiffs,)	
)	
v.)	No. 88 C 5599
)	Hon. Jorge L. Alonso
GEORGE H. SHELDON, Director,)	Judge Presiding
Illinois Department of Children and)	
Family Services,)	
)	
Defendant.)	

AMENDED AND REVISED DCFS B.H. IMPLEMENTATION PLAN

TABLE OF CONTENTS

	Page
Introduction	1
I. Implementation Plan Leadership	2
II. Application of Implementation Science to the Implementation Plan	3
III. Overarching Outcome Measures	4
A. Safety	5
B. Permanency and Stability	5
C. Wellbeing	6
IV. Implementation of Specific Recommendations of the Expert Panel	7
A. Recommendation #1: <i>Institute a children’s system of care demonstration program that permits POS agencies and DCFS sub-regions to waive selected policy and funding restrictions on a trial basis in order to reduce the use of residential treatment and help children and youth succeed in living in the least restrictive, most family-like setting.</i>	7
1. Therapeutic Foster Care Pilots	8
2. Care Management Entity Pilot	13
3. Dually-Involved Youth Pilots	19
B. Panel Recommendation #2: <i>Engage Department offices in a staged ‘immersion’ process of retraining and coaching front-line staff in a cohesive model of practice that provides children and their families with access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families.</i>	25
1. Immersion Sites Overview	25
2. Description of Family-Centered, Trauma-Informed, Strength-Based Practice Model	29
3. Description of Model of Supervisory Practice (MoSP)	32
4. Initiation of MoSP Training Model	33
5. Core Practice Model Expert	33
6. Statewide Summit	34
7. Quality Service Reviews	34
8. Development of Regional Capacity to Expand Service Array	35
9. Use and Oversight of Flexible Funds	36
10. Evaluation	37
C. Panel Recommendation #3: <i>“Fund a set of permanency planning initiatives to improve permanency outcomes for adolescents who enter state custody at age 12 or older either by transitioning youth to permanent homes or preparing them for reconnecting to their birth families reaching adulthood.”</i>	38

1. State-funded guardianship assistance should be extended to all children aged 12 and older regardless of IV-E eligibility.	39
2. The definition of kin should be revised to include the current foster parent of a child who has established a significant and family-like relationship with the child, whether related or unrelated by birth or marriage.	39
3. Both changes will result in a savings since the administrative savings are well above the state costs for guardianship assistance payments and revision to the definition of kin will qualify more assistance payments for IV-E reimbursement.	40
4. Implement specific “family finder” strategies as part of permanency planning for adolescents who do not have an obvious reunification plan.	40

D. Panel Recommendation #4: “Retain an organizational consultant to aid the Department in “rebooting” a number of stalled initiatives that are intended to address the needs of children and youth with psychological, behavioral or emotional challenges.”.....

1. Reorganization, Strategic Planning and Cultural Change	42
2. Full Implementation of Designed Initiatives	43
3. Training and Coaching Program	52

E. Panel Recommendation #5: Restore funding for the Illinois Survey of Child and Adolescent Wellbeing that uses standardized instruments and assessment scales modeled after the national Survey of Child and Adolescent Wellbeing to monitor and evaluate changes in the safety, permanence, and wellbeing of children for a representative sample of DCFS-involved children and their caregivers.

1. Illinois Survey of Child and Adolescent Wellbeing (ISCAW)	53
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F. Panel Recommendation #6: The implementation plan will provide for the Department to contract with an external partner to perform an effective residential and group-home monitoring program. The Department shall use an external partner for that function until such time as the Department has sufficient staff with the necessary experience and clinical expertise to perform the function internally and further has developed an in-house program that can monitor residential and group-home placements effectively.

1. Theory of Change	54
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V. Communication Plan

VI. Project for Target Group of Children and Youth.....

DCFS B.H. IMPLEMENTATION PLAN

Introduction

In April 2015, this Court appointed a panel of experts pursuant to Federal Rule of Evidence 706 to evaluate the services and placements provided to plaintiff class members with psychological, behavioral or emotional challenges. In July 2015, the Expert Panel submitted a report to the Court outlining specific findings and making six recommendations for systemic change at DCFS. Under the leadership of then-newly appointed Director George H. Sheldon, DCFS did not dispute the factual findings and committed to address the challenges described by the Expert Panel. DCFS is committed to take action to correct systemic deficiencies and to strive for the safety, permanence, and wellbeing of children and youth in care.

In October 2015, the Court adopted the Expert Panel's findings, subject to certain revisions proposed by the parties, and reappointed an Expert Panel. The October 2015 Order contemplates collaboration of the parties and the Expert Panel to develop an implementation plan for DCFS to follow as it addresses systemic reform.

Although Director Sheldon was initiating multiple steps to address the challenges and concerns he observed at DCFS, the July 2015 Expert Panel recommendations sparked further urgency and a broader approach to DCFS reform. DCFS now has a number of critical and innovative initiatives under way that are intended to address many of the underlying challenges referenced in the report, but there is still a long way to go to implement those initiatives fully in order to evaluate and sustain their success. These initiatives are being implemented in accordance with the requirements of implementation science. Work has already begun to spread seeds of cultural change, a sense of urgency and clear planning and ownership at multiple levels of DCFS. Success in those efforts will be a critical factor as the broader work begins. In addition, DCFS continues its work to determine an overarching strategy that will connect

projects and initiatives together to truly reform the child welfare system and in so doing address the psychological, behavioral and emotional needs of the Plaintiff class.

The Parties jointly submitted the DCFS B.H. Implementation Plan to the Court on February 23, 2016. Since the submission of the Implementation Plan, at the Court's instruction, the parties have submitted additional and supplemental information regarding the initiatives in the Implementation Plan. These are incorporated into this Amended and Revised DCFS B.H. Implementation Plan.

This Amended and Revised Implementation Plan sets forth the specific steps DCFS will take to begin addressing the six recommendations and the specific needs of children and youth in care with psychological, behavioral or emotional challenges. Additionally, in accordance with implementation science, each initiative contains a logic model which incorporates the Expert Panel's comments.

The Plan represents a core component of the overarching DCFS strategic plan a draft of which has been published for public comment. The direction of DCFS is to embed child and family centered practice into a system where all leaders, administrators and staff have a sense of urgency toward reaching the best possible outcomes for children and families in Illinois.

I. Implementation Plan Leadership

With the input of the Expert Panel, DCFS has appointed Pete Digre as Deputy Director for Placement and Community Services with complete authority and responsibility for operationalizing the Implementation Plan. Mr. Digre reports directly to Director Sheldon and has authority to direct DCFS staff and private providers, and to assign staff to specific aspects of the Implementation Plan. This definition of authority and unequivocal leadership will assist in the breakdown of silos between divisions and drive implementation in a cohesive and integrated manner.

Mr. Digre has extensive experience in developing and implementing child welfare programs in Illinois, Philadelphia, Florida and Los Angeles, including specialized intensive and therapeutic foster care programs. Exhibit A, Resume of Pete Digre.

II. Application of Implementation Science to the Implementation Plan

In developing the overall Implementation Plan as submitted on February 23, 2016, DCFS was guided by principles of implementation science as put forth by the National Implementation Research Network (NIRN). These principles suggest that successful implementation requires thoughtful phasing (“Stages of Implementation”), teaming, and continuous data monitoring (“Plan-Do-Study-Act” cycles), as well as careful examination of organizational drivers that may help or hinder innovation and provide the organizational capacity to address technical and adaptive challenges. Exhibit B, Stages of Implementation Analysis: Where Are We?; Implementation Science: Changing Hearts, Minds, Behavior and Systems to Improve Educational Outcomes.

A logic model for each initiative and project has been developed and reviewed by the Expert Panel. Logic models are graphical depictions of the logical relationships between the resources, activities, outputs, and outcomes of a program. Logic models are tools used by evaluators of programs to evaluate the effectiveness of the programs. One of the important uses of logic models is for program planning, helping program managers to plan with the end or desired results in mind. See *Designing Evaluations, Applied Research and Methods*, U.S. Government Accountability Office, 2012 Revision.

In order to operationalize the Implementation Plan in a structured way, evaluation templates were prepared by Mark Testa to assist the Strategic Planning and Innovation Division and DCFS project managers and staff. The templates are adapted from materials that Dr. Testa helped develop. Exhibit C, *A Framework To Design, Test, Spread, and Sustain Effective*

Practice in Child Welfare, Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services (2014).

Logic models and status reports based on the evaluation templates are provided for each pilot and initiative described in the Implementation Plan.

The National Implementation Science Research Network (NIRN) will assist DCFS in the application of implementation science to its implementation efforts for the B.H. Implementation Plan. DCFS is in the process of completing the contract with Alison Metz, NIRN Senior Scientist. After consultation with the Expert Panel, the current plan will require Dr. Metz to review and comment on DCFS's adherence to best practices in implementation science and assist with an assessment of DCFS's implementation capacity and strategy. DCFS will provide NIRN with logic models and implementation plans for each separate pilot, project and initiative. With respect to each initiative, Dr. Metz will provide guidance and direction on: what is going well, the identification of potential barriers to implementation of reform, and possible ways to overcome and address such barriers. In particular, Dr. Metz will offer guidance around the architecture and teaming structure of the pilots, projects and initiatives. In addition, DCFS will, as needed, seek assistance from Dr. Metz as implementation moves forward. Under the consulting arrangement, the Plaintiffs and the Expert Panel members will be permitted to freely communicate with Dr. Metz about their work on an *ex parte* basis.

III. Overarching Outcome Measures

As a result of collaboration with the Expert Panel and DCFS consultant Dr. Mark Courtney, DCFS identified specific outcome metrics to assess the safety, permanency and wellbeing of class members. These metrics are intended to monitor changes in both the quality of, and capacity to provide, services and supports for children and families in the Illinois child welfare system. Notably, every state child welfare system is measured by the United States

Department of Health and Human Services, Administration for Children and Families. For purposes of this Implementation Plan, DCFS will use the same safety and permanency outcome measures that are currently utilized by the federal government in the Child and Family Service Review (CFSR) process. The data for the safety, permanency, and stability metrics will be drawn from existing DCFS data sources and based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS). Though not as a measure of compliance with the Expert Panel's report, DCFS will routinely track and monitor other data indicators as part of this Implementation Plan that are discussed under Recommendation #4. See discussion *infra* at pp. 42-52.

The CFSR, however, does not track wellbeing outcomes with specificity. Therefore, DCFS will use wellbeing measures developed by the Illinois Child Welfare Advisory Committee (CWAC) Sub-Committee on Wellbeing. CWAC was established pursuant to executive order and provides counsel regarding emerging policy issues and best practices in child welfare. The CWAC Sub-Committee on Wellbeing is comprised of experienced, credentialed DCFS and private agency stakeholders and child welfare experts at Northwestern University. Exhibit D, CWAC Sub-Committee and Sub-Committee membership list.

A. Safety

The selected safety measure from the CFSR is maltreatment in foster care:

“Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?”

See Exhibit E, Final Notice of Statewide Data Indicators and National Standards for Child and Family Services Reviews.

B. Permanency and Stability

The selected permanency and stability measures are:

1. Permanency in 12 months for children entering foster care: “Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care?”
2. Permanency in 12 months for children in foster care 12 to 23 months: “Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) between 12 and 23 months, what percent discharged from foster care to permanency within 12 months of the first day of the period?”
3. Permanency in 12 months for children in foster care 24 months or more: “Of all children in foster care on the first day of a 12-month period, who had been in foster care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?”
4. Re-entry to foster care in 12 months: “Of all children who enter foster care in a 12-month period who discharged within 12 months to reunification, living with a relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?”
5. Placement stability: “Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?”

C. Wellbeing

Because the CFSR process does not provide for specific data measures for child wellbeing, DCFS will measure wellbeing based on a matrix that was developed by the CWAC Sub-Committee. The matrix is premised on the four functional domains (cognitive functioning; physical health; emotional/behavioral functioning; and social functioning). The CWAC Sub-Committee has submitted a final matrix which has been forwarded to the Expert Panel for review. Exhibit F, Matrix.

Many of the wellbeing indicators in the matrix will be gathered from existing DCFS data sources. For the indicators that are not currently available because DCFS does not have accessible data sources, the DCFS Office of Information Technology will develop and incorporate data sources to measure the outcomes associated with the wellbeing matrix.

One of the existing DCFS data sources from which the wellbeing indicators will be gathered is the Child and Adolescent Needs and Strength Assessment tool (CANS). CANS

data-capturing and reporting activity is maintained by the Northwestern University Illinois Outcomes system. To assess the validity of CANS findings, DCFS will develop and implement in the selected immersion sites an independent quality service and progress review consisting of the periodic collection of data from external sources, such as children and youth, foster parents and teachers to compare to CANS findings. The Psychiatric Hospital database has been finalized. It permits DCFS to collect data regarding youth who have been and are currently psychiatrically hospitalized, critical information to confirm the CANS.

In addition, DCFS is developing a database for data from the Illinois State Board of Education (ISBE) that will include the Student Information System that monitors a student's progress over time and tracks school enrollment, attendance and progress. The DCFS technology upgrade required to allow the acceptance of this data into the Statewide Automated Child Welfare Information System (SACWIS) is due to be completed in 6-12 months.

IV. Implementation of Specific Recommendations of the Expert Panel

A. Recommendation #1: *Institute a children's system of care demonstration program that permits POS agencies and DCFS sub-regions to waive selected policy and funding restrictions on a trial basis in order to reduce the use of residential treatment and help children and youth succeed in living in the least restrictive, most family-like setting.*

DCFS will begin implementing Recommendation #1 through four pilot projects targeted at populations of children with emotional and behavioral needs and/or youth involved in both the juvenile justice and child welfare systems ("dually involved"). The goal of the pilot projects is to reduce lengths of stay in residential facilities and increase placements in community and home-based settings. DCFS is committed to the pilot project process, and the four pilots described below have been launched. Each of these pilots includes a rigorous evaluation component. If the evaluation demonstrates that the pilots are meeting stated goals, it is anticipated that they will be rolled out more broadly across the state. If they are not effective,

they will be modified or discontinued, and alternative approaches will be pursued as appropriate and necessary.

1. Therapeutic Foster Care Pilots

a. Pilot Overview

DCFS will pilot the use of therapeutic foster care through evidence-based or evidence-informed models in three sites over the next five years. Therapeutic Foster Care (TFC) is a community-based service for children and youth whose emotional or behavioral health needs can be met through services delivered primarily by foster parents, as an alternative to high-end, restrictive placements such as residential treatment, incarceration, and/or psychiatric hospitalization. See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5310a1.htm>. The goal of the Therapeutic Foster Care Pilot is to develop and test the effectiveness of various models of Therapeutic Foster Care for children and youth with emotional disturbance who are in DCFS custody.

i. Theory of Change

The Theory of Change employed by DCFS in the therapeutic foster care pilot is that children and youth thrive when cared for within a home and family environment and that placement in a residential setting is a point-in-time intervention to respond to the clinical needs of children and youth. Therapeutic foster care will be implemented in areas of high need in Illinois to reduce the number of youth in residential treatment facilities and increase both placement stability and clinical functioning. Exhibit G, DCFS Logic Model and Status Report, Therapeutic Foster Care.

DCFS set a two-year goal for each program for the recruitment of therapeutic foster parents and placements. This goal will include the placement of a minimum of 40 children and youth in TFC licensed homes at the end of the first contractual year; and placement of a

minimum of 100 children and youth in TFC licensed homes at the end of the second contractual year. At least 60% of the youth served in TFC licensed homes will be aged 12 years and over. Exhibit H, Chart of TFC programs with numbers.

b. Development of Therapeutic Foster Care Evidenced-Based Models

DCFS began the pilot project in September 2015 with the issuance of request for proposals for TFC programs. The programs were targeted for Cook, Kane and Winnebago counties based on an analysis of the current DCFS population by Chapin Hall at the University of Chicago (Chapin Hall), because those areas were found to have the highest need for alternative placements for youth with serious emotional or behavioral health needs.

DCFS identified three groups of children and youth for the TFC pilots which include: children who without more intensive services were likely to later enter residential care (i.e., deflection group, later entry), children who were entering residential care directly upon placement with DCFS (i.e., deflection group, direct entry), and children who were ready for step down from residential care (i.e., step-down group). DCFS specifically identified these groups to correspond with the requirements of the Children and Family Services Act.¹

DCFS received twenty-six responses to the RFP, which were reviewed and analyzed. A pre-bidders conference was held to answer questions from bidders. DCFS then scored the proposals based on a matrix developed in collaboration with Chapin Hall. In early 2016,

¹ The Act provides: “Multi-dimensional treatment foster care. Subject to appropriations, beginning June 1, 2016, the Department shall implement a 5-year pilot program of multi-dimensional treatment foster care, or a substantially similar evidence-based program of professional foster care, for (i) children entering care with severe trauma histories, with the goal of returning the child home or maintaining the child in foster care instead of placing the child in congregate care or a more restrictive setting or placement, (ii) children who require placement in foster care when they are ready for discharge from a residential treatment facility, and (iii) children who are identified for residential or group home care and who, based on a determination made by the Department, could be placed in a foster home if higher level interventions are provided.” 20 ILCS 505/5.40.

bidders with top scores gave oral presentations to DCFS staff. DCFS selected three private agencies based on the combination of their written proposals, proposal scores, and oral presentations: Lutheran Social Services of Illinois (LSSI) for pilots in Cook County, Aurora and Rockford; Children's Home and Aid of Illinois (CHAID) and Jewish Child and Family Services (JCFS) for pilots in Cook County.

During the exploration phase, DCFS Chapin Hall, LSSI, CHAID and JCFS reassessed the potential match between the target population, the proposed evidenced-based model, program needs, and community resources. The exploration phase included meetings and discussions with the developers of the various evidenced-based models and consultation with Marci White. As a result of the Expert Panel's guidance, each private agency modified their original proposals to implement improvements.

LSSI will implement the Treatment Foster Care Oregon Children (TFCO) model in combination with a number of programs, for children 6 – 11 years of age in all three target regions. LSSI expanded their proposal to also include youth ages 12 – 14 in consultation with the TFCO developers for all three sites. LSSI will be serving 30 youth, 10 in each site. LSSI will implement a professional foster parent model where one parent will not work outside of the home. Exhibit I, LSSI Therapeutic Foster Care Implementation Plan.

CHAID and JCFS both proposed a Therapeutic Foster Care model that meets DCFS' Therapeutic Foster Care definition through implementation of the Keeping Foster and Kin Parents Supported and Trained (KEEP) model. After discussions with the KEEP model developer, however, it was decided that the KEEP model was not a good fit for this population. With assistance from both Chapin Hall and Marci White, CHAID and JCFS identified other evidence-based interventions that would meet the DCFS Therapeutic Foster Care model definition. CHAID will be serving youth ages 12 to 18 in the step down population. CHAID

will be using a number of evidence-based interventions in their pilot, including Therapeutic Crisis Intervention for Families (TCI), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Attachment, Self-Regulation and Competency (ARC), Quality Parenting Initiative (QPI), Excellence Academy and Adult Connections. Exhibit J, CHAID Therapeutic Foster Care: Implementation Plan and Theory of Change. Through the use of the above mentioned programs, CHAID will serve youth in Cook County and anticipates serving ten youth in the first year.

JCFS will serve youth ages 12 to 18 in the deflection step down and trauma populations. JCFS be using the Together Facing the Challenge model, which is an evidence-based practice model that provides comprehensive training for both agency staff and treatment foster care parents. JCFS anticipates serving 10 youth in the first year. Exhibit K, Jewish Child and Family Services Therapeutic Foster Care Pilot Implementation Plan.

Each private agency and DCFS staff has had in person meetings with the developers of the evidence-based models. LSSI and DCFS met with the developers of TFCO on June 20, 2016, CHAID met with the developers of TCI on August 15, 2016 and JCFS met with the developers of Together Facing the Challenge on August 29, 2016. The meetings allowed the private agencies and DCFS to get a clear understanding of the specific model, the required training, fidelity monitoring and sustainability issues. DCFS has established rates and has finalized grant contracts for each agency. The grant contracts will allow the agencies to hire, recruit and train staff for the pilots and each agency has begun the recruitment and hiring process. After each agency has appropriate staff in place, DCFS will develop service contracts to be put in place by the time the first children or youth are placed in the pilot.

c. Oversight of TFC Implementation Steps

DCFS and the private agencies developed a committee structure to provide necessary guidance for future decisions. Exhibit L, Therapeutic Foster Care Committee Structure. The TFC Steering Committee includes representation from each agency and high level DCFS staff and meets on a monthly basis. The Steering Committee serves in an advisory capacity to provide input and guidance throughout both the implementation and evaluation phases. Steering Committee members will assist with identifying solutions to system barriers that may affect implementation of evidence based practices.

The TFC Evaluation/Eligibility Sub-Committee is responsible for developing eligibility criteria for youth entering the pilot and criteria for step down from therapeutic foster care treatment. The sub-committee will be responsible for compiling and analyzing data relevant to decision making. The sub-committee will also be responsible for developing the evaluation plan. The committee is co-chaired by Dr. Cynthia Tate, DCFS Senior Deputy Director, Program Practice and Dr. Richard Epstein, Chapin Hall.

Implementation sub-committees will be developed. An implementation team will be established for each evidence-based model that is being used in the TFC pilot (Therapeutic Foster Care Implementation Sub Committee, Together Facing the Challenge Implementation Sub Committee and Therapeutic Crisis Intervention for Families Sub Committee.) Each implementation sub-committee will provide direction for the operational planning and initial and ongoing implementation of the evidence-based model. The sub-committees will be responsible for identifying barriers to implementation and decision making regarding the principles of plan- do-study-act to support information based decision making and continuous learning.

d. Evaluation by Chapin Hall

The evaluation of the TFC pilot programs will be conducted by Chapin Hall. Chapin Hall completed a comparison of the providers' programs and the Foster Family Treatment Association Standards. Exhibit M, Program Comparison. While the evaluation component is not complete, wellbeing measures will be included. DCFS identified proximal and distal outcomes for the TFC pilots. The proximal outcomes include decreased percentages of entries and re-entries into residential care, increased placement stability and increased clinical functioning. The distal outcomes include increased safety, improved permanency, and improved wellbeing outcomes.

e. DCFS Leadership of the TFC Pilot

The implementation of this project will be led by Twana Cosey, M.S.W., Statewide Recruitment Administrator, working in close collaboration with Peter Digre. Mr. Digre leads a team that includes managers from the DCFS Clinical, Licensing, Operations and Training Divisions.

2. Care Management Entity Pilot

The Illinois Care Management Entity (CME) pilot arose out of changes that began in 2012 in federal and state law which signaled a shift toward managed care and a potential impact on Medicaid behavioral health services to children and youth in DCFS custody. At the same time, DCFS noticed a trend in the increased length of time that children and youth were remaining in care and also remaining in institutional settings. DCFS and other state agencies worked with Shelia Pires, a national System of Care expert, in researching viable options to address these issues for Illinois. This work led to the identification of Choices, a CME with over 15 years of experience providing care coordination services. The CME pilot began in February 2014 and currently serves DCFS youth ages three to 21 who are placed in congregate care settings, in psychiatric hospitals, in specialized foster homes and in traditional foster homes, but

who are experiencing placement stability issues or who have been screened for possible psychiatric hospitalization through Screening, Assessment and Support Services programs.

The Theory of Change for this pilot is that implementation of system of care principles, such as the increased use of cost-effective home and community based services and care coordination oversight, will result in better clinical and permanency outcomes for children and youth with mental health conditions. The implementation of the CME pilot is set forth in the Logic Model. Exhibit N, CME Logic Model. An status report is also attached. Exhibit O, CME Status Report.

a. Pilot Overview

As the CME, Illinois Choices provides care coordination services based upon Systems of Care principles to children with severe and complex behavioral health concerns. The pilot serves children in DCFS custody who have a head of household address or legal county of origin in Champaign, Ford, Iroquois or Vermilion counties and who are either: 1) in psychiatric hospitals, residential /group home facilities, or specialized foster care; or 2) have been screened due to a psychiatric crisis; or 3) in traditional foster care and are experiencing placement stability issues. The four counties for the pilot were selected based upon high intake rates and long lengths of stay for children in those areas.

b. Child and Family Teaming Model

The CME's care coordination services are provided through an intensive Child and Family Teaming (CFT) model that is implemented according to High Fidelity Wraparound standards. See National Wraparound Standards, attached as Exhibit P. When a child is enrolled in the CME pilot, a care coordinator is assigned and begins an engagement process to establish a CFT that includes the child, the permanency worker, any available family members, and other natural supports, such as teachers, friends, mentors and neighbors. The care coordinator

facilitates a meeting with this CFT at least every 30 days to ensure that the child's and family's needs are being met. The CFT uses the strengths and needs that are identified through completion of CANS when the child is enrolled to develop a Plan of Care that authorizes all services required for the child and family. Those services are provided by agencies who are members of the CME's Provider Network.

Each member of the CFT has specific responsibilities. The care coordinator is responsible for scheduling and facilitating the CFT, for ensuring that all necessary services are properly authorized and that access to services is streamlined. The assigned permanency worker is responsible for ensuring that the permanency goal drives all of the CFT planning and that DCFS rules, procedures and policies and all court orders are being met. The permanency worker and care coordinator work as a team.

c. CME Provider Network

The CME provides care coordination, administration and oversight of the Provider Network, which is comprised of community-based providers who are willing to offer services to children and families enrolled in the program. Importantly, the CME is not a direct provider of therapeutic services. This permits "conflict-free" care coordination.

The CME pays providers directly, thus maintaining control of the network and allowing for flexibility to add new providers and services as needed for an individual child. The Provider Network began with only providers who had existing contracts with DCFS for both placement and therapeutic services. The CME has expanded the network to include other non-traditional providers (e.g., equine therapist, mentors, family peer supports, etc.) not previously under contract with DCFS. The CME Provider Network continues to expand to cover additional service types and providers.

Home and community-based behavioral health services currently available within the CME Provider Network include, but are not limited to: therapy – individual, family, group, and specialty (e.g., equine); community support – individual and group; evaluation and testing services; and behavior management services. Expanded child welfare support services include, but are not limited to: team meeting participation; court hearing attendance; mentoring – educational, social, recreational, life coach, independent living skills, family and parent; tutoring; supervised visitation; shared parenting and coaching; family support services including camp; childcare reimbursement; transportation; incentives; utilities; supplies; activities; medical; clothing; and restitution and damage repaid.

d. Flexible Funding

The CME manages specific funds for “flexible spending” for each child enrolled in the program. These funds are pooled across all children providing the opportunity to secure additional creative and flexible services and supports for children with higher needs. The CME accesses Medicaid reimbursed services whenever possible to ensure that flexible funds are only utilized for services and supports not already available in the community.

Mental health services currently available through flexible funding include home-based services (utilizing evidence-informed practices), enhanced mobile crisis response, crisis stabilizers, crisis respite, therapeutic mentoring services, peer support and non-crisis respite. The goal is for such services to be integrated by the Illinois Department of Healthcare and Family Services (which is the Illinois State Medicaid agency) into the federally approved Medicaid service array.

e. Enhanced Mobile Crisis Response

In April 2016, an enhanced Mobile Crisis Response program was launched as part of the CME pilot. The Mobile Crisis Response program is for youth in care and also youth in the

community who are experiencing behavioral health crises that may require hospitalization or may lead to them being removed from their current placement. This enhanced Mobile Crisis Response replaces the previous pre-hospitalization screening service that was offered prior to the CME pilot being implemented. The enhancements to the crisis program include a team-based response with a crisis responder and care coordinator (for children enrolled in the CME pilot), expanded services available immediately to the youth/caregiver and an expanded definition of what constitutes a “crisis.” Previously, a youth had to be experiencing a “psychiatric” crisis, however, under the new Mobile Crisis Response, a crisis can include behavioral health issues that may result in the child losing their current placement or being removed from the home.

f. Goals and Outcomes for CME Pilot

The CME pilot is intended to keep children stabilized in the least restrictive placement possible, to move children to sustained permanency as soon as they are ready, and to ensure children’s and families’ interests and participation directly influence the planning and delivery of services. The goal is to develop a network of community providers who offer a long-term community-based support system after the children achieve permanency.

g. DCFS Leadership of CME Pilot

The CME pilot is administered by DCFS’s Care Coordination Office, overseen by Kristine Herman, Associate Deputy Director of Medicaid Behavioral Health and Care Coordination within the Strategic Planning and Innovation Division. The Care Coordination Office authorizes all referrals to the CME, oversees the implementation of the pilot program and ensures that administrative issues are addressed at the field level by interacting directly with both private agency and DCFS permanency workers and other staff.

The Care Coordination Office is also responsible for ongoing oversight of the implementation of the pilot through CME compliance reviews and quarterly and annual

outcomes reports by the CME. Additional baseline data, outcomes and performance benchmarks will be reported by the University of Illinois at Urbana-Champaign tasked with evaluating the CME project. These reports will be used to assess the impact of the pilot as it continues to be implemented and before the final evaluation is completed.

h. CME Pilot Time Frames and Capacity

The CME pilot started in February 2014 and is currently scheduled to last for three years. The pilot is designed to serve approximately 200 children annually and 600 during the course of the three year pilot. The daily census as of approximately September 9, 2016, is 150, and a total of 310 children have been served in the pilot since February 2014.

Lessons learned from the two years of the CME pilot have been applied to the development of the immersion sites as set forth in Recommendation #2. See discussion *infra* at pp. 25-38. Through the CME pilot, DCFS has begun to localize processes within the regional structure of the CME allowing more local control and further empowering CFTs to make decisions regarding the best services and placement types for children. For example, the Clinical Intervention for Placement Preservation (CIPP) has been eliminated for children enrolled in the CME and the centralized process for placing children in substitute care (Central Matching) is being replaced. DCFS is committed to continuing the process of reinforcing local control of various policies and processes, since this local integration has been shown to be effective in the CME pilot.

In addition, DCFS recognizes that any system change processes, such as those undertaken in the CME pilot, must have strong administrative oversight and support. Because changing the culture of a system requires consistent messaging, over time, a single administrator of the program with direct access to executive leadership was established. This administrative structure has allowed policy, procedural and other system barriers to be addressed in the pilot helping to

propel culture change. This also ensures that both DCFS and private agency staff are held accountable for honoring the CFT model integral to the pilot, which represents a completely new way of doing business.

i. CME Evaluation

The Psychology Department at the University of Illinois at Urbana-Champaign will be performing a full evaluation of the CME pilot project. DCFS and the University of Illinois are completing a data sharing agreement. The current plan for the evaluation includes identification of a comparison group by the end of December 2016 and the completion of an interim evaluation by March 2017. A full evaluation of the efficacy of the pilot will be completed after the full three years period of the pilot has been completed in 2017.

3. Dually-Involved Youth Pilots

Dually-involved youth are involved with the child welfare and juvenile justice systems simultaneously. These youth face complicated challenges and generally require a more intense array of services and supports than other youth known to each system individually. There is little cross-systems collaboration between the child welfare and the juvenile justice systems.

To address the unique challenges of this population, DCFS initiated two separate pilots to determine the most effective strategies for attaining better outcomes for these youth. The Regenerations pilot provides intensive placement finding with additional supportive services to move children out of detention as soon as possible. The Pay for Success pilot is funded by private dollars and offers intensive care coordination through a fidelity wraparound process to dually involved youth. Both pilots are running simultaneously to determine which model produces the best outcomes for dually-involved youth. The pilots are described in more detail below.

a. Regenerations Pilot Project for Dually-Involved Youth at Cook County Juvenile Detention Center

DCFS engaged Dr. Alan Morris and Deann Muehlbauer, from the University of Illinois at Chicago Behavioral Health Program to review and assess the DCFS system, placement resources and the current system for matching and placing youth in residential treatment facilities in response to the Plaintiffs' Motion to Enforce the Consent Decree. This review identified a high-risk population of youth who remain in the Cook County Juvenile Temporary Detention Center (JTDC) for long periods of time after their release date and who are often placed directly from JTDC into residential treatment facilities, where they remain for long periods of time. Exhibit Q, JTDC RUR/Regenerations Pilot Presentation. The consultants further determined that this population of youth and families were often difficult to engage and resistant to services, presented complex mental health and behavioral challenges and exhibited high levels of environmental stress. The Regenerations/RUR pilot (Release Upon Request) was initiated to address these long stays of youth at the JTDC by developing additional placement and resources for this population. In order to support the Regenerations process DCFS has contracted with ChildServ and National Youth Alternatives Program to develop more foster homes for dually involved youth.

i. Theory of Change

The theory of change developed for the Regenerations RUR project is that services provided under a wraparound philosophy result in better outcomes for youth being released from detention, including placements in less restrictive settings than residential treatment facilities. The wraparound services include intensive care coordination, family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization and use of flexible funds. Federal research supports this theory of change.

The implementation of the Regenerations pilot is set forth in the Logic Model attached as Exhibit R. A status report which adheres to the structure of the Logic Model is attached as Exhibit S.

ii. Pilot Overview

The Regenerations/RUR (Release Upon Request) pilot began July 6, 2015, and serves youth ages 12 - 18 years old who are 1) in the custody of DCFS, 2) are detained in the Cook County Juvenile Temporary Detention Center (JTDC), and 3) have been determined by a judge to be ready for release (RUR). Based upon the evaluation of dual ward detention data in previous years, the pilot was developed to serve a total of 65 youth, and 56 youth are currently enrolled. Youth in this pilot receive specialized services including intensive mentoring services and priority placement in home and community settings.

Upon the notification from the courts that a youth is eligible for RUR, DCFS Legal notifies a DCFS Child Protection Supervisor and the Regenerations pilot program manager to open the case. Regenerations pilot staff interview the youth within 24 hours of notification. Immediately upon assignment to the Regenerations pilot, an assessment is initiated to identify the youth's strengths and needs, while still detained at JTDC. Family and court-appointed stakeholders also are engaged in this assessment. Shortly after the initial assessment begins, a CIPP meeting is held at JTDC to establish a Child and Family Team (CFT), which is led by the Regenerations staff assigned to the case and includes a CIPP Facilitator. The CIPP Facilitator completes the Child and Adolescent Service Intensity Instrument (CASII) to document the youth's service intensity level. The CFT utilizes the CASII to develop an Individualized Service Plan that identifies the services required to support the youth's strengths and needs. The Individualized Service Plan is completed within 30 days.

At least quarterly, continued CFTs take place to provide care coordination, assuring the Individualized Service Plan is implemented according to the youth's case plan action steps and timeframes for implementing those steps. The plan includes additional services such as comprehensive mental health assessment, mentoring and advocacy services at a minimum 7 ½ to 30 hours a week, program-funded employment, crisis intervention, and flexible funding to meet the needs of individualized youth.

iii. Evaluation

Chapin Hall anticipates finalizing its evaluation for the Regenerations Pilot by late 2017 or early 2018, with periodic interim evaluations. The key outcome measures will focus on the reduction in the days youth are detained in the JTDC beyond their release date, increase in the number of youth released directly to home and community-based settings, increase in the provision of needed community-based behavioral health services, and child welfare support services resulting in a reduction in the days youth reside in a residential placement.

iv. DCFS Leadership

This project is being led by Pete Digre, Deputy Director of Placement and Community Services. The Project Manager for this pilot is Elizabeth Kling, Associate Deputy Director, Juvenile Justice and Pilot Programs.

b. Illinois Pay for Success Pilot for Dually Involved Youth

In September 2013, the Governor's Office of Management and Budget announced a request for proposals (RFP) for Social Impact Bonds to spur better outcomes for Illinois youth. The RFP focused on two specific areas: 1) increasing placement stability and reducing re-arrests for youth in DCFS legal custody with histories of justice involvement; and 2) improving educational achievements and living wage employment opportunities for justice involved youth most likely to reoffend upon return to their communities. Exhibit T,

Press Release on Social Impact Bonds. The Social Impact Bond model is premised on government agencies teaming up with service providers and private sector investors to create and fund innovative social programs. Private sector investors provide start-up funds and then get re-paid when the programs reach specific outcome targets. Social Impact Bonds are designed to create innovative evidence based solutions to address social issues while at the same time limiting risks to tax payers. In May 2014, the Conscience Community Network, LLC (CCN) was selected through the RFP process to develop a Pay for Success project for dually involved youth in Illinois. Exhibit U, Illinois Dually-Involved Youth Pay for Success Initiative Ramp-Up Fact Sheet.

i. Theory of Change

The theory of change for the Pay for Success Pilot is premised on the belief that many youth in the juvenile justice system get involved in the child welfare system due to the breakdown of family and community services. Extensive collaboration with the multitude of systems in which the families of these youth are involved, and development of support systems for these youth and families through a wraparound approach, will return the youth to a more healthy community and family support system.

The implementation of the Pay for Success for dually involved youth pilot is set forth in the Logic Model, attached as Exhibit V. A status report, which adheres to the structure of the Logic Model, is attached as Exhibit W.

ii. Overview

The Pay for Success pilot will serve dually-involved youth who are not in Regenerations. This pilot utilizes the Crossover Youth Practice Model (CYPM), developed by the Georgetown University McCourt School of Public Policy – Center for Juvenile Justice Reform. This pilot will provide intensive care coordination through a fidelity wraparound model that will ensure

youth have access to evidence-based, community-based and non-traditional treatments and supports that address the individual's and family's behavioral health needs.

Youth aged 11 to 17 who are in DCFS legal custody who are arrested for a crime or youth who are in the juvenile justice system and placed into the legal custody of DCFS are eligible for the pilot. When a youth is assigned to the Pay for Success pilot, a Wraparound Facilitator will coordinate the CFT process, which includes a thorough and joint assessment of the youth's strengths and needs and the development of a service plan within 30 days. In addition, the pilot will provide access to evidence-based services through a network of home and community-based service providers along with flexible funds that will be utilized to fund specialized services when needed. The Wraparound Facilitator will also support the permanency worker by identifying resources, sharing information, and connecting youth to non-traditional programming.

The pilot will support collaboration between governmental systems to rapidly identify issues, engage in case coordination, and provide increased access to therapeutic programs. The ramp-up phase of the pilot began January 2016 with children from Cook and Lake Counties. There was a significant period of negotiation regarding contract terms, which has been recently been resolved. It is anticipated that the pilot will commence in Cook, Lake, Jefferson and Franklin counties shortly after September 1, 2016. The current plan calls for the identification and start up in three additional counties during the next six months.

iii. Service Array

Youth enrolled in the Pay for Success pilot will have access to the following services: functional family therapy; multi-systemic therapy; brief strategic family therapy; Attachment, Regulation and Competency (ARC); Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); academic supports; counseling/therapy; recreational activities;

substance abuse treatment; workforce development; and other services that will benefit the youth's functioning. Some youth will be placed in Treatment Foster Care – Oregon foster homes.

iv. Pay for Success Payment Structure and Evaluation

The Pay for Success project is funded through a social impact bond that is supported by private investors, philanthropies and foundations. The private funds will be used to pay for the pilot services ensuring that DCFS has no fiscal investment in the project while the project is in operation. DCFS only pays if it is clearly demonstrated that the services that were provided had a statistically significant impact on the outcomes of the youth that are enrolled in the program.

The evaluation is being designed by the University of Michigan School of Social Work and will include outcomes focused on the reduction in the number of days youth are placed in residential facilities and an increase in home and community-based service capacity and provision.

v. DCFS Leadership of the Pay for Success Pilot

Lee Annes, CIPP and D-CIPP Statewide Administrator, is the DCFS Project Manager for the Pay for Success project. The Strategic Planning and Innovation Division liaison for this pilot is Kristine Herman.

B. Panel Recommendation #2: *Engage Department offices in a staged 'immersion' process of retraining and coaching front-line staff in a cohesive model of practice that provides children and their families with access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families.*

1. Immersion Site Overview

Immersion sites are test or pilot sites representing a small geographic area where youth, birth parents, foster parents, DCFS staff, private agency staff and multiple other stakeholders work together to fully build and implement a "core practice model" of child welfare practice that

puts children and families at the center of service planning and builds community and home based resources to service children and families. DCFS will use the immersion site process as the center of its transformation in order to achieve better outcomes for safety, permanency and stability for Illinois families.

The immersion site process will incorporate a number of key components. Central to the immersion site process is extensive training and coaching of all DCFS and private agency staff in the new “core practice model,” which is comprised of the Family Centered, Trauma Informed and Strength Based (FTS) training for all staff and the Model of Supervisory Practice (MoSP) training and coaching model for all supervisors. The centerpiece of the core practice model is parental engagement and child and family team meetings.

DCFS will also integrate its Quality Assurance Division and Monitoring Division in the immersion site development. The Quality Assurance and Monitoring Divisions will implement a Quality Service Review Process (QSR), with the input and guidance of Paul Vincent and the Child Welfare Group, for a variety of activities in the immersion site. One aspect of the Quality Service Review process will be to ensure establishment of the FTS and MoSP model, focusing on the establishment of parental engagement and child and family team meetings.

Another key piece of the immersion site process is the development of community and home based services for children and families. These services will be developed on a local level with the input of key stakeholders. DCFS will also develop a system for of flexible funding so any services that are needed to achieve permanency and assist families can be purchased quickly and on a local level.

DCFS will engage in a number of structural changes to improve the overall child welfare system. These changes include improving case flow and day to day operational process by reviewing and revising rules, policies, practice and operational procedures which are ineffective,

redundant and hinder achievement of permanency for children and youth. The DCFS organizational structure will also be revamped to increase integration and decentralize various functions. In particular, DCFS will modify some current central office functions such as matching children with placements (Central Matching) and case opening (Case Assignment and Placement Unit) to determine if efficiencies can be achieved through local management. DCFS intends to reorganize the DCFS field office structure around Judicial Circuits to better align its operations with the Juvenile Court.

a. Theory of Change

The theory of change underlying the immersion sites is that the enhancements to training for all casework staff and coaching for supervisors coupled with a quality service review process will improve casework practice. The improvements in casework practice will assist in the development of services that are family centered and individualized, which will result in improved outcomes in terms of safety, stability, and permanency. A logic model is attached as Exhibit X. A status report which adheres to the structure of the logic model is attached as Exhibit Y.

b. Identification of Immersion Sites

In August 2016, DCFS began the immersion site process in the four initial sites. The four initial immersion sites include: (1) Lake County, (2) St. Clair County, (3) the Rock Island area, including Rock Island, Whiteside, Mercer and Henry counties, and (4) the five counties in the Mount Vernon area, including Clay, Hamilton, Jefferson, Marion and Wayne Counties. At the urging of the Administrative Office of the Illinois Courts, DCFS agreed to realign the territory of its Rock Island field office so that Whiteside County, the only county in the Fourth Judicial Circuit not part of the original selection, would be included in the immersion site. Recognizing the importance of the court system to the success of the immersion sites, the Director made the

decision to realign the DCFS boundaries. DCFS is in the process of assessing DCFS office coverage areas in relation to judicial circuit areas as they do not currently align. The initial immersion sites encompass approximately 11% of children and youth in care.

It is expected to take approximately one year to complete the process in the first four immersion sites. This timeline has been intentionally extended beyond that first anticipated, based on feedback and advice from the immersion site consultants Paul Vincent and Narell Joyner.

Additional immersion sites will be rolled-out on a regular basis. The current goal is to complete the immersion site process in the entire state by 2019.

c. Immersion Site Activities

After identifying the first four immersion sites, DCFS established Immersion Site Director positions in each of the four sites. Candidates for those positions were interviewed and are in the final selection process.

DCFS designed an outcome data tracking system that will allow DCFS to track information for an immersion site and for comparison sites. Key elements of the design of the data set to be tracked include the following. Other data sets will be developed with the experts during the project.

- a. Historical trend lines for proximal and distal outcomes;
- b. Tracking outputs and proximal and distal outcomes for both Immersion and Comparison sites as well as statewide;
- c. Alerts when the stability of the placement for the following cohorts of youth has been disrupted:
 - i. Youth who have been in shelter over 30 days;
 - ii. Youth who have been stepped down from residential care;
 - iii. Youth who have stayed in a psychiatric hospital beyond medical necessity;
 - iv. Youth who have stayed in detention beyond their release upon request date.

DCFS leadership staff held listening visits in the four initial immersion sites.² The listening visits were conducted with DCFS leadership staff from both the Director's office and the local regional office, DCFS front line personnel, judges currently sitting in Juvenile Court in each immersion site, other key court personnel, such as State's Attorneys and guardians ad litem, private agency staff, counseling and other service providers, children and youth in care, birth parents and foster parents.

DCFS began initial steps toward decentralizing various programmatic pieces. A pilot was established for regionalization of the matching process for placements for children and youth and for the case opening process in the Southern region. This includes the immersion sites of Mount Vernon and East St. Louis.

2. Description of Family-Centered, Trauma-Informed, Strength-Based (FTS) Practice Model

The FTS component of the Core Practice Model sets forth clear guidelines for caseworkers and supervisors that establish a more effective process of family engagement, assessment and case planning. The FTS trains caseworkers to engage with youth and families in a continuous, rather than episodic, manner that ensures open, honest, and culturally-aware communication with children and families. This level of engagement requires seeking out and listening to the opinions and goals of the children and families, respecting and implementing their suggestions whenever possible, and providing them with essential information and education in a respectful and understandable way.

a. Theory of Change

² DCFS held the initial listening visit in Mount Vernon on August 3 and 4, 2016. A listening visit was held on August 9, 2016 in East St. Louis, August 18, 2016 in Rock Island and August 24, 2016 in Lake County. DCFS will be returning to St. Clair County in mid-September and will return later in September to meet with additional stakeholders in the Mt. Vernon area.

The theory of change developed for the FTS training model is that Illinois needs a core practice model that shapes the way that all persons within the system will work with the children and families served. Implementation of the FTS practice model will provide practical guidance on the behaviors needed to engage with families and partner with stakeholders in an effort to increase child safety, permanency, and well-being. Adoption and implementation of the FTS Core Practice Model across the child welfare system will require time, resources, system patience, risk tolerance, support at all levels and the involvement of parents, families and youth in partnership with purchase of service agencies, judicial, community stakeholder, and other state agencies to fully achieves the desired outcomes for safety, permanence, and wellbeing. Key components of the FTS training model include: Child and Family Teams, individualized case and service planning, development of pathways to permanency and methods to address issues of disproportionality and disparity in the child welfare system. A logic model is attached as Exhibit Z. A status report which adheres to the structure of the logic model is attached as Exhibit AA.

b. Child and Family Teams

A major component of the FTS model is that caseworkers must establish and facilitate Child and Family Teams (CFT) that plan and coordinate interventions. The child's permanency worker will be responsible for facilitation of the CFT, which includes the child, the family, any natural supports identified by the family and all providers of services to the child and family. The CFT is responsible for assessment, case planning and monitoring progress of permanency goals. The FTS model establishes accountability of everyone involved, because it requires a continuous review of the plans and responsibility for implementation. The FTS model requires that children and families are treated as full partners in assessment, planning, intervention, review, evaluation and decision-making. FTS also requires caseworkers to collaborate with all

individuals who are involved with a child and family in the planning, delivery, coordination and management of services.

c. Individualized Case/Service Planning

FTS provides guidance to ensure that all assessment and planning is backed by clearly identified goals that are measured, reviewed and revised to meet children and families' changing needs and strengths. The training will focus on developing individualized plans that include deliberate action steps and identify specific individuals responsible for implementing each step. Caseworkers will better understand that all plans must set forth meaningful and well-articulated timeframes. Relevant action steps are reviewed regularly by the permanency worker with the CFT (e.g., a minimum of every three months) to evaluate the feasibility of existing goals and appropriateness of services as the youth progresses.

d. Safe and Sustained Transition to Permanence

FTS focuses on early and meaningful engagement of the family to develop pathways to permanency. FTS requires the identification and engagement of formal and natural supports to maintain the child's connections to their community, culture, relatives and fictive kin, which is critical to ensuring that children transition to adulthood with a robust support network.

e. Disproportionality/Disparity in the Child Welfare System

Issues of disproportionality and disparity are also addressed by FTS. Disproportionality relates to the under- or over-representation of a particular racial or ethnic group involved in child welfare compared to their representation in the general U.S. population. Disparity refers to the unequal treatment of individuals across racial and ethnic groups. FTS strives to reduce, if not eliminate, disproportionality and disparity through the reform of permanency workers' engagement practices. Under FTS, permanency workers and supervisors will be trained, coached

and evaluated on their ability to interact with children and families in a continuous, open, honest, culturally-aware manner, with the aim of eliminating cultural biases.

f. Implementation of FTS in Immersion Sites

DCFS training staff, working with Paul Vincent and the Child Welfare Group, are developing a training plan for all immersion sites. The current plan includes training of direct service staff, including permanency and intact staff, child protection staff, licensing staff and adoption staff. Training staff is currently developing a training plan by role and specialty.

3. Description of Model of Supervisory Practice

The Model of Supervisory Practice (MoSP) is the second component of the Core Practice Model. The MoSP trains supervisory staff to continuously coach the permanency worker through reflective supervision. The MoSP clearly defines the duties and boundaries of supervisors, and facilitates their ongoing learning of social work best practices. The training gives supervisors enhanced techniques for teaching staff the skills to engage families, facilitate CFTs, and develop comprehensive assessments that lead to strengths-based, individualized case planning with clear pathways to permanency.

a. Theory of Change

The theory of change developed for the MoSP is that Illinois needs a model of supervisory practice that will shape the way supervisors within the system work with child welfare staff. Provision of consistent quality supervision will support the application of the DCFS FTS Child Welfare Practice Model and will contribute to a supported and committed workforce that is able to deliver services to children aimed at achieving the outcomes of safety, permanency, and wellbeing. Exhibit BB, MoSP Logic Model. A status report which adheres to the structure of the logic model is attached as Exhibit CC.

b. MoSP Overview

Supervisors will be trained to conduct case-specific supervision that includes: a brief historical summary of the case; the current level of engagement and any additional engagement strategies that could be explored; current safety and risk factors or concerns; protective factors; follow-up on previous case instruction; and a review of the child and family's progress toward meeting case planning goals, timeframes and supports in light of changing needs and strengths of the child and family.

In the event case planning goals have not been accomplished, the supervisor will be trained to evaluate with staff why the plan was not successful; in retrospect, what specific steps could have been taken earlier to achieve success; and, what specific changes to the plan are needed to ensure the family's success.

4. Initiation of MoSP Training Model

DCFS piloted the MoSP training curriculum from January 2016 until May 2016. The piloted training included pre-engagement webinars and implementation surveys. Classroom based learning sessions were conducted between January and April 2016. Additionally, coaching and content reinforcement between the various learning sessions were provided to each participant with an emphasis on application of the MoSP content. The four modules of the MoSP training were delivered over two days of in-person training over four months and there was a minimum of 90-minute coaching sessions between each of the learning sessions.

5. Core Practice Model Expert

Because the Core Practice Model represents a fundamental shift in casework and supervisory practice in Illinois, DCFS has retained Paul Vincent, Director, The Child Welfare Policy and Practice Group, as an expert to lead and direct the implementation of the model. Mr. Vincent, Narelle Joyner, and others from The Child Welfare Policy and Practice Group will

assist DCFS with development of the curriculum, development and implementation of the training model, and training logistics at immersion sites.

6. Statewide Summit

In October 2016, a statewide Summit will be held by DCFS and the Casey Family Programs. The courts, contracted private agencies and other community stakeholders have been engaged in the planning and presentations. The Summit will include an announcement of the implementation of the Core Practice Model and the immersion site process. The Summit provides an opportunity for all stakeholders to be introduced to the common language and principles of the Core Practice Model encouraging a sense of shared mission. The Summit will include participants from throughout DCFS and its private agency partners. It will also include representatives from the judiciary, involved youth, families, members of the Illinois Children and Family Services Advisory Council and members of CWAC committees, State's Attorneys, Guardians ad Litem, Court Appointed Special Advocates, and public defenders.

7. Quality Service Reviews

An essential piece of the Core Practice model is the implementation of a Quality Service Review (QSR) process. A QSR is a practice improvement approach designed to assess current outcomes and system performance by gathering information directly from families, children and service team members. DCFS, with the assistance of Paul Vincent and the Child Welfare Group, will utilize an Illinois specific review protocol for the examination of FTS model of practice that includes a model of supervision and the effective utilization of Child and Family Team meetings.

a. Theory of Change

The theory of change developed for the QSR process in immersion sites is premised on the belief that staff who receive relevant information and coaching through the results of quality service reviews, dashboards and data reports and also receive support and encouragement

through teaming and utilization of an improvement cycle will begin to understand the benefits of implementing data driven behavior and practice. The improved behavior and practice should show positive impacts on outcomes on children and families in Illinois. A logic model is attached as Exhibit DD. A status report which adheres to the structure of the logic model is attached as Exhibit EE.

b. Implementation of the QSR Process

The first step in implementing the QSR process in the immersion sites is the development of the draft tool. DCFS will begin a review of the draft review tool by October 15, 2016. Personnel from the Divisions of Quality Assurance, Training and Monitoring will be part of the design team for the QSR tool, working in conjunction with Paul Vincent and George Taylor from the Child Welfare Group. The review tool will be finalized by the middle of November 2016.

Once the QSR review tool is finalized, staff will be trained on the tool. It is anticipated that this training will be two days in length and will be completed by January 30, 2017. DCFS intends to begin to pilot use of the QSR process by February 1, 2017. The initial pilot review will encompass a single immersion site, which permits any identified adjustments in the tool before use in other immersion sites. Mentors will be provided for each of the initial reviews. Each reviewer will have at a least two week long mentoring experience and the mentors will be on site during the initial reviews.

8. Development of Regional Capacity to Expand Service Array

Within the immersion sites, DCFS will build sufficient capacity within the community to provide services to meet the unique needs of the children and families. DCFS has begun discussions with the federal Children's Bureau regarding the development and enhancement of Title IV-E waivers for out-of-home care funds to develop and build an intensive array of services in the immersion sties. DCFS plans on finalizing the Title IV-E waiver in September 2016.

DCFS children and families may also require enhanced behavioral health services and interventions to address concerns that are impeding permanency. DCFS will begin to offer these enhanced behavioral health services in the immersion sites by utilizing existing Intensive Placement Stabilization (IPS) contracts. Currently, IPS contracts provide community-based, in-home therapeutic interventions to children in traditional foster care who are experiencing trauma reactions, emotional and/or behavioral problems putting them at risk of losing their current placement. To enhance the availability of evidence-based/trauma-informed services, IPS has integrated Trauma Affect Regulation: Guide for Education and Therapy (TARGET), an evidence-based psycho-educational approach to treat trauma symptoms, into the available service array.

Within the immersion sites, DCFS will expand the availability of IPS programs and services to DCFS children who are in psychiatric hospitals, residential placements, or group home placements to assist in their transition to a less restrictive setting. DCFS also will use the existing IPS contracts and providers to develop additional critically-needed behavioral health services such as home-based services, family and youth peer support, crisis and non-crisis respite, and evidence/trauma-informed services.

9. Use and Oversight of Flexible Funds

As another avenue of ensuring that children and families receive needed supports and services, immersion sites will incorporate the use of flexible funding as part of the Core Practice Model. Flexible funds will allow permanency workers to respond to the unique needs of children and families by purchasing goods and services beyond what is available through existing contractual services. Permanency workers and supervisors will be trained on appropriate services and supports that can be purchased with flexible funding, as well as on mechanisms that ensure the funds are readily available and monitored for appropriateness. With the guidance of

the Core Practice Model expert, DCFS will establish time frames for the finalization of flexible funding policies and procedures.

Within the immersion sites, DCFS will access Medicaid reimbursed services whenever possible and to the extent available. Flexible funds will be utilized to purchase non-Medicaid services and to help support the development of new services that are not already available.

Within the immersion sites, where needed, DCFS will utilize flexible funding to develop and implement additional mental health services. An example of those services that could be developed and implemented with flexible funds include some of those services that have been developed through the CME pilot, including enhanced mobile crisis response, crisis stabilizers, crisis respite, therapeutic mentoring services, peer support and non-crisis respite care. With the understanding that DCFS is not the Illinois State Medicaid agency, the goal is for such services to be integrated by the Illinois Department of Healthcare and Family Services (which is the Illinois State Medicaid agency) into the federally approved Medicaid service array.

10. Evaluation

Implementation of the Core Practice Model will comprise both a process and outcomes-based evaluation.

Prior to the implementation of the immersion site coaching and training, Chapin Hall will complete a statewide baseline analysis for all areas anticipated to be impacted by the Core Practice Model including:

- Web-based survey of DCFS and POS caseworkers and supervisors around knowledge, beliefs, and practices to assess congruence with the new practice model.
- Surveys of parents (in-home and permanency planning cases) to assess their strengths and needs as well as their experience of their caseworker and services they receive through DCFS. Sample sizes within immersion sites to provide estimates that are accurate enough to allow for comparison to later assessments at the immersion site level.

- Assessment of children's functioning, and, for age-appropriate youth, their experience of their caseworker and services they receive through DCFS, through measures used to audit CANS going forward (i.e., from independent sources such as caregivers, teachers, and children). Sample sizes within immersion sites to provide estimates that are accurate enough to allow for comparison to later assessments at the immersion site level.

Once the Core Practice Model is implemented at immersion sites, Chapin Hall will evaluate DCFS's and provider staff's fidelity to the Core Practice Model, utilizing audits of immersion sites that measure staff adherence to the model through assessments of staff engagement, assessment, and case planning with children and families. Chapin Hall assessments will include reviews of individual children's files, interviews of children and families, and interviews of DCFS and provider staff. In addition, Chapin Hall will evaluate outcomes for children and families based on the implementation of the Core Practice Model. Against established baselines for each immersion site, Chapin Hall will evaluate children's absence of maltreatment, placement stability, permanency, foster care re-entry, and wellbeing as defined by the overarching metrics outlined in Section I above.

C. Panel Recommendation #3: *"Fund a set of permanency planning initiatives to improve permanency outcomes for adolescents who enter state custody at age 12 or older either by transitioning youth to permanent homes or preparing them for reconnecting to their birth families reaching adulthood."*

Youth over the age of 12 require additional services and assistance to achieve permanency so they do not age out of the system without substantial relationships and community-based supports. DCFS is focusing on this population through statutory, policy and practice initiatives. Specifically, DCFS is expanding age eligibility for state-funded guardianship regardless of Title IV-E eligibility, and DCFS is expanding the definition of 'fictive kin' to include current foster parents. Finally, DCFS is strengthening its family findings initiatives to enhance family relationships for all children and youth in care.

1. State-funded guardianship assistance should be extended to all children aged 12 and older regardless of IV-E eligibility.

On August 24, 2016, the Department issued Policy Guide 2016.09, which changed the eligibility criteria for state funded guardianship. Exhibit FF. Children who are 12 years and older and who are placed with a licensed or unlicensed relative are now eligible for the state funded option of subsidized guardianship. DCFS will engage in formal rulemaking to revise DCFS Rule 302.410 which should be completed by December 2016.

a. Theory of Change

The theory of change for the implementation of revised criteria for state-funded guardianship is premised on the evidence that by lowering the age for youth eligible for state funded guardianship, more youth may find permanency with relatives and the opportunity for youth to return to their family of origin may be enhanced. The results of lowering the age of eligible youth to 12 years of age will improve options for permanency and lead to improved well-being. A logic model is attached as Exhibit GG. A status report which adheres to the structure of the logic model is attached as Exhibit HH.

2. The definition of kin should be revised to include the current foster parent of a child who has established a significant and family-like relationship with the child, whether related or unrelated by birth or marriage.

Effective January 1, 2015, the Children and Family Services Act was amended to expand the definition of “relative” for placement purposes to include fictive kin. Fictive kin “means any individual, unrelated by birth or marriage, who is shown to have close personal or emotional ties with the child or the child’s family *prior* to the child’s placement with the individual.” 20 ILCS 505/7 (emphasis added). On August 19, 2016, Governor Rauner signed House Bill 5551 which further expands the definition of fictive kin to include “any individual, unrelated by birth or marriage, who is the current foster parent of a child in the custody or guardianship of the

Department . . . if the child has been in the home for at least one year and has established a significant and family-like relationship with the foster parent has been identified by the Department as the child's permanent connection, as defined by Department rule.” P.A. 99-0836. The effective date of this statute is January 1, 2017 and DCFS is in the process of updating its administrative rules.

3. Both changes will result in a savings since the administrative savings are well above the state costs for guardianship assistance payments and revision to the definition of kin will qualify more assistance payments for IV-E reimbursement.

After the above-described rules are amended, many current foster parents will qualify for KinGap, a federally-funded reimbursement program for guardians. The foregoing rule changes thus should enhance the flexibility of foster parents to move from traditional foster care to subsidized guardianship. Conservative estimates indicate that 85 youth who are between ages 12 to 14 would be eligible for subsidized guardianship as a permanency option. This expansion would save DCFS an estimated \$600,000 a year.

4. Implement specific “family finder” strategies as part of permanency planning for adolescents who do not have an obvious reunification plan.

The 2008 federal Fostering Connections to Success and Increasing Adoptions Act sought to promote additional permanency options for children in care by funding grants to locate relatives and requiring agencies to provide notice to relatives when children enter foster care. DCFS received a five year grant for intensive family finding services called Illinois Recruitment and Kin Connection Project – Getting Connected, Staying Connected. The grant was awarded in October, 2010 and ended September, 2015. The project provided intensive front-end family finding services in urban Cook County and suburban Will County for children ages six through 13 entering the child welfare system for the first time in order to

improve permanency options.³ Illinois Recruitment and Kin Connection Project, Final Report: Executive Summary, attached as Exhibit II.

The program focused on identifying maternal and paternal family members and fictive kin immediately after custody was granted to DCFS. A Kin Connection Specialist was assigned to the case immediately after the granting of temporary custody and sought to locate family members who could participate in service planning and serve as a resource for placement, be a back-up placement, host sibling visits, host parent visits and act as a mentor for the family.

The theory of change for the Family Finding program is premised on the belief that relatives will step up to care for their own family and that parents can be empowered to engage in the placement process by identifying relatives and fictive kin as placement options. These changes will lead to improved permanency for youth in care. A logic model is attached as Exhibit JJ. A status report which adheres to the structure of the logic model is attached as Exhibit KK.

DCFS will revise its rule and procedures to enhance family findings efforts on all levels. Family finding efforts will be conducted for all children and youth entering care with a return home goal. The revised rules and procedures will require all child protection, intact and-permanency staff to seek out non-custodial parents, relatives and fictive kin when placing a child or youth. These individuals will be identified to serve not just as placement options, but also as individuals to provide support to the family during their involvement with the Department. DCFS Permanency Achievement Specialists within each DCFS region will conduct family finding tasks. Permanency Achievement Specialists will also be available to both DCFS and private agency staff to provide technical assistance on complex or difficult cases to identify

³ At the request of DCFS personnel, the project was expanded to Kankakee and Grundy counties.

barriers to permanency through methods of file mining, family meetings, trainings or other assistance. Trainings on family findings will be provided to DCFS staff and private agency staff and administrators.

Additionally, Administrative Case Review staff will flag cases where family finding is not occurring or where there is a barrier to permanency so that DCFS and private agency staff can be made aware of the issues and take steps to rectify the problems. In 2015, DCFS revised Procedures 315, Permanency Planning, to include and highlight new family finding strategies that must begin early and continue throughout the life of every child's case. The amended procedures require caseworkers to speak with children and youth throughout the life of the case to identify relatives and other individuals with whom they have a connection. The amended procedures also formalize family findings issues as part of the ACR process. ACR staff will flag a case when it is determined that staff have not taken the necessary steps to locate and engage family and fictive kin and alerts will be sent to the caseworker supervisor and DCFS or Purchase of Service manager. <http://www.nrcpfc.org/downloads/SixSteps.pdf>. In order to expedite permanency DCFS has automated the family finding forms and tools as a step toward achieving these permanency goals. Training on Procedure 315 of all DCFS and POS permanency staff began in February 2016. Based upon feedback from the initial training cohort, the training is currently being revised and will continue upon finalization.

D. Panel Recommendation #4: *“Retain an organizational consultant to aid the Department in “rebooting” a number of stalled initiatives that are intended to address the needs of children and youth with psychological, behavioral or emotional challenges.”*

1. Reorganization, Strategic Planning and Cultural Change

- *To oversee implementation of this plan, the Department should create a high level unit with cross-organization authority to develop an implementation plan, manage the implementation and resolve system barriers*

- *The consultant should evaluate the organizational structure and culture of DCFS; the effectiveness of DCFS' policies, procedures and programs; the effectiveness of the Department's leadership and managerial structure and function and to assess the supervisory functions of the agency.*

Director Sheldon obtained approval for a departmental reorganization of leadership and managerial structure from the Illinois Civil Service Commission. The final organization structure was implemented in October 2015. See DCFS Organizational Structure, attached as Exhibit LL. As part of the process of reorganization and structural change, the Director formed the Strategic Planning and Innovation Division ("Strategic Planning") in September 2015. This division works with Pete Digre and focusses on driving the implementation of innovation for DCFS. Strategic Planning will ensure that DCFS does not take a siloed approach to initiatives. Strategic Planning has cross-divisional authority and has responsibility for reform, including the B.H. Implementation Plan.

The Strategic Planning Division, in conjunction with Pete Digre, is expanding to include both internal and external experts to guide initiatives and act as liaisons to the projects, stakeholders and DCFS divisions. The division will partner with DCFS leadership and staff, POS providers, and other external stakeholders to support and drive consistent progress toward the goals envisioned in this Plan. Pete Digre, Strategic Planning, and Project Managers will meet weekly and report to during bi-weekly supervision meetings. Project Managers will support and collect reports from each university or external partner at least quarterly as well as ensure compliance with the four-month implementation plan status reports. Project Managers are responsible for tracking data and outcomes for each initiative and for supporting consistent evaluation of success, progress and lessons learned in conjunction with the contracted expert support and other members of the Strategic Planning team.

2. Full Implementation of Designed Initiatives

- *Development of new programs and retention of existing initiatives in DCFS should be done after determining how it fits in with the DCFS core mission, after a thorough review of other programs that may already be in existence to address the problem or need driving the new initiative, and that duplicate services and initiatives already in place be eliminated or revised to prevent inefficient use of resources. Mechanisms must be enacted to make effective programs and policies be self-sustaining such as through changing reimbursement strategies or revising job descriptions.*
- *Full implementation of several excellently designed initiatives, including among others: the Illinois Birth thru Three Demonstration, Integrated Assessment, Residential Services Performance-Based Contracting, DCFS Monitoring of Residential Services, and Home-Based Mental Health Services, is being stalled or undermined by a variety of systemic and external factors, such as lengthy court delays to adjudication, categorical funding restrictions, challenges of client engagement, inflexible bureaucratic rules, and discontinuities in the handoff of case management responsibilities among public and private agencies.*

DCFS has multiple initiatives in progress across the state. The Strategic Planning Division has been put into place to help drive those initiatives, assess barriers, and track outcomes so that staff can update the program plans quickly to determine if strategies are productive. The Expert Panel mentions numerous specific initiatives that are currently designated as stalled, many of which are addressed in other areas of this report.

The initiatives including Integrated Assessment (Recommendation #2), Residential Services Performance-Based Contracting (Recommendation #6), DCFS Monitoring of Residential Services (Recommendation #6), and Home Based Mental Health Services (Recommendation #1) are discussed in the other sections of this plan. The additional stalled initiatives, Illinois Birth thru Three Demonstration Project and SAFE Families for Children, are detailed below. Barriers to successful implementation of both of these initiatives persist.

a. Illinois Birth Thru Three Demonstration Project

DCFS was awarded a five year demonstration project in 2012 which targets caregivers and their children aged birth through three years of age who enter foster care through out-of-home placements regardless of Title IV-E eligibility in Cook County. These children are provided one of two evidence-based interventions, Child Parent Psychotherapy (CPP), a dyadic therapeutic intervention for children ages 0 to 5 who have experienced on or more traumatic events and experience behavior, attachment or other mental health problems, and/or Nurturing Parenting Program (NPP), a curriculum based psycho-educational and cognitive behavioral group intervention that modifies maladaptive beliefs which contribute to abuse parenting, in an effort to improve attachment, reduce trauma symptoms, prevent foster care re-entry, improve child wellbeing and increase permanency.

The project identifies children ages 0 to 3 years of age entering foster care in Cook County. Following random assignment of the child's case to DCFS regions and foster care agencies, children are referred on a rotational basis to receive developmental screenings by early childhood developmental specialists and are selected for the interventions based on those screenings. Children assessed as high risk are referred immediately to CPP. Biological parents participate in NPP. A unique feature of the project is the comprehensive assessment of trauma and risk for children within the targeted age group. The IB3 assessment protocol requires clinicians to consider the trauma experiences of the child *in relation to* the needs of the caregiver.

The theory of change is predicated on the assumption that improvements in parenting competencies will enhance early brain development in infants and children and provide a responsive parenting environment that will allow children to be returned to their parents. A logic model is attached as Exhibit MM. A status report which adheres to the structure of the logic model is attached as Exhibit NN.

i. Current Status

This demonstration project has completed year three of full implementation. Strategies and approaches to address the issues and challenges with engagement of foster parents in NPP (e.g. NPP Alumni Orientation, working with agency licensing staff, arranging for child care during class participation time) have resulted in increased participation. Engagement of foster parents continues to be a focus and in addition to orientation sessions and home outreach, the current plan includes focusing on day care supports for foster parents to increase engagement.

Although implementation challenges still exist, the intervention group demonstrates a statistically significant difference in permanency outcomes. While both CPP and NPP have progress to report, known challenges include:

- CPP continues to experience a waiting list for clients in need of services. For example, fee-for-service contracts do not allow for billing for the intensive engagement work required to get families involved in treatment and, as a result, providers are struggling.
- Challenges in engaging foster parents also exist. As the pilot shifts additional responsibility to the caregivers, additional foster parent training and supports are needed.

The Strategic Planning and Innovations Division will drive progress in overcoming the barriers discussed. Kristine Herman will be the Strategic Planning and Innovations Liaison. The operations lead for this project is Kimberly Mann, Project Director for the IB3 Title IV-E Waiver.

b. SAFE Families for Children

Safe Families for Children (SFFC) is a nationwide program that recruits and oversees a voluntary network of host families where parents can safely place their children in a time of need. The program is designed to create an extended family- like support system for parents and provides a safe place for children while parents stabilize and get back on their feet, and

may prevent a child from coming into foster care. The core objectives of SFFC include child welfare deflection, child abuse prevention, and family support and stabilization. Exhibit OO, Safe Families for Children Fact Sheet.

SFFC maintains several unique features. Host families are volunteers and receive no compensation for providing care for a child. A parent retains all rights to make decisions for their child while in a Safe Families host home. SFFC also provides mentors and family coaches available to work with the parents and family towards reunification and ongoing stabilization of the family unit. SFFC's focus is to reunify families and make them stronger and more successful and resilient.

The theory of change underlying the Safe Families program is that birth parents who voluntarily place their children with a host family can receive resources and support to reduce crises and chronic problems. This will lead to a reduction in child maltreatment and avoid the removal and placement of children in foster care. The use of trained volunteer host families will also assist parents in avoiding social isolation and help to improve parent and child functioning.

SFFC has been in operation in Cook and Northern regions of Illinois for thirteen years. Due to a grant from the Arnold Foundation, SFFC was recently expanded state-wide to provide services to children and to evaluate the program. The program evaluation requires a total of 950 families with 475 families in the control group and 475 families in the comparison group.

Initial challenges in implementation include a lack of participation by caseworkers and identified clients. DCFS and Safe Families worked together touring the state and providing information and education regarding the Safe Families program, referral process and benefits of the program. Additionally, a second randomizer was also implemented within the Safe

Families program that could be utilized when investigators were unwilling to use the initial randomizer. DCFS continues to train and educate staff on the Safe Families program and is providing the front line investigative staff with information sessions on Safe Families.

The Project Manager on this project is Nora Harms-Pavelski, M.S.W. The Strategic Planning team will drive the continued progress of this initiative by breaking down barriers to success.

A logic model and a status report are attached as Exhibit PP.

i. Theory of Change

Data analytics helps DCFS to provide timely and accurate data to identify patterns, correlations, and trends. This will support decision making by providing key real-time data to stakeholders to improve overall performance and achievement of child and family outcomes, as measure by the CFSR indicators.

c. Information Systems

DCFS is reviewing the updated regulations on SACWIS to replace the existing SACWIS system to improve integration of information through web services to third parties, other internal systems, and to enhance its caseworkers' business processes through mobility. DCFS will receive federal reimbursement for the majority of this investment.

<https://www.federalregister.gov/articles/2015/08/11/2015-19087/comprehensive-child-welfare-information-system>. Given the investment in a new SACWIS system, all current IT projects are being evaluated by the Technology Governance Board (TGB). The TGB is comprised of the Director, Chief of Staff, Chief Deputy Director, all Senior Deputy Directors and several other key executives and advisors. The State CIO, Director of HHSi2 and Director of Enterprise Applications also participate. TGB prioritizes all technology-based project work and aligns

DCFS and Governor's Office strategy. TGB directs OITS to maximize technology and human capital.

i. Near Term Plan (6-12 months)

DCFS will enhance SACWIS while it evaluates and selects a replacement system. It is expected that the following SACWIS updates will be made:

- Education Data Feed from ISBE
- Unusual Incident Reporting

In addition, the following projects are also in process to support DCFS's improved technology.

- Mobile Application
- On-line Licensing Application
- Tablet Application for Licensing Site Inspections

ii. Long Term Plan (Beyond 12 months)

The SACWIS replacement system will include all existing systems, such as Child and Youth Computer Information System, and other case management reporting systems. Resources will be redirected to the new system other than those previously mentioned. Selection of the new SACWIS system will be the result of an RFP process. This RFP will be released within the next twelve months. The time frame for activating the new system will be determined when the vendor is selected.

d. Predictive Analytics

DCFS intends to reduce reliance on external entities to collect and analyze data to drive outcomes. DCFS is officially establishing an internal team in OITS to bring the reporting needs and the data analytics into a centrally managed organization.

Eckerd has developed a predictive model that will be used to identify those incoming investigations with the highest probability of serious injury or death and has researched the Department's current Child Protective Services Investigations practices. Utilizing the results of

the predictive model and the practice research, Eckerd has developed a web-based secure portal that will present to the Department Quality Assurance staff the cases to be reviewed, the review questions to be answered, the documentation and tracking of any follow-up activities required of the investigator and data for analysis. Training of staff is ongoing.

i. Theory of Change

Data analytics helps DCFS to provide timely and accurate data to identify patterns, correlations, and trends. This will support decision making by providing key real-time data to stakeholders to improve overall performance and achievement of child and family outcomes, as measure by the CFSR indicators. A logic model is attached as Exhibit QQ. A status report which adheres to the structure of the logic model is attached as Exhibit RR.

ii. Short Term

While internal positions are being established and filled, there will be some transitional activity including a contract with MindShare and with Eckerd. MindShare will collaborate with the Division of Quality Assurance, the Division of Strategic Planning and Innovation, and the Illinois Department of Innovation and Technology (DoIT). Contracts began in September 2015 and will be in place until January 2018 to assist with the transition and to provide additional assistance.

MindShare will provide a dashboard view of DCFS key outcomes in real time. MindShare will provide dashboards for each level of staff from caseworker to Director. This solution will use embedded metrics to present actionable intelligence to front line as well as administrative staff. The CFSR measures will be delivered by MindShare via dashboards within 30 days of the finalized contract. There will be additional dashboards delivered to include the Director's 26 Metrics and others. See Contract Cover Page and Scope of Services for the ICARE Program, attached as Exhibit SS.

iii. Long Term (Beyond 18 Months)

The State of Illinois is establishing a state-wide enterprise data analytics platform (“Enterprise IT”). DCFS intends to reduce reliance on external entities to collect and analyze data to drive outcomes. DCFS expects to reduce, but not eliminate, the need for occasional external services. Enterprise IT is currently under review by the State CIO’s office and the Health and Human Services Innovation Incubator’s (HHSi2) office. DCFS will continue to work closely with the state’s new CIO to adopt an interoperable Health and Human Services framework that will be conducive to data sharing and integrated service delivery across state agencies. The TGB will prioritize IT initiatives to ensure alignment with the state’s vision for Enterprise IT.

e. Data Not Included in Overarching Outcome Measures

DCFS recognizes that the safety and permanency outcome measures currently utilized by the federal government in the CFSR process do not capture other relevant information related to safety and permanency. The Children and Family Research Center (CFRC) publishes its annual Monitoring Report of the B.H. Consent Decree entitled *Conditions of Children In or At Risk of Foster Care In Illinois*. This report tracks data indicators related to child safety; children in substitute care; legal permanence; and child wellbeing. Though not as a measure of compliance with the Expert Panel’s report and recommendations, DCFS will obtain from CFRC and track additional indicators of re-entry, stability and maltreatment for the B.H. class. Additional indicators include, but are not limited to: re-entry rates for children in foster care 12 to 23 months and longer than 23 months who are discharged to reunification, adoption, living with a relative, or guardianship; rate of placement moves per day for all children in foster care; and maltreatment recurrence for all children within 12 months of a substantiated report (including those children who remain at home, those served in intact family cases and those who do not receive services;

any maltreatment recurrence for children who leave substitute care through adoption, guardianship, and return home).

3. Training and Coaching Program

- *The Department should initiate a program for training and ongoing coaching of project administrators on how to provide effective coordination and supervision. This training should not only include supervision on completion of responsibilities but on clinical matters as well.*
- *The training should emphasize that data should be used positively as a means for assisting managers in exploring new ways of improving program performance rather than negatively as an excuse for rendering unsatisfactory assessments of the performance of managers responsible for the program.*

DCFS is initiating the MoSP as detailed in Recommendation # 2 that includes in-depth training and coaching in recognition of the need for mid-level managers to have appropriate skills and training to manage projects from planning to implementation and for ongoing success. DCFS will implement additional training to: 1) build the knowledge and skill set of mid-level DCFS managers, 2) educate DCFS managers on the use of data to improve performance, 3) foster collegiality among DCFS managers, and; 4) enhance the effectiveness of managers as they safely and appropriately reduce the number of children and youth in care in Illinois. The additional training, called the Success Academy, will include ten workshops over a six-month period, eventually including all mid-level managers. The initial cohort of participants completed the program in July 2016. The initial series of trainings focused on enhancing and building knowledge and skill sets, understanding how organizations work, effective communication, effective decision making and problem solving. Exhibit TT, Director's Announcement. The second cohort of participants began the Success Academy in approximately August 2016. Monico Whittington-Eskridge, Associate Deputy Director of the Office of the Office of Professional Development, will lead the project.

E. Panel Recommendation #5: *Restore funding for the Illinois Survey of Child and Adolescent Wellbeing that uses standardized instruments and assessment scales modeled after the national Survey of Child and Adolescent Wellbeing to monitor and evaluate changes in the safety, permanence, and well-being of children for a representative sample of DCFS-involved children and their caregivers.*

1. Illinois Survey of Child and Adolescent Wellbeing (ISCAW)

DCFS is working with the Children and Family Research Center to plan for reinstituting the Illinois Survey of Child and Adolescent Wellbeing. A logic model is attached as Exhibit UU. A status report which adheres to the structure of the logic model is attached as Exhibit VV. In August 2016, the Steering Committee for the Illinois Child Well-Being Study 2017 reached consensus on all major elements of the methodology for the study. The well-being study will be a point-in-time study of the well-being of the population of children in open placement cases as of a selected date during FY2017. It will replicate most of the methods of the Illinois Child Well-Being Year 3 launched in 2004, with additional new features including: updated methods to enhance caseworker participation and increase caseworker response rates and a brief measure of child life satisfaction to enhance measurement of positive child well-being.

The team is also exploring opportunities to enrich the well-being study by supplementing primary data collection with data on the sample from other sources, including Child and Adolescent Needs and Strengths Scale (CANs); Trauma Comprehensive Version collected during the Integrated Assessment; health data in SACWIS, education data from the Illinois State Board of Education (ISBE);, and placement data from the DCFS Integrated Database. Any use of these data sets will take time to develop, and will postdate primary data collection for the study to enable the most timely possible implementation of the study.

F. Panel Recommendation #6: *The implementation plan will provide for the Department to contract with an external partner to perform an effective residential and group-home monitoring program. The Department shall use an external partner for that function until such time as the Department has sufficient staff with the necessary experience and clinical expertise to perform the function internally and further has developed an in-house program that can monitor residential and group-home placements effectively.*

DCFS will develop a new plan for monitoring of residential and group homes.

1. Theory of Change

The theory of change developed for residential monitoring is premised on the fact that to achieve positive outcomes, residential programs must effectively implement and sustain appropriate evidence-based or evidence-informed interventions within an enabling organizational culture and climate. Consequently, residential performance teams should be clinically driven and draw upon Continuous Quality Improvement (CQI) principles and research on organizational effectiveness and implementation science. In addition, these teams should perform traditional monitoring functions that prioritize youth safety as well as provide additional support for youth with urgent clinical needs. A logic model is attached as Exhibit WW. A status report which adheres to the structure of the logic model is attached as Exhibit XX.

DCFS, along with the University of Illinois at Chicago and Northwestern University have developed a redesigned residential monitoring program. The aims of the redesigned residential monitoring program will be the increased safety of youth placed at residential treatment facilities and the enhancement of the effectiveness of the residential services provided at the residential treatment facilities. The core components of the redesign include: a therapeutic residential program model that is aligned with the FTS core practice model and DCFS policy, assessment of organizational effectiveness and capacity building activities, systemic and structured monitoring of the implementation of the child's plan developed by the CFT, clinically driven monitoring process that incorporates the CFT-developed plan, clinical consultation and interventions,

communication and collaboration with DCFS staff to break down silos, prioritization of family and youth voices and concerns, integrated data system and advocacy to address system barriers.

The plan will require the development of regional multi-disciplinary monitoring teams that will assess a residential program's effectiveness utilizing multiple data sources and inputs. The focus of the teams will be on the CQI and individualized approach to monitoring. The monitoring team will promote a strong CFT and discharge planning process for all youth placed in a residential treatment facility. The Residential Monitoring Redesign Project Work Plan is attached as Exhibit YY. DCFS will continue to work with the Expert Panel and University partners and will update when additions or revisions are made to the monitoring program.

V. Communication Plan

In furtherance of the collaborative process that has been established as part of this Implementation Plan, DCFS will engage in robust and mutual communication with the Expert Panel throughout the implementation process. A Communication Plan was submitted to the Court for approval on July 25, 2016. The plan includes bi-weekly conferences by telephone or in person with the Expert Panel and the Parties during which there will be discussion each initiative set forth in the Implementation Plan, including barriers encountered and potential solutions. DCFS will provide a monthly report to the Expert Panel and Plaintiffs' Counsel which will detail the specific steps that have been taken regarding actual implementation of each initiative set forth in the Implementation Plan, the actual results achieved, any barriers that exist and strategies to eliminate or resolve the barriers and a comparison to the planned results as documented in the Implementation Plan. The Communication Plan does not limit the Experts from requesting additional meetings, teleconferences or communications, or from requesting implementation-related information from the Department (whether in written form or otherwise), or the Department's or Plaintiffs' ability to raise matters in consultation with the Experts.

VI. Project for a Target Group of Children and Youth

On June 17, 2016, the Expert Panel submitted a letter to the Court asking that DCFS develop and executed a plan to provide services for an agreed-upon subset of the Plaintiff class. While the parties and the Expert Panel agree that systemic change accomplished through the application of implementation science is not a speedy process, there is a need to address immediate concerns. Accordingly, following the July 11, 2016, hearing, the parties submitted a proposed project for a target group of children and youth.

The Expert Panel requested that DCFS identify a target group of one hundred (100) children and youth from Cook County who are in psychiatric hospitals beyond medical necessity in order to determine their specific service and support needs and develop an approach to better care for and serve them. The parties and the Expert Panel agree that the target group shall initially include children and youth from Cook County who are in psychiatric hospitals and determined to be beyond medical necessity. The parties and the Expert Panel will evaluate whether to add additional children and youth, including youth in residential treatment facilities ready for discharge, as the project is developed and operationalized.

Fifty (50) youth with whom the caseworker has been assessed to have a strong relationship will be assigned coaches. These coaches and caseworkers will be authorized to purchase and tailor services to meet the needs of the youth. The child and family teams will include everyone important in the youth's life, including the caseworker, the coach, providers, family, mentors, caregivers, clinicians, and the youth. A comparison group of fifty (50) will also consist of youth who have a strong relationship with the caseworker, but the caseworker will not be assigned a coach. Instead, the children will receive services as usual with no expanded array of intensive evidence-based services beyond what is customarily available. A second

comparison group will be fifty (50) BMN youth who are assessed not to have a strong relationship with their caseworker and their outcomes will be tracked as part of the evaluation.

The program will be evaluated by the B.H. Experts by tracking proximal and distal outcomes. Children and youth will be selected from the actual population in beyond medical necessity status during the time the project is operational.

The timeline for implementation begins in September, 2016 with the review of five cases to further refine the plan the logic model. It is anticipated that the project will be operational by November, 2016. A logic model is attached as Exhibit ZZ. A status report which adheres to the structure of the logic model is attached as Exhibit AAA.

ENTERED:

9/28/16

A handwritten signature in dark ink, consisting of a stylized 'J' and 'A' with a dot, enclosed within an oval shape.

Jorge L. Alonso
United States District Judge

EXHIBIT A

Pete Digre

Experience

- July, 2016- Present: Associate Director for BH and Immersion Site Implementation. Illinois Department of Children and Family Services (DCFS).
- December, 2105 to July, 2016: Deputy Director, Placement and Community Services, DCFS.
- May, 2015 - December, 2016: Consultant, including work with the Tulane University Medical School Family Resource Center.
- August, 2009 - May, 2015: Assistant Secretary for Operations/Deputy Secretary for Operations, Chief Operating Officer, Florida Department of Children and Families. Responsible for statewide regional operations including child and adult protection, child welfare, state welfare programs, refugees, and substance abuse and mental health.
- July 1999 - August 2009: Consulting practice as Division Vice-President and Division President for MAXIMUS 2000-2006), Annie E. Casey Foundation (1999), and private practice (2006-2009). Provided human services process and outcome improvement, revenue maximization and federal compliance services to over 30 state and county government agencies.
- January 1991 - June 1999: Director, Los Angeles County Department of Children and Family Services. Overall leadership and management for a billion dollar budget child protection and child welfare program.
- April 1987 - December 1990: Deputy Secretary for Operations, Florida Department of Health and Rehabilitative Services. Chief Operating Officer of State's child welfare, adult and child protection, public health, juvenile justice, refugee, disability determination, child support enforcement, Medicaid, welfare and substance abuse and mental health department.
- April 1984 - March 1987: Director, Philadelphia County Children and Youth Agency and Deputy Commissioner for the Department of Human Services. Overall leadership and management of the child welfare agency.
- June 1978 - March 1984: Deputy Director for Youth and Community Services (1981 - 1984) and Associate Deputy Director for Planning, Research and Development (1978 - 1981), Illinois DCFS.
- June 1972 - June 1978: Director, Omni Youth Services, private child welfare and juvenile justice agency in the Chicago area.

Education

- D.Min. University of Chicago. Focus- Religion and Psychotherapy.
- MSW George Williams College. Major focus Clinical.
- MPA Roosevelt University, Chicago. Public Administration.
- BA University of Minnesota. Sociology and Philosophy.

EXHIBIT B



Stages of Implementation Analysis: Where Are We?

National Implementation Science Network (NIRN)

Frank Porter Graham Child Development Institute
UNIVERSITY OF NORTH CAROLINA CHAPEL HILL

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The mission of the National Implementation Research Network (NIRN) is to contribute to the best practices and science of implementation, organization change, and system reinvention to improve outcomes across the spectrum of human services.



When creating Implementation Teams to provide supports that are effective, integrated, efficient, and sustainable, the first task is map the current implementation landscape. The goal is, build on current strengths and collect information to inform planning the best path toward developing implementation capacity in this provider organization.

Background

Human service provider organizations (e.g. child welfare units, child care settings, community centers, education settings, healthcare clinics, residential care facilities) are attempting to make use of interventions (e.g. evidence-based programs and other innovations) to improve outcomes for children, families, individuals, and communities. For the past few decades policy makers, researchers, and technical assistance providers have focused on *interventions*.

The same attention and support has not been given to *implementation* of interventions. Consequently, in most cases human service organizations have been left to their ingenuity to figure out how to make use of evidence-based programs. In a few instances, evidence-based program developers have created a purveyor group that can provide effective supports for implementation of that intervention. The lack of attention to implementation methods has led to what some have termed the quality chasm: we know what to do, but we are not making use of that knowledge to improve outcomes in human services.

The National Implementation Research Network encourages policy makers, practitioners, and communities to make greater use of evidence-based programs and other innovations (collectively called “interventions” in this document). The United States far outspends any other country on human services yet our outcomes rank near the bottom of the 30 or so most developed countries globally. Evidence-based interventions hold the promise of better outcomes.

Common sense tells us that children, families, individuals, and communities cannot benefit from interventions they do not experience. Thus, the promise of evidence-based interventions will not be realized unless they are used fully and effectively in practice, every day for everyone who could benefit. The growing science of implementation and documentation of implementation best practices provide guidance for effectively and efficiently supporting evidence-based programs in human service provider organizations. To realize benefits on a

socially-important scale, policy makers and directors of provider organizations must invest in creating effective implementation supports for practitioners.

Implementation supports for interventions

Implementation capacity is embodied in Implementation Teams. An Implementation Team consists of three or more full-time individuals who know interventions well, are skilled specialists regarding implementation science and best practices, and are well-versed in the many uses of improvement cycles to continually advance practices, organizations, and systems.

Implementation Team members do the work of implementation in organizations and systems. To create an Implementation Team, current positions are re-assigned, functions are re-purposed, team members develop new competencies, and reporting relationships are re-aligned so no new costs are added. Implementation Teams are built into organization and system structures to provide lasting and sustainable supports for using a variety of evidence-based interventions and other innovations fully and effectively. Implementation Team members conduct ImpleMap interviews.

Readers are encouraged to visit the National Implementation Research Network website (<http://nirn.fpg.unc.edu>) and the State Implementation and Scaling up of Evidence-based Programs website (www.scalingup.org) for further information about implementation science, Implementation Teams, and infrastructures to support implementation on a large scale.

Stages of Implementation Analysis

EBP or Evidence-Informed Innovation:

This tool provides the team with the opportunity to plan for and/or assess the use of stage-based activities to improve the success of implementation efforts for EBPs or evidence-informed innovations. The tool can be used to assess current stage activities (e.g. “We are in the midst of Exploration”) or past efforts related to a stage (e.g. “We just completed most of Installation? How did we do? What did we miss?). For activities scored as “Not Yet Initiated” the planning team may wish to:

- a) Examine the importance of the activity in relationship to achieving success
- b) Identify barriers to completion of the activity
- c) Ensure that an action plan is developed (sub-activities, accountable person(s) identified, timeline, evidence of completion) and monitored

A ‘strength of stage score’ can be computed for each stage to help guide and measure effective use of stages.

NIRN | Stages of Implementation Analysis: Where Are We?

Stage-Related Activities for <u>Exploration</u> <input type="checkbox"/> Current <input type="checkbox"/> Past	In Place	Initiated or Partially In Place	Not Yet Initiated
1. Form Implementation “Team” or Re-Purpose/Expand a Current Group			
2. Develop communication plan to describe the exploration process (e.g. activities, participants, timeline, benefits, risks) to key stakeholder groups			
3. Analyze Data to determine need and prevalence of need			
4. Select Targeted Areas to address Need (e.g. child, adult, family outcomes)			
5. Review and identify programs, practices, interventions that match target area and address need			
6. Review and discuss “eligible” programs and practices (use the Hexagon) in relation to:			
a) Need			
b) Fit			
c) Resources – Sustainability			
d) Strength of Evidence			
e) Readiness for Replication			
f) Capacity to Implement			
7. Select programs/practices for continued exploration based on assessment results from above			
8. Develop methods to promote exploration and assess “buy-in” for range of impacted stakeholders			
9. Analyze information and results of exploration activities			
10. Work group makes recommendation to appropriate level (e.g. state level team, local partners, alliance, funders)			
Average % in Each Category - Strength of Exploration Score:			
What should we do to further strengthen our Exploration Process? Are there Exploration Activities we need to revisit? And what are the “next right steps”?			

NIRN | Stages of Implementation Analysis: Where Are We?

Stage-Related Activities for <u>Installation</u> <input type="checkbox"/> Current <input type="checkbox"/> Past	In Place	Initiated or Partially In Place	Not Yet Initiated
1. Identify structural and functional changes needed (e.g. policies, schedules, space, time, materials, re-allocation of roles and responsibilities, new positions needed)			
a) at provider/agency level			
b) at local level (e.g. collaborative groups)			
c) at District or County level			
2. Make structural and functional changes needed to initiate the new program, practice, framework			
a) at provider/agency level			
b) at local level (e.g. collaborative groups)			
c) at District or County level			
3. Development of selection protocols for “first implementers”			
a) at provider/agency level			
b) at local level (e.g. collaborative groups)			
c) at District or County level			
4. Selection of “first implementers”			
a. Agency administrators			
b. Practitioner/Front line			
c. Other:			
5. Identification of Training Resources, logistics			
6. Training of first cohort of implementers			
a) Practitioners			
b) Agency administrators			
c) Trainers:			
d) Coaches:			
e) Other:			
7. Develop coaching and support plans for practitioners			
8. Evaluate “readiness” and sustainability of data systems at consumer level (e.g. child, adult, family)			
9. Evaluate “readiness” and sustainability of fidelity data system			
10. Analyze and problem-solve around the sustainability of training, coaching, data systems			
11. Establish communication links to report barriers and facilitators during next stage (e.g. Initial Implementation)			
Average % in Each Category - Strength of Installation Score:			
What might we do to further strengthen our Installation Process? Are there Installation Activities we need to revisit? And what are the “next right steps” to engage in or revisit Installation Activities?			

NIRN | Stages of Implementation Analysis: Where Are We?

Stage-Related Activities for <u>Initial Implementation</u> <input type="checkbox"/> Current (monitored at least bi-weekly for first 4 months) <input type="checkbox"/> Past	In Place	Initiated or Partially In Place	Not Yet Initiated
1. Communication plan(s) developed to inform stakeholders of “launch dates”, activities, and convey support			
2. Communication protocols developed for identifying barriers and adaptive challenges and problem-solving at each “level” (e.g. weekly implementation team meetings to identify issues, create plans, review results of past problem-solving efforts, forward issues to next “level” as appropriate)			
3. Leadership develops support plan to promote persistence			
4. Written coaching plan developed at relevant levels (e.g. school, teacher; agency, practitioner)			
5. Coaching system in place (see Best Practices for Coaching Systems)			
6. Data systems in place for measuring and reporting outcomes			
7. Data systems in place for measuring and reporting fidelity			
8. Document that reviews initial implementation challenges			
Revision recommended for Implementation Drivers based on review of challenges and with sustainability considerations			
a) Recruitment and Selection			
b) Training and Booster Training			
c) Coaching processes and data			
d) Outcome data measures and reporting process			
e) Fidelity measures and reporting processes			
f) Agency Administrative policies and practices			
g) Other Levels of Administrative policies and practices			
9. If appropriate, plan for next cohort of “implementers”			
Average % in Each Category - Strength of Initial Implementation			
What might we do to further strengthen our Installation Process? Are there Installation Activities we need to revisit? And what are the “next right steps” to engage in or revisit Installation Activities?			

NIRN | Stages of Implementation Analysis: Where Are We?

Stage-Related Activities for <u>Full Implementation</u> <input type="checkbox"/> Current (every 6 months) <input type="checkbox"/> Past (when there has been a shift back to Initial Implementation due to turnover)	In Place	Initiated or Partially In Place	Not Yet Initiated
1. Monitoring and support systems are in place for each Implementation Driver:			
a) Recruitment and Selection			
b) Training and Booster Training			
c) Coaching processes and data			
d) Outcome data measures and reporting process			
e) Fidelity measures and reporting processes			
2. Feedback process from practitioners to Agency administrators is in place and functional (e.g. practitioner participation on Leadership and Implementation Teams, changes to facilitate best practices)			
3. Feedback process from Agencies (e.g. schools, care settings, clinics) to next levels of administration in place and functional			
4. Feedback process to State or to TA support is in place and functional. (e.g. system in place for Agencies to feed information and feedback to appropriate State and/or TA entities)			
5. Agency Leadership and Implementation Teams use data to make decisions (e.g. clinical outcomes, behavior, academics, and fidelity)			
6. Improvement processes are employed to address issues through the use of data, development of plans, monitoring of plan execution and assessment of results (PDSA cycles)			
Average % in Each Category - Strength of Initial Implementation			
What might we do to further strengthen and maintain Full Implementation? Are there Activities we need to revisit? And what are the “next right steps” to engage in or revisit Full Implementation Activities?			

IMPLEMENTATION SCIENCE: CHANGING HEARTS, MINDS, BEHAVIOR, AND SYSTEMS TO IMPROVE EDUCATIONAL OUTCOMES

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“Good ideas and missionary zeal are sometimes enough to change the thinking and actions of individuals; they are rarely, if ever, effective in changing complicated organizations (like the school) with traditions, dynamics, and goals of their own.” ~ Seymour Sarason, 1971, p. 213

INTRODUCTION AND BACKGROUND

In the United States, many attempts to make use of data and to embrace evidence-based innovations in education have met with limited success (Wallace, Blase, Fixsen, & Naoom, 2008). Yet the push toward encouraging or even requiring the use of “evidence-based,” or at least “best evidence,” in instruction, intervention, and technical assistance at state and federal levels continues (Westat, Chapin Hall Center for Children & James Bell Associates, 2002; O’Donoghue, 2002; Pennucci & Lemon, 2014; U.S. Department of Education, 2015). The intention and hope are that more evidence-based—or, at minimum, evidence-informed—approaches to education can play an important role in significantly improving student outcomes. Nationally, for the past few decades, student outcomes have hovered around a mediocre mean without appreciable gains in reading and math, as documented by the National Center for Education Statistics (NCES, 2011).

Thus, the need for evidence-based approaches to education has never been clearer. However, the pathway to using evidence-based innovations and significantly improving student outcomes is fraught with potholes, detours, and U-turns. Efforts to embrace evidence-based and evidence-informed practices, like other reform efforts, often are abandoned (Bryce et al., 2010; Glennan, Bodilly, Galegher, & Kerr, 2004). New programs and practices or the use of a new

curriculum often ends prematurely and often with disappointing outcomes. What follows is a return to “education as usual” or the enthusiastic introduction of the next “silver bullet” (Adelman & Taylor, 2003; Fixsen, Blase, Duda, Naoom, & Van Dyke, 2010).

While data are necessary for productive change, frequently data are not sufficient to prompt the adoption of innovations, nor are data sufficient to create and sustain changes in practice in classrooms and schools (Carnine, 2000). For example, Project Follow Through was one of the most extensive and best funded evaluation studies in education. It compared the basic, academic, and cognitive outcomes of a number of “constructivist” models to explicit or direct instruction approaches for teaching at-risk children from kindergarten through third grade. In every category on the Metropolitan Achievement Test Scores, direct teaching of academics showed better results in math, language, spelling, and reading (Glennan et al., 2004). Yet the Department of Education’s Joint Dissemination Review Panel recommended all the programs for dissemination to school districts, declaring that “a program could be judged effective if it had a positive impact on individuals other than students.” Watkins (1995) noted that as a result of the panel’s judgment, “programs that had failed to improve academic achievement in Follow Through were rated as ‘exemplary and effective.’”

Education is not alone when it comes to evidence-grounded innovations withering on the vine. For example, medicine has had its share of failures to improve practice in the face of persuasive data. It took 25 years following the publication of data linking medical x-rays on pregnant women with fetal damage and childhood cancer until x-rays during pregnancy and early childhood were curtailed (Stewart, Webb, Giles, & Hewitt, 1956). Similarly, early data on the benefits of hand washing in preventing puerperal fever during childbirth were not published until 14 years after the data were collected, and even then the medical establishment actively rejected the practice for nearly two decades (Best & Neuhauser, 2004). And recent data show that hand washing occurs only one third to one half as often as it should (Gawande, 2004).

Ensuring that hand washing occurs seems straightforward compared with efforts to improve education. Soap dispensers don’t decide not to show up in the operating room, have competing demands, or resist engaging in the intervention. And the persons washing their hands do not have to respond to the soap in different ways based on the antiseptic’s engagement with them. The implementation of hand washing draws attention to the complex change required in more dynamic settings where the exchanges required are transactional and multilevel. That is, teachers influence students, who in turn influence their teachers; administrators influence teachers and teachers influence other teachers, and so on. It is no wonder that evidence is not enough.

If evidence is not enough, what else is required? Clearly, there are significant challenges related to choosing, implementing, sustaining, and improving evidence-based approaches to academic

instruction and interventions. This paper broadly frames those challenges by integrating two key considerations: the need to address both technical and adaptive challenges, and the need to engage in active, effective implementation strategies.

First, there is the need to recognize that the challenges related to practice, organization, and system changes are both *technical and adaptive* (Heifetz, 1994). Technical challenges, while complicated and formidable, are well defined, generally agreed upon, and able to be addressed with current strategies and often with traditional top-down leadership. The term “adaptive” refers to challenges that require revising and rethinking values, beliefs, and current ways of work. They are likely to generate feelings of loss, grief, disloyalty, and incompetence. Adaptive challenges also trigger legitimate but competing agendas for which solutions are not likely to be found by relying on mandates, to-do lists, and project management plans. In fact, tried-and-true solutions are not necessarily at hand (Heifetz & Laurie, 1997), and the very act of attempting to address such challenges often causes the very nature of the problem to change (Rittel & Webber, 1973). The shifting nature of the problem occurs because frequently, the attempted solutions create new and unforeseen problems. Of course, purely technical and purely adaptive challenges are rare. Often one flows into or generates the other. That is, a technical challenge can precipitate adaptive issues as progress becomes difficult and stalls. Similarly, adaptive challenges not only require addressing divergent perspectives and engaging in new learning but also must lead to action plans (technical approaches) or risk having progress stall in a never-ending process loop.

This frame of adaptive and technical challenges is an apt one since it draws attention to the challenges in education resulting from a lack of clarity and/or consensus about the definition of the problem and therefore the potential solutions. In addition, systemic, scientific solutions are often suspect in terms of historical and preferred educational pedagogy. The education ‘system’ is characterized by diverse opinions about diverse teaching methods, mixed with a penchant for autonomy at every level (classroom, curriculum domain, school, school district) and a passion for local determination. The United States, with its history of and propensity for individualism and exceptionalism, is the quintessential “you are not the boss of me” culture. For example, even when years of collective effort by educators, researchers, stakeholders, and policy makers result in presumed consensus about academic standards (e.g., the Common Core Standards), the drive in many states to tailor, brand, or totally discard the standards reflects a system driven by pedagogy, exceptionalism, and individualism (e.g., “Our children are different,” “We don’t agree; nobody asked us,” “The government can’t tell us what to do,” and “The standards aren’t developmentally appropriate”). Adaptive challenges can emerge from attempts to engage in more technical work and are not resolved so much as they re-solved iteratively. Large-scale, sustained change in education certainly has all the conditions necessary for generating adaptive challenges.

Improving student outcomes requires not only engaging the hearts and minds of educators and stakeholders by addressing adaptive challenges, but also changing the actions and behavior patterns of teachers, administrators, professional development providers, and policy makers (e.g., instructional practices, administrative supports and routines, policy guidance), and getting involved in system change. This calls for using the best evidence related to implementation. In the context of this paper, implementation refers to specific, observable actions and methods associated with reliably using evidence-based programs to benefit students in typical education

“Tra il dire e il fare c'è di mezzo il mare.” - “Between the saying and the doing is the sea.”

settings (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Of the many attempts to “use” evidence-based and evidence-informed practices, programs, and innovations, few actually result in “implementing” with fidelity, sustainability, and positive outcomes.

Purposeful attention to implementation requires using *evidence-based and evidence-informed implementation strategies and frameworks* to improve teachers’ and administrators’ confidence and competence, to create hospitable organization and system environments for new ways of work, and to engage in the right leadership approach for the diverse challenges encountered in any change process (technical and/or adaptive). In short, attention to implementation science acknowledges that improved education will require attention to two outcomes: implementation outcomes and intervention outcomes. Implementation outcomes focus on changes in teacher and staff behavior as well as changes in the organization and system environment (e.g., administrative guidelines, policy, funding) in order to support better ways of educating students. Student outcomes that are educationally and socially significant must be preceded by implementation outcomes; students cannot benefit from evidence-based instruction they do not receive.

SETTING THE CONTEXT

Improved student academic and social-emotional outcomes are worthy goals. And the process for achieving these goals is complex and messy, as the Italian proverb “Between the saying and the doing is the sea” reminds us.

What do we know about changing classroom practices and instruction, organizations, culture, and policy in pursuit of better student outcomes? What do we know about creating and supporting change at multiple levels when there are legitimate but competing agendas, pedagogies, and practices?

This paper examines these two questions in light of what we know about using implementation science and about the nature of adaptive challenges. Given the relatively nascent nature of implementation science and best practices and the data related to leadership and adaptive challenges and strategies, we readily acknowledge that this approach to the change process requires further study, debate, and testing in typical educational settings.

The remainder of this article expands on implementation science and best practices through the lens of the five active implementation frameworks. The frameworks are based on implementation research and evaluation studies synthesized in the monograph *Implementation Research: A Synthesis of the Literature* (Fixsen et al., 2005). Each framework is briefly reviewed along with the hypothesized interaction with adaptive challenges and adaptive strategies and the benefits of implementation with fidelity to produce reliable student outcomes and sustainable interventions.

Creating change in classrooms, schools, districts, and states is a nonlinear, multilevel, multiyear, iterative process. Unfortunately, sentences are laid down linearly. So, of necessity, each framework is discussed individually followed by reflections on its contributions to fidelity, outcomes, sustainability, and the amelioration or exacerbation of adaptive challenges. Although the frameworks are interactive, let's begin with a brief definition of each.

BRIEF DEFINITIONS OF THE FIVE ACTIVE IMPLEMENTATION FRAMEWORKS

USABLE INTERVENTIONS

To be usable, an innovation must not only demonstrate the feasibility of improving outcomes, but it also must be well operationalized so that it is teachable, learnable, doable, and able to be assessed in classrooms and schools (Fixsen, Blase, Metz, & Van Dyke, 2013).

IMPLEMENTATION STAGES

Implementation is a process that occurs over time, and stages of implementation require thinking through the right activities for each stage to increase the likelihood of success. The stages are exploration, installation, initial implementation, and full implementation (Felner et al., 2001; Fixsen et al., 2005).

IMPLEMENTATION DRIVERS

Implementation drivers are key components of the infrastructure and capacity that influence the successful use of an innovation. There are three implementation driver domains: competency drivers, organization drivers, and leadership drivers. Within each of these three domains, specific implementation-informed processes are detailed. These processes can be used to improve staff competence and confidence, create organizations and systems that

enable the innovation to be sustained and used with fidelity, establish processes that actively use data to manage change, and utilize leadership strategies that are appropriate for complex change challenges (Blase, Van Dyke, Fixsen, & Bailey, 2012).

IMPROVEMENT CYCLES

Improvement cycles are iterative processes by which improvements are made and problems solved. Whether they are used for rapid-cycle problem solving, early testing of new ways of work, or improving alignment in systems, they are based on the plan-do-study-act (PDSA) cycle. Each of these processes is detailed later in the paper. The PDSA process is derived from industrial improvement and quality control efforts (Deming, 1986; Shewhart, 1931) and is the foundation of improvement science in health and human services (Onyett, Rees, Borrill, Shapiro, & Boldison, 2009).

IMPLEMENTATION TEAMS

Implementation teams (typically comprised of a minimum of three to five people) are accountable for planning and seeing the implementation process through to full implementation. They actively integrate implementation stages, implementation drivers, and improvement cycles in service of implementing, sustaining, and sometimes scaling up usable interventions, leading to improved student outcomes.

BROAD APPROACHES TO ADAPTIVE CHALLENGES

Next, let's review the differences between adaptive and technical challenges and then summarize recommended approaches for addressing adaptive challenges.

Heifetz, Grashow, and Linsky (2009) observed that *technical challenges* may be very complex and important to solve but can be addressed by present-day knowledge, authoritative expertise, and current organization structures and processes. In contrast, the distinguishing features of *adaptive challenges* include lack of clear agreement on the definition of the challenge, and solutions that are unlikely to be found in the present-day knowledge base and current ways of work. Requiring changes in people's beliefs, habits, and loyalties is a messy process. And new learning is required while acknowledging and dealing with feelings of loss and incompetence. As noted previously, change initiatives are always a mix of technical and adaptive challenges. However, as Heifetz and Laurie (1997) noted, one of the biggest mistakes is to treat an adaptive challenge with a technical approach. In their classic paper *The Work of Leadership*, published in the Harvard Business Review, they summarized these six broad approaches to addressing adaptive challenges:

- *Getting on the balcony.* This requires stepping up onto the metaphorical balcony to survey the broader context and relevant history, patterns, data, emerging themes, and processes. The ability to be involved in the work while observing it more broadly is viewed as a prerequisite for the remaining strategies. The danger is in becoming mired in the day-to-day efforts and failing to identify broader leverage points for change as well as adaptive challenges.
- *Identifying adaptive challenges.* Diagnosing, identifying, and naming adaptive challenges are accomplished by gathering information and recognizing points of conflict that may be proxies for differing norms and values. And in some instances, leadership also must recognize that it has contributed to creating the adaptive challenges that now must be resolved.
- *Regulating distress.* In short, regulating distress requires pacing and sequencing the change and setting priorities. The goal is a continuing sense of urgency that does not overwhelm the people doing the work.
- *Maintaining disciplined attention.* In many aspects, this is a corollary to *regulating distress*. One way of avoiding tension is to return to comfortable methods of work, even when they do not result in the desired outcomes. The key to forward movement is recognizing work avoidance and redirecting energies back to the difficult work at hand.
- *Giving the work back to the people.* This approach involves creating conditions to let groups and individuals take the initiative in addressing challenges. It is a shift away from a hierarchical system of leaders leading and others taking direction and following. This means rewarding risk taking, engaging in trial and learning, and encouraging meaningful participation in defining challenges and proposing solutions.
- *Protecting all voices.* Sometimes the most insightful perspectives are provided in discomforting ways. When people are mustering the courage to speak their truth and perhaps offer critical insights, they may not always choose the right time and place to do so. Or they may cover their anxiety by speaking so fervently that *how* they are communicating gets in the way of *what* they are trying to say. It is necessary to hear all voices and continue to focus on what is being said while helping to regulate how issues are being communicated.

IMPLEMENTATION FRAMEWORKS: SUPPORTING CHANGE AND ADDRESSING ADAPTIVE CHALLENGES

Keep in mind the brief definitions of the five active implementation frameworks (AIF) and the overview of adaptive and technical challenges as we bring these two constructs together and

discuss how AIF supports sound implementation and how it can help address or, in some cases, aggravate adaptive challenges.

The hypothesis is that the use of AIF keeps the change process moving forward while surfacing and dealing with difficult issues. In essence, the frameworks provide pathways for addressing the challenging problems that might otherwise be avoided or exacerbated. As noted earlier, the frameworks provide processes, tools, and approaches for executing the broad plan and are not a linear set of steps. The collective use of AIF aligns with planning for emergent adaptive challenges.. As Heifitz et al. (2009, p. 31) noted, “You need a plan, but you also need freedom to deviate from the plan as new discoveries emerge, as conditions change, and as new forms of resistance arise.”

USABLE INTERVENTIONS AND ADAPTIVE CHALLENGES

As the evidence-based movement has swept through education and other human services, a great deal of attention has been paid to experimental rigor and effect size, as evidenced by more than 500 reviews of interventions by the What Works Clearinghouse and meta-analytic work by John Hattie (2009). Indeed, the rigor and evidence behind interventions are important. Research and evaluation findings help to *identify* what might be helpful for addressing the particular needs of students to improve specific outcomes. While rigorous research is important, it’s worth noting that teachers and administrators don’t implement experimental rigor. They implement programs and practices in typical educational settings.

Fixsen et al. (2005, p. 5) defined implementation as “a specified set of activities designed to put into practice an activity or program of known dimensions.” This definition directs attention to an important characteristic of a program or practice: *known dimensions*. Vernez, Karam, Mariano, & DeMartini (2006) noted that poorly defined programs are an impediment to effectively employing evidence-based practices or evidence-informed innovations and achieving good outcomes. Knowing the core components and having them operationalized well are key to supporting changes in the behavior of teachers and school administrators (Blase & Fixsen, 2013). In short, to be usable a program or practice must not only be effective, but it must be specific enough so that it is teachable, learnable, and doable, and can be observed and assessed in classrooms and schools (Fixsen et al., 2013).

Usable innovation criteria include the following:

- Clear description of the innovation (for whom it is intended, philosophy, procedures).
- Clarity about the essential functions or core components that define the innovation.
- Operational definitions of essential functions (what teachers and staff say and do).

- Practical fidelity processes/performance assessments that measure teacher behavior and instructional practices (answering the question, are we doing what we said we would do?).

Addressing each of the above criteria can variously exacerbate or ameliorate the adaptive challenges associated with identifying, selecting, and operationalizing innovations. As an innovation becomes more usable and clarity is developed regarding the philosophy, procedures, functions, and observable practices and processes, teachers and staff are better able to assess



how their current practices match up with the proposed innovation. Feelings of grief, loss, disloyalty, and incompetence may be more pronounced if the innovation diverges significantly from the current methods used to instruct and support students. The process of defining the intervention will produce the fodder needed to *identify the adaptive challenges* as teachers and staff react to greater

specificity and contribute to the process. Alternatively, clarity about the core features and information about *how* the innovation manifests itself in the classroom might (a) increase consensus on the definition of the solution, (b) improve educator confidence and competence in utilizing the practices expected, and (c) provide information (e.g., fidelity) that can be used to improve the supports for teachers and staff (e.g., improved professional development, skill-based training, and coaching) and further *regulate distress*.

Since many innovations lack enough specificity to be usable, a knowledgeable and representative team may need to come together to further operationalize the practices. Collective work by the team to further define the innovation *gives the work back to the people* by supporting meaningful engagement and participation. The work of the team can take the form of creating an innovation configuration (Hall & Hord, 2011) or a practice profile (National Implementation Research Network, 2011). Both specify the essential functions and, in the case of innovation configurations, elaborate by specifying levels of use. For a practice profile, the descriptions of activities and behaviors are classified as expected, developmental, or not appropriate. Of course, these seemingly technical activities of specifying the work of the teacher or staff person generate additional adaptive challenges to pedagogy, philosophy, beliefs, and values that must be sorted out. Hopefully, the sorting process is based on the theory of change and the literature related to effectiveness of the essential functions and the associated activities and behaviors to meet the identified student needs. Alternatively, but still usefully, the process allows teachers and staff to sort themselves—by either continuing to work in that setting or finding a new work setting more aligned with their values, beliefs, and pedagogy. The importance of *protecting all voices* during the process allows concerns to surface and be addressed. Simultaneously, *maintaining disciplined attention* redirects the work back to

the process of creating a usable intervention, increasing ownership of the innovation, and reducing feelings of incompetence, loss, and disloyalty.

IMPLEMENTATION STAGES AND ADAPTIVE CHALLENGES

As noted, implementation takes time and occurs in stages: exploration, installation, initial implementation, and full implementation. When the key activities necessary to implement an evidence-based innovation are stage appropriate, the mission-driven process is more likely to be successful. The overall journey from exploration to full implementation can take from 2 to 4 years (Chamberlain, Brown, & Saldana, 2011; Fixsen et al., 2001; Panzano & Roth, 2006). And as Gill et al. (2005, p. xxxiv) observed, “In today’s high-stakes accountability environment, district and school staff typically face pressure to demonstrate immediate gains in student achievement. But reforming schools takes time. It is important that everyone involved...understand that the desired results might not materialize for a few years.”

Although the stages of implementation are sequential, they are not “one and done” sequences nor are they mutually exclusive (Fixsen et al., 2013; Horner et al., 2014). That is, some stages will need to be revisited as the participants change (e.g., teacher selection processes need to *explore* whether or not applicants understand and buy into the instructional practices and philosophy of the school). In addition, the end of one stage is expected to overlap with the beginning of another stage. For example, even as some teachers are still participating in a training sequence (installation), other teachers are beginning to try out the new practices in their classrooms (initial implementation). A truism is that you don’t get to skip any of the stages, and challenges will emerge that require backtracking if the right work is not done at the right time.

What adaptive challenges are likely to be encountered in each stage? How might careful attention to stage-based work incorporate adaptive strategies to address adaptive challenges? Such challenges are sure to emerge during the 2- to 4-year process required to arrive at full implementation, when the student outcomes more fully materialize. Briefly examining the work to be done in the exploration and installation stages illustrates the connection of stage-based work to adaptive challenges and strategies to address them.

EXPLORATION STAGE

Hallmarks of the exploration stage include forming an implementation team, using data to examine the needs of students, and exploring the root causes prior to looking for possible solutions (Fixsen et al., 2005). The exploration of need is followed by the exploration of possible practices, programs, and frameworks to address the need. This involves engaging teachers, staff, content experts, community, and technical assistance providers in examining the fit, feasibility, evidence, resources required, readiness for use in classrooms, and capacity to implement the

innovation as intended and to sustain it over time. Accompanying all of these exploration activities are opportunities to discover, name, and address adaptive challenges.

Rather than engage a diverse implementation team in the exploration stage, leadership at the school, school district, or state level may yield to pressure to move quickly and give short shrift to this stage, thus inadvertently exacerbating adaptive challenges. Leadership at any level may decide to meet behind closed doors to carefully plan or select innovations or new instructional approaches. Announcing the kick-off of the next new thing and calling people to action with little opportunity for discussion, debate, understanding, and buy-in predictably lead to resistance to change.

Organizational change studies indicate that only about 20% of staff members are ready to embrace a new initiative (Laforge, Velicer, Richmond, & Owen, 1999; Velicer et al., 1995), so “it should come as no surprise that a majority of action initiatives fail” (Prochaska, Prochaska, & Levesque, 2001, p. 249). While concerns can and will arise during any stage of implementation, it is logical that the first two introductory stages are especially likely to generate *adaptive challenges*. However, when examination and dissemination of data about student needs and provision of information about potential programs under consideration (e.g., elements, goals, and philosophy) are core features of exploration, then non-coercive buy-in, acceptance, and commitment are facilitated. Activities related to reviewing data and programs create the opportunity to *get on the balcony* and survey both strengths and emerging adaptive challenges—and select a solution that takes advantage of current strengths and resources. Engaging a team *gives the work back to the people* supporting the development of greater consensus in defining the problem at hand and possible solutions. Well-defined exploration activities serve to *maintain disciplined attention* and *regulate distress* by keeping the work moving at a manageable pace.

A thoughtful exploration stage does not eliminate adaptive challenges or prevent them from arising in later stages; nor should it. However, attention to exploration activities does seem to impact the success and sustainability of programs and practices in education and human services (Fagan & Mihalic, 2003; Fashola & Slavin, 1997; Han & Weiss, 2005; Horner et al., 2014; Horner & Sugai, 2005; Romney, Israel, & Zlatevski, 2014; Slavin & Madden, 1999).

INSTALLATION STAGE

Before students can actually experience an educational innovation, preparatory activities are essential so that the organization as a whole supports the new ways of work, and teachers and staff feel competent and confident in using the innovation in their classrooms and schools (Wallace et al., 2008). Resources must be allocated, guidance documents created, communication protocols developed, and data routines articulated for monitoring student outcomes and tracking teacher fidelity assessments. Instrumental changes may be needed to

secure space and to purchase equipment (e.g., software, computers) and curriculum materials for classrooms. Professional development, training, and coaching routines must be put in place for the first cohort of teachers and staff and made sustainable to support subsequent cohorts.

Adaptive challenges may emerge during installation. They could cause proponents to become impatient and lose interest, or they could fuel the reluctance of those who remain skeptical about the feasibility and benefits of implementing the innovation. Resources are being expended, time is passing, and students are not improving. The real challenge is to maintain a sense of urgency and avoid letting the innovation fall by the wayside as the next legitimate but competing issue surfaces. Leaders and members of the implementation team must maintain disciplined attention to the activities needed to set the stage for successful initial implementation. And they must communicate the activities that are creating readiness and progress, to build supportive structures and processes at multiple levels.

INITIAL AND FULL IMPLEMENTATION STAGES

Adaptive challenges are never fully put to rest. New adaptive challenges can emerge or previously resolved challenges can re-emerge during initial implementation if the launch is awkward. During initial implementation, often a feeling of incompetence and a desire to return to familiar routines can derail the initiative. Not only are classroom instructional practices and routines new, but often those providing training, coaching, and monitoring fidelity are new to their roles and feeling equally awkward and less than competent. This means that positive responses from students, parents and professional colleagues may not be occurring and that new and fragile behaviors will likely fall away unless there is an opportunity to work through the awkward stage (Bierman et al., 2002; Joyce & Showers, 2002). *Regulating the distress* that comes with uncertain and wobbly implementation and *maintaining disciplined attention* by providing additional support, coaching, and troubleshooting are required as the classroom, training, coaching, and data routines are put in place for the first time.

Full implementation marks the point when the innovation is now “our way of work.” However, there are always new teachers, new staff, new school board members, and new families and students entering the scene. Exploration, installation, and initial implementation along with their attendant adaptive challenges are always in play. This means that leadership and the implementation team must continue to scan for patterns, strengths, and challenges; be willing and able to name adaptive challenges; actively regulate distress while maintaining disciplined attention to the work at hand and preparing for the work to come; and be willing to listen to and discuss concerns as they are raised.

IMPLEMENTATION DRIVERS AND ADAPTIVE CHALLENGES

As noted earlier, implementation drivers are the processes required to improve staff competence and confidence, create organizations and systems that enable the innovation to be

used with fidelity and sustained over time, and orient leaders to the right strategies for the types of challenges they are encountering (Blase et al, 2012; Fixsen, et al., 2005). There are three types of implementation drivers: competency drivers, organization drivers, and leadership drivers (Figure 1).

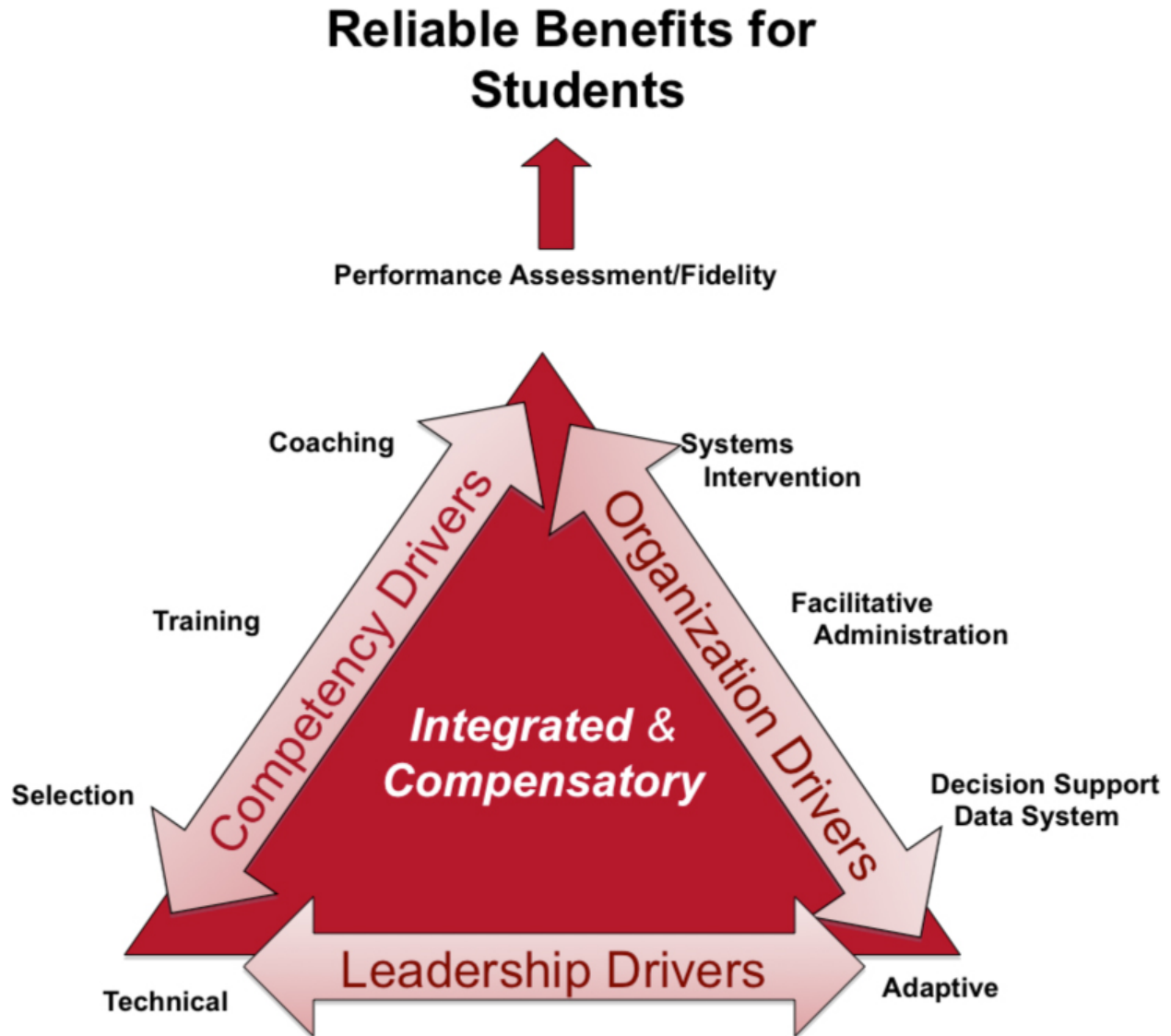


Figure 1. Implementation Drivers

© Fixsen & Blase, 2008

Source: Reprinted with permission. Fixsen, D. L., & Blase, K. A. (2008). *Drivers framework*. Chapel Hill, NC: The National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill.

The specific implementation drivers within each of the three domains are operationalized and based on best evidence related to each driver (Fixsen et al., 2005). That is, each driver is viewed through an implementation lens, and best practices are operationalized to increase the likelihood of creating necessary changes at the practice, organization, and system levels.

Organizations sometimes indicate that they already use many of the implementation drivers to create change: They select staff, provide professional development opportunities, and engage in activities labeled as coaching. Increasingly, they have outcome data available. However, they may or may not use these levers for change in an implementation-informed way that is likely to result in improved fidelity, sustainability, and functional improvement processes. An examination of three competency drivers—staff selection, coaching, and fidelity assessment—reveals the importance and value of an implementation-informed approach to drivers as well as revealing the interplay with adaptive challenges and the strategies to address those challenges.

STAFF SELECTION

Implementation-informed staff selection means being clear about the required knowledge, skills, and values, including those needed to implement an evidence-based or evidence-informed innovation (Blase, Fixsen, & Phillips, 1984; Reiter-Lavery, 2004).

What are the unteachables in terms of educators' values and attitudes? What knowledge and skills are required at entry because they will not be highly supported through additional training and coaching? What knowledge and skills are required because deficiencies will make it difficult for the applicant to be successful in implementing the innovation in the educational setting?

For example, most applicants arrive with a viewpoint and experiences formed by interacting with family members. If meaningful family engagement is a core feature of the school district's or school's culture and of the innovation, then the interview process for all staff should include vignettes, scenarios, or behavior rehearsals that tap this set of values and skills. In particular, behavior rehearsals are used to allow applicants to move beyond describing their skills and attitudes to demonstrating them. When a trained interviewer follows a purposefully scripted scene and takes on the role of a family member, then the interviewers can assess the following:

- How the applicant responds to a challenging interaction with the "family member."
- Whether the applicant is willing to discuss his or her own behavior.
- Whether the applicant asks the "family member" questions in order to understand his or her concerns.
- And most important, the degree to which the applicant is able to accept and use feedback from the "family member" and subsequently from the interviewer after the behavior rehearsal.

This last item, the ability and willingness to accept feedback professionally and use it for self-improvement, is key to implementing any innovation well. Most new routines are not mastered instantly, classroom and school environments are complex, and the needs of students vary across students and over time. The judgment and skills required to appropriately and effectively use new instructional or learning support strategies require time, feedback, the use of data, and a commitment to learning and improvement. When feedback transactions are unpleasant or unproductive, people will quit seeking feedback and people will quit giving feedback—to the detriment of educators and students.

An implementation-informed selection process can help *identify adaptive challenges* that are likely to arise by hiring certain applicants. The scenarios, vignettes, and behavior rehearsals serve a dual purpose. They provide the interviewers with information about the degree to which applicants fit the current culture, practices, and expectations as well as provide applicants with the opportunity to assess their own comfort and competencies. This mutual selection process may result in applicants opting out. While no applicant will be a perfect fit, the interview process can feed information about a new employee's strengths and developmental needs to administrators, coaches, and trainers. This feed-forward process provides anticipatory guidance that will get new staff off to a better start.

Having a knowledgeable person present at and participating in all interviews creates the opportunity for that individual to *get on the balcony*. He or she can more broadly assess the available workforce and consider implications for recruitment practices, hiring timelines, overall suitability of candidates, and implications of training and coaching intensity for new teachers and staff.

In summary, an implementation-informed selection process (selection driver) uses carefully designed scenarios, vignettes, and behavior rehearsals to assess prerequisite values, attitudes, and skills. Behavior rehearsals are structured to assess applicants' willingness and ability to listen to and incorporate feedback. This implementation-informed selection procedure increases the likelihood of applicants more fully understanding expectations. In addition, administrators and others gain relevant information for selecting applicants who are more aligned with the expectations of the educational setting and are receptive to training and coaching.

COACHING

Focusing on knowledge acquisition, primarily through institutes and training days, is not as effective as combining training with implementation-informed coaching in increasing teacher knowledge and improving student outcomes (Garet et al., 2011). Coaching that is implementation informed is an important implementation driver to improve staff competence and confidence in using new instructional practices, assessments, and data (Denton, Vaughn, &

Fletcher, 2003; Joyce & Showers, 2002; Schoenwald, Sheidow, & Letourneau, 2004). Some of the core features of implementation-informed coaching include regular observation of the teacher or staff member (e.g., direct, video, audio) by a knowledgeable person who provides prompt, helpful, and descriptive feedback of strengths, and works with the educator to identify areas and strategies for improvement. It also includes goal-setting conversations between the teacher and coach as the basis for future iterative cycles of observation and feedback to support the teacher's continued development. Asking teachers to reflect on their own skill development early in their acquisition of new skills *without* observational or student data and/or without a knowledgeable coach may result in teachers feeling supported in the short term. However, the process is unlikely to promote increased competence and ultimately confidence—the by-product of improved competency (Harchik, Sherman, Sheldon, & Strouse, 1992).

Implementation-informed coaching also requires support, data, and feedback for the people who do the coaching. A coaching service delivery plan details the type, frequency, and products (e.g., written feedback) for which the coach is accountable. This allows for an informed assessment of fidelity to the coaching routines in terms of “dosage” (e.g., Are we coaching as often as intended?) and targeted supports for coaches (e.g., examining the barriers to coaching as intended; ensuring coaches have resources and get feedback). Regular, formal, anonymous feedback from those being coached combined with educator fidelity data provides fodder for developing targeted supports for coaches (e.g., What should we do to improve support, training, and coaching for our coaches so that they are viewed as helpful? How can our coaches more routinely help educators achieve better fidelity?).

FIDELITY ASSESSMENTS

This paper employs the term “fidelity assessments” for assessments that measure the degree to which educators used the intervention as intended. The term is synonymous with treatment integrity, program adherence, intervention integrity, and fidelity to the practice. It is no accident that the fidelity assessment driver is at the apex of the implementation drivers graphic (see Figure 1), in terms of both focus and importance. Durlak and DuPre (2008) estimated that evidence-based programs used with acceptable fidelity have effect sizes 3 to 12 times greater than those used with low fidelity. Therefore, focusing the competency, organization, and leadership drivers on producing high-fidelity use of the innovation (e.g., evidence-based instructional practices, assessments, behavioral interventions) is useful.

The ability to answer the question “Did educators do what was required to use the innovation in the classroom?” is critical to improving education. Only when an organization has information about fidelity can it engage in efficient and effective improvement processes. Fidelity assessment data serve as a system improvement diagnostic. This requires asking about

the quality of the supports provided by the organization,, “Did the organization and leadership do what was necessary to support educators in the use of the innovation?”. Fidelity data can help discriminate problems that are due to poor or non-existent use of the intervention as intended from poor choices in selecting the intervention or the need to further develop the intervention to meet student needs (Detrich, 2014). Without fidelity assessments, quality improvement strategies are like random acts of tinkering. It is important to ask questions such as “Do we need to improve the integrity with which the intervention is being implemented? Did we select the wrong thing to do or need to revise the intervention itself?” Without fidelity assessment data, the organization won’t know.

According to NCES, approximately 50 million students are taught by some 3.1 million teachers in about 98,000 schools in roughly 13,600 school districts. Given the scale of the “educational laboratory” available for research and program development, the development and use of valid fidelity assessments in educational research are still relatively scarce (Goncy, Sutherland, Farrell, Sullivan, & Doyle, 2014; Hagermoser Sanetti, & Kratochwill, 2009). And the development of practical, valid fidelity assessments that can be used routinely in educational settings is equally scarce, with some notable exceptions related to social-emotional interventions (Bradshaw, Reinke, Brown, Bevans, & Leaf, 2008; Snyder, Hemmeter, Fox, Bishop, & Miller, 2013) or included in some commercially available curricula and programs (e.g., Archer & Hughes, 2011).

Inclusion of the fidelity assessment driver as a core feature of effective implementation is a lightning rod for *adaptive challenges*. Perhaps adaptive challenges arise because of the history of teacher evaluations being used—or perceived as being used—punitively. This is in sharp contrast to an implementation-informed use of fidelity data as a system diagnostic for critically analyzing ways to improve the implementation drivers, thus supporting teachers in achieving higher fidelity and improving student outcomes. Fidelity assessments also may cut to the heart of differing philosophies and pedagogies in education (i.e., constructivist versus explicit instruction).

Use of fidelity data helps to *maintain disciplined attention* by redirecting supports for educators back to accomplishing the hard work at hand. Reviewing fidelity data over time and across educators also helps facilitate *getting on the balcony* work. This balcony view and discussion of fidelity data not only highlight patterns and systemic issues but also can *regulate distress* if the data reviews are implementation informed. This means that the reviews from the balcony are not related to shaming and blaming teachers but are directed at critically analyzing the implementation drivers and determining how to improve their effectiveness to better support teachers. And while bringing the fidelity data to those who generated it and asking for their input and perspectives might be uncomfortable, there are benefits to *giving the work back to*

the people; soliciting their advice about what's working to support them and what else may be needed is enlightening and functional. .

SUMMARY: COMPETENCY DRIVERS AND ADAPTIVE CHALLENGES

The very act of ensuring that competency drivers (e.g., selection, training, coaching, fidelity) are in place, implementation informed, and integrated can create *adaptive challenges*. Fortunately, the recommended approaches for addressing such challenges can be facilitated by and incorporated into the use of the implementation drivers.

A common implementation-informed core feature for all the competency drivers is the collection and use of data to shine a light on successes and challenges, including adaptive challenges. But it is not the stand-alone availability of data that generates change in behavior and addresses adaptive challenges. Rather, it is the integrated use of data for improvement with collective accountability for the proximal outcome of good fidelity and more distal results of improved student outcomes.

IMPROVEMENT CYCLES AND ADAPTIVE CHALLENGES

Implementation teams use improvement cycles to improve the likelihood that new innovations are launched, implemented well, and sustained over time, and that they achieve hoped-for outcomes. Embedded in each implementation stage, improvement cycles are useful in developing a more usable intervention and in assessing and improving the effectiveness of the implementation drivers. In short, improvement cycles are purposeful processes that can be used to do the following:

- Rapidly assess and solve problems.
- Test the impact of small changes.
- Improve proximal outcomes (e.g., fidelity, quality of implementation drivers).
- Conduct early tests of new practices.
- Focus efforts on an initial cohort to identify and make needed changes in subsequent scale-up efforts.
- Create more hospitable organization and system environments (e.g., aligned policies, guidelines, resources) to better support and sustain new practices and programs.

At the core of each variation on the improvement process is the plan-do-study-act (PDSA) cycle. This improvement process was initially developed by Bell Laboratories in the 1920s (Deming, 1986; Shewhart, 1931). The process was widely adopted in post–World War II Japan to rapidly reconstruct and revitalize the manufacturing sector (DeFeo & Barnard, 2005). The process is now more widely used in health and human service sectors (Akin et al., 2013; Daniels & Sandler, 2008; Varkey, Reller, & Resar, 2007).

PDSA cycles are used productively during each implementation stage, in installing and improving each implementation driver. Implementation teams apply them to increase the likelihood of effective use and beneficial outcomes related to the innovation. The core elements of the PDSA cycle include:

- **PLAN** – This phase involves identifying current or anticipated challenges, gathering data and information to understand the dimension of the problem, and developing hypotheses about why barriers exist or might exist in the future (e.g., root cause analyses). The next step is to detail action plans that are aligned with the hypotheses, informed by data and that address the challenges, and then to specify measures and data collection protocols.
- **DO** – This next phase involves conducting the processes as intended. Attempts to follow the PLAN are documented for discussion in the STUDY section.
- **STUDY** – Monitoring the process comes next (i.e., Did we DO the processes that were specified in the PLAN? Did we collect the data we intended to collect?). The STUDY phase also includes analyzing the data related to the outcomes and determining whether the PLAN made a difference.
- **ACT** – If the results were adequate, this phase involves embedding the solution into the setting and processes so that improvements are reliably replicated over time and across staff. But if the results were insufficient, then the purpose of this phase is to apply what was learned to develop an improved PLAN for the next cycle.
- **CYCLE** – Solutions to important problems rarely appear after one attempt. Data from other fields indicate that three to five cycles may be required to find an acceptable and effective solution. Be prepared to repeat the PDSA cycle a few times (Nielsen, 2000).

THREE TYPES OF PDSA IMPROVEMENT CYCLES AND ADAPTIVE CHALLENGES AND STRATEGIES

Reviewing the three types of PDSA improvement cycles provides the opportunity to examine how they support improved implementation. It also sets the stage for understanding the adaptive challenges that may arise and the adaptive strategies that can be employed while engaging in the PDSA process. The three types of PDSA improvement cycles are (a) rapid-cycle problem solving, (b) usability testing, and (c) practice–policy communication cycle.

Rapid-cycle problem solving. Not all difficulties can be anticipated when launching a new innovation, no matter how much time is spent in the exploration and installation stages. Therefore, rapid-cycle problem solving is useful when any new practice or routine is first implemented (e.g., new instructional practice, new coaching routines, new data collection processes). This PDSA process is characterized by prompt problem detection and reporting, pulling together of the right team, and use of the process as intended. There are challenges to using the PDSA process as intended including failing to adhere to the process itself (Taylor et al.,

2014). When anticipatory guidance is provided about the upcoming use of rapid-cycle problem solving, the awkwardness of engaging in new practices during initial implementation is normalized.

Adaptive challenges are likely to emerge during initial implementation as teachers and staff experience the reality of putting a new innovation into practice and are likely to feel awkward and less competent. A normal response is to avoid such discomfort by retreating to previous, more comfortable ways of work (Hinds et al., 2015). Using a rapid-cycle PDSA process to address pressing and often unanticipated issues helps improve implementation as well as maintain *disciplined attention* and *regulate the distress* that accompanies new approaches. Providing guidance about rapid-cycle problem solving and engaging teachers and staff in problem solving also serves to *give the work back to the people*.

Usability testing. This process is helpful when an innovation is multifaceted or complex (e.g., differentiated instruction routines, first steps in a multipronged approach to reducing disparities in disciplinary practices, launching professional learning communities). Usability testing can be planned by proactively identifying processes likely to be challenging and setting desired benchmarks for success. This proactive approach helps *maintain disciplined attention*, and it is particularly beneficial if the first steps in an intervention must meet a certain criterion for the intervention to continue rolling out successfully and ultimately producing results (Akin et al., 2013). If the early work with students, teachers, or staff is unsuccessful, then there is little chance of achieving fidelity and producing a desirable outcome. Data from other fields indicate that three to five rounds of improvement (e.g., with limited numbers in each cohort) will detect and correct most critical problems (Lewis, 1994). This avoids the scenario of large-scale rollouts that are unsuccessful and burdensome, and therefore often are abandoned. Instead, usability testing quickly detects challenges that can be addressed early on.

The adaptive challenges that emerge during usability testing are similar to those reviewed in the section on rapid-cycle problem solving. However, because the complexity of the intervention is different and the process less discrete, accurately *identifying adaptive challenges and discriminating them from technical challenges* may be more difficult. The *balcony work of the leader* can be facilitated by relying on both quantitative and qualitative data. Interviews and/or focus groups with teachers, staff, and administrators who are expected to use the innovation can help tease out what is working well and what is not, and detect points of conflict. Engaging teachers, staff, and administrators in this way serves to *protect all voices and gives the work back to the people*. Engaging in successive rounds of PDSA sends the message that the innovation is a priority and here to stay; *disciplined attention is maintained*.

Practice–policy communication cycle. This process (Figure 2) is useful and necessary when organizations and systems are the targets of the change process or are likely to heavily

influence the success and sustainability of the innovation. The goal of the practice–policy communication cycle is to create transparent and reliable communication processes for relaying policy to the practice level and for the practice level to inform the policy level about actual impact in the educational setting (Fixsen et al., 2013).

Initiate and Manage Change

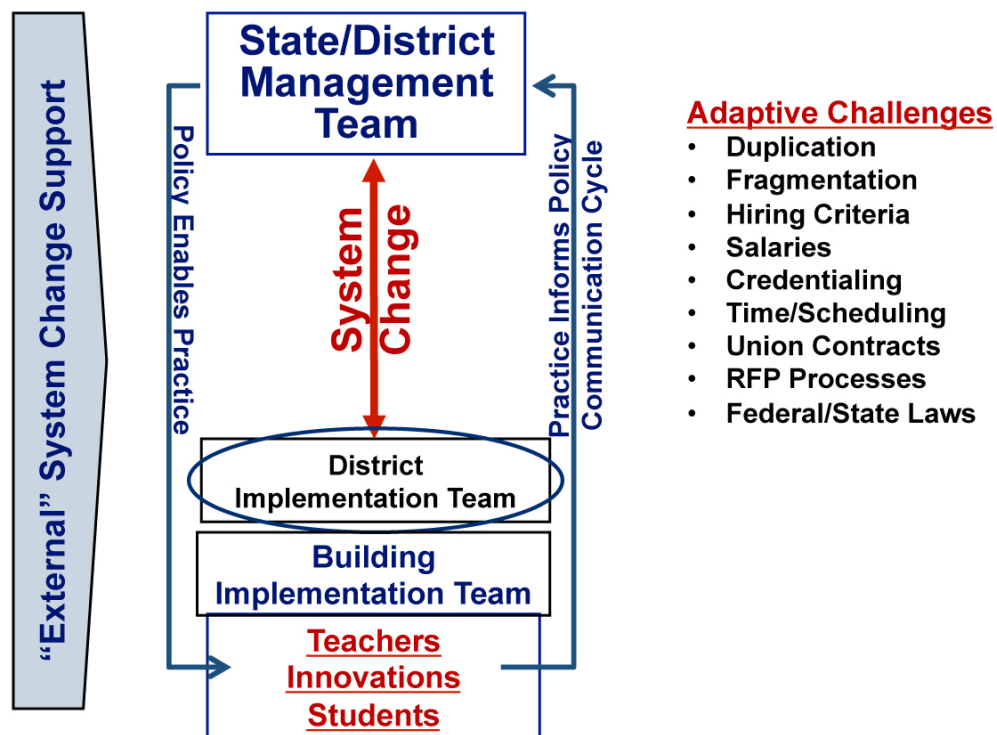


Figure 2. Practice–Policy Communication Cycle

Source: Adapted from: Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2013). Statewide implementation of evidence-based programs. *Exceptional Children* (Special Issue), 79(2), 213-230.

The core features of this cycle include the following:

- Clarity about the functions of each team.
- Agreements among teams or entities to receive and welcome information, communicate successes, and engage in timely problem solving. The information may consist of descriptions of experiences and/or data collected.
- The development and use of linking communication protocols to specify in writing the means, frequency, and types of issues that are best attended to by each level.

- In some cases, linked teams are structured so that key people on a team also sit on another team at another level and are charged with facilitating the communication cycle.

Communicating policy directives or new guidelines has its own challenges in terms of clarity and timeliness of communication. Policy to practice communication occurs through multiple channels (e.g., website, email, documents, meetings) is common. However, functional and transparent mechanisms for the practice level to inform the policy level are not typical. Having administrative layers between those implementing the innovation and policy makers help to ensure that the right problems get resolved at the right level. Still, a process and a culture that allow challenges to be raised to the next level for resolution are required. Without a known and transparent process for communicating challenges to the right level, the layers serve to buffer the organization's leaders and policy makers from hearing about the successes, challenges, and unintended consequences of the new policy, guidelines, incentives, or reporting requirements (Barber & Fullan, 2005; Blase, et al. 2012). One-way communication (i.e. solely top down) prevents understanding the variables that may be preventing implementation from occurring as intended.

The practice–policy communication cycle can bring to the surface and resolve the *technical challenges* that accompany the use of an innovation. Issue can be lifted up to a level (e.g., from single grade to whole school, from individual school to school district) that can address the technical challenges (e.g., funding, improved access to training, use of professional development days, coaching, new data systems). The practice–policy communication cycle also has the potential to identify and address *adaptive challenges* inherent in using and scaling up innovations (e.g., pace of change, agreement on the definition of the problem, learning by doing, solving new problems created when using an innovation, new roles and responsibilities). The practice–policy communication cycle facilitates leaders *getting on the balcony* because patterns across a level can be detected and signal issues that need to be lifted up to the next level. This balcony work helps leaders *identify adaptive and technical challenges* that are systemic rather than one-off. The work at each level not only *gives the work back to the people* but it also *gives the work “up” to the people* most able to resolve the issues.

But there are *adaptive challenges* in even attempting to put a practice–policy communication cycle in place. Legislative and political timelines do not nicely match implementation timelines. And the notion that practice-level feedback will find a timely and unfiltered pathway to the policy maker or administrator may challenge the ability to *protect all voices*. Once information starts to flow, there must be supportive action that allows the status quo to be illuminated and challenged. As Onyett et al. (2009, p. 11) noted, “There is need to develop capacity for delivering such whole systems interventions wherein thinking can be challenged, issues about authority and the exercise of power candidly explored and where participants can continue to

learn and adapt to ever-changing circumstances.” This means that policies, guidelines, and resources must be reviewed, challenged, and aligned so that the actual intent of policies and legislation can be realized. Leaders must be ready to *regulate the distress* that this communication process creates by *identifying and naming these adaptive challenges*, and they must *maintain disciplined attention* as the work of system alignment becomes difficult and uncomfortable.

Given the challenges of exploring, installing, and using a functional practice–policy communication cycle, the role of external facilitators or change agents (Figure 2) is critical (Barber & Fullan, 2005; Khatri & Frieden, 2002; Klein, 2004; Waters, Marzano, & McNulty, 2003). In their studies of implementation of complex innovations, Nord and Tucker (1987) noted that external facilitation was able to overcome the inertia and influence of the status quo to prevent the demise of new initiatives. External facilitators can help to initiate and manage change; make good use of the strategies for addressing adaptive challenges; and coach teams and key persons in the use of implementation best practices and adaptive strategies. Also, they may face less risk than employees in identifying adaptive challenges. In education, groups such as the Center on Innovation and Improvement (www.centerii.org), Positive Behavioral Interventions and Supports (www.pbis.org), and the State Implementation and Scaling-up of Evidence-based Practices Center (www.scalingup.org) are external change agents that help organizations initiate and manage change processes.

In summary, PDSA improvement cycles are useful throughout the implementation process and can rapidly improve practices, implementation processes, and data systems. They are used to test and improve elements of interventions or challenging implementation processes. Over time and across levels of a system, improvement cycles are employed to identify and sustain what’s working, raise challenges and barriers to the level that can resolve the issues, and prevent the institutionalization of barriers. While improvement cycles are productive in identifying and resolving adaptive challenges, they can create their own adaptive challenges simply by being used.

IMPLEMENTATION TEAMS AND ADAPTIVE CHALLENGES AND STRATEGIES

Implementation teams are structures accountable for steering the implementation process through to full implementation, as well as for ensuring ongoing improvement and sustainability. An implementation team uses sound implementation practices (e.g., stages, implementation drivers, improvement cycles) as it works toward full and effective operation of usable interventions. It is accountable for selecting, installing, supporting implementation, ensuring high fidelity, and making the necessary organizational changes to improve and sustain the work. The team is responsible for either directly providing these processes or arranging for them (e.g., subgroup work, consultants, technical assistance centers). And because an implementation

team is in the messy business of managing change, it inevitably creates and then must identify and address *adaptive challenges*.

Meaningful and large-scale implementation efforts at the system or practice level are more likely to be successful with the active engagement and accountability of implementation teams (Brown et al., 2014; Fixsen et al., 2010; Higgins, Weiner, & Young, 2012; Saldana & Chamberlain, 2012; Sugai & Horner, 2006). The number and levels of teams (e.g., school, school district, state) depend on the scope of the endeavor and the degree to which system change is needed. Each team represents the system at a particular level. Functional practice and system change are more likely when teams at multiple levels are integrated so that each team's information, knowledge, successes, and challenges are appropriately shared with other teams at other levels (Figure 3). Each team is charged with developing the overall infrastructure needed for implementation *and* with actively supporting the work of the team or teams below its level. As noted in the section on practice–policy communication cycles, communication pathways must be transparent and focused on solving both technical and adaptive problems, building capacity, ensuring implementation, and aligning policies, procedures, and funding to support new ways of work (Spoth, Greenberg, Bierman, & Redmond, 2004).

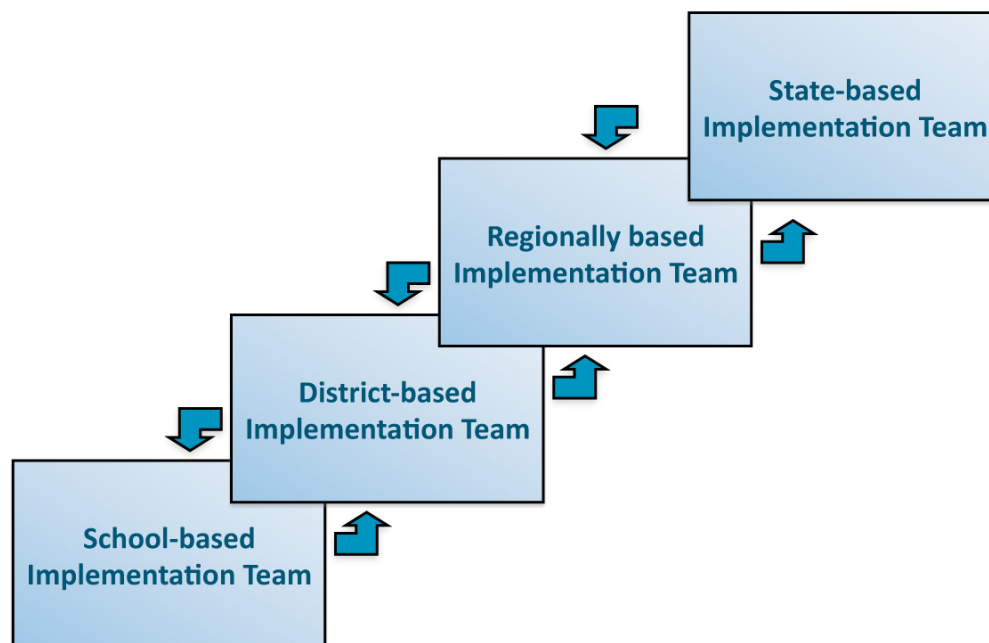


Figure 3. Linked Teaming Structure

Adaptive challenges can emerge in creating a functional implementation team since the team's roles and responsibilities require sharing power, along with accountability for achieving agreed-upon outcomes, with leadership. This is a paradigm shift for many. An implementation team is *not* an advisory group or committee that provides input (e.g., periodic meetings for decision making, discussion). The team is actively involved on a daily basis with implementation efforts devoted to ensuring the full use of the innovation. It has work to do between formal meetings, and systemic problem solving is a core feature of its work.

Developing terms of reference (ToR) or a team charter is one way to *address adaptive challenges*. Terms of reference outline the purpose of the implementation team, how the group will be structured, how the work will be done, limits of authority, values, and decision making processes (e.g., majority, unanimity). If the ToR document is productively debated, collaboratively developed, and actively used, it can do the following:

Help *identify adaptive challenges* (e.g., Are we still aligned on values? We seem to have very different ideas about our mission. Do we need to change our terms of reference?).

- Help *maintain disciplined attention* (e.g., That's not in our scope of work according to our terms of reference. Maybe we need to refocus on our mission and goals.). The ToR also can be used in recruiting and orienting new team members. In addition, the document can be used as a touchstone for reviewing the mission, timelines, expected results, and other details.
- Help *regulate distress* and *protect all voices* because the conflict is with the ToR (i.e., the need to adhere to it or change it) rather than with people on the team.
- Help *view the work of the team from the balcony* by having a review of the ToR and updating it. The review allows the team to step back from the day-to-day work to determine if the right work is being done by the right people to achieve agreed-upon goals.
- Consistently *give the work back to the people* as the implementation team engages in new learning, uncovers adaptive challenges, and reassesses the currency of the ToR and the need for revisions.

Of course, implementation team members need the capacity and courage to recognize when *adaptive challenges* are in play. And those challenges will come not only from within the team but also from outside the team along the rocky road to implementation. If the team ignores the adaptive challenges and continues to pursue technical solutions in the face of adaptive issues, it is unlikely to be successful.

In summary, implementation teams are the linked structures accountable for engaging the relevant stakeholders and executing high-quality implementation of evidence-based and

evidence-informed innovations. They are the focal point for identifying and addressing adaptive challenges, all the while creating readiness, making sure that implementation occurs as intended, monitoring outcomes, communicating successes and challenges, and engaging in system alignment.

CONCLUSION

Introducing and effectively supporting evidence-based instructional and behavioral practices in education are simultaneously promising and problematic. While knowledge about the effectiveness of an innovation is important in choosing a pathway to improvement, such knowledge is not sufficient to change practice in the classroom and school. Nor does evidence about innovation effectiveness shed light on the organization and system changes needed to create a hospitable environment for the new ways of work. In a briefing report on school improvement, Jerald (2005, p. 2) noted, “As thousands of administrators and teachers have discovered too late, implementing an improvement plan—at least any plan worth its salt—really comes down to changing complex organizations in fundamental ways....”

This paper makes the case for attending to the “how” of implementation to ensure that the “what” of evidence-based innovations is available, effective, and sustainable in typical classroom settings (Metz & Bartley, 2012). It also proposes integrated attention to adaptive challenges accompanying systemic change as deeply held beliefs and practices are challenged (Heifetz et al., 2009). Conceptualizing a multilevel change process that relies on implementation science and best practices as well as attention to adaptive challenges provides an opportunity to successfully navigate the complex and lengthy education improvement journey.

The five active implementation frameworks require multilevel consideration and application when engaging in school improvement through the use of evidence-based and evidence-informed innovations. As discussed, each of the five frameworks has the potential to generate and identify adaptive challenges and can serve as the means to address them with adaptive strategies. While addressing adaptive challenges can be challenging, making progress in addressing the technical challenges is just as important. The implementation journey requires balanced leadership and strategies that can flow from adaptive to technical and back again (Daly & Chrispeels, 2008; Waters et al., 2003). And it requires managing this flow in conjunction with attention to usable interventions, stages of implementation, implementation drivers, and improvement cycles, and with the focus and expertise of implementation teams.

Considering that this paper began with a quote from Seymour Sarason, it seems fitting to close with another of Sarason’s astute observations. He observed, “The way in which a change process is conceptualized is far more fateful for success or failure than the content one seeks to

implement. You can have the most creative, compellingly valid, productive idea in the world, but whether it can become embedded and sustained in a socially complex setting will be primarily a function of how you conceptualize the implementation change process” (Sarason, 1996, p. 78). Implementation science and best practices with integrated attention to adaptive challenges provide a promising conceptualization.

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EXHIBIT C

A FRAMEWORK

TO DESIGN, TEST, SPREAD,
AND SUSTAIN EFFECTIVE
PRACTICE IN CHILD WELFARE



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Building on the momentum created during the 2011 National Child Welfare Evaluation Summit, the Children's Bureau convened three Child Welfare Research and Evaluation Workgroups. Each workgroup examined a particular evaluation topic or issue, with the goal of improving child welfare research and evaluation and strengthening the link between research and practice. This product was created by the Framework Workgroup, whose members included:

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TABLE OF CONTENTS

Executive Summary	1
Introduction	5
The Framework	7
Identify and Explore	8
Develop and Test	11
Compare and Learn	13
Replicate and Adapt	16
Apply and Improve	18
Critical Considerations	21
Conclusion	23
References	24
Appendix A: Reference Frameworks and Clearinghouse Web Sites	25
Appendix B: Determination of Phase and Next Steps	26
Appendix C: Framework Task Checklist	27

> EXECUTIVE SUMMARY

A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare is a practical guide for strengthening child welfare systems. It describes a process for exploring problems in child welfare, developing interventions, building evidence about their effectiveness, integrating effective interventions into routine child welfare practice, and continually improving on their delivery. The framework is designed to promote better integration of evaluation with program and policy decision-making, to encourage stronger partnerships between child welfare stakeholders, and to serve as a tool for three target audiences:¹

- Those who evaluate programs
- Those who make decisions about the development and implementation of interventions (and the funding of those activities)
- Those who fund research and evaluation studies

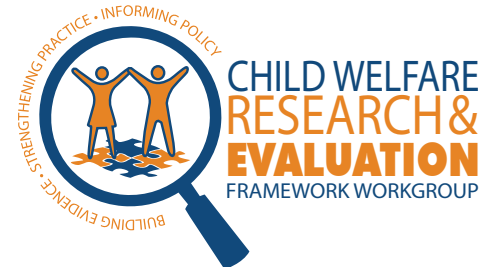
This framework benefits from what has already been learned about achieving effective practice in child welfare, building on the experiences and expertise of child welfare practitioners, prior and emerging research, well-accepted principles of sound evaluation, and ongoing analyses of child welfare data. It also acknowledges tensions between stakeholder groups and recognizes the importance of social, cultural, and contextual diversity as key in the decision-making process.

As shown on the outer ring of the diagram on the next page, the Identify and Explore phase of the framework process comprises several steps. These include identifying the problem; studying it to better understand its prevalence among a particular target population, its potential causes, and its larger environmental context; constructing a well-reasoned theory of change; and researching and choosing interventions that address the problem.

Once an intervention is chosen, it proceeds through four sequential phases shown as the smaller circles inside the outer ring of the diagram. These include developing and testing the intervention, comparing it to alternatives and learning more about its effectiveness, replicating or adapting it for other groups or contexts, and continuously monitoring and improving it over time.

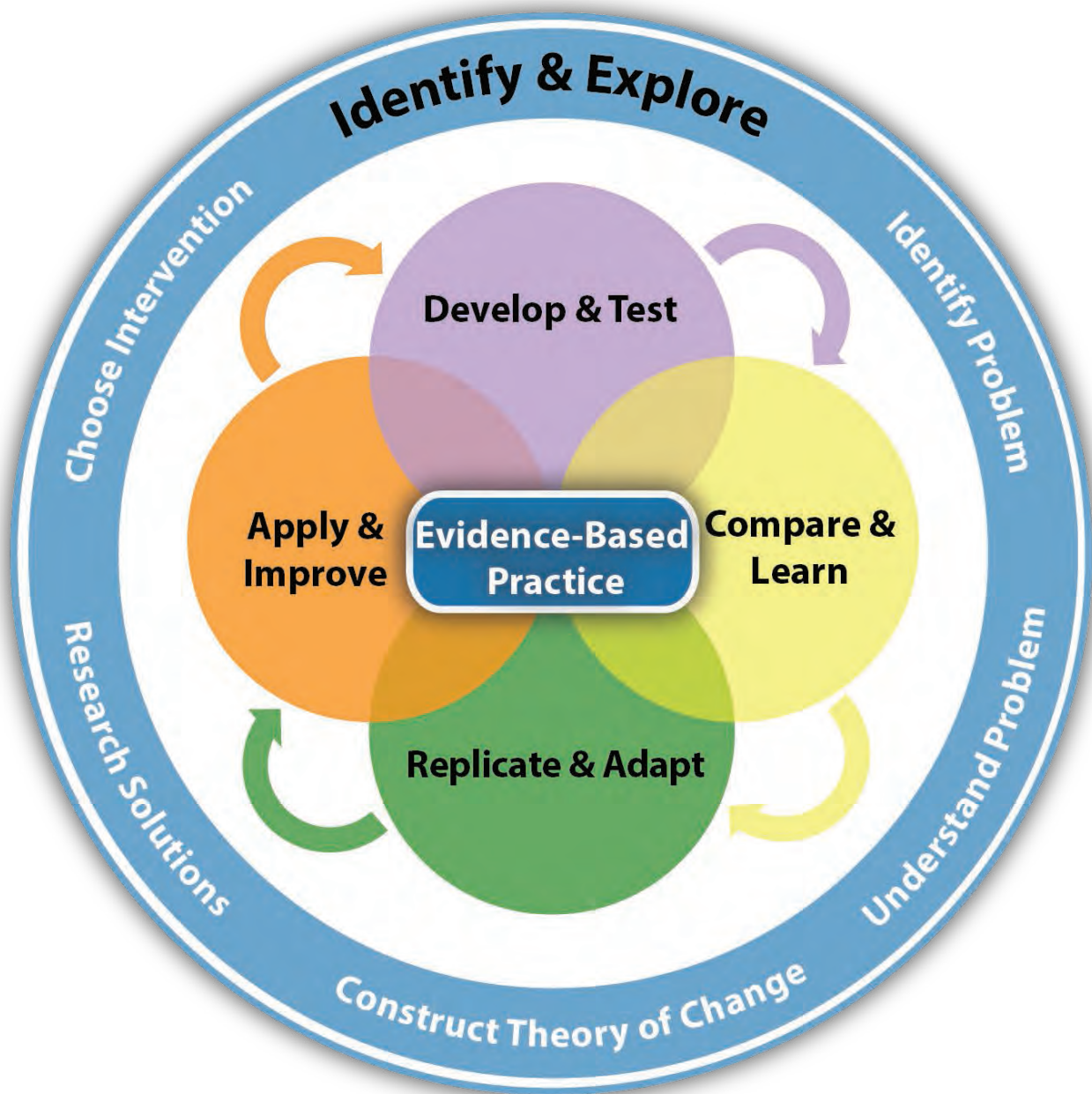
The framework's five phases are intended to guide a user through the process of designing, implementing, and evaluating interventions in a manner that builds empirical evidence about their effectiveness and supports their integration into routine practice. As depicted in the center of the diagram, child welfare systems achieve the best outcomes for children and families when interventions with strong research evidence are combined with practitioner expertise that takes into account specific child and family characteristics, preferences, and culture. This is evidence-based practice.

Because of its flexibility, the framework is applicable to anyone responsible for developing or delivering an intervention in child welfare, whether starting from scratch, implementing an existing evidence-supported intervention, or continuing to perform a longstanding practice that has yet to be formally tested.



¹For purposes of this report, those who perform program evaluation are referred to as *program evaluators*, those who make decisions about the development and implementation of interventions (and their funding) are referred to as *decision-makers*, and those who fund research and evaluation studies are referred to as *funders*.

A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare



Intended Outcomes and Questions Answered During Each Phase

The following chart summarizes the components of each of the five phases, which are described in the rest of this document.

Identify and Explore

Intended Outcome: Selection of an intervention with an existing evidence base, or development of a new intervention based on well-reasoned theory, practice experience, cultural and community knowledge, and relevant research and evaluation that address the identified problem

Sample Questions

- What is the problem?
- What is the prevalence and nature of the problem?
- Who is the target population?
- What is the theory of change that identifies the best strategies for addressing the identified problem and that articulates the linkages between these strategies and desired outcomes?
- Can the problem be addressed through a change in practice? A systems change?
- Is an effective intervention already in place elsewhere that could address the problem here? Does the intervention match the characteristics and needs of the target population? Has it been tested with this population for this problem?
- Do parts of the intervention need to be adapted for cultural differences and/or different child welfare settings?
- What intervention will be the best “fit” for the theory of change, the needs of the target population, and the agency’s capacity for implementation?

Develop and Test

Intended Outcome: A set of specific practices, program components or activities, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention

Sample Questions

- How was the intervention designed to work?
- What are the core components of the intervention? Are they defined well enough to be identified and evaluated?
- What key skills and knowledge are required to deliver the intervention?
- Is the target population participating in and receiving the intervention as intended?
- Is the intervention working as planned?
- What types of barriers were observed during implementation pilots?
- Have the implementation process and intervention been defined well enough for further testing?

Compare and Learn

Intended Outcome: An intervention with evidence that suggests it is more likely than one or more alternatives to improve outcomes

Sample Questions

- Are the observed outcomes attributable to the intervention?
- Are the outcomes better than outcomes resulting from practice as usual?
- For whom was the intervention most and least effective?
- What components of the intervention were most effective?
- How well can the findings be applied to persons and settings that were not the focus of the original intervention and evaluation?

Replicate and Adapt

Intended Outcome: Widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes

Sample Questions

- Will an already existing evidence-supported intervention be applied in a similar or different context, to similar or different groups, in similar or different locations, and/or under similar or different circumstances?
- Has the impact of historical factors on participating populations been considered?
- Under what circumstances is replication or adaptation most likely to achieve desired outcomes?
- If replication: Can the intervention be replicated as it was originally designed? What implementation approaches are most likely to increase this fidelity to the original intervention?
- If adaptation: How much adaptation will it need? In what ways does the new population differ from the one for which the intervention was originally tested? Are the results similar? Different? What factors have the greatest influence on whether the intervention is adapted as planned?
- How do contextual factors and implementation strategies affect efforts to achieve widespread adoption and implementation?

Apply and Improve

Intended Outcome: Improved agency decision-making about the intervention, delivery of the intervention, and performance over time in relation to child and family outcomes

Sample Questions

- How well do agency staff understand the intervention, and do they have the skills for delivering the intervention?
- Which indicators should be continually assessed to monitor performance and support continuous quality improvement?
- How well are evaluation and continuous quality improvement findings about the intervention communicated to agency staff and stakeholders?
- Are the intended results of the intervention sustained over time?
- Are core components of the intervention and the implementation process being maintained as designed?
- Where are desired outcomes being achieved and not being achieved?
- How can performance be improved?
- How do implementation, participation, and outcomes vary across contexts and demographic groups, and what can be learned from such variation?
- What resources are needed to sustain or expand the reach of this intervention?

A FRAMEWORK TO DESIGN, TEST, SPREAD, AND SUSTAIN EFFECTIVE PRACTICE IN CHILD WELFARE

> INTRODUCTION

Research evidence has the potential to influence decisions about policies and practice that can improve outcomes for children and families across the country. Yet the evidence base in many areas of child welfare policy and practice is limited. As of February 2014, only 27 of the 325 programs (8 percent) catalogued in the California Evidence-Based Clearinghouse for Child Welfare (CEBC) met the criterion of “well supported by research,”² and only two of those had been rated as having “high” relevance to child welfare systems.³ When called on for key decisions, child welfare leaders must often make important choices about which policies to implement and which services children and families should receive without solid evidence about what works.

Intervention: Any specific practice, service, policy, strategy, program, practice model, or combination thereof that is clearly defined, operationalized, and distinguishable from one or more alternatives

Evidence-supported interventions (ESIs)⁴ can improve outcomes for children and families. Many child welfare systems, however, miss opportunities to identify, determine, and communicate which interventions work,

for whom they are most effective, and how they can be consistently implemented. In the absence of a more systematic and deliberate approach to designing, testing, spreading, and sustaining ESIs, child welfare workers, managers, administrators, and evaluators are left with inadequate knowledge about what worked in the past and what is likely to work in the future.

In recent years, this lack of evidence in child welfare has inspired a movement to bridge the gap between child welfare practice and research. As part of these efforts, the Children’s Bureau convened two National Child Welfare Evaluation Summits and created three Child Welfare Research and Evaluation Workgroups to explore ways that stakeholders in child welfare can partner to more successfully build evidence, strengthen practice, and inform policy.

One of these workgroups developed *A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, which responds to the need for a relevant, accessible, and practical guide for integrating research and practice in child welfare. This framework describes a process for systematically improving child welfare practice.

Several existing “research-to-practice” frameworks that describe the process of using exploratory research to design new treatments, test them in controlled laboratory settings, and deliver discrete, efficacious therapies and

²An intervention defined this way by the CEBC represents a practice with strong research evidence and at least two rigorous randomized control trials—the highest standard of evidence in the CEBC.

³“Child Welfare System Relevance Level allows [users] to see if the program specifically targets child welfare populations (High), populations similar to those found in child welfare (Medium), or populations not similar to those found in child welfare (Low) whether or not the program has outcomes from comparison studies published in a peer-reviewed journal” (<http://www.cebc4cw.org/>)

⁴Well-defined policies, programs, and services that have shown, through rigorous evaluation, the potential to improve outcomes for children and families.

procedures on a large scale do not easily translate for child welfare interventions. So the workgroup reviewed and modified frameworks from social work and other fields and applied them to child welfare policy and practice (a list of these frameworks can be found in Appendix A).

The resulting *Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare* serves as both an overarching conceptual model and a useful guide for decision-making and action. The framework is designed to encourage stronger partnerships, to promote better integration of evaluation with program and policy decision-making, and to strengthen the knowledge base and support evidence-based practice in child welfare.

The five phases of the framework (visually represented as an outer ring and four inner circles, as shown on page 2) represent the sequential development of an intervention and its implementation over time. The framework describes how a promising theory or practice-based solution can mature into a well-designed ESI that eventually becomes widely accepted as a major contributor to evidence-based practice (EBP). Moving through these developmental phases requires the combined efforts and contributions of numerous parties. Incremental gains in knowledge and evidence are achieved as the intervention is developed, compared, replicated or adapted, scaled up, and continually improved in different places, at different times, and often by different people. The research and evaluation findings generated during this research-

to-practice process contribute to the knowledge base in child welfare about what has worked, and they inform theory-building and problem-solving regarding what is likely to improve outcomes for children and families in the future.

The framework also serves as a practical tool. It helps users to identify at what phase in the developmental process their particular intervention is, and it guides their decisions about next steps. It assists the child welfare administrator who is making plans to pilot a new initiative; for example, a funder considering how best to study and support broad implementation of a proven practice, or an evaluator monitoring performance in an area of service delivery that has not changed in years. The framework helps to identify the tasks and questions that are most germane to the user's objectives while also contributing knowledge to the child welfare field as a whole. At each phase of the framework, it is essential that stakeholders participate in asking questions, making choices, sharing evaluation findings, and taking actions that apply this knowledge to practice in order to improve the safety, permanency, and well-being of children and families.

Stakeholders and Framework Users

This framework is applicable to three groups of stakeholders:⁵

Funders

Much of the discussion in this document focuses on the roles of program evaluators and decision-makers involved in the development and implementation of interventions. The framework may also assist funders of research and evaluation by helping them to consider the following questions:

- What are the funder's priorities?
 - For example, is the funder's principal objective to promote innovation in response to a particular problem? To adapt proven interventions for particular populations or settings?
- Which types of studies does the funder intend to support?
 - For example, does the funder intend to build evidence about promising interventions? To study factors that will facilitate successful implementation?
- In which areas of practice does the funder intend to build knowledge?
 - Are there particular interventions of interest?
 - Will the funder invest in the spread of interventions with a certain level of evidence only?

⁵For purposes of this report, those who perform program evaluation are referred to as *program evaluators*, those who make decisions about the development and implementation of interventions (and their funding) are referred to as *decision-makers*, and those who fund research and evaluation studies are referred to as *funders*.

1. Those who perform program evaluation—program evaluators
2. Those responsible for making decisions about the development and implementation of interventions (as well as funding of those activities)—decision-makers
3. Those who fund research and evaluation studies—funders

In various ways, these three groups of stakeholders are responsible for building evidence in child welfare. The framework acknowledges that their roles and responsibilities often overlap, and it assists them in systematically developing a shared approach to building evidence and scaling up interventions. To help readers understand the perspectives and priorities of these stakeholders who influence the process of applying evaluative research to improved practice, this document also acknowledges tensions within these groups. An in-depth discussion of these tensions can be found in the Critical Considerations section following the discussion of the framework.

Evidence Is Based on Evaluation

Adapted from a definition used by the American Psychological Association, *evidence-based practice* (EBP), when used in this document, refers to “the integration of the best available research evidence with clinical [and child welfare practice] expertise in the context of [child and family] characteristics, culture, and preferences” (Levant & Hasan, 2008). *Evidence-supported interventions* (ESIs) are well-defined practices, programs, services, or policies that have been shown, through rigorous evaluation, to improve outcomes for children and families in comparison to one or more alternatives. When an ESI that

was previously tested in a particular location or under certain conditions is appropriately selected and applied as intended in the “real world” by a practitioner with a specific child, family, or community, it is integrated into evidence-based practice.

> THE FRAMEWORK

A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare offers a sound process for building evidence and for making decisions about how and when to translate and implement interventions as part of everyday practice. It focuses on improving the process of building evidence in child welfare at each step along the continuum, from designing an intervention to embedding it into everyday practice. The framework consists of five interrelated but distinct phases, represented in figure 1 by the blue outer ring and the four overlapping circles inside it:

- Identify and Explore
- Develop and Test
- Compare and Learn
- Replicate and Adapt
- Apply and Improve

In the center of the diagram, arrows indicate that the phases are dynamic, progressive, and cyclical and represent the ideal developmental path to performing

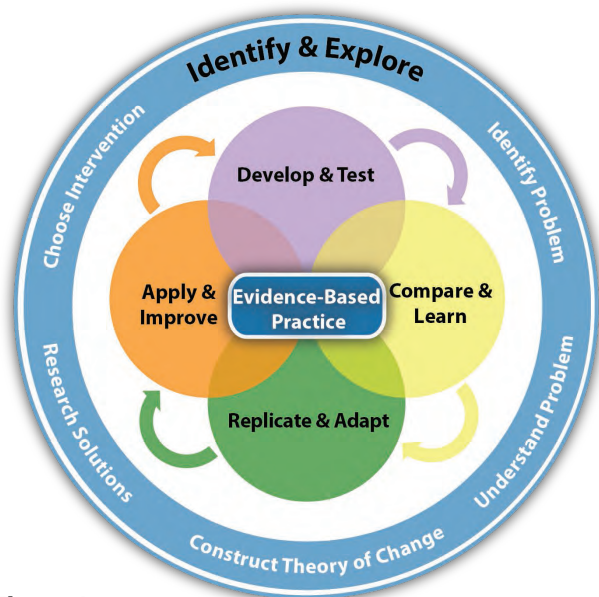


Figure 1.

Evidence-Supported Interventions (ESI):

Specific well-defined policies, programs, and services that have shown the potential, through rigorous evaluation, to improve outcomes for children and families

Evidence Based Practices (EBP) : “[T]he integration of the best available research with clinical [or practitioner or cultural] expertise in the context of [child and family] patient characteristics, culture, and preferences” (Levant & Hasan, 2008).

evidence-based practice in child welfare. Although emphasizing that evaluation is critical for building evidence and supporting decision-making, the framework also acknowledges the important roles that other factors play in these processes.

This framework addresses the development and implementation of not only discrete interventions but also complex, multi-faceted, and wide-ranging interventions, such as those related to policy, legislation, and systems change. The framework involves a series of well-planned phases, but it acknowledges that at times child welfare professionals may have to diverge from the planned process. Ideally, users who forgo a particular phase or step within a phase will make methodological decisions about the next-best alternative for achieving desired outcomes.

Because of its flexibility, the framework is applicable to anyone responsible for developing or delivering an intervention in child welfare, whether starting from scratch,

What this framework is not . . .

- ☒ A Plan, Do, Study, Act cycle (PDSA)
- ☒ An implementation framework
- ☒ A continuous quality improvement (CQI) cycle

implementing an existing ESI, or continuing to perform a longstanding practice that has yet to be formally tested. The framework can also be used to support partnerships and collaboration among program evaluators, decision-makers, and funders. These collaboration opportunities are discussed in each phase.

IDENTIFY AND EXPLORE



The outer ring of the framework in figure 2 represents the Identify and Explore phase. The purpose of this phase is to identify the problem and target population, to develop a theory of change (TOC), and to identify possible solutions to the problem. The intended outcome of this phase is the selection of an intervention with an existing evidence base or development of a new intervention. The intervention is based on well-reasoned theory, practice experience, cultural and community knowledge, and relevant research and evaluation that address the identified problem. The key activities in this phase include: identify

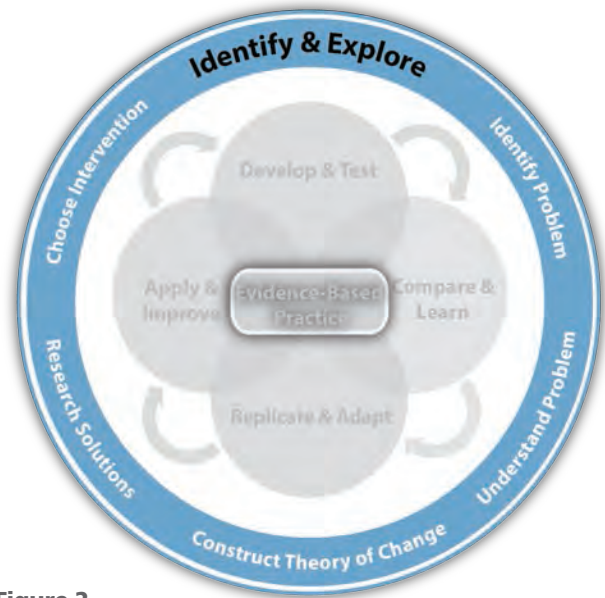


Figure 2.

the problem, understand it, construct a TOC, research solutions, and choose an intervention.

In the Identify and Explore phase, framework users will ask the following questions:

- ✓ What is the problem?
- ✓ What is the prevalence and nature of the problem?
- ✓ Who is the target population?
- ✓ What is the TOC that identifies the best strategies for addressing the identified problem and articulates the linkages between these strategies and desired outcomes?
- ✓ Can the problem be addressed through a change in practice? A systems change?
- ✓ Is an effective intervention already in place elsewhere that could address the problem here? Does the intervention match the characteristics and needs of the target population? Has it been tested with this population for this problem?

Target Population: The population (children, parents, staff, stakeholders, etc.) whose outcomes the intervention is attempting to improve.

- ✓ Do parts of the intervention need to be adapted for cultural differences and/or different child welfare settings?
- ✓ What intervention will be the best “fit” for the TOC, the needs of the target population, and the agency’s capacity for implementation?

These questions help framework users build a sound rationale that explains why a particular intervention has been selected to address a specific problem.

Activities

During the Identify and Explore phase, decision-makers, program evaluators, and funders must work together as early as possible. Evaluators may provide key data analysis techniques and tools to identify and understand the problem and who it is statistically most likely to affect. The following activities are associated with this phase.

Identify the Problem—Problems in child welfare are identified in a variety of ways:

- Through an agency's internal monitoring and review processes
- Through periodic Federal monitoring
- Through other external oversight, investigation, auditing, or review (for example, court oversight, accreditation processes, media scrutiny, etc.)

Regardless of how the problem is identified, studying and understanding it fully before trying to address it is critical.

Understand the Problem—After a problem is identified, it must be studied to better understand the key dynamics of how it “behaves.” Disparity in experiences and outcomes or disproportional representation of children and families should be part of this analysis. Child and family characteristics such as age, race, culture, and other variables must be examined. If differences and disparity between groups exist, further analyses may be necessary to fully understand the prevalence of the problem, the nature of the problem, and whether cultural or contextual factors need to be taken into consideration. Anderson (2005) emphasizes that exploring the problem—and developing a TOC (see the next section)—helps stakeholders to think more strategically about how to solve the problem.

Construct a Theory of Change—The next step in the outer circle is to develop a TOC. A TOC relies on prior research about the problem and describes assumptions about how the desired change will occur. It clearly states how, through a series of logical steps, potential interventions are expected to address the problem and achieve short- and long-term outcomes. During this process, decision-makers, evaluators, funders, and community members must work together to define and reach consensus about the desired outcomes.

Ideally, a TOC that addresses a child welfare problem draws from a diverse base of science and practice wisdom. A good TOC for a policy, program, or practice that addresses a complex problem in child welfare needs to employ a multi-level (practice, community, system) per-

Example: Identify and Understand the Problem—After looking at agency administrative reports, a child welfare administrator is concerned about the large number of families with histories of referrals for neglect. This has resulted in multiple agency investigations with the same families. The agency might begin exploring the problem by studying its referral, investigation, and case data to better understand the neglect allegations, investigation findings, and related service decisions. It might look for similarities in child and family characteristics, behavior, and circumstances; try to identify factors that put families at risk or protect them from risk; or examine the agency’s investigation processes and quality of service delivery. The administrator might even discuss findings with other jurisdictions to consider the potential influence of social and economic conditions.

Sample research questions that may guide this exploration include:

- Which children and families are most likely to be referred for child neglect multiple times?
- Are there racial or cultural differences among families with multiple reports over time?
- What risk and protective factors increase or decrease the likelihood of repeat reports of neglect?
- Are there differences in the agency’s initial investigation and response to families with multiple reports and those without additional referrals?

spective to determine what is required to achieve positive and sustainable effects with a particular intervention. The first part of any TOC will define the area of focus as specifically as possible, describing what the problem is, for whom it is a problem, its prevalence, and major contributing factors.

Research Solutions and Choose an Intervention—To complete the TOC, the next step is to search for and choose an intervention that can be expected to address the problem. The intervention will “fit” the needs and characteristics of the target population and the capacity of the agency.

Questions To Guide the Search for and Choice of an Intervention

- Has the identified intervention been evaluated? How rigorous were previous evaluations of the intervention? Have these evaluations been conducted with child welfare populations?
- Is there evidence that the intervention was effective at achieving the desired outcomes for the specific population for whom a solution is now being sought? How strong is the evidence?
- Has the intervention been replicated with fidelity? Are there practice manuals, fidelity criteria, and assessment systems? Are the developers available to support effective implementation for a cost that fits with the available resources?

There are several ways to identify an appropriate intervention. For example, many child welfare administrators and decision-makers consult their colleagues to learn about interventions. National technical assistance entities often track up-to-date information about interventions being implemented across the country, and they can direct decision-makers to relevant research literature and evaluation reports.

A wealth of knowledge is also available from information clearinghouses and Web sites about interventions and the evidence supporting them (Web sites for several clearinghouses are listed in Appendix A). Starting with existing research reviews of model practices and programs may be a helpful and efficient way to identify

interventions. Clearinghouses often categorize and synthesize available research, and many assess the relevance of the interventions to specific target problems and populations and the degree to which they are evidence-supported.

Clearinghouses are useful but rarely sufficient. They should not be viewed as comprehensive repositories of information. Each differs in its standards for including interventions and the frequency with which it conducts evidence reviews. Many promising interventions or recent studies may not be included in their lists or reflected in their ratings. Framework users can further inform their decision-making by collecting source documents about an intervention, such as published journal articles and evaluation reports, and speaking directly with intervention developers.

Research and Evaluation Considerations

A variety of sources and different approaches to collecting and analyzing relevant information and specific research methods may assist stakeholders in working through the activities of the Identify and Explore phase. They include but are not limited to:

- Descriptive statistics derived from child welfare agencies’ analyses of administrative data, specific program strategy data, and cost data
- Systematic reviews of existing interventions
- Organizational assessments, including assessments of culture, climate, and readiness
- Case reviews—structured reviews of case files and/or case-related interviews
- Surveys, interviews, and focus groups with consumers or other groups

Theoretically, if the intervention is an effective solution to the problem and is implemented as designed, the end result should be improved outcomes as outlined in the TOC. Increasing the chances that the chosen intervention will work requires knowing where to look for relevant interventions; assessing whether an intervention is applicable to the target population in the new context and for the desired outcomes; determining whether research and evaluation evidence supporting the TOC is available; and judging the strength and credibility of the available evidence.

Completing the steps described in Identify and Explore allows framework users to determine which of the four other phases to enter next. Conceptually, each phase serves a distinct purpose in the process of developing and spreading effective practice. But in reality these phases, the evaluation questions inherent in each, and their associated activities often overlap. The phases are progressive and sequential, but the boundaries between them are not rigid or mutually exclusive. For example, decision-makers, program evaluators, and funders may revisit and revise their understanding of the problem or their TOC as they learn from evaluation findings during subsequent phases in the framework.

DEVELOP AND TEST



The highlighted circle in figure 3 represents the Develop and Test phase. When it is necessary to design, develop, or substantially adapt an intervention to address the identified problem or need, Develop and Test is the next appropriate phase. This phase is also applicable to interventions that appear to have successfully achieved their intended outcomes but whose core components have never been fully developed and/or operationalized. The key activities in this phase include: develop and specify core components, test the options for installation and implementation, monitor intervention fidelity, and assess feasibility and short-term outcomes.



Figure 3.

Core Components: The principles, functions, activities, or elements of the intervention that will address the identified problem and are essential to achieving the outcomes desired (Blase & Fixsen, 2013).

The intended outcome of the Develop and Test phase is a set of specific practices, program components, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention. The intervention should include clearly defined practices that have been tested in the field with at least a small number of practitioners. Evidence that practitioners can use the intervention as intended is crucial, as are indicators suggesting that if the intervention is practiced as intended, it will produce the desired outcomes.

The following questions are addressed in the Develop and Test phase:

- ✓ How was the intervention designed to work?
- ✓ What are the core components of the intervention? Are they defined well enough to be identified and evaluated?
- ✓ What key skills and knowledge are required to deliver the intervention?
- ✓ Is the target population participating in and receiving the intervention as intended?
- ✓ Is the intervention working as planned?
- ✓ What types of barriers were observed during implementation pilots?
- ✓ Have the implementation process and intervention been defined well enough for further testing?

These questions help framework users to work through this phase and develop and test a strong program, practice, or intervention that is ready for more rigorous testing in the next phase.

Activities

Developing and testing interventions in child welfare requires the skills of all levels of child welfare staff, stakeholders, and program evaluators. To develop a new

intervention or adapt an already existing intervention, the following common activities should occur.

Develop and Specify Core Components—The core components of the intervention must be developed and specified. This includes outlining how they are aligned with and how they will address key aspects of the chosen problem. Core components are the principles, functions, activities, or elements of the intervention that will address the identified problem and are essential to achieving the outcomes desired (Blase & Fixsen, 2013).

Program experts and practitioners are usually responsible for developing core components, but involving program evaluators is important. After they have a clear understanding of the intervention, evaluators can develop an evaluation plan, assist stakeholders in developing fidelity measures, further clarify short- and long-term outcomes, and select outcome measures and data collection tools. With open communication and partnership, intervention design and evaluation planning can be complementary processes.

Test the Options for Installation and Implementation—Many factors can influence the success of early implementation efforts. It is important to identify, select, test, and improve processes and strategies that are intended to prepare the organization or system

and support implementation. Early tests of communication, outreach, enrollment, training, and data collection strategies, for example, may prove helpful. Determining whether the intervention is working as designed involves collecting and analyzing data associated with intervention delivery, the implementation process, and early intervention outputs.

Fidelity: “[T]he extent to which delivery of an intervention adheres to the protocol or program model originally developed” (DePanfilis, Lutzker, & Girvin, 2005).

Monitor Intervention Fidelity—Fidelity monitoring, or monitoring the degree to which the intervention is delivered as intended, is also essential to the implementation process. The results of fidelity monitoring should be routinely integrated into ongoing coaching and technical assistance. “Small tests” and improvement cycles support learning and can be used to refine key aspects of implementation and intervention delivery before larger tests of the effectiveness of the intervention are conducted.

Assess Feasibility and Short-Term Outcomes—Decision-makers and evaluators must collaborate to determine the intervention’s feasibility (whether the core components

Example: Develop and Test—When developing or adapting an intervention at the practitioner level, it is important to take further steps to refine its core components.

- **Specify how the core components will work in operation.** This includes clarifying each of the activities that make up the component and what they look like in practice. Core components should consist of activities that can be taught to practitioners (Blase & Fixsen, 2013). These activities reflect what practitioners do on a daily basis in delivering the intervention. They should be aligned with the TOC and the philosophical principles underlying the intervention.
- **Outline the practice standards and criteria for meeting fidelity.** This refers to the level of mastery a practitioner must display to indicate that the defined intervention is being performed as intended. Intervention developers must clearly define what constitutes excellent practice, acceptable practice, and subpar practice. Fidelity criteria should be developed in conjunction with program evaluators.
- **Draft intervention or program manual.** This includes describing the activities associated with each intervention component in detail and defining the amount of intervention to deliver. A manual is a well-defined set of procedures for a particular service or intervention (Bond et al., 2000) that is based on the best available evidence and planning. A manual should include a description of intervention administration and operations, including the credentials and training of providers; a description of the organizational structure; and provider-to-consumer ratios or total caseloads required to provide the intervention. It should detail the intake process, the number and length of sessions, and data collection procedures, and include a section on supervision and coaching. It should also clarify the connections between the intervention, data collection, and evaluation.

can be delivered as intended) and whether early tests suggest that it is achieving the desired short-term outcomes. When the new or adapted intervention is stable (that is, it has been sufficiently defined and consistently delivered) and preliminary evaluation findings indicate that it is associated with the desired change, it is ready for a rigorous evaluation.

Research and Evaluation Considerations

Formative evaluation is appropriate during the Develop and Test phase. Formative evaluations are designed to “strengthen or improve the object being evaluated.” They help form the intervention by examining its system of delivery, the quality of its implementation, and its organizational context, including personnel, procedures, and inputs (Trochim, 2006).

A range of research methods is available to framework users in this phase:

- Qualitative interviews—focus groups or key stakeholder interviews about aspects of the program rollout and perspectives on outcomes
- Quasi-experimental designs (see the box below) to compare outcomes between groups that receive different versions of the intervention
- Validity, reliability, and usefulness analyses of fidelity and outcome measures
- Preliminary collection of data related to intervention costs to guide future cost analyses
- Small-scale experimental or quasi-experimental tests of different implementation methods (for example, differences in training and coaching)
- Small-scale randomized trials to test efficacy in controlled environments
- Assessments of the program’s readiness for more rigorous impact evaluation (Trochim, 2006)

When an intervention is stable and evaluation findings show promise for improving practice, it may proceed through as many as three additional interrelated but distinct phases of implementation and evaluation: Compare and Learn, Replicate and Adapt, and Apply and Improve.

COMPARE AND LEARN

The purpose of the Compare and Learn phase (figure 4) is to assess whether an intervention will result in better



Figure 4.

outcomes and to identify for whom the intervention was most and least effective and under what conditions. The following activities are key to this phase: design the evaluation, promote evaluation design integrity, collect data, render a summary judgment of comparative effectiveness, and decide on the intervention’s replicability. The intended outcome is an intervention with credible evidence that it is more likely than one or more alternatives to improve outcomes.

Compare and Learn addresses the following questions:

- ✓ Are the observed outcomes attributable to the intervention?
- ✓ Are the outcomes better than outcomes resulting from practice as usual?
- ✓ For whom was the intervention most and least effective?
- ✓ What components of the intervention were most effective?
- ✓ How well can the findings be applied to persons and settings that were not the focus of the original intervention and evaluation?

These questions help framework users to determine whether the tested intervention improved outcomes for the identified problem.

Randomized Control Trial: A study that estimates the impact of an intervention by randomly assigning participants to receive either the intervention or one or more alternatives, such as practice as usual.

Quasi-experimental design: A study that estimates the impact of an intervention without randomly assigning individuals to either the intervention or comparison group. Instead, study participants self-select into the intervention or are assigned using other methods.

Activities

In the Compare and Learn phase, evaluation is typically led by a professional evaluator who seeks input from and intensively collaborates with stakeholders, including community members, funders, decision-makers, and child welfare staff at many levels of the organization. The following five sets of activities are associated with this phase.

Design the Evaluation—The first step in Compare and Learn is to choose the most rigorous evaluation design for determining whether the intervention results in positive outcomes. The chosen evaluation design must be feasible given the context and culture of the organization and target population being evaluated. Technical decisions about the evaluation design are led by an evaluation professional but with substantial input from decision-makers and program staff. These stakeholders can contribute valuable expertise and knowledge about the intervention, the community, and the service structure and delivery. An important goal of this step is to ensure collaboration by all stakeholders to address common concerns and apprehensions and to design a rigorous evaluation that results in meaningful and useful data for all involved.

Promote Evaluation Design Integrity—After an evaluation design is chosen, it is necessary to obtain the approval of an institutional review board (IRB) and, if necessary, the informed consent of the target population. (More information about IRBs and the protection of intervention participants can be found at <http://www.hhs.gov/ohrp/index.html>.) If the evaluation involves the assignment of participants to intervention and comparison groups, child welfare decision-makers and staff can help identify ways to encourage client participation and to safeguard against dropout and the spread of the intervention to participants who were not assigned to receive it. Assignment to intervention and comparison groups is generally the responsibility of evaluators and can be

a source of tension when building evidence in child welfare. To mitigate this tension, child welfare decision-makers and staff should be involved in designing and facilitating the comparison.

Collect Data—Next, the intended outcomes of the intervention are measured. Data are collected over an appropriate length of time, including data regarding potential unintended consequences, to assess whether client interests are sufficiently served. Existing administrative data can often be used after participants have been assigned to intervention and comparison groups to efficiently track and compare short- and long-term differences in outcomes. Data should also be collected, as defined in a logic model, to measure the extent to which specified core intervention components are delivered as intended, how fully the intervention is implemented, how well anticipated rates of response and participation are meeting projections, and how often participants are crossing over from intervention to comparison groups.

Render a Summary Judgment of Comparative Effectiveness—After analyzing the data, stakeholders decide whether the intervention had a convincing and large enough effect on the intervention group's outcomes compared with the comparison group's outcomes. This step includes using the data gathered to dig deeper and determine whether the intervention was more or less effective for certain groups of people. This step can be extended to analyze whether the intervention was effective in certain circumstances and not others.

Decide on Intervention Replicability—If there is credible evidence that the intervention is effective and was implemented with fidelity, the process proceeds to Replicate and Adapt. If not, steps in either Develop and Test or Compare and Learn should be revisited to make appropriate modifications. Harmful interventions must be discarded. With the help of both rigorous evaluation evidence and direct practice knowledge, decision-makers can better determine in which communities and

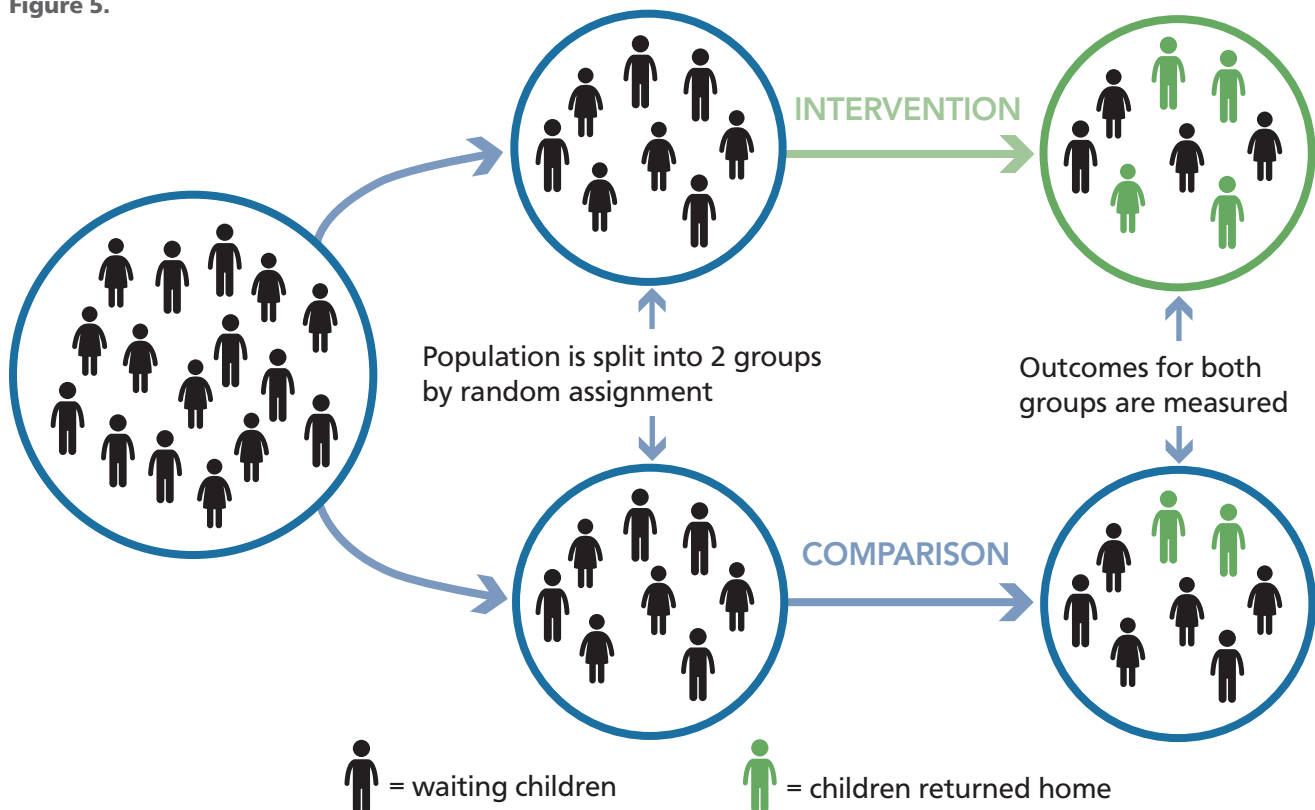
organizations the intervention is most likely to succeed. Collaboration between evaluators, program staff, and decision-makers enhances the lessons learned during the Compare and Learn phase and can foster critical thinking about whether the intervention should be spread more widely in the next phase.

Research and Evaluation Considerations

Randomized controlled trials (RCTs) are considered the most rigorous evaluation design for determining the effectiveness of an intervention. RCTs track outcomes for a group of people who receive an intervention and a comparison group that does not (see figure 5). RCTs are different from quasi-experimental and observational studies because the process of randomly assigning each

participant to either the intervention or comparison group provides greater assurance that the two groups will be as similar as possible at the start of the experiment. Random assignment protects against the possibility that a difference between the two groups (other than who receives the intervention and who does not) could be responsible for a difference in outcomes. Theoretically, randomization can even protect against potential differences in unobservable factors like motivation or resilience. RCTs are the closest alternative to an ideal (but impossible) experiment that would compare the effects of a new intervention on a group to *what would have happened* if the same group had never received that intervention but instead experienced an alternative, such as services as usual.

Figure 5.



The basic design of a randomized controlled trial (RCT), illustrated with a test of a new “family reunification” intervention. From the illustration, we can see that those who received the family reunification intervention were much more likely to return home than those who did not. Because there was a randomly assigned comparison group, we can have greater confidence that it is the intervention that achieves the effect and not some other factor, such as declining poverty rates or changes in juvenile court leadership. Without the comparison group, it would be difficult to know if the improvement in reunification was a result of the intervention or these other factors.

Source: Adapted from Haynes, L., Service O., Goldacre, B. & Torgerson, D. (2012). *Test, learn, adapt: Developing public policy with randomised controlled trials*. London: Cabinet Office, Behavioral Insights Team.

Quasi-experimental and observational studies also can be used during Compare and Learn as alternative evaluation methods if an RCT is not an option. However, these statistical methods must be used in ways that make it reasonable to assume that the intervention and comparison groups are as similar as possible before the intervention is implemented. Using statistical methods to create similar groups is much more challenging than using randomization. But if a credible comparison with statistically equivalent groups is created, the observed differences in outcomes can be attributed to the intervention.

Findings from program evaluation, even from an RCT, are about average causal effects and may not be applicable to particular subgroups of the population or to an individual participant. To learn how well these findings apply to subgroups and across variations in local settings, framework users should follow the steps outlined in the Replicate and Adapt phase.

REPLICATE AND ADAPT



The Replicate and Adapt phase (figure 6) is designed to spread interventions that have been demonstrated to work, to assess their effectiveness in the "real world," and to integrate them into routine child welfare practice. The purpose of this phase is to integrate ESIs with practitioner expertise to improve child and family outcomes, while taking into consideration client and community characteristics, culture, and preferences. This is often done by adapting an ESI for use by professionals in the child welfare system or by adapting an ESI for use with a community whose experiences and culture may differ from the population with whom it was tested during Compare and Learn. The main activities that occur during this phase include: determine the need for intervention modification, modify the intervention for implementation in child welfare and/or a specific population, implement the modified intervention, gather implementation and outcome data, and examine the results. The intended outcome of Replicate and Adapt is widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes.

Replicate and Adapt addresses the following questions:

- ✓ Will an already existing ESI be applied in a similar or different context, to similar or different groups, in similar



Figure 6.

or different locations, and/or under similar or different circumstances?

- ✓ Has the impact of historical factors on participating populations been considered?
- ✓ Under what circumstances is replication or adaptation most likely to achieve desired outcomes?
- ✓ If replication: Can the intervention be replicated as it was originally designed? What implementation approaches are most likely to increase fidelity to the original intervention?
- ✓ If adaptation: How much adaptation will it need? In what ways does the new population differ from the one in which the intervention was originally tested? Are the results similar? Different? What factors have the greatest influence on whether the intervention is adapted as planned?
- ✓ How do contextual factors and implementation strategies affect efforts to achieve widespread adoption and implementation?

These questions help framework users to adapt and test an ESI within different contexts and cultures.

Activities

During the Replicate and Adapt phase, evaluators and decision-makers must work together to examine factors

Decisions about adaptation and further implementation can be very complex. Often stakeholders must negotiate and reconcile differing perspectives about how much adaptation is necessary with communities, providers, and systems.

- When are modifications necessary to increase adoption of the intervention and its implementation?
- When are modifications proposed that will compromise intervention fidelity and effectiveness?

Reaching answers requires engaging intervention developers (if applicable), members of the target population and their communities, and the relevant service systems. Failure to understand the importance of key factors (such as the culture, experiences, and worldview of prospective service recipients; the organizational readiness and capacity of a provider agency; implementation costs; or the relationship between key components of the intervention and its efficacy) and to address them can greatly affect implementation and outcomes in Replicate and Adapt.

that affect adoption and implementation, investigate the fit of the intervention for the organizational context of the implementing agency, and consider how much adaptation is necessary to spread the intervention successfully to new communities while maintaining fidelity to its core components. They also share responsibility for partnering closely with members of the implementing agency and target population to make culturally appropriate changes to the intervention and implementation approach when necessary. The following activities are associated with this phase.

Determine the Need for Intervention Modification—When translating an ESI to different locations, in different contexts, and with diverse groups of people, the questions and activities associated with the Identify and Explore phase should be reviewed to confirm that the problem has been clearly identified and its prevalence and nature are clearly understood. Confirmation that the target population and its needs have been identified and will be addressed by the selected intervention is important. The agency and community must also have the capacity to support implementation of the selected intervention.

For ESIs to be successfully implemented, they must be applicable in “real world” child welfare contexts and acceptable to the children, families, and communities served by child welfare systems. Understanding different communities and contexts and asking evaluation questions about cultural differences (differences in words and concepts related to the intervention, for example) is essential and will be useful when determining whether and how much adaptation needs to be made.

Modify the Intervention for Implementation in Child Welfare and/or for a Specific Population—If core

intervention components are not changed, modifications to items like the delivery approach, language of service provision, or implementation strategies may be appropriate during this phase. Collaboration among community members, child welfare staff, child welfare decision-makers, funders, and program evaluators is critical. Community members and staff are especially important because they can recommend modifications that will make the intervention more accessible to the target population.

Implement Modified Intervention—In addition to making choices about whether and how to modify the intervention, deliberate decisions must be made about implementation as well. Practitioner training prior to service delivery, for example, may need to be adjusted based on organizational or contextual differences between implementing agencies. The Replicate and Adapt phase presents an opportunity to study differences in implementation success and effectiveness as a result of calculated changes to the intervention and implementation strategies.

Adoption: “[T]he intention, initial decision, or action to try or employ an innovation.... Adoption also may be referred to as ‘uptake’” (Proctor et al., 2010).

Gather Implementation and Outcome Data—During this phase, it is important to identify and collect data about the factors that might influence adoption and implementation of the intervention and outcomes. Gathering data about the implementation process and the strategies and approaches used to support implementation, as well as data about adoption, fidelity, cost, and

related variables, can create opportunities for decision-makers and funders to explore which factors increase fidelity to the intervention and under what circumstances the intervention is more likely to spread and be effective. Data about the acceptability and appropriateness of the intervention may inform further decision-making about modifications, and outcome data from children and families must be captured to connect influencing factors to the intended results. Comparison groups can be particularly useful when attempting to discern differences in implementation and outcomes (Proctor et al., 2010).

Examine Results—Results should be examined with the goal of determining under what conditions and with what adaptations the desired outcomes were achieved. Careful review of the implementation and outcome data can indicate, for example, which aspects of the intervention or its delivery were successfully adapted for the new population. Reviewing data also can reveal which strategies and modifications need strengthening to fully apply the intervention in the chosen context. When comparing the modified intervention or implementation approach to practice as usual, data could indicate to what extent the modified intervention affected outcomes in the target population.

Research and Evaluation Considerations

Adaptations are intended to increase the chances that an intervention will work under new conditions. If any of the core components of an intervention have been changed, the updated intervention should pass again through the Develop and Test and the Compare and Learn phases. This will ensure that added or removed components have been clearly defined and that the updated intervention has been tested and refined. Before moving to more rigorous evaluation and before fully implementing the updated intervention with various populations, evidence that the intervention will likely produce the desired outcomes must be generated.

When the updated intervention is stable or has cycled through Develop and Test and Compare and Learn, it can be fully implemented and rigorously evaluated. One of the most rigorous evaluation methods for testing a replicated intervention is a summative evaluation (an examination of the effects of the intervention) with three groups:

1. Original Intervention: This group experiences the original intervention.
2. Adapted Intervention: This group experiences the adapted intervention.
3. Comparison Group: This group receives practice as usual.

RCTs and quasi-experimental designs also may be appropriate, depending on available resources and the organizational context within which the evaluation takes place. Which type of evaluation to conduct is an important decision for all involved stakeholders to make together.

During Replicate and Adapt, the central issue is whether and how an intervention can be delivered to different populations and in different settings with the same positive outcomes. Program evaluators have an important role in spreading ESIs for use in different systems, communities, and cultures.

It is important to remember that not all adaptations will require additional rigorous testing such as an RCT. Some might undergo assessment and pilot studies so the evaluation team can determine whether the adaptation is successful. If the selected intervention can be replicated with a different population or in a new environment with no changes to the core components of the intervention, evaluation activities may focus on the influence of various factors and strategies on effective and efficient implementation. Modifications that alter the core components of the intervention require it to cycle through the Develop and Test phase.

After an ESI has been successfully spread and integrated into a service system, it becomes part of routine evidence-based practice and the focus of Apply and Improve.

APPLY AND IMPROVE

The Apply and Improve phase (figure 7) is the final phase of the framework. The intended outcomes of this phase are improved agency decision-making, agency performance, and child and family outcomes. Rather than attempting to develop new interventions or prove their effectiveness, Apply and Improve is most concerned with continually improving the delivery of interventions that are already part of routine practice and applying



Figure 7.

evaluation findings to improve results. The key activities associated with this phase include: identify which aspects of the system to monitor and track, ensure access to data, review data for barriers and facilitators to service delivery, share the results, and plan for the future.

This phase provides opportunities to investigate barriers to implementation and systematically build knowledge about effective practice strategies (Schorr & Farrow, 2011). Apply and Improve offers opportunities to explore areas such as cost offset and cost-effectiveness, unmet needs, and consumer preferences and satisfaction. Stakeholders can use what they learn about variations in intervention service delivery and outcomes to strengthen practice, build consistency, or further understand the intervention. Questions answered during this phase include:

- ✓ How well do agency staff understand the intervention and do they have the skills for delivering the intervention?
- ✓ Which indicators should be continually assessed to monitor performance and support continuous quality improvement?
- ✓ How well are evaluation and continuous quality improvement findings about the intervention communicated to agency staff and stakeholders?
- ✓ Are the intended results of the intervention sustained over time?

- ✓ Are core components of the intervention and the implementation process being maintained as designed?
- ✓ Where are desired outcomes being achieved and not being achieved?
- ✓ How can performance be improved?
- ✓ How do implementation, participation, and outcomes vary across contexts and demographic groups, and what can be learned from such variation?
- ✓ What resources are needed to sustain or expand the reach of this intervention?

Questions answered during this phase help framework users continue to strengthen practice and build knowledge and understanding about interventions that work in child welfare.

Cost Offset: Refers to the reduction in [child welfare] costs resulting from the [intervention] (Von Korff, 1998)

Cost Effectiveness: Refers to the average [child welfare] costs divided by the measure of [intervention] effectiveness (Von Korff, 1998)

Activities

Activities in the Apply and Improve phase are typically performed by evaluation or quality improvement staff internal to the child welfare agency but may involve data sharing with external evaluation partners. The steps associated with this phase involve strengthening implementation of the intervention by using continuous quality improvement strategies.

Identify Which Aspects of the System to Monitor and Track—Typically, decision-makers collaborate with program evaluators to identify which aspects of the system to monitor. For example, tracking and analysis might focus on training practices and skills, fidelity, outcome monitoring, and any other quality assurance data that enable the intervention to operate in the system as intended.

Ensure Access to Data—Access to qualitative and quantitative data is crucial when monitoring expected outcomes and performing quality assurance. Data from case

The time it takes to see results can vary:

For example, a child welfare agency might expect changes to its outreach and recruitment practices to immediately increase rates of enrollment in foster parent training courses. However, changes designed to improve placement stability among children with the longest stays in foster care could take years to detect.

reviews, surveys, interviews, and other sources should complement data from an agency's information systems.

Review Data for Barriers and Facilitators of Service Delivery—These data will be used to explore the relationship between the results of ongoing performance monitoring and intervention outcomes. For example, analyses may help to target improvement efforts based on data about the rate of eligible families that receive the intervention, the dosage they receive, early and late adoption of the intervention, and differences across geographic regions and groups of service recipients. Child welfare decision-makers and program staff will use the data to engage in problem solving and action planning to strengthen performance and system improvement. Program evaluation findings may also identify strategies that can be eliminated without diminishing results.

Share Results—Analyses need to be presented to decision-makers and program staff in a simple, jargon-free, visual, and usable fashion (e.g., using graphs, pictures, stories). Results should make connections and synthesize information, spark diagnostic discussions, and facilitate dialogue about needs for modification.

Plan for the Future—Evidence obtained during Apply and Improve can increase understanding of the intervention and help decision-makers and their staff make decisions about sustainability, expansion, adaptation, or discontinuation of the intervention in the future. These decisions often rely on information about costs, underserved populations, systemic barriers, pockets of excellence, and projected resource needs. When the intervention fails to achieve the expected results for a particular group or under certain conditions, this may suggest the need for a different or substantially modified intervention, which requires moving to the Identify and Explore or Develop and Test phase of this framework.

Research and Evaluation Considerations

Apply and Improve is best conducted using a philosophy and approach that engages practitioners, agency management, and other stakeholders as equal partners in the design, implementation, interpretation, and especially the use of the findings from the intervention evaluation. The logic model, TOC, implementation strategies, and expected outcomes must be shared throughout the agency so that everyone understands why the intervention is in place. The relationship between strategies and outcomes may be tested to understand how the intervention works and to identify and address system-specific impediments to achieving results.

Decision-makers in child welfare systems must understand the skills and capacities that their agencies need to conduct program evaluation, rather than relying solely on external evaluators. Evaluation and continuous quality improvement teams require a combination of knowledge and skills that include program expertise; knowledge of research and evaluation methods, instrument design, data collection, and quantitative and qualitative analysis; and interpretation and communication abilities. In addition, staff implementing the intervention provide information to child welfare decision-makers and practitioners to strengthen their knowledge and deepen the focus on results (Wilson, Lavis, Travers, & Rourke, 2010).

As conceptualized in this framework, evaluation that takes place as part of the Apply and Improve phase can play a key role in the continuous quality improvement process. The goal is to strengthen the agency's capacity to improve practice, processes, delivery systems, and outcomes, with evaluators serving as scientific advisors and catalysts for strengthening the learning organization (Wandersman, Chien, & Katz, 2012). This is a nontraditional and emerging role for evaluators in the process of building evidence in child welfare. In this role, evaluators:

- Are often immersed in the organization and establish strong relationships with staff at all levels
- Serve as teachers and coaches to develop the conceptual capacity and skills of agency staff for formative, summative, and translational ways of thinking that contribute to the development of a results-oriented culture (Hodges & Wotring, 2012; Moore, 2010)

- Are influenced by the needs and ideas of the agency and guided by the current issues and outcomes that the agency desires
- Produce reports that may take many forms and are designed to stimulate assessment within the agency and thoughtful action planning to improve the intervention and the agency's results

> CRITICAL CONSIDERATIONS

A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare is built on underlying principles of evaluation; acknowledges tensions between stakeholder groups; and recognizes the importance of social, cultural, and contextual diversity as key to any decision-making process. These critical elements should be considered when using the framework.

Underlying Principles

The framework is built on the principles described in the table below. These assume that building and scaling ESIs in the child welfare system are most effective when the purpose is to increase positive outcomes for children and families and when social, cultural, and contextual sensitivities are a key part of the decision-making process.

These critical principles focus on the importance of building evidence, and they assert that evaluation in child welfare should empower agencies, systems, and communities to strengthen families and prevent and mitigate the effects of child maltreatment. Developing,

adapting, and evaluating interventions in “real world” contexts and cultures is essential. Using the framework while embracing these principles creates a basis for evaluation that builds evidence and replicates successful practices and programs.

Acknowledging Tensions

As in other fields like mental health, criminal justice, and substance abuse treatment, tensions between stakeholder groups have at times stymied evidence-building in child welfare. Often decision-makers, program evaluators, and other stakeholders have different educational backgrounds, experiences, jobs, and types of expertise. Despite sharing the common goal of improving the lives of children and families, they may have competing priorities and different perspectives.

Efforts to solve complex problems in a high-stakes environment can bring these tensions among priorities to the forefront. For example, designing, testing, spreading, and sustaining effective practice in child welfare takes time. For some, the time necessary to carefully develop and test an intervention can feel at odds with an urgent and/or emergent need to spread an intervention so that it reaches more children and families. Similarly, strong assertions that an intervention needs to be substantially adapted for a particular community may seemingly conflict with calls for strict adherence to intervention protocols that have been effective in other contexts.

Because stakeholders also may hold different views about how best to design, test, spread, and sustain effective

Underlying Principles for Evaluation

The ultimate purpose of program evaluation in child welfare is to determine the effectiveness of programs for improving outcomes for children and families.

Evaluation in child welfare should empower agencies, systems, and communities to effectively prevent and mitigate the effects of child maltreatment, to protect children, and to strengthen families.

Although program evaluators must satisfy funders that support their work, they must also remain sensitive to the interests of other stakeholders, including the subjects of their studies.

It is possible to build evidence in a rigorous manner while still being responsive to the complexities and needs of those addressing child abuse and neglect in different cultures and different contexts.

Disseminating research findings and communicating the results of research are critical to building evidence in child welfare and are the responsibility of all involved stakeholders.

In each phase of the framework, dialogue and communication among stakeholders about the meaning, implication, and use of evaluation results are essential in making sound decisions.

practice, tensions can sometimes threaten efforts to build evidence. Perhaps the most familiar is the tension about whether and when to conduct RCTs in child welfare. RCTs are helpful for evaluating core intervention components, determining causality, and determining the impact of the intervention with different audiences. At the same time, RCTs can be disruptive and time-consuming, and they may be perceived as “withholding treatment” from the children and/or families in the control group.

To accomplish the goals of the framework, the viewpoints of all stakeholders must be respected and taken into consideration. The framework encourages stakeholders to examine the consequences of and alternatives to:

- Implementing interventions that have limited evidence to support their effectiveness
- Implementing interventions that have limited support to indicate a good fit with the agency and/or with the target population
- Widely implementing ESIs that have been tested only under strictly controlled conditions or in unrelated service systems or settings
- Hastily adopting and spreading untested child welfare practices in response to politics, poor agency performance, or public pressure
- Missing opportunities to build the knowledge base about whether interventions work, why they work, how well they have been implemented, and for whom they are most and least effective

Despite the tensions, stakeholders share the motivation to improve outcomes for children and families. This framework is designed to build on this motivation to encourage power sharing; increased trust; and mutual respect, accountability, and transparency.

Cultural Considerations

Culture and context are essential considerations during all phases of the framework. For the most part, ESIs have been classified as such by individuals and institutions that share a specific paradigm and worldview about science and what constitutes credible evidence. If the prevailing definition of effectiveness is based on only one cultural view of evidence, then decision-makers in child welfare face a dilemma when replicating and adapting interventions for communities with different cultural perspectives and social constructs that affect their understanding of what is effective.

Evaluation should be grounded in culture and context, and it must be informed by the community’s cultural values and its views about the purpose of research and evaluation. This may include unique perspectives on what it means to “know,” how to establish research outcomes and data collection methods based on different ways of “knowing” and “understanding,” and what the appropriate role of culture is in evaluation research.

Culturally competent evaluation involves a cross-cultural exchange and the evaluation of an individual, family, agency program, or organization in a manner that respectfully accounts for ethnic culture and social environment. The evaluation process, including data collection and interpretation, explanation of results, and reporting and distribution of findings, requires a cultural lens. Those involved in the evaluation process, such as administrators, clients, and practitioners, must understand that the same results may be viewed in different ways according to culture. Evaluation results that are framed in culturally appropriate ways may be more likely to be shared and used in the communities that were studied (Cheung and Leung, 2008).

In October 2012, the Children’s Bureau convened a group of experts to discuss evaluation in Tribal communities. This group, largely comprising members of Tribal communities, addressed ways in which oral tradition is sometimes discounted because in the dominant culture the written word is seen as “true” or “more true” than spoken ideas or stories. But oral tradition has historically been the primary mode of transmission of culture and values in many indigenous communities. It has been central to preserving ceremonies, cultural protocols, language, and other elements of Native culture. Words—both spoken and written—are seen as sacred. Understanding the importance and value of oral tradition is critical to both gathering and disseminating information in Tribal communities.

Community-Based Participatory Research

Community-Based Participatory Research (CBPR) provides another approach that is useful for evaluating an intervention. CBPR is an applied collaborative approach that empowers community residents to participate more actively in the full spectrum of research (from conception to design, data collection, analysis, interpretation, formulation of conclusions, and communication of results (National Institutes of Health, Office of Behavioral and Social Sciences Research, n.d.). An important goal of this framework is to integrate ESIs with practitioner expertise to improve child and family outcomes, while taking into consideration client and community characteristics, culture, and preferences. CBPR may offer one helpful way to achieve that goal.

> CONCLUSION

Too often, interventions in child welfare are piloted with limited evaluation, and untested interventions are hastily adopted and spread in response to politics, poor agency performance, or public pressure. Changes in service delivery have the potential to improve outcomes for children and families, but child welfare agencies and systems often miss opportunities to build the knowledge base and to answer questions about whether these new practices work, for whom they are most and least effective, and how consistently they are implemented. In some cases outcomes improve, and in others they do not, but in the

absence of a systematic and deliberate approach to building, sharing, and using knowledge, those responsible for making decisions and for performing evaluations can be left without answers. These missed opportunities leave decision-makers, program evaluators, funders, and their many partners in the field of child welfare without the necessary information to understand and explain why the outcomes changed (or did not change) and whether the new practice made a difference. *A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare* will help to address these challenges.

Framework Application

To support the application of this framework, the following tools are provided in the appendices:

- **Determination of Phase and Next Steps**—This tool is intended to assist users of the framework with locating the current phase of their intervention and the phase they can expect to focus on next.
- **Framework Task Checklist**—This tool is intended to assist users of the framework with keeping track of and completing the tasks associated with the phases of the framework.

Brief video shorts explaining the framework will be available on the Children's Bureau Web site at <http://www.childwelfare.gov> in 2014.

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> APPENDIX A: REFERENCE FRAMEWORKS AND CLEARINGHOUSE WEB SITES

REFERENCE FRAMEWORKS

Results-Oriented Accountability (ROA) Stages

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Testa, M. F., & White, K. R. (2014). Insuring the integrity and validity of social work interventions: The case of the subsidized guardianship waiver experiments. *Journal of Evidence-Based Social Work*, 11(1-2), 157–172.

Evidence-Based Public Health (EBPH) Framework

Brownson, R.C.; Baker, E.A.; Leet, T.L.; & Gillespie, K.N. (2003). *Evidence-based public health*. Oxford University Press.

Cycle of Evidence-Based Child Welfare (EBCW)

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Intervention Research Steps

Fraser, M.W., Richman, J.M., Galinsky, M.J., & Day, S.H. (2009). *Intervention research: Developing social programs*. Oxford University Press.

Expanded Intervention Research Steps

DePanfilis, D. (2012). *Back to the future: Conducting intervention research to increase child safety*. [Handout]. Workshop conducted at the 18th National Conference on Child Abuse & Neglect, Washington, DC. Retrieved from <http://archive.hshsl.umaryland.edu/handle/10713/1718>.

EBP Steps

McCracken, S.G., & Marsh, J.C. (2008). Practitioner expertise in evidence-based practice decisionmaking. *Research on Social Work Practice*, 18(4), 301–310.

Implementation Stages

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

CLEARINGHOUSE WEB SITES

Blueprints for Healthy Youth Development: <http://www.blueprintsprograms.com/>

California Evidence Based Clearinghouse (CEBC): <http://www.cebc4cw.org/>

Campbell Collaboration Web site for extensive information about systematic reviews of research on specific interventions: <http://www.campbellcollaboration.org>

Evidence-Based Program Directory at the National Resource Center for Community-Based Child Abuse Prevention: <http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory>

FindYouthInfo Program Directory: <http://findyouthinfo.gov/program-directory>

National Resource Center for Permanency and Family Connections, Evidence-Based Practices in Child Welfare micro-site: <http://www.nrcpfc.org/ebp/index.html>












Office of Juvenile Justice and Delinquency Programs Model Practice Guide: <http://www.ojjdp.gov/mpg/>

Promising Practices Network: <http://www.promising-practices.net/programs.asp>

Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (NREPP): <http://www.nrepp.samhsa.gov/>

> APPENDIX B: DETERMINATION OF PHASE AND NEXT STEPS

This table is intended to assist users of the framework with locating the current phase of their intervention and the phase on which they can expect to focus next.

Phase Determination Question	If the answer is yes, the current or completed phase is...	Next Phase
Is the agency working to understand the prevalence and nature of a current child welfare-related problem? Or is the agency unsure of how to address a well-understood problem?	Identify and Explore 	Identify and Explore 
Is the agency trying to find an intervention with an existing evidence base that addresses the problem and that is a good “fit” with the theory of change, the needs of the target population, and the capacity of the agency? If such an intervention does not exist, does the agency plan to develop an intervention to address the problem?	Identify and Explore 	Develop and Test 
Is the agency currently delivering a longstanding program or service that seems to be working? Is the agency unsure of exactly how it works and what the core components are?	Apply and Improve 	Develop and Test 
Has the agency recently piloted a well-defined intervention that shows early signs of success? Would the agency like to compare this new intervention to practice as usual to see which one achieves better outcomes?	Develop and Test 	Compare and Learn 
Has an intervention been implemented in the past to address a problem? Was the intervention evaluated and found to be more effective than an alternative? Would the agency like to adapt this intervention to serve another population or roll out the intervention statewide?	Compare and Learn 	Replicate and Adapt 
Has the agency replicated an effective intervention and adapted it for additional populations and application in new contexts? Does that intervention continue to achieve the desired outcomes? Would the agency like to sustain the intervention and improve its delivery and performance over time in relation to child and family outcomes?	Replicate and Adapt 	Apply and Improve 

> APPENDIX C: FRAMEWORK TASK CHECKLIST

This checklist is intended to assist users of the framework with keeping track of and completing the tasks associated with the phases of the framework.

Identify and Explore

- ☐ Use agency data to identify potential issues to address
- ☐ Study the problem to understand its nature and prevalence
- ☐ Construct a theory of change using data, research, and practice wisdom
- ☐ Research solutions to address the problem—this could be an already existing intervention, the modification of an existing intervention, or the development of a new intervention
- ☐ Choose an intervention with the best “fit” for the theory of change, the needs of the target population, and the capacity of the agency to support the implementation

Develop and Test

- ☐ Develop and specify a set of core components that outline the principles, activities, and guidelines of the intervention
- ☐ Test the options for installation and implementation
- ☐ Monitor intervention fidelity to ensure it is being delivered as intended
- ☐ Assess feasibility of delivering core components with fidelity and whether short-term outcomes are being achieved

Compare and Learn

- ☐ Design a rigorous evaluation to compare the new intervention to practice as usual
- ☐ Promote evaluation design integrity
- ☐ Set up a data system to collect intervention, outcome, and fidelity data
- ☐ Compare outcomes of the new intervention with practice as usual and determine which results in better outcomes for clients
- ☐ Decide whether the intervention should be replicated with a broader population

Replicate and Adapt

- ☐ Assess whether modifications to the intervention need to be made
- ☐ Modify the intervention implementation in a child welfare population and/or other specific populations
- ☐ Implement modified intervention or implementation approach
- ☐ Gather implementation and outcome data from modified intervention
- ☐ Determine under what conditions and with what adaptations desired outcomes were achieved

Apply and Improve

- ☐ Identify data aspects of the intervention to track (training, performance, outcomes, communication strategies, etc.)
- ☐ Ensure access to data
- ☐ Review data to identify barriers to and facilitators of service delivery
- ☐ Share results in a straightforward manner to facilitate dialogue
- ☐ Use data to plan for use of intervention in the future

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EXHIBIT D

DCFS Child Welfare Advisory Committee

CWAC Sub-Committee Organization

George Sheldon
Director

Trish Fox
CWAC Chair

Zack Schrantz
CWAC Chair

Well-Being/ Outcomes

Margaret Vimont
Larry Small - DCFS

Oversight and analysis of data needs and system performance outcomes for indicators of youth well-being across levels of care/ treatment to include but not limited to: specific developmentally sensitive indicators for 0-3 early childhood pre-school/school readiness, elementary age, middle school age, high-school age and young adult/youths in transition; Indicators for outcomes for these developmental/age groups should follow the ACYF* well-being framework for outcome domains.

System of Care

Arlene Happach
Kristine Herman - DCFS

Monitors performance and makes recommendations regarding pilot programs and new methods of service delivery. Identifies and addresses inter-agency service delivery gaps and duplications in order to ensure the best care for children, youth and families in child welfare. Oversees Medicaid Workgroup.

Finance & Administration

Melissa Riddle
Matt Grady - DCFS

Provides input, oversight, and monitoring that supports overall improvements in efficiency and accountability across broad functional areas:

- DCFS budget review and recommendations
- Reasonable rates and reimbursement
- IT/SACWIS* planning and priorities
- Workforce development and training
- Diversity and inclusion (including Transformation Teams)

Front-End/Intact

Kathy Grzelak
Nora Harms-Pavelski - DCFS

Monitors, reports on and makes recommendations related to front-end/intact service delivery needs, initiatives and performance outcomes. Works closely with DCP Leadership to identify Front-End system improvement opportunities.

Foster Care

Hope Carbonaro
Deborah Kennedy -DCFS

Monitors, reports on and makes recommendations related to foster care service delivery needs, initiatives, outcomes, rule, monitoring, and contracts. Makes recommendations related to Foster Parent recruitment, licensing, development and retention. Bridges with Residential and Front-End as needed to strengthen transition process and client outcomes.

Residential/ Transitional & Independent Living

Ann Percy
Michael C. Jones - DCFS

Monitors, reports on and makes recommendations related to service delivery needs, initiatives and performance outcomes in residential treatment, transitional and independent living programs/opportunities. Reviews service needs/outcomes related to psychiatric hospitalization utilization. Considers implications related to possible development of PRTF* and locked facilities. Bridges with Foster-Care to strengthen transition process and client outcomes. Identifies and makes recommendations for 18+ population service delivery reform and federal reimbursement opportunities.

- Workforce Development
- Ad Hoc
- Bev Jones
- Pete Digre

* ACYF – Administration of Children, Youth & Families – US Department of Health & Human Services
 * IT/SACWIS – Information Technology/Statewide Automated Child Welfare Information System
 * PRTF – Psychiatric Residential Treatment Facilities

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13	Margaret Vimont	Jewish Child and Family Services	margaretvimont@jcfcs.org	312-819-1950	Well-Being Outcomes	2019
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17	Rick Velasquez	Youth Outreach Services, Inc	rickv@yos.org	708-747-7100		2017
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20	Tricia Fox	The Center for Youth and Family Solutions	tfox@cyfsolutions.org	773-846-4600 x-2224		2017
21	Zack Schrantz	Uhhich Children's Advantage Network (UCAN)	zack.schrantz@ucan.org	309 657-3076		2018
22	Open			773-588-0180		2018
23	Open					
24	Open					
Appointed Advisors - Non-Providers						
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27	Elizabeth Richmond	IL Adoption Advisory Council	erichmond21@yahoo.com	309-697-9720		2017
28	Fred Long	Former Youth in Care		773-419-0015		2019
29	Layla Suleman-Gonzalez	Illinois Latino Family Commission	layla.suleman@illinois.gov	312-758-9352		2019
30	Roxy Kozyckij	IL Assoc. Rehabilitation Facilities	rkozyckij@iars.org	217-753-1190 x109		2017
31	Michael Holmes	African American Family Commission	mholmes@aafc.org	312-326-0368		2018
32	Yvonne Zehr	Cook County Public Guardian Office	yvonne.zehr@cookcountyil.gov	312-433-5174		2018

Name	Agency	Email Address	Contact Number	Sub-Committee Co-Chairs	Tenure Class
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Updated February 23, 2016

EXHIBIT E

Final Notice of Statewide Data Indicators and National Standards for Child and Family Services Reviews **Executive Summary**—AMENDED May 13, 2015

On October 10, 2014, and May 13, 2015, the Administration for Children and Families (ACF) published public notices in the Federal Register of statewide data indicators and national standards that the Children's Bureau will use to determine substantial conformity with titles IV-B and IV-E of the Social Security Act through the Child and Family Services Reviews (CFSRs).

Background

The Children's Bureau (CB) implemented the CFSRs in 2001 in response to a mandate in the Social Security Amendments of 1994. The legislation required the U.S. Department of Health and Human Services to issue regulations for the review of state child and family services programs under titles IV-B and IV-E of the Social Security Act (see § 1123A of the Social Security Act). CB uses the required reviews to determine whether such programs are in substantial conformity with title IV-B and IV-E plan requirements. The review process, as regulated at 45 CFR § 1355.31-37, grew out of extensive consultation with interested groups, individuals, and experts in the field of child welfare and related areas.

The CFSRs enable the CB to: (1) ensure conformity with federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist states in enhancing their capacity to help children and families achieve positive outcomes. We conduct the reviews in partnership with state child welfare agency staff and other partners and stakeholders involved in the provision of child welfare services. We have structured the reviews to help states identify strengths as well as areas needing improvement within their agencies and programs.

The CB uses the CFSRs to assess state performance on seven outcomes and seven systemic factors. The seven outcomes focus on key items measuring safety, permanency, and well-being. The seven systemic factors focus on key state plan requirements of titles IV-B and IV-E that provide a foundation for child outcomes.¹ If we determine that a state has not achieved substantial conformity in one or more of the areas assessed in the review, the state must develop and implement a program improvement plan within two years addressing the areas of nonconformity. The CB supports the states with technical assistance and monitors implementation of their program improvement plans. We withhold a portion of the state's federal title IV-B and IV-E funds if the state is unable to complete its program improvement plan successfully.

The CB uses national standards for state performance on statewide data indicators to determine whether a state is in substantial conformity with two outcomes. Statewide

¹ See the Quick Reference Items List at http://kt.cfsportal.org/action.php?kt_path_info=ktcore.actions.document.view&fDocumentId=73093 for a brief summary of the items subject to review in the CFSR.

data indicators are aggregate measures, and we calculate them using administrative data available from a state's submissions to the Adoption and Foster Care Analysis and Reporting System (AFCARS),² the National Child Abuse and Neglect Data System (NCANDS),³ or a CB-approved alternate source for safety-related data. If we determine that a state is not in substantial conformity with a related outcome due to its performance on an indicator, the state must include that indicator in its program improvement plan. The improvement a state must achieve is relative to the state's baseline performance at the beginning of the program improvement plan period.

In the April 23, 2014, Federal Register notice (79 FR 22604), the CB proposed statewide data indicators and an approach to national standards for the third round of CFSRs that differed from that used for the second round of reviews. In that notice we provided a detailed review of the consultation with the field and information considered in developing the third round of the CFSRs. We reviewed research literature, consulted with an expert panel, considered the availability and quality of data available, and conducted statistical testing to examine relationships between available data and outcomes. During the 30-day public comment period following the notice, we received 52 unique responses from state and local child welfare agencies, national and local advocacy and human services organizations, researchers, and other interested persons. CB reviewed and considered all public comments and questions before making final decisions regarding the statewide data indicators and the methodology.

We considered all public comments and issued a final notice in the October 10, 2014, Federal Register (79 FR 61241). That public notice includes a summary of our response. The public comments and questions that were submitted are available in their original form (<http://www.regulations.gov>). CB made some corrections to the October notice and published a new notice in the Federal Register on May 13, 2015. The May 2015 notice is published at <https://federalregister.gov/a/2015-11515>.

Summary of Final Statewide Data Indicators and Methods

Most commenters expressed strong support for the proposed statewide data indicators and national standards. We changed two indicators in response to the public comments. We will measure the recurrence of maltreatment instead of repeat reports of maltreatment, as we proposed in the April 2014 Federal Register notice. We will also add a new indicator to measure permanency in 12 months for children who have been in foster care for 12 months to 23 months.

Therefore, our final plan is to use two statewide data indicators to measure maltreatment in foster care and recurrence of maltreatment in evaluating Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect. We will use statewide data indicators to measure achievement of permanency in 12 months for children entering foster care, permanency in 12 months for children in foster care for 12 months to 23 months, permanency in 12 months for children in foster care for 24 months or more, re-

² AFCARS collects case-level information from state and Tribal title IV-E agencies on all children in foster care and those who have been adopted with title IV-E agency involvement. Title IV-E agencies must submit AFCARS data to the Children's Bureau twice a year.

³ NCANDS collects child-level information on every child who receives a response from a child protective services agency due to an allegation of abuse or neglect. States report these data to the Children's Bureau voluntarily. In FFY 2013, all 50 states, the District of Columbia, and Puerto Rico submitted NCANDS data.

entry to foster care in 12 months, and placement stability. We will use these five permanency indicators in evaluating Permanency Outcome 1: Children have permanency and stability in their living situations.

A description of each of the seven statewide data indicators, how we will calculate them, our rationale for each indicator, inclusions, and exclusions is provided in the final public notice and notice of corrections. These Federal Register notices include our approach to measuring a state's program improvement on the indicators should the state not meet a national standard. We provide information on how we will share data and information related to state performance as well as data quality issues that may affect the indicators and methods.

On May 13, 2015, CB issued CFSR Technical Bulletin #8A, which provides additional technical information and discussion relevant to the statewide data indicators, national standards, and states' performance on them. Technical bulletin #8A is available on the CB's website at <http://www.acf.hhs.gov/programs/cb/laws-policies/technical-bulletins/cw-monitoring>.

The seven statewide data indicators are described briefly below.

Statewide Data Indicators for CFSR Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

Maltreatment in foster care

This indicator is described as: Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?

Numerator: Of children in the denominator, the total number of substantiated or indicated reports of maltreatment (by any perpetrator) during a foster care episode within the 12-month period (NCANDS, AFCARS)

Denominator: Of children in foster care during a 12-month period, the total number of days these children were in foster care as of the end of the 12-month period (AFCARS)

We include this indicator to measure whether the state child welfare agency ensures that children do not experience abuse or neglect while in the state's foster care system. The indicator holds states accountable for keeping children safe from harm while under the responsibility of the state, no matter who perpetrates the maltreatment while the child is in foster care.

Recurrence of maltreatment

This indicator is described as: Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month reporting period, what percent were victims of another substantiated or indicated maltreatment report within 12 months of their initial report?

Numerator: The number of children in the denominator who had another substantiated or indicated maltreatment report within 12 months of their initial report (NCANDS)

Denominator: The number of children with at least one substantiated or indicated maltreatment report in a 12-month period (NCANDS)

We include this indicator to measure whether the agency was successful in preventing subsequent maltreatment of a child if the child was the subject of a substantiated or indicated report of maltreatment.

Statewide Data Indicators for CFSR Permanency Outcome 1: Children have permanency and stability in their living situations.

Permanency in 12 months for children entering foster care

This indicator is described as: Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care? Permanency, for the purposes of this indicator and the other permanency-in-12-months indicators, includes discharges from foster care to reunification with the child's parents or primary caregivers, living with a relative, guardianship, or adoption.

Numerator: The number of children in the denominator who are discharged to permanency within 12 months of entering foster care (AFCARS)

Denominator: The number of children who enter foster care in a 12-month period (AFCARS)

We include this indicator to measure whether the agency reunifies or places children in safe and permanent homes as soon as possible after removal.

Permanency in 12 months for children in foster care 12 to 23 months

This indicator is described as: Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) between 12 and 23 months, what percent discharged from foster care to permanency within 12 months of the first day of the period?

Numerator: The number of children in the denominator who discharged from foster care to permanency within 12 months of the first day (AFCARS)

Denominator: The number of children in foster care on the first day of a 12-month period who had been in foster care in that episode between 12 and 23 months (AFCARS)

We include this indicator to measure whether the agency reunifies or places children in safe and permanent homes timely if permanency was not achieved in the first 12 to 23 months of foster care.

Permanency in 12 months for children in foster care for 24 months or longer

This indicator is described as: Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?

Numerator: The number of children in the denominator who are discharged from foster care to permanency within 12 months of the first day (AFCARS)

Denominator: The number of children in foster care on the first day of a 12-month period who had been in foster care in that episode for 24 months or more (AFCARS)

We include this indicator to measure whether the agency continues to ensure permanency for children who have been in foster care for longer periods of time.

Re-entry to foster care in 12 months

This indicator is described as: Of all children who enter foster care in a 12-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?

Numerator: The number of children in the denominator who re-entered foster care within 12 months of their discharge from foster care (AFCARS)

Denominator: The number of children who entered foster care in a 12-month period who discharged within 12 months to reunification, living with a relative, or guardianship (AFCARS)

We include this indicator to measure whether the agency's programs and practice are effective in supporting reunification and other permanency goals so that children do not return to foster care.

Placement stability

This indicator is described as: Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?

Numerator: Among children in the denominator, the total number of placement moves during the 12-month period (AFCARS)

Denominator: Among children who enter foster care in a 12-month period, the total number of days these children were in foster care as of the end of the 12-month period (AFCARS)

We include this indicator to measure whether the agency ensures that children whom the agency removes from their homes experience stability while they are in foster care.

National Standards and State Performance

The national standard is set at the national observed performance for each of the seven indicators. The following tables show the national standards for each indicator.

**National Standards for CFSR R3 Statewide Data Indicators:
Safety Outcome 1**

Statewide Data Indicators for Safety Outcome 1	National Standard
Maltreatment in foster care	8.50 victimizations per 100,000 days in foster care
Recurrence of maltreatment	9.1%

**National Standards for CFSR R3 Statewide Data Indicators:
Permanency Outcome 1**

Statewide Data Indicators for Permanency Outcome 1	National Standard
Permanency in 12 months for children entering foster care	40.5%
Permanency in 12 months for children in foster care between 12 and 23 months	43.6%
Permanency in 12 months for children in foster care for 24 months or more	30.3%
Re-entry to foster care in 12 months	8.3%
Placement stability	4.12 moves per 1,000 days in foster care

Calculation of the National Standards

For indicators in which the outcome for a child either occurred or did not occur, the standard is calculated as the number of children in the nation experiencing the outcome divided by the number of children in the nation eligible for, and therefore at risk, of the outcome. This is the case for the indicators that measure permanency (for all cohorts) in 12 months, re-entry to foster care in 12 months, and recurrence of maltreatment. The result of the calculation is a proportion. We present the standard as a percentage by multiplying the proportion by 100 to show a number that is more easily understood.

For indicators in which the outcome for a child is a count per day in foster care, the standard is calculated as the sum of counts for all children in the nation divided by the sum of days these children were in foster care. This is the case for the indicators for placement stability (moves per days in foster care) and maltreatment in foster care (number of victimizations per days in foster care). The result of the calculation is a rate. We multiply the rates to show more understandable numbers: for placement stability by 1,000 to yield a rate of moves per 1,000 days, and for maltreatment in foster care by 100,000 to give a rate of victimizations per 100,000 days in foster care.

Multi-Level Modeling Approach

State performance on each statewide data indicator will be assessed using a multi-level model appropriate for that indicator. The multi-level model that we employ when assessing each state's performance takes into account: (1) the variation across states in the age distribution of children served for all indicators, and the state's entry rate for selected indicators (risk adjustment); (2) the variation across states in the number of children they serve; and (3) the variation across states in child outcomes. The result of this modeling is a performance value that is a more accurate and fair representation of

each state's performance than can be obtained by simply using the state's observed performance.

Risk Adjustment

We will risk-adjust on child's age for each indicator (depending on the indicator, it is the child's age at entry, exit, or on the first day). We will also risk-adjust on the state's foster care entry rate for two indicators: permanency in 12 months for children entering foster care, and re-entry to foster care in 12 months. Adjusting on age allows us to control statistically for the fact that children of different ages have different likelihoods of experiencing the outcome, regardless of the quality of care a state provides. Adjusting on foster care entry rate allows us to account for the fact that states with lower entry rates tend to have children at greater risk for poor outcomes.

After we perform all the calculations in the model, the result will be the state's risk-standardized performance. The risk-standardized performance is the ratio of the number of predicted outcomes over the number of expected outcomes, multiplied by the national observed performance.

State Performance Relative to the National Standards

A state's risk-standardized performance can be compared directly to the national observed performance to determine whether the state performed statistically higher or lower than the national observed performance. To make this assessment, the CB calculates approximate 95 percent interval estimates around each state's risk-standardized performance.

The CB will compare each state's interval estimate to the national observed performance, and assign each state to one of three groups:

- "No different than national observed performance"
- "Higher than national observed performance"
- "Lower than national observed performance"

Whether it is desirable for a state to be higher or lower than the national observed performance depends on the indicator. For the indicators assessing permanency by 12 months for the three cohorts, a higher value is desirable and will be considered to have met the national standard. For the remaining indicators, a lower value is desirable and will be considered to have met the national standard. For all indicators, we will consider states that are "no different than national observed performance" to have met the national standard.

Sources and Data Periods

The datasets used for the national standard calculations depend on the indicator. Some indicators require more data periods than others. For example, the re-entry to foster care in 12 months indicator requires six report periods of AFCARS data. This is because the cohort of children used requires a look at all children who enter foster care over a 12-month period; then they are followed for another 12 months to establish whether they have exited to permanency; then they are followed for a subsequent 12 months after their exit to see if they re-enter foster care.

Monitoring Statewide Data Indicators in Program Improvement Plans

The CB will require a state that does not meet the national standard for any indicator to include improvement on that indicator in its program improvement plan. If we are unable to determine a state's performance on an indicator due to data quality issues, we will also require the state to include that indicator in its program improvement plan.

Companion Measures

If a state has a program improvement plan that includes improving on the indicator of "Permanency in 12 months for children entering foster care," the CB's determination of whether the state has improved successfully will take into consideration its performance on the "Re-entry to foster care" indicator as a companion measure. The reverse is also true. Specifically, the state must not allow performance on the companion measure to fall below a certain level from its baseline performance.

Thresholds are established as the inverse of performance goals. For example, a state must stay below a threshold for the companion "Re-entry to foster care" indicator as well as achieve its goal on the "Permanency in 12 months for children entering foster care" indicator to successfully complete the program improvement plan. If a state must improve on the "Re-entry to foster care" indicator in its program improvement plan, it must not fall below the threshold established for permanency in 12 months for children entering foster care.

Setting Goals and Monitoring Progress

The key components for setting improvement goals and monitoring a state's progress over the course of a program improvement plan involve calculating baselines, setting improvement goals and, when companion measures are included in an improvement plan, also establishing thresholds.

The CB will set the baseline for each statewide data indicator included in a program improvement plan at the state's observed performance on that indicator for the most recent year of available data at the beginning of the program improvement plan. Because the CFSR schedule is staggered, the applicable year or data periods used in establishing the baseline will vary from state to state.

We will establish improvement factors for program improvement goals and thresholds (if applicable) for the data indicators based on the variability in a state's observed performance in the three most recent years of data. The resulting improvement goal or threshold may be limited or increased for a state based on the floor and cap for improvement that we have set for each indicator. We set the floors and caps such that no states are required to improve by more than the amount of improvement at the 50th percentile, and all states engaged in a program improvement plan are to improve by at least the amount of improvement at the 20th percentile (or 80th percentile, depending on whether higher or lower performance is preferable on the indicator).

The following tables show the floor and cap for program improvement goals for each indicator.

**Improvement Goals for CFSR R3 Statewide Data Indicators:
Safety Outcome 1**

Statewide Data Indicators for Safety Outcome 1	Floor	Cap
Maltreatment in foster care	0.904	0.812
Recurrence of maltreatment	0.951	0.902

**Improvement Goals for CFSR R3 Statewide Data Indicators:
Permanency Outcome 1**

Statewide Data Indicators for Permanency Outcome 1	Floor	Cap
Permanency in 12 months for children entering foster care	1.031	1.063
Permanency in 12 months for children in foster care 12 to 23 months	1.046	1.082
Permanency in 12 months for children in foster care 24 months or more	1.042	1.091
Re-entry to foster care in 12 months	0.891	0.834
Placement stability	0.959	0.904

Successful Completion of Program Improvement Plans

A state can complete its program improvement plan successfully with regard to the indicators in one of two ways: (1) the state can meet its improvement goal and not exceed the threshold for its companion measure, if applicable, at some point before the end of the program improvement monitoring; or (2) the CB can relieve the state of any further obligation to improve for CFSR purposes if the state meets the national standard for an indicator before the CB approves a program improvement plan or during the course of program improvement monitoring.

Data

Setting national standards and measuring state performance on statewide data indicators for CFSR purposes relies upon the states submitting high-quality data to AFCARS and NCANDS. We have set data quality limits for calculating the national standards and estimating states' risk-adjusted performance. We will exclude states that have data quality issues that exceed the data quality limits established from the model we use to calculate the national standard (i.e., the national observed performance) and estimate states' risk-adjusted performance. Data quality issues can also prevent us from using child-level records in our calculations.

We will provide data profiles of state performance to each state before the state's CFSR on all seven of the statewide data indicators and other contextual data available from AFCARS and NCANDS. This data profile will assist the state in developing its statewide assessment and beginning to plan for program improvement, if appropriate. In addition, we will provide data profiles semi-annually to assist states in measuring progress toward the goals identified in their program improvement plans.

EXHIBIT F

Well Being Outcomes for DCFS Youth Matrix

Final Committee Recommendations

Submitted by Larry Small and Dr. Kimberly Mann, DCFS and Margaret Vimont, Jewish Child and Family Services, Chairs

Preface:

In addition to the measures suggested below, the committee gave careful consideration to other data sets that measure factors that substantively affect well being, but do not measure well being per se. These will be particularly important as a particular domain of well being needs intervention. The committee's list of these items so far are:

Domain-->	Cognitive Functioning (Education)	Physical Health	Emotional/Behavioral Functioning	Social Functioning
Measurable factors that can affect each wellbeing domain	Quality of Educational Context: CANS: Educational Setting	Health Service Quality Indicators (e.g., immunizations, timely well child visits, regular dental appointments, vision/hearing, etc..)	Continuity/Quality of Care: Family and Living Situation (CANS), Placement disruptions (906); staying in psychiatric hospital Beyond Medical Necessity (PHT)	
	School Attendance		Family Involvement/Support: Substitute Caregiver Strengths and Needs, Biological Parent Strengths and Needs (CANS)	
			Use of the BASC and Ohio scales as used in parts of the system	
	Outcomes in other domains	Outcomes in other domains	Outcomes in other domains	
	Individualized Educational Plan (IEP) –the presence of an adequate IEP if indicated by needs of the youth, the effectiveness of its implementation, the involvement of parents/ caregivers in plan			

DOMAIN 1: Cognitive Functioning (Education)

Age	CANS Items	Independent Measure	Comments
Infancy and Early Childhood (0-5)	<ul style="list-style-type: none"> Developmental Needs, Young Child Development Needs 	<ul style="list-style-type: none"> Ages and Stages (ADQ and ASQSE) 	
Middle Childhood (6-12) and Adolescence 13-18	<ul style="list-style-type: none"> Developmental Needs and School Achievement 	<ul style="list-style-type: none"> GPA Standardized testing scores in reading and math 	

DOMAIN 2: Physical Health

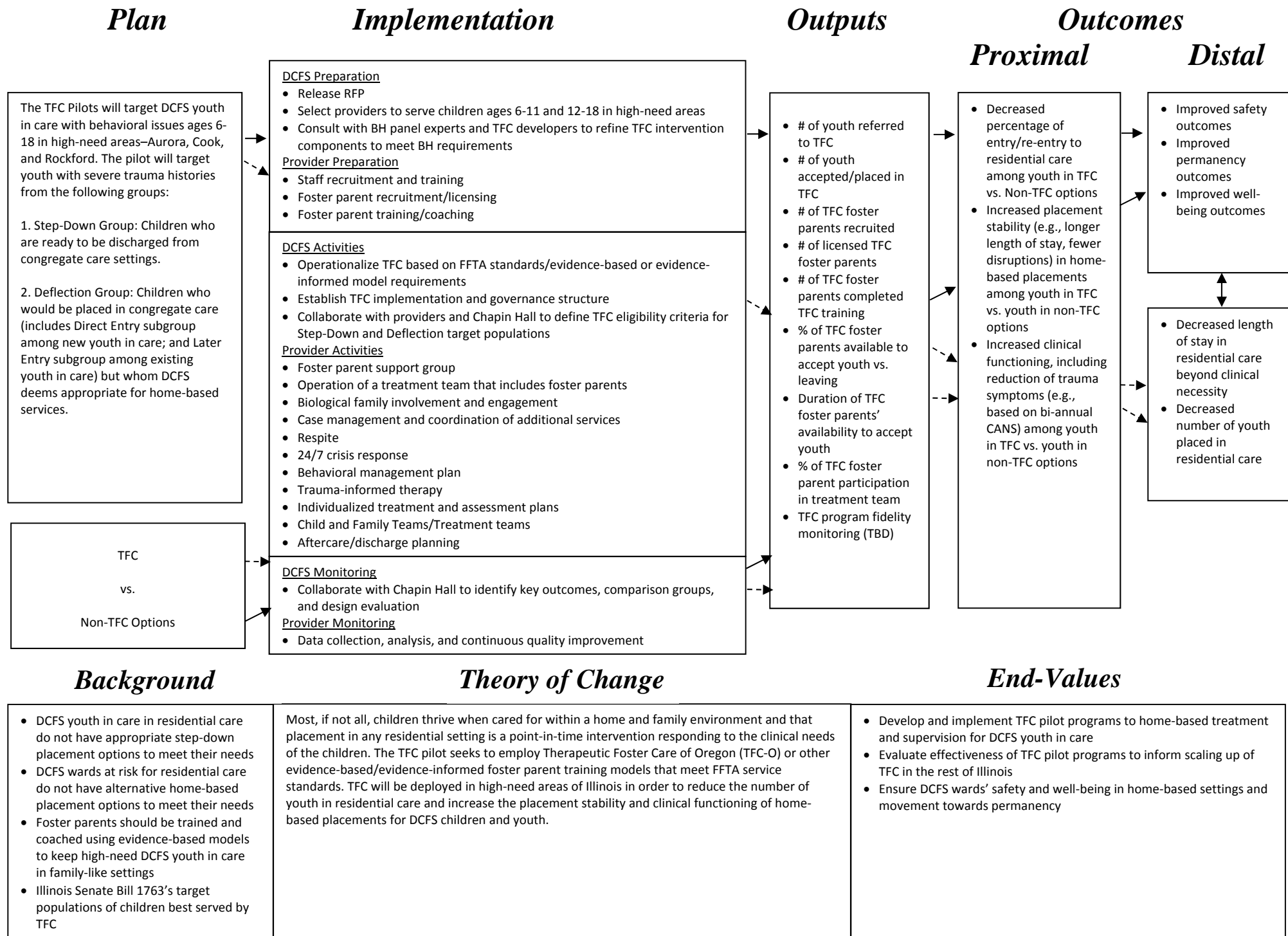
Age	CANS Items	Independent Measure	Comments
Infancy and Early Childhood (0-5)	<ul style="list-style-type: none"> Medical/Physical Health, Young Child Physical Health 	<ul style="list-style-type: none"> Growth/Development as recorded in the Health Passport Emergency room visit frequency (for non chronic health dx) For sub population of children with chronic health dx: Acute HHF visits for that health condition 	
Middle Childhood (6-12) and Adolescence 13-18	<ul style="list-style-type: none"> Medical/Physical Health 	<ul style="list-style-type: none"> Emergency room visit frequency (for non chronic health dx) For sub population of children with chronic health dx: Acute HHF visits for that health condition 	

DOMAIN 3: Emotional/Behavioral Functioning:

Age	CANS Items	Independent Measure	Comments
Infancy and Early Childhood (0-5)	<ul style="list-style-type: none"> • CANS: Emotional strengths, traumatic stress symptoms, emotional/behavioral needs, select risk behaviors 	<ul style="list-style-type: none"> • ITSC, DECA, ASQSE for under 5 group • 906 for Psych Hospitalization 	
Middle Childhood (6-12) and Adolescence 13-18	<ul style="list-style-type: none"> • CANS: Traumatic Stress Symptoms, Emotional/Behavioral Strengths, Emotional/Behavioral Needs, select Risk Behaviors 	<ul style="list-style-type: none"> • SDQ (Strengths and Difficulties Questionnaire • School expulsions • 906 form for detention • 906 and Psych Hospital Database (PHT): psychiatric hospitalization/readmission • Child Intake and Recovery Unit (CIRU) and 906: Running away • <i>See Comments</i> 	Not currently in use and will depend on universal roll out in all sectors of the child welfare system.

DOMAIN 4: Social Functioning <i>Final recommendation pending July 2016 discussion</i>			
Age	CANS Items	Independent Measure	Comments
Infancy and Early Childhood (0-5)	<ul style="list-style-type: none"> CANS: Social Functioning Strengths, Social Functioning Behaviors, and Young Child Social Behaviors 	<ul style="list-style-type: none"> Informed by Ages and Stages (ADQ and ASQSE) 	Currently done at the beginning of all cases, but updated assessments are now done unevenly across the state and will need to universally implemented.
Middle Childhood (6-12)	<ul style="list-style-type: none"> CANS: Social Functioning Strengths and Social Functioning Behaviors 	<ul style="list-style-type: none"> SDQ, relevant items 	Not currently in use and will depend on universal roll out in all sectors of the child welfare system.
Adolescence 13-18	<ul style="list-style-type: none"> CANS: Social Functioning Strengths and Social Functioning Behaviors For Adolescence: CANS: Intimate Relationships 	<ul style="list-style-type: none"> SDQ, relevant items Social Network Questionnaire 	Not currently in use and will depend on universal roll out in all sectors of the child welfare system.

EXHIBIT G



THERAPEUTIC FOSTER CARE- FOUR MONTH STATUS REPORT

AUGUST 19, 2016

I. Plan

TFC will focus on meeting the needs of children and youth entering care at ages 6 – 12 years and /or 12 years and older who are included in one or more of the following 3 target populations:

1. Children and youth entering care with severe trauma histories, as defined by the having 2 or more “actionable” experiences, rated on the Integrated Assessment CANS (IA CANS), from among: Physical Abuse, Sexual Abuse, Emotional Abuse, Witness to Family Violence, and Witness to Criminal Activity or 1 severely actionable item from among these 5.

2. Children and youth who are ready to be discharged from congregate care settings.

3. Children and youth who would be placed in residential care but who may be stabilized in a home-based setting with the addition of appropriate, intensive supports for the child and the foster parent. These fall into 2 separate categories:

i. Direct Entry – Direct Entry is defined as children and youth who enter residential as their first child welfare placement. Youth mostly come to the child welfare from hospitals, detentions, or home based settings, most often under neglect or dependency cases. Proposals should discuss interventions for this category of children who would ensure that when the children exit the hospital or detention they are served in home-based settings with intensive services.

ii. Deflection – Deflection is defined as children and youth who have been identified by their clinical characteristics, as rated by their initial IA CANS, to be “at-risk” for residential/congregate care and who can be served in community settings with appropriate supports. The “at-risk” clinical characteristics include identification of two or more 2’s among the following IA CANS domains: Trauma Symptoms, Emotional Behavioral Needs, Life Domain Functioning, and Risk Behaviors”.

II. Background

In Illinois, children with high end needs are served within a restrictive residential environment for a long period of time because there are no appropriate step-down

placement options to meet their needs. Children at risk for residential care do not have alternative home-based placement options to meet their needs. As a result the Department is implementing a Therapeutic Foster Care Pilot. Treatment will be provided in a home environment by foster parents who have been trained and coached in an evidenced based model to keep children with high end needs out of residential settings and to provide children stepping down from residential with a structured treatment home option.

III. Theory of Change

Most, if not all, children thrive when cared for within a home and family environment and that placement in any residential setting is a point-in-time intervention responding to the clinical needs of the children. The TFC pilot seeks to employ Therapeutic Foster Care of Oregon (TFC-O) or other evidence-based/evidence-informed foster parent training models that meet FFTA service standards. TFC will be deployed in high-need areas of Illinois in order to reduce the number of youth in residential care and increase the placement stability and clinical functioning of home-based placements for DCFS children and youth.

IV. Implementation Status

We are currently engaged in the Pre-installation phase of implementation. The Department has established rates for each project and working to secure grant contracts estimated to begin September 1, 2016. Grant program plans describe the expectations of hiring, recruitment and training. Service contracts will be developed prior to the placement of the first child in a therapeutic foster home. Agencies have begun to identify appropriate individuals for specific positions and in some cases have begun the hiring process and hired implementation coordinators, managers and recruiters.

Agencies along with Department staff have met or will be meeting with the developers of the evidence based models that will be implemented. A meeting was held with LSSI and the developers of Therapeutic Foster Care Oregon on June 20, 2016. A meeting was held with CHASI and the developers of Therapeutic Crisis Intervention Family on August 15, 2016 and a meeting will be held with JCFS and the developers of Together Facing the Challenge on August 29, 2016. The purpose of each meeting is to get a clear understanding of the model, training involved, fidelity monitoring and sustainability. In addition the developers have an opportunity to ask questions and become familiar with the internal agency system and the larger system.

In an effort to get a clear depiction of the interventions, recruitment, staff and training that will be provided by each agency, Chapin Hall, the Department and the agencies identified the program components for each intervention. The program components were guided by the Foster Family Treatment Home Association standards for therapeutic foster care. The program components spreadsheet will be included with the report.

With the understanding that the current ways of doing the work may have to change for this pilot, we have taken a look at the current process in place to determine eligibility for specialized foster care, adolescent foster care and residential treatment. We have also taken a look at the process in place to determine residential step down readiness. In looking at the "as is model" we are working on the "to be model". We are currently working to identify the process by which youth in the target population will enter and the instrument that will be used to determine eligibility for therapeutic foster care. We are currently exploring the Child and Adolescent Service Intensity Instrument (CASII) to determine level of care. Currently the instrument is used to determine placement levels of care such as specialized foster care, adolescent foster care and residential treatment. There is a need to research CASII scores and identify treatment provided within these levels of care to estimate appropriate scoring and specific distinguishing criteria for therapeutic foster care. In addition we must determine when the first CASII will be completed as well as the frequency with which it will be completed. A subgroup has been identified to work on this. Northwestern University built a database for the Department to document CASII scores. In addition we are identifying data sources for information regarding youth in residential. We are currently looking at RTOS, which provides a list of youth in residential, the length of time they have been there and phase of treatment they are currently in. This will assist the Department with identifying which youth based on age, phase in treatment, admit date and home county that may meet the initial criteria to be considered for therapeutic foster care. We have also identified a subgroup that will take a look at the RTOS system.

V. Outputs

We do not have any data on outputs yet. However, we have identified some outputs for the project but this is still under development. The outputs can be found on the logic model.

VI. Proximal Outcomes

The table below lists the proximal outcomes that have been identified for the project. Chapin Hall is currently working on the comparison group. The therapeutic foster care project has not started yet, as a result there are no significant differences to note.

Proximal Outcome	Intervention Group	Comparison Group	Significance and Explanation of Difference
Decreased percentage of entry/re-entry to residential care among youth in TFC vs. Non-TFC options			
Increased placement stability (e.g., longer length of stay, fewer disruptions) in home-based placements among youth in TFC vs youth in non-TFC options			
Increased clinical functioning, including reduction of trauma symptoms (e.g. based on bi-annual CANS) among youth in TFC vs. youth in non-TFC options			

VII. Distal Outcomes

The table below lists the distal outcomes that have been identified for the project. . Chapin Hall is currently working on the comparison group. The therapeutic foster care project has not started yet, as a result there are no significant differences to note.

Distal Outcome	Intervention Group	Comparison Group	Explanation of Status
Improved safety outcomes			
Improved permanency outcomes			
Improved well- being outcomes			
Decreased length of stay in residential care beyond clinical necessity			
Decreased number of youth placed in residential care			

VIII. Other Consequences

Through the exploration and pre-installation stages, barriers have been identified that may impact the implementation of this pilot project. Agencies are responsible for recruiting therapeutic foster parents. This will prove to be difficult to find individuals willing to dedicate the time and effort that it will take to be trained and to provide the level of supervision and treatment required. Recruitment will be challenging. Each agency has trained licensing works that will be responsible for licensing the therapeutic foster parents. Each prospective foster parent must be fingerprinted and a background check conducted prior to licensure and placement of a child. According to the agencies background checks could take 2 to 3 months to be completed. Prospective foster parents must also complete PRIDE training.

According to the agencies PRIDE training does not occur with consistency. I have secured a list of PRIDE Training dates and will provide this list to the agencies. We will also touch base with the coordinator of the PRIDE training to convey the urgency. Finally, the Department must work on specific coding in the system to identify homes as therapeutic foster homes and children placed in therapeutic foster homes for the purpose of the evaluation.

IX. Plan Revisions

None to report at this time.

EXHIBIT H

Agency	Year 1		Year 2	
	6-12	12 plus	6-12	12 plus
LSSI (Aurora, Cook, Rockford) - TFCO	21 deflect and trauma history	9 step down, trauma	45 deflect and trauma history	
JCFS (Cook) - Together Facing the Challenge		10 deflect, step down, and trauma history		32 deflect, step down, and trauma history
CHASI (Cook) - TCI-Family, ARC, TFCBT, QPI		10 deflect, step down, and trauma history		40 deflect, step down, and trauma history
Overall Capacity				
Required by BH	16	24	40	60
Total Youth Served Required by BH	40		100	
Projected by Agencies	21	29	45	72
Total Youth Served Across Agencies (Projected)	50		117	

EXHIBIT I



THERAPEUTIC FOSTER CARE IMPLEMENTATION PLAN – DRAFT 5/2/16

1. Introduction: Theory of Change

LSSI believes that early screening and identification of children with severe trauma histories and emotional/behavioral needs coupled with the highly effective, short-term, evidence based treatment model of TFCO for Children (TFCO-C), which creates opportunities for the child to successfully live in a family rather than a more restrictive level of care and simultaneously works with the identified aftercare home to provide effective parenting for that individual child, will result in sustainable success over time. The two key components to our theory of change is that the children are identified and referred to the program early, both in terms of age and in terms of their involvement in the child welfare system and that a committed aftercare family is identified and is ready to work at intake into the program. This family may be the family of origin, other relatives or committed adults as identified by the fictive kin protocol and Lifebook process. The expected program outcomes are an improvement in the level of functioning of the children, including the reduction of trauma symptoms, an increase of placement stability and the likelihood of permanency occurring in the aftercare home, as well as a decrease in the number of youth placed in residential programs.

2. Clearly Defined Target Population(s)

The target population for LSSI's TFCO-C program are children six (6) to fourteen (14) years of age who are included in one or both of the following groups:

1. Trauma Group: Children and youth entering care with severe trauma histories, as defined by having 2 or more "actionable" experiences, rated on the Integrated Assessment CANS (IA CANS), from among: Physical Abuse, Sexual Abuse, Emotional Abuse, Witness to Family Violence, and Witness to Criminal Activity or 1 severely actionable item from among these 5.
2. Deflection Group: Children and youth who would be placed in residential care but who may be stabilized in a home-based setting with the addition of appropriate, intensive supports for the child and the foster parent. These fall into 2 separate categories:
 - i. Direct Entry – Direct Entry is defined as children and youth who enter residential as their first child welfare placement. Youth mostly come to child welfare from hospitals, detentions, or home based settings, most often under neglect or dependency cases. Proposals should discuss interventions for this category of children who would ensure that when the children exit the hospital or detention they are served in home-based settings with intensive services.
 - ii. Deflection – Deflection is defined as children and youth who have been identified by their clinical characteristics, as rated by their initial IA CANS, to be "at-risk" for residential/congregate care and who can be served in community settings with

appropriate supports. The “at-risk” clinical characteristics include identification of two or more 2’s among the following IA CANS domains: Trauma Symptoms, Emotional Behavioral Needs, Life Domain Functioning, and Risk Behaviors”.

3. Step Down Group: Children and youth who are ready to be discharged from congregate care settings. LSSI’s TFCO-C program will accept children and youth from this category if they meet the intake criterion for the program, which is foremost the availability of a possible aftercare family.

The Treatment Foster Care Oregon (TFCO) program was developed in the early 1980’s as an alternative to institutional, residential, and group care placements for adolescents with severe conduct disorders, and delinquency. Subsequently, the TFCO model has been adapted for and tested with children and adolescents with severe emotional and behavioral disorders, girls referred from juvenile justice, and with youth in regular state-supported foster care. TFCO-C was adapted to serve children ages seven (7) to thirteen (13) who are in need of an out-of-home placement due to serious emotional, behavioral or mental health problems hence the target population served in this pilot project. LSSI will work with TFC Consultants to further adapt the model to serve children six (6) to fourteen (14). This model has been successfully used with children referred by the child welfare, mental health and juvenile justice systems.

3. Clearly Defined Intervention(s)

LSSI will work with TFC Consultants, Inc. to hire, onboard and train three (3) full TFCO-C teams, one in Chicago, one in Aurora and the final in Rockford. It is the intention of LSSI to replicate the model with fidelity and become a certified provider. LSSI will recruit, screen, license and train ten (10) to twelve (12) professional foster parents in each area. The program will accept screened and appropriate children, deliver the intervention effectively and move each child into the carefully chosen and prepared aftercare home within six (6) to nine (9) months of treatment. The program will include an aftercare component. The intended outcomes are to reduce the number of youth placed in residential care by deflecting those children who may be at risk of residential treatment without intervention; increase placement stability and improve the level of functioning of children and youth, including the reduction of trauma symptoms. Three fully implemented TFCO-C teams will be effectively treating thirty (30) children by the end of the first year of the project, with twenty-one (21) children in the age range of six (6) to eleven (11) and nine (9) in the age range of twelve (12) to fourteen (14).

It is anticipated that it will take five (5) to six (6) months of implementation activities before the first placement into the program will occur. It is recommended by TFC Consultants that placements are staggered during the startup phase so that ongoing intake and placements into the aftercare homes also are staggered. Placements into the program will proceed as such:

Month	6	7	8	9	10
Placements	2	2	2	2	2

There are two major aims of TFCO-C; to create opportunities so that children are able to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents, relatives, or other aftercare resources to provide effective parenting so that the positive changes made during TFCO placements can be sustained over the long-run. Four key elements of treatment are targeted during placement and aftercare:

- Providing the child with a consistent reinforcing environment where he or she is mentored and encouraged to develop socially, emotionally, and academically.
- Providing daily structure with clear expectations and limits, with well-specified consequences delivered in a positive, supportive, teaching-oriented manner.
- Providing close tracking of the child's behavior and emotional adjustment in family and school settings and with peers.
- Helping the child to develop positive attachments to adults and to peers.

Young children who are entering the child welfare system for the first time with severe behavioral or mental health needs and/or trauma histories have often experienced multiple hospitalizations and disruptions. They are better served in a family based setting but their families of origin are often overwhelmed and may have multiple areas of need or dysfunction. These children often enter the child welfare system because of the lack of systematic support and services which results in neglect or dependency cases. The program will also serve children who may have experienced numerous placements in the child welfare system and now are at risk of residential placement due to their behaviors, however, it is the goal to eliminate this pattern of disrupted placements of youth in care and have children referred to and treated by the TFCO-C program as early as possible. A vital element of the program is that the aftercare placement is identified and committed to working with the children as the children enters the TFCO program. This resource may be the biological parents, a relative or a previous foster parent. This program capitalizes on the tremendous positive potential of families, both the professional foster families who are the key therapeutic agents and the biological or adoptive families who will be able to meet the child's needs in a positive and permanent environment and sustain success over time.

TFCO-C is delivered by a carefully selected, highly motivated and trained team which consists of the Team Leader, Case Manager, Child Therapist, Family Therapist, Skills Coaches, Foster Parent Specialist (recruiter/licensing/trainer) and the Professional Treatment Foster Parent. The foster families are the key therapeutic change agent for the children and need to fully understand, embrace and execute the model with fidelity. One (1) child will be placed in the highly trained and certified home in which one (1) parent remains at home and is available to the child. Each child will be thoroughly assessed and receive an individualized TFCO-C treatment plan and daily point chart. The treatment plan and interventions are age appropriate and there are modifications of the program for the younger and the older age group. Daily feedback from the therapeutic foster parent is used to hone and modify the plan and targeted behaviors. Weekly team meetings are used to discuss each child, their plan and their progress as well as the progress of the targeted aftercare family. The team leader coordinates multiple interventions within the child's key settings (treatment foster care home, aftercare home, school and community) which consist of foster parent training and support (weekly team meetings and daily phone calls), family therapy and parenting skills training for the identified aftercare home, therapy and skill building for the

child, school-based intervention and academic support and psychiatric consultation and medication management, if indicated.

TFCO has been shown to be an effective and viable method of preventing the placement of children and adolescents in institutional or residential settings. The below research has found that placement in TFCO can present escalation of placement disruptions, emotional problems, delinquency and other problem behaviors such as violence. Cost effectiveness analysis have found that placement in TFCO is more economical and more effective than placement in group care.

Martin Bergström & Lotta Höjman: Is multidimensional treatment foster care (MTFC) more effective than treatment as usual in a three-year follow-up? Results from MTFC in a Swedish setting, *European Journal of Social Work* (2015)

Poulton R, Van Ryzin MJ, Harold GT, Chamberlain P, Fowler D, Cannon M, Arseneault L, Leve LD, Effects of Multidimensional Treatment Foster Care on Psychotic Symptoms in Girls, *Journal of the American Academy of Child & Adolescent Psychiatry* (2014).

Rhoades, K. A., Leve, L., Harold, G. T., Kim, H., Chamberlain, P. (Proof) Drug Use Trajectories After a Randomized Controlled Trial of MTFC: Associations With Partner Drug Use *Journal of Research on Adolescence*, 1-15 (2014).

Harold, G., Kerr, D., Van Ryzin, M., DeGarmo, D., Rhodes, K., Leve, L. Depressive Symptom Trajectories Among Girls in the Juvenile Justice System: 24-month Outcomes of an RCT of Multidimensional Treatment Foster Care. *Prevention Science*, Published online February 17, 2013

A full list of supporting research and literature review can be found at <http://www.tfcOregon.com/publications/peer-reviewed-journal-articles/>

4. Implementation Capacity Assessment (Assessing Drivers)

Please provide information about the Exploration Stage work related to understanding TFCO through the “what”, “how” and “who” lenses. The developers of TFCO are the “who”. They have already been identified to provide the intervention. This information is important to assess both the evaluability and the implementability of the intervention.

THE “WHAT”

1. Has the developer/researcher of TFCO identified, through research and/or theory-building, the core intervention components that must be present for the intended outcomes to be achieved? If so, briefly list the core elements.

The developer has identified the core intervention component and will work closely with LSSI to implement the model with full fidelity. The core elements are:

TFCO treatment goals are accomplished by providing:

- close supervision
- fair and consistent limits
- predictable consequences for rule breaking

- a supportive relationship with at least one mentoring adult
- reduced exposure to peers with similar problems

The intervention is multifaceted and occurs in multiple settings. The intervention components include:

- behavioral parent training and support for TFCO foster parents
- family therapy for biological parents (or other aftercare resources)
- skills training for youth
- supportive therapy for youth
- school-based behavioral interventions and academic support
- psychiatric consultation and medication management, when needed

2. Are materials available that are required for implementation of the intervention (e.g., manuals, training videos, assessment instruments, technical equipment)? If yes, what is available?

Yes, TFC Consultants Inc. will provide detailed technical assistance to LSSI which includes guidance in staff selection, development of the recruitment plan for foster parents, development of the Foster Parent: Program Values, Policies and Procedures Manual; the Agreement between Foster Parents and the Program, which includes the Foster Parent Job Description; the Parental and Youth Consent Forms for Participation in the Program and Treatment Plan and Point Charts, three (3) to five (5) days of intensive training for the TFCO-C team members, weekly consultation calls with the assigned TFC site consultant to review the implementation of the model and process the videos of the weekly foster parent and clinical meetings, as well as regular site visits and implementation reviews.

3. Are optional intervention components specified?

There are not.

4. Are there fidelity assessments/measures? Please describe them (e.g., dosage, quality, content, and timing). Be sure to note whether or not research and/or evaluation efforts demonstrate that the fidelity measures have been positively correlated with better outcomes and/or help to distinguish the intervention from service or treatment as usual.

TFCO includes the following fidelity measures:

Prior to program certification:

- PDR data. The program collects and records data daily on youth behavior and foster home stress level, thus providing information about behavior change patterns and stability of the foster home.
- Point and Level charts generated by the foster parents. Each day is review with the youth in terms of behavior standards met or not met. Daily scores are tied to privileges. P & L charts provide insight in behavioral progress of the youth and foster parent skill in utilizing the system to motivate and reinforce youth.
- Periodic program progress reports provided by TFC Consultants. Measures adherence to the model and provides comparisons from report to report.

- Program Assessments. At the end of the first year and thereafter as determined necessary, the program is assessed against 7 model standards. The assessment identifies any areas in need of further development. Once all criteria are met, the program applies for TFCO program certification.

Program Certification:

- Once program assessments show that the program is meeting fidelity standards, the program applies for TFCO program certification. Certification indicates that the program is operating with fidelity and that outcomes are consistent with effectiveness standards. Initial program certification is valid for a period of two years, re-certifications are valid for 3 years.

Post-Certification:

- Post-certification program assessments are conducted at 9 and 18 months after initial certification and at 10, 20 and 30 months after re-certification. Short-term corrective services are provided by TFC Consultants if model drift is identified.

Program Certification Criteria:

- Outcomes
- Therapy Components
- Behavioral Components
- Foster Parent Meetings
- Clinical Team Meetings
- Program Staffing
- Staff Training

THE “HOW”

Demonstrate that you understand “how” this intervention will be successfully implemented and sustained.

Describe current knowledge and information related to the following areas:

1. Ensuring Staff Competence at the Practice Level

For each front-line person (e.g., caseworker, foster parent, therapist, other) involved in direct service with children or family members, please describe what is currently planned in relation to:

- Using criteria relevant to the intervention for recruiting and/or selecting the direct service provider (e.g., qualifications, pre-requisites, experience, attitude, ability)

Each TFCO-C team at LSSI will serve ten (10) children and consist of:

- Team Leader – 1 FTE
- Foster Parent Specialist (Recruiter, Licensing, Trainer and Parent Daily Report Caller) – 1 FTE
- 10 – 12 Professional Foster Families
- Case Manager – 1 FTE

- Child Therapist - .5 FTE
- Family Therapist - .5 FTE
- Skills Coaches – hourly
- Consulting Psychiatrist

Recruiting, selection and training of the team members is a key factor to the success of the program. The TFCO Team Leader will report directly to the regional Program Director as LSSI intends to ensure that the program is successfully implemented and knows that the time, resources, and commitment must be allocated from the highest levels. LSSI's Senior Associate Executive Director, Ruth Jajko and Bill Franklin, Associate Executive Director will serve as the foremost champions of the program with support from John Schnier, Vice President. This senior team represents a deep and comprehensive knowledge of child welfare best practice, effective clinical interventions and implementation of innovative and evidence-based programs.

The TFCO-C treatment model is an intensive team based model requiring the professionals to really enjoy working in an intensive team environment and be open and comfortable with the multiple roles involved. Ideal team members are positive, nurturing, flexible, creative, able to problem solve and communicate well as well as having good senses of humor. They are consistent and able to execute the behavioral interventions and chart effectively. TFC Consultants Inc. will consult on the selection process and LSSI will use their considerable expertise in recruiting, screening and selecting the team members. Other replication sites have a very high retention rate amongst their team members by following TFC Consultants' guidance on recruiting and selecting people with the above characteristics.

- The training needed, timing and length of training required, qualification of trainers, availability and access to qualified trainers

The TFCO-C teams will engage in the required training delivered by TFC Consultants, Inc. The Team Leaders are required to complete five (5) days of training and other staff members are required to attend four (4) days of training. The Foster Parents are required to complete three (3) days of training. The training sessions will occur in Illinois at considerable cost savings. Training the staff and foster parents from three implementation sites will naturally create a learning community and provide a strong support system for each team. LSSI's TFCO champions, Ruth Jajko, Senior Associate Executive Director and Bill Franklin, Associate Executive Director will attend the training as well as the Program Directors from the three sites to ensure that there is a deep institutional knowledge of the model. Anne Larrea Barclay, the consultant that LSSI has engaged to assist with the implementation of the project, will also attend the training.

- The supervision and coaching model, including the qualifications needed for the supervisor and/or coach

The Team Leader is the supervisor of the TFCO-C team and as such must be a Master's Level, clinically licensed professional who is the most experienced and qualified clinician on the team. The team meets weekly to discuss each child, the treatment plan and the child's progress as well as the progress of the targeted aftercare family. The Team Leader will also meet individually with team members to provide feedback and opportunities for professional

growth. TFC Consultants will provide ongoing coaching and technical assistance to each team and specifically to the Team Leader through weekly phone calls in which the videos of the weekly team meetings are reviewed and discussed. Three site visits per year will occur and can include attendance of the foster parent and clinical meeting, booster training, problem solving and in the moment consultation and support. The Team Leader will work with the TFC consultant to set the agenda.

- The *fidelity data system*, including whether or not a data system and associated infrastructure (e.g., Web-based data entry) are available or if you will be developing the data system to track fidelity. Has IT support been identified to assist with entering fidelity data and uploading video recordings should there be a problem.

The FOCUS PDR system is the web-based system required by TFC Consultants to record the data from the daily calls to the foster parents. These daily calls measure two factors: the daily behavior of the child (30 specific behaviors) and the level of stress the behavior caused the foster parent. Staff will be trained on how to enter the data and use the reporting features of the system in order to best make ongoing treatment decisions for individual children and system decisions for the program.

- The outcome measures, monitoring, and data systems that are required or optional and that will be developed and sustained over time

Additional systems for tracking fidelity and outcomes is an area that still needs to be assessed and determined. LSSI uses EVOLV to manage information in the Child Welfare program as well as SACWIS as required by DCFS. LSSI will work closely with members of the Evaluation/Eligibility Subcommittee to develop the systems needed to monitor this project and the outcomes for the children and families who are part of the program.

2. Organizational Supports Needed

- a. Describe how your agency will need to change in order to support new ways of work. What new policies, procedures, or resources likely will be needed at the agency level?

As the largest statewide provider of social services in Illinois, Lutheran Social Services of Illinois (LSSI) served 73,000 people last year through 190 programs at 85 sites across Illinois. The demographics of clients served by LSSI generally reflect those of Illinois' population, with one important exception—more than 80 percent of clients report an annual household income under \$15,000, compared to just 12 percent of all Illinois households. LSSI provides critical programs for the state's most vulnerable residents, including foster care, adoption, mental health services, alcohol and drug treatment, home care services for seniors, affordable senior housing, programs that help formerly incarcerated individuals integrate back into society and residential programs for people with developmental disabilities. Founded in 1867, LSSI is a nonprofit social service agency of the three Illinois synods of the ELCA. LSSI is a licensed child welfare agency and is accredited with the Council on Accreditation (COA).

Through the Children's Community Services division, LSSI provides supportive services for children in need and their families. Foster care services, which served approximately 2000 children in more than 10 program sites, focuses on placing children who have experienced neglect or abuse in a loving and secure home and works to reunify families whenever possible. Adoption services work to place children of all ages, some with special medical or emotional needs, in permanent, loving homes. Children's Community Services division offers numerous other services to at-risk children and their families in their communities, such as Community Child Care, Family Support Services and the Nachusa Lutheran Home.

LSSI has a long history of offering high quality and innovative services with strong outcomes for children and families. LSSI hires staff who fully meet the Illinois Department of Children & Family Services' (DCFS) requirements and offers pre-service and ongoing training for its staff and foster parents. As a full service agency, LSSI builds upon its internal collaborations and expertise as well as many external partnerships and will bring this expertise to the project. The biggest shift in practice will be the intensive team approach that this model requires. It will also require additional and more focused work between the three program sites, their leaders and staff. LSSI believes there is a strong inherent advantage to implementing the program in three sites simultaneously. There will be cost savings as the TFC Consultants will be able to deliver the training to staff in Illinois. Training the three teams together will be the first step in developing natural supports and a learning community where problems can be discussed, solutions shared and mastery of the program obtained. Ongoing training and support will be both individualized by site as well as targeted for all the TCFO staff and foster parents. LSSI intends to take the learning from this project and use it on behalf of all the children and families served.

At the moment, no new policies or procedures are anticipated. There are additional resources that are needed, including the purchase of video recording equipment and the TFCO team will be trained in the use of the equipment and confidential transmission of the recordings to the TFC consultant. Recordings of the weekly foster parent and clinical team meetings will be used by the implementation consultant to provide ongoing feedback to the team until the program is fully model-adherent and TFCO certification is obtained. LSSI will ensure that all team members understand this requirement, are comfortable with being recorded and sign consents, if required.

3. System Supports

Describe the systemic supports that will facilitate the implementation of this intervention, including:

- Anticipated changes in funding mechanisms and streams during the grant period

If DCFS identifies additional or different funding streams during the pilot project, LSSI will work with DCFS to maximize resources to maintain quality services. It should be

noted that priority will need to be placed on meeting projected outcomes and maintaining fidelity to the model.

- The financial resources that might/will be able to sustain this intervention after the grant period ends

It is intended that this pilot project will identify new ways of working with children and families, reducing incidents of residential care, lengths of stay in substitute care and overall cost of care. These saved resources could be reinvested in expanding the target population, thus reaching more children.

- Any significant changes in policies, procedures, or contracting relationships that will be needed at any level (e.g., State, county, agency)

The current practice that requires children to fail multiple placements prior to receiving the level of care they need is a change that will be needed. This will be accounted for in the intake/referral process to TFCO. In addition, it is anticipated that as DCFS implements the Immersion Sites and LSSI implements TFCO, barriers to service delivery will be identified that may be able to be addressed more efficiently. It is anticipated that these processes will encourage more collaboration among local providers.

- Systems partners who have agreed to collaborate (e.g., mental health, education, courts, substance abuse providers, other providers)

LSSI has good working relationships with local service providers in all of the target communities. It should be noted that some community partners have had to reduce their services due to the ongoing budget crisis in the State of Illinois.

- Systems partners who will need to partner or collaborate differently but are not yet on board (e.g., mental health, education, courts, substance abuse providers, other providers)

Partners will need to be educated on the model and its goals. The foster home will be the provider of treatment, not merely a placement, with the professional foster parent having extensive responsibility for the treatment intervention. Providers will need to understand and support the professional foster parent's role and understand the importance of focusing on the stepdown resource so that they are fully prepared to take on the parenting role when the brief stay in the treatment foster home is completed. Schools, courts, and other providers will all need to learn about this new treatment modality. The courts, in particular, will play a key role in supporting the goal of timely reunification for children stepping out of the treatment home to the home of a parent.

In this section of the Implementation Plan, Providers should provide an analysis and overview of what will be required to implement the intervention(s) as intended (Organizational and Competency Drivers), including:

- Assessing the program and associated interventions relationship to identified **needs** of the target population(s) and **fit** with organizational structure and current priorities/values

LSSI staff have long observed that system resources have not been adequate to address the needs of young children with significant trauma histories. These children tend not to receive intensive enough services to meet their needs and their trauma histories are being compounded by multiple failed placements, up to and including residential care. This intervention is aimed at early identification of these children for intensive, but short-term, treatment that helps the children and their caregivers learn the skills needed to live in a family home.

- **Resources available** to support implementation

LSSI offices have skilled licensing workers who will be resources for the Treatment team in both assessing and licensing new foster homes. The agency has an Associate Executive Director who focuses on both licensing and Quality Improvement available to assist each location. Each region has training staff who work with staff and foster parents. In addition to the two champions, the Management team includes leaders from across the state, each with over 20-30 years of child welfare experience that are available for consultation. The local program directors have excellent experience and relationships with one another that will foster collaboration, shared learning and support.

- **Readiness of the intervention(s)** for implementation in service settings and the **capacity** to implement the initiative/intervention (including training and technical assistance capacity)

LSSI has extensive organizational history of meeting the changing of children and families over an almost 150 history, ranging from orphanage care to cutting edge evidence based treatment. Throughout LSSI's history, there is a commitment towards providing services in a home-based, family-centered setting. LSSI has operated multiple residential programs over the years, but has continuously moved away from residential care and toward a family-centered approach. In addition, LSSI has experience with Treatment Foster Care, as well as years of providing both medical and behavioral specialized foster care. LSSI has also implemented other evidence-based therapy models and can draw on that experience. LSSI has committed to implementation of this evidence-based model and has secured the services of a consultant who will assist in implementing the model with fidelity across three program sites. LSSI has committed significant resources to implementing the National Child Trauma Stress Network trauma training curriculum for foster caregivers and has a well-developed Lifebook program that assists children in care with maintaining connections to their birth families and development a coherent narrative of their experiences.

Assessments of the **capacity to implement** should focus on Implementation Drivers currently in place to support the implementation of the intervention(s). They should also focus on current processes and service system functioning that need attention because they are incompatible with successful implementation and therefore will not facilitate achieving the desired goals and outcomes. Finally, they should focus on implementation supports that need to be developed to ensure that the intervention(s) are able to be executed as intended.

Implementation Drivers:

1. Staff Selection:

What skill set must each team member possess for effective implementation? What are the educational requirements for each team member? How many years of experience is needed? Please also include the foster parent as a part of the team. Please describe recruitment efforts for staff and foster parents.

The Team Leader:

This position is full-time and the Master's level and clinically licensed professional must be the most experienced and qualified clinician on the team as this position is key to running a successful TFCO team. The ideal candidate has a background in behavioral approaches, has supervisory experience and skills, is very organized and able to coordinate and supervise the many team members and stakeholders. This professional tends to be one who is seasoned and at the mid-career point of their professional life. This professional needs to have a lot of energy, enthusiasm, positivity, creativity and the ability to problem solve effectively. The Team Leader will ensure that the program staff will provide 24 hour/7days/365 days of on call availability for crisis intervention services. LSSI will insure that clinical consultation and management supervision will be available to on call staff when crisis intervention is needed. The Team Leader will be an integral part of all planning and implementation the TFCO program

The Foster Parent Specialist (Recruiter, Licensing, Trainer and PDR caller):

This will be a full time, Bachelor's level position, as in addition, to the TFCO responsibilities, this individual will have the responsibility of licensing the foster homes and thus must meet the qualifications laid out in Rule 401 of DCFS Rule and Procedure. This position has the responsibility of recruiting foster homes, conducting the TFCO foster parent training and conducting the daily PDR calls. The ideal candidate is warm, outgoing and comfortable with computers. They should be relationally focused as they provide the initial recruitment and engagement and continue to be a primary support for the foster parents thorough the training and daily conversations. They participate in the weekly team meeting. This position is often successfully filled by a professional with foster parenting experience.

The Professional Foster Family:

Several key characteristics have been identified by TFC Consultants, Inc. as indicators of a successful TFCO foster parent as these foster parents tend to be distinct from other foster parents. They should be highly interested in the short-term treatment aspects of the program and willing and able to work with the child's identified aftercare family. They must enjoy working in an intensive team environment and open and comfortable with many people in their homes, participating in daily calls and weekly team meetings. They should be positive, nurturing, flexible and consistent and able to execute the behavioral interventions and chart effectively. They will become certified in the TFCO model. Successful TFCO foster parent recruiting tends to occur among people in service professions, such as education, social services or nursing; among foster parents who have "given up" due to past lack of support or teamwork; and retired people. They may have children of their own who are still in the home and often do, which is accounted for during the matching process. One of the benefits of the TFCO model is that with the close teamwork including the weekly foster parent meeting, TFCO foster parents continue to learn and grow with the program and with each other. They master the skills needed to deliver the program with each scenario and placement and develop a strong support system in

which they rely on each other for advice, respite, or simply an ear to listen. Foster parents who are the right fit rarely leave the program and are often the best recruiters for the program. This is a professional foster parent model thus the TFCO foster parent will receive a stipend entitled “Differential of Care” for their investment in the TFCO program, as well as the standard per diem reimbursements for the care of the child. They will also receive funding to provide for rewards and incentives to the child as the child has the opportunity to earn privileges and rewards during the course of treatment. Recruitment and retention of successful TFCO foster parents is the vital to a strong TFCO program and thus LSSI is committed to providing an attractive package.

The Case Manager:

This TFCO-C role has been adapted by replication sites depending on the level of case management paperwork and tasks required by the individual state or country. In Illinois, the state mandated case management requirements are considerable thus LSSI will add a team member who will be responsible for completing the Risk Assessments, Service Plans, updating the Integrative Assessment, completing all other paperwork, managing the Statewide Automated Child Welfare Information System (SACWIS), attending Administrative Case Reviews (ACR's) and court dates, facilitating sibling and family visitation, coordinating Child and Family Team Meetings and working with the birth parents towards return home. This full-time Bachelor's or Master's level position will work under the supervision of the Team Leader and be a full member of the treatment team, including attending the weekly team meeting. The case manager would continue to be responsible for case management for three (3) to six (6) months after discharge from the program ensuring continuity of care and increasing the stability of the aftercare placement.

The Child and the Family Therapists:

These Master's level therapists will be hired at a .5 FTE dedicated to the TFCO program. However, they will be hired as a full-time LSSI staff members as it is believed that offering full time employment and benefits will increase the candidate pool of highly qualified and enthusiastic professionals who will be invested in and committed to the program. The ability to attract and maintain a full team of TFCO staff is as vital to the success of the pilot program as the ability to attract and maintain highly invested and trained professional foster parents. The therapists will spend the other 50% of their time serving children and families in the foster care programs and thus will be available to continue to work with the TFCO child and families when the child moves into his or her aftercare placement. The child therapist will meet with the child weekly in the home or in the community and serves the important role of the child's advocate providing a high level of support and guidance to the child. The child therapist works with the children ages eleven (11) to fourteen (14) to identify problem areas and designs interventions, along with the treatment team, to help the child improve his or her skills in those areas. The therapy, which is delivered in the highly structured and positive environment, focuses on “in the moment” behaviors and daily regulation. In addition to being trained in the TFCO model, the child therapist will be trained in and deliver Trauma Focused Cognitive Behavioral Therapy (TF-CBT) to those children whose trauma experience and symptoms indicate that they would benefit from this additional layer of treatment. The effectiveness of this dual modality of treatment has been used by other TFCO programs and has been determined to enhance the outcomes of the program. The family therapist will work with the child's biological family or identified aftercare family and meets with the family weekly to prepare the family for the return of the child by identifying and implementing the appropriate changes for the child to live successfully in the home. This mean the parents must change the way the family functions.

The parents need support and encouragement, in addition to intensive training in specific parenting skills. These skills typically include using discipline effectively, reinforcing the child's pro-social behaviors and skills, and improving communication and problem-solving strategies. The therapists should be professionals who have a background in behavioral approaches and have a deep understanding of trauma informed practice. They should demonstrate a strength based orientation, enjoy working in a team environment and have strong communication skills.

The Skills Coaches:

LSSI will hire hourly individuals to serve as Skill Builders. The Skill Builders travel to the foster homes on a weekly basis and deliver specially designed recreational activities which target 2 or 3 behaviors as indicated by the Treatment Team. The Team Leader delivers skill instructions before each session and debriefs with the Skill Builder after the session. All activities have modeling and shape positive behaviors. Effective Skill Builders may be paraprofessionals or students who understand their role in the treatment team and have good boundaries so they do not step out of the role. Several may be hired on a team to effectively deliver the service to the children.

The Psychologist:

LSSI currently has contracts with child psychiatrists who provides assessments, medication monitoring and psychiatric consultation for the Foster Care Programs. In the Chicago program, Dr. Andrea Bacon, MD has worked with the program since 2002. She is board certified in Child and Adolescent Psychiatry and board certified in Psychiatry with over 15 years in the field. In the Northern Region, Dr. Daniel Martinez, MD provides the assessments, medication monitoring and consultation required to serve the children and youth in the programs since 2002. Due to the geographic area that the program covers, he has provided the service via tele-psychiatry. Dr. Martinez has board certifications in Child and Adolescent Psychiatry and in Psychiatry and has over 20 years of experience in the field. The existing contracts will be expanded to include an additional 10 hours per month of psychiatric consultation, assessment and medication monitoring for each TFCO team.

2. Preservice and In-service training:

Describe the training that will be provided to each team member. Who will provide the training, developer? What other training may be required in addition to training on the evidence based practices?

The TFCO-C teams will engage in the required pre-service training delivered by TFC Consultants, Inc. The Team Leaders are required to complete five (5) days of training and other staff members are required to attend four (4) days of training. The Foster Parents are required to complete three (3) days of TFCO-C training, in addition to completing PRIDE training and ongoing training required to maintain their DCFS Foster Parent License. LSSI will train all team members, including the foster parent in the use of Lifebooks, as it an identified component of the program used to assist in the healing experience for the children and in the process of identifying important people and relatives in children's lives will bring rich potential resources in securing the aftercare families. LSSI has also made a commitment to ensure that the child welfare case managers and therapists fully understand the effects of trauma on children in the child welfare system. The NCTSN curriculum is being used for all child welfare staff in the Chicago region with hopes to expand it to the rest of the state. All staff are required to attend the De-escalation/Safety training on an annual basis,

which is a modified version of the foster parent training and incorporates trauma informed language and practice. Staff have also watched and discussed the video “Removed” as part of the efforts to become trauma capable (<http://removedfilm.com/>). LSSI staff are required to participate in Cultural Diversity and Blood-borne Pathogen training annually. LSSI has invested in delivering high quality and trauma informed training to foster parents and staff and has a team that consists of four (4) trainers under the direction of the Statewide Foster Parent and Staff Development Manager.

3. Ongoing consultation and Coaching:

Who will provide consultation and coaching? How will it be provided? How often will it be provided?

Consultation and coaching will be provided by TFC Consultants, Inc. The consultation and coaching is provided to each team and specifically to the Team Leader through weekly phone calls in which the videos of the weekly team meeting are reviewed and discussed. Three site visits per year will occur and can include attendance of the foster parent and clinical meeting, booster training, problem solving and in the moment consultation and support. LSSI will also have learning and support opportunities build in between the three (3) teams for additional support.

4. Staff Evaluation:

Who will be responsible for assessing and evaluating the skills that are reflected in selection criteria and taught in training and reinforced in consultation and coaching? Performance as well as fidelity to the model must be assessed and evaluated. How will this evaluation take place?

LSSI will be responsible for assessing and evaluating the skills of the TFCO-C teams in close concert with TCO Consultants. The Team Leader is the key professional who works closely with the assigned TCO consultant, participating in weekly phone calls to review and discuss implementation. The Team Leader supervises all team members and is responsible for their evaluation and professional growth. Each Team Leader will be supervised by the regional Program Director (Carol Taylor, MSW, LCSW in Chicago, Laura Vargas MSW, LCSW in Rockford and Kathy Reese MSW, LCSW in Rockford) and provided support from Anne Larrea Barclay, LSSI Implementation Consultant as well as the program champions, Ruth Jajko, Senior Associate Executive Director and Bill Franklin, Associate Executive Director. The Team Leader will meet with each team member individually minimally monthly, in addition to the weekly meetings, and a yearly formal evaluation will occur.

5. Facilitative Administrative Support:

Who will provide the leadership and support necessary to keep staff and team members organized and focused on desired outcomes? How will the necessary supports be determined? How will decision making be informed? What data should be collected and what systems will need to be built to capture the data?

This project has the strong commitment of the senior leadership at LSSI. LSSI’s Senior Associate Executive Director, Ruth Jajko and Bill Franklin, Associate Executive Director will serve as the foremost champions of the program with support from John Schnier, Vice

President. This senior team represents a deep and comprehensive knowledge of child welfare best practice, effective clinical interventions and implementation of innovative and evidence-based programs. Knowing the time and attention the implementation of an evidence-based replication program needs, an additional investment is being made and an Implementation Consultant hired. Anne Larrea Barclay, a professional over 25 years of experience in human services, mental health and child welfare fields will serve in this capacity over the life of the grant. The systems of communication, feedback and quality assurance are in place for current LSSI programs and will be adapted to serve this program, with additional connections to TFC Consultants, the TFC Steering Committee, DCFS and Chapin Hall.

6. Systems Interventions:

How will systems barriers to implementation be identified? How will the barriers be addressed? Who will be responsible for addressing the barriers?

The Therapeutic Foster Care Steering Committee will be the main avenue to address barriers that may arise in the implementation of the pilot program. Ruth Jajko, Senior Associate Executive Director, Bill Franklin, Associate Executive Director, and Anne Larrea Barclay, Implementation Consultant will serve on the Steering Committee as well as designated subcommittees. They will proactively bring issues, ideas and contributions to the committee in order to problem-solve and break down barriers towards while moving towards success.

5. Logic Model

The Implementation Plan must include the logic model developed by the Provider. . The logic model should be consistent with the population, program/interventions, and outcomes described above.

The logic model for LSSI's TFCO-C program is under development and will be finalized once the Team Leaders and key TFCO staff have been hired by the agency. Having the Team Leaders involved in the process is very important as they are the drivers of the program.

TFC Consultants have used the following logic model for TFCO-A:

Intervention	Outcomes
Intensive supervision (at home, school, w/peers) + daily adult mentoring and reinforcement of normative behaviors + clear and consistent no harsh limit setting	Less association with delinquent peers Fewer arrests Less time incarcerated Less pregnancy (girls) More school engagement Less substance use Less depression/suicide ideation

6. Work Plan for Installation and Implementation Activities for the Project Initiative and Each Associated Intervention

The Implementation Plan should provide a plan and estimated timeline for activities associated with installation, initial implementation, and full implementation of the program and interventions. It should also provide plans and timelines related to the development of a communication plan and a quality assurance plan. To the extent possible, this section should include a description of the activities, the responsible parties, the timeframes for beginning and completing activities, and the products or benchmarks of progress that will serve as evidence of completing the activities. Providers should do their best to ensure that plans for the first four months of FY2017 are very detailed. The plans for the following eight months of FY2017 can be more general.

- **Installation Activities:** Implementation Plan will summarize plans for initiating service delivery, that would include such activities as establishing referral and matching processes, implementing assessment protocols/tools, who is doing what, and when and how staff will begin providing services associated with the program interventions. Provide plans to develop the resources needed to support the intervention(s) such as: Supports to be developed to address systemic barriers, staffing, training, coaching, consultation, data collection systems, administrative/organizational supports, and fiscal leveraging.
- **Initial Implementation Activities:** Once Providers have a plan for installing the drivers to support implementation, Providers should make a plan for the initial implementation stage of the program and associated interventions. This includes: final exploration with and selection of any partnering agencies, expected processes and dates for hiring staff, training staff, developing supervision and coaching plans, plans for installing any required data systems relevant to intervention (e.g., fidelity), development of communication and feedback loops, and pro-active problem-solving protocols.
- **Communication Plan and Strategies:** Since each Provider is responsible for effectively communicating with a number of teams and partners, both internally (with partners and teams implementing the intervention) and externally (with the Department of Children and Family Services), the Implementation Plan must detail the processes, procedures, and strategies for maintaining efficient and effective communication for all applicable partners.
- **Quality Assurance:** Describe how the continuous monitoring of quality and fidelity of the intervention(s) will take place regularly throughout the implementation process. Provide a framework for continuous quality assurance and implementation. Provide the activities, responsible parties' timeframes and outputs. Include the process for refinement of the intervention according to the model and the process for making adjustments to the model, if needed, based on the monitoring of the quality of the

implementation (e.g., quality of training, coaching) and the quality of the intervention (e.g., fidelity).

Please see attached plan. Note, this plan is a living document which will guide the implementation process and completed, changed and adapted throughout the process as need and demands dictates.

7. Anticipated Major Barriers and Risk Management Strategies

Grantees should identify any anticipated major barriers to executing the Implementation Plan and any planned risk management strategies associated with the anticipated barriers.

There are two possible barriers that may impact the implementation of the project. The first is that the historical practice of the system is that children's needs are not identified early in the case. Children tend to fail through multiple placements before they are referred to the level of care that may provide the treatment that they need and often, their needs and behaviors have become more acute because of the multiple moves and disruptions. And as the children fail, their relationships with family members and other resources are damaged and often, never repaired. Practice will need to change to best serve the children referred to the TFCO-C program. The child should be screened and needs identified as the earliest possible opportunity, such as the initial Integrated Assessment, so the child can received the short term intensive treatment he or she needs and the identified aftercare home, selected from caring and involved kin, prepared and able to care for the child. Systems to accomplish this will need to be carefully built and monitored.

The second possible barrier is the many interested parties in the project, such as DCFS, Chapin Hall, the BH Consent Decree monitor, the ACLU, the court, the Governor's Office, TFC Consultants, Inc., Oregon Social Learning Center, LSSI, JCFS, and CHASI, who may have competing priorities as the project is implemented. The Steering Committee and the fact that DCFS has designated a point person for the project should assist with managing this and LSSI is committed to raising and working through barriers as they arise in order to successfully implement this innovative program which will improve the future of children and families.

EXHIBIT J



children's home + aid

THERAPEUTIC FOSTER CARE: IMPLEMENTATION PLAN

JUNE 2016

1. Introduction: Theory of Change

The proposed model pairs Children's Home + Aid's Adolescent Foster Care model – known as the Excellence Academy – with evidence-based clinical services, and TCI-F, an evidence-informed foster parent training and support model which teaches crisis prevention and de-escalation techniques for families who are caring for challenging children in their homes. All services will be trauma-informed and grounded in the Attachment, Self-Regulation and Competency (ARC) approach and delivered in team approach by a range of adolescent foster care professionals.

Long term goals of the program and activities to achieve each goal include:

1. Safe and stable placement in a family setting
 - a. Intensive case management (10:1 caseloads)
 - b. Respite services
 - c. Pre-service and ongoing training for foster parents in TCI-F and ARC
 - d. Weekly coaching and support for foster parents
2. Improved level of child functioning
 - a. Comprehensive mental health assessment and evidence-based therapy
 - b. A supportive peer environment for the youth (Excellence Academy) with focus on education, therapeutic mentoring and social-emotional learning
 - c. Psychiatric consultation as needed
 - d. Individualized behavior management plans grounded in TCI principals and built on the youth's residential treatment success
3. Legal permanency
 - a. Family finding and engagement
 - b. Activities to engage birth parents via the QPI principles of shared parenting

- c. Matching with Success Coaches for increased relational competencies

2. Clearly Defined Target Population(s)

Target Population: The target population is youth ages 12 to 18 with mental health needs and a history of placement instability. Target youth will be ready for discharge from residential or shelter care. The target geographic area is Cook County. It is anticipated that these interventions will be most successful with youth that have received treatment from a program that utilizes TCI.

3. Clearly Defined Intervention(s)

Children's Home + Aid will implement a model that provides skills to the foster family and youth in order to support stability, establish health connections and facilitate permanency. It pairs the agency's Excellence Academy program – which has shown promising results with youth stepping down from residential care – with evidence-based trauma-focused clinical services. The proposed pilot will include intensive training and support for foster parents via TCI-F, a research-based training curriculum for foster parents. TCI-F teaches crisis prevention and crisis de-escalation techniques for families who are caring for challenging children in their homes. All program staff will also be trained trainers of TCI-F, in order to support individual coaching with families and youth.

All services will be trauma-informed and grounded in the ARC approach. Children's Home + Aid is adopting a trauma-focused approach across the entire organization using the ARC framework to inform the way the agency views and interacts with clients and caregivers affected by trauma. ARC, recognized as a promising practice by the National Child Traumatic Stress Network, is a systems-based approach to trauma-informed practice for providers working with children and youth and their caregivers or care giving systems. All agency staff will be trained to have a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal from trauma. Foster parents will also participate in the Resource Parent Curriculum (RPC) - an eight module program designed to provide resource parents with the knowledge and skills needed to effectively care for youth who have experienced trauma.

All children will have access to a comprehensive mental health assessment and evidence-based, trauma-focused clinical services. The evidence-based clinical treatment model offered will include TF-CBT, which has been proven effective in treating traumatized children. It has the strongest research evidence of any treatment model for this population. TF-CBT improves post-traumatic stress symptoms, depression, anxiety, externalizing, sexualized behavior problems, shame, trauma-related cognitions, interpersonal trust, and social competence.

Children's Home + Aid's Excellence Academy is designed to support youth in remaining stable in their placements. An analysis of placement change rates for clients two years before they entered the Excellence Academy and two years after they began receiving Excellence Academy services shows that, on average, youth experienced fewer placement disruptions after they entered the Excellence Academy and fewer disruptions the longer they received Excellence Academy services. These services include life skills training, social-emotional learning and educational advocacy, delivered via group and individual therapeutic mentoring.

A full team approach will be utilized to provide training, support and case management:

Placement Stabilization: Program staff will work with the youth, caregivers, and case management to facilitate placement stabilization. Staff can assist caregivers with navigating through stressors that often arise in the caregiver-youth relationship. Services will support caregivers through conflict mediation and guidance on effective ways to work with youth. Staff will provide training in TCI-F and on various topics regarding parenting traumatized youth.

Caregiver and Professional Engagement: Program staff will have weekly contact with caregivers to address issues regarding attendance, schedule confirmation, and any other needs that may arise. Excellence Academy staff will work with caregivers and case management staff to develop goals, plan stabilization services, and assess the youth's needs. **Transitioning Youth from Residential Care:** The target population includes youth returning to a family setting after placement in residential treatment. These youth require additional transitional supports for both the young person and the family. To help prepare the youth and family, the Case Manager will facilitate visits between the residential youth and the foster family, provide individual coaching and support, ensure that all service needs are identified and resources confirmed to meet the needs upon placement, help to develop a behavioral treatment plan for use in the foster home, provide weekly in-home support for youth transitioning from residential care to the community for at least the first 90 days foster home placement, and deliver group and individual foster parent training specific to residential step-down clients.

Behavior Management, Crisis Management, and Parenting Approach: All youth will have individualized behavioral treatment, respite and crisis intervention plans. Children's Home + Aid's AFC program uses a strengths-based approach and incorporates youth voice into program planning and delivery. Use of TCI-F techniques will minimize restrictive parenting techniques. All foster parents will be trained in the TCI-F model, which teaches crisis intervention and crisis de-escalation in ways that help children learn to avoid losing control. Children's Home + Aid staff will become trainers in this model, and will provide pre-service training to foster parents as well as ongoing, on-site coaching. The TCI-F method gives parents strategies to prevent and de-escalate crises and avoid power struggles. Parents will be trained in: behavior support techniques; emotional first aid; how to assess a crisis situation; how awareness of self, the child and the environment relates to crisis prevention; how managing the environment, setting clear expectations, and using active listening skills can prevent crises; how to negotiate rules and expectations; use of consequences; how to assess what children need; crisis co-regulation techniques to defuse a potentially violent/ aggressive situation; Life Space Interviewing; and developing individual crisis management plans.

Case Management: The AFC Case Managers will have a caseload ratio of 10:1 and will provide intensive case management and crisis intervention to support the youth and the family, working in coordination with the Advocates who provide mentoring. The Case Manager will provide 24-hour availability to respond to crises in the foster family and youth to support trauma, and how to de-escalate, problem-solve, and manage behavior in the home so the youth is able to remain stable in their placement. Individualized wrap planning for these youth will support non-traditional supports including extracurricular equipment, additional transportation, etc. The AFC Case Managers will provide individual crisis intervention and respite plans for each youth, developed jointly with the youth, foster family and treating clinician. Case management services will include: mental health services, including psychiatric care, and individual treatment planning; community and onsite mentoring provided by Advocates; training for foster parents serving specialized foster youth; educational support and advocacy via the public school system, Legal Assistance Foundation and Children's Home + Aid's Educational Coordinators; after-hours on call system; and permanency planning for youth and families based on the best interest of the youth, considering the youth and families' wishes.

Respite: Foster parents will be provided with a minimum of 15 hours per month of respite services. All families will have an approved respite plan developed within 30 days of placement and reviewed and revised as needed at least every six months, based on the youth and family's need. Respite for foster parents will be provided by Advocates on a regular basis in the form of mentoring and on-site programming, and will be available in crisis situations as well. All youth will have individualized behavioral treatment, respite, and crisis intervention plans in place.

Quality Parenting Initiative: Children's Home + Aid is the first child welfare agency in Illinois to implement the Quality Parenting Initiative ("QPI"). Starting in 2015, Children's Home + Aid adopted the QPI approach to recruiting and supporting foster parents. In adopting the QPI approach, Children's Home + Aid's goal is to ensure that all children have excellent and loving parents by providing foster and relative parents with the support they need to meet each child's needs and by partnering with birth family whenever possible to facilitate stability and permanency.

4. Implementation Capacity Assessment (Assessing Drivers)

The proposed TFC-Adolescent Foster Care model will include the following core elements:

- Intensive mentoring with Excellence Academy Youth Advocates and other adult connections such as biological family members and trained community volunteers;
- at least weekly home visits;
- regular (at least 15 hours per month) respite for foster parents;
- intensive support and training for foster parents through TCI-F and RFC;
- classroom and individualized life skills training;
- youth voice and input through the VOICES Youth Advisory Board;
- 24/7 on-call availability;
- family engagement and family finding;
- psychiatric consultation; and
- Individualized behavioral treatment, respite, and crisis intervention plans.

Are materials available that are required for implementation of the intervention (e.g., manuals, training videos, assessment instruments, technical equipment)? If yes, what is available?

Children's Home + Aid will contract with Cornell University to receive all TCI-F materials and participate in a five-day train-the-trainer certification. This is scheduled for October 2016. ARC training has begun, and additional training will be provided by the National Center on Traumatic Stress specific to the Resource Family Curriculum. Although clinicians experienced with TF-CBT are already on staff, additional clinicians will require training in the model.

Are there fidelity assessments/measures? Please describe them (e.g., dosage, quality, content, and timing). Be sure to note whether or not research and/or evaluation efforts demonstrate that the fidelity measures have been positively correlated with better outcomes and/or help to distinguish the intervention from service or treatment as usual.

None of the interventions require specific fidelity assessments or measures, although each requires certification in the model post training. These certifications will be complete in Fall 2016. Cornell University will provide ongoing consultation to Children's Home + Aid to monitor fidelity to the TCI-F model and provide guidance on agency implementation.

Ensuring Staff Competence at the Practice Level

The Case Managers will have at least a bachelor's degree in Social Work or a related field from an accredited school and a minimum of two years' experience or a master's degree in Child Welfare or a related field and meet all regulatory requirements. All staff providing clinical services will have a master's degree in Social Work, Counseling, or a related field and are supervised by an LCSW or LCPC. We will give preference to those with experience and a track record of performance.

All Case Managers will complete the DCFS required Foundations Training. All program staff will be trained in the ARC model, which includes the ten building blocks of trauma-informed treatment and service. Program and clinical staff will be trained on standardized measures (such as the Ohio Scales) and any other tools required by the evaluator, and staff will participate in Client-Driven Service Planning trainings delivered by DCFS. The trainings will focus on family-focused practice, strength-based practice and trauma-informed service planning.

Children's Home + Aid will follow DCFS policy, rule and procedure regarding case management services. Case Managers will have strong case management experience and decreased caseloads of 10:1 to best meet the needs of the youth. Children's Home + Aid will assign experienced Case Managers to this pilot project as the project is launched.

Children's Home + Aid has a talent management program that includes career development and training designed to recruit and retain high quality staff. This includes: regular developmental supervision sessions that occur at least bi-weekly to set, track, and review expectations and goals, and give and receive performance-related feedback on an ongoing and timely basis; annual performance reviews to evaluate and assess employee performance; and an Individual Development Plan ("IDP") that is reviewed and revised yearly. Through supervision and the IDP, employees explore and engage in advanced career learning and professional development. The process is designed to foster development through goal setting, defined metrics, and individual and/ or group projects and to align with both agency needs and individual aspirations. As goals and metrics are met, employees gain a higher level of job skill, knowledge, and experience within their current position. Continuous learning opportunities include LGBTQ cultural competency training, safety training, cultural diversity training, trauma-informed/ ARC training, client engagement and documentation, and online learning opportunities. Supervisors and Case Managers participate in a Supervisor/ Manager development series and a formal mentoring program matches new or junior employees with leadership staff for ongoing mentoring.

Organizational Supports Needed

Children's Home + Aid is changing our practice around foster parent recruiting and support through TFC and QPI. Utilizing a marketing professional informed by program content, Children's Home + Aid will develop and implement a targeted recruitment plan. . The plan will be informed by the QPI approach, which uses branding and marketing principles to strengthen foster care, including kinship care, and to improve recruitment, training, and retention systems for foster parents. Five Committees are working on the following areas:

1. Foster Parent Orientation
2. Foster Parent/Birth Family Relationship
3. Foster Parent Training
4. Better Teaming (Case management, licensing, clinical, etc)
5. Electronic Communication

Preservice and In-service training:

As mentioned above, all Case Managers will complete the DCFS required Foundations Training. The Program Manager will attend TCI-F training along with any staff on board at the time. Training will be a train-the-trainers model so that staff can continue to provide coaching to foster parents. All program staff will be trained in the ARC model, which includes the ten building blocks of trauma-informed treatment and service. Program and clinical staff will be trained on standardized measures (such as the Ohio Scales) and any other tools required by the evaluator, and staff will participate in Client-Driven Service Planning trainings delivered by DCFS. The trainings will focus on family-focused practice, strength-based practice and trauma-informed service planning.

5. Logic Model

Please see attached Logic Model/Theory of Change

6. Work Plan for Installation and Implementation Activities for the Project Initiative and Each Associated Intervention

Installation and Initial Implementation Activities:

Exploration and Adoption phase (Months 1-3)

- Create an organizational readiness assessment
- Hire project manager and foster home recruitment specialist
- Identify fidelity measures and assessment protocols
- Identify evaluation tools in conjunction with the project evaluator

Program Installation Phase (Months 4-5)

- Recruit and hire staff program staff.
- Train case managers in TCI-Family.
- Train program team in ARC framework.
- Create and implement TFC foster parent recruitment strategy
- Create Best Results process for TFC (theory of change, data collection protocol).
- Conduct a detailed assessment of programmatic/system needs and strengths, perceived barriers to providing proposed intervention services. Factors are likely to include community and environmental attributes, access and service delivery platform, public and private resources, existing policies and procedures and existing collaboration and provider and DCFS accountability.

Initial Implementation Phase (Months 4-6)

- License and train TFC foster homes (1-2 children per home)
- Establish placement criteria.
- Refine referral, matching and placement process.
- Implement assessment protocols/tools

Full Implementation Phase (Months 7-60)

- Screen, match and place referred youth.
- Conduct TFC-specific pre-service training of new TFC foster parents.
- Provide 24/7 on-call support for TFC foster parents.
- Hold quarterly BestStat meetings to review program data, create action items, and assess progress.
- Develop a plan for providing ongoing professional development and training for project staff to ensure lessons learned from program implementation can be readily incorporated into ongoing project management.
- Maintain data collection strategy.
- Support evaluation work as necessary.
- Participate in on-site and remote trainings.
- Analyze challenges and obstacles yearly for the following year with a corrective action plan.

Quality Assurance:

Children's Home + Aid's Department of Quality Improvement was established nearly 20 years ago and provides evaluation, support, and technical assistance for all agency programs and systems. While the QI Department was initially compliance driven, it has evolved over time to help programs incorporate compliance standards that are both qualitative and quantitative in nature. Program reviews involve the evaluation of program documentation AND practice standards and QI staff are available to assist with program development and improvement needs (e.g., quality improvement plans, training.) Children's Home + Aid's QI Department is responsible for overseeing the agency's COA reaccreditation process, facilitating all record reviews, reviewing all unusual incidents, and managing the agency's risk management process. The QI Department also provides leadership and oversight to the agency's trauma-informed initiative and is currently in the early stages of implementing the ARC Framework (Attachment, Self-Regulation, and Competency) throughout the agency.

7. Anticipated Major Barriers and Risk Management Strategies

The possible barriers to providing the proposed intervention services are: community and environmental attributes; access and service delivery platform; public and private resources; existing policies and procedures; existing collaboration; and provider and DCFS accountability.

As challenging youth step out of residential care and into the community, risks include elopement, criminal activity, injury to youth or others and return to residential care. Children's Home + Aid has a risk management protocol which is triggered by any out-of-the-ordinary situation and involves a comprehensive risk assessment and recommendations that are tracked by the quality assurance department. Additionally there is an ad hoc risk management committee at the Trustee level that analyzes and mitigates risk at the agency level.

CHILDREN'S HOME + AID TFC: THEORY OF CHANGE

June 2016

Children age 12-18 stepping down from congregate care

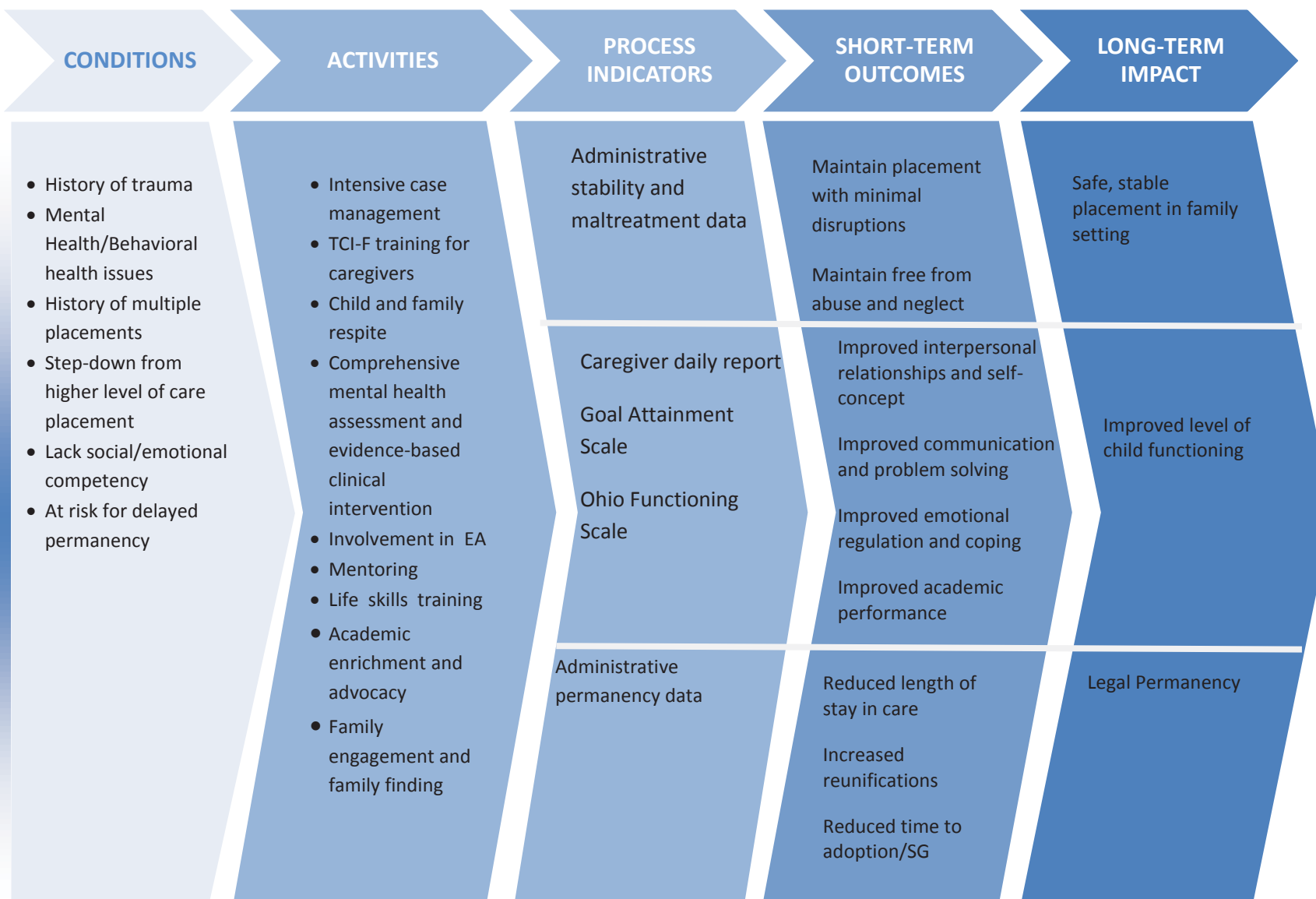


EXHIBIT K

JEWISH CHILD AND FAMILY SERVICES

THERAPEUTIC FOSTER CARE PILOT

IMPLEMENTATION PLAN

1. Introduction: Theory of Change

Please provide a short introduction to describe the project's overall theory of change. It should summarize the target population(s), the program and associated interventions, the expected short-term and long-term outcomes of the program and interventions, and briefly how and why they are expected to address the identified needs of the target population(s). More detail on the Theory of Change will be requested in the Logic Model section, below.

Through our substantial experience supporting and serving foster families, we have found the most common block to the effective use of foster homes for children who often end up in group care is the foster parents' lack of sufficient understanding and effective approach to the challenging reactions and behaviors of the children. Foster parents have huge hearts, but as they face the challenges these children present, the lack of understanding of their needs can lead to frustration and helplessness.

The reality of these children, ages 12 and over, often includes acting out behaviors, lack of response to the most heartfelt parenting and confusing or frightening emotional and behavioral responses to stressors. With an opportunity to inject both a conceptual understanding of the children and their behaviors and a toolkit of responses, the homes will be equipped to care for children with a wider range of challenges that could otherwise lead to requests for removal due to the strain. In order to achieve this, strong training, support, re-enforcement and self-care are key.

The project's theory of change is as follows. Initial program interventions will target the foster parents, including a comprehensive training protocol combined with the 6-week Together Facing the Challenge curriculum, weekly home visits to support care coordination/case management, taking a view of foster parents as key change agents and a team approach to treatment, focusing on preparation for adulthood, and respite. This stable parenting foundation combined with individual youth and family counseling to address trauma using Trauma Focused Cognitive Behavioral Therapy (TF-CBT) will lead to positive youth outcomes, including decreased symptoms, reduction in problem behaviors, and increased strengths. The Together Facing the Challenge builds on past work done by Chamberlain and colleagues to develop the evidence-based model in Oregon, Multidimensional Treatment Foster Care (MTFC) by adding critical components that were lacking: intense supervision and support of foster parents by staff and a proactive teaching-oriented approach to problem behaviors. By effectively addressing the youth's needs in the home, and concurrent aftercare planning with the identified permanency option, this pilot will lead to enhanced placement stability and permanency for youth.

2. Clearly Defined Target Population(s)

The Target Population are children and youth entering care 12 years and older who are included in one or more of the following 3 groups (content supplied by DCFS):

1. Step Down Group: Children and youth who are ready to be discharged from congregate care settings.
2. Deflection Group: Children and youth who would be placed in residential care but who may be stabilized in a home-based setting with the addition of appropriate, intensive supports for the child and the foster parent. These fall into 2 separate categories:
 - i. Direct Entry – Direct Entry is defined as children and youth who enter residential as their first child welfare placement. Youth mostly come to child welfare from hospitals, detention, or home based settings, most often due to neglect or dependency cases.
 - ii. Deflection – Deflection is defined as children and youth who have been identified by their clinical characteristics, as rated by their initial IA CANS, to be “at-risk” for residential/congregate care and who can be served in community settings with appropriate supports. The “at-risk” clinical characteristics include identification of two or more 2’s among the following IA CANS domains: Trauma Symptoms, Emotional Behavioral Needs, Life Domain Functioning, and Risk Behaviors.
3. Trauma Group: Children and youth entering care with severe trauma histories, as defined by having 2 or more “actionable” experiences among: Physical Abuse, Sexual Abuse, Emotional Abuse, Witness to Family Violence, and Witness to Criminal Activity or 1 severely actionable item from among these 5 CANS items. This third group of youth will likely comprise a portion of the Step Down and Deflection groups outlined above.

Providers must identify the Target Population intended to be served and must identify the elements of TFCO or KEEP that will address the clinical needs of the children and youth in the categories defined above.

While the paths into the TFC pilot may be different, the needs of the youth will be rooted in the trauma and instability they have experienced and the skill deficits which impair their functioning and success. The Together Facing the Challenge model is a tool kit of excellent parenting skills and awareness that will equip the parents to respond to the variety of specific behaviors that may present themselves. The TF-CBT model is based in the understanding of trauma and its effects. The perspective, understanding and responses to the youth by all the adults involved in the foster home will thus be informed by the optimally therapeutic approach.

3. Clearly Defined Intervention(s)

Providers should describe their program with the associated list of intervention(s) for each of their target population(s). In this section of the plan, Providers should describe:

- *The program and interventions for the target population*
- *Who will participate in the program (e.g., child, parents, foster parents)*
- *How the program and interventions will address the various needs of the target population*

- *The short and long-term outcomes expected for each project component*

Please see the logic model attached at the end of this document which generally describes the program components, the participants for each one, the short and long term outcomes expected (Attachment B).

To address the question of how each intervention will address the needs of the target population, see below.

Program Element	Needs addressed
Foster Parent Recruitment	Youth's particular array of needs will be matched with the abilities and characteristics of the foster parents.
Foster Parent Training (including PRIDE, Together Facing the Challenge, Assessment)	Foster parents will be prepared with the understanding of the needs of the youth, how trauma has shaped the perspective and reactions of the youth and how to approach the youth to build the skills necessary for social and emotional wellbeing.
Caregiver-Child Matching	
Placement Adjustment Support	
Home visits with foster parents and youth (weekly by case manager and clinician, regularly by program supervisor)	Substantive in home support of foster parents by team to provide coaching, support and skill development by entire team. This will allow the parent-child relationship to thrive, the staff-foster parent relationship to grow, and for difficulties to be surfaced and addressed early, preventing serious acting out incidents.
On call crisis intervention	Youth's behavioral needs addressed through the skill building, support and coaching received through the Together Facing the Challenge curriculum.
Parent Daily Report (PDR)	Parent Daily Report (PDR) will be used to support communication between the foster parents and staff, monitor progress at the youth level, and facilitate outcome evaluation.
Individual and family therapy for youth (TF-CBT will be provided unless otherwise clinically indicated)	Youth's clinical needs rooted in abuse and turbulent life circumstances addressed in therapy sessions to address root causes for challenges youth is facing and provide healing through clinical interventions.
Weekly stipend for youth, individualized use	Each family will determine the best use of stipend funds to address each youth's challenges whether educational (tutoring), physical/ social (recreation,

Program Element	Needs addressed
	sports), social / emotional (respite involvement) or a combination.
Child and Family Team Meetings (CFTM) at 30 days and then every 60 days	This assembly of all important persons in a youth's life to review progress, obstacles and plans will ensure that no critical aspect is unattended, that all steps towards stability and permanency are being taken expediently and that all adults are working in concert on the youth's behalf.

The research and/or data linking the model to the key outcomes and/or meeting the needs of the identified Target Population of children and their families.

A summary of how "ready" the program and associated interventions are to be implemented and how much program development work remains to be done.

The project involves the use of Together Facing the Challenge, an enhanced therapeutic foster care model that builds on the MTFC-O approach, and TF-CBT to address previous trauma. The California Evidenced Based Clearing House assigned a scientific rating of 2 to Together Facing the Challenge and a 1 to TF-CBT. The use of the two models within the pilot will create a synergistic base of understanding and approach that gives the staff and foster parents a common language and tool kit. Farmer et al. (2010) summarized a 5-year randomized control trial conducted with 247 youth in therapeutic foster care in southeastern states. Youth placed in the intervention group (Together Facing the Challenge) demonstrated significant improvements over those in the control group (treatment as usual, therapeutic foster care) in all three youth outcomes: reduced symptoms, reduced behavior problems, and increased strengths. This study built on existing best practice within agencies to infuse additional training, consultation, and support to overcome barriers and deficits. Two additional articles published on Together Facing the Challenge (Murray et al, 2010; Murray et al, 2014) describe lessons learned in changing practice and recommendations for implementing Together Facing the Challenge.

TF-CBT was utilized during the RCT described above and best suited to meet the trauma needs of the youth served in this pilot. The joint parent-child therapy model fits well with Together Facing the Challenge for addressing behavioral difficulties related to traumatic life experiences.

TF-CBT was developed by Drs. Anthony Mannarino, Judith Cohen and Esther Deblinger. TF-CBT is an evidence-based treatment that has been evaluated and refined during the past 25 years to help children and adolescents recover after trauma. Currently, 14 randomized controlled trials have been conducted in the U.S., Europe and Africa, comparing TF-CBT to other active treatment conditions. All of these studies have documented that TF-CBT was superior for improving children's trauma symptoms and responses. TF-CBT is a structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 8-25 sessions with the child/adolescent and caregiver. Although TF-CBT is highly effective at improving youth posttraumatic stress disorder (PTSD) symptoms and diagnosis, a PTSD diagnosis is not required in order to receive this treatment. TF-CBT also effectively addresses many other trauma impacts, including affective (e.g., depressive,

anxiety), cognitive and behavioral problems, as well as improving the participating parent's or caregiver's personal distress about the child's traumatic experience, effective parenting skills, and supportive interactions with the child.

4. Implementation Capacity Assessment (Assessing Drivers)

Please provide information about the Exploration Stage work related to understanding of the model through the "what", "how" and "who" lenses. The developers of the model are the "who". They have already been identified to provide the intervention. This information is important to assess both the evaluability and the implementability of the intervention.

THE “WHAT”

1. *Has the developer/researcher identified, through research and/or theory-building, the core intervention components that must be present for the intended outcomes to be achieved? If so, briefly list the core elements.*

Together Facing the Challenge core components include:

- 3-day training with all TFC pilot staff, including the director, supervisor, recruiter, clinicians, and case managers
 - Train-the-Trainer model will facilitate future training of staff and ongoing training and support of foster parents
- Monthly staff follow-up consultation with the Developer/Trainer
- 6-week training for foster parents
 - 2 hours per week
 - Components of Training include:
 - 1) Building Relationships and Teaching Cooperation: evidence base; developing positive relationships with kids; Social Learning Theory Model (ABCs); and tracking behavior.
 - 2) Setting Expectations: power of praise; building a trusting relationship one day at a time; giving effective vs. ineffective instructions; and setting up, revising, or fine-tuning house rules.
 - 3) Use of Effective Parenting Tools to Enhance Cooperation: button pushing; what is a power struggle? what is a conflict cycle and what does it look like? how to avoid and get out of a power struggle; “you messages” vs. “I messages”; teachable moments; and developing a behavior contract.
 - 4) Implementing Effective Consequences: what is a consequence? time out; privilege removal; natural and logical consequences; restitution; work chores; making behavior management work; consistency and follow through; what works and what doesn’t? when consequences are not working...what then?
 - 5) Preparing Kids for the Future: Transition to Independence Process (TIP); family communication and problem solving; success at school starts at home; developing short and long range goals; essential life skills for transition to adulthood; problem-solving and decision-making; and identifying resources – “Circle of Support”.
 - 6) Taking Care of Self: family communication and problem-solving; recognizing, talking about, and dealing with feelings; taking care of self; what’s stress got to do with it? pie of life; and managing daily life stressors.
- Booster training for foster parents at 6-months and 12-months following initial training
- Care coordination/case management
- View of foster parents as key change agents
- Team approach to treatment
- Respite
- Appropriate intensity of support for foster parents
- Proactive teaching-oriented approach to problem behaviors
- Preparation for Adulthood
- Address previous trauma (e.g. TF-CBT)

2. *Are materials available that are required for implementation of the intervention (e.g., manuals, training videos, assessment instruments, technical equipment)? If yes, what is available?*

Materials provided by the TFC developer include:

- a. A digital copy [DVD] of the Together Facing the Challenge Toolkit, 2nd Edition, containing the:
 - i. Train-the-Trainer Manual
 - ii. Foster Parent Manual
 - iii. Training PowerPoint
- b. Detailed instructions for how to duplicate & share the aforementioned files among agency staff.
- c. A hard copy of the Together Facing the Challenge Manuals from which to model all printed copies
- d. A detailed list of forms and handouts to prepare in advance for the Three-Day Training.

TF-CBT training includes: completion of the TF-CBT web-based training (www.tfcbt.musc.edu), attendance at a 2-day learning session, and participation in 12 consultation calls in which cases are presented and discussed. Training will be led by Dr. Elssa Brown, Ph.D. There are different training dates and location. Clinicians who receive two days of TF-CBT training and at least 12 TF-CBT consultation/supervision sessions from approved trainers/supervisors during their graduate training will be eligible for certification once they have completed the other requirements and are licensed. Visit <https://tfcbt.org> for more information.

3. *Are optional intervention components specified? Please describe.*

JCFS plans to add several components to enhance youth outcomes and the overall success of the pilot:

- Annual 1-day booster training for staff with the Together Facing the Challenge developer
- Financial incentives for foster parents to participate in the training sessions
- Transportation and childcare assistance to support foster parent participation in trainings
- Weekly contact with Case Managers and the Program Supervisor
- Child and Family Team Meetings (CFTM) at 30 days and every 60 days
- Weekly stipend for youth
- Concurrent aftercare planning and training with the identified permanency placement

4. *Are there fidelity assessments/measures? Please describe them (e.g., dosage, quality, content, and timing). Be sure to note whether or not research and/or evaluation efforts demonstrate that the fidelity measures have been positively correlated with better outcomes and/or help to distinguish the intervention from service or treatment as usual.*

In conversation with the model developer and lead researcher, Maureen Murray, it was clear that fidelity to the approach is maintained by the monthly consultation call. Each agency that has implemented Together Facing the Challenge has developed an individualized approach to process and outcome evaluation, including fidelity measures. Following our initial 3-day training, the Implementation Committee will determine the most appropriate measures and process for ensuring fidelity alongside standard program evaluation activity done in concert with Chapin Hall.

THE “HOW”

Demonstrate that you understand “how” this intervention will be successfully implemented and sustained.

Describe current knowledge and information related to the following areas:*1. Ensuring Staff Competence at the Practice Level*

For each front-line person (e.g., caseworker, foster parent, therapist, other) involved in direct service with children or family members, please describe what is currently planned in relation to:

- *Using criteria relevant to the intervention for recruiting and/or selecting the direct service provider (e.g., qualifications, pre-requisites, experience, attitude, ability)*

Type of staff/provider	Minimum Educational Requirements	Qualifications in experience, attitude, ability, etc
Foster Parent	High School	Has parented in the past, or has been a foster parent for several years with successful placements. Recruiter will do a family find for youth to see if any relatives are an option for placement or resources. In addition, talking with the youth about fictive kin options as well. If not parented before, have several years of experience working with adolescents. Has demonstrated a clear understanding of adolescent behavior and is willing to learn new ways of working with youth. The person needs to have a can do attitude and not give up on youth. Must be willing to work with a team and be willing to have staff involved on a regular basis in their home, including phone support.
Case Managers	Bachelor's Degree	Minimum of one year experience working with youth and families, ability to be flexible, can make decisions on own or with minimum support, ability to engage teenagers and parents (both foster and biological), and has an understanding of cultural differences with families and youth.
Case Manager Supervisor	Master's Degree in social service or related	Minimum of three years as a case manager in child welfare; CWEL certified. Has the ability to help workers learn and grow professionally, and can work independently in making decisions yet will reach out for support for critical decisions. Has an understanding of cultural differences with families and staff.
Clinicians	Master's Degree in SW or a clinical counseling degree	Minimum of two years providing clinical services to youth who have significant trauma histories, as well as working with adolescents. The ability to lead groups and an understanding of cultural differences with families and youth.

Type of staff/ provider	Minimum Educational Requirements	Qualifications in experience, attitude, ability, etc
Program Supervisor	Master's Degree in SW or other human services field	Minimum of five years in clinical work with highly traumatized youth in the child welfare system. CWEL certified or the ability to be. Has a strong leadership ability to develop a new team. Has the ability to work with and understand cultural differences with families and youth. They must be licensed or in the process of being licensed

- The training needed, timing and length of training required, qualification of trainers, availability and access to qualified trainers

The trainers and all other staff in the program will attend the 3-day Together Facing the Challenge training provided by the developers of the model. The pilot staff will then participate in the monthly consultation provided by the developer to ensure fidelity. The master's level clinicians and the program supervisor will be the trainers for foster parents, see qualifications above.

Below is a description of the TF-CBT certification requirements and process for the supervisor and clinicians:

1. Master's degree or above in a mental health discipline;
2. Professional licensure in home state;
3. Completion of [TF-CBTWeb](#);
4. Participation in a live TF-CBT training (two days) conducted by a treatment developer or an approved national trainer (graduate of our TF-CBT Train-the-Trainer Program); or Live training in the context of an approved national, regional, or state TF-CBT Learning Collaborative of at least six months duration in which one of the treatment developers or a graduate of our TF-CBT Train-the-Trainer (TTT) Program has been a lead faculty member;
5. Participation in follow-up consultation or supervision on a twice a month basis for at least six months or a once a month basis for at least twelve months. The candidate must participate in at least nine out of the twelve consultation or supervisory sessions. This consultation must be provided by one of the treatment developers or a graduate from our TTT program. Supervision may be provided by one of the treatment developers, a graduate of our TTT program, or a graduate of our TF-CBT Train-the-Supervisor (TTS) Program (In the latter instance, the supervisor must be employed at the same organization as the certification candidate);
or
Active participation in at least 3/4 of the required cluster/consultation calls in the context of an approved TF-CBT Learning Collaborative;

6. Completion of three separate TF-CBT treatment cases with three children or adolescents with at least two of the cases including the active participation of caretakers or another designated third party (e.g., direct care staff member in a residential treatment facility)
7. Use of at least one standardized instrument to assess TF-CBT treatment progress with each of the above cases;
8. Taking and passing TF-CBT Therapist Certification Program Knowledge-Based Test.

JCFS has their own internal CBT lead clinician; she will be certified with another case. She will be working with the program supervisor by providing additional consultation on cases as well as being the additional trainer for the team. She will devote 4 hours a month to the program. She will also be attending the two day training.

- The supervision and coaching model, including the qualifications needed for the supervisor and/or coach

The master's level clinicians in the program (see qualifications above) will serve as the trainers of the Together Facing the Challenge model for foster parents. The supervisor, foster parent support personnel and case managers will also be trained in the model so that every JCFS staff member in the program is coaching and re-enforcing the model with the foster parents and youth.

Case managers have formal supervision 1 -1/2 hours per week with their supervisor. There is discussion of the ways in which trauma is being played out, the interventions used in the home, Court involvement, wellbeing and permanency. The case manager will review the life skills development taking place with the youth. Additionally, there is informal supervision that occurs throughout the week to proactively problem solve or deal with a crisis.

There will be formal weekly supervision for at least 1 ½ hours with each clinician. Discussion will focus on the foster parent training that is currently being done, as well as issues or concerns. There will also be supervision around each youth that is seen, discussion about youth progress or issues in treatment, the nature of trauma and the healing of this. There will also be informal supervision that occurs as needed when the clinician is dealing with a crisis or problem solving. There will be a twice monthly group supervision that occurs with the other clinicians to discuss specific cases or to have a training around specific identified needs. In addition there is a TF-CBT consultation both internally and from New York training center that will be provided to ensure fidelity to the therapeutic approach. The purpose is for learning as well as case direction.

- The *fidelity data system*, including whether or not a data system and associated infrastructure (e.g., Web-based data entry) are available or if you will be developing the data system to track fidelity. Has IT support been identified to assist with entering fidelity data and uploading video recordings should there be a problem.

At this time no fidelity data system has been identified. Following the initial 3-day training when all materials have been received and reviewed, JCFS will develop the system and related measures. JCFS has the IT support necessary to embed this data collection mechanism into the

JCFS client information system, and we are willing to work with Chapin Hall in whatever capacity to support the project.

- The outcome measures, monitoring, and data systems that are required or optional and that will be developed and sustained over time

The outcomes demonstrated during the 5-year RCT of Together Facing the Challenge will be measured for this pilot: decreased symptoms, decreased behavioral problems, and increased strengths. Foster parents will complete the Parent Daily Report (PDR) to support communication with the case manager and supervisory staff regarding behavioral concerns, and to facilitate evaluation of behavioral problems over time. The foster parent will complete the Strengths and Difficulties Questionnaire (SDQ) at baseline, every 6 months and discharge. Finally, the CANS will be completed as part of a collaborative assessment process consistent with communimetric theory which puts the shared vision of the work at the center – the youth. This will involve input from the youth, foster parent, case manager, supervisors, and other relevant stakeholders in the youth's life. Results from the PDR and SDQ will facilitate a reliable CANS assessment. Youth will be directly involved in assessment in a clinically-sensitive and youth-determined manner (i.e. case-by-case assessment approach).

See the project logic model and outcome indicator worksheet for specific details, Attachment B.

2. *Organizational Supports Needed*

- a. Describe how your agency will need to change in order to support new ways of work. What new policies, procedures, or resources likely will be needed at the agency level?*

JCFS is clear that the right amount of autonomy from its current specialized foster care program is critical to its goals. JCFS plans to establish a parallel but distinct unit for the TFC pilot that will be contiguous but not fully integrated into its Foster Care program. In order to properly assess the effectiveness of this new approach, we intend to allow this unit to evolve autonomously as some of the "standard operating procedure" in our other foster care might encourage more "group think" and migration to what is now standard practice. The additional support and use of evidence based practices will influence the evolution of this pilot in ways that should be encouraged and may divert from current practice in ways not envisioned. That said, the Director of Foster Care will oversee the entire department in order to ensure that access to clinical, consultation, after hours coverage, Continuous Quality Improvement (CQI) and other resources are accessible, and to enhance the strength of the pilot and inform overall practice.

JCFS is bringing its experience helping children with mental health, behavioral and developmental challenges in its long standing Specialized Foster Care program to this pilot. We have found that strong clinical services combined with highly supportive connections to foster parents and attuned case management services help these children develop, heal and progress to permanency. JCFS' history of clinically-based child welfare programs, agency wide dedication to quality and clinically minded administrative leadership give it a base of strength and stability in this new endeavor.

IT and CQI will work together to identify all data that needs to be collected and modify current data systems. Training will be provided to existing staff, and incorporated into new hire training for new staff. Depending on the scope of changes, additional staff resources may be needed during the brief startup phase. Automated reports will be developed to assist program management in the ongoing evaluation of project deliverables and milestones. The Foster Care program currently has a CQI Committee comprised of program staff and managers that meets quarterly. This project will be added to the standing agenda to allow for another layer of oversight and insight into ways in which interventions can be optimally implemented for youth.

3. System Supports

Describe the systemic supports that will facilitate the implementation of this intervention, including:

- *Anticipated changes in funding mechanisms and streams during the grant period*
- *The financial resources that might/will be able to sustain this intervention after the grant period ends*
- *Any significant changes in policies, procedures, or contracting relationships that will be needed at any level (e.g., State, county, agency)*
- *Systems partners who have agreed to collaborate (e.g., mental health, education, courts, substance abuse providers, other providers)*
- *Systems partners who will need to partner or collaborate differently but are not yet on board (e.g., mental health, education, courts, substance abuse providers, other providers)*

JCFS' ability to provide foster care to Illinois youth is dependent on a strong connection to DCFS, its strategic direction and the budget implications of that direction. DCFS has articulated a clear direction towards the reduction of residential placements as the various initiatives to develop adequate community based homes take hold. As this is simultaneously the direction Illinois wards need for their well-being and a far more efficient use of financial resources, funding for initiatives such as TFC are among the highest priority for the Department and are as stable as any funding in our current State environment. When the grant ends, JCFS anticipates that this type of foster care will be folded into overall programming according to the efficacy it has demonstrated over the grant period. JCFS' ability to provide foster care is, however, reliant on the state's ability to fund it.

There are two areas of system improvements or developments that would be needed to fully actualize the goals of the TFC pilot. One, the successful permanency goal depends on adequate community resources in the areas of mental health, recreation, medical and others to support the youth and their families. This gap between need and resources has been articulated in many contexts, and will affect the ultimate success of this and other foster care initiatives in order to prevent attrition.

Secondly, Illinois Juvenile Courts are not in complete alignment with the goals and strategies of this and other projects. Both because of bureaucratic inefficiencies and differences in the assessment of best interest, permanencies can be stalled for extended periods of time due to a misalignment with the court system.

JCFS' recruitment plan involves the engagement of community partners such as Sinai, churches, community centers and the like. JCFS is building on a foundation of these connections currently in

place with its foster care program but will need to be expanded and deepened to meet its goals for this pilot.

In this section of the Implementation Plan, Providers should provide an analysis and overview of what will be required to implement the intervention(s) as intended (Organizational and Competency Drivers), including:

- *Assessing the program and associated interventions relationship to identified **needs** of the target population(s) and **fit** with organizational structure and current priorities/values*
- ***Resources available** to support implementation*
- ***Readiness of the intervention(s)** for implementation in service settings and the **capacity** to implement the initiative/intervention (including training and technical assistance capacity)*

*Assessments of the **capacity to implement** should focus on Implementation Drivers currently in place to support the implementation of the intervention(s). They should also focus on current processes and service system functioning that need attention because they are incompatible with successful implementation and therefore will not facilitate achieving the desired goals and outcomes. Finally, they should focus on implementation supports that need to be developed to ensure that the intervention(s) are able to be executed as intended.*

For over 150 years, JCFS has been committed to serving and caring for vulnerable populations, particularly traumatized youth. One of our core values is supporting, nurturing, and protecting families. Toward that end, JCFS continuously strives for excellence in everything that we do. One primary way in which we do that is by identifying the most current research and evidence-supported methods for serving our target populations. Based on our experience utilizing TF-CBT in our outpatient counseling, IPS and Maintaining Adoption Connections programs, we are confident that this trauma informed approach will help youth and foster parents. By combining this with the Together Facing the Challenge model, we will truly be equipping our foster parents to care for and nurture the youth in their homes, which flows from another core JCFS value - Ensuring our staff receives high quality training, knowledge, and resources to succeed.

In addition to the resources covered by the project budget, JCFS will tap into various organizational resources to support implementation. First, JCFS staff will participate in ongoing training offered throughout the year (e.g. orientation, clinical training sequence, core management, case manager training sequence). Second, the agency's client information system (Avatar) will be modified to capture client admissions, demographics, and service delivery data. Third, data collected via Avatar and other data sources (e.g. CANS, SDQ, PDR) will be analyzed and shared with the Foster Care CQI Committee for ongoing implementation oversight and quality improvement. Consistent with our other programming, JCFS will not wait until year end to identify areas for change. This is built into the very structure of our work to ensure positive outcomes for each youth.

JCFS's readiness and capacity to implement is contingent upon the Together Facing the Challenge developers. As previously noted, we are submitting our enrollment application in May 2016. This will be reviewed to assess our readiness, and then the developers will be in touch to initiate training.

Implementation Drivers:

1. Staff Selection:

What skill set must each team member possess for effective implementation? What are the educational requirements for each team member? How many years of experience is needed? Please also include the foster parent as a part of the team. Please describe recruitment efforts for staff and foster parents.

Type of staff/provider	Minimum Educational Requirements	Years and type of experience desired	Recruitment Efforts used or planned
Foster Parent	High School or Bachelor's Degree preferred	Parenting experience with adolescents OR experience working with adolescents in some capacity for two years minimum.	Work with recruiter and current foster parents to identify potential foster parents. Offer an incentive for a successful find and placement. Recruit young professionals and offer a housing stipend for them to have a child placed with them. Full plan listed under Item #7, Work Plan
Case Managers	Bachelor's Degree	1	Consider current pool of case managers; offer a stipend for employees who successfully refer friends or other professionals. Advertise on professional sites.
Case Manager Supervisor	Master's in social work or related field	3	Advertise on professional sites; offer a stipend for employees who successfully refer friends or other professionals.
Clinicians	Master's Degree in social work or a related clinical counseling degree	3	Place ads on professional sites for this position. Talk with colleagues and look at current clinicians in spec program.
Program Supervisor	Master's Degree in social work or other human services field	5	Look within JCFS for potential transfer. Place ads in professional sites for this position.

2. Preservice and In-service training:

Describe the training that will be provided to each team member. Who will provide the training, developer? What other training may be required in addition to training on the evidence based practices?

Type of staff/ provider	Training Provided on EBPs	Training Provider	Other training provided	Training Provider
Foster Parent	6 weeks (12 hours) Together Facing the Challenge	JCFS staff	Pride if needed TCIF JCFS training curriculum covering topics of : Attachment Trauma Adolescent development Assessment Individualized Learning plans developed and implemented	JCFS staff
Case Managers	Initial 3-day Together Facing the Challenge Annual 1-day Together Facing the Challenge Booster Training Monthly Consultation Call with Together Facing the Challenge Developer	Together Facing the Challenge JCFS Staff – Train the Trainer Model	Foundation (if needed) Core Management Training Trauma 101, 201 Adolescent Development Crisis Intervention TCIF CANS Certification Ongoing bi monthly training developed in response to team need	DCFS JCFS
Case Manager Supervisor	Initial 3-day Together Facing the Challenge Annual 1-day Together Facing the Challenge Booster Training Monthly Consultation Call with Together Facing the Challenge Developer	Together Facing the Challenge	Core Management Training Foundation if not completed Adolescent development, TCIF CANS Certification	JCFS Faculty DCFS JCFS

Type of staff/ provider	Training Provided on EBPs	Training Provider	Other training provided	Training Provider
Clinicians	Initial 3-day Together Facing the Challenge	Together Facing the Challenge	Trauma informed clinical skills	JCFS Faculty
	Annual 1-day Together Facing the Challenge Booster Training	JCFS Staff – Train the Trainer Model	Adolescent development	TCBT trainer
	Monthly Consultation Call with Together Facing the Challenge Developer		Trauma 101, 201 CANS Certification	
	TF-CBT Attend two day training with certified TCBT trainers. Monthly consultation by JCFS CBT faculty.	TF-CBT and internally certified training staff	TCIF TF-CBT training	
Program Supervisor	Initial 3-day Together Facing the Challenge	Together Facing the Challenge	JCFS Orientation	JCFS Faculty
	Annual 1-day Together Facing the Challenge Booster Training		Avatar Training	DCFS
	Monthly Consultation Call with Together Facing the Challenge Developer	TF-CBT?	Core Management Training	
	Attend two day training with certified TCBT trainers. Monthly consultation for certification process. In addition internal consultation.		Adolescent Development	
			Trauma 101, 201	
			Foundation if needed	
			Individualized training plan based on need	
			CANS Certification	

3. Ongoing consultation and Coaching:

Who will provide consultation and coaching? How will it be provided? How often will it be provided?

To ensure fidelity to the model, the Together Facing the Challenge developer will provide monthly phone consultation to the TFC staff. The clinicians and program supervisor will be provided monthly phone consultation regarding TF-CBT, which will lead towards certification of the model. This will be done with the group together. JCFS also has an internal CBT trainer who will provide additional consultation to the team as well and provide training when needed.

4. *Staff Evaluation:*

Who will be responsible for assessing and evaluating the skills that are reflected in selection criteria and taught in training and reinforced in consultation and coaching? Performance as well as fidelity to the model must be assessed and evaluated. How will this evaluation take place?

The Program Supervisor will oversee the incorporation of Together Facing the Challenge expectations into the evaluation process in place at JCFS. The current written evaluation provides for the flexibility to build in all unique expectations of the program. The Program Supervisor will be in contact with the developer providing oversight and coaching to ensure the seamless integration of the model into the evaluation of all staff, both those providing the groups and the staff who are providing the coaching and re-enforcement of the skills and perspective in the foster homes themselves.

Evaluation of foster parent skills, knowledge and competencies is built into the overall project evaluation plan. Utilizing the CANS assessment, the Foster Parent will engage in a collaborative assessment process to develop a baseline. This will be done prior to training and the 16-week group, and then following these targeted interventions. Foster Parents will continue to be assessed every 6 months alongside the youth living in their home. Baseline and ongoing results will be used to identify areas of needs and strengths to be built. The developer of Together Facing the Challenge acknowledged that some early stage questionnaires have been developed related to parenting knowledge, however, nothing has been formally approved and recommended for implementation. JCFS will reach out to other agencies using this model to identify the most appropriate measures and questionnaires to evaluate knowledge gains made by foster parents.

5. *Facilitative Administrative Support:*

Who will provide the leadership and support necessary to keep staff and team members organized and focused on desired outcomes? How will the necessary supports be determined? How will decision making be informed? What data should be collected and what systems will need to be built to capture the data?

There are three staff members who are not involved in providing services in the TFC model who will be monitoring its progress, analyzing its outcomes and managing the evolution of the project closely. The Project Manager role is being played by the Chief Operating Officer. She is putting together the work plan, convening meetings for implementation and monitoring, identifying the issues that need attention and being the liaison to DCFS on the pilot. JCFS Senior Director of Child Welfare will be closely guiding the implementation phase including hiring. She will then directly supervise the Program Supervisor and provide back up support wherever needed to ensure that the operations run smoothly. Finally, JCFS' Assistant Director of Quality Improvement and Evaluation is permanently attached to this pilot to participate in monthly/regular implementation meetings over the entire 5-year project to document progress, pitfalls, barriers, and anomalies. She will be building new data collection functions within our client database, training staff on the completion of assessment tools and outcome measures, and ensuring that reports are available at the client as well as program level to evaluate progress. See the project logic model for a summary of process measures and outcome measures (Attachment B).

6. *Systems Interventions:*

How will systems barriers to implementation be identified? How will the barriers be addressed? Who will be responsible for addressing the barriers?

Monthly project meetings will be held in the first year, with a possible move to every other month in subsequent years if operations are sufficiently smooth. These will be the “tree top” level look at all elements of roll out to identify all levels of barriers from staff level to system level. This project team will create and monitor an action list to address all barriers identified. Barriers that involve JCFS personnel will be addressed by the Senior Director of Child Welfare and her staff, barriers that might arise in the system will also be addressed by her and the COO, both of whom have connections to DCFS’ pilot champions who can often determine the best course. Data difficulties will be address by the CQI leadership who will be a part of the team.

5. Logic Model

The Implementation Plan must include the logic model developed by the Provider. The logic model should be consistent with the population, program/interventions, and outcomes described above.

See Attachment B.

6. Work Plan for Installation and Implementation Activities for the Project Initiative and Each Associated Intervention

- **Installation Activities, Initial Implementation Activities, Communication Plan and Strategies and Quality Assurance:**

The JCFS work plan is included as a separate document, see Attachment A.

7. Anticipated Major Barriers and Risk Management Strategies

Grantees should identify any anticipated major barriers to executing the Implementation Plan and any planned risk management strategies associated with the anticipated barriers.

As of this writing, JCFS is aware of the following potential barriers to successful execution of the plan. First, DCFS is still working on key system elements that will support success such as the referral mechanism for youth has not yet been developed, the budget has not been finalized, the mechanism for determining outcomes is not determined, and DCFS foster parent required training is under-resourced. The Department has prioritized this project and is working steadily on all of these items but their successful resolution will be necessary for project support. JCFS is fully engaged in naming these elements and working with DCFS for resolution. Should one or more not be resolved, JCFS will modify its plans to work around it while naming the inhibitor clearly.

Secondly, the recruitment of foster parents is a national challenge. JCFS feels optimistic about its plan. As most of the costs of the pilot will ramp up in proportion to the rate cases are placed in homes, JCFS will be able to work with this inhibitor should it prove resistant to our efforts.

EXHIBIT L

Therapeutic Foster Care Committee Structure

June 2, 2016

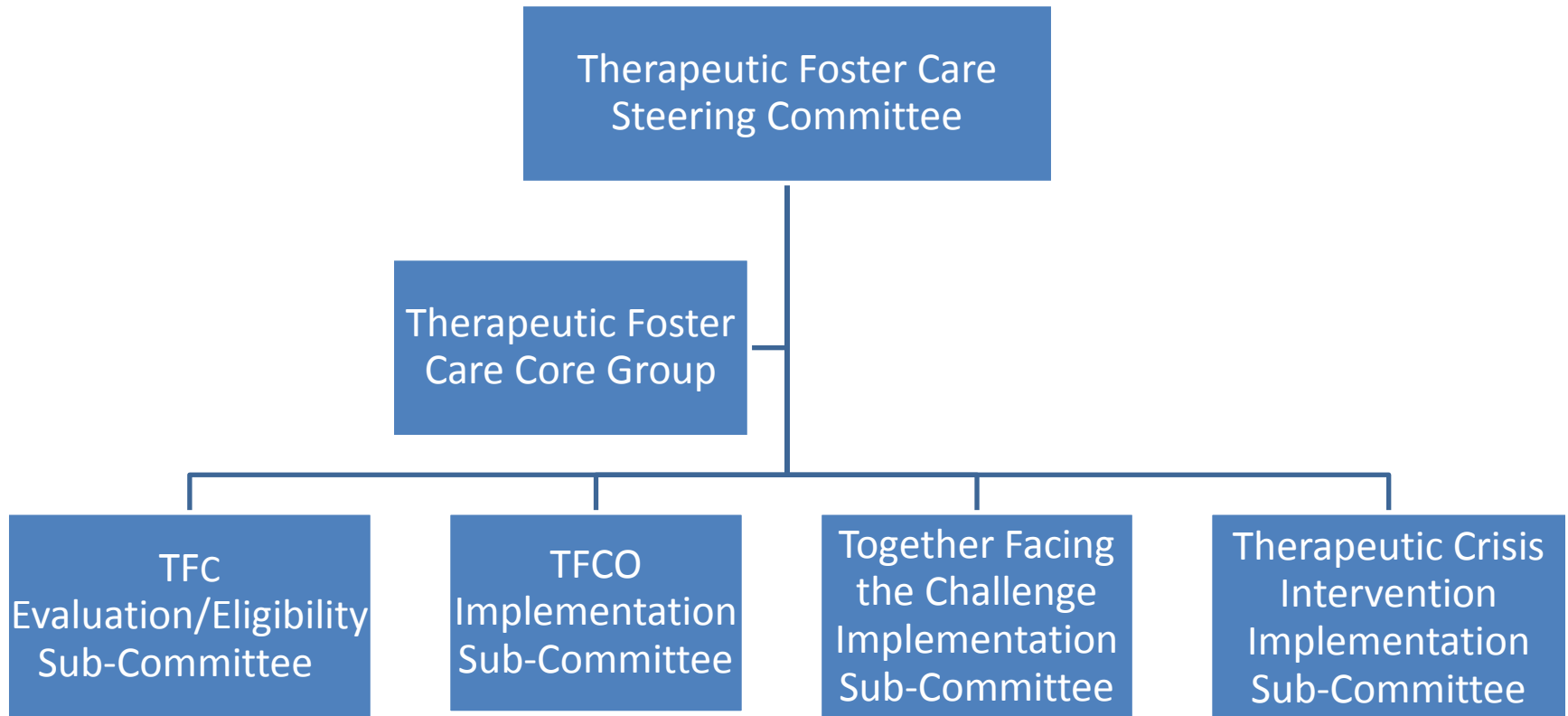


EXHIBIT M

I. Chapin Hall Summary of Provider Responses to TFC Requirement/FFTA Standards.

TFC Requirements/FFTA Standards	Chapin Hall Summary of Provider Responses
TFC Provider Agencies will:	
FFTA 2: Consistently implement and monitor a specific and defined TFC model that includes behavioral management, social learning, an eco-systemic approach and /or a strengths approach that minimizes restrictive parenting techniques (see also Additional Component 15 – Behavior Management Plan)	✓
FFTA 3: Place no more than 2 TFC children per TFC home.	✓
FFTA 4: Assign no more than 12 cases per caseworker (see also Additional Component 7 – Case Load Ratio)	✓
FFTA 5: Provide caseworkers with 24/7 back-up supports.	✓
FFTA 6: Recruit foster parents through a variety of sources	✓
FFTA 7: Recruit foster parents who bring high levels of commitment, flexibility, and financial and emotional stability.	✓
FFTA 8: Enhance the “fit” between foster families and foster children by attending to and matching needs, strengths, cultural, religious, and other preferences.	✓
FFTA 9: Provide an optimal and transparent level of honest information about child/youth strengths and needs to the TFC family prior to placement.	✓
FFTA 10: Provides foster parent(s) with at least 20 hours of pre-service training and at least 24 annual hours of ongoing training. At its best, trainings are individualized to the specific needs and strengths of the foster parent(s) (see also Additional Component 3 – Foster Parent Training (e.g. Quality Parenting Initiative QPI)).	✓
FFTA 11: Provide supports for foster parent(s) including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parent(s) address their own needs and those of their own biological children. (See also Additional Component 1 – Respite; Additional Component 11 – 24-Hour Crisis Response; Additional Component 13 – Non-Clinical Treatment Support Services for Caregiver/Parents; and Additional Component 14 – Caseworker Contact Requirements).	✓
FFTA 12: Consider and treat foster parent(s) as full professional members of the treatment team.	✓
FFTA 13: Train and support foster parent(s) to negotiate other systems in the community and serve as advocates for the child.	✓
FFTA 14: Emphasize the role of and frequently involve biological families in the TFC process.	✓
FFTA 15: Provide assistance for foster parent(s) to consistently engage with biological families.	✓
FFTA 16: Provide for aftercare for TFC foster parent(s) and biological families.	✓
FFTA 17: Allow for career opportunities for TFC parent(s) within the program.	✓
FFTA 18: Provide resources for independent and transitional living for older TFC-enrolled	✓

TFC Requirements/FFTA Standards	Chapin Hall Summary of Provider Responses
youth.	
FFTA 19: Consistently gather and review data on children, TFC foster parent(s), biological families, and the various components of the TFC process and outcomes.	✓
FFTA 20: Frequently seek the input of TFC foster parent(s), biological families, children, and professionals.	✓
Additional Component 2: Management of Case Care Coordination.	✓
Additional Component 4: Foster Parent Payment	DCFS to review provider cost proposals.
Additional Component 5: Staff Credentialing & Certification.	✓
Additional Component 6: Staff Training.	✓
Additional Component 8: Access to Psychiatric or Psychological Consultation (see also Additional Component 10 – Access to Psychiatric Treatment and/or Medication Management).	✓
Additional Component 9: Access to Evidence-Based or Evidence-Informed Clinical Treatment Services (e.g., ARC, TARGET, etc.).	✓
Additional Component 10: Access to Psychiatric Treatment and/or Medication Management (see also Additional Component 8 – Access to Psychiatric of Psychological Consultation).	✓
Additional Component 12: Non-Clinical Treatment Support Services for Children and Youth (e.g., extra-curricular activities and services, etc.)	✓
Trauma-Informed EBP Requirements: Bidders must include trauma-informed interventions in their model of therapeutic foster care.	✓

II. Provider Verbatim Responses to TFC Requirements/FFTA Standards.

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
FFTA 1 (RFP Appendix p. 21)	Defines and follow standards of care provided by the FFTA.	Children's Home + Aid reviewed the FFTA Standards and completed the Standards Review Instrument. We assess that we are in compliance at least 90% of the time.	✓	Yes, see below.
FFTA 2 (RFP Appendix p. 22)	Consistently implements and monitors a specific and defined model for TFC that includes behavioral management, social learning, an eco-systemic approach and /or a strengths approach that minimizes restrictive parenting techniques. See also Additional Component 15 – Behavior Management Plan (RFP Appendix p. 23).	The model pairs Children's Home + Aid's Excellence Academy with evidence-based clinical services, and TCI-F, an evidence-informed foster parent training and support model which teaches crisis prevention and de-escalation techniques for families who are caring for challenging children in their homes. All services will be trauma-informed and grounded in the Attachment, Self-Regulation and Competency (ARC) approach and delivered in team approach by a range of adolescent foster care professionals. The 'Excellence Academy' provides seamless service across the school-day, extended day program and life in the foster home. Underlying this program is the belief that "all young people need ongoing supports and opportunities on the road to successful adulthood." This program creates a supportive peer environment for the youth, with focus on education, mental health and independent living skills, while being able to maintain stable family life in a permanent home. The program provides the foster parents greater support and assist with the stability of the placements through crisis intervention, respite and	Together Facing the Challenge http://sites.duke.edu/tftc/ 6-week training for foster parents • 2 hours per week; Components of Training include: 1) Building Relationships and Teaching Cooperation: evidence base; developing positive relationships with kids; Social Learning Theory Model (ABCs); and tracking behavior. 2) Setting Expectations: power of praise; building a trusting relationship one day at a time; giving effective vs. ineffective instructions; and setting up, revising, or fine-tuning house rules. 3) Use of Effective Parenting Tools to Enhance Cooperation: button pushing; what is a power struggle? what is a conflict cycle and what does it look like? how to avoid and get out of a power struggle; "you messages" vs. "I messages"; teachable moments; and developing a behavior contract. 4) Implementing Effective Consequences: what is a consequence? time out; privilege removal; natural and logical consequences; restitution; work chores; making behavior management work; consistency and follow through; what works and what doesn't? when consequences are not working...what then? 5) Preparing Kids for the Future: Transition to Independence Process (TIP); family communication and problem solving; success at school starts at home; developing short and	Model (Age: 6-11): TFCO-C is the model implemented at LSSI, which meets the requirements for TFC and is monitored by TFC Consultants Inc. http://www.tfcOregon.com/ Model (Age: 12-14): TFCO-C is the model implemented at LSSI, which meets the requirements for TFC and is monitored by TFC Consultants Inc. It is adapted reflect the TFCO-A model for adolescents. TFCO was developed in 1983 based on the social learning treatment approach. The program is a short-term treatment intervention with two major aims: to create opportunities so that children are able to successfully live in families rather than in congregate care setting and to simultaneously prepare their parents, relatives or other aftercare resources to provide effective parenting so that the positive behavioral changes made during the TFC placement can be sustained over the long-run. Four key elements of treatment are targeted during placement and aftercare: • Providing the child with a consistent reinforcing environment where he or she is mentored and encouraged to develop socially, emotionally and academically.

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>community support. Successful engagement in this program has yielded greater placement stability, improved educational outcomes as measured by grades, standardized student achievement tests, improved attendance, grade completion, reduced school-based disciplinary actions and delinquent behaviors, and demonstrated skills promoting independent living and employment.</p> <p>TCI-F trains and develops competencies in the foster caregiver and program staff to help be a primary change agent with the youth. Via TCI-F, caregivers will be able to:</p> <ul style="list-style-type: none"> - Prevent and de-escalate potential crisis; - Avoid power struggles and enlist the youth's cooperation; and - Utilize the crisis as an opportunity for the youth to learn new coping skills. <p>Caregivers will be expected to successfully complete TCI-F certification prior to accepting placement of a TFC youth.</p> <p>Each youth will have an individualized behavior management plan, developed in cooperation with the youth and the treatment team. TCI-F will be incorporated into the plan to reflect youth's coping skills and tools.</p>	<p>long range goals; essential life skills for transition to adulthood; problem-solving and decision-making; and identifying resources – "Circle of Support".</p> <p>6) Taking Care of Self: family communication and problem-solving; recognizing, talking about, and dealing with feelings; taking care of self; what's stress got to do with it? pie of life; and managing daily life stressors.</p> <p>In addition to the model content listed above, all Foster Parents complete DCFS Pride training and participate in JCFS training sessions focused on TCIF, Attachment, Trauma, Adolescent Development, and Strength Based Assessment.</p> <p>Training content is reinforced during weekly visits and by the professional team, which consists of the foster parent, case manager, supervisor, clinician, foster parent support specialist, and licensing.</p>	<ul style="list-style-type: none"> • Providing daily structure with clear expectations and limits, with well specified consequences delivered in a positive supportive, teaching-oriented manner. • Providing close tracking of the child's behavior and emotional adjustment in family and school settings and with peers. • Helping the child to develop positive attachments to adults and peers. <p>This strength based program capitalizes on the tremendous positive potential of families, both the professional foster families who are the key therapeutic agents and the biological or adoptive families who will be able to meet the child's needs in a positive and permanent environment and sustain success over time. Each child is thoroughly assessed and receives an individualized TFCO-C treatment plan and daily point chart focused on developing and reinforcing pro-social behaviors. The treatment plan and interventions are age appropriate and there are modifications of the program for the younger and the older age groups. Daily feedback from the therapeutic foster parent is used to hone and modify the plan and targeted behaviors. Weekly team meetings are used to discuss each child, their plan and their progress as well as the progress of the aftercare and biological family. The team leader coordinates multiple interventions within the child's key settings (treatment foster care home, aftercare home, school and community) which consist of foster parent</p>

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
				training and support (weekly team meetings and daily phone calls), family therapy and parenting skills training for the identified aftercare home, therapy and skill building for the child, school-based intervention and academic support and psychiatric consultation and medication management, if indicated.
FFTA 3 (RFP Appendix p. 22)	Places no more than 2 TFC children to a family.	No more than two TFC children will be placed with a family at the same time.	No more than 1 or 2 TFC youth placed in a TFC home	Only one TFC child is placed in each therapeutic foster home.
FFTA 4 (RFP Appendix p. 22)	Assigns no more than 12 cases to a caseworker. See also Additional Component 7 – Case Load Ratio (RFP Appendix p. 23).	Dedicated Adolescent case managers will carry caseloads of 10:1	8:1	10 TFC cases are assigned to the case manager. They may follow 1 – 2 cases in the aftercare home but will not be the legal case manager.
FFTA 5 (RFP Appendix p. 22)	Provides caseworkers with 24/7 back-up supports.	Case management staff will be on-call 24/7 to provide back-up support to caregivers and youth	On call system in place, including case worker, supervisor, and clinician	The TFCO team leader provides 24/7 back up support for the team, with the Program Director and/or other designated qualified staff available for consultation or coverage. Note: TFCO is delivered by a carefully selected, highly motivated and trained team, of which, the case manager is one member.
FFTA 6 (RFP Appendix p. 22)	Recruits foster parents through a variety of sources, including the pool of general foster care providers, word-of-mouth, and creative advertisements.	A dedicated recruitment specialist will develop a written, measurable recruitment plan for TFC. It will highlight current recruitment successes as well as consider new opportunities. Children's Home + Aid has engaged in the Quality Parenting Initiative that supports the recruitment and licensing of foster parents who bring high levels of commitment, flexibility, and financial and emotional stability. Children's	Recruitment will involve the entire foster parent recruitment licensing team of JCFS. JCFS Marketing will support efforts through materials and multi-faceted communication plan. Recruitment plan involves the engagement of community partners such as Sinai, churches, community centers and the like. Recruiter and current foster parents to identify potential foster parents. Offer an incentive for a successful find and placement.	The recruitment plan will include these avenues. Recruitment will also use techniques found to be successful by other TFCO programs. An individualized recruitment plan will be developed for each team in consultation with TFC Consultants with the goal of successfully recruiting and onboarding 10 – 12 professional foster parents per team.

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>Home + Aid provides a financial incentive to foster parents who recruit a new foster parent who becomes licensed and accepts a stable placement. Foster parenting is promoted on the Children's Home + Aid website, with booths at volunteer fairs, within schools, and through talks in community churches and businesses. Foster parent newsletters contain schedules for foster parent informational meetings. The agency strives to have a diverse population of foster parents to meet the children's needs.</p> <p>Children's Home + Aid has produced a full-color recruitment booklet specifically to recruit specialized foster parents.</p>		
FFTA 7 (RFP Appendix p. 22)	Recruits foster parents who bring high levels of commitment, flexibility, and financial and emotional stability.	<p>Children's Home + Aid screens and licenses all foster parents per DCFS Rule 402 standards, in addition to an individualized homestudy which identifies their strengths and recommends the population of youth with whom they would best work.</p> <p>TFC foster parents must demonstrate a willingness to be an active member of the treatment team and have experience working with and/or parenting adolescents. Children's Home + Aid will identify current foster parents that have successfully parented teens to pursue possible engagement with TFC.</p> <p>CH+A foster parents must believe and</p>	<p>Foster parents will demonstrate parenting experience with adolescents or experience working with adolescents in some capacity for two years minimum. Has parented in the past, or has been a foster parent for several years with successful placements. Recruiter will do a family find for youth to see if any relatives are an option for placement or resources. In addition, talking with the youth about fictive kin options as well. Has demonstrated a clear understanding of adolescent behavior and is willing to learn new ways of working with youth. The person needs to have a can do attitude and not give up on youth. Must be willing to work with a team and be willing to have staff involved on a regular basis in their home, including phone support. May recruit young professionals and offer a housing stipend for them to have a child placed with them.</p>	<p>Foster parents are recruited with these characteristics as well as those found by TFC Consultants to be successful TFCO foster parents (interested in short term treatment, flexible, creative, team oriented, good sense of humor).</p>

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>demonstrate that: All children deserve a safe and stable home with healthy relationships to guide them to adulthood. The road to achieve this can be different for each child.</p> <p>Caregivers:</p> <ul style="list-style-type: none"> • Partner in parenting with the child's family; • Support and strengthen the child's important relationships; • Are empathetic and committed to the child; • Provide normalcy, nurturing and advocate for the child; • Work as a respected member of the team and support the team's efforts to achieve permanency. 		
FFTA 8 (RFP Appendix p. 22)	<p>Enhances the "fit" between foster families and foster children by attending to and matching needs, strengths, cultural, religious, and other preferences.</p>	<p>The Foster Care Recruiter and Licensing Specialist will work together to pre-identify existing licensed homes, and new homes as they become licensed, that would be a good fit for TFC. Children's Home + Aid will aim to keep children in their school and home community and work to avoid disrupting daily functioning. The matching process will be youth-driven and begin with an interview of the youth to discuss his/her expectations and wishes regarding their foster home placement. Life books and video vignettes will be used in the matching process to help youth describe who they are and what they want and need in life and in a family. Video vignettes will feature the youth sharing about themselves in order to do targeted matching with existing</p>	<p>Youth's particular array of needs will be matched with the abilities and characteristics of the foster parents via careful assessment. JCFS will use range of targeted assessments recommended by the Residential Step Down Committee.</p> <p>During the Home Study, we evaluate Foster Parents strengths so that we can determine the most appropriate and beneficial placement for youth. Staff complete the DCFS Matching Tool and a thorough Home Study which is shared with the JCFS Home Study Committee. Clinical summaries from DCFS are also shared with the Committee to inform placement decisions.</p> <p>Licensing staff complete the Home Study and present to the Committee comprised of licensing staff, all supervisors, and the intake coordinator. This collaborative, dynamic and comprehensive process ensures that each placement enhances the fit between youth and foster parents based on</p>	<p>The TFCO team is responsible for recruiting, screening, licensing, developing and training TFCO foster families and as such have a deep understanding of the skills, strengths and preferences of each family. Daily phone calls and weekly meetings serve to deepen the working relationship and support the placement.</p> <p>The Team Leader is responsible for conducting an individualized assessment on each referral to the program to determine suitability for TFCO and to assess potential matches. The process consists of thoroughly reading all referral documentation and talking to the referring case manager, past caretakers and other significant stakeholders. Whenever possible, the Team Leader meets with the child to assess his/her needs and desires, including cultural, religious, educational</p>

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>licensed homes and with new homes.</p> <p>Staff will take cultural and religious needs, location (close to biological family, close to school, etc.) and the wishes of the youth into consideration when making a determination about match. A visit with the potential foster family will help ensure the match is a good fit.</p>	<p>strengths, needs, cultural considerations, and other preferences.</p>	<p>and other preferences. The Team Leader examines the constellation of behaviors that the child is presenting, including looking at types, severity, and patterns. The Team Leader then carefully matches the child to a TFCO family based on these needs, strengths and behavioral analysis. The TFCO foster parent is given a copy of all referral documentation on the child, with proper releases and has a detailed conversation with the Team Leader. As TFCO is a treatment program, not a foster care placement, the TFCO foster parent must have full confidence that they can effectively and safely deliver the intervention with the referred child's presenting behavioral constellation. TFCO foster parents have the ability to reject any referral.</p> <p>TFC Consultants will work closely with the Team Leader to assess each referral and potential match. Other TFCO programs have found that they assess 3 – 4 referrals for each successful placement.</p>
FFTA 9 (RFP Appendix p. 22)	Provides an optimal and transparent level of honest information about child/youth strengths and needs to the TFC family prior to placement.	Children's Home + Aid complies with DCFS Procedure 301, including Sharing Information with caregivers. The matching process will be youth –driven, which empowers the youth to share honest information about their needs and strengths prior to placement.	Foster parents will be prepared with the understanding of the needs of the youth, how trauma has shaped the perspective and reactions of the youth and how to approach the youth to build the skills necessary for social and emotional wellbeing. Foster parents are provided with redacted copies of the IA, service plan and any other current assessment reports and sign off on a Check List of documents provided.	The foster parent(s) is a full member of the TFCO treatment team and receives the referral information, the behavioral analysis and is a key decision maker prior to placement. They participates in weekly team meetings after placement where information is shared and decisions are made.
FFTA 10 (RFP Appendix p. 22)	Provides foster parent(s) with at least 20 hours of pre-service training and at least 24	All foster parents will complete the mandatory 27 hours of pre-service PRIDE. TFC foster parents will receive at least 20 additional hours of pre-service	<p><u>Pre-Service = 43-45 hours</u></p> <ul style="list-style-type: none"> • 27 hours PRIDE • 12 hours of TCIF • 2 hours attachment and trauma 	TFCO foster parents receive 27 hours of PRIDE training and 6 hours of educational surrogacy training, (although, the option of using a truncated version of PRIDE will be

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
	<p>annual hours of ongoing training. At its best, trainings are individualized to the specific needs and strengths of the foster parent(s).</p> <p>See also Additional Component 3 – Foster Parent Training (e.g. Quality Parenting Initiative QPI) (RFP Appendix p. 23).</p>	<p>training (15 will be TCI-F) and at least 24 hours of ongoing training related to the needs of the child in the home.</p>	<ul style="list-style-type: none"> • 2-4 hours of adolescent development, behavior planning, assessment <p><u>In Service = 24-30 hours</u></p> <ul style="list-style-type: none"> • <i>Initial Together Facing the Challenge: 2 hours/week for 6 weeks (12 hours)</i> • <i>Booster Together Facing the Challenge at 6-months and 12-months (TBD)</i> • <i>12 hours additional training based on individualized plans; each Foster Parent has individualized plan developed post-placement of youth</i> 	<p>explored that honors the 12 hours of TFCO training they must complete), as well as 2 days (12 hours) of TFCO training prior to placement. They may also participate in NCTSN complex trauma training, de-escalation training, Lifebook training through LSSI. They are required to participate in the 90 minute weekly foster parent meeting which contains elements of training, support and treatment planning. They can attend LSSI's ongoing foster parent training including de-escalation training yearly. TFCO foster parents receive booster training in the model as needed.</p>
<p>FFTA 11 (RFP Appendix p. 22)</p>	<p>Provides supports for foster parent(s) including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parent(s) address their own needs and those of their own biological children.</p> <p>See also RFP Appendix p. 23:</p> <ul style="list-style-type: none"> • Additional Component 1 – Respite • Additional Component 11 – 24-Hour Crisis 	<p>The TFC model will include the following elements:</p> <ul style="list-style-type: none"> • intensive in home support and coaching from Excellence Academy Youth Advocates and other TFC team members; • at least weekly home visits; • regular (at least 15 hours per month) respite for foster parents; • intensive support and training for foster parents through the Quality Parenting Initiative ("QPI") and TCI-F; • 24/7 on-call availability; • Monthly caregiver support groups; • Information via a quarterly FP newsletter; and • support from TFC specific staff, including a licensing specialist and foster family support specialist. 	<p>Substantive in home support of foster parents by team to provide coaching, support and skill development by entire team. Weekly home visits with child and foster parent. Weekly supervisory phone calls. CFTM held every 60 days. Each family will determine the best use of weekly Recreation stipend to address youth's needs and strength development. On call crisis intervention available 24 hours/7 days a week.</p> <p>In addition to supports related to the child's placement, Foster Parents will receive group supervision to support and enhance their professional development. This Team Meeting will be regularly scheduled and facilitated by the Foster Parent Support Specialist.</p>	<p>LSSI's TFCO foster parents receive a very high level of support from the TFCO team and from other foster parents on the team. The Foster Parent Support Specialist's sole responsibility is to recruit, train and support the foster parent through the placement and each subsequent placement. This includes making a daily phone call (PDR) to the foster parent which specially asks about 34 behaviors from the child, the foster parents' stress level in working with the child and about their own day.</p> <p>Each foster parent has at least weekly in-home visits by a TFCO team member and participates in a 1.5 hour weekly team meetings which provide support, guidance and training as ongoing review and revision of the treatment plan.</p> <p>TFCO foster parents develop a network of support for their team members and often</p>

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	<p>Response</p> <ul style="list-style-type: none"> • Additional Component 13 – Non-Clinical Treatment Support Services for Caregiver/Parents • Additional Component 14 – Caseworker Contact Requirements 			<p>provide respite for each other. Individualized respite plans are developed for each child and foster parent.</p> <p>In addition, the information gathered from the daily PDR is reviewed daily by the Team Leader ensuring that additional support, referrals and assistance can be offered immediately should the foster parent seem to be becoming stressed or the child's behaviors seem to be escalating. The TFCO team provides 24 hour crisis response support as needed, however, with the clinically appropriate response to the daily information, most potential crisis situation can be addressed before they become crisis.</p>
FFTA 12 (RFP Appendix p. 22)	Considers and treats foster parent(s) as full professional members of the treatment team.	Foster parents will participate as full members of the professional team and will attend and participate in all interdisciplinary team meetings to complete treatment planning and review the youth's progress and implement relevant parts of the treatment plan at home.	Consistent with Together Facing the Challenge model (View of foster parents as key change agents; Team approach to treatment). Supported by weekly supervisory phone calls with foster parents and CFTM at 30 days and every 60 days. Participation in Team Meetings with other foster parents and Foster Parent Support Specialist.	TFCO foster parents are full members of the treatment team, working fully with the team and shaping the interventions in the foster home and in school. They participate in 1.5 hour weekly team meetings and daily PDR calls. They are the key therapeutic change agent.
FFTA 13 (RFP Appendix p. 22)	Trains and supports foster parent(s) to negotiate other systems in the community (schools, mental health, clubs, etc...) and serve as advocates for the child.	Foster parents will participate as full members of the professional team and will attend and participate in all interdisciplinary team meetings to complete treatment planning. They will be trained and coached on how to advocate and negotiate the other services that are part of the treatment team. Minimally, this will include DCFS Educational Surrogate training, Educational Advocacy training, and monthly TFC special training. In addition, the Foster Parent Specialist	<p>Foster parents are trained on Educational Advocacy in addition to the Together Facing the Challenge content. Then ongoing support is provided during weekly contact with Case Managers and the professional team, in addition to CFTMs.</p> <p>The goal is proactive identification of issues and guidance for foster parents so that they can successfully navigate child-serving systems, such as school, mental health, community, and medical institutions. Successful strategies are shared during group supervision sessions with other</p>	The TFCO model seeks as many normative experiences for the child as possible. The team supports the foster parent in ensuring community systems are utilized by continually assessing the strengths, needs and interests of the child and assisting the foster parent in accessing resources and advocating for the child. In addition to education and medical systems, these community resources include after-school programs, chess club, tutoring, team sports, boy/girl scouts, band, libraries, movie theater, museums,

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		will be available to directly support the caregiver in navigating systems as well as to develop training on identified topics.	foster parents.	parks, YMCA, and any other experiences that the team feels would enhance the child's pro-social learning.
FFTA 14 (RFP Appendix p. 22)	Emphasizes the role of and frequently involves biological families in the TFC process.	The QPI approach supports involvement of birth parents in the TFC process. The birth parent is a partner with the foster parent and the case manager to support the child through a team approach. Child and Family Team meetings will be held at least quarterly to discuss the child's treatment plan, any necessary services and supports needed for the youth, the birth family and the foster family. The CFTM attendees will be determined in conjunction with the youth to ensure participation of all significant adults in the youth's treatment.	<p>Outreach to biological family will be conducted in all cases to promote and strengthen family connections. Services will be provided to biological parents consistent with the DCFS Service Plan. Services will be coordinated with the caseworker for the family. CFTM process will be utilized to engage and involve biological family. If biological family is a viable permanency option, they are trained in Together Facing the Challenge model when appropriate.</p> <p>Together Facing the Challenge can be implemented in a group or individual coaching model. For reunification cases, Case Managers will coach the biological parents in the model to prepare them for how to best support their child when he or she returns home. This coaching and support will then carry over to aftercare services. If biological family is not viable, staff will engage in family-find efforts and determine the appropriate level of ongoing involvement in the case.</p>	<p>It is the goal of TFCO to prepare the aftercare home for the child which will be the permanent placement, ideally the birth family or a significant relative. Weekly therapy and ongoing communication is provided by the Family Therapist to assist the family in learning to parent the child. The Case Manager works with the biological family to address the goals as laid out in the family service plan if they carry the family case or they work closely with the assigned family worker. All efforts are coordinated through the quarterly Child and Family Team Meeting (CFTM), which requires the active participation of all stakeholders, including the foster parent, the biological parents and the child, as clinically appropriate.</p> <p>If the goal is not to return the child to the biological parents, an individualized contact plan is developed and supported by the Family Therapist.</p>
FFTA 15 (RFP Appendix p. 22)	Provides assistance for foster parent(s) to consistently engage with biological families.	The QPI approach supports involvement of birth parents in the TFC process. From the point of licensure, foster parents are expected to engage with birth family; the first introduction should occur within five days of placement and be facilitated by case management staff. The Foster Parent specialist will work with the caregivers to help understand birth family needs and strengths, and to understand the	Substantive in home support of foster parents by team to provide coaching, support and skill development by entire team. Work with foster parents to help understand biological family's needs and strengths. CFTM at 30 days and every 60 days.	The TFCO model calls for therapeutically designed engagement between the foster parents and the biological family and aftercare home. TFCO has found this to be important because contact can be counter-therapeutic and unproductive for high end children and their families, as triangulation and pulls in loyalty can occur. Protocols are in place for when the foster parent interacts with the biological parent/aftercare home and for when they

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>importance in the youth's development.</p> <p>The birth parent is a partner with the foster parent and the case manager to support the child through a team approach. Child and Family Team meetings will be held at least quarterly to discuss the child's treatment plan, any necessary services and supports needed for the youth, the birth family and the foster family. The CFTM attendees will be determined in conjunction with the youth to ensure participation of all significant adults in the youth's treatment.</p>		<p>talk with the child about the family. These protocols included being positive and supportive in language and having pleasant interaction which focuses on the positive. The child's behavior and progress is never discussed. The goal is to foster an environment of support and positivity. The Family Therapist's role is to gather information from the visits and incorporate it into the treatment planning with the team. The Family Therapist provides much of the treatment oriented and progress communication with the biological family, in addition to the aftercare home. The TFCO foster parent will transport the child to visits, facilitate and host sibling visitation, facilitate regular phone calls and supports the child in these significant relationships.</p>
FFTA 16 (RFP Appendix p. 22)	Provides for aftercare for TFC foster parent(s) and biological families.	Children's Home + Aid provides aftercare services in accordance with DCFS policy 315, which includes case management and accessing other goods and services that may be necessary to ensure successful family reunification.	Aftercare services are recommended and offered in each case. For reunification cases, biological parents will be trained and supported in the Together Facing the Challenge model and continue to receive case management support. For other case dispositions, aftercare services are provided at the discretion of the placement (e.g. adoptive home, TLP).	The TFCO model provides up to 90 days of aftercare for the child and aftercare family. This is usually done by the Family Therapist and/or Skill Coach. TFCO foster parents remain a part of the team and thus receive ongoing support as they transition the child and accept another placement.
FFTA 17 (RFP Appendix p. 22)	Allows for career opportunities for TFC parent(s) within the program.	TFC foster parents will be encouraged to apply for employment as recruiters.	Foster parents will be involved in screening and hiring of program staff. Following the initial training, foster parents will be given the opportunity to co-facilitate the Together Facing the Challenge training.	The TFCO Foster Parent is a professional foster parent who receives ongoing training and support to develop and enhance their skills. They will be given opportunities to co-facilitate trainings, lead discussions in the weekly team meeting, recruit new foster parents to the program and any other opportunity which may further develop their strengths, knowledge and abilities.
FFTA 18	Provides resources for	Transition planning will be provided to	• Case Managers and our Coordinator of Family	N/A

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
(RFP Appendix p. 23)	independent and transitional living for older TFC-enrolled youth.	<p>every youth regardless of the permanency goal. This begins within thirty days after the youth's fourteenth birthday, or within thirty days of a youth's placement in foster care for a youth over fourteen years of age. The Ansel-Casey Life Skills Assessment tool is used at required intervals to assess the youth's individualized needs and to monitor progress. The youth's service plan will address the specific timeframes and conditions for transitioning youth, services that are required, and who will provide and/or monitor these services. The following services are an integral part of transition planning and will be provided as deemed necessary:</p> <ul style="list-style-type: none"> • Training in basic life skills (i.e., food preparation, housing, housekeeping, personal hygiene, sexual development, health care, health insurance, pregnancy prevention, parenting, prevention and treatment of STDs, laundry skills, leisure time activities, money management, transportation, problem solving, decision making, social communication, and compiling important documents such as birth certificate, medical records, school records, etc.); • Supports which encourage the youth to attend and complete high school; • Vocational assessment, skill building, and job placement; • Casework and counseling aimed at the resolution of problems related to 	<p>Development meet with youth on an individual basis and as part of the weekly sessions, to promote life skills and to discuss educational and vocational plans.</p> <ul style="list-style-type: none"> • Completion of Casey Life Skills Assessment. • Youth participate in <i>Countdown to 21</i>, a financial literacy education program of Illinois DCFS. • Foster Youth Advisory Board • Life Skills groups • Foster Parents engage in TFC curriculum, 5th session ("Preparing Kids for the Future"). 	

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		separation, preparation for placement, emancipation, and interpersonal relationships; <ul style="list-style-type: none"> Determine the need for services from the adult system, and assist the youth to prepare all necessary documentation and facilitate the transition of services. 		
FFTA 19 (RFP Appendix p. 23)	Consistently gathers and reviews data on children, TFC foster parent(s), biological families, and the various components of the TFC process and outcomes.	Children's Home + Aid will use its Best Results and Best Stat processes to define clear outcome measures and data collection procedures for the TFC program and review demographic and program outcome data regularly to continuously improve service delivery. The Best Stat process will determine the measures on which to focus form data collected including: <ul style="list-style-type: none"> Youth engagement in the Excellence Academy and other services Ohio Scales for clients engaged clinical treatment CANS for all youth Youth Connectedness Birth family engagement in treatment 	<p>Youth, foster parents and biological family are routinely assessed using the Child and Adolescent Strengths Assessment (CANS). This assessment is completed in partnership with all parties in order to reflect and develop the shared vision in the case – the youth. The CANS is completed in SACWIS but also entered into the JCFS client information system to allow for internal communication. To facilitate accurate assessment and evaluate program efficacy, the youth and foster parent will complete the Strengths and Difficulties Questionnaire at intake and discharge from JCFS services. Staff may select to administer the tool again during the case to support service planning, progress review, and communication. The Parent Daily Report (PDR) will be utilized by case management staff and foster parents to promote communication about the youth's needs. Service Plan Reviews are completed every 6 months to monitor biological family progress and progress in the case.</p> <p>Specifically related to Together Facing the Challenge, a fidelity monitoring system will be implemented to ensure that all service components are in place. Following the 6-week TFC training with foster and biological parents, a knowledge acquisition questionnaire will be administered to learn how the training was successful and ways in which it can be improved.</p>	<p>Daily phone calls (PDR) are made to the foster parent recording information on 34 problem behaviors from the child and the foster parents stress level regarding each behavior as well as a "grade your day" inquiry to assess the foster parent's stress level aside from the child. This information is used to support the foster parent, inform the treatment planning and focus on the behaviors to be targeted in the child. The biological family's progress towards treatment goals is reviewed in the weekly clinical team meeting as well as in the quarterly Child and Family Team Meeting (CFTM). The progress of the child and the targeted aftercare family are also reviewed weekly and in the quarterly CFTM.</p> <p>During the first year of implementation, TFC Consultants will review videos of the weekly team meeting, the weekly foster parent meeting and the family therapy sessions to ensure progress toward fully compliance with all model components and will provide ongoing consultation and training until the program is certified. Data is gathered on specific component criterion and evaluated.</p>

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
			Aggregate data will be reviewed quarterly by the Foster Care CQI Committee to proactively identify areas for improvement. This committee will review internal reports as well as DCFS generated reports, such as monthly Dashboards (e.g. Share Point).	
FFTA 20 (RFP Appendix p. 23)	Frequently seeks the input of TFC foster parent(s), biological families, children, and professionals.	The QPI approach supports involvement of birth parents in the TFC process. The birth parent is a partner with the foster parent and the case manager to support the child through a team approach. Child and Family Team meetings will be held at least quarterly to discuss the child's treatment plan, any necessary services and supports needed for the youth, the birth family and the foster family. Based on the child's permanency goal and treatment plan, birth family (parents and other relatives) may be offered clinical services, advocacy, transportation and training.	JCFS routinely engages the entire team to support progress towards service plan goals. CFTM are held at 30 days and every 60 days. The team is comprised of the youth, foster family, biological family, program staff and attorneys. They will discuss the child's treatment plan, any necessary services and supports needed for the youth, pathways to permanency and development of step-down plans. Biological parents are invited and encouraged to participate in CFTM. Case managers meet with bio parents every month to discuss progress, obtain input on their visits and solicit feedback. In addition to the methods described above, JCFS also utilizes more formal methods of soliciting input to guide program development and quality improvement: <ul style="list-style-type: none"> • Annual Client Satisfaction Study (foster parents and youth) • Foster Parent Advisory Board • Foster Youth Advisory Board 	Weekly team meetings and daily phone calls are part of the program, as well as weekly home visits by a TFCO team member. The Team Leader coordinates communication and case direction and is the central figure in case coordination, involving the child, foster parent, biological family, aftercare resource, school personnel and other significant professionals. The Family Therapist and Case Manager work directly with the biological family and regularly seeks their input in the routine care of their child, family visitation and their active participation in case planning, including the quarterly CFTM, the bi-annual ACR and Juvenile Court Proceedings.
Additional Component 2 (RFP Appendix p. 23)	Management of Case Care Coordination.	Children's Home + Aid will comply with DCFS Rule & Procedure on Permanency Planning, Visitation and Placement. Minimally, this includes: <ul style="list-style-type: none"> - assessment; - worker interventions and contacts; - family meetings; - development and implementation of service plans; and 	Case managers have formal supervision for 1 -1/2 hours per week with their supervisor. There is discussion of the ways in which trauma is being played out, the interventions used in the home, Court involvement, wellbeing and permanency. The case manager will review the life skills development taking place with the youth. Additionally, there is informal supervision that occurs throughout the week to proactively	

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		<p>monitoring and evaluating parent, youth and caregiver progress.</p> <p>Dedicated TFC case managers, with support from the supervisor, will be responsible for coordination of all services to the youth, foster parent and birth family. The supervisor is responsible for ensuring quarterly CFTM's are convened and that all treatment team members are invited and encouraged to participate.</p>	<p>problem solve or deal with a crisis. Case Manager and Supervisor utilize a supervisory log, which lists the services needed, services in place, outstanding tasks, ACR schedule and permanency efforts for each case.</p> <p>Case Manager Supervisor also receives formal supervision 1 -1/2 hours per week with the Program Director. Completes a monthly log sheet to track visits and other case milestones.</p> <p>In addition, the overarching care coordination process for the case is the Child and Family Team Meeting (CFTM). This is a process that the program may move in and out of depending on the status of the family case. Existing CFTM teams will be engaged and CFTM will be convened at 30 days and every 60 days to support the treatment for the TFC youth.</p> <p>The Program Supervisor and clinicians are also actively involved in managing care for the youth. This is achieved during team meetings held at least monthly which involve all members of the professional team.</p>							
Additional Component 4 (RFP Appendix p. 23)	Foster Parent Payment	Confidential	Confidential	Confidential						
Additional Component 5 (RFP Appendix p. 23)	Staff Credentialing & Certification.	Children's Home + Aid will maintain personnel records for all TFC staff that includes: proof of education; a detailed summary of work experience; annual employee performance evaluations; documentation that a background check, including but not limited to a CANTS check, was completed; copy of a valid driver's license and auto liability	<table><tr><td colspan="2">Credentials vary depending on staff role.</td></tr><tr><td>Type of provider</td><td>Education and Qualifications</td></tr><tr><td>Foster Parent</td><td>High School. Has parented in the past, or has been a foster parent for several years with successful placements. Recruiter will do a family find for youth to see if any relatives are an</td></tr></table>	Credentials vary depending on staff role.		Type of provider	Education and Qualifications	Foster Parent	High School. Has parented in the past, or has been a foster parent for several years with successful placements. Recruiter will do a family find for youth to see if any relatives are an	<p>TFCO-C is delivered by a carefully selected, highly motivated and trained team which consists of the Team Leader, Case Manager, Child Therapist, Family Therapist, Skills Coaches, Foster Parent Specialist (recruiter/licensing/trainer) and the Professional Treatment Foster Parent.</p> <p>The credentials and certification are as</p>
Credentials vary depending on staff role.										
Type of provider	Education and Qualifications									
Foster Parent	High School. Has parented in the past, or has been a foster parent for several years with successful placements. Recruiter will do a family find for youth to see if any relatives are an									

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		<p>insurance coverage if applicable; staff medical exam form, and proof of state required licensure if applicable.</p> <ul style="list-style-type: none"> - Foster Parents must meet DCFS 402 licensing standards. See responses to FFTA-7 regarding additional qualifications. - Case Management Supervisors will have a master's degree in social work or a related field and two years of child welfare or related experience. Two years of supervisory experience is preferred. Supervisors can supervise a maximum of seven staff. - TFC Caseworkers have at least a bachelor's degree in social work or a related field from an accredited school and a minimum of two years' experience or a master's degree in child welfare or a related field and meet all regulatory requirements. - Staff Providing Clinical Services have a master's degree in social work, counseling or a related field and are supervised by an LCSW or LCPC. - Youth Advocates will have a Bachelor's degree in social work or in another human service field preferred or a High School Diploma and five plus years of experience working with youth in a residential or foster care setting 	<p>option for placement or resources. In addition, talking with the youth about fictive kin options as well. If not parented before, have several years of experience working with adolescents. Has demonstrated a clear understanding of adolescent behavior and is willing to learn new ways of working with youth. The person needs to have a can do attitude and not give up on youth. Must be willing to work with a team and be willing to have staff involved on a regular basis in their home, including phone support.</p> <p>Case Managers Bachelor's Degree. Minimum of one year experience working with youth and families, ability to be flexible, can make decisions on own or with minimum support, ability to engage teenagers and parents (both foster and biological), and has an understanding of cultural differences with families and youth.</p> <p>Case Manager Supervisor Master's Degree in social service or related. Minimum of three years as a case manager in child welfare; CWEL certified. Has the ability to help workers learn and grow professionally, and can work independently in making decisions yet will reach out for support for critical decisions. Has an understanding of cultural differences with families and staff.</p> <p>Clinicians Master's Degree in SW or a clinical counseling degree. Minimum of two years providing clinical services to</p>	<p>follows:</p> <p>Team Leader/Case Manager Supervisor – Ph.D. or Master's degree and clinical license.</p> <p>Case Manager – Master's degree or Bachelor's degree with experience. Both these position must have DCFS required certification such as CWLE, CERAP, 402 and Child Care Act.</p> <p>Therapists (Child and Family) – Ph.D. or Master's degree with clinical license. The Child Therapist will be trained in CBT-TF.</p> <p>Foster Parent Specialist – Bachelor's degree or HS diploma with experience, foster parent experience preferred.</p> <p>Skill Builders – Bachelor's degree or HS diploma.</p> <p>Foster Parents – Must meet DCFS licensing standards.</p> <p>Psychiatrist – MD with Board Certification in Child and Adolescent Psychiatry</p> <p>All team members must pass required background checks and medical requirements.</p>

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
			<p>youth who have significant trauma histories, as well as working with adolescents. The ability to lead groups and an understanding of cultural differences with families and youth.</p> <p>Program Supervisor Master's Degree in SW or other human services field. Minimum of five years in clinical work with highly traumatized youth in the child welfare system. CWEL certified or the ability to be. Has a strong leadership ability to develop a new team. Has the ability to work with and understand cultural differences with families and youth. They must be licensed or in the process of being licensed</p>	
Additional Component 6 (RFP Appendix p. 23)	Staff Training.	All caseworkers will complete the DCFS required Foundations Training. The program supervisor and four Adolescent Foster Care caseworkers will attend a two-day TCIF training to become certified trainers of this model. All program staff will be trained in the ARC model, which includes ten building blocks of trauma-informed treatment and service. TFC staff will also be trained in the YMCA of San Diego's emerging CAVE model of adolescent engagement- Compassion, Attunement, Validation and Empathy.	<ul style="list-style-type: none"> • 3-day Together Facing the Challenge with monthly consultation with developer • 2-day TF-CBT with twice monthly consultation/supervision for 6 months or monthly consultation for 12 months • Annual 1-day Together Facing the Challenge Booster Training • Foundations training • JCFS Core Management training • CANS certification • TCIF • Trauma 101, 201 • Adolescent Development • JCFS Client Information System training (Avatar) 	In addition to the DCFS and LSSI required training, the TFCO staff will attend TFCO training consisting of 5 days for the Team Leaders, Case Managers, Program Directors, Senior Leadership and Implementation Consultant, 4 days for the Therapists, 3 days for Foster Parent Specialist and Skill Coaches and 2 days for the Foster Parents. TFC Consultants will review videos of the weekly team meeting, weekly foster parent meeting and family therapy session and provide ongoing consultation and training until the program is certified.
Additional Component 8 (RFP Appendix p. 23)	Access to Psychiatric or Psychological Consultation. See also Additional Component 10 –	A contracted psychiatrist will provide expertise on treatment and service plans for youth with mental health/behavior special needs and will provide consultation to workers and therapists, conduct assessments and	JCFS utilizes the DCFS psychological services liaison for psychological consultation and evaluation. Psychiatric consultation is sought by the JCFS Psychiatrist and/or HRDI depending on where the youth resides to minimize family travel time.	A Psychiatrist is a member of the treatment team and is available for consultation with the TFCO team and foster parent. They may also provide consultation for the aftercare family and/or biological family. Children in the

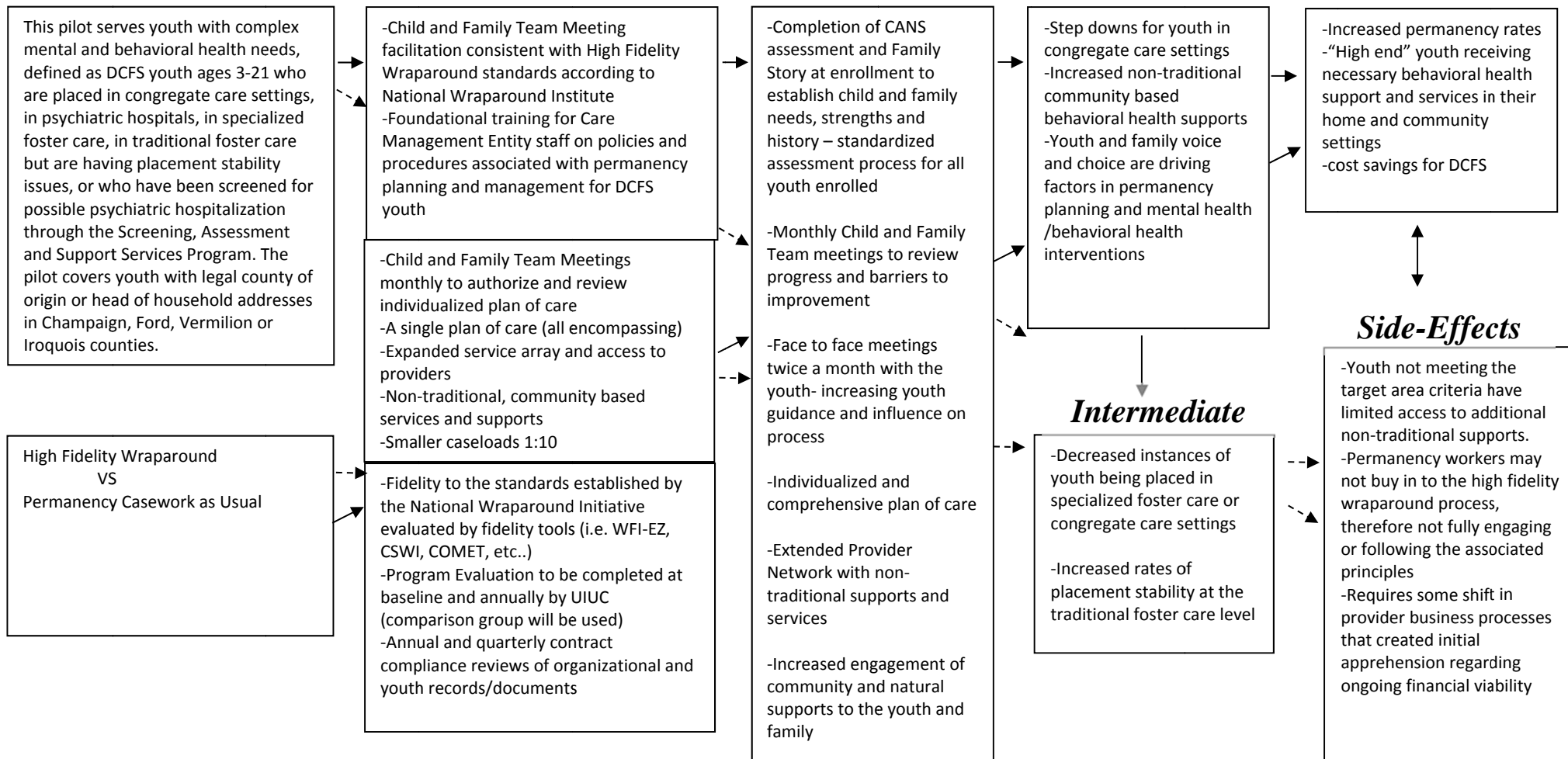
TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
	Access to Psychiatric Treatment and/or Medication Management (RFP Appendix p. 23).	<p>evaluations, and consult with foster parents and biological parents. The consulting psychiatrist will prescribe and monitor medications for the youth with consent from the DCFS Guardian.</p> <p>Psychological assessment, if appropriate, will be accessed through the DCFS Psychologist approval process and be conducted by a DCFS approved Psychologist.</p> <p>Clinical services beyond consultation will be provided by Children's Home + Aid's behavioral health team. More information can be found in <i>TFC Requirement Source Additional Component 9</i>.</p>	Each youth is assigned a clinical therapist (e.g. LSW, LCSW) for at least weekly therapy, based on need. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) will be used as appropriate along with other therapeutic interventions.	program are provided therapy by the child therapist as clinically indicated, who may be a Master's Level licensed professional or a licensed Psychologist. The Family Therapist works with the Aftercare placement and biological family if they are engaged and not the aftercare resource. This therapist may be a Master's Level licensed professional or a licensed Psychologist and cannot be the same professional as the Child Therapist.
Additional Component 9 (RFP Appendix p. 23)	Access to Evidence-Based or Evidence-Informed Clinical Treatment Services (e.g., ARC, TARGET, etc.).	All TFC youth will have access to evidence-based clinical treatment using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These services will be provided by Children's Home + Aid's behavioral health team. TF-CBT has been proven effective in treating traumatized children. It has the strongest research evidence of any treatment model for this population. TF-CBT improves post-traumatic stress symptoms, depression, anxiety, externalizing and sexualized behavior problems, shame, trauma-related cognitions, interpersonal trust and social competence. The TF-CBT approach aids youth in reducing the negative symptoms associated with trauma to prevent aggression and violence.	TF-CBT	TFCO CBT-TF

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>Children's Home + Aid has adopted a trauma-focused approach across the entire organization using the ARC framework to inform the way the agency views and interacts with clients and caregivers affected by trauma. ARC, recognized as a promising practice by the National Child Traumatic Stress Network, recognizes three core domains that are frequently impacted among traumatized children and youth and which are relevant to future resiliency. These core domains are attachment, self-regulation, and competency. ARC is a systems-based approach to trauma-informed practice for providers working with children and youth and their caregivers or caregiving systems.</p>		
Additional Component 10 (RFP Appendix p. 23)	Access to Psychiatric Treatment and/or Medication Management	A contracted psychiatrist will prescribe and monitor medications for the youth with consent from the DCFS Guardian.	Psychiatric services are sought by the JCFS Psychiatrist and/or HRDI depending on where the youth resides to minimize family travel time.	A Psychiatrist is a member of the TFCO team. This position is contractual. The Psychiatrist provides psychiatrist evaluations and medication monitoring for any child in the program who needs this service.
Additional Component 12 (RFP Appendix p. 23)	Non-Clinical Treatment Support Services for Children and Youth (e.g., extra-curricular activities and services, etc.)	Through the Excellence Academy, youth build networks of caregivers, peers, employers and schools to support their successful transition into adulthood. All youth will participate in classroom and individualized life skills training and intensive mentoring with the youth advocates. Non-clinical support programming includes: job readiness training; computer skills; financial literacy; health and self-care; home economics; tutoring and	\$100 recreation stipend per week in addition to \$250 per year provided by DCFS for extracurricular activities.	Children involved in TFCO received many opportunities to be involved in normative activities and to explore their interests as they develop their skills.

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		<p>homework help; educational enrichment activities; standardized test preparation; recreational activities; social-emotional learning; leadership building; character development; conflict resolution; and community service.</p> <p>The Excellence Academy helps youth learn the skills necessary for navigation of daily stressors and obstacles. Socio-emotional learning is implemented in efforts to gain relational competency and improved problem solving. Interventions are targeted toward healthy relationship building, decision making, social awareness, self-management, and self-awareness. These lessons can then be applied to community and home life and the transition to independence.</p> <p>Educational services address educational deficits, with a particular focus on the social-emotional barriers to achievement. During on-site programming, staff will provide one-on-one academic help and tutoring in areas of difficulty. Youth enrolled in higher education will also be provided with information regarding financial aid, ACT assistance and preparation, and visits to colleges in the greater Chicagoland area.</p> <p>Further, individualized wrap planning for these youth will support non-traditional supports including</p>		

TFC Requirement	TFC Program Component	CHASI Age: 12-18	JCFS Age: 12-18	LSSI Age: 6-11 & 12-14
		extracurricular equipment, additional transportation, etc.		
Trauma-Informed EBP Requirements (RFP Appendix p. 23-24)	Bidders must include trauma-informed interventions in their model of therapeutic foster care.	<p>Children's Home + Aid has adopted a trauma-focused approach across the entire organization using the ARC framework to inform the way the agency views and interacts with clients and caregivers affected by trauma. ARC is recognized as a promising practice by the National Child Traumatic Stress Network.</p> <p>All TFC youth will have access to evidence-based clinical treatment using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These services will be provided by Children's Home + Aid's behavioral health team. TF-CBT has been proven effective in treating traumatized children. It has the strongest research evidence of any treatment model for this population.</p>	TF-CBT Together Facing the Challenge	TFCO is trauma informed and child therapist will be trained in CBT-TF.

EXHIBIT N

Logic Model Template -- CME**Plan****Implementation****Outputs****Outcomes****Proximal****Distal**

External Conditions

-The target area is mostly comprised of rural areas with limited resources for non-traditional behavioral health supports. Substantial investment in developing the provider network and additional services / supports has been required.

-Community and county official culture has been difficult to impact, as many stakeholders are cautious and guarded regarding the pilot entity's ability to positively shift practices and outcomes.

Theory of Change

Children with mental health conditions have complex and intensive needs, access the most costly services, are often involved in multiple child-serving systems (e.g., child welfare, Medicaid, special education, juvenile justice, etc.) and are in out-of-home placements and intensive treatment settings for extended lengths of stay. For children involved in child welfare, this often results in them "aging out" of child welfare rather than attaining permanency. Often these youth exit child welfare into homelessness and incarceration. System of Care initiatives, such as the CME pilot, have been shown to positively impact clinical and permanency outcomes for children and youth. The system of care approach has been referred to as an "innovation in service delivery" that has focused on improving services and supports for children with serious mental health conditions by moving care from highly restrictive levels of care (e.g., residential, detention, psychiatric hospitalization, etc.) to community-based alternatives (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014). A central premise of systems of care is that safety and positive outcomes can be achieved through the increased use of more cost-effective home- and community-based services and supports. These services allow children and families to have their needs met without requiring the child to be placed in more intensive levels of care as a means of accessing services. Service plans are developed with the child and family at the center, and services come to the child rather than the child having to go to the services. To accomplish this shift toward a greater emphasis and utilization of home- and community based services, the system of care approach incorporates care coordination models that offer effective ways for stakeholders to customize the planning and delivery of services for high-utilizing populations of children. Referred to as "wraparound," this approach has been the primary way that systems of care are operationalized at the child and family level, and there is a growing evidence base documenting its effectiveness in achieving positive outcomes along with cost savings (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014).

End-Values

- Improved Permanency Rates
- Improved clinical outcomes
- Increased youth and family involvement in care planning
- Lower recidivism for foster care
- Decreased length of stay in congregate care placements
- Broader array of community based and non-traditional services (paraprofessionals and natural supports)
- Fiscal savings

EXHIBIT O

CME Status Report

September 12, 2016

The template outlines the content of the four-month Implementation Plan Status Reports. The Sections of the Status Report should adhere to the structure of the Logic Model. Both qualitative and quantitative updates should be provided in each section on progress, results, and barriers.

I. Plan

Project the number of population units (children, families, office) that are expected to be reached by the intervention subdivided into the intervention group and comparison group(s) against which comparisons will be made. Include further demographic and clinical subdivisions of the group(s), which might moderate the intervention's impact.

This pilot serves youth with complex mental and behavioral health needs, defined as DCFS youth ages 3-21 who are placed in congregate care settings, in psychiatric hospitals, in specialized foster care, in traditional foster care but having placement stability issues, or who have been screened for possible psychiatric hospitalization through the Screening, Assessment and Support Services Program. The pilot covers youth with legal county of origin or head of household addresses in Champaign, Ford, Vermilion or Iroquois counties.

A daily average census of 170 youth has been maintained over the last 12 months. Currently there are 155 youth enrolled with 59 youth in the residential, 1 in an ILO, 39 in specialized foster care, and 75 in the traditional foster care tier. More than 300 youth have been served since the pilot began.

No comparison group exists for this pilot as an external evaluation is still in the process of being established. Once a data sharing agreement is executed to support the evaluation of this project, a comparison group will be established.

II. Background

Provide a short introduction to the plan that summarizes the problem(s) the Department is attempting to address.

In 2012, several changes in federal and state law impacted the provision of Medicaid behavioral health services to children in DCFS custody. First, the Patient Protection and Affordable Care Act increased significantly the number of Illinois residents that are eligible for Medicaid. Second, the Illinois Saving Medicaid and Resources Together (SMART) Act mandated a \$2 billion cut to Medicaid spending and also required that over 50% of the Medicaid-eligible population be enrolled in newly emerging managed care plans. Third, the Illinois Department of Healthcare and Family Services, the state Medicaid agency, announced the goal of enrolling 80% of the Medicaid-eligible population in managed care, including children and families as well as individuals.

DCFS recognized that the statewide provision of Medicaid behavioral health services was shifting to a new model. Given that 97% of children and youth in DCFS' legal custody are Medicaid eligible, the system shifts could have wide ranging impacts on services for these youth, even though they were statutorily exempt by federal regulation from being automatically moved into managed care plans. DCFS began researching managed care-like programs that could be utilized to offer better services to children and youth in DCFS legal custody that would also eventually fit within the new managed care landscape.

In addition, DCFS was tracking the following problematic trends: 1) the length of time that children and youth were in DCFS care was well above the national average; 2) the length of time that children and youth spent in institutional settings was over three years; 3) intake numbers in the Central Region were increasing; 4) children and youth in DCFS legal custody were moving to increasingly intensive levels of care without being stepped down to lower levels of care; 5) Child and Family Teams, while required at least quarterly, were often not occurring and were not well attended by family members and natural supports; 6) real-time data relating to outcomes for children and youth was lacking or non-existent; and 7) a full, robust, coordinated array of home and community based services was lacking.

DCFS and other state agencies engaged Shelia Pires, a national System of Care expert, who offered assistance in researching viable solutions for Illinois. Through this process, DCFS became aware of Choices, Inc., a Care Management Entity with over 15 years of experience providing care coordination (a managed care-like service) for children and youth involved in child welfare systems. Choices coordinates individualized care for children and youth and their families through the facilitation of robust, fully engaged and fully empowered Child and Family Teams (CFT); collaborates with child-serving agencies to maximize resources; and enhances community-based provider networks. Based on their experience, DCFS selected Choices as the vendor for the first DCFS CME pilot.

The CME design was rooted in System of Care Principles that services should be:

- 1) Community based, family and consumer driven and youth guided, and culturally and linguistically competent;
- 2) Comprehensive, incorporating a broad array of services and supports;
- 3) Individualized;
- 4) Provided in the least restrictive appropriate setting;
- 5) Coordinated both at the system and service delivery levels;
- 6) Involve consumers, families and youth as full partners in their care; and
- 7) Emphasize early identification and intervention.

The CME care coordinators engage families and youth in the wraparound process as defined by the National Wraparound Initiative (NWI). Studies consistently have shown that systems with higher levels of fidelity to wraparound achieve better outcomes. According to the NWI, the wraparound process consists of ten principles and a series of activities organized within four phases: engagement and team preparation, initial plan development, implementation, and transition.

The CME model is dependent upon a robust provider network that includes both traditional community service providers and non-traditional and peer-based services and supports. Within a CME System of Care, all providers are accountable to the CFT for quality of care. This ensures the right services are provided to the youth and family at all times and offers many opportunities to identify and build new service opportunities. Establishing a balance between professional and more informal supports on a team enhances family and youth engagement, increases creativity, and promotes sustainability.

The CME has invested in both technological and human resources to collect, analyze, report and use data to inform decision making throughout the organization. The CME uses an information management system specifically designed for care coordination that serves as a youth's primary clinical record and includes demographic, clinical, service utilization and outcome information. Data collected by care coordinators during their ongoing interactions with youth and their families are

analyzed by the CME's outcomes and evaluation team and shared with funders and partners; available to supervisors and directors as needed via an internal reporting tool; and used to inform ongoing quality improvement activities.

III. Theory of Change

Discuss any modifications of the theory of change about why a program or intervention is proposed to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised outcomes chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

Children with mental health conditions have complex and intensive needs, access the most costly services, are often involved in multiple child-serving systems (e.g., child welfare, Medicaid, special education, juvenile justice, etc.) and are in out-of-home placements and intensive treatment settings for extended lengths of stay. For children involved in child welfare, this often results in them "aging out" of child welfare rather than attaining permanency. Often these youth exit child welfare into homelessness and incarceration.

System of Care initiatives, such as the CME pilot, have been shown to positively impact clinical and permanency outcomes for children and youth. The system of care approach has been referred to as an "innovation in service delivery" that focuses on improving services and supports for children with serious mental health conditions by moving care from highly restrictive levels of care (e.g., residential, detention, psychiatric hospitalization, etc.) to community-based alternatives (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014).

A central premise of Systems of Care is that safety and positive outcomes can be achieved through the increased use of more cost-effective home- and community-based services and supports. These services allow children and families to have their needs met without requiring the child to be placed in more intensive levels of care as a means of accessing services. Service plans are developed with the child and family at the center, and services come to the child rather than the child having to go to the services.

To accomplish this shift toward a greater emphasis and utilization of home- and community based services, the System of Care approach incorporates care coordination models that offer effective ways for stakeholders to customize the planning and delivery of services for high-utilizing populations of children. Referred to as "wraparound," this approach has been the primary way that Systems of Care are operationalized at the child and family level, and there is a growing evidence base documenting its effectiveness in achieving positive outcomes along with cost savings (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014).

IV. Implementation Status

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

To date, the CME pilot has been successful in establishing a broader array of services and supports to the counties in which it operates. The Provider Network has increased for an initial enrollment of

24 providers who were already contracted with DCFS to over 70 providers, most of which are contracted with the CME only to provide additional services and supports to enrolled youth. This is a particularly significant change for youth placed in more rural parts of the pilot area. Specialized therapies that are now available include Equine Assisted Psychotherapy, in-home behavioral management support, therapeutic and recreational mentoring as well as specialized mentoring and supports for caregivers. There has also been recent implementation of newly developed services, Home Based Clinical and Home Based Support that provide in-home evidence-informed clinical services to youth and foster parents. These two services are provided by a team that includes the youth, the family, a clinician and a support staff. The therapist provides clinical services to the family and the support staff works with the family to implement the interventions on an on-going basis. This team approach allows the family the needed level of support to successfully implement clinical interventions in a reliable and sustainable manner.

There has also been a noticeable increase and integration of youth and family voices through their involvement in their monthly Child and Family Teams as well as through a local Family Run Organization, The Youth and Family Peer Support Alliance, that was developed with support of the CME. Preliminary analysis of client satisfaction surveys suggest increased youth, family and natural support engagement in the Child and Family Team process. Client satisfaction surveys compiled from a total of 224 teams during March through June of 2016 show that 84.6% of team members were satisfied or very satisfied with how the team was working. More than 80% of the team members surveyed were also satisfied or very satisfied with the youth and family's individual plan of care, services and supports put in place, and felt that their voice was heard and respected on the team.

Preliminary outcomes reported by the CME have shown that of youth enrolled in the pilot 37.9% remained in home and community based settings and 28.1% of youth who were in a restrictive setting at the time of enrollment transitioned to the community. Other findings have shown that 85.7% of youth in foster care placements remained in stable placements during their enrollment. While these are very encouraging outcomes, an external evaluation with an identified comparison group will need to be conducted to determine the significance of these outcomes.

In addition, an enhanced Mobile Crisis Response program was launched as part of the CME pilot in April 2016. Prior to the launch of the Mobile Crisis Response program, 50% of children who were screened as a result of a crisis were admitted to a psychiatric hospital for stabilization. Since the launch of the new Mobile Crisis Response program, only 30% of children screened have been hospitalized resulting in better outcomes for children and families and significant cost savings for the state of Illinois.

While positive outcomes have been noted, significant challenges were encountered during the launch of the CME pilot. These challenges included the following:

- Vigorous resistance by the Child Welfare Advisory Committee that slowed initial referrals;
- Challenges to the development of the Provider Network due to provider resistance and DCFS payment and contracting arrangements;
- Administrative staff changes throughout DCFS with varying degrees of support for the pilot;
- Caseworker and supervisory turnover, shortages and temporarily increased caseloads;
- Extremely challenging court system in Vermilion County;
- Differences in existing casework processes and High Fidelity Wraparound Care Coordination model;
- Time intensive process for obtaining fully completed Consents and Authorizations;

- Administrative changes within the CME;
- Increased pressure on internal DCFS staff dedicated to the administration of the pilot due to delay in hiring additional administrative staff; and,
- Reconciliation processes that were not sustainable.

Over the course of the two years since implementation of the pilot, many of these challenges have been addressed. However, the culture shift required within the CME pilot area has to be attended to on a regular basis to address the constant pull to return to “treatment as usual”. Quarterly meetings are held with CME, POS and DCFS administrative staff to evaluate the implementation of the pilot, to determine if staff are following expectations established in the pilot area and to ensure that communication is strong between all stakeholders. Bi-weekly meetings are held with clinical and administrative staff from the CME and DCFS to address child specific issues that may be problematic and to ensure that barriers are removed as quickly as possible. Occasionally, staff issues are also addressed, if staff are unable to abide by the practice model of the pilot area.

Ongoing outreach and engagement particularly of the court staff in Vermilion County has been an extremely important and challenging aspect of the pilot implementation. The Vermilion County Court has specific expectations for services for children. Those expectations did not always match what the Child and Family Team desired for the child, resulting in court orders for much more restrictive levels of care (e.g., residential) than the Child and Family Team recommended. Education and outreach has continued with a noticeable reduction in court orders for residential services. However, more progress is needed in this area.

Staffing shortages for caseworkers and supervisors has been an ongoing challenge in the pilot area as well, resulting in a more intensive need for ongoing education, training and outreach than was initially anticipated. New staff have to be introduced to the System of Care principles and operations and often struggle at first to make the shift to youth and family driven care through intensive Child and Family Teams.

V. Outputs

Discuss the extent to which intervention components were delivered as intended (outputs). Describe the numbers and proportion of the target population that received the intended intervention content (reach), the amounts of intervention content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation). Also describe the unique features of the intervention, which make it distinguishable from business as usual, and the extent to which the comparison group didn't receive similar features of the intervention (differentiation).

Through the implementation of the CME pilot, the intervention of intensive care coordination through High Fidelity Wraparound has been delivered as intended. The vast majority of the children enrolled and subsequently discharged from the program have completed all four phases of the wraparound process and have been discharged from the program with positive outcomes. Monthly reports show that over 90% of children are participating in Child and Family Teams at least monthly, that CANS assessments are being completed every 90 days and that the children and families are showing decreased needs and increased strengths. The “dosage” seems to be adequate for the majority of children involved in the pilot, as evidenced by the very low drop-out rate and the increase in positive outcomes that are being observed.

While a control group is yet to be established, it should not be a difficult process. Outside of the CME pilot area, child welfare practice as usual is the norm, outside of other pilot initiatives. Child

and Family Teams are very sparsely attended and completed once a quarter at a maximum. Service plans are developed by case workers often with little input from the family. Services recommended are often uncoordinated, overlapping and sometime inaccessible for the families under the plan. The service array available is very sparse, especially in rural areas. Therefore, it is anticipated that the control group will be easily identifiable and that the core components of the CME intervention will not be similar in the services provided to the comparison group.

At this time, we are awaiting an executed data sharing agreement between DCFS and the Psychology Department at the University of Illinois at Urbana-Champaign, which we expect to be completed by the end of September 2016. It is anticipated that a comparison group will be established, and all the relevant data points identified for comparison by the end of December 2016. An interim evaluation of the pilot will be completed by the end of March 2017 to begin to analyze the successfulness of the pilot to date. A full evaluation of the efficacy of this pilot will be completed after the full three year period of the pilot has been completed at the end of September 2017. The full evaluation will be completed in the first quarter of calendar year 2018. All of these dates are contingent upon the full execution of the data sharing agreement and could be extended should the data sharing agreement take longer to execute than anticipated.

VI. Proximal Outcomes

Use the table provided below to report progress in attaining the proximal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the “Significance and Explanation of Difference,” briefly describe whether the differences are trending in the expected direction.

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
The utilization/expenditure ratio for congregate care versus other community based services	TBD	TBD	TBD
15% of enrolled wards who are in congregate care at time of referral will be transitioned to step-down placements with foster, home of relative, or fictive kin caregivers within six (6) months of their enrollment date. An additional 15% will be transitioned within 12 months of their enrollment date	TBD	TBD	TBD
Increased non-traditional community based behavioral health supports	TBD	TBD	TBD
Youth and family voice and choice are driving factors in permanency planning and mental/ behavioral health interventions.	TBD	TBD	TBD
Improved placement stability, including a decrease in the number of moves for foster children and number of days on run and in detention for residential children	TBD	TBD	TBD
Improvement in school behavior and attendance, as measured by	TBD	TBD	TBD

the CANS			
Improvement in caregiver's ability to meet the needs of the ward, as measured by the CANS	TBD	TBD	TBD
Clinical improvement across life domains, as evidenced by the CANS	TBD	TBD	TBD

VII. Distal Outcomes (if applicable to the reporting period)

Use the table provided below to report progress in attaining the distal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the "Explanation of Status," briefly describe whether the differences in the long-term outcomes, which were intended to result from the intervention, are in alignment with expectations.

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
80% of enrolled foster children in traditional foster care, home of relative, or fictive kin placements will remain stable (i.e., in their current placement) for at least 12 months from their date of enrollment (unless permanency is achieved sooner)	TBD	TBD	TBD
80% of enrolled foster children in specialized foster care will remain stable, (i.e., in their current placement) for at least 12 months from their date of enrollment (unless they are moved to a less restrictive placement or permanency is achieved sooner)	TBD	TBD	TBD
Of enrolled wards stepped down from congregate care to traditional, specialized foster, home of relative, or fictive kin care, fewer than 20% will experience a re-admission to congregate care that lasts longer than 30 days for stabilization	TBD	TBD	TBD
75% of wards enrolled through the mobile crisis screening process will not receive another crisis screening for crisis intervention services	TBD	TBD	TBD
Enrolled wards in traditional, specialized foster, relative, or fictive kin care will achieve a 30% reduction in the number of psychiatric hospital days during the first year of enrollment	TBD	TBD	TBD
90% of enrolled wards will have received annual preventative physical health care and dental services within four (4) months of	TBD	TBD	TBD

enrollment			
100% of enrolled wards will be up to date on immunizations (i.e., Tdap, Meningococcus, HPV) within 60 days of enrollment	TBD	TBD	TBD
Enrolled wards will achieve a 30% reduction in the number of emergency room visits during the first year of enrollment	TBD	TBD	TBD

VIII. Other Consequences

Describe any unexpected issues or concerns that impacted either positively or negatively (ex. leadership or organizational changes, exogenous factors beyond the agency's control) the Department's ability to implement or evaluate the plan.

Implementation challenges were articulated in Section IV. Implementation Status. However, the establishment of the external evaluation has continued to hamper efforts to complete initial and interim evaluations of this particular pilot. There were significant difficulties in educating the initial evaluation team regarding the concepts underlying the pilot, the core components of the implementation, which lead to intense challenges in developing a viable evaluation design. An outside consultant with a background in data analysis and evaluation was brought in to help the design of the evaluation, but progress was still much too slow.

It was finally determined that a new evaluation team would be established utilizing university partners that have a very strong background in evaluating System of Care initiatives at a local and statewide level. While this was a positive step forward, the new evaluation team could not begin work until a data sharing agreement was established. DCFS' legal team continues to work on the finalization of the data sharing agreement. However, that process has also taken longer than expected. It is anticipated that by the end of September, we should have an executed data sharing agreement and will be moving forward with the design and implementation of a robust external evaluation.

IX. Plan Revisions

Describe what the Department learned from the results, successes, and challenges of the reporting period and what changes (programmatic, evaluative or organizational) will be made based on these lessons.

The current challenges regarding staff retention are a particular focus at this point in the pilot. Not only have DCFS and POS casework staff shown a high rate of turnover, staff at the CME are starting to turnover as well. Several key administrative and clinical positions have recently been filled by the CME. While the new staff are well-versed in System of Care initiatives and fully buy-in to the concepts, they do not have intimate knowledge of the local system in which they are working. A new round of stakeholder engagement has to be completed, new relationships have to be established and credibility built. This process takes time and support from all stakeholders involved and is often challenging.

In addition, many other initiatives (e.g., immersion sites, Pay for Success, strategic planning initiatives, etc.) are being rolled out both in and around the pilot area. The multiple number of initiatives can leave stakeholders feeling overwhelmed and can lead to confusion about DCFS' commitment to the current pilot when other initiatives are rolling out. Again, engagement, support

and clear messaging from DCFS is critically important to ensure that existing gains within the pilot area are not undermined by stakeholders being overwhelmed by real or perceived changes in DCFS' focus.

It has also become very important to recognize that within the foster parent community, there are "Veteran" foster parents who sometimes act as advocates for foster parents in their counties or areas. Reaching out to these veteran foster parents is crucial, because their expertise can be utilized to help other foster parents understand how the CME pilot model is different than the usual process and how the new model is beneficial to both youth and foster parents alike. This specific outreach to foster parents also creates an opportunity for more community collaboration as often times these foster parents are pillars in their communities. DCFS will be enhancing foster parent engagement activities in the upcoming months.

Expansion of the Care Management Entity model will be contingent upon further design of a managed care plan to serve youth in care.

X. Reference

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EXHIBIT P

This document was produced through the full NWI consensus process.

The Principles of Wraparound: Chapter 2.1

Ten Principles of the Wraparound Process

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National Wraparound Initiative Advisory Group



The philosophical principles of wraparound have long provided the basis for understanding this widely-practiced service delivery model. This value base for working in collaboration and partnership with families has its roots in early programs such as Kaleidoscope in Chicago, the Alaska Youth Initiative, Project Wraparound in Vermont, and other trailblazing efforts.

Perhaps the best presentation of the wraparound value base is provided through the stories contained in *Everything Is Normal until Proven Otherwise* (Dennis & Lourie, 2006). In this volume, published by the Child Welfare League of America, Karl Dennis, former Director of Kaleidoscope, presents a set of stories that illuminate in rich detail how important it is for helpers to live by these core principles in service delivery. As described in the *Resource Guide's* Foreword, these stories let the reader "experience the wrap-around process as it was meant to be" (p.xi).

For many years, the philosophy of wraparound was expressed through the work of local initiatives and agencies such as Kaleidoscope, but not formally captured in publications for the field. Critical first descriptions were provided by VanDenBerg & Grealish (1996) as part of a special issue on wraparound, and by Goldman (1999) as part of an influential monograph on wraparound (Burns & Goldman, 1999).

These resources presented elements and practice principles that spanned activity at the team, organization, and

This is an updated version of *The Ten Principles of the Wraparound Process*, which was originally published in 2004.



The Resource Guide to Wraparound

Section 2: The Principles of Wraparound

system levels. In other words, some elements were intended to guide work at the team level with the youth, family and hands-on support people, while other elements described activities at the program or system level. For many, these documents were the best means available for understanding the wraparound process. They also provided the basis for initial efforts at measuring wraparound implementation. (See the chapter on wraparound fidelity in chapter 5e.1 of this *Resource Guide*.)

The Ten Principles as Presented by the National Wraparound Initiative

At the outset of the National Wraparound Initiative's work, it was recognized that presentation of the principles of wraparound would be a central part of the NWI's mission to enhance understanding of wraparound and support high-quality wraparound practice. So what, if anything, was needed to communicate the principles clearly?

In the first place, the early descriptions of wraparound's philosophical base included a series of elements that were described only briefly, or not at all. If these values were truly to guide practice, it seemed important to provide some information about what was meant by key terms and phrases like "culturally competent," "based in the community" and "individualized." Secondly, since the principles were intended to serve as a touchstone for wraparound practice and the foundation for the NWI's subsequent work, it was important that a document describing the principles receive formal acceptance by the advisors who comprised the NWI. Finally, for clarity, it seemed optimal to express the principles at the level of the family and team. Once the principles were clarified and written in this way, descriptions of the organizational and system supports necessary to achieve high-quality wraparound practice (see Chapter 5a.1 of this *Resource Guide*) could be presented as *"what supports are needed to achieve the wraparound principles for families and their teams?"* Furthermore, descriptions of the practice model for wraparound (See chapter 4a.1 of this *Resource Guide*) could be presented as *"what activities must be undertaken by wrap-around teams to achieve the principles for youth and families?"*

The current document began with the efforts

of a small team of wraparound innovators, family advocates, and researchers working together over several months. This team started with the original elements and practice principles, reviewed other documents and training manuals, and drafted a revised version of the principles as expressed at a family and team level. These descriptions were then provided to a much larger national group of family members, program administrators, trainers, and researchers familiar with wraparound. Through several stages of work, these individuals voted on the principles presented, provided feedback on wording, and participated in a consensus-building process.

Though not complete, consensus on the NWI principles document, initially created in 2004, was strong. Nonetheless, there were several key areas where the complexity of wraparound made consensus difficult within our advisory group. In many cases, advisors were uncomfortable with brief definitions of the principles because they did not acknowledge tensions that could arise in "real world" efforts to put the principles into practice. These tensions were acknowledged and addressed in the consensus document in several ways:

- First, in addition to the one- to two-sentence definition for each principle, more in-depth commentary is also provided, highlighting tensions and disagreements and providing much greater depth about the meaning of each principle.
- Second, we have allowed our NWI "community of practice" to revisit the principles. Most notably, at the behest of a number of advisors, the NWI revisited the principle of *Persistent*, and asked whether the original name for the principle, *Unconditional Care*, might be more appropriate and a new definition possible. The results of this 2008 survey of advisors are reflected in the definitions presented here, and a description of this process is presented for your information in Chapter 2.5 of this *Resource Guide*.
- Finally, true to the wraparound model, all the materials of the NWI are intended to be resources for use by local initiatives, families, and researchers to use as

they see fit. Thus, documents such as this one, as well as the *Phases and Activities of the Wraparound Process*, are conceived as “skeletons” to be “fleshed out” by individual users. For example, in Canada, a new nationwide initiative north of the border has adapted the NWI principles. As a result, they have used the NWI principles to describe the value base in ways to suit their purposes, such as a description of the paradigm shifts necessary for wraparound and the personal values expected of participating helpers.

Many have expressed a need to move beyond a value base for wraparound in order to facilitate program development and replicate positive outcomes. However, wraparound’s philosophical principles will always remain the starting point for understanding wraparound. The current document attempts to provide this starting point for high-quality practice for youth and families.

Considered along with the rest of the materials in the *Resource Guide to Wraparound*, we hope that this document helps achieve the main goal expressed by members of the NWI at its outset: To provide clarity on what it means to do wraparound, for the sake of communities, programs, and families. Just as important, we hope that NWI documents such as this continue to be viewed as works in progress, updated and augmented as needed based on research and experience.

The Ten Principles of the Wraparound Process

1. Family voice and choice. Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members’ perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

The wraparound process recognizes the importance of long-term connections between people, particularly the bonds between family members. The principle of family voice and choice in wrap-

around stems from this recognition and acknowledges that the people who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the wraparound process and its outcomes. This principle further recognizes that a young person who is receiving wraparound also has a unique stake in the process and its outcomes. The principle of family voice and choice affirms that these are the people who should have the greatest influence over the wraparound process as it unfolds.

This principle also recognizes that the likelihood of successful outcomes and youth/child and family ownership of the wraparound plan are increased when the wraparound process reflects family members’ priorities and perspectives. The principle thus explicitly calls for family voice—the provision of opportunities for family members to fully explore and express their perspectives during wraparound activities—and family choice—the structuring of decision making such that family members can select, from among various options, the one(s) that are most consistent with their own perceptions of how things are, how things should be, and what needs to happen to help the family achieve its vision of well-being. Wraparound is a collaborative process (principle 3); however within that collaboration, family members’ perspectives must be the most influential.

The principle of voice and choice explicitly recognizes that the perspectives of family members are not likely to have sufficient impact during wraparound unless *intentional* activity occurs to ensure their voice and choice drives the process. Families of children with emotional and behavioral disorders are often stigmatized and blamed for their children’s difficulties. This and other factors—including possible differences in social and educational status between family members and professionals, and the idea of professionals as experts whose role is to “fix” the family—can lead teams to discount, rather than prioritize, family members’ perspectives during group discussions and decision making. These same factors also decrease the probability that youth perspectives will have impact in groups when adults and professionals are present.

Furthermore, prior experiences of stigma and shame can leave family members reluctant to express their perspectives at all. Putting the prin-

Section 2: The Principles of Wraparound

ciple of youth and family voice and choice into action thus requires intentional activity that supports family members as they explore their perspectives and as they express their perspectives during the various activities of wraparound. Further intentional activity must take place to ensure that this perspective has sufficient impact within the collaborative process, so that it exerts primary influence during decision making. Team procedures, interactions, and products—including the

The wraparound team should be composed of people who have a strong commitment to the family's well-being.

wraparound plan—should provide evidence that the team is indeed engaging in intentional activity to prioritize the family perspectives.

While the principle speaks of *family* voice and choice, the wraparound process recognizes that the families who participate in wraparound, like American families generally, come in many forms. In many families, it is the biological parents who are the primary caregivers and who have the deepest and most enduring commitment to a youth or child. In other families, this role is filled by adoptive parents, step-parents, extended family members, or even non-family caregivers. In many cases, there will not be a single, unified “family” perspective expressed during the various activities of the wraparound process.

Disagreements can occur between adult family members/ caregivers or between parents/caregivers and extended family. What is more, as a young person matures and becomes more independent, it becomes necessary to balance the collaboration in ways that allow the youth to have growing influence within the wraparound process. Wraparound is intended to be inclusive and to manage disagreement by facilitating collaboration and creativity; however, throughout the process, the goal is always to prioritize the influence of the

people who have the deepest and most persistent connection to the young person and commitment to his or her well-being.

Special attention to the balancing of influence and perspectives within wraparound is also necessary when legal considerations restrict the extent to which family members are free to make choices. This is the case, for example, when a youth is on probation, or when a child is in protective custody. In these instances, an adult acting for the agency may take on caregiving and/or decision making responsibilities vis-à-vis the child, and may exercise considerable influence within wraparound. In conducting our review of opinions of wraparound experts about the principles, this has been one of several points of contention: How best to balance the priorities of youth and family against those of these individuals. Regardless, there is strong consensus in the field that the principle of family voice and choice is a constant reminder that the wraparound process must place special emphasis on the perspectives of the people who will still be connected to the young person after agency involvement has ended.

2. Team based. The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

Wraparound is a collaborative process (see principle 3), undertaken by a team. The wraparound team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle 1, choices about who is invited to join the team should be driven by family members' perspectives.

At times, family members' choices about team membership may be shaped or limited by practical or legal considerations. For example, one or more family members may be reluctant to invite a particular person—e.g., a teacher, a therapist, a probation officer, or a non-custodial ex-spouse—to join the team. At the same time, not inviting that person may mean that the team will not have access to resources and/or interpersonal support that would otherwise be available. Not inviting a particular person to join the team can also mean that the activities or support that he or she offers

will not be coordinated with the team's efforts. It can also mean that the family loses the opportunity to have the team influence that person so that he or she becomes better able to act supportively. If that person is a professional, the team may also lose the opportunity to access services or funds that are available through that person's organization or agency.

Not inviting a particular professional to join the team may also bring undesired consequences, for example, if participation of the probation officer on the wraparound team is required as a



condition of probation. Family members should be provided with support for making informed decisions about whom they invite to join the team, as well as support for dealing with any conflicts or negative emotions that may arise from working with such team members. Or, when relevant and possible, the family should be supported to explore options such as inviting a different representative from an agency or organization. Ultimately, the family may also choose not to participate in wraparound.

When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with principle 1, efforts should be made to include participation of family members and others who have a long-term commitment to the young person and who will remain connected to him or her after formal agency involvement has ended.

3. Natural supports. The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

This principle recognizes the central importance of the support that a youth/child, parents/caregivers, and other family members receive "naturally," i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are sustainable and thus most likely to be available for the youth/child and family after wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations also may be able to provide certain types of support that more formal or professional providers find hard to provide.

The primary source of natural support is the family's network of interpersonal relationships, which includes friends, extended family, neighbors, co-workers, church members, and so on. Natural support is also available to the family through community institutions, organizations, and associations such as churches, clubs, libraries, or sports leagues. Professionals and paraprofessionals who interact with the family primarily offer paid support; however, they can also be connected to family members through caring relationships that exceed the boundaries and expectations of their formal roles. When they act in this way, professionals and paraprofessionals too can become sources of natural support.

Practical experience with wraparound has shown that formal service providers often have great difficulty accessing or engaging potential team members from the family's community and informal support networks. Thus, there is a tendency that these important relationships will be underrepresented on wraparound teams. This

Section 2: The Principles of Wraparound

principle emphasizes the need for the team to act intentionally to encourage the full participation of team members representing sources of natural support.

4. Collaboration. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.



Wraparound is a collaborative activity—team members must reach collective agreement on numerous decisions throughout the wraparound process. For example, the team must reach decisions about what goals to pursue, what sorts of strategies to use to reach the goals, and how to evaluate whether or not progress is actually being made in reaching the goals. The principle of collaboration recognizes that the team is more likely to accomplish its work when team members approach decisions in an open-minded manner, prepared to listen to and be influenced by other team

members' ideas and opinions. Team members must also be willing to provide their own perspectives, and the whole team will need to work to ensure that each member has opportunities to provide input and feels safe in doing so. As they work to reach agreement, team members will need to remain focused on the team's overarching goals and how best to achieve these goals in a manner that reflects all of the principles of wraparound.

The principle of collaboration emphasizes that each team member must be committed to the team, the team's goals, and the wraparound plan. For professional team members, this means that the work they do with family members is governed by the goals in the plan and the decisions reached by the team. Similarly, the use of resources available to the team—including those controlled by individual professionals on the team—should be governed by team decisions and team goals.

This principle recognizes that there are certain constraints that operate on team decision making, and that collaboration must operate within these boundaries. In particular, legal mandates or other requirements often constrain decisions. Team members must be willing to work creatively and flexibly to find ways to satisfy these mandates and requirements while also working towards team goals.

Finally, it should be noted that, as for principles 1 (family voice and choice) and 2 (team-based), defining wraparound's principle of collaboration raises legitimate concern about how best to strike a balance between wraparound being youth- and family-driven as well as team-driven. This issue is difficult to resolve completely, because it is clear that wraparound's strengths as a planning and implementation process derive from being team-based and collaborative while also prioritizing the perspectives of family members and natural supports who will provide support to the youth and family over the long run. Such tension can only be resolved on an individual family and team basis, and is best accomplished when team members, providers, and community members are well supported to fully implement wraparound in keeping with all its principles.

5. Community based. The wraparound team implements service and support strategies that take place in the most in-

clusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

This principle recognizes that families and young people who receive wraparound, like all people, should have the opportunity to participate fully in family and community life. This implies that the team will strive to implement service and support strategies that are accessible to the family and that are located within the community where the family chooses to live. Teams will also work to ensure that family members receiving wraparound have greatest possible access to the range of activities and environments that are available to other families, children, and youth within their communities, and that support positive functioning and development.

6. Culturally competent. The wrap-around process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

The perspectives people express in wrap-around—as well as the manner in which they express their perspectives—are importantly shaped by their culture and identity. In order to collaborate successfully, team members must be able to interact in ways that demonstrate respect for diversity in expression, opinion, and preference, even as they work to come together to reach decisions. This principle emphasizes that respect toward the family in this regard is particularly crucial, so that the principle of family voice and choice can be realized in the wraparound process.

This principle also recognizes that a family's traditions, values, and heritage are sources of great strength. Family relationships with people and organizations with whom they share a cultural identity can be essential sources of support and resources; what is more, these connections are often "natural" in that they are likely to endure as sources of strength and support after formal services have ended. Such individuals and organizations also may be better able to provide types of support difficult to provide through more formal

or professional relationships. Thus, this principle also emphasizes the importance of embracing these individuals and organizations, and nurturing and strengthening these connections and resources so as to help the team achieve its goals, and help the family sustain positive momentum after formal wraparound has ended.

This principle further implies that the team will strive to ensure that the service and support strategies that are included in the wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond wraparound team meetings.

7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

This principle emphasizes that, when wrap-around is undertaken in a manner consistent with all of the principles, the resulting plan will be uniquely tailored to fit the family. The principle of family voice and choice lays the foundation for individualization. That principle requires that wrap-around must be based in the family's perspective about how things are for them, how things should be, and what needs to happen to achieve the latter.

Practical experience with wraparound has shown that when families are able to fully express their perspectives, it quickly becomes clear that only a portion of the help and support required is available through existing formal ser-

Undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound.

Section 2: The Principles of Wraparound

vices. Wraparound teams are thus challenged to create strategies for providing help and support that can be delivered outside the boundaries of the traditional service environment. Moreover, the wraparound plan must be designed to build on the particular strengths of family members, and on the assets and resources of their community and culture. Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources.

8. Strengths based. The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

The wraparound process is strengths based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life. The wraparound plan is constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. Wraparound is intended to achieve outcomes not through a focus on eliminating family members' deficits but rather through efforts to utilize and increase their assets. Wraparound thus seeks to validate, build on, and expand family members' psychological assets (such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (such as social competence and social connectedness), and their expertise, skill, and knowledge.

9. Unconditional. A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the

team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of youth or family "failure" and are not seen as a reason to reject or eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

At the same time, it is worth noting that many wraparound experts, including family members and advocates, have observed that providing "unconditional" care to youth and families can be challenging for teams to achieve in the face of certain system-level constraints. One such constraint is when funding limitations or rules will not fund the type or mix of services determined most appropriate by the team. In these instances the team must develop a plan that can be implemented in the absence of such resources without giving up on the youth or family. Providing unconditional care can be complicated in other situations, such as the context of child welfare, where unconditional care includes the duty to keep children and youth safe. Regardless, team members as well as those overseeing wraparound initiatives must strive to achieve the principle of unconditional care for the youth and all family members if the wraparound process is to have its full impact on youth, families, and communities.

10. Outcome based. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

This principle emphasizes that the wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part of wraparound team functioning. Outcomes monitoring allows the team to regularly assess the effectiveness of plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for wraparound teams throughout the community.

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Section 2: The Principles of Wraparound

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Wraparound Practice: Chapter 4a.1

Phases and Activities of the Wraparound Process: Building Agreement About a Practice Model

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In 2004, the National Wraparound Initiative (NWI) focused its attention on building agreement about essential elements of wraparound practice.¹ To begin this work, a small core group came together to review existing wraparound manuals and training materials. This core group, which included researchers, trainer/consultants, family members and administrators, used these materials as the basis for an initial version of a practice model. This initial version saw the wraparound process as consisting of a series of activities grouped into four phases: engagement, initial plan development, plan implementation, and transition.

This initial version of the practice model was circulated by email to an additional ten NWI members, primarily administrators of well-regarded wraparound programs. These stakeholders provided feedback in written and/or verbal form. This feedback was synthesized by the NWI coordinators and incorporated into a new draft of the practice model, which was reviewed and approved by the core group. The practice model that emerged from this process did not include any activities that were completely new (i.e., all the activities had appeared in one or more of the existing manuals or materials). However, the overall model was still quite different from any single model that had been described previously.



¹ A more detailed description of the process for defining the practice model can be found in Walker, J. S., & Bruns, E. J. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services*, 57, 1579-1585.

Section 4: Wraparound Practice

As a next step in building agreement about practice, the core group sought feedback from the entire NWI advisory group which, at the time, had grown to include 50 members. Advisors were asked to rate each activity in the model in two

Teams may use a variety of processes or procedures for eliciting needs or goals.

ways: first, to indicate whether an activity like the one described was essential, optional, or inadvisable for wrap-around; and second, whether, as written, the description of the activity was fine, acceptable with minor revisions, or unacceptable. Advisors were also given the opportunity to provide open-ended feedback about each activity, about the grouping of activi-

ties into phases, and about whether or not there were essential activities missing from the practice model.

Overall, the 31 advisors who provided feedback expressed a very high level of agreement with the proposed set of activities. For 23 of the 31 activities presented, there all or all but one of the advisors agreed that the activity was essential. Advisors also found proposed descriptions of the activities generally acceptable. For 20 of the 31 proposed activities, the advisors were unanimous in finding the description acceptable.

The coordinators again revised the phases and activities, incorporating the feedback from the advisors. A document was prepared that described the phases and activities in more detail, and provided notes on each activity. These notes provided additional miscellaneous information, including the purpose of the activity, documentation or other products that should emerge from the activity, and/or cautions or challenges that might arise during the course of the activity. This document was reviewed by the core group and accepted by consensus.

The practice model, together with some of the commentary that accompanied it in its origi-

nal form, is reproduced in the pages that follow. The final model included 32 activities grouped into the four phases. The intention was to define the activities in a manner that is sufficiently precise to permit fidelity measurement, but also sufficiently flexible to allow for diversity in the manner in which a given activity might be accomplished. The intention is to provide a "skeleton" of essential activities that can be accomplished or "fleshed out" in ways that are appropriate for individual communities or even individual teams. For example, an important activity during the phase of initial plan development is for the team to elicit a range of needs or goals for the team to work on, and then prioritize a small number of these to work on first. The practice model specifies that both of these two steps must happen, but does not specify *how* the steps should happen. Teams may use a variety of processes or procedures for eliciting needs or goals, and priority needs or goals can be selected using any of a variety of forms of decision making, including forms of voting or consensus building.

The remainder of this chapter is reproduced from the original *Phases and Activities* document. It begins with a few points that are important to keep in mind when reading about the phases and activities. Following these notes, the document lists and defines each of the four phases of the wraparound process. For each phase, the document describes the main goals to be accomplished in the phase and the activities that are carried out to meet each goal.



Phases and Activities of the Wraparound Process²

Some notes:

- *The activities that follow identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities, and we have not tried to specify exactly who should be responsible for each activity. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a care coordinator is responsible for other activities. On other teams, a care coordinator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a care coordinator to a parent, family member, or other natural support person, during the course of a wraparound process.*
- *The families participating in wraparound, like American families more generally, are diverse in terms of their structure and composition. Families may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.*
- *The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.*

² The remainder of this article was originally published as Walker, J.S., Bruns, E.J., VanDenBerg, J.D., Rast, J., Osher, T.W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Section 4: Wraparound Practice

Phases and Activities of the Wraparound Process: Phase 1

MAJOR GOALS	ACTIVITIES	NOTES
<p align="center">PHASE 1: Engagement and team preparation</p> <p><i>During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.</i></p>		
<p align="center">1.1. Orient the family and youth</p> <p>GOAL: To orient the family and youth to the wraparound process.</p>	<p align="center">1.1 a. Orient the family and youth to wraparound</p> <p>In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).</p>	<p>This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.</p>
	<p align="center">1.1 b. Address legal and ethical issues</p> <p>Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.</p>	<p>Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.</p>

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.</p>	<p>1.2 a. Ask family and youth about immediate crisis concerns Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).</p>	<p>The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.</p>
	<p>1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.</p>	<p>Information about previous crises and their resolution can be useful in planning a response in 1.2.c.</p>
	<p>1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.</p>	<p>This response should describe clear, specific steps to accomplish stabilization.</p>
<p>1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.</p>	<p>1.3 a. Explore strengths, needs, culture, and vision with child/youth and family. Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).</p>	<p>This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.</p>

Section 4: Wraparound Practice

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>1.3. Facilitate conversations with family and youth/child</p> <p>GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. (Continued from previous page)</p>	<p>1.3 b. Facilitator prepares a summary document</p> <p>Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.</p>	
<p>1.4. Engage other team members</p> <p>GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles</p>	<p>1.4 a. Solicit participation/ orient team members</p> <p>Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.</p>	<p>The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.</p>
<p>1.5. Make necessary meeting arrangements</p> <p>GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.</p>	<p>1.5 a. Arrange meeting logistics</p> <p>Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.</p>	

Phases and Activities of the Wraparound Process: Phase 2

MAJOR GOALS	ACTIVITIES	NOTES
<p align="center">PHASE 2: Initial plan development</p> <p><i>During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.</i></p>		
<p align="center">2.1. Develop an initial plan of care</p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles</p>	<p align="center">2.1 a. Determine ground rules</p> <p>Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.</p>	<p>In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.</p>
	<p align="center">2.1 b. Describe and document strengths</p> <p>Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.</p>	<p>While strengths are highlighted during this activity, the wrap-around process features a strengths orientation throughout.</p>
	<p align="center">2.1 c. Create team mission</p> <p>Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wrap-around.</p>	<p>The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.</p>

Section 4: Wraparound Practice

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>2.1. Develop an initial plan of care</p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wrap-around principles (Continued from previous page)</p>	<p>2.1 d. Describe and prioritize needs/goals</p> <p>Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.</p>	<p>The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.</p>
	<p>2.1 e. Determine goals and associated outcomes and indicators for each goal</p> <p>Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.</p>	<p>Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.</p>
	<p>2.1 f. Select strategies</p> <p>Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.</p>	<p>This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.</p>

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>2.1. Develop an initial plan of care</i></p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles (Continued from previous page)</p>	<p><i>2.1 g. Assign action steps</i></p> <p>Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.</p>	<p>Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.</p>
<p><i>2.2. Develop crisis/safety plan</i></p> <p>GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.</p>	<p><i>2.2 a. Determine potential serious risks</i></p> <p>Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.</p>	<p>Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.</p>
	<p><i>2.2 b. Create crisis/safety plan</i></p> <p>In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.</p>	<p>One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wrap-around plan as well as youth, family, and team strengths.</p>
<p><i>2.3. Complete necessary documentation and logistics</i></p>	<p><i>2.3 a. Complete documentation and logistics</i></p> <p>Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.</p>	

Section 4: Wraparound Practice

Phases and Activities of the Wraparound Process: Phase 3

MAJOR GOALS	ACTIVITIES	NOTES
<p align="center">PHASE 3: Implementation</p> <p><i>During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.</i></p>		
<p>3.1. Implement the wraparound plan</p> <p>GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wrap-around principles.</p>	<p>3.1 a. Implement action steps for each strategy</p> <p>For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.</p>	<p>The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.</p>
	<p>3.1 b. Track progress on action steps</p> <p>Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.</p>	<p>Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.</p>
	<p>3.1 c. Evaluate success of strategies</p> <p>Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.</p>	<p>Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?</p>
	<p>3.1. d. Celebrate successes</p> <p>The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.</p>	<p>Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.</p>

Phases and Activities of the Wraparound Process: Phase 3 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>3.2. Revisit and update the plan</i></p> <p>GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.</p>	<p><i>3.2. a. Consider new strategies as necessary</i></p> <p>When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.</p>	<p>Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.</p>
<p><i>3.3. Maintain/build team cohesiveness and trust</i></p> <p>GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.</p>	<p><i>3.3 a. Maintain awareness of team members' satisfaction and "buy-in"</i></p> <p>Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.</p>	<p>Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.</p>
	<p><i>3.3 b. Address issues of team cohesiveness and trust</i></p> <p>Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).</p>	<p>Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.</p>
<p><i>3.4. Complete necessary documentation and logistics</i></p>	<p><i>3.4 a. Complete documentation and logistics</i></p> <p>Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.</p>	<p>Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.</p>

Section 4: Wraparound Practice

Phases and Activities of the Wraparound Process: Phase 4

MAJOR GOALS	ACTIVITIES	NOTES
<p align="center">PHASE 4: Transition</p> <p><i>During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.</i></p>		
<p>4.1. Plan for cessation of formal wraparound</p> <p>GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.</p>	<p>4.1 a. Create a transition plan</p> <p>Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.</p>	<p>Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.</p>
	<p>4.1 b. Create a post-transition crisis management plan</p> <p>Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.</p>	<p>At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.</p>
	<p>4.1 c. Modify wraparound process to reflect transition</p> <p>New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.</p>	<p>Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.</p>

Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>4.2. Create a "commencement"</p> <p>GOAL: To ensure that the cessation of formal wrap-around is conducted in a way that celebrates successes and frames transition proactively and positively.</p>	<p>4.2 a. Document the team's work</p> <p>Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)</p>	<p>This creates a package of information that can be useful in the future.</p>
	<p>4.2 b. Celebrate success</p> <p>Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.</p>	<p>This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.</p>
<p>4.3. Follow-up with the family</p> <p>GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.</p>	<p>4.3 a. Check in with family</p> <p>Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.</p>	<p>The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.</p>

Section 4: Wraparound Practice

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Supporting Wraparound Implementation: Chapter 5e.4

Wraparound is Worth Doing Well: An Evidence-Based Statement

Eric Bruns, Co-Director, National Wraparound Initiative, and Associate Professor, University of Washington School of Medicine



“Anything worth doing is worth doing well.” At some point, a parent, teacher, coach, or supervisor probably has given you this sage advice. Did you ever ask (maybe to yourself) whether there was evidence to support it?

In fact there is. Research tells us we should heed this guidance when delivering our children’s behavioral health services. Meta-analyses of interventions delivered in “real world” systems have shown that “services as usual” are often no more effective than no service at all. Services based on evidence for effectiveness have a better chance of succeeding, but they must be delivered with quality and model fidelity if they are to produce positive effects.

Wraparound care coordination is no exception. Over 20 years, findings from controlled, peer-reviewed research articles (see Suter & Bruns, 2009; Bruns & Suter, 2010; Bruns, Walker, et al., 2014 for reviews) and federal evaluation reports (e.g., Urdapilleta et al., 2011) have consistently found wraparound to be associated with positive residential, functioning, and cost outcomes. Most of these studies were small pilot projects, however, in which implementation was tightly overseen and staff were well-trained and supervised (e.g., Bruns, Rast, Walker, Peterson, & Bosworth, 2006; Pullmann et al., 2006).

In 2014, two studies were published that provide cautionary notes to policymakers and providers involved in the increasingly common enterprise of taking wraparound programs to scale in real world public systems. The first study, funded by the National Institute of Mental Health, randomly assigned 93 youths with complex emotional and behavioral



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Section 5: Supporting Wraparound Implementation

needs and involved in the Nevada child welfare system to wraparound care coordination (N=47) versus more traditional intensive case management (N=46). The wraparound group received more mean hours of care management and services and demonstrated initially better residential outcomes. By 12 months, however, there were no group differences in functioning or emotional and behavioral symptoms (Bruns, Pullmann, Sather, Brinson, & Ramey, 2014).

The second study evaluated whether the addition of a wraparound facilitator to regular child protection services (CPS) in Ontario, Canada, improved child and family functioning over 20 months. While both groups improved significantly in child functioning, caregiver psychological distress, and family resources, addition of a facilitator did not improve outcomes above regular CPS (Browne, Puente-Dura, Shlonsky, Thabane, & Vericchio, 2014).

In addition to rigorously examining wraparound outcomes at some level of scale in “real world” systems, these two studies also shared another thing in common—both found Wraparound implementation quality to be poor.¹ In the Ontario study, fidelity as assessed by the Wraparound Fidelity Index (WFI) was found to be in the “below average” or “not wraparound” ranges for six of the scale’s 10 subscales, per standards disseminated by the NWI (Bruns, Leverentz-Brady, & Suter, 2008). The authors concluded that “some of the major components of wraparound may not have been sufficiently provided in order to promote optimal support and care for families” and that “a little bit of wraparound fidelity may not be enough for optimal treatment success.”

In the Nevada study, fidelity as assessed by the WFI was worse than 80% of sites nationally for parent reports and worse than 90% of sites nationally per a team observation measure. Parents and caregiver responses on the WFI and observation of team meetings suggested that the program did not consistently do things associated with high-quality implementation, such as:

- Involve youths and family members in the development of the wraparound team
- Actively engage and integrate the family’s natural supports
- Develop proactive crisis plans based on functional assessments
- Link caregivers to social supports
- Involve youths in community activities
- Develop statements of team mission or family priority needs
- Brainstorming individualized strategies to meet needs
- Ensure team members followed through on tasks
- Develop effective transition plans

In contrast, earlier studies of smaller-scale wraparound initiatives in the same system with only 4-5 WSM facilitators and extensive training and coaching showed high levels of fidelity and far better residential and functional outcomes for wraparound than for a comparison group of similar youths (Bruns, Rast, et al., 2006; Mears, Yaffe, & Harris, 2009). To put the differences in perspective, youths enrolled in the pilot project improved by an average of 35 points on the Child and Adolescent Functional Assessment Scale (CA-FAS), compared to only 13 points in the study of wraparound taken to scale.

Looking at the big picture, these two studies bring the total number of controlled (experimental or quasi-experimental) wraparound studies in peer reviewed journals to 12. Among these, only one other study (Bickman, Smith, Lambert, & Andrade, 2003) found uniformly null effects for the wraparound condition. Perhaps not surprisingly, this is also the one other study among the 12 that documented a lack of adherence to the prescribed wraparound model. In this study, the authors concluded, “many elements of the practice model of wraparound were not present” and that the wraparound condition “was not meaningfully different

¹ Notably, both studies also applied wraparound facilitation to youth involved in child welfare. It is possible that this also played a factor in the finding of no significant effects over services as usual.

from the comparison condition.”

Thus, many may initially interpret the results of these studies as evidence against the growing movement by states and large jurisdictions to invest in care coordination using the intensive procedures recommended by the National Wraparound Initiative (Walker & Bruns, 2006) for youths at risk for costly and disruptive out of community placement. Closer examination of the studies, however, suggests their findings may simply be an extension of hard lessons learned about implementation of evidence-based practices in general. *Not only is it worth doing these practices well, outcomes for youth and families probably depend on it.*

Doing Wraparound Well

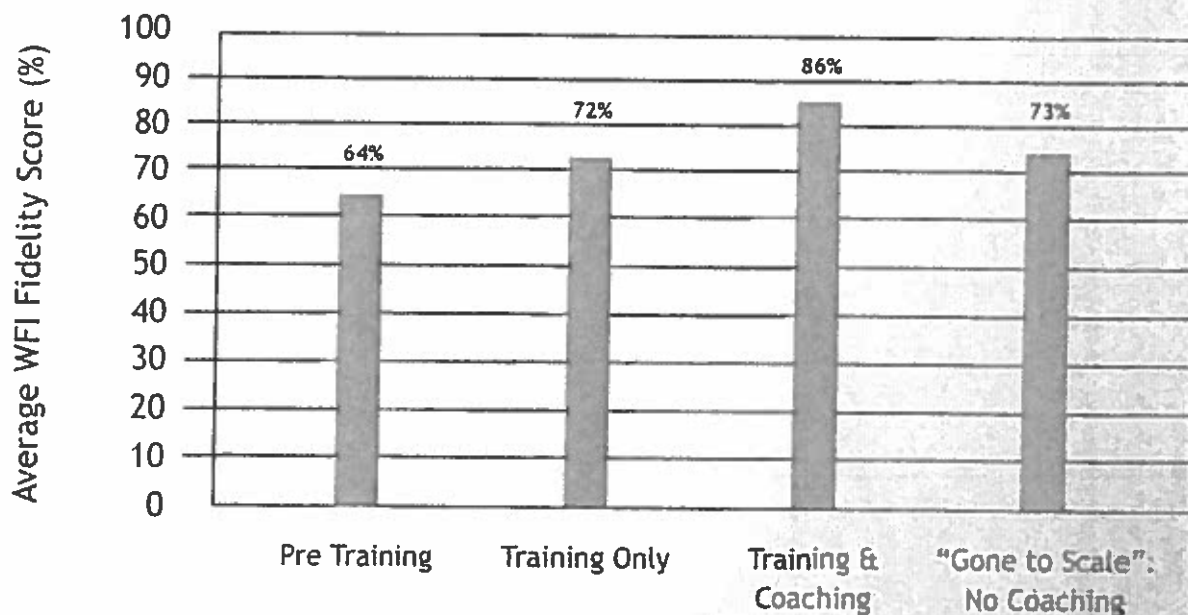
So, what does it mean to “do wraparound well”? Obviously, the research summarized above suggests that implementation with fidelity to the prescribed practice model is critical. As has been described in multiple research articles and program descriptions (e.g., Walker & Bruns, 2006; Walker & Matarese, 2011), these practice-level

elements must be in place for wraparound to live up to its theory of change and represent the well-coordinated, youth- and family-driven, multisystemic strategy that it is intended to be.

To achieve high-quality practice, system and program supports must be accounted for into the initiative. According to implementation science, the three big implementation drivers to keep in mind are Leadership, Workforce Development, and Program and System Support. Obviously, it would be ideal to do this from the beginning, but many wraparound projects have also successfully developed these “implementation drivers” over time.

Training, Coaching and Supervision. Wraparound projects require a thoughtful and deliberate approach to building staff and personnel capacity. This includes effective training, coaching, and supervision as well as other types of human resource decisions such as appropriate job descriptions, hiring practices, caseload sizes, performance systems, and staff support, including compensation.

Figure 1. Wraparound Fidelity in a System of Care with Variable Workforce Development Over Time



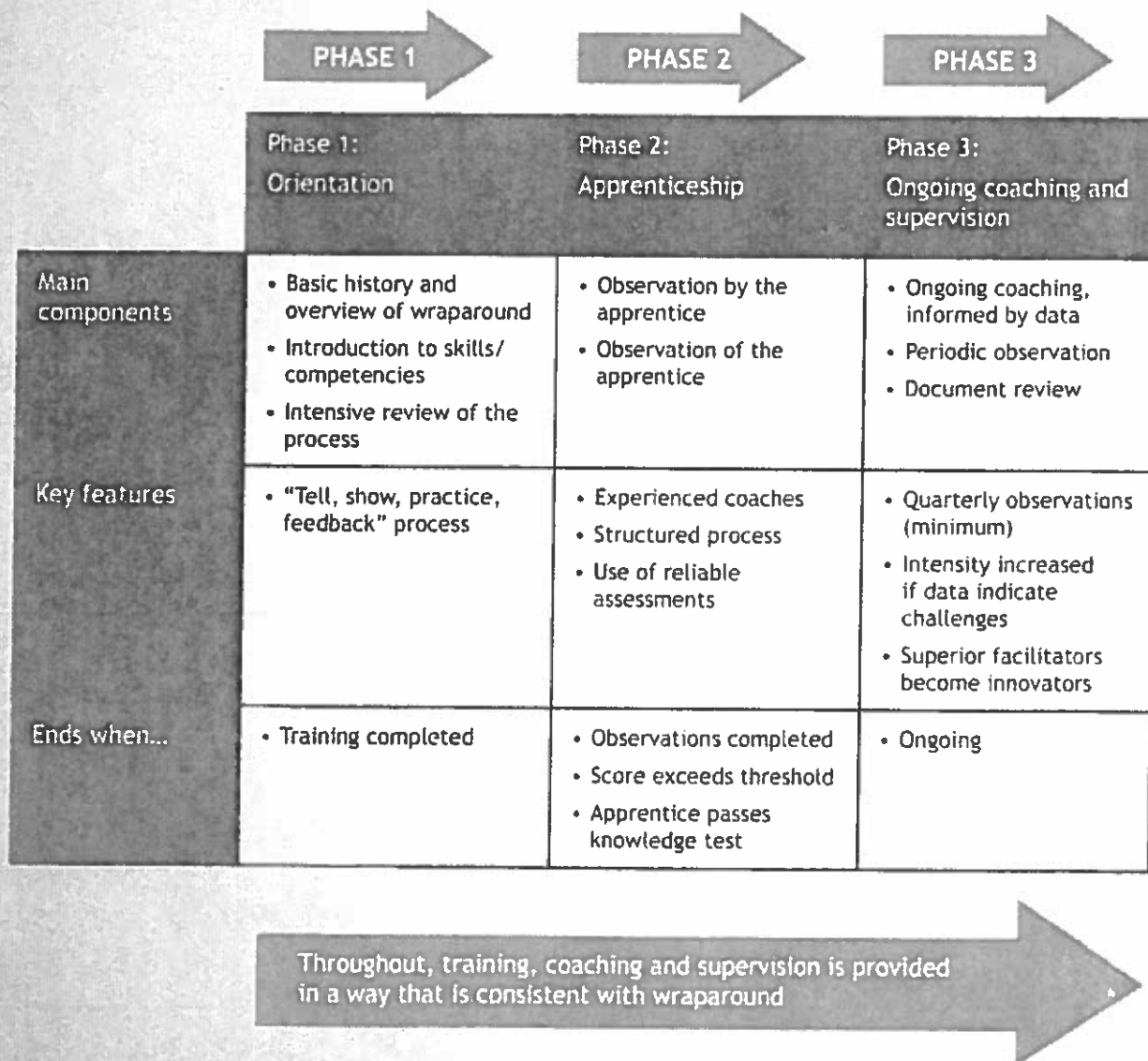
Section 5: Supporting Wraparound Implementation

When it comes to training, coaching, and supervision, the evidence is growing crystal clear in human services that the “train and hope” model is destined to fail to achieve high-quality implementation. In the Nevada study cited above, for example, the drop off in fidelity and outcomes coincided with the withdrawal of resources for

staff training and coaching that accompanied the national recession of 2007 that hit that states particularly hard (See Figure 1).

To help ensure states and systems understand what is important to attend to in workforce development, the National Wraparound Initiative (NWI) worked with its community of practice to develop

Figure 2. Workforce Development in Wraparound, from Orientation to Innovation



2. See <https://www.nwi.pdx.edu/pdf/wrap-training-guidelines-2013.pdf>

guidelines for training, coaching and supervision for Wraparound Facilitators.² As shown in Figure 2, this guidance describes the types of content and practice activities to which facilitators should be exposed in initial training and orientation before they start to work with families. It goes on to describe the all-too-often neglected “apprentice” period, during which facilitators work in tandem with an experienced facilitator—a “coach”—who uses a structured process to help them gradually develop the ability to work independently with families. In a third phase of skill development, ongoing coaching and supervision should be provided to ensure that facilitators continually develop their skills and expertise. In each of the phases, the learning experience should be characterized

by a “tell, show, practice, feedback” process, whereby training and coaching shifts gradually from imitation of skillful performance to production of skillful performance.

Program and System Supports. Critical though it may be, training and coaching alone is unlikely to ensure skillful practice and successful implementation. Over a decade ago, Walker, Koroloff, & Schutte (2003) showed that “doing wraparound well” is a complex undertaking that requires a focus on an array of systems-level structures, policies, and supports necessary to ensure quality practice-level implementation and positive outcomes. These “necessary support conditions” have since been codified by the NWI in the form of six themes, shown in Table 1.

Table 1. Necessary Support Conditions for Wraparound

Theme	Description
<i>Theme 1: Community Partnership</i>	Collective community ownership of and responsibility for wraparound is built through collaborations among key stakeholder groups.
<i>Theme 2: Collaborative Action</i>	Stakeholders involved in the wraparound effort translate the wraparound philosophy into concrete policies, practices and achievements.
<i>Theme 3: Fiscal Policies and Sustainability</i>	The community has developed fiscal strategies to meet the needs of children participating in wraparound and methods to collect and use data on expenditures for wrap-around-eligible youth.
<i>Theme 4: Access to Needed Supports and Services</i>	The community has developed mechanisms for ensuring access to the wraparound process and the services and supports that teams need to fully implement their plans, including evidence-based practices.
<i>Theme 5: Human Resource Development & Support</i>	Wraparound and partner agency staff support practitioners to work in a manner that allows full implementation of the wraparound model, including provision of high-quality training, coaching, and supervision.
<i>Theme 6: Accountability</i>	The community has implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall wrap-around effort.

Section 5: Supporting Wraparound Implementation

Subsequent research has shown that these conditions can be measured and that they are associated with positive implementation on the ground level (Bruns, Leverentz-Brady, & Suter, 2006; Walker & Sanders, 2011). In the “real world” of wraparound implementation, the following are examples of topics that will require careful attention:

- *System structures for governance and management*, including consideration of options such as care management entities³ and health homes⁴;
- *Investment in quality assurance and accountability*⁵ structures;
- *Sustainable financing* of high quality Wraparound, including the use of Medicaid and other federal financing mechanisms⁶;
- *Developing centers of excellence* for ongoing implementation, quality assurance, policy, financing, and evaluation support;
- *Building, enhancing, and/or implementing workforce development initiatives* outside of the Wraparound practice model, including shifting providers from residential services to quality home- and community-based services; and
- *Implementation of Wraparound in the context of other systems of care efforts*, including developing and implementing other *evidence-based and promising practices*.

Conclusion

In the late 1990s and early 2000s, many feared that the exciting innovations in family- and youth-driven, team based “wraparound” care would become a passing fad. Instead, wraparound has become a touchstone for children’s mental health, recommended as a strategy in federal

guidance documents,⁷ and available in nearly every one of the United States. While it is encouraging that wraparound has gone to scale in this way, wraparound applied inappropriately or implemented “in name only” may represent a waste of our increasingly scarce behavioral health dollars.

Though it is no longer radical, wraparound has the potential to be quite powerful. To make the most of their investment in wraparound, however, states and communities must heed the lessons learned from recent research, lest they be doomed to repeat them.

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4. See <http://www.chcs.org/resource/seizing-opportunity-early-medicare-health-home-lessons-chcs-webinar>

5. See <http://nwl.pdx.edu/accountability>

6. See <http://nwl.pdx.edu/finance-and-sustainability>

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EXHIBIT Q

December 18, 2015 Program Accountability Forum

JTDC RUR/Regenerations Pilot

Deann Muehlbauer, MPH, UIC
Alan Morris, PsyD, UIC

Problem Statement

- **Challenging population**
 - Youth and families difficult to engage and typically resistant to services
 - Often present complex mental health and behavioral challenges
 - High level of environmental stress
 - Multiple system involvement
- Youth stay too long in JTDC after their RUR date – part of the system-wide gridlock
- Too many youth are released from JTDC to residential care
- Youth released from JTDC to residential care stay in residential care too long

RUR Pilot Population

DCFS wards currently detained at JTDC and eligible for RUR or discharged to the Shelter

- **Ages 12-18**
- **Eligibility for Regenerations determined on case by case basis. No standard exclusionary criteria.**
- **Serving youth since July 2015**

Pilot Intervention Components

- Mobilize a sense of urgency
- Address policy and procedural barriers
- Collaboration and partnership
- CIPP process
- Regenerations services
 - Proxy for intensive home and community based community services
 - Capacity to engage youth and family
- Short term residential services

Targeted Outcomes

Intermediate:

- Youth spend fewer days in JTDC/Shelter after their release date
- Fewer youth released directly from JTDC/Shelter to residential care
- Fewer days in residential care among youth discharged directly from to residential care from JTDC/Shelter
- More youth placed with family or in a family-like setting

Long Term:

- Child and Family Team capacity to support youth and family
- Stronger family connections
- Improved school attendance and performance
- Increased vocational skills and work experience
- Increased youth well being

Population

RUR Population

- 37 pilot youth
 - 24 newly committed youth
 - 13 current wards
 - 1 discharged youth
- 17 non-pilot youth

Pilot Youth

Age

- 11 youth - 13-14 yrs
- 21 youth - 15-16 yrs
- 5 youth - 17-18 yrs

Sex

- 31 boys
- 6 girls

Status of Pilot Youth

- 30 youth placed from JTDC/Shelter
- 9 youth currently waiting for placement
 - 1 youth in shelter, 8 youth at JTDC
 - 2 youth (*who were previously placed*) detained at JTDC
 - 4 youth *matched to residential*
 - Wait time between 6-43 days

Days to Placement

30 Pilot Youth

- Range: 4-279 days
- Average: 40 days
- Median: 25 days

**missing data for 1 youth

Previous Practice

JTDC staff indicated that dually involved youth typically waited 75-80 days from RUR designation to placement prior to the initiation of the pilot.

Placement Living Arrangements

30 Pilot Youth

1 st Living Arrangement	Youth
Relative Foster Care	9
Non-Related Foster Care	18
Residential	3

Previous Practice

A significant majority of dually involved youth were referred for residential placement prior to initiation of the pilot.

Placement Stability

Types of Placement Moves	1 st Placement: Relative Caregiver	1 st Placement: Non-Related Caregiver	1 st Placement: Residential
No Moves	6	8	3
Move to Related Caregiver	1	1	0
Move to Non-Related Caregiver	1	4	0
Move to Home of Parent**	0	2	0
Detained at JTDC	1	2	0
Sentenced to IYC	0	1	0

CIPP Resources

- 149 CIPPS completed for 54 youth
- 113 CIPPs held for 30 placed youth
 - Average 3.75 CIPPs per placed youth
- CIPP locations – JDTC and DCFS offices

Implementation Issues

- Key takeaway – tremendous time/energy DCFS/UIC involvement and oversight
- Responding to a crisis. Building the plane while flying it.
- Policy and procedural barriers -
- Collaboration and partnership – aligning components
- Shift from usual practice, the rubber band, and need to build in sustainability

Outcomes?

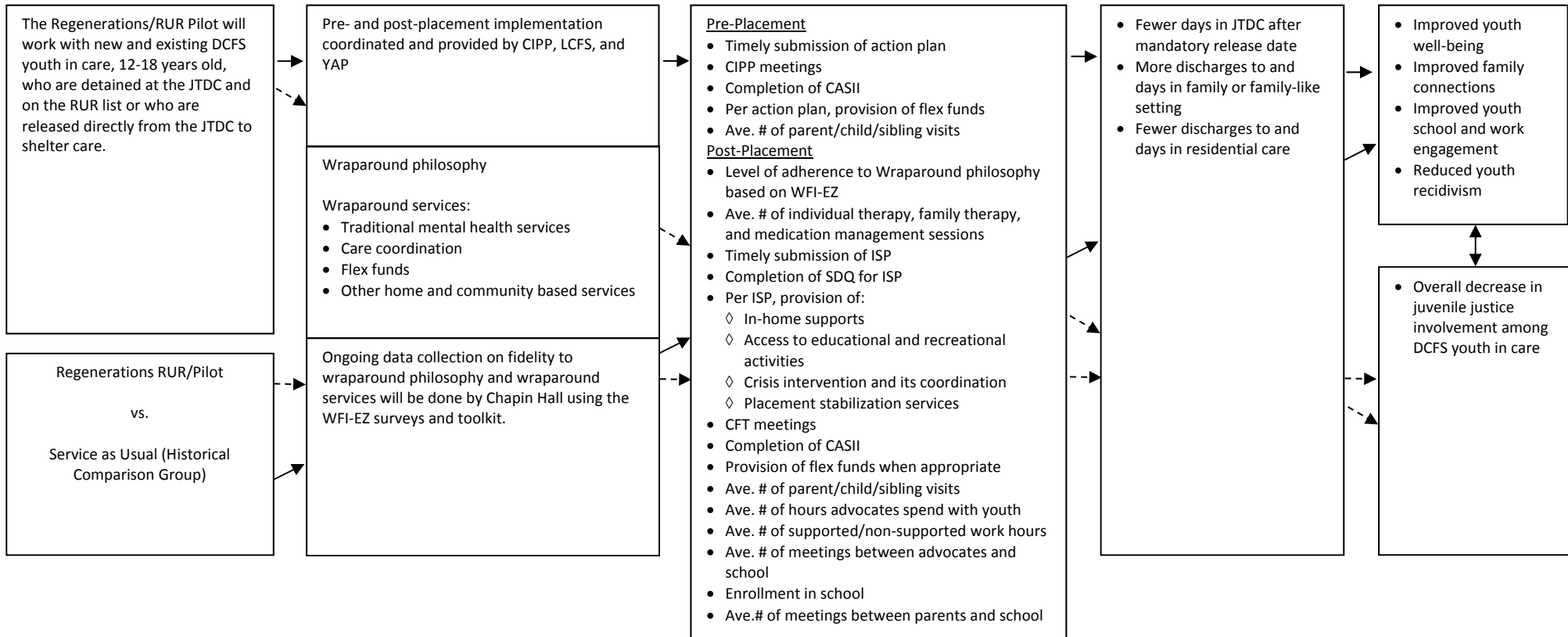
- Too early to tell
- Seem to be initially addressing the access to services and placement concerns
- This intervention is a moving target. Struggling to define the intervention as needed in order to complete implementation study and outcome evaluation. Chapin Hall is guiding us.

Next Steps:

Lavish more attention on implementation integrity

- Come to agreement on Theory of Change – what combination of the intervention components will make the difference?
- Identify and implement valid strategies to measure youth and family engagement, and strength of Child and Family Team
- Focus on placement phase
 - Service intensity
 - What works to support families
- Maximize learning
 - Regular review of data
 - Increase collaboration among stakeholders

EXHIBIT R

DCFS Regenerations RUR/Pilot Logic Model***Plan******Implementation******Outputs******Outcomes***
Proximal***Distal******Background******Theory of Change******End-Values***

- Societal (e.g., poverty, racism)
- Family (e.g., lack of resources, lack of involvement)
- Child (e.g., mental illness, school problems)

Youth in JTDC are at-risk for being detained beyond their release date, discharged to residential care when residential care is not necessary, and staying in residential care longer than necessary. In the context of a Wraparound philosophy and the CMCS and SAMHSA (2013) informational bulletin, federal projects have demonstrated that in addition to traditional mental health services, youth outcomes are improved by also providing 1) Intensive care coordination (often called Wraparound service planning/facilitation), 2) Family and youth peer support services, 3) Intensive in-home services, 4) Respite care, 5) Mobile crisis response and stabilization, 6) Flex funds, and 7) Other home and community based services.

The goal of the regenerations pilot/theory of change will be to improve conditions for youth in terms of well-being, school and work engagement, and increase the likelihood that they will remain in stable family-like settings and not return to the juvenile justice system.

EXHIBIT S

Evaluation of the Regenerations/RUR Pilot

I. PICO Question

Among new and existing DCFS wards who are detained at the Cook County Juvenile Temporary Detention Center (JTDC) and on the Release upon Request (RUR) list or are released directly from the JTDC to a shelter (P), does participation in the Regenerations/RUR Pilot (I), compared to similar youth who received service as usual before the Pilot (C), improve youth's placement stability, well-being, school and work engagement, and reduce recidivism (O)?

A. Target Population

The Regenerations/RUR Pilot target population includes new and existing DCFS wards, 12-18 years old, who are detained at the JTDC and on the RUR list or who are released directly from the JTDC to shelter care. Note that beginning July 2016, new DCFS wards in the JTDC who meet other inclusion criteria for the Pay-for-Success (P4S) program will be randomized to either receive or not receive P4S. Youth not randomized to receive P4S will be eligible for inclusion in the Regenerations/RUR Pilot.

B. Intervention

The Regenerations/RUR Pilot is being implemented by the Illinois Department of Children and Family Services (DCFS), in collaboration with the JTDC, Cook County Juvenile Probation, Lutheran Child and Family Services (LCFS), Youth Advocate Programs (YAP), and the University of Illinois at Chicago (UIC), using a Wraparound philosophy to provide traditional mental health services, care coordination (e.g., Wraparound, the service), and other home and community based services (Center for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration, 2013). The Wraparound philosophy has been described as a set of principles administered through a collaborative child and family team process to plan and implement services and supports to meet individualized needs of the child and family (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004; Kernan, 2014).

In the context of a Wraparound philosophy, the CMCS and SAMHSA (2013) informational bulletin describes that years of federal demonstration projects have demonstrated that **in addition to traditional mental health services**, youth outcomes are improved by also providing the following services:

1. Intensive care coordination (often called wraparound service planning/facilitation),
2. Family and youth peer support services,
3. Intensive in-home services,
4. Respite care,
5. Mobile crisis response and stabilization,
6. Flex funds, and
7. Other home and community based services.

The Regenerations/RUR Pilot program uses a Wraparound philosophy to provide youth in the target population with care coordination (also called Wraparound services planning/facilitation) and other home and community based services, in addition to traditional mental health services (Table 1).

Table 1. Overview of Regenerations/RUR Pilot Program.

Wraparound Philosophy		
Program Service Components	Pre-placement	Post-placement
Traditional mental health services	N/A – provided by JTDC or shelter per system of care (not by the Regenerations/RUR Pilot)	Led and provided by LCFS
Care coordination	Led and provided by Clinical Intervention for Placement Preservation (CIPP) Facilitator; LCFS and YAP are involved	Led and provided by LCFS; YAP and CIPP are involved
Flex Funds	Led and provided by LCFS; YAP is involved	Led and provided by LCFS; YAP is involved
Other home and community based services	Led and provided by LCFS (family engagement and caregiver support); YAP is involved	Led and provided by LCFS (family engagement and caregiver support) and YAP (school and work support)

Wraparound Philosophy. The Wraparound philosophy can be operationalized as 10 principles (Bruns, Walker, & The National Wraparound Initiative Advisory Group, 2008): 1) Family voice and choice; 2) Team based; 3) Natural supports; 4) Collaboration; 5) Community based; 6) Culturally competent; 7) Individualized; 8) Strengths based; 9) Unconditional; and 10) Outcome based.

The National Wraparound Initiative has developed multiple instruments to assess fidelity to these wraparound principles. This evaluation will use the Wraparound Fidelity Index, Brief Version (WFI-EZ; Wraparound Evaluation & Research Team, 2016), a self-report measure of five key Wraparound elements—1) effective strategies; 2) effective teamwork; 3) natural/community supports; 4) needs-based; and 5) strength- and family-driven—that will be completed by youth, caregivers, and LCFS and YAP program staff after youth is enrolled in the program for at least two months, as recommended by the National Wraparound Initiative. The fidelity score for each of the five Wraparound elements will be the mean score for the items associated with that element.

Program Service Components. Additional information about Regenerations/RUR Pilot program service components includes:

- 1. Traditional Mental Health Services.** Pre-placement traditional mental health services will be provided by the JTDC or shelter and are, therefore, not considered part of the Regenerations/RUR Pilot. Post-placement traditional mental health services will be provided by LCFS' Clinical Services Department and LCFS' subcontractors.
- 2. Care Coordination (also known as Wraparound “the service”).** As a service, care coordination includes assessment and service planning, assessing and arranging for services, coordinating multiple services, including access to crisis services (CMS and SAMHSA, 2013). Pre-placement care coordination is led by the CIPP Facilitator and involves LCFS and YAP. The CIPP Facilitator ensures an action plan is completed, identifies resources, and includes youth and family voice. There is a pre- to post-placement care coordination handoff from CIPP to LCFS. While LCFS provides some pre-placement coordination, LCFS is exclusively responsible for post-placement care coordination.

To facilitate continuity, LCFS assumes case management responsibility when youth detained at the JTDC are placed on the RUR list or released from the JTDC directly to shelter care for new wards. For existing wards, LCFS assumes case management responsibility when

youth detained at the JTDC are placed on the RUR list or released from the JTDC directly to shelter care if it is determined that youth: 1) do not have a placement option and 2) transferring case management is not contra-indicated. Post-placement care coordination activities include coordinating in-home supports to caregivers and youth, crisis intervention services, and access to educational and recreational activities.

3. **Flex-funds.** Youth's need for flex-funds is assessed and indicated in the action plan (pre-placement) and the individualized service plan (post-placement). LCFS and YAP are responsible for assessing for and providing flex-funds.
4. **Other Home and Community Based Services.** Pre-placement services provided by LCFS include weekly parent, child, or sibling visits. Post-placement services are provided by LCFS and YAP and include a) advocacy, b) therapeutic recreation, c) supported employment, and d) family engagement and support (e.g., crisis intervention/response system, placement stabilization services, weekly parent, child, or sibling visits).

Please see the Regenerations/RUR Pilot procedures and associated appendices for more information (herein attached by reference).

C. Comparison

It is not possible to create a contemporaneous comparison group for the outcome evaluation of the Regenerations/RUR Pilot for two reasons. First, both the Regenerations/RUR Pilot and the P4S Pilot target the same youth population and are being implemented concurrently. Second, inclusion in the P4S Pilot is prioritized over the Regenerations/RUR Pilot because only youth not randomly assigned to P4S are eligible for the Regenerations/RUR Pilot. In the absence of a contemporaneous comparison group, we plan to compare the outcomes of youth participating in the Regenerations/RUR Pilot during Phase 2 (July 2016-June 2017) to those of an historical comparison group.

The evaluation team will construct the historical comparison group by examining the characteristics of the youth who participated in Phase I of the Regenerations/RUR Pilot (July 2015-June 2016) and then identifying a group of youth with similar characteristics who were in detention in FY13 to FY15 (i.e., before the Regenerations/RUR pilot began). The data used to compare the historical comparison group with youth in the Regenerations/RUR Pilot is described in the data collection plan below.

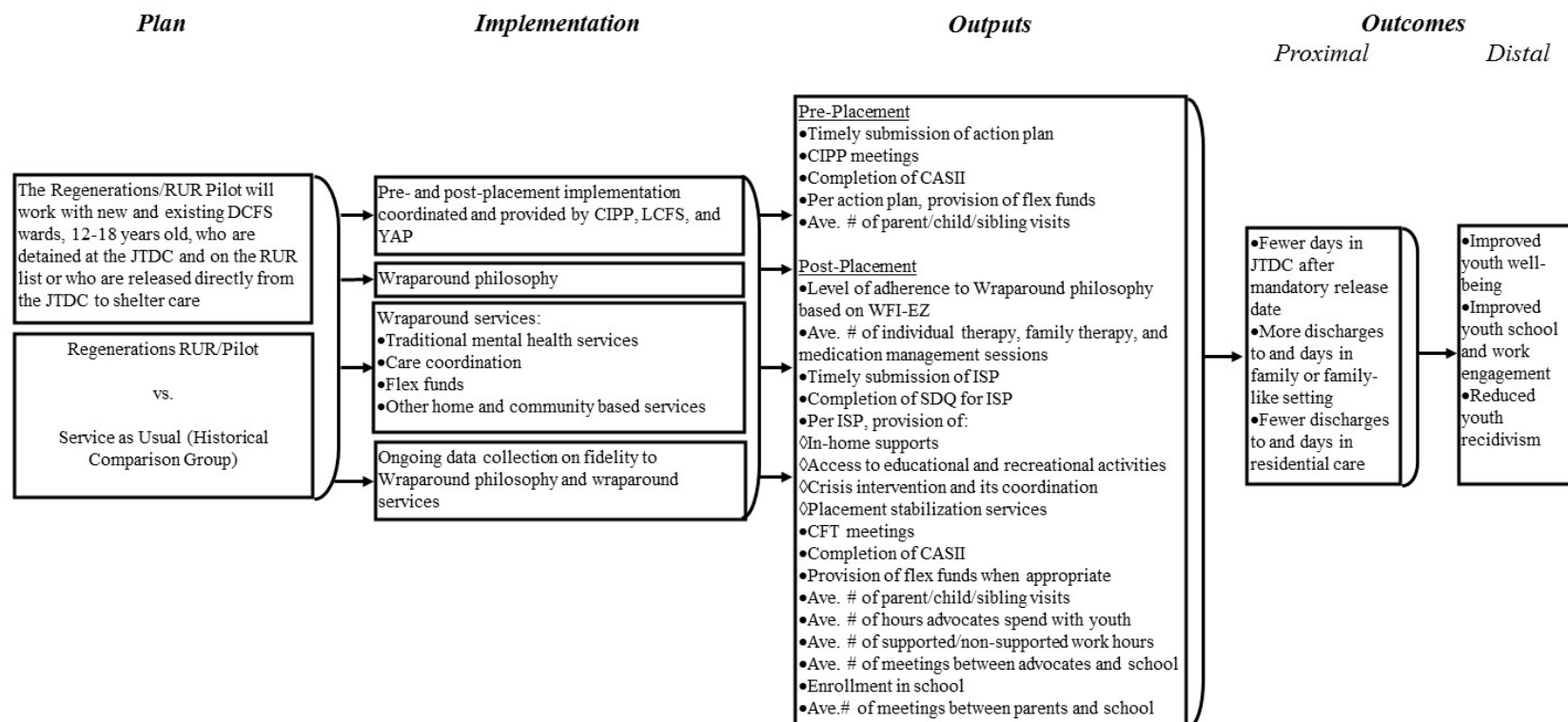
D. Outcomes

The Regenerations/RUR Pilot is aimed at reducing 1) days in JTDC after the release date, 2) discharges to and days in residential care, and increasing 3) discharges to family or family-like settings, with the long-term goals of improving youth 1) well-being, 2) school and work performance, and 3) reducing recidivism in juvenile justice involvement. The evaluation of the Regenerations/RUR Pilot will include an implementation and outcome study. The implementation study will examine whether the Regenerations/RUR Pilot's Wraparound philosophy and services are being implemented with fidelity to Wraparound and the program model, respectively. The outcome study will examine the outcomes described above.

II. Theory of Change/Logic Model

Figure 1 depicts the theory of change/logic model guiding implementation activities and the evaluation. It illustrates the links between the problem the Regenerations Pilot is designed to address, the Regenerations Pilot activities, and both intermediate and longer term outcomes.

Figure 1. Regenerations Pilot/RUR theory of change/logic model.



External Conditions

- Societal (e.g., poverty, racism)
- Family (e.g., lack of resources, lack of involvement)
- Child (e.g., mental illness, school problems)

Theory of Change

Youth in JTDC are at-risk for being detained beyond their release date, discharged to residential care when residential care is not necessary, and staying in residential care longer than necessary. In the context of a Wraparound philosophy and the CMCS and SAMHSA (2013) informational bulletin, federal projects have demonstrated that in addition to traditional mental health services, youth outcomes are improved by also providing 1) Intensive care coordination (often called Wraparound service planning/facilitation), 2) Family and youth peer support services, 3) Intensive in-home services, 4) Respite care, 5) Mobile crisis response and stabilization, 6) Flex funds, and 7) Other home and community based services.

End Goals

The goal of the regenerations pilot/theory of change will be to improve conditions for youth in terms of well-being, school and work engagement, and increase the likelihood that they will remain in stable family-like settings and not return to the juvenile justice system.

III. Projected Timeline

Table 5 includes a timeline of the evaluation activities.

Table 5. Evaluation timeline.

Evaluation Activity	Phase I (July 2015-June 2016)				Phase II (July 2016-June 2017)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Evaluation Preparation								
• Conceptualize Regenerations/RUR Pilot program with DCFS, LCFS, and YAP	X	X	X	X				
• Finalize theory of change/logic model			X	X				
• Finalize evaluation plan			X	X				
• Submit IRB applications and requests for permissions to use data			X	X				
Implementation Study								
• Collect and analyze Wraparound philosophy data using WFI-EZ					X	X	X	X
• Collect and analyze fidelity metrics for traditional mental health services, intensive care coordination, and other home and community based services using SharePoint and SACWIS data					X	X	X	X
• Conduct analysis of implementation data						X		X
Outcome Study								
• Identify historical comparison group				X				
• Collect and analyze intermediate and long-term outcomes data:								
• Length of stay in JTDC after mandatory release date					X	X	X	X
• Placement type (home-based vs. residential)					X	X	X	X
• Length of stay in placement					X	X	X	X
• Collect and analyze long-term outcomes data:								
• Youth well-being (CANS, SDQ)					X	X	X	X
• Connections to family outcome (YCS)					X	X	X	X
• School performance (school attendance rate)					X	X	X	X
• Work performance (supported employment hours)					X	X	X	X
• Recidivism							X	X
• Conduct analysis of outcomes data						X		X
Evaluation Report								
• Finalize mid- and end-of-year evaluation outlines					X		X	
• Submit mid- and end-of-year evaluation reports						X		X

Phase I extends from 7/1/2015 to 6/30/2016 or when the Pilot reaches 65 youth, whichever comes first. Phase II extends from 7/1/2016 to 6/30/2017.

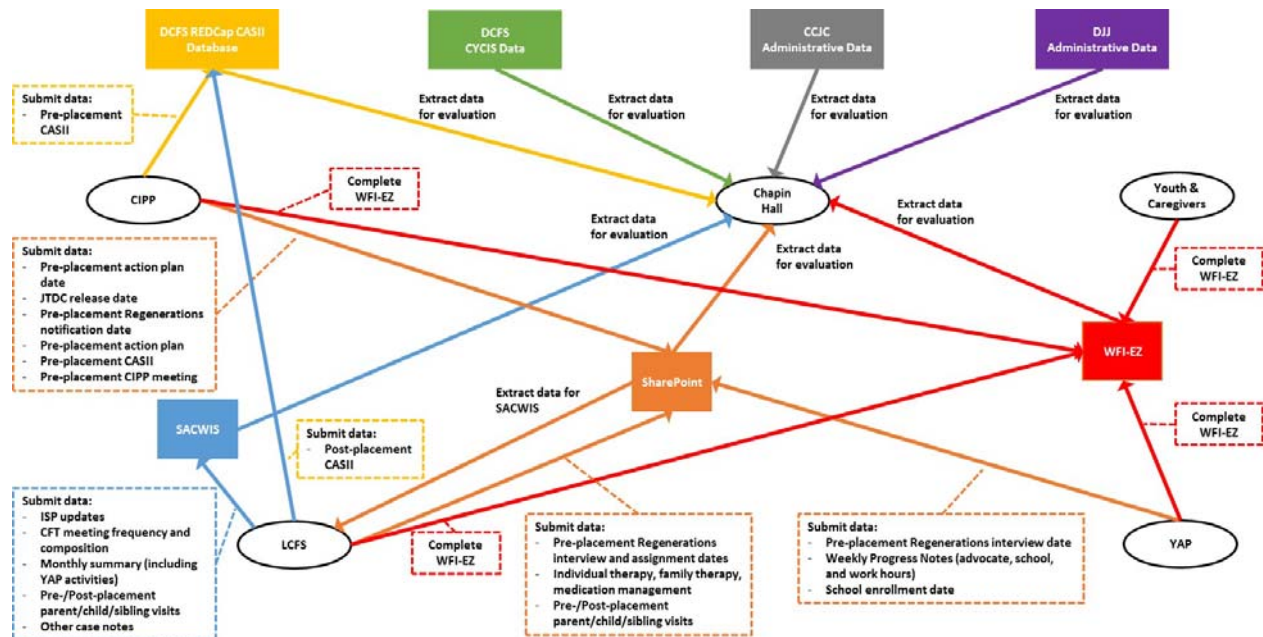
Chapin Hall deliverables for Phase I are: 1) Approval letters from the University of Chicago and DFCS IRBs, and permissions to use data from CCJC and Illinois Department of Justice (DJJ); 2) Theory of change/logic model for the Regenerations/RUR Pilot; 3) Description of Phase I participants; and 4) Phase II evaluation plan.

Chapin Hall deliverables for Phase II are: 1) Mid-year evaluation progress report; and 2) End-of-year evaluation report.

IV. Evaluation Design and Data Collection Plan

The evaluation will include an implementation study and an outcome study. Each is described separately below. Figure 2 shows how information will be shared and used for the evaluation. The evaluation will use data from multiple sources including DCFS, LCFS, YAP, CCJC and DJJ. Please refer to DCFS' process and communication plan for more information about the operation of the Regenerations/RUR Pilot.

Figure 2. Data workflow for evaluation.



A. Implementation Study

The goals of the implementation study are to: 1) Continuously adapt the Regenerations/RUR Pilot theory of change/logic model (see Figure 1, above); and 2) Examine fidelity for the program to its Wraparound philosophy and each individual program service component (see Table 2, below). Data collected on fidelity metrics will be used to measure the program's adherence to the Wraparound philosophy and program service components.

The WFI-EZ will be used to assess adherence to a Wraparound philosophy. The WFI-EZ will be administered at the 2 month post-placement CFT meeting. Assessing adherence to a Wraparound philosophy at the 2 month post-placement CFT meeting is consistent with developer recommendations to assess adherence after a CFT has been established long enough that its members will have had time to form a team and reflect upon their experiences. LCFS will coordinate with Chapin Hall to have research team members on-site at applicable CFT meetings to administer the WFI-EZ. Individual WFI-EZ data, by role, will be aggregated at the program-level for analysis.

The fidelity metrics related to the program service components will be measured using data being captured in SharePoint or in SACWIS. Table 2 indicates the fidelity metrics and data sources that will be used.

Table 2. Regenerations Pilot/RUR Pilot fidelity metrics and data sources.

Last updated on 08-05-16

	Fidelity Metric	Data Source
Wraparound Philosophy	<ul style="list-style-type: none"> Key elements of the wraparound experiences based on these 5 wraparound fidelity scales: <ul style="list-style-type: none"> Effective strategies Effective teamwork Natural/Community supports Needs-based Strength- and family-driven 	<ul style="list-style-type: none"> Wraparound Fidelity Index Short Form, Version EZ (WFI-EZ) completed by youth, caregivers, LCFS and YAP staff, and other CFT members

Program Service Components	Pre-placement		Post-placement	
	Fidelity Metric	Data Source	Fidelity Metric	Data Source
Flex-funds	<ul style="list-style-type: none"> Flex-funds assessments and services are indicated in the pre-placement action plan 	<ul style="list-style-type: none"> Action plan in SACWIS <p>Data submitted by CIPP</p>	<ul style="list-style-type: none"> Flex-funds assessments and services are indicated in the pre-placement action plan 	<ul style="list-style-type: none"> Individualized service plan (ISP) in SACWIS <p>Data submitted by LCFS</p>

Program Service Components	Pre-placement		Post-placement	
	Fidelity Metric	Data Source	Fidelity Metric	Data Source
Traditional Mental Health Services			<ul style="list-style-type: none"> Average number of individual therapy session per program week/month (if assessment indicates service need) 	<ul style="list-style-type: none"> SharePoint <p>Data submitted by LCFS</p>
			<ul style="list-style-type: none"> Average number of family therapy session per program week/month (if assessment indicates service need) 	<ul style="list-style-type: none"> SharePoint <p>Data submitted by LCFS</p>
			<ul style="list-style-type: none"> Average number of medication management session per program week/month (if assessment indicates service need) 	<ul style="list-style-type: none"> SharePoint <p>Data submitted by LCFS</p>

Intensive care coordination	<ul style="list-style-type: none"> Pre-placement action plan 	<ul style="list-style-type: none"> Action plan submission date in SharePoint <p>Data submitted by CIPP</p> <p>Expectation: Initial action plan must be focused, strengths-based and time-sensitive.</p>	<ul style="list-style-type: none"> Number of days between placement (home-based or residential) and submission of an Individual Service Plan (ISP) <p>Expectation: ISP must be submitted within 30 days of case opening</p>	<ul style="list-style-type: none"> Placement date in SharePoint and DCFS CYCIS; ISP submission date in SACWIS <p>Data submitted by LCFS</p>
	<ul style="list-style-type: none"> Number of days between DCFS commitment date (for new wards) or notification by 	<ul style="list-style-type: none"> CIPP date and DCFS commitment date in SharePoint <p>Data submitted by</p>	<ul style="list-style-type: none"> Frequency of updating ISP <p>Expectation: At least every 3</p>	<ul style="list-style-type: none"> ISP submission dates in SACWIS <p>Data submitted by LCFS</p>

Program Service Components	Pre-placement		Post-placement	
	Fidelity Metric	Data Source	Fidelity Metric	Data Source
	DCFS legal (for existing wards) and the initial CIPP meeting	CIPP Expectation: Initial CIPP meeting must take place within 10-14 days of DCFS commitment date	months; and updated as needed	
	• Number of days between notification and initial interview by Regenerations	• Youth interview date and Regenerations notified date in SharePoint • Data submitted by CIPP (notification date), LCFS (interview date), and YAP (interview date)	• Youth Strengths and Difficulties Questionnaire (SDQ) is conducted to create the ISP	• ISP in SACWIS Data submitted by LCFS
	• Frequency of CIPP meetings while youth is in JTDC/RUR or shelter	• Pre-placement CIPP dates in SharePoint • Data submitted by CIPP	• ISP indicates coordination of in-home supports to caregivers and youth and access to educational and recreational activities	• ISP in SACWIS Data submitted by LCFS
	• Number of days between decision to transfer case to LCFS and actual transfer (existing wards only)	• Regenerations notified date and Regenerations assignment date in SharePoint • Data submitted by CIPP (notification date) and LCFS (assignment date)	• ISP indicates coordination of crisis intervention services,	• Case notes in SACWIS Data submitted by LCFS
	• Pre-placement CASII	• CASII completion date and score (total and domain scores) in DCFS REDCap CASII Database Data submitted by CIPP Expectations: Initial CASII must be completed by the end of the first 2 CIPP meetings; CASII is revised prior to youth's release from JTDC.	• Frequency of CFT meetings Expectation: At least every 3 months/quarterly; and as needed per CFT member request	• CFT meeting dates in SACWIS Data submitted by LCFS
	• Consistency of Pre-Placement CASII recommendation with placement	• CYCIS and DCFS REDCap CASII Database Data submitted by CIPP	• Composition of CFT meetings Expectation: At minimum must	• Members and member roles at each CFT recorded in SACWIS Data submitted by

Last updated on 08-05-16

Program Service Components	Pre-placement		Post-placement	
	Fidelity Metric	Data Source	Fidelity Metric	Data Source
			include youth, family, case manager, LCFS, YAP, and other service provider(s)	LCFS
			<ul style="list-style-type: none"> Frequency of CASII following home-based placement Expectation: At least every 3 months/quarterly	<ul style="list-style-type: none"> CASII completion date and score (total and domain scores) in DCFS REDCap CASII Database Data submitted by LCFS
			<ul style="list-style-type: none"> Consistency of Post-Placement CASII recommendation with placement 	<ul style="list-style-type: none"> SharePoint, DCFS CYCIS and DCFS REDCap CASII Database Data submitted by LCFS
Flex-Funds	Flex-funds assessments and services are indicated in the pre-placement action plan	<ul style="list-style-type: none"> Action plan in SACWIS Data submitted by CIPP	Flex-funds assessments and services are indicated in the pre-placement action plan	<ul style="list-style-type: none"> Individualized service plan (ISP) in SACWIS Data submitted by LCFS
Other Home and Community Based Services	<ul style="list-style-type: none"> # of parent/child/sibling visits 	<ul style="list-style-type: none"> LCFS weekly data entry in SACWIS and SharePoint Data submitted by LFCS	<ul style="list-style-type: none"> # of parent/child/sibling visits 	<ul style="list-style-type: none"> LCFS weekly data entry in SACWIS and SharePoint Data submitted by LFCS
			<ul style="list-style-type: none"> ISP indicates provision of crisis intervention/response system and placement stabilization services 	<ul style="list-style-type: none"> ISP in SACWIS Data submitted by LCFS
			<ul style="list-style-type: none"> Number of hours advocates spend with youth each week post-placement (home-based or residential) 	<ul style="list-style-type: none"> YAP weekly progress notes recorded in SharePoint and SACWIS Data submitted by YAP in SharePoint; monthly summary by LFCS in SACWIS
			<ul style="list-style-type: none"> # of work hours (supported and non-supported) per week in program 	<ul style="list-style-type: none"> YAP weekly progress notes recorded in SharePoint and SACWIS Data submitted by YAP in SharePoint; monthly summary by LFCS in SACWIS

Program Service Components	Pre-placement		Post-placement	
	Fidelity Metric	Data Source	Fidelity Metric	Data Source
			<ul style="list-style-type: none"> # of weeks advocate met with school/# of weeks in program 	<ul style="list-style-type: none"> YAP weekly progress notes recorded in SharePoint and SACWIS <p>Data submitted by YAP in SharePoint; monthly summary by LCFS in SACWIS</p>
			<ul style="list-style-type: none"> Time from release from JTDC/shelter to enrollment in school 	<ul style="list-style-type: none"> Release date and school enrollment date in SharePoint <p>Data submitted by CIPP (release date) and YAP (school enrollment date) in SharePoint and LCFS (monthly summary) in SACWIS</p>
			<ul style="list-style-type: none"> # of weeks parent met with school/# of weeks in program 	<ul style="list-style-type: none"> YAP weekly progress notes recorded in SharePoint and SACWIS <p>Data submitted by YAP in SharePoint; monthly summary by LCFS in SACWIS</p>
			<ul style="list-style-type: none"> Frequency of case notes <p>Expectation: At least weekly</p>	<ul style="list-style-type: none"> Case notes in SACWIS <p>Data submitted by LCFS</p>

The evaluation team received approval from the University of Chicago's School of Social Service Administration Institutional Review Board (IRB) in February 2016 and is currently awaiting approval from the DCFS IRB and permission to use data from CCJC and DJJ.

B. Outcome Study

As was said before, a contemporaneous comparison group for the outcome evaluation of the Regenerations/RUR Pilot is not possible. The outcomes of a historical comparison group, constructed by examining the characteristics of the youth who participated in Phase I of the Regenerations/RUR Pilot (July 2015-June 2016) and identifying a group of youth with similar characteristics who were in detention in FY13 to FY15 (i.e., before the Regenerations/RUR pilot began) will be measured using DCFS and CCJC administrative data summarized in Table 3 below:

Table 3. Intermediate outcomes

Intermediate Outcome	Data Source
1. Number of days youth remain in JTDC after the mandatory release date	<ul style="list-style-type: none"> CCJC DCFS (RUR list)
2. Number of youth who are released from JTDC to residential	<ul style="list-style-type: none"> CCJC

care versus family or family-like settings	• DCFS
3. For youth who are discharged to residential care, the number of days youth spend in residential care.	• DCFS
4. Placement stability in community – length of stay in home-based placement and number of placement moves (to be operationalized).	• DCFS

Because each of these intermediate outcomes will be measured using administrative data, they can also be measured for the historical comparison group.

The long-term outcomes that will be measured using a combination of administrative and program data (e.g., SharePoint) are summarized in Table 4 below: Only two of the long term outcomes—caseworker assessment of youth well-being and recidivism—will be measured for the historical comparison group.

Table 4. Long-term outcomes

Long-term Outcome	Data Source
Youth well-being. • Child and Adolescent Needs and Assessment (CANS) data will provide caseworker assessments of youth well-being	• DCFS CANS
School performance. • School enrollment status recorded by LCFS • Percentage of weeks youth are attending school while in the program (i.e., number of weeks attended/number of weeks enrolled in program), based on weekly data on youth's school status recorded by YAP. Work performance • Number of hours spent each week in supported and non-supported employment among older youth (age≥16) enrolled in the program, based on weekly data on youth's employment status recorded by YAP.	• SharePoint (school enrollment status submitted by LCFS) • SharePoint (weekly school attendance data submitted by YAP) • SharePoint (weekly employment data submitted by YAP)
Recidivism. • Time until re-involvement with the juvenile justice system (e.g., returning to JTDC).	• CCJC • DJJ

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EXHIBIT T

FOR IMMEDIATE RELEASE

May 5, 2014

Governor Quinn Announces Illinois' First Pay for Success Project
Innovative Project Will Increase Support for At-Risk Youth Through Performance-Based
Contracts Backed by Private Investment

CHICAGO – Governor Pat Quinn today announced the state's first Pay for Success (PFS) contract will increase support for at-risk youth who are involved in both the child welfare and juvenile justice systems in Illinois. Also known as Social Impact Bonds, the first contract awarded under this innovative initiative will go to One Hope United, in partnership with the Conscience Community Network (CCN). Today's announcement is part of Governor Quinn's agenda to ensure that all Illinois youth have the opportunity to follow their dreams and reach their full potential.

"The innovative Pay for Success model will generate major investments and improve outcomes for some of our most at-risk youth," Governor Quinn said. "One Hope United and CCN's evidence-based approach will help these youth successfully transition into adulthood."

Governor Quinn launched the PFS program one year ago, aiming to provide critical resources to address community needs while decreasing long-term negative outcomes that are costly for taxpayers. The innovative program invests private dollars into proven social programs, which are then paid back by the state when results are achieved and long-term savings are realized. The state will then see continued savings as benefits accrue after the investments are paid off.

For the state's first PFS project, the program will generate new private investment for support programs targeting at-risk youth, putting them on the right path by reducing their dependence on the state's welfare and criminal justice systems, which will lead to long-term savings for taxpayers. Today's announcement is expected to generate up to \$30 million in direct investment into these critical programs. Because success payments by the state are based upon achievement of outcomes, the PFS program will always be cost-neutral to taxpayers.

In September of 2013, the Governor's Office launched a Request for Proposals (RFP) from organizations seeking to partner with the state to fund new opportunities for at-risk youth involved in the child welfare and juvenile justice systems. One Hope United and the Conscience Community Network were selected from six applications submitted in response to the RFP. As part of Governor Quinn's commitment to transparency, Illinois was the first state in the nation to publish responses related to a Pay for Success Request for Information.

"Scars of trauma and pain can lead abused and neglected youth towards criminal behavior as well as a deeper involvement in the child welfare system," Mark McHugh, Executive Director of One Hope United said. "This Pay for Success project will catalyze a comprehensive solution that responds to the unique challenges of dually-involved youth throughout the state. Together with the partners of the Conscience Community Network, we are establishing the foundation for lasting cross-systems change that benefits Illinois' most disadvantaged children and families."

One Hope United will serve as lead provider of the Conscience Community Network. They have proposed a project based on the Crossover Youth Practice Model, a set of proven interventions

developed by the Center for Juvenile Justice Reform at Georgetown University. Third Sector Capital Partners is providing financial advisory services to the network.

The Conscience Community Network is a collaboration of seven child welfare and juvenile providers with more than 741 years of collective service in Illinois: Lawrence Hall Youth Services, Maryville Academy, OMNI Youth Services, One Hope United, SGA Youth & Family Services, UCAN and Youth Outreach Services.

The Governor's Office of Management and Budget will be entering into negotiations with One Hope United on a project to improve placement outcomes and reduce re-arrests through evidence-based community alternatives to institutional care. The program will serve approximately 800 youth cared for by Illinois' Department of Children and Family Services with histories of justice-involvement, commonly referred to as dually-involved youth.

In his fiscal year 2015 budget, the Governor committed to growing the state's use of PFS contracts as part of his five-year fiscal stabilization plan.

The Harvard Kennedy School's Social Impact Bond Technical Assistance Lab (SIB Lab), in partnership with the Rockefeller Foundation, received a grant from the Aurora-based Dunham Fund to support the initiative in Illinois. The Rockefeller Foundation has been a leader in helping to bring the PFS model to U.S. and the Dunham Fund is expanding that investment to Illinois. The Harvard SIB Lab is providing technical assistance to 10 state and local governments around the country that are implementing PFS contracts. Innovation Fellow Scott Kleiman is leading the SIB Lab's work in Illinois.

In the PFS model, governments partner with service providers and private and philanthropic investors to scale and fund proven social programs. Investors are repaid by the state from accrued savings only when a rigorous third-party evaluation determines that programs reach specific outcome targets. Because effective programs can help avoid expensive negative outcomes, PFS contracts help avert long-term taxpayer costs. They represent a smarter way for government to do business, furthering transparency and accountability to ensure that taxpayer funds are not spent on ineffective programs.

Illinois is on the leading edge of PFS among states in the U.S., following New York and Massachusetts. The world's first PFS contract was introduced in the U.K. in 2010. Illinois becomes the third state in the country to announce a PFS project and the first to implement PFS towards improving child welfare outcomes, as well as the first to partner with a network of community providers for service delivery.

For more information on Pay for Success in Illinois, please visit payforsuccess.illinois.gov.

EXHIBIT U

Illinois Dually-Involved Youth Pay for Success Initiative RAMP-UP FACT SHEET

- The State of Illinois is committed to improving outcomes for youth involved in the child welfare and juvenile justice systems. Recognizing the challenges faced by state agencies and nonprofits, this initiative is piloting a new, collaborative approach that will redesign internal systems, expand access to evidence-based programming, and increase the use of data-driven decision-making.
- In Illinois, three-fourths of youth dually-involved in the child welfare and juvenile justice systems are not living with a parent or relative; more than half recidivate within two years; many experience substance abuse, exhibit symptoms of traumatic stress, and experience acts of self-harm; and few will achieve reunification with their biological family or adoption. Additionally, roughly two-thirds of dually-involved youth will experience frequent and extended time in costly, deep-end institutional placements, such as residential treatment centers, detention centers, and group homes for adolescents.
- The Conscience Community Network, LLC (CCN) – a network of six Illinois nonprofit service providers – is collaborating with the State of Illinois and local community partners to serve dually-involved youth throughout the state. CCN will provide these children with intensive case coordination and timely access to evidence-based treatments in order to reduce or prevent time in costly institutional care, prevent repeat criminal behavior, and foster successful transitions to adulthood.
- In November 2015, CCN and the Illinois Department of Children and Family Services (DCFS) will launch the ramp-up phase of a Pay for Success (PFS) project. Over a six-month period, CCN will enroll 50 dually-involved youth in Cook, Lake, Franklin and Jefferson counties. The purpose of the ramp-up is to pilot and refine project operations, including referral mechanisms and intake and service enrollment processes. In addition, the ramp-up will allow CCN to scale service capacity and conduct trainings.
- CCN is currently negotiating details for a PFS contract with the Illinois' Department of Children and Family Services. This initiative will provide additional services for troubled youth and aligns with the administration's commitment to establishing innovative, evidence-based pilot programs to tackle challenges facing young people in the state of Illinois.
- Participating organizations include:
 - **Government:** Illinois Department of Children and Family Services
 - **Service Provider:** Conscience Community Network, LLC
 - **Transaction Coordinator:** Third Sector Capital Partners, Inc.
 - **Government Advisor:** Harvard Kennedy School Social Impact Bond Technical Assistance Lab
 - **Independent Evaluator:** University of Michigan School of Social Work
 - **Ramp-Up Funders & Early Community Supporters:** Laura and John Arnold Foundation; Nonprofit Finance Fund (through a grant from the Social Innovation Fund); Living Cities in partnership with The Chicago Community Trust; Conscience Community Network, LLC; and Dunham Fund
 - **Ramp-Up Evaluation Funder:** Illinois Juvenile Justice Commission
- Pay for Success (PFS) is a performance contracting model that drives government resources toward social programs that prove effective at achieving positive results for the people who need them most. PFS tracks the effectiveness of programs over time and requires governments to pay for those services only if and when they succeed in measurably improving the lives of people most in need.
- PFS enables initiatives to tap third party funders to cover the upfront costs of the programs. If the program is successful in improving the lives of the people it is meant to serve, as measured by an independent evaluator, then government makes success payments to the initiative that can be shared with those who provided the original funding. If the program does not achieve its target results, the government does not make success payments. This model ensures that taxpayer dollars are being spent wisely, on programs that actually work.

PROGRAM SERVICE MODEL

Since dually-involved youth interact with multiple government systems and have unique personal challenges, this project aims to improve outcomes by changing both systems behavior and child and family behavior. This is only possible as a result of the close collaboration of CCN, DCFS, and juvenile courts/probation in developing a system of care that coordinates rapid identification, comprehensive and collaborative case coordination, and increased access to proven clinical programs for Illinois' dually-involved youth.

This Project re-engineers how Illinois identifies and coordinates services for dually-involved youth by:

- Identifying and referring youth through multiple pathways that overcome data silos, jurisdictional gaps, and notification delays;
- Convening caseworkers and therapists from child welfare and juvenile courts/probation for information sharing, joint assessment, and integrated case planning;
- Intervening early in justice trajectory for high-risk youth – providing upstream, ongoing wraparound services instead of waiting to respond to crisis or placement instability; and
- Investing in expanding evidence-based clinical solutions and community-based interventions that address the individual and family behavior needs for dually-involved youth.

CCN's approach is based on the Crossover Youth Practice Model (CYPM), a set of proven practices developed by the Georgetown University McCourt School of Public Policy – Center for Juvenile Justice Reform (CJJR). CYPM has been implemented throughout the U.S. and is focused on breaking down systematic barriers to enable early identification, advocacy in the courts, access to trusted care alternatives, and coordination of case management of dually-involved youth. CCN has partnered with CJJR on the implementation of the model.

Complementing and enhancing the systems change work made possible by the CYPM are a set of evidence-based clinical solutions and additional community-based interventions that address the individual and family behavior needs for dually-involved youth. The Project will scale the available clinical and community-based resources and wraparound services for this population and provide access, as required by each youth and family, to Treatment Foster Care Oregon (TFCO), Multisystemic Therapy (MST), Functional Family Therapy (FFT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and Attachment Self-Regulation and Competency (ARC). All youth will receive comprehensive case coordination and wraparound services coordinated by CCN in close collaboration with DCFS.

SERVICE PROVIDERS

Conscience Community Network, LLC (CCN) members are some of the oldest and most experienced child welfare and juvenile justice providers in Illinois. Members include: One Hope United, Maryville Academy, UCAN, SGA Youth and Family Services, OMNI Youth Services, and Youth Outreach Services. The network was formed in 2011 to explore a care coordination model in response to the Affordable Care Act, and its mandate to use care coordination to address the social determinants of health. When the State of Illinois released the PFS Request for Proposals, CCN recognized that their network, unlike a single service provider, would be needed to provide the continuum of services necessary to serve dually-involved youth effectively and at scale across the state. In addition to the many and diverse services CCN members currently deliver to youth and their families, the members also have significant and trusted relationships with key stakeholders, including DCFS, county court/probation, and IDJJ, that are essential to building the system of care for the initiative. One Hope United will serve as the lead agency for the initiative and will coordinate intake and referrals to different CCN members, and serve as the fiscal agent. Two other critical steps to formalizing this collaboration are integrating separate IT systems, and developing a fidelity monitoring system to ensure consistency in the service delivery model.

GOVERNMENT

The State of Illinois supports innovative, evidence-based approaches to solve our toughest social problems. This PFS ramp-up is a multi-agency collaborative effort to provide more effective care to youth as well as direct feedback on how to improve the systems overall. This program aligns with the Governor's criminal justice reform efforts as well as expanding opportunities and securing better outcomes for our hardest to reach

populations. The Illinois Department of Children and Family Services' mission is to provide safe, loving homes and brighter futures to all children in Illinois. This Pilot initiative will develop a greater capacity for community-based treatment options and shed light on how the Department can better serve their dually-involved population.

RAMP-UP FUNDERS & EARLY COMMUNITY SUPPORTERS

The initial ramp-up phase of the project is being funded through a consortium of philanthropic funders, including the service providers. Ramp-up funders will not earn success payments.

- **Laura and John Arnold Foundation** will provide more than \$600,000 of funding.
- **Nonprofit Finance Fund** will provide \$135,000 of funding as part of its federal Social Innovation Fund Pay for Success grant. The \$135,000 will be matched dollar for dollar by ramp-up funders.
- **Illinois Juvenile Justice Commission** will provide \$102,521 of funding.
- **Living Cities** will provide a \$100,000 loan with funds provided by the **Chicago Community Trust**.
- **Conscience Community Network, LLC** will provide \$100,000 of funding.
- **Dunham Fund**, based in Aurora, Illinois, provided early catalytic support for the initiative. In 2013, the Dunham Fund provided funding for a fellow for the State from the Harvard Social Impact Bond Technical Assistance Lab (SIB Lab). In December 2014, the Dunham Fund provided a \$125,000 loan to CCN to support the development of the initiative.

INDEPENDENT EVALUATORS

Professors Joe Ryan, PhD and Brian Perron, PhD from the **University of Michigan School of Social Work** are serving as independent evaluators for the initiative. This team brings substantial expertise on the experiences and outcomes of children engaged with child welfare and juvenile justice systems, both in Illinois and across the nation. They have significant experience designing and implementing rigorous evaluations of social programs, have deep familiarity with Illinois' child welfare and juvenile justice systems and data sources, and serve as principal investigators on high-profile federal grant projects in both Illinois and Michigan, including the Illinois Title IV-E (Alcohol and Other Drug Abuse) Waiver Demonstration. Youth in the ramp-up phase will not be evaluated on any payment metrics and will be excluded from future success payments.

TRANSACTION COORDINATOR

Third Sector Capital Partners, Inc. leads governments, high-performing nonprofits, and private funders in building evidence-based initiatives that address society's most persistent challenges. As experts in innovative public-private financing strategies, Third Sector is an architect and builder of the nation's most promising PFS projects including the Commonwealth of Massachusetts; Cuyahoga County, Ohio; and Santa Clara County, California. A 501(c)(3) nonprofit based in Boston and San Francisco, Third Sector has provided on-going advisory services to CCN throughout the development of the initiative.

GOVERNMENT ADVISOR

The **Harvard Kennedy School Social Impact Bond Technical Assistance Lab** (SIB Lab) conducts research on how governments can foster social innovation and improve the results they obtain with their social spending. With support from the Dunham Fund, the SIB Lab has provided pro bono technical assistance to the State of Illinois since 2013.

INITIATIVE TIMELINE

In spring 2013, the State of Illinois announced the launch of a Pay for Success program. The Harvard Kennedy School's Social Impact Bond Technical Assistance Lab (SIB Lab) received a grant from the Aurora-based Dunham Fund to support the initiative in Illinois, and the Governor's Office of Management and Budget (GOMB) issued a Request for Information to solicit ideas for issue areas that could be a fit with the PFS model. In September 2013, the state issued a Request for Proposals offering additional services and resources for troubled youth by providing service providers with flexible upfront funds to pursue innovation and scale.

In May 2014, through this Request for Proposals process, the Conscience Community Network, LLC (CCN), a pre-existing coalition of six leading Illinois nonprofit child welfare and juvenile justice providers, was selected to

develop a PFS project that would be the first in the nation to use a multi-provider, collective action model. CCN partnered with Third Sector Capital Partners, Inc. during the development of the RFP response. Third Sector has provided on-going advisory services to CCN throughout project development while the Harvard SIB Lab continues to provide technical assistance to the state. The ramp-up was launched in November 2015. CCN is currently negotiating full project details with the various State of Illinois stakeholders.

EXHIBIT V

Logic Model Template

Plan

Pay for Success

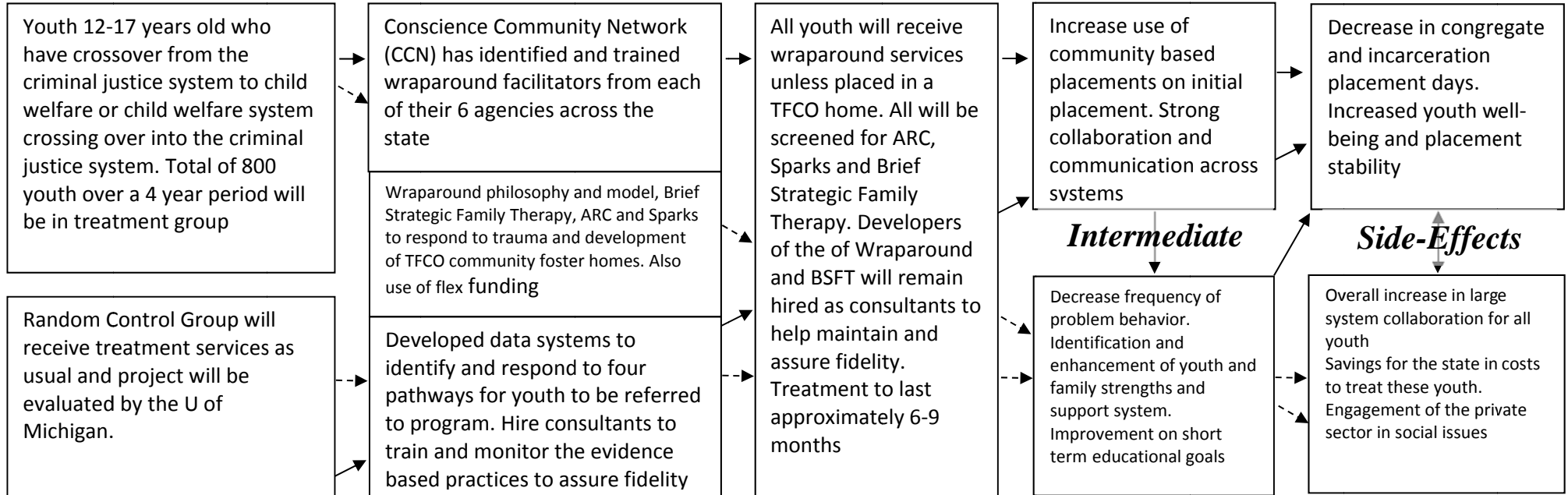
Implementation

Outputs

Outcomes

Proximal

Distal



External Conditions

Theory of Change

End-Values

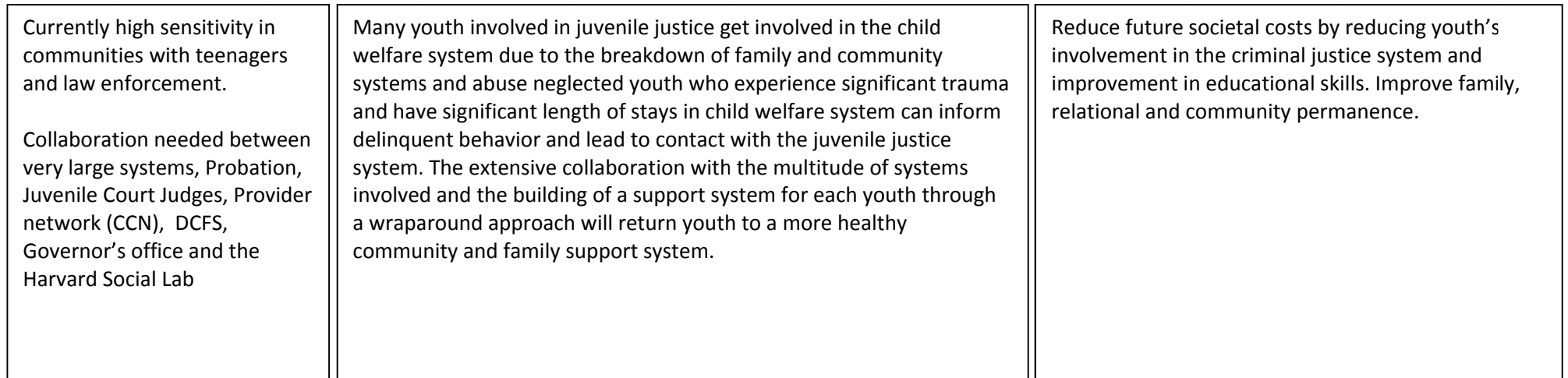


EXHIBIT W

PAY FOR SUCCESS STATUS REPORT

Plan

Youth 12-17 years old who have crossover from the criminal justice system to child welfare or child welfare system crossing over into the criminal justice system. Total of 800 youth over a 4 year period will be in treatment group

Random Control Group (800 youth) will receive treatment services as usual and project will be evaluated by the U of Michigan. Pilot is expected to start 9/1/2016. They are currently completing the ramp up phase of the project in which they enrolled 50 in the treatment group.

Background

We are completing negotiations and development of a contract by 9/1/2016, which will then start the process of securing the private funders over the next six months.

Theory of Change

Many youth involved in juvenile justice get involved in the child welfare system due to the breakdown of family and community systems and abuse neglected youth who experience significant trauma and have significant length of stays in child welfare system can inform delinquent behavior and lead to contact with the juvenile justice system. The extensive collaboration with the multitude of systems involved and the building of a support system for each youth through a wraparound approach will return youth to a more healthy community and family support system.

Implementation Status

The past four weeks put the project on hold, only last Friday, 8/19/2016, did we break through and can hopefully start the pilot on 9/1. We will start pilot in Cook, Lake, Jefferson and Franklin counties and over the next six months identify and start intake in at least three more counties.

Outputs

All youth will receive wraparound services unless placed in a TFCO home. All will be screened for ARC, Sparks and Brief Strategic Family Therapy. Developers of the Wraparound and BSFT will remain hired as consultants to help maintain and assure fidelity. Treatment is to last approximately 6-9 months. During the ramp up phase 48 youth are receiving Wraparound services and the other two are in TFCO.

Proximal Outcomes

Increase use of community based placements on initial placement. Strong collaboration and communication across systems

Since the pilot is based on outcomes three years after involvement in PFS, we are working with the evaluation team on what analysis can be done with the 50 youth in the ramp up phase.

Distal Outcomes

Decrease in congregate and incarceration placement days. Increased youth well-being and placement stability N/A

Other Consequences

If private funding has not been secured within 6 months after 9/1 the pilot will not be able to go forward.

Plan Revisions

During ramp up phase we learned about our challenges in our UIR system, a major referral pathway to this pilot. Also the level of communication needed to reach individual staff to engage in the pilot and partner with a wrap facilitator.

EXHIBIT X

Logic Model: Immersion Sites

Plan

Caseworkers, care providers, and protective investigators serving children and youth and their families where there has been a preponderance of evidence of abuse, neglect or dependency and the safety and risk conditions are such that the children or youth must enter state custody or be considered "candidates" for state custody.

Development of Immersion Sites through which a new model of practice will be implemented, and services and processes improved. The comparison group will be site history and comparable non-immersion sites.

Implementation

1. Hire Immersion Directors
2. Develop FTS/QSR/MoSP practice model.
3. Provide coaching and QA to ensure fidelity to FTS/QRS
4. Develop new evidence based service array and process and organization simplifications.
5. Align field offices and regions with Judicial Circuits.

Training, coaching, QA using QSR, Intensive evidence based wrap around array, simplified processes, improved organization.

1. Quality assurance processes using QSR scoring.
2. Process and outcome tracking and evaluation
3. Comparing outcomes with non-immersion sites

Outputs

1. N, % of all case related personnel in Immersion Sites who are trained and coached in QSR and FTS/MoSP model of practice
2. N, % of child and family teams (CFTM) that engage families and youth
3. N, % of families utilize new intensive array of services
4. Indicators of effective and efficient processes and organization.
5. Align with Judicial Circuits.

Outcomes

Proximal

% children that remain in same family as initially engaged in CFTM (+)
Frequency of supervised & unsupervised family visits (+)
% reunification goal (+)

Intermediate

Average N of placement moves (-)
Increase the % of children reunited with their families, children adopted, or children entering guardianship
Time to reunification (-)
Increase in family based care (+)

Distal

Reduce the average number of days of residential care %
indicated repeat maltreatment (-)
Reduce the average number of days in foster care

Side-Effects

% disrupted reunifications, adoptions and guardianships (0)

External Conditions

IL DCFS has one of the longest lengths of stays in non-permanent care in the country. It has strong unions and provider networks. Most staff and providers are eager for better outcomes but some may resist. High turnover among POS case workers. Overreliance on residential care and a lack of an array of intensive in home services. Lack of focus on families and their strengths and little understanding of trauma and attachment.

Theory of Change

The QSR with FTS enhancements has proven to be effective in improving case work practice and outcomes in several states. Considerable evidence supports the effectiveness of intensive evidence based or supported wrap around family based services to resolve problems so that children and youth can live in families who are committed to them for life. Attachment and trauma theory has abundant evidence that the safety and security of a permanent home with consistent and committed adult parents or mentors improves self-regulation and executive function and the ability for children and youth to live in families. Case work is negatively impacted by a plethora of unnecessary procedures and by an overly complex and unaccountable organizational structure.

End-Values

Improved child and youth stability and permanency and improved family functioning will reduce reliance on institutional care creating a virtuous cycle in which increased resources are available to further improve family and child permanency and stability.

EXHIBIT Y

Immersion Sites Status Update

September 1, 2016

1. Plan:

- a. Through an Immersion Site process the safety, permanency, stability and wellbeing outcomes for DCFS children and youth will be improved. The immersion process is progressive developing with four sites initiated in August, 2016. Sequentially other Immersion Sites will be developed until the new practices, processes and services are in effect statewide.**
- b. The first four Immersion Sites are the Mount Vernon area (5 adjacent counties), East St. Louis/St. Clair County, the 14th Judicial Circuit centered in Rock Island, and the 19th Judicial Circuit of Lake County. These sites cover about 11% of the statewide caseload.**
- c. The Immersion Site process will have the following components:**
 - i. Extensive training and coaching in a new model of practice named “FTS” for family centered, trauma informed and strengths based. The FTS implementation details are in the Logic Model and Status Update for FTS.**
 - ii. The FTS training will be integrated with Paul Vincent’s Child Welfare Group’s Quality Service Review (QSR) processes to ensure that parental engagement and child and family teams are well established in the training.**
 - iii. Extensive training and coaching for supervisors in the Model of Supervisory Practice (MoSP).**
 - iv. Quality assurance and monitoring to ensure that the new FTS practice model is fully implemented in the Immersion Sites. The implementation details are in the Logic Model and Status Updates for Quality Assurance. The QA process will be integrated with Paul Vincent’s Child Welfare Group’s QSR process to ensure that parental engagement and child and family teams are fully implemented in the Immersion Sites.**
 - v. Development of an intensive and immediately available array of in home evidence supported services for parents, caregivers and children and youth; including flexible funding so any services that are needed to achieve permanency can be purchased.**
 - vi. To create additional funding flexibility in providing the immediately available intensive array of in home evidence based services DCFS is working with the federal Children’s Bureau to secure waiver authority to use funds that were formerly restricted to out of home care to provide that array of in home services.**
 - vii. Improving the case flow and day to day operational process by changing rules, policies, practices and operational procedures which have proven to be ineffective or redundant, and which hinder achieving permanency outcomes for children and youth.**

- viii. Making structure changes in the DCFS organization to increase integration and remove further barriers to achieving better outcomes.
- ix. Piloting decentralization of some current central office functions such as matching children with placements (Central Matching) and case opening (Case Assignment and Placement Unit) in order to determine if efficiencies can be achieved through local management in the regions and field offices.
- x. Reorganizing the DCFS field office structure around Judicial Circuits to better align its operations with the Juvenile Court.
- d. Major milestones achieved during August include:
 - i. Field office, personnel and contract data gathered for each Immersion Site.
 - ii. Immersion Site Director position was established, interviews were conducted and Immersion Site Directors were initially selected and are under final vetting.
 - iii. The FTS in person training module was completed.
 - iv. An outcome data tracking system for Immersion and comparison sites was designed including:
 - 1. Data set for trend lines for key outputs and proximal and distal outcomes defined.
 - 2. Data base defined and planned with outcome and failure alerts for BH class kids including shelter over 60 days, step down, BMN (in psychiatric hospitals beyond medical necessity) and RUR kids (in detention beyond their release date and parents or caregivers have refused to take custody).
 - v. Listening visits were held in all sites with focus on organizational, resource and procedure/process challenges. Discussions were conducted with Judges (East St. Louis Judges' meeting deferred to September), DCFS front line personnel, private child welfare agency leaders and front line personnel, counseling and services providers, foster parents, children and youth and biological children. Dates for these visits were as follows:
 - 1. August 3-4: Mount Vernon
 - 2. August 9: East St. Louis
 - 3. August 18: Rock Island
 - 4. August 24 : Lake County
 - vi. During the August listening visits many important barriers to permanency were uncovered which will lead to plans to resolve them to improve outcomes. A few of the several dozen commonly cited were:
 - 1. Ineffective and untimely processing of adoption and guardianship subsidy documents.

2. Lack of a readily available and effective array of intensive and in home evidence supported services for parents and children and youth.
 3. Constant changes in caseworkers leading to discontinuity in service delivery and lack of consistent support and an effective casework relationship for children, youth and families.
 4. Difficulties in obtaining consent for critical care needs such as oral surgery.
 5. Complaints of a lack of partnership and team work between foster parents, biological parents and caseworkers.
 6. Child and family teams not being used for case assessment, planning and ongoing service delivery. This is leading to disconnects between assessment findings, plans developed and services actually delivered.
- vii. Initial decentralization began with the establishment of a pilot for the matching process and the case opening process in the Southern Region including covering the Immersion Sites of Mount Vernon and East St. Louis.
- viii. Planning was initiated to align the field office and regional boundaries with the Judicial Circuits.
- ix. Plans were developed with Paul Vincent's Child Welfare Group to align the FTS training and coaching and the Quality Assurance process with the Quality Services Review.
- x. IV-E Wavier discussions were engaged with the federal Children's Bureau to obtain a waiver to use out of home care funds for the intensive array of in home services.
- e. In September the following milestones will be completed:
 - i. Steering Committees will be established in each Immersion Site involving Judges, DCFS front line personnel, private child welfare agency leaders and front line personnel, counseling and services providers, foster parents, children and youth and biological children.
 - ii. The lessons learned from the four listening visits will be consolidated and prioritized and plans will be developed to solve the highest priorities.
 - iii. A detailed mapping of the processes and barriers of each site will be conducted and plans for resolution developed.
 - iv. All Immersion Directors will be on board and trained to do their jobs.
 - v. Additional Judges' meetings will be held in the outlying Mount Vernon counties and in St. Clair County.
 - vi. Tracking process improvements outcomes performance data will be implemented.

- vii. The dashboards for tracking progress and youth with complex problems will be completed.
 - viii. The reorganization of DCFS field offices around Judicial Circuits will commence.
 - ix. Additional FTS training modules will be completed specifically
 1. On-line FTS overview FTS training for managers, Judges and other stakeholders.
 2. Child and Family team training module.
- b. October:
 - i. The Casey Family Services Foundation will do business process and life of case reviews to identify opportunities to improve processes and organization by eliminating unnecessary processes and simplifying the organization.
 - ii. Model arrays of evidence supported services, with assessment tools to match services with children's, youth's and family's needs, will be completed.
 - iii. An October 17-19 "Summit" Conference with Judges, DCFS front line personnel, private child welfare agency leaders and front line personnel, counseling and services providers, foster parents, children and youth, and biological parents will publically launch the Immersion Site training and coaching and provide extensive information on the FTS/QSR/MoSP content and the Immersion goals and outcomes.
 - iv. Specific plans will be developed and implemented to eliminate the major process barriers and redundancies which hinder the achievement of permanency.
 - v. The IV-E Waiver will be finalized for federal consideration.
 - vi. Decentralization pilots for matching, and possibly case opening, will be expanded from the Southern Region to the Northern and Central regions for their Immersion Sites.
- c. November
 - i. Kick off events held in each Immersion Site to initiate all activities including the FTS training and coaching, the implementation of an intensive array of in home services, the process modifications to eliminate redundancies and barriers to permanency, the organizational simplifications, and other Immersion Site components.
 - ii. An FTS online self-directed training module will be completed for managers and support personnel so that managers and support personnel will also understand the model of practice.
 - iii. The FTS model of practice and coaching team will be continuously and progressively training all service personnel in person and all administrative and support personnel via the online module.

- iv. Paul Vincent's Child Welfare Group will finalize an Illinois version of the Quality Services Review to use in our Quality Assurance efforts. These will be real onsite interviews of actual participants, for example in the child and family team, to ensure that the model of practice is fully embedded and followed with fidelity in day to day operations.
- v. The Quality Assurance tools embedding the principles of the Quality Services Review will be finalized.
- vi. The provision of an intensive array of in home services will be implemented in each immersion site
- vii. Plan to maximize the IV-E Waiver if approved will be developed.
- viii. Decentralization of matching and case assignment and opening will be assessed and a plan for future implementation developed.
- ix. Local organizational integration and better alignments will be completed.
- x. Establishment of comparison counties completed so that progress of the Immersion Sites outcomes can be compared against them.
- d. December/January:
 - i. Paul Vincent's group will be providing a team of national expert coaches to support our in-field coaching experts and they will be fully engaged in the Immersion Sites.
 - ii. The following components will be continuously in the process of progressive implementation from this point forward:
 - 1. Ongoing FTS training and coaching for all personnel.
 - 2. Paul Vincent will have national expert coaches in the field to support the DCFS coaches.
 - 3. The intensive array of in home services will be operational in all immersion sites.
 - 4. The initial process improvements to eliminate barriers and redundancies will be completed and a second priority group will be planned.
 - 5. Increased organization integration and simplification will be achieved.
 - 6. Matching will be decentralized and the results of decentralizing matching and case assignment and opening will be evaluated.
 - 7. Field offices and regions will be aligned with Judicial Circuits.
 - 8. A special child and family team curriculum will be completed to reinforce the practical management of child and family teams.
 - 9. Certification of the coaches will be completed.
 - iii. Federal decision on Title IV-E Waiver anticipated.
- e. February:

- i. **Quality Assurance will be piloting reviewing cases using the Illinois QSR on February 1 with onsite interviews to ensure family engagement and effective child and family teams. After the pilot any necessary adjustments will be made and the QSR reviews will be fully operational in February.**
 - ii. **A child and family team online module which provides practical information on how to conduct a child and family team will be completed.**
 - iii. **Roll out of the Model of Supervisory Practice will begin the process of training all supervisors in organizational leadership and management within the context of FTS.**
 - iv. **The progressive implementation described above will continue.**
 - f. **January: Assessment, Corrections and Enhancements, and Further Implementation Plan Development.**
 - i. **In January we will complete an assessment of our efforts to date and develop a report indicating the effectiveness of the results of each component and the whole process and any corrections or enhancements of the implementation Plan needed.**
 - ii. **Particularly important will be making a determination of the time requirements to maximize the effectiveness of the Immersion Process and to fully embed it into day to day practice in a sustainable way. DCFS has learned from Paul Vincent and his Child Welfare Group that our initial plan of four month sequential Immersion Sites was much too ambitious to attain sustainable outcomes from the Immersion Process.**
 - iii. **DCFS will have considerable experience by January and, with the Child Welfare Group's support, should be able to determine how long an immersion process takes to achieve maximum improved outcomes.**
 - iv. **Therefore we will be able to adjust our plans and lay out a realistic timeline for the balance of the state. When this is completed a detailed plan forward will be developed and submitted to the Court correcting the past assumptions in the Implementation Plan.**
- 2. Background:**
 - a. **IL DCFS has one of the longest lengths of stays in non-permanent care in the country. The 2010 federal Child and Family Services Review data indicated that Illinois is in 50th place of 50 states for the length of time it takes for a child to achieve permanency. Last place among the states is totally unacceptable for the well-being of Illinois children.**
 - b. **DCFS has strong unions and provider networks. Most staff and providers are eager for better outcomes but some resist efforts to change.**
 - c. **Neither DCFS nor its provider network has a consistent model of practice that uses the considerable emerging research in trauma care and the**

ultimate importance of a secure and healthy attachment to a consistent and committed adult.

- d. High turnover among POS case workers creates case discontinuities as do ill-conceived organizational processes, rules and procedures.
 - e. Overreliance on residential care and a lack of an array of intensive in home services results in many unnecessary deep end placements with poor results.
 - f. Lack of focus on families and their strengths and little understanding of trauma and attachment leads to children being unnecessarily placed and extensive lengths of stay.
 - g. Both the overly complex processes and non-integrated and highly centralized organization components create multiple barriers to achieving better outcomes.
 - h. The DCFS field and regional offices are not well aligned with the Judicial Circuits leading to less than optimal working alliances with the courts.
3. Theory of Change:
- a. The Quality Service Review concepts, which we have embedded in our FTS practice model enhancements, has proven to be effective in improving case work practice and outcomes in several states.
 - b. Considerable evidence supports the effectiveness of intensive evidence based or supported wrap around family based services to resolve problems so that children and youth can live in families who are committed to them for life.
 - c. Attachment and trauma theory has generated abundant evidence that the safety and security of a permanent home with consistent and committed adult parents or mentors improves self-regulation and executive function and the ability for children and youth to live in families.
 - d. Case work is negatively impacted by a plethora of unnecessary procedures and by an overly complex and unaccountable organizational structure which if simplified would release considerable energy for improved practice.
 - e. Since the court is the ultimate permanency decision maker alignment with the Judicial Circuits is critical for a close working alliance.
4. Implementation status: Previously discussed in the Plan section above but repeated here. Major milestones achieved during August include:
- a. Field office, personnel and contract data gathered for each Immersion Site.
 - b. Immersion Site Director position was established, interviews were conducted and Immersion Site Directors were initially selected and are under final vetting.
 - c. The FTS in person training module was completed.
 - d. An outcome data tracking system for Immersion and comparison sites was designed including:
 - i. Data set for trend lines for key outputs and proximal and distal outcomes defined.

- ii. Data base defined and planned with outcome and failure alerts for BH class kids including shelter over 60 days, step down, BMN (in psychiatric hospitals beyond medical necessity) and RUR kids (in detention beyond their release date and parents or caregivers have refused to take custody).
- e. Listening visits were held in all sites with focus on organizational, resource and procedure/process challenges. Discussions were conducted with Judges (East St. Louis Judges meeting deferred to September), DCFS front line personnel, private child welfare agency leaders and front line personnel, counseling and services providers, foster parents, children and youth and biological children. Dates for these visits were as follows:
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- f. During the August listening visits many important barriers to permanency were uncovered which will lead to plans to resolve them to improve outcomes. A few of the several dozen commonly cited were:
 - i. Ineffective and untimely processing of adoption and guardianship subsidy documents.
 - ii. Lack of a readily available and effective array of intensive and in home evidence supported services for parents and children and youth.
 - iii. Constant changes in caseworkers leading to discontinuity in service delivery and lack of consistent support and casework relationship for children, youth and families.
 - iv. Difficulties in obtaining consent for critical care needs such as oral surgery.
 - v. Complaints of a lack of partnership and team work between foster parents, biological parents and caseworkers.
 - vi. Child and family teams not being used for case assessment, planning and ongoing service delivery. This is leading to disconnects between assessment findings, plans developed and services actually delivered.
- g. Initial decentralization began with the establishment of a pilot for the matching process and the case opening process in the Southern Region including covering the Immersion Sites of Mount Vernon and East St. Louis.
- h. Planning was initiated to align the field office and regional boundaries with the Judicial Circuits.
- i. Plans were developed with Paul Vincent's Child Welfare Group to align the FTS training and coaching and the Quality Assurance process with the Quality Services Review.

- j. **IV-E Wavier discussions were engaged with the federal Children's Bureau to obtain a waiver to use formerly out of home care funds for the intensive array of in home services.**
- 5. **Outputs: The following are being operationalized:**
 - a. **N, % of all case related personnel in Immersion Sites who are trained and coached in QSR and FTS/MoSP model of practice.**
 - b. **N, % of child and family teams (CFTM) that engage families and youth.**
 - c. **N, % of families utilize new intensive array of in home services.**
 - d. **Indicators of effective and efficient processes and organization.**
 - e. **Alignment with Judicial Circuits.**
- 6. **Proximal Outcomes: The immersion counties will be the Intervention Group. Comparison Groups will be established from matched non-immersion counties in November. The following proximal outcomes have been agreed to:**
 - a. **% children that remain in same family as initially engaged in CFTM (+)**
 - b. **Frequency of supervised & unsupervised family visits (+)**
 - c. **% goal of reunification (+)**
 - d. **% families reunited, children adopted or entering guardianship (+)**
 - e. **Average N of placement moves (-)**
 - f. **% families reunited, children adopted or entering guardianship (+)**
 - g. **Time to reunification (-)**
 - h. **Increase in family and community based care (+)**
- 7. **Distal Outcomes: The immersion counties will be the Intervention Group. Comparison Groups will be established from matched non-immersion counties in November. Improved child and youth stability and permanency and improved family functioning will reduce reliance on institutional care creating a virtuous cycle in which increased resources are available to further improve family and child permanency and stability. The following Distal outcomes have been agreed to:**
 - a. **Average days of residential care (-)**
 - b. **Length of stay in foster care (-) due to achievement of permanency through reunification, guardianship or adoptions within 1 year, 2 years**
 - c. **% indicated repeat maltreatment (-)**
 - d. **Disrupted reunifications, adoptions, guardianships (0)**
- 8. **Other Consequences:**
 - a. **Disrupted reunifications, adoptions and guardianships will be tracked to determine the rate of negative outcomes.**
 - b. **Some push back from a few providers who indicate that their level of practice is sufficient so that they do not need training and coaching.**
- 9. **Plan Revisions:**
 - a. **This will be an iterative process from which we will learn and redevelop plans from the results and lessons learned from the first Immersion Sites. Based on the initial results a significant Implementation plan update will be completed in January.**
 - b. **As discussed, the original Implementation Plan was based on the assumption that the Immersion Site process would take four months and therefore the Immersion process would be a series of sequential four month Immersion Site engagements.**

- c. **Our work with Paul Vincent and his Child Welfare Group has made it clear that this is neither a viable nor an effective plan. The experience in the several states where the Child Welfare Group has implemented the Quality Services Review process using Immersion Sites indicates that the Immersion Site process must be at least one year in duration to fully internalize the new practice model, build the array of services and make the organizational and process changes. If this process is short circuited it will not result in sustainable changes since the core principles will not be deeply embedded and reinforced sufficiently in practice.**
- d. **Based on this understanding we will conduct an assessment of the first Immersion Site roll out and develop additional plans and resources to progressively develop the Immersion Sites statewide by January/February, 2017. This will be a plan based on actual experience which will allow us to make much more realistic projections. This new plan will be submitted to the court in advance of our next hearing.**

EXHIBIT Z

FTS Practice Logic Model Template

Plan

DCFS an purchase of service investigations, placement, intact direct service management, supervisors and staff.
Judicial and community stakeholders. Child welfare service providers. Parents, youth, traditional and relative caregivers

Training of current and hiring of new staff as facilities and coaches to deliver the content and reinforce the learning related to the FTS practice..

External Conditions

Results of the baseline practice assessment
Lack of adherence to or constraints of the current rule and procedure regarding timeliness of permanency.
Individual court jurisdictions.
Lack of available resources (human and financial).
Agency culture that negatively impact staff, parent, youth, caregiver, and service provider motivation and attitude which may impact their wiliness to engage in partnership to embrace change.
External stakeholders (courts, providers, etc.) need to be actively engaged in the change initiative.

Implementation

Curriculum Development
Identification of Initial Immersion Sites
Identification of staff to be trained
Development of train-the-trainer model
Development of training plan
Determination of training delivery system
Core Practice Model Implementation
Expert
Identification of additional immersion sites
Integration of Lessons Learned
Statewide FTS/MOSP Summit

Pre-service: FTS Practice Overview (SDL)
In-service:
Keeping Siblings Together (SDL)
Trauma 101 (SDL)
FTS Core Practice curriculum (Classroom)
CFTM Facilitation (Classroom)

Self-directed Learning
Classroom Learning
Coaching and content reinforcement with supervisors and middle management
QA/QI Baseline assessment and ongoing outcome monitoring
Chapin Hall evaluation

Theory of Change

Illinois is in need of a core practice model that will shape the way that all persons within the system will work with the children and families served. Implementation of the FTS practice model will provide practical guidance on the behaviors needed to engage with families and partner with stakeholders in an effort to increase child safety, permanency, and well-being. Adoption and implementation of the FTS Core Practice Model across the child welfare system will require time, resources, system patience, risk tolerance, support at all levels and the involvement of parents, families and youth in partnership with purchase of service agencies, judicial, community stakeholder, and other state agencies to fully implement and sustaining the desire outcomes for safety, permanence, and wellbeing, By comparison, the practice related to Child and Family Team meetings, frequency and quality, youth, family, and stakeholder interviews as measured by the QSR in non-immersion sites can be measured as baseline data for the effectiveness of the intervention.

Outputs

FTS Immersion Sites
Regional Hubs
Localization of quality assurance and quality implementation (QA/QI)
• Dedicated QA/QI staff per Immersion Site
• Evaluation of case planning and progress
Expanded, Revised services and Practice
• Visitation support services
• Concurrent planning services
• Emergency foster care
• In home stabilization services
Dedicated QA/QI staff per Immersion Site
• Evaluation of case planning and progress
Expanded, revised services and Practice
• Visitation support services
• Concurrent planning services
• Emergency foster care
In home stabilization

Outcomes

Proximal

QA/QI Feedback Loops
• Twice monthly random reviews
• Evaluating and reporting Fidelity to the Model
• Performance evaluation
• QA/QI Fidelity Monitoring
• Continuous Quality Improvement

Intermediate

Engagement of child and family
• Children and families are full partners
• Coaching for caseworkers
Strength-based, integrated assessment
• Accurate identification of strengths and needs
• Services and supports
Child and family teams
• Robust and regularly convened
• Coaching for caseworkers and supervisors
• Strengthening partnerships
Individualized Case/Service Planning
• Clearly identified goals
Deliberate and relevant action steps

Distal

Absence of maltreatment
Improved placement stability
Improved permanency
Lower foster care re-entry
Improved well-being

Side-Effects

Staff may not adhere to the interventions or Immersion Site process.
Turnover in the field which would require additional ongoing training.
Parent, caregiver, youth and systemic variables that may delay achievement if of desired outcomes.

End-Values

Achievement of the goals and values articulated in thee DCFS strategic plan and the BH consent decree recommendations. Children and families safely remaining home, returning home, or achieving permanence through adoption or guardianship.

EXHIBIT AA

THERAPEUTIC FOSTER CARE- FOUR MONTH STATUS REPORT

AUGUST 19, 2016

I. Plan

TFC will focus on meeting the needs of children and youth entering care at ages 6 – 12 years and /or 12 years and older who are included in one or more of the following 3 target populations:

1. Children and youth entering care with severe trauma histories, as defined by the having 2 or more “actionable” experiences, rated on the Integrated Assessment CANS (IA CANS), from among: Physical Abuse, Sexual Abuse, Emotional Abuse, Witness to Family Violence, and Witness to Criminal Activity or 1 severely actionable item from among these 5.

2. Children and youth who are ready to be discharged from congregate care settings.

3. Children and youth who would be placed in residential care but who may be stabilized in a home-based setting with the addition of appropriate, intensive supports for the child and the foster parent. These fall into 2 separate categories:

- i. Direct Entry – Direct Entry is defined as children and youth who enter residential as their first child welfare placement. Youth mostly come to the child welfare from hospitals, detentions, or home based settings, most often under neglect or dependency cases. Proposals should discuss interventions for this category of children who would ensure that when the children exit the hospital or detention they are served in home-based settings with intensive services.

- ii. Deflection – Deflection is defined as children and youth who have been identified by their clinical characteristics, as rated by their initial IA CANS, to be “at-risk” for residential/congregate care and who can be served in community settings with appropriate supports. The “at-risk” clinical characteristics include identification of two or more 2’s among the following IA CANS domains: Trauma Symptoms, Emotional Behavioral Needs, Life Domain Functioning, and Risk Behaviors”.

II. Background

In Illinois, children with high end needs are served within a restrictive residential environment for a long period of time because there are no appropriate step-down

placement options to meet their needs. Children at risk for residential care do not have alternative home-based placement options to meet their needs. As a result the Department is implementing a Therapeutic Foster Care Pilot. Treatment will be provided in a home environment by foster parents who have been trained and coached in an evidenced based model to keep children with high end needs out of residential settings and to provide children stepping down from residential with a structured treatment home option.

III. Theory of Change

Most, if not all, children thrive when cared for within a home and family environment and that placement in any residential setting is a point-in-time intervention responding to the clinical needs of the children. The TFC pilot seeks to employ Therapeutic Foster Care of Oregon (TFC-O) or other evidence-based/evidence-informed foster parent training models that meet FFTA service standards. TFC will be deployed in high-need areas of Illinois in order to reduce the number of youth in residential care and increase the placement stability and clinical functioning of home-based placements for DCFS children and youth.

IV. Implementation Status

We are currently engaged in the Pre-installation phase of implementation. The Department has established rates for each project and working to secure grant contracts estimated to begin September 1, 2016. Grant program plans describe the expectations of hiring, recruitment and training. Service contracts will be developed prior to the placement of the first child in a therapeutic foster home. Agencies have begun to identify appropriate individuals for specific positions and in some cases have begun the hiring process and hired implementation coordinators, managers and recruiters.

Agencies along with Department staff have met or will be meeting with the developers of the evidence based models that will be implemented. A meeting was held with LSSI and the developers of Therapeutic Foster Care Oregon on June 20, 2016. A meeting was held with CHASI and the developers of Therapeutic Crisis Intervention Family on August 15, 2016 and a meeting will be held with JCFS and the developers of Together Facing the Challenge on August 29, 2016. The purpose of each meeting is to get a clear understanding of the model, training involved, fidelity monitoring and sustainability. In addition the developers have an opportunity to ask questions and become familiar with the internal agency system and the larger system.

In an effort to get a clear depiction of the interventions, recruitment, staff and training that will be provided by each agency, Chapin Hall, the Department and the agencies identified the program components for each intervention. The program components were guided by the Foster Family Treatment Home Association standards for therapeutic foster care. The program components spreadsheet will be included with the report.

With the understanding that the current ways of doing the work may have to change for this pilot, we have taken a look at the current process in place to determine eligibility for specialized foster care, adolescent foster care and residential treatment. We have also taken a look at the process in place to determine residential step down readiness. In looking at the “as is model” we are working on the “to be model”. We are currently working to identify the process by which youth in the target population will enter and the instrument that will be used to determine eligibility for therapeutic foster care. We are currently exploring the Child and Adolescent Service Intensity Instrument (CASII) to determine level of care. Currently the instrument is used to determine placement levels of care such as specialized foster care, adolescent foster care and residential treatment. There is a need to research CASII scores and identify treatment provided within these levels of care to estimate appropriate scoring and specific distinguishing criteria for therapeutic foster care. In addition we must determine when the first CASII will be completed as well as the frequency with which it will be completed. A subgroup has been identified to work on this. Northwestern University built a database for the Department to document CASII scores. In addition we are identifying data sources for information regarding youth in residential. We are currently looking at RTOS, which provides a list of youth in residential, the length of time they have been there and phase of treatment they are currently in. This will assist the Department with identifying which youth based on age, phase in treatment, admit date and home county that may meet the initial criteria to be considered for therapeutic foster care. We have also identified a subgroup that will take a look at the RTOS system.

V. Outputs

We do not have any data on outputs yet. However, we have identified some outputs for the project but this is still under development. The outputs can be found on the logic model.

VI. Proximal Outcomes

The table below lists the proximal outcomes that have been identified for the project. Chapin Hall is currently working on the comparison group. The therapeutic foster care project has not started yet, as a result there are no significant differences to note.

Proximal Outcome	Intervention Group	Comparison Group	Significance and Explanation of Difference
Decreased percentage of entry/re-entry to residential care among youth in TFC vs. Non-TFC options			
Increased placement stability (e.g., longer length of stay, fewer disruptions) in home-based placements among youth in TFC vs youth in non-TFC options			
Increased clinical functioning, including reduction of trauma symptoms (e.g. based on bi-annual CANS) among youth in TFC vs. youth in non-TFC options			

VII. Distal Outcomes

The table below lists the distal outcomes that have been identified for the project. . Chapin Hall is currently working on the comparison group. The therapeutic foster care project has not started yet, as a result there are no significant differences to note.

Distal Outcome	Intervention Group	Comparison Group	Explanation of Status
Improved safety outcomes			
Improved permanency outcomes			
Improved well- being outcomes			
Decreased length of stay in residential care beyond clinical necessity			
Decreased number of youth placed in residential care			

VIII. Other Consequences

Through the exploration and pre-installation stages, barriers have been identified that may impact the implementation of this pilot project. Agencies are responsible for recruiting therapeutic foster parents. This will prove to be difficult to find individuals willing to dedicate the time and effort that it will take to be trained and to provide the level of supervision and treatment required. Recruitment will be challenging. Each agency has trained licensing works that will be responsible for licensing the therapeutic foster parents. Each prospective foster parent must be fingerprinted and a background check conducted prior to licensure and placement of a child. According to the agencies background checks could take 2 to 3 months to be completed. Prospective foster parents must also complete PRIDE training.

According to the agencies PRIDE training does not occur with consistency. I have secured a list of PRIDE Training dates and will provide this list to the agencies. We will also touch base with the coordinator of the PRIDE training to convey the urgency. Finally, the Department must work on specific coding in the system to identify homes as therapeutic foster homes and children placed in therapeutic foster homes for the purpose of the evaluation.

IX. Plan Revisions

None to report at this time.

EXHIBIT BB

MOSP Logic Model Template

Outcomes

Plan

DCFS and purchase of service investigations, placement, intact, licensing, adoptions direct service management and supervisors

DCFS and purchase of service non-direct service management and supervisors s designated by the agency (i.e. budget and finance, communications, training)

Training of current and hiring of new staff as facilities and coaches to deliver the content and reinforce the learning related to the MOSP.

External Conditions

Results of the baseline practice assessment
Lack of adherence to or constraints of the current rule and procedure regarding timeliness of permanency.
Individual court jurisdictions.
Lack of available resources (human and financial).
Agency culture that negatively impact staff, parent, youth, caregiver, and service provider motivation and attitude which may impact their wiliness to engage in partnership to embrace change.
External stakeholders (courts, providers, etc.) need to be actively engaged in the change initiative.
Instability in agency leadership (public and private)
Culture of compliance monitoring

Implementation

Curriculum Development
Identification of MOSP Sites
Identification of staff to be trained
Determination of training delivery system
Development of train-the-trainer model
Development of training plan

Train the Trainers

In-service:
MOSP curriculum (Classroom)
Coaching and content reinforcement

Self-directed Learning
Classroom Learning
Coaching and content reinforcement with supervisors and middle management

QA/QI Baseline assessment and ongoing outcome monitoring
Chapin Hall evaluation

Theory of Change

Illinois is in need of a model of supervisor practice that will shape the way that all supervisors within the system will work with child welfare staff on behalf of the children and families served. Provision of consistent quality supervision will support the application of the DCFS Family-centered, Trauma-informed, Strength-based Child Welfare Practice Model and will contribute to a supported and committed workforce that is able to deliver services to children aimed at achieve the outcome of safety, permanence, and wellbeing. By comparison, practice related supervision, in terms of frequency and quality will be measured by the QSR in non-immersion sites as baseline data for the effectiveness of the intervention.

Outputs

Pre-engagement implementation engagement webinars

Pre-engagement implementation surveys and participant interviews

Classroom-based learning sessions

Ongoing educational opportunities and CEUs

Coaching and content reinforcement between

MOSP learning sessions

Case presentation framework

Reinforce and support previous learning

Practical application plan

Proximal

Supervisors learn and apply MOSP competencies to FTS practice
Managers/administrators provide uninterrupted weekly individual and monthly group supervision
Supervisors provide uninterrupted weekly individual and monthly group supervision
Teams and individuals at all levels have action plans that support desired outcomes
Staff understands their roles and responsibilities
Workers are engaged with children and families

Intermediate

Supervisors master supervisory competencies
Supervisors balance administrative, clinical, developmental and supportive supervision
Case presentations are incorporated into group supervision
Workers are guided in the application of FTS practice in their work with families
Youth and family voice is evident in planning
Increased worker engagement with children and families
Increased caseworker contact with families
Increased caseworker/caregiver facilitated parent-child visitation
Child and family teams and connections are built and maintained

Distal

Increase child safety
Reduced incidence of repeat maltreatment
Increased child well being
Expedited permanencies

Side-Effects

Staff may not adhere to the interventions or Immersion Site process.
Turnover in the field which would require additional ongoing training.
Parent, caregiver, youth and systemic variables that may delay achievement of desired outcomes.
Culture of risk aversion may limit innovation.

End-Values

Achievement of the goals and values articulated in thee DCFS strategic plan and the BH consent decree recommendations. Children and families safely remaining home, returning home, or achieving permanence through adoption or guardianship.

EXHIBIT CC

> FOUR-MONTH STATUS REPORT TEMPLATE**MOSP – Updated by Monico Eskridge 8.25.2016**

The template outlines the content of the four-month Implementation Plan Status Reports. The Sections of the Status Report should adhere to the structure of the Logic Model. Both qualitative and quantitative updates should be provided in each section on progress, results, and barriers.

I. MOSP Training and Coaching Plan

Key Action Steps	Timeframe	Expected Outcome	Data Source and Evaluation Methodology	Person/Area Responsible	Comments
Establish data collection schedule	9/1/2016	Post surveys sent out at the 3, 6, 9 and 12 month intervals	Measure implementation and impact of the MOSP content overtime	David Moore	
Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Person/Area Responsible	Comments
Identify Immersion Sites supervisors for the MOSP cohort	9/30/2016	Determination of the number of MOSP cohorts needed in each Immersion Site	Office of Professional Development Virtual Training Center and Agency Performance Team Data	David Moore	This date is tentative based on the identification of the Immersion Sites.
Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Person/Area Responsible	Comments
Schedule MOSP cohort dates and send out MOSP session announcements	Tentative based on FTS and CFTM training roll out 11/30/2016	Scheduling of cohorts	Office of Professional Development Virtual Training Center and Agency Performance Team Data	Brooke Taylor David Moore	Brooke Taylor Scheduling David Moore for the announcement
Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Person/Area Responsible	Comments
Schedule and conduct pre-engagement meetings with MOSP cohort supervisors and their management	1/2/2017 – 1/3/2017	Inform participants and their management of the logistic and expectations of the MOSP	Office of Professional Development Virtual Training Center and Agency Performance Team Data	David Moore Victor Lasko	David Moore for scheduling the webinars Victor Lasko for conducting the webinars

Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Person/Area Responsible	Comments
Conduct MOSP cohorts and coaching sessions.	2/1/2017 – 5/30/2017	Establish baseline of current supervisors practice and organizational readiness to support the enhanced supervisory practice	Office of Professional Development Virtual Training Center and Agency Performance Team and supervisory pre-engagement interview Data	STEP and IS staff	Approximately 2 cohorts per Immersion Site with 15-20 participants

II. Background

The Department's Model of Supervisory Practice provides a context for supervision in which the Department's values, philosophy and structure for conducting child welfare practice is supported by best practice principles, policy, and training for the purposes of achieving the Department's mission, which are reflected in the Department's Family-Centered, Trauma-Informed, Strength-Based (FTS) Child Welfare Practice Model. This Model supports race-informed practice and strives to improve the outcomes for children of color by reducing and/or eliminating race-based disproportionality and disparities in practice.

The Department's commitment to accountability and effectiveness has impacted the focus of child welfare practice. Supervisors play a pivotal role in ensuring safety, permanency and well-being for children and families involved in the child welfare system. They are responsible for ensuring effective service delivery and are accountable for achieving the desired outcomes of safety, permanency and well-being for children and families in consideration of the child's sense of time. Supervisors are not only required to manage change; they must lead change. Supervisors in child welfare provide the guidance, development and support required for direct service staff to carry out the Department's mandate.

Supporting the work of the direct service supervisor and direct service staff is the responsibility of each employee in the Department, beginning with administration. It is essential that all staff are cognizant of their actions and how these actions impact the direct service supervisor and worker. DCFS and purchase of service investigations, placement, intact, licensing, adoptions direct service management and supervisors need to be trained in a comprehensive Model of Supervisory Practice that articulates their role and the expectations of supervisors in ensuring the application of the FTS Model of Child Welfare Practice throughout all levels within the agency.

III. Theory of Change

Illinois is in need of a model of supervisor practice that will shape the way that all supervisors within the system will work with child welfare staff on behalf of the children and families served. Provision of consistent quality supervision will support the application of the DCFS Family-centered, Trauma-informed, Strength-based Child Welfare Practice Model and will contribute to a supported and committed workforce that is able to deliver services to children aimed at achieve the outcome of safety, permanence, and wellbeing.

IV. Implementation Status

The MOSP curriculum was piloted January 2016-May 2016. Focus groups were completed with each of the three cohorts and feedback from the focus groups and training evaluations have been incorporated into the curriculum and the revised draft has been completed.

V. Outputs (MOSP Pilot)

Outputs:

Pre-engagement implementation engagement webinars were completed and used to provide supervisors and their manager with the expectations and logistics related to the pilot cohorts.

Pre-engagement implementation surveys and participant interviews were conducted for the pilot participants and the baseline data was collected which reflected that due to variable such as scheduling conflicts some participants were not able to be interviewed prior to attending the sessions. There does not seem to be a significant impact on the data results.

Classroom-based learning sessions for the pilot cohort were conducted between January 2016 and April 2016. Evaluation data shows a consistent understanding of the content and that the content was relevant to their jobs.

Ongoing educational opportunities and CEUs have not been developed for the pilot cohorts but they will be exposed to additional training related to the FTS Practice Model and CFTM facilitation and coaching content through the Immersion Sites.

Coaching and content reinforcement between MOSP learning sessions was provided to each pilot participant with an emphasis on application of the MOSP content with at least one staff member immediately following the learning session.

Case presentation framework was introduced in the Clinical module as an example with the expectation that the supervisors could use their own agency framework. The goal is to use case presentation as a tool for shared learning in group supervision.

Reinforce and support previous learning was done throughout the modules to build upon content, practice and theory introduced through the learning collaborative, STEP coaching and skill labs, and other trainings. Feedback from veteran staff was that in some cases they felt the content was redundant. To account for this some content was scaled back with instructions to the facilitator to go more in depth with the content if needed in coaching sessions to ensure each participant is able to understand and draw the appropriate connections. Some self-directed learning or supplemental reading may also be provided as the coach's discretion.

Practical application plan were completed for each pilot participant at the end of each module and were used as the basis for coaching sessions.

Reach:

Pilot participants included DCFS and private sector supervisory and managerial staff. The cohort areas included Harvey, Waukegan, and Rockford with representation from investigations, permanency, intact, licensing, adoptions, and other supportive supervisory roles. Having mixture of direct and non-direct service role is a unique feature for supervisory training.

Dose:

The four modules were delivered over two days of in person content for 4 months with a minimum of 90 minute of coaching between the in person classroom learning sessions. This amount was considered more than adequate. The content has been streamlined by recommendation of the pilot cohorts from 2 day for

the modules to 1.5 days with a stronger emphasis on the use of coaching to action plan for application of the content and to support and review the supervisor's progress.

The control for the MOSP is the evaluations from the Foundations for Managers and Supervisors that has been offered in the past.

VI. Proximal Outcomes

Use the table provided below to report progress in attaining the proximal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the "Significance and Explanation of Difference," briefly describe whether the differences are trending in the expected direction.

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
Supervisors learn and apply MOSP competencies to FTS practice	NA	NA	NA – This cannot be measured until a baseline is , sampled and analyzed using the QSR and training in the FTS and MOSP models and CFTM facilitation is provided.
Managers/administrators provide uninterrupted weekly individual and monthly group supervision	NA	NA	NA – This cannot be measured until a baseline is , sampled and analyzed using the QSR and training in the FTS and MOSP models and CFTM facilitation is provided.
Supervisors provide uninterrupted weekly individual and monthly group supervision	NA	NA	NA – This cannot be measured until a baseline is , sampled and analyzed using the QSR and training in the FTS and MOSP models and CFTM facilitation is provided.
Teams and individuals at all levels have action plans that support desired outcomes	NA	NA	NA – This cannot be measured until a baseline is , sampled and analyzed using the QSR and training in the FTS and MOSP models and CFTM facilitation is provided.
Staff understands their roles and responsibilities	NA	NA	NA – This cannot be measured until a baseline is , sampled and analyzed using the QSR and training in the FTS and MOSP models and CFTM facilitation is provided.
Workers are engaged with children and families	NA	NA	NA – This cannot be measured until a baseline is , sampled and analyzed using the QSR and training in the FTS and MOSP models and CFTM facilitation is provided.

VII. Distal Outcomes (if applicable to the reporting period)

Use the table provided below to report progress in attaining the distal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the “Explanation of Status,” briefly describe whether the differences in the long-term outcomes, which were intended to result from the intervention, are in alignment with expectations.

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Absence of maltreatment	NA	NA	Intervention has not yet begun
Improved placement stability	NA	NA	Intervention has not yet begun
Improved permanency	NA	NA	Intervention has not yet begun
Lower foster care re-entry	NA	NA	Intervention has not yet begun
Improved well-being	NA	NA	Intervention has not yet begun

VIII. Other Consequences

- Staff may not adhere to the interventions or Immersion Site process.
- Turnover in the field which would require additional ongoing training.
- Parent, caregiver, youth and systemic variables that may delay achievement of desired outcomes.
- Culture of risk aversion may limit innovation.

IX. Plan Revisions

Based on the initial pilot feedback the MOSP curriculum has been revised, a data collection process has been established, and the pre-engagement session has been revised to include a curriculum overview for the managers as part of the orientation.

EXHIBIT DD

Logic Model Template

Plan

Quality Service Review in Immersion Sites

Implementation

Outputs

Outcomes

Proximal

Distal

Specific to the identified Immersion site: Families and children referred for child welfare services as a result of an investigation for abuse/neglect or dependency services

Comparable DCFS teams and POS agencies that are not identified as Immersion site: Families and children referred for child welfare services as a result of an investigation for abuse/neglect or dependency services

Quality Service Review (QSR) a practice improvement approach designed to assess current outcomes and system performance by gathering information directly from families, children and service team members; utilizing an Illinois specific review protocol for the examination of Family centered, Trauma focused, Strength based model of practice that includes a model of supervision and the effective utilization of Child and Family Team meetings.

In partnership with the Immersion site director, APT Performance monitoring staff and Quality Assurance staff coordinate the QSR process from sampling, qualitative case review, through feedback and reporting. Provide leadership and accountability as review processes (QSR) identify areas for improvement. Provide leadership on CQI improvement cycle to improve safety permanency and well being outcomes

Direct service staff gain access to QSR case review results, data reports, and receive support in using an improvement cycle

Intermediate

Direct service staff gain knowledge and insight into how a change in their Field behavior and practice impacts outcomes for children and families. Staff through the use of qualitative and quantitative data begin to test and learn innovative and creative methods for improving practice and outcomes.

Children safely maintain in their home of origin with reduced risk for repeat maltx, children placed do not experience maltx in foster care. Children placed experience reduced length of stay, children intact or placed experience a growth producing home environment

Side-Effects

External Conditions

Theory of Change

End-Values

If staff receive relevant information and coaching through the results of quality service reviews, dashboards and data reports and receive support and encouragement through teaming and utilization of an improvement cycle; then staff will begin to understand the benefits of implementing data driven behavior and practice that shows positive impacts on outcomes.

A child welfare system that promotes safety permanency and wellbeing for children that come to the attention of the system

EXHIBIT EE

**EXPERT'S MONTHLY REPORT TEMPLATE
QUALITY SERVICE REVIEW (QSR) IN THE IMMERSION SITES
8/31/2016**

I. Plan

Population Focus: Specific to the identified Immersion sites: Families and children referred for child welfare services as a result of an investigation for abuse/neglect or dependency services.

Comparable DCFS teams and POS agencies that are not identified as Immersion sites: Families and children referred for child welfare services as a result of an investigation for abuse/neglect or dependency services

Intervention is the utilization of Quality Service Review (QSR) a practice improvement approach designed to assess current outcomes and system performance by gathering information directly from families, children and service team members; utilizing an Illinois specific review protocol for the examination of Family centered, Trauma focused, Strength based model of practice that includes a Model of Supervision and the effective utilization of Child and Family Team meetings.

II. Background

Illinois desires a child welfare system that not only promotes safety, permanency, and wellbeing for children that come to the attention of the system but shows measurable improvements in outcomes for children.

III. Theory of Change

If staff receive relevant information and coaching through the results of quality service reviews, dashboards and data reports and receive support and encouragement through teaming and utilization of an improvement cycle; then staff will begin to understand the benefits of implementing data driven behavior and practice that shows positive impacts on outcomes.

IV. Implementation Status

- Illinois will receive the draft review tool **by October 15, 2016**
- The 2 day design process to customize the review tool will be scheduled prior to **November 1**
- Quality Assurance in partnership with Monitoring and Training will begin

establishing staff to participate in the design team along with consultants **Paul Vincent and George Taylor**

- The design team will complete work on the review tool with a final version **by November 18**
- A comprehensive data base version, is available for a modest cost and should be purchased as the finalization of the review tool.
- Training of the QSR review tool and the review process is two days in length and occurs after the pilot protocol design version is completed. **the training will be scheduled prior to January 30, 2017 followed by the pilot review beginning February 1, 2017.** Note that the site needs four-five weeks to do the case scheduling prior to the beginning of the review itself, so scheduling of the review should anticipate lead time.
- The initial pilot review will encompass a single site, which permits any identified adjustments in the instrument before scheduling subsequent reviews in the other three sites.
- For the initial review of 12 cases, 6 mentors will be provided and on site, each of which would mentor a single Illinois reviewer on two cases in a review week. There will be at least two week-long mentoring experiences for each reviewer, with a 1-day – 1 1/2 day follow up advanced training once local reviewers have some experience.
- While many systems do a monthly review, and eventually that is the goal, initially we will start slower until the system has more experience and enough local reviewers.
- Even with QA staff from both DCFS and POS as well as Monitoring staff, there will need to be additional staff to complete a round of reviews. It may be necessary for the QA and Monitoring staff to provide the leadership, sampling, review logistics, quality control, data entering and reporting, with Field staff and supervisors trained as the peer reviewers for the QSR.

V. Outputs

Discuss the extent to which intervention components were delivered as intended (outputs). Describe the numbers and proportion of the target population that received the intended intervention content (reach), the amounts of intervention content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation). Also describe the unique features of the intervention, which make it distinguishable from business as usual, and the extent to which the comparison group didn't receive similar features of the intervention (differentiation).

VI. Proximal Outcomes

Use the table provided below to report progress in attaining the proximal outcomes. The Outcomes listed should match those detailed in the Logic Model. In the “Significance and Explanation of Difference,” briefly describe whether the differences are trending in the expected direction.

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
Direct service staff gain access to QSR case review results, data reports, and receive support in using an improvement cycle			
Direct service staff gain knowledge and insight into how a change in their Field behavior and practice impacts outcomes for children and families. Staff through the use of qualitative and quantitative data begin to test and learn innovative and creative methods for improving practice and outcomes.			

VII. Distal Outcomes (if applicable to the reporting period)

Use the table provided below to report progress in attaining the distal outcomes. The Outcomes listed should match those detailed in the Logic Model. In the “Explanation of Status,” briefly describe whether the differences in the long-term outcomes, which were intended to result from the intervention, are in alignment with expectations.

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Children safely maintain in their home of origin with reduced risk for repeat maltx, children placed do not experience maltx in foster care. Children placed			

experience reduced length of stay, children intact or placed experience a growth producing home environment			
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VIII. Other Consequences

Describe any unexpected issues or concerns that impacted either positively or negatively (ex. leadership or organizational changes, exogenous factors beyond the agency's control) the Department's ability to implement or evaluate the plan.

IX. Plan Revisions

Describe what the Department learned from the results, successes, and challenges of the reporting period and what changes (programmatic, evaluative or organizational) will be made based on these lessons.

Logic Model Template

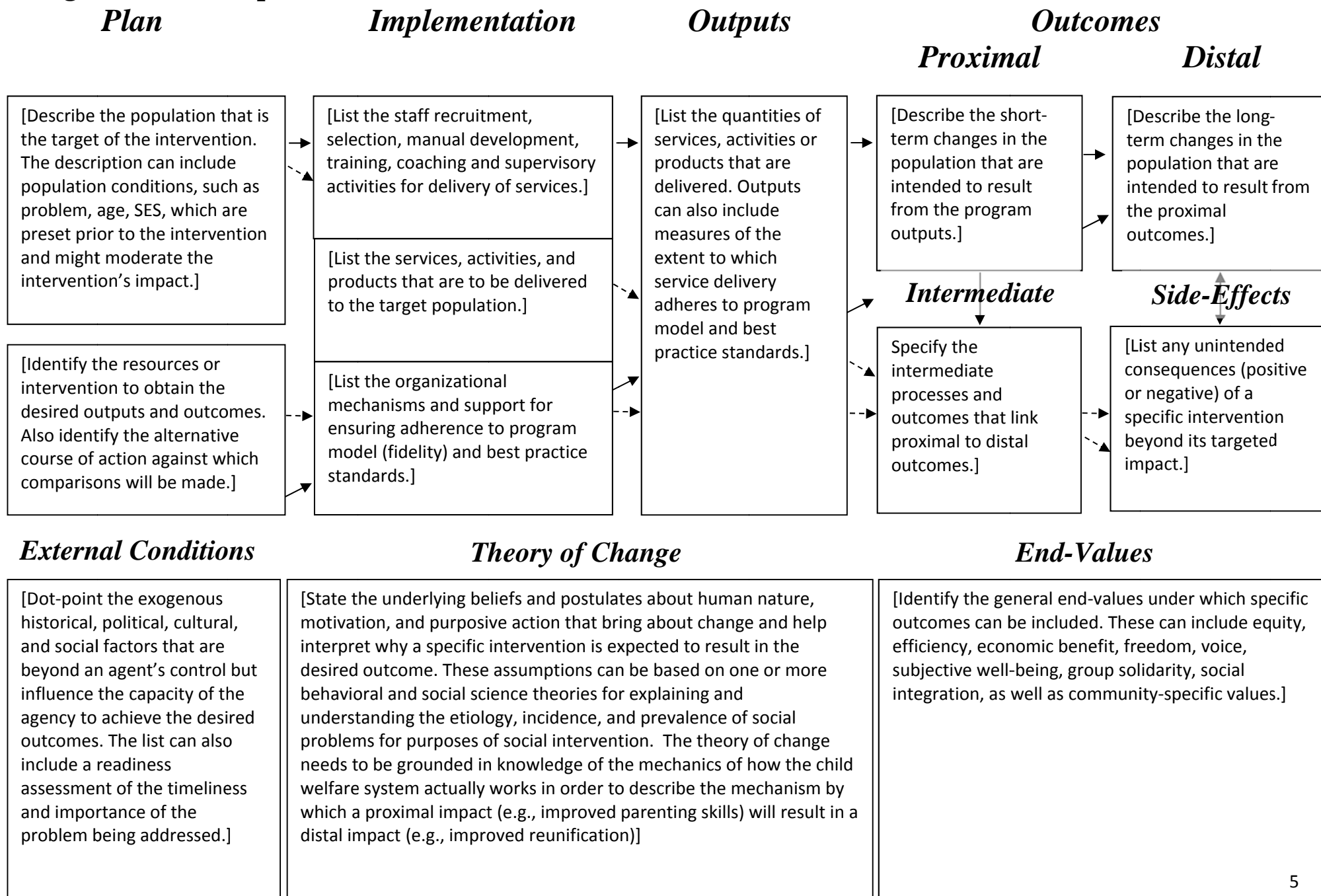


EXHIBIT FF

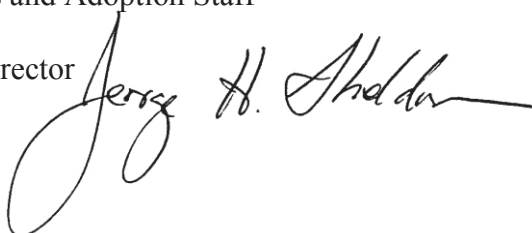
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Policy Guide 2016.09

**SECTION 302.410, SUBSIDIZED GUARDIANSHIP PROGRAM (KINGAP)
CHANGES TO THE ELIGIBILITY CRITERIA FOR THE STATE FUNDED OPTION
OF SUBSIDIZED GUARDIANSHIP**

DATE: August 24, 2016

TO: All DCFS and Private Agency Permanency Workers and Supervisors,
Adoption Coordinators and Adoption Staff

FROM: George H. Sheldon, Director 

EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to inform Staff of changes to the eligibility criteria for the State funded option of Subsidized Guardianship. Children who are 12 years of age or older and placed with a licensed or unlicensed relative caregiver shall now also be eligible for the State Funded Option of Subsidized Guardianship. The manner of calculating recurring monthly subsidy payment amounts has not changed.

II. PRIMARY USERS

The primary users of this Policy Guide are POS and DCFS permanency workers and supervisors, DCFS and POS adoption workers, coordinators, their supervisors and managers.

III. SUMMARY OF CHANGES

Effective immediately the following criteria shall be used when determining eligibility for the state funded option of subsidized guardianship for children for whom the Department is legally responsible;

- A) the child is **12 years** of age or older; and
- B) the child has lived with a **licensed or unlicensed relative caregiver** or licensed non-relative for at least the 6 consecutive month period prior to the establishment of the guardianship and meets the following:
 - i) the child was removed from his or her home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home



would be contrary to the welfare and best interest of the child; and

- ii) the child was eligible for foster care maintenance payments while residing for at least 6 consecutive months in the **licensed or unlicensed home of relative or** licensed non-relative home immediately prior to establishing guardianship; and
- iii) the prospective **non-relative** guardian has been a licensed foster parent for at least the consecutive 6 month period immediately prior to the establishment of the guardianship; and
- iv) being returned home or adopted are not appropriate permanency options for the child; and
- v) the child demonstrates a strong attachment to the prospective guardian and the prospective guardian has a strong commitment to caring permanently for the child; and
- vi) the child has been consulted and has agreed to the guardianship arrangement.

Section 302.410 shall be amended to reflect the above expanded eligibility criteria in the near future.

IV. ATTACHMENTS

CFS 1800 A-G, Subsidized Guardianship Eligibility Determination form (Rev. 8/2016).

V. QUESTIONS

Questions regarding this Policy Guide may be directed to the Office of Child and Family Policy at 217-524-1983 or via Outlook at OCFP – Mailbox. Non Outlook users may e-mail questions to cfpolicy@idcfs.state.il.us.

VI. FILING INSTRUCTIONS

File this Policy Guide immediately following, Rule 302.410, Subsidized Guardianship Program (KinGap).

CFS 1800-A-G
Rev 8/2016State of Illinois
Department of Children and Family Services**SUBSIDIZED GUARDIANSHIP
ELIGIBILITY DETERMINATION**

This form is to be completed by the child's assigned worker and reviewed by the supervisor.

I. Identifying DataName on Birth Certificate: _____ Birth date: _____
LAST FIRST MIDDLE

ID No.: _____ Race: _____ Gender: _____ S.S.#: _____

Date Child Came into Care: _____

Date of Placement with Caregiver: _____

Is the Department legally responsible for the child? ☐ Yes ☐ No

If yes, enter initial legal date ____ / ____ / ____ County of Jurisdiction _____

Docket # _____

Have parental rights been terminated? (Please check all that apply)

Mother: ☐ Yes ☐ No If "yes", How?☐ Involuntary Termination _____
Date☐ Voluntary Surrender _____
Date☐ Specific Consent _____
Date☐ Death _____
Date**Father:** ☐ Yes ☐ No If "yes", How?☐ Involuntary Termination _____
Date☐ Voluntary Surrender _____
Date☐ Specific Consent _____
Date☐ Death _____
Date**II. Subsidized Guardianship Eligibility Factors (Please check all factors that apply)**

- 1) Was this child removed from his/her home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare and best interest of the child?

☐ Yes ☐ No

- 2) Was the child eligible for foster care maintenance payments while residing for at least 6 consecutive months in the home of a licensed prospective relative guardian immediately prior to the establishment of the guardianship?

☐ Yes ☐ No

- 3) Has the prospective relative guardian been a licensed foster parent for at least the consecutive 6 month period that the child has been in his/her home?

☐ Yes ☐ No

- 4) The permanency goals of return home and adoption have been ruled out for this child and documented in the case record.

☐ Yes ☐ No

Child's Birth Name: _____

Guardian(s) Name: _____

Date: _____

- 5) The child has a strong attachment to the potential guardian and the guardian has a strong commitment to the child.

☐ Yes ☐ No

- 6) With respect to a child who has attained 14 years of age, the child has been consulted and the child has agreed to the guardianship arrangement.

☐ Yes ☐ No ☐ N/A

OR

- 7) The child is a sibling of an eligible child who is placed with the same relative under a kinship guardianship agreement and the Department and the relative guardian agree that the placement is appropriate.

☐ Yes ☐ No

OR

- 8) The child is 12 years of age or older, who has lived with a licensed or unlicensed relative caregiver or a licensed NON-RELATIVE for at least the 6 consecutive month period AND meets the following:

- a) the child was removed from his or her home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare and best interest of the child; and
- b) the child was eligible for foster care maintenance payments while residing for at least 6 consecutive months in the licensed or unlicensed home of relative or licensed non-relative home immediately prior to establishing guardianship; and
- c) the prospective guardian has been a licensed foster parent for at least the consecutive 6 month period immediately prior to the establishment of the guardianship; and
- d) the child demonstrates a strong attachment to the prospective guardian and the prospective guardian has a strong commitment to caring permanently for the child; and
- e) the child has been consulted and has agreed to the guardianship arrangement.

☐ Yes ☐ No

- 9) The parent(s) has consented to the subsidized guardianship arrangement.

☐ Yes ☐ No

- 10) The Department has good cause to seek a private guardian without consent and will give notice of the guardianship hearing.

☐ Yes ☐ No

IF THE ANSWERS TO SECTION II. #s 1-5 ARE YES AND #6 IS YES OR N/A OR THE ANSWER TO #7 IS YES OR THE ANSWER TO #8 a) THROUGH e) IS YES, THE CHILD IS ELIGIBLE FOR SUBSIDIZED GUARDIANSHIP or IF THE ANSWER TO 8 c) IS "NO," THE CHILD IS ELIGIBLE FOR THE STATE FUNDED OPTION OF SUBSIDIZED GUARDIANSHIP; OTHERWISE, THE CHILD IS NOT ELIGIBLE FOR SUBSIDIZED GUARDIANSHIP.

CFS 1800-A-G
Rev 8/2016

Child's Birth Name: _____

Guardian(s) Name: _____

Date: _____

11) Is the child eligible for subsidized guardianship?

☐ Yes

☐ No

Signature of Worker Completing the Form

Agency

_____/_____/_____
Date

Print Name of Worker Completing the Form

Signature of Supervisor

Agency

_____/_____/_____
Date

Print Name of Supervisor

Signature of DCFS Adoption Supervisor/Coordinator

Region

_____/_____/_____
Date

Print Name of DCFS Adoption Supervisor/Coordinator

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EXHIBIT GG

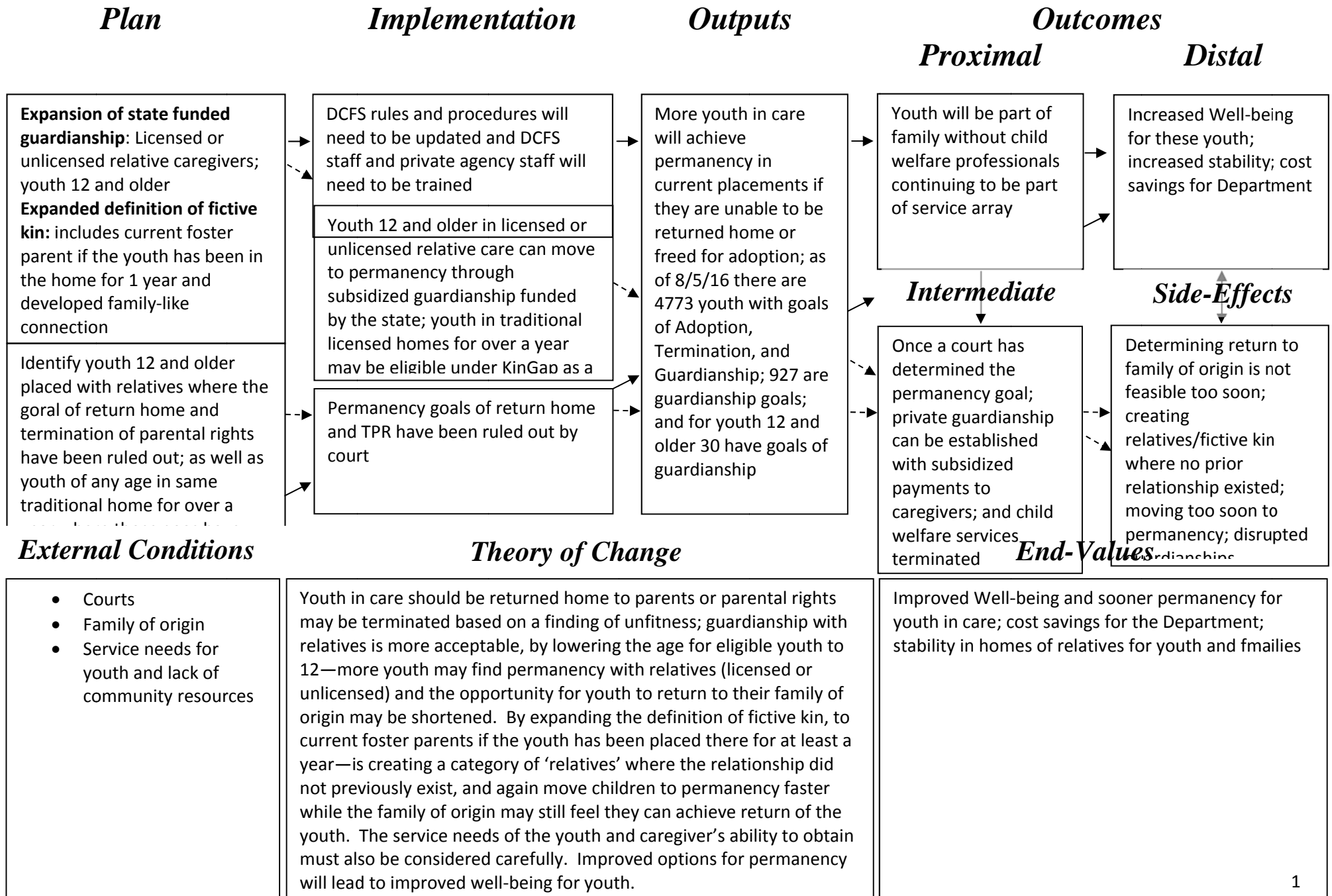
Logic Model Template – State Funded Guardianship

EXHIBIT HH

9/2/16 update

State funded guardianship---12 yo and older youth in unlicensed or licensed relative care

Fictive Kin—youth in traditional licensed foster care for over a year who have developed a family like connection—these foster parents become fictive kin/relatives—and eligible for Kin Gap federally funded guardianship

I. Plan

Expansion of state funded guardianship: Licensed or unlicensed relative caregivers; youth 12 and older;

Expanded definition of fictive kin: to include any individual, unrelated by birth or marriage, who is the current foster parent of a child in the custody or guardianship of the Department pursuant to the Act and the Juvenile Court Act of 1987, if the child has been placed in the home for at least one year and has established a significant and family-like relationship with the foster parent, and the foster parent has been identified by the Department as the child's permanent connection, as defined by Department rule. As these foster parents can now be considered as 'fictive kin' and therefore a 'relative'—under KinGap.

II. Background

Identify youth in care 12 years old and older placed with relatives (licensed or unlicensed) where the goal of return home and termination of parental rights have been ruled out; as well as youth of any age in the same traditional non-relative home for over a year where those goals have been ruled out in order to increase well-being and permanency for these youth in care.

III. Theory of Change

Youth in care should be returned home to parents or parental rights may be terminated based on a finding of unfitness; guardianship with relatives is more acceptable, by lowering the age for eligible youth to 12—more youth may find permanency with relatives (licensed or unlicensed) and the opportunity for youth to return to their family of origin may be shortened. By expanding the definition of fictive kin, to current foster parents if the youth has been placed there for at least a year—is creating a category of 'relatives' where the relationship did not previously exist, and again move children to permanency faster while the family of origin may still feel they can achieve return of the youth. The service needs of the youth and caregiver's ability to obtain must also be considered carefully. Improved options for permanency will lead to improved well-being for youth.

IV. Implementation Status

STATE-FUNDED GUARDIANSHIP—Policy Guide 2016.09 was issued on **8/24/16** to immediately update Rule 302.410 and update to the Rule is also complete and in rule-making process. **Rule anticipated completion date December 2016.**

FICTIVE KIN--The Governor signed **P.A. 99-0836 on 8-19-16**. The affected rules include 300, 301, 302, 304, 309, 315, 316, 328, 337, 338, 359, and 402. Updates to these rules have been drafted and are awaiting approval by the Director and others. This law is effective **1/1/17. Rules anticipated completion date 1/1/17.**

TRAINING: Procedures 315, Permanency Planning have been revised and include updates to fictive kin definitions and state-funded guardianship expansion. Permanency Achievement Specialists (PAS) will co-facilitate training and 'training of trainers' (TOT) will begin **September 26, 2016**, and **mid-October 2016** training for all DCFS and POS staff will begin. This is a 2 day training and is anticipated to be **complete by March 2017**.

V. Outputs

More youth in care will achieve permanency in current placements if they are unable to be returned home or freed for adoption; as of 8/5/16 there are **4773 youth with goals of Adoption, Termination, and Guardianship; 927 are guardianship goals**; and for **youth 12 and older 30 have goals of guardianship**. With expanded opportunities and flexibility for foster homes to move from traditional to guardianship there will also be a reduction in the length of stay.

It may be that youth with current goals of independence might actually be amended to a guardianship goal, this is being explored. As of 8/10/16, there were **514** youth 12 and older in traditional homes, and relative homes (including fictive kin) with a goal of independence.

VI. Proximal Outcomes

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
Increase in permanency for youth 12 and older in relative care			
Increase in permanency for youth in licensed non-relative homes for over 1 year			
Reduction in length of stay in care			

VII. Distal Outcomes (if applicable to the reporting period)

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Increased well-being for youth			
Increase in stability for youth			
Less need for service intervention			

VIII. Other Consequences

The Court will have to rule out the goals or return home and/or termination of parental rights for these youth in care. The opportunity for youth to return to their family of origin may be shortened.

IX. Plan Revisions

N/A

EXHIBIT II

Illinois Recruitment and Kin Connection Project

Federal Fiscal Years 2010-2015

Final Report – Grant #90-CO-5013



Getting Connected. Staying Connected.



EXECUTIVE SUMMARY	1
OVERVIEW OF THE COMMUNITY, POPULATION AND NEEDS.....	9
OVERVIEW OF THE PROGRAM MODEL	15
COLLABORATION	26
SUSTAINABILITY	34
EVALUATION	44
CONCLUSIONS	90
RECOMMENDATIONS	92
APPENDICES	95
Appendix A: Full Executive Summary of Results	86
Appendix A–1: Kin Connection Specialist Curriculum Overview	95
Appendix A-1a: The Kin Connection Specialist Training Competencies, Knowledge Base and Skill Set	96
Appendix A-2: Kin Connection Specialist New Case Assignment Checklist	97
Appendix A-3: Associate Director/Kin Connection Specialist Supervision Note	100
Appendix A-4: Baseline Genogram Prior to Family Finding Outreach	102
Appendix A-5: Subsequent Genogram after Family Finding Outreach	103

Appendix A-6: Family Finding Information Sheet	104
Appendix A-7: CFS-458B – Relative Resource and Positive Supports Worksheet	105
Appendix A-8: RKCP Family Outreach Letter – Notification to Relatives.....	106
Appendix A-9: CFS 151H – Notification to Relatives	107
Appendix A-10: Family Finding Websites and Data Systems*	108
Appendix A-11: CFS 458A – Statement of Relationship	109
Appendix A-12: Example of Child-Centered Ecomap	110
Appendix A-13: RKCP Family Search and Engagement Summary Report	111
Appendix A-14: RKCP’s Influence on IDCFS Placement and Visitation Services (June 1, 2015 – P.T. 2015.14) Policy Section 301.80 Relative Home Placements	115

I. EXECUTIVE SUMMARY

The Illinois Recruitment and Kin Connection Project (RKCP) was a federally funded project administered through the Health & Human Services, Children's Bureau of the Administration for Children and Families, Administration for Children, Youth and Family Division beginning October 2010 and ending September 2015. Child-Centered recruitment efforts and front-end family finding intervention services began in Cook County in October 2011. Service expansion to additional counties began in March 2013. Intervention services for all four counties closed in September 2014.

The Illinois Department of Children and Family Services (IDCFS), a state based system, in partnership with Adoptions Unlimited, Inc. (known as Illinois Center for Adoption & Permanency since October 1, 2015), a private not-for-profit agency contracted by IDCFS was awarded a 5-year grant to provide intensive front-end family finding services in urban Cook County and suburban Will County for children ages 6 through 13 entering the child welfare system for the first time in order to improve permanency outcomes. At the request of IDCFS personnel, the RKCP family-finding efforts expanded to rural Grundy and Kankakee Counties.

Expansion into Kankakee and Grundy Counties was in response to the original goals and objectives outlined in the RKCP proposal. The goal of the project was to improve permanency outcomes and to facilitate active concurrent planning strategies across the 102 counties in Illinois.

The involvement of two additional counties contributed to the project's objectives to create a child welfare culture that believes that locating and involving relatives and fictive kin is a permanent part of case planning and should be clearly incorporated and documented in policy. The project staff worked diligently to apply this belief into practice, by ensuring that collaborative partners have an understanding of the evidence based family finding research model. Our project's goal was to impact policy change, and in order to do so, our efforts needed to expand beyond Cook County to support the public and private agencies and the court personnel across the state of Illinois.

Expansion into additional counties allowed the project team to explore how the family finding model could be applied in three counties outside of Cook County. The expansion served as a mean to establish credibility and collateral buy-in for the other counties that were not included in the originally proposed intervention areas. Project sustainability relied on application in the 102 counties in the state of Illinois so it was best suited that there was an appropriate representation of urban, rural and suburban communities.

The inclusion of two new counties was approved by the assigned Federal Project Officer. Expansion intervention services required no additional staff members. The planning phases for the expansion was a replication of the Cook County implementation plan and required minimum start-up time since all key child welfare stakeholders, including court personnel, were involved in the decision to expand the program. The request was met with enthusiasm and support for child-centered recruitment efforts and front-end family.

The Recruitment and Kin Connection Project (RKCP), ***Getting Connected. Staying Connected.***, was an unique program that initiated interest and eager willingness to participate in the demonstration project on the part of those key stakeholders in Illinois who are decision makers within the state run child welfare system. The original proposal responded to the Child and Family Service Review (CFSR) finding that, "Illinois is not making consistent efforts to locate and assess relatives as potential placement resources for children." In addition, current practice data collected from the Illinois Post-Adoption Unit revealed that caseworkers in this unit responded to three to five deaths per week of elderly parents. In addition, incapacitated elderly parents who were not able to meet the needs of their children were identified as not having viable back-up permanency plans. The plan for changing practice in this area was to develop an intensive front-end family finding unit that would locate viable placement and resource options intended to last a life-time.

Our planning phase adopted these identified issues as our project drivers, which assisted us with setting our goals to improve permanency outcomes, improve active concurrent planning, and improve the system's response to permanency. We proposed implementing an intensive front-end family finding model that involved maternal and paternal family members and fictive kin immediately after temporary custody was granted. By meeting these goals and objectives, it was our intention to implement a well thought out plan that created a culture that would embrace relative location and involvement as best practice during case planning, from the point of case entry to case closure achieved by permanency. Realistically, the team acknowledged that this shift in paradigm could be met with resistance; therefore it was imperative to assemble a Steering Committee representative of IDCFS leadership, policy and advocacy, court personnel, general counsel and professional development to assist with the sustainability of the demonstration project.

Our goal was to keep children connected or get children connected to safe, nurturing relationships intended to last a lifetime by engaging the birth family and child when appropriate, immediately after temporary custody was granted. We empowered the birth parents by including them in the family finding process. As stated, our target population was children ages 6 through 13; however, the Kin Connection Specialist engaged all children in the family as long as there was one child who met this population criteria. Our demonstration project proposed that locating and engaging family members at the beginning of a child welfare case would decrease the likelihood of placement disruptions, decrease the length of stay in care, and eventually improve permanency outcomes.

The program model introduced the concept of additional ancillary support surfacing between the investigation stage and the follow-up stage and case hand off to the assigned Child Welfare Specialist. The project staff member in this role was titled a Kin Connection Specialist who supported the philosophy that locating family is essential and engaging family is crucial. The Kin Connection Specialist was coached to respect the family connection and to facilitate supporting relationships between children and their birth families, their fictive kin, and significant others in their lives. As a member of the family's professional team, the Kin Connection Specialist attempted to locate family members who could participate in service planning and act as resources for placement, back-up placement, hosting sibling visits, hosting parent visits, or as mentors for the family. Outreach efforts began the same day temporary custody was granted.

All family finding efforts were documented and the assigned Child Welfare Specialist received a Family Finding Information Sheet and a comprehensive Family Search and Engagement Summary Report. The Kin Connection Specialist entered family finding information directly in SACWIS so that the front-end family finding information became part of the child's permanent record documented in case notes under the Diligent Search section.

The Kin Connection Specialist conducted an intensive family search and engagement outreach service for the Child Welfare Specialist. The information was intended to provide positive supportive resources for service planning and concurrent planning. The 40 day front-end family finding model consists of these components: (1) interviews the birth parents and family members in person who were present at Juvenile Court immediately after temporary custody is granted; (2) gather information the same day temporary custody is granted and conduct outreach efforts the same and next day; (3) create a baseline genogram; (4) search for and engage additional birth family members, fictive kin, and

significant others who can act as resources for the family; (4) ask family members if they will consent to a CANTS (Child Abuse and Neglect Tracking System) and LEADS (Law Enforcement Agencies Data System) checks for those who were willing to participate in concurrent and service planning; (5) when appropriate, meet with the child within ten days of case opening in order to conduct an interview complete with a child-centered Ecomap documented in his/her words; (6) document all family finding efforts in SACWIS throughout the front-end family finding process and forward this information to the Child Welfare Specialist to be used as resources ten days after case opening; (7) meet with the assigned Child Welfare Specialist in-person to share the information gathered; (8) re-assess identified family members throughout the case as a means of concurrent and service planning; (9) conduct additional in-person and telephone interviews at the request of the Child Welfare Specialist; (10) assess levels of support the family member can provide (placement, respite, transportation, supervise visits) and document in SACWIS and in the Family Search and Engagement Summary Report due 40 days after case opening; and (11) facilitate in-person child-centered recruitment summary meeting with the assigned Child Welfare Specialist in order to share the family information obtained during the discovery and engagement phase.

In summation, the RKCP model, based upon family finding models noted in literature, followed the philosophy of discovery, location and engagement of birth parents, maternal and paternal family members, fictive kin and others who offered additional support to the family. Engagement of the Child and Family Team that included the Child Welfare Specialist and court personnel was a critical component of this model. Together, the birth family and the case management team who were active participants in the family search and engagement process developed a child-centered concurrent and service plan based upon information gathered in the discovery phase.

We were able to achieve our original goal and effectively locate a network of relatives, fictive kin, and significant others who supported the birth parent's efforts to comply with relevant and necessary services to ensure that permanency goals are achieved at an acceptable rate. The location and engagement of family members increased the frequency of parent-child visitation, sibling visitation, and kept the children connected to their family of origin throughout the case history.

During the planning phase, it became abundantly clear that involving key partners at the state level was crucial to program sustainability and to making an impact of relevant change in Illinois' child welfare system. During July 2011, the RKCP team facilitated the first Steering Committee meeting for the Project. At the table sat an impressive group of representatives from child welfare, the courts, training and development and information systems. The Committee quickly embraced the vision of the demonstration project and assisted with coordinating dissemination meetings between RKCP administration and the Child Protection Presiding Judge and Cook County Judges, Public Defenders, Public Guardians, State's Attorneys, IDCFS Legal staff, Mediation Staff, and members of the Cook County Clerk's Office. Membership was fluid throughout the implementation of the project but core members remained intact and provided the direction and leadership necessary for sustainability.

In addition, presentations were made for the Agency Performance Team Liaisons, the managers of the IDCFS Cook Central, North, and South Regions, the managers of the Child Protection and Intact workers of the IDCFS Cook Central, North, and South Regions and managers of all private agencies in Cook County. In consultation with the grant Federal Project Officer (FPO), it was recommended and agreed upon to conduct additional dissemination meetings every six months.

The Recruitment and Kin Connection Project influenced change at the legislative level, the state policy level, the professional development level and achieved sustainability by receiving a partial IDCFS contract to continue front-end family services after the end of the grant period. Project impact exceeded the expectations of the original RKCP team and the efforts of intensive front-end family finding are now an integral part of best practice in the Illinois child welfare system.

In March of 2014, SB 3283 (P.A. 98-0846) was passed unanimously into law expanding the definition of relative to include fictive kin. The bill was signed August 1, 2014 and went into effect on June 1, 2015. This new law set a course in motion of integrating the project's findings into policy. Family Finding protocols and procedures were imbedded in Illinois state Policy 301.80 Relative Home Placements and later in Policy 315 Permanency Planning. The project influenced the development of three new mandatory forms: (1) CFS-151H – Notice to Relatives now in compliance with the Fostering Connections to Success and Increasing Adoptions Act of 2008; (2) CFS-458 A – Statement of Relationship; and (3) CFS 458-B – Relative Resources and Positive Supports Worksheet. The Levels of Support Assessment tool, the composition of a genogram and a child directed Ecomap at case opening were integrated into Illinois state policy as well.

In addition, HB 2543 (P.A. 99-0340) amended the Children and Family Services Act requiring IDCFS to notify all adult relatives within 30 days of temporary custody that a child is involved in the child welfare system. This bill was signed on August 11, 2015 and goes into effect January 1, 2016. Early notification to relatives is now a formalized procedure in Illinois.

Major changes were incorporated into Illinois' SACWIS program. A Family Finding tab was included as an option for case note documentation. The aforementioned documents are located on SACWIS and are not part of the child and family's permanent electronic file. Family members entered into the system are now recognized as collateral contacts for future concurrent planning needs if necessary.

The influential changes made by the project were rolled out in a statewide training in June 2015 entitled "Fictive Kin as an Option for Placement and Permanency." A subsequent training will be rolled out statewide in February of 2016 entitled "P315: Permanency for All." The statewide dissemination of information has contributed to a shift in thinking when considering relatives and fictive kin as positive resources.

Our evaluation of the RKCP for Cook County employed a quasi-experimental design, with an intervention group (n=196) and a control group (n=262). These groups were derived by assigning cases at the Concourse level of the Cook County Juvenile Court to the intervention and the Ground level to the control group in Year 1, switching them in Year 2, and alternating them in six month intervals in Year 3. For the Will County evaluation, since all children were served, we created a comparison group of children who were served in the preceding 18 months leading to when the RKCP began delivering services. Information regarding children's placement and permanency outcomes were derived from Illinois DCFS placement and payment data; information regarding kin and fictive kin identification and engagement were derived from file reviews and worker interviews; information regarding well-being outcomes was derived from longitudinal foster parent and child surveys collected during home visits.

Our research questions can be broadly grouped into three outcome categories: 1) placement and permanency outcomes; 2) family identification and engagement outcomes; and 3) well-being outcomes. In terms of placement outcomes, RKCP services identified more alternative placements, more relative placements, and more relative placements as a proportion of total placements. RKCP services were associated with a longer time to placement disruption for Will cases only. In terms of permanency outcomes, RKCP services are associated with better Concurrent Planning. RKCP services

had their biggest impact on family identification and engagement outcomes. RKCP services identified more overall kin/fictive kin, more involvement among the kin/fictive kin identified, and more positive attachment figures in families. RKCP services were not associated with long-term well-being outcome differences (e.g., behavior problems, self-esteem, and family connectedness). Further, RKCP services were not associated with number of placement disruptions, time to placement disruption (Cook County), time in care, or likelihood of a return home disposition.

It appears that RKCP services have a larger impact on more proximal indices that are a direct output of service, such as number kin/fictive kin identified. However, RKCP services had less of an impact on more “downstream” and distal outcomes such as well-being and time in care. These outcomes are often the result of a more myriad set of influences than can be affected by a short-term intervention such as those delivered by the Recruitment and Kin Connections Project. As family finding and engagement services and practice guidelines become more integrated into child welfare practice, it will be critical to determine if longer-term outcome differences (e.g., well-being outcomes) are found.

However, for now, family finding and engagement services such as those offered here reveal that casework as usual is leaving almost 30% of kin/fictive kin in a family unknown to the system. Further, identifying more kin/fictive kin makes it more likely that children will remain in kinship placements as their number of placements increases.

There were several challenges and identified barriers during the grant start up in Year 2 that the program and evaluation team encountered. Dr. Leon and the evaluation team encountered an unexpected barrier with acquiring consent for the children to participate in the well-being pencil and paper surveys. The Guardian’s office stated that even though Dr. Leon followed all the proper steps for the Institutional Review Board (IRB) it was overlooked that the children were at a temporary custody status and the Guardian could only consent to medical treatment. This issue was resolved with the assistance of Steering Committee members; however, it did cause a delay in the collection of well-being data. In addition, the evaluation team had a difficult time engaging Child Welfare Specialists for phone interviews. Once again, this issue was addressed at the Steering Committee meeting, and the evaluation team reported a significant increase in response to the evaluator’s questions as a result of the committee’s intervention.

Programmatically, in spite of our best marketing efforts, RKCP was viewed as a “placement program” instead of a family finding program that strives to build a life-long supportive network for our

new-to-care children. Placement stability was a key component as well as identifying a placement back-up; however, it was not the only component of the project. In spite of our best efforts, child welfare collaterals did not readily embrace increased family involvement. Identified barriers in Year 2 were as follows:

- Some case managers discouraged the Kin Connection Specialist from locating/involving birth fathers.
- Some attorneys discouraged the Kin Connection Specialist from reaching out to birth fathers.
- There was significant feedback from some case managers that stated “it is too much work to involve grandparents, aunties, and uncles.”

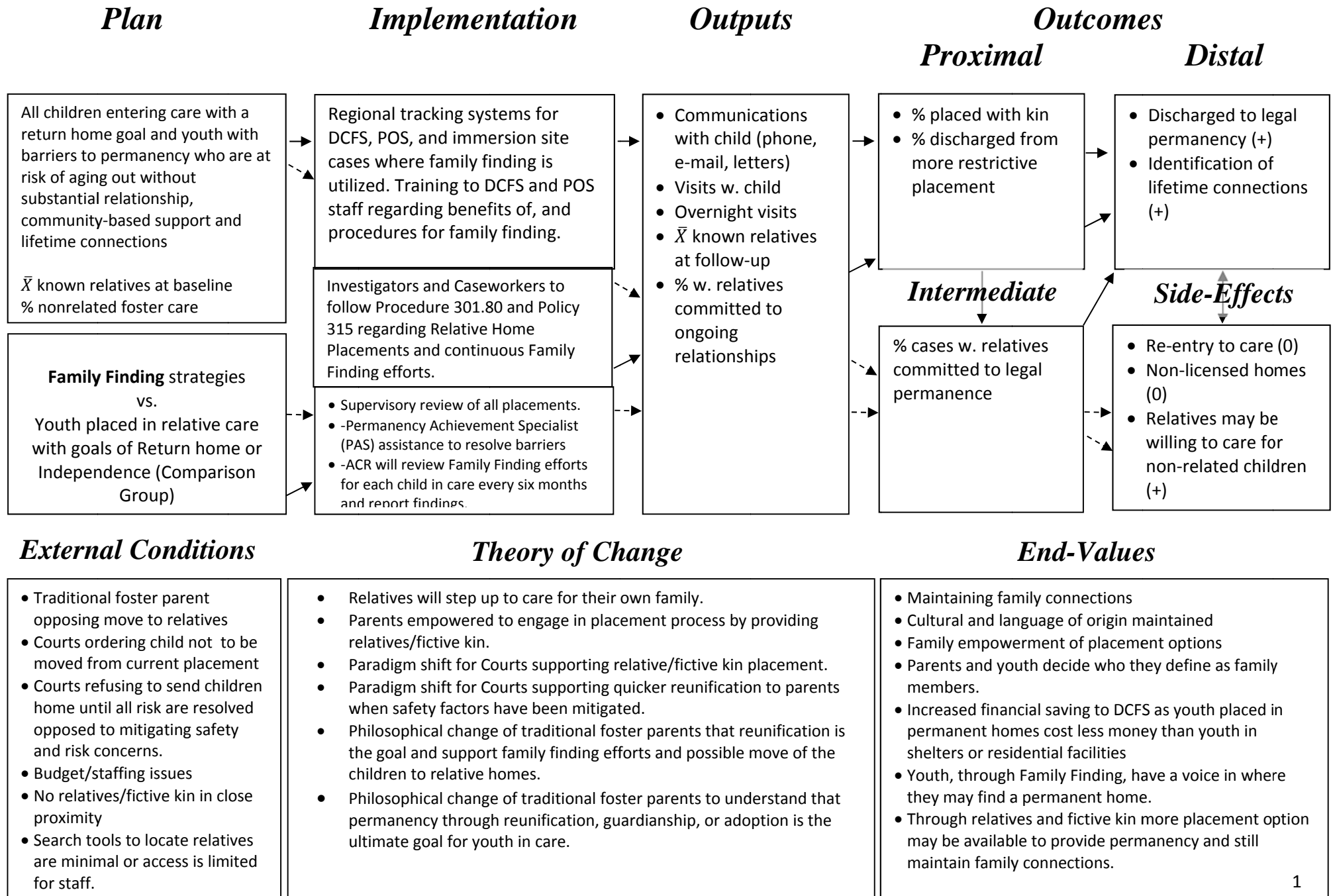
These issues were presented to members of the Steering Committee, and a plan was developed to increase buy-in from the public and private agencies. This barrier triggered several discussions that led to the revision of current IDCFS policy. The collaborative efforts of the RKCP team and the Steering Committee members addressed the barriers and impacted change in policy and procedures.

Throughout the grant, identified barriers were addressed through a collaborative approach that resulted in a positive change in legislation, policy and procedures, information systems and professional development. Continued education and dissemination of the positive results for families and the influence of intensive front-end family finding services on their lives has resulted in dispelling the earlier identified barriers. Workers in the field have started to embrace family and fictive kin resources as a means to planning and permanency. Recommendations for future implementation include early identification of barriers, early assessment of family dynamics and a redefinition of placement stability. In addition, educating Child Welfare Specialists about family systems theory is an important tool for assessment.

Too often, as long as a placement is stable, efforts to achieve permanency are stalled. Further discussion is needed that addresses the belief that a stable placement does not necessarily have the desired end result of permanency and connections. A child’s sense of time partnered with urgency and passion from the child welfare team should be the underlying driver of service planning. Keeping children connected to supportive family members needs to begin the day a child enters the child welfare system and should continue until permanency is achieved. Those supportive relationships need to be sustained throughout their lives.

EXHIBIT JJ

Family Finding Logic Model Template (Revised)



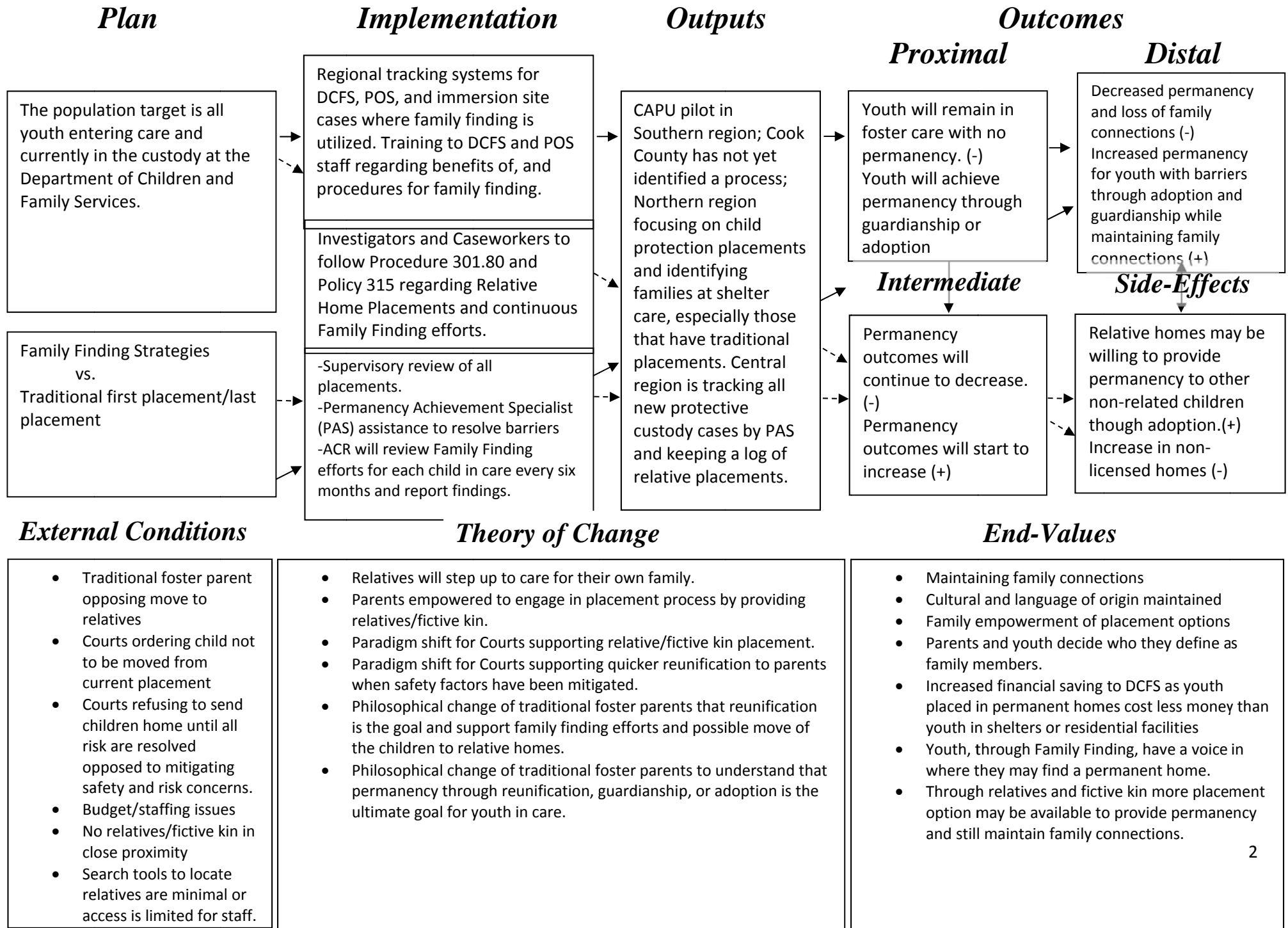
Logic Model Template (Original)

EXHIBIT KK

FAMILY FINDING FOUR-MONTH STATUS REPORT TEMPLATE

The template outlines the content of the four-month Implementation Plan Status Reports. The Sections of the Status Report should adhere to the structure of the Logic Model. Both qualitative and quantitative updates should be provided in each section on progress, results, and barriers.

I. Plan

Project the number of population units (children, families, office) that are expected to be reached by the intervention subdivided into the intervention group and comparison group(s) against which comparisons will be made. Include further demographic and clinical subdivisions of the group(s), which might moderate the intervention's impact.

The population expected to be reached will be consistent with number of youth in care beginning July 1, 2016. It will be inclusive of youth who entered substitute care regardless of the placement type with the exception of relative placement. The comparison group (those youth who would not receive family finding) would be those youth who are placed in relative placements, while maintaining that living arrangement. The youth who are case managed by DCFS and have a current living arrangement that does not fall within "relative" placement will be referred to Permanency Achievement Specialists who will complete initial family finding efforts. The results of such efforts will then be provided to the Permanency Worker for follow up or continued efforts.

The secondary group of youth who will receive Family Finding services will be those youth who are in jeopardy of aging out of substitute placement without substantial relationships, community based supports and lifetime connections. These youth will be identified as those youth who have a goal of independence regardless of their living arrangement. These youth will be referred to the

Permanency Achievement Specialist for family finding activities. The comparison group for these youth will be youth who placed in relative care with a goal of independence.

Current efforts:

Southern Region: Due to the large geographic area and shortage of Permanency Achievement Specialist (PAS) they are unable to go into the field to directly assist placement staff. PAS have been file mining for possible relatives. There have been 6 cases referred however, it is to be noted that efforts for family finding did not begin in this region until July 21.

Central Region: Central Region is also down PAS staff due to mandated details back to child protection. Since July 1 there have been 7 new referrals in the Central region. Permanency Specialist also assisted with 6 older youth exiting care. PAS staff also conducted one training to the Center for Youth and Family Services in Springfield.

Northern Region: Northern Region PAS staff has been meeting with families at the shelter care hearing or within 3 days after shelter care in order to complete the genogram and ecomaps. Northern region has also been focusing on older youth with goals of independence and youth stepping down from residential care to help ensure they are connected to family when possible and has had 19 referrals since July 1st.

Cook County: A Program Manager has not been identified and the PAS supervisor is currently detailed back to child protection. This region has not begun family finding activities.

Background

Provide a short introduction to the plan that summarizes the problem(s) the Department is attempting to address.

Successful Permanency outcomes for youth as well as maintaining connections are paramount to a child's safety, permanency and well-being. Due to less than successful permanency rates of youth in care

in Illinois, procedures 315 have been revised to include Family Finding. Family finding efforts are important as it is widely recognized that kinship care for children entering the child welfare system is often highly advantageous to both children and their families, specifically to assist in permanency for the youth. Family finding is designed to assure that the child welfare system acknowledge the critical importance of separation and loss to children's long-term protection and permanency and consistently act to decrease the subsequent impact. Family Finding is designed to identify or maintain connections whether that is formal, informal or natural supports to the family that allow the child to be connected, support permanency and aide in the well-being of the child.

II. Theory of Change

Discuss any modifications of the theory of change about why a program or intervention is proposed to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised outcomes chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions. At this time there is no need to adjust the theory of change. Additional connections will need to be made with the Courts by DCFS legal and Permanency staff in order to educate and discuss relative and fictive kin placements. The training division will also need to restructure their PRIDE training in order to help foster parents understand that the primary goal is reunification and placement with relatives as the next best option to maintaining family connections. The Family Finding model will need to be infused into the training of new foster parents.

III. Implementation Status

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

Both DCFS and POS remain understaffed throughout the State.

There is always significant staff turnover especially in the private sector. Currently training is being developed in conjunction with the office of training and professional development in partnership with the permanency achievement staff. Training on Family Finding will be provided to the private agencies. This training which is at the end of development will be provided to the private agency administrative staff as a training of trainers who will then be expected to train their staff in house. This is anticipated to be rolled out to the private agencies in October. The model of family finding will be reiterated also in the revised training for Procedure 315, with an anticipated date of late September for Training of Trainers. Ongoing training to capture newly hired staff will need to occur to ensure staff is familiar with Family Finding. Regional data systems are still in the developmental stages to track Family Finding.

IV. Outputs

Discuss the extent to which intervention components were delivered as intended (outputs). Describe the numbers and proportion of the target population that received the intended intervention content (reach), the amounts of intervention content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation). Also describe the unique features of the intervention, which make it distinguishable from business as usual, and the extent to which the comparison group didn't receive similar features of the intervention (differentiation).

Although there will be variance in the regional specific issues surrounding permanency, all family finding activities will be uniform within the regions. The outcome measures will be gained via data

collection to assure that the targeted population is being identified, reviewed by Permanency Achievement Specialist as well as documentation of efforts or success. The idea of family finding is not new to DCFS however the steps and mandated efforts to not only seek relative placement options for youth but also to seek family who can provide supports in general is emphasized in this model. A family member prior to this change in Procedures 315 may have been identified but not in a position to provide placement to the youth. However in the new model of family finding they would be able to provide visitation, phone calls, involvement of family milestones, and or support to the family in an effort to aide in permanency.

V. Proximal Outcomes

Use the table provided below to report progress in attaining the proximal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the “Significance and Explanation of Difference,” briefly describe whether the differences are trending in the expected direction.

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
% placed with kin			
% discharged from more restrictive placement			

Data reports have been requested for all youth entering substitute care since July 1, 2016. The parameters of this data will also include youth with a Return Home goal who were not initially placed in living arrangements with relatives to be identified by HMP (Home of Parent) HFK (Home of Fictive Kin) and HMP (Home of Parent). Additionally youth with a goal of Independence who are not placed in relative care will also be identified. The report will further identify youth who are

case managed by DCFS versus POS (Purchase of Service agencies). Regional breakdown of the youth entering care will also be included on in the report. The creation and dissemination of these reports will assure accurate identification of youth who will be referred to Permanency Achievement specialist for Family Finding activities.

Currently Permanency Achievement specialists are notified by child protection field staff of the protective custody (new referral) or by other entities for older youth (existing cases). The weekly reports will help reconcile data and referrals for maximum outcomes for youth towards permanency.

Below are the parameters in which data will be collected for youth served with Family Finding Efforts:

Number of youth entering substitute placement (unknown at this time)

Number of youth placed in relative placement at time of initial placement with a Return home goal (unknown at this time)

Number of youth placed in relative care with a goal of independence (unknown at this time)

Number of youth placed in non-relative placement with a goal of return home (unknown at this time)

Number of youth placed in non-relative placement with goal of independence (unknown at this time)

Currently the number of youth referred for Family Finding per Region

Central Region 7 new referrals and 6 existing cases (older youth

Northern Region 19 new referral

Southern Region 6 new referrals

Cook Region 0-currently no supervisor

VI. Distal Outcomes (if applicable to the reporting period)

Use the table provided below to report progress in attaining the distal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the "Explanation of Status," briefly describe whether the differences in the long-term outcomes, which were intended to result from the

intervention, are in alignment with expectations.

<i>Distal Outcome</i> <i>(per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Discharged to legal permanency (+)			
Feelings of belonging (+)			
Academic Achievement (+)			

VII. Other Consequences

Describe any unexpected issues or concerns that impacted either positively or negatively (ex. leadership or organizational changes, exogenous factors beyond the agency's control) the Department's ability to implement or evaluate the plan.

The Family Finding model which is part of Procedures 315 is currently in its infancy and there is very little data to support the Outcomes either Proximal or Distal. In review of the data that has been gathered by the four separate regions, it appears that there will need to be revisions made to the data collection by the regions for consistency of information and to reflect outcomes that are included in the logic model. Additionally there need to be several reports sent to the program managers of the regions to assure they have accurate data on incoming youth in care and to assure that they are receiving the appropriate number of referrals. These reports will reflect number of youth in relative care (comparison group*) and those who are not placed in relative care (family finding).

There will also be a report of youth who currently have a goal of independence who are not in relative placement. The comparison group for these youth will be those youth who have a goal of independence but are placed in relative placement.

The inclusion of these reports will assist in assuring reconciliation of data as well as to assure appropriate referrals to permanency achievement specialist.

*Relatives are considered Home of Parent (HMP), Home of Relative (HMR), and Fictive Kin (HFK).

VIII. Plan Revisions

Describe what the Department learned from the results, successes, and challenges of the reporting period and what changes (programmatic, evaluative or organizational) will be made based on these lessons.

Since review and revisions of the Logic model for family finding were made, there will also need to be revisions to the tracking tools to assure that the measurable outcomes are captured. Two additional items will be added: has the youth been placed in a relative home (formal supports) and or secured family connections (informal/natural supports).

Additional items to review in the coming weeks include the use of the Ansel Casey tool for readiness to independence as well as launch plans for youth that will assist in reviewing and gaining data of the youth's readiness for gaining or utilizing community based supports. At this time it is unclear if extractable data can be gained from these tools.

EXHIBIT LL

ORGANIZATIONAL STRUCTURE

FEBRUARY 16, 2016

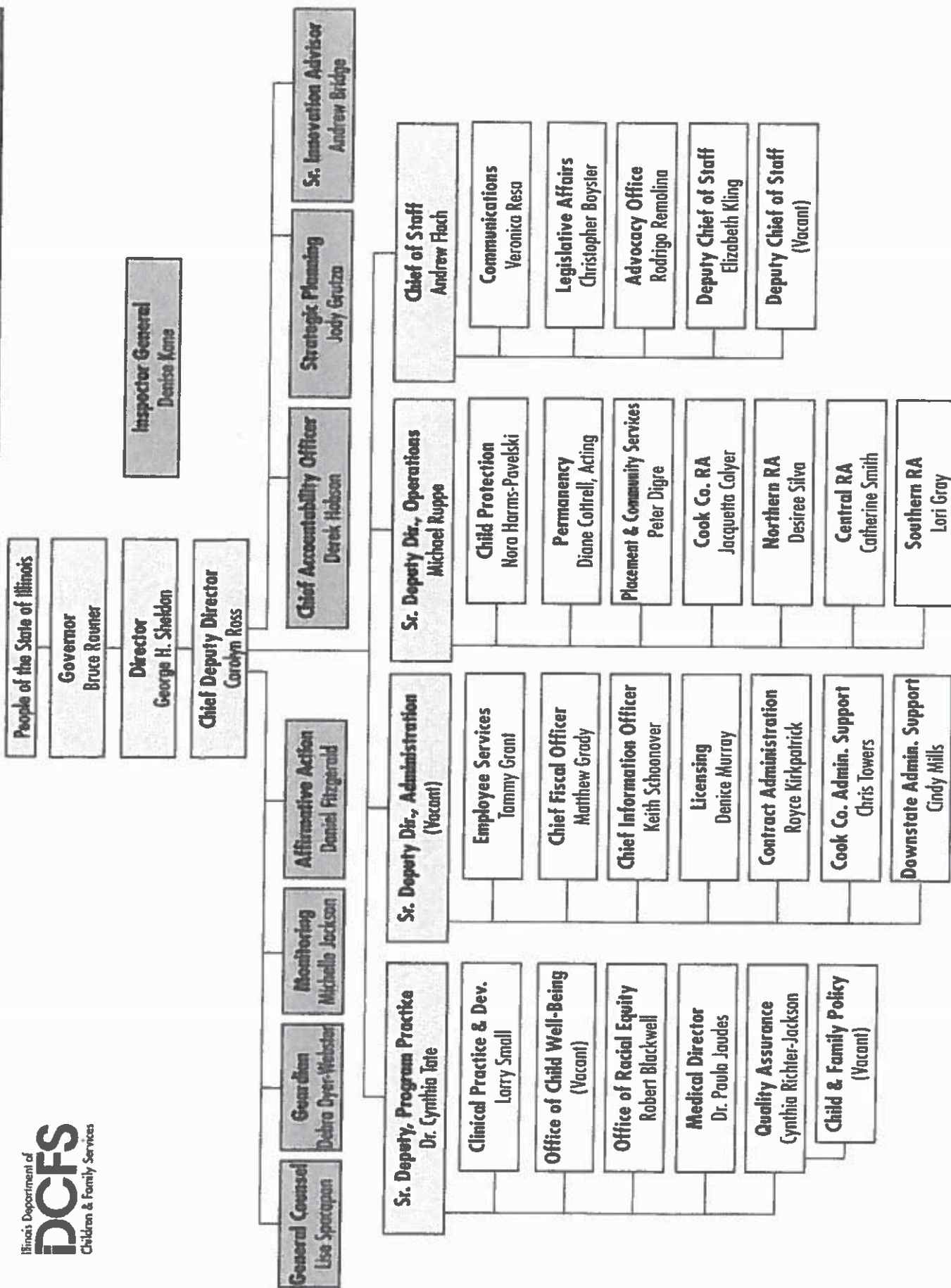


EXHIBIT MM

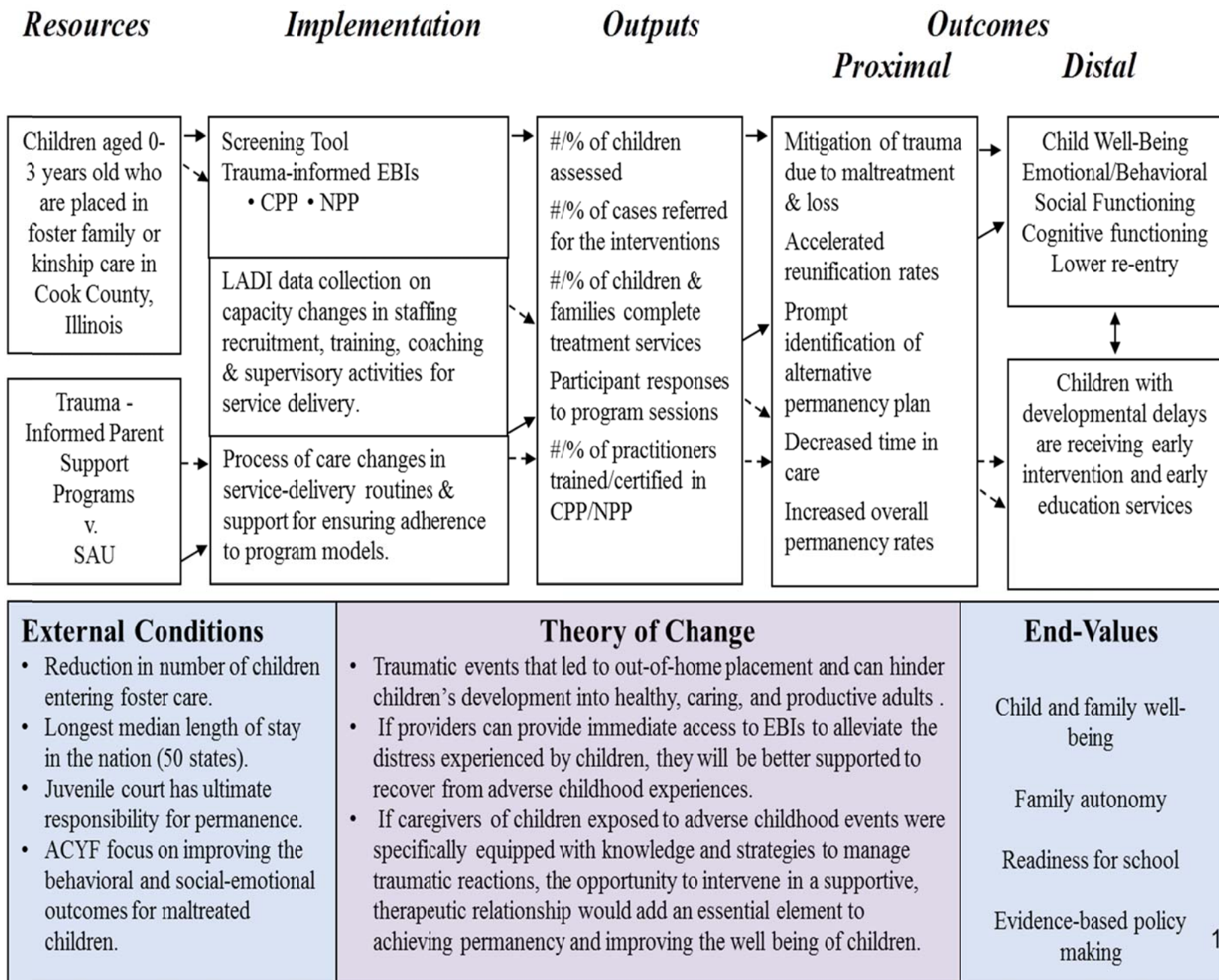


EXHIBIT NN

EXPERT'S REPORT-IB3

July, 2016



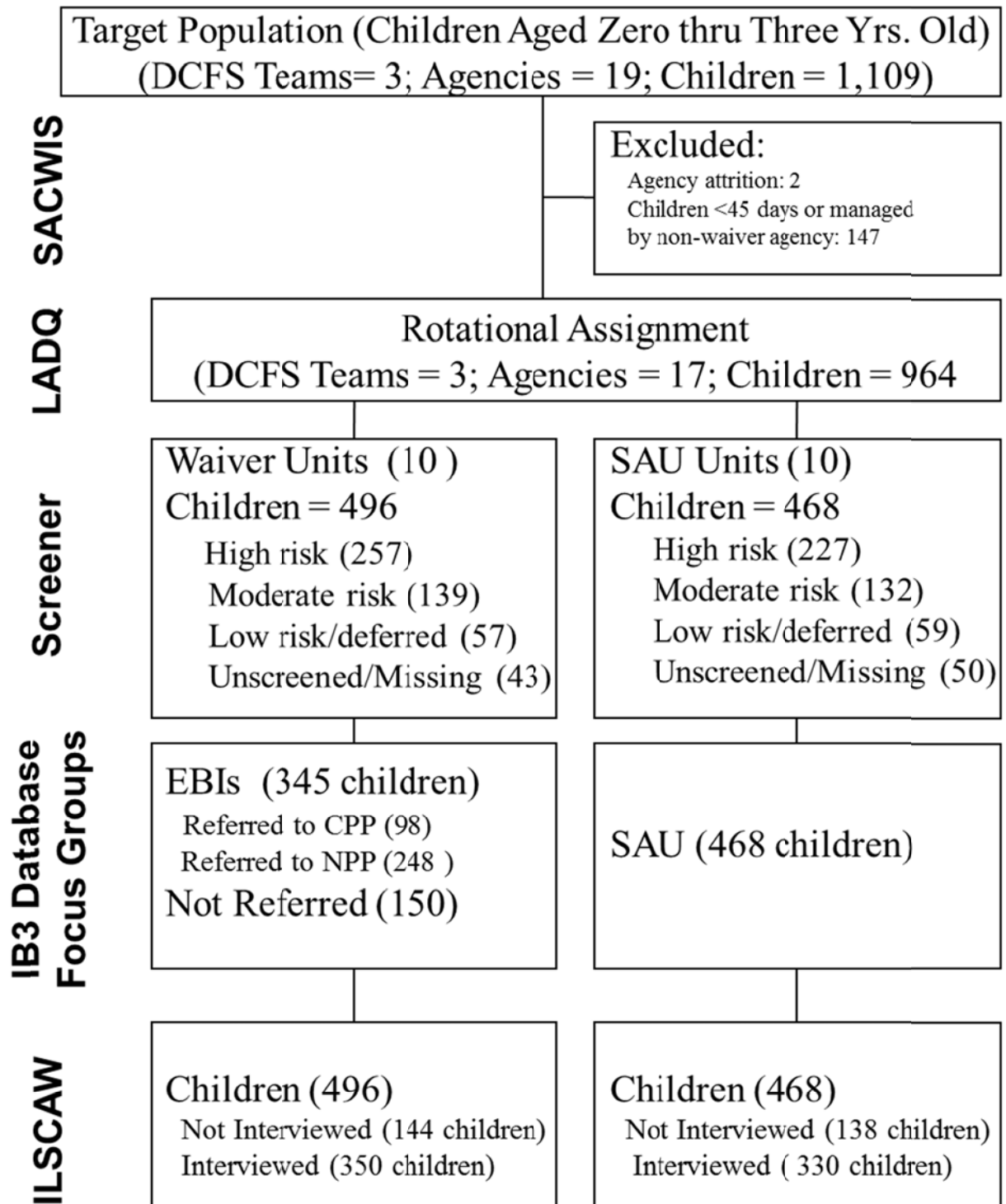
The template outlines the content of the four-month Implementation Plan Status Reports. The Sections of the Status Report should adhere to the structure of the Logic Model. Both qualitative and quantitative updates should be provided in each section on progress, results, and barriers.

I. Plan

Project the number of population units (children, families, office) that are expected to be reached by the intervention subdivided into the intervention group and comparison group(s) against which comparisons will be made. Include further demographic and clinical subdivisions of the group(s), which might moderate the intervention's impact.

Illinois's IB3 waiver demonstration targets caregivers and their children aged birth through three who newly enter out-of-home placement following implementation of the demonstration on July 1, 2103, regardless of title IV-E eligibility. Based on the average size of entry cohorts that were placed in Cook County during Federal Fiscal Years 2007-2010, it is projected that approximately 3,000 children aged birth through three in Cook County will be placed into foster care during the five-year demonstration period (see Figure 2). Rotational assignment is expected to evenly distribute these 3,000 children into the intervention services cluster (1,500) and the comparison cluster (1,500).

Following the start of the IB3 Waiver demonstration, children assigned to both intervention and control group clusters will be screened for trauma and other functional impairments. Based on prior experiences in Illinois, in the planning phase it was anticipated that 45% of the screened children will exhibit moderate to high trauma symptoms and other mental health problems. Applying this percentage to the 3,000 screened children yields approximately 1,350 children who could potentially benefit from one or both of the trauma-informed evidence based interventions (EBI) offered under the waiver demonstration-half of whom will be in the intervention group (675) and the other half in the comparison group (675).

Figure 1 Sample Sizes by Data Collection Methods

SAMPLING PLAN

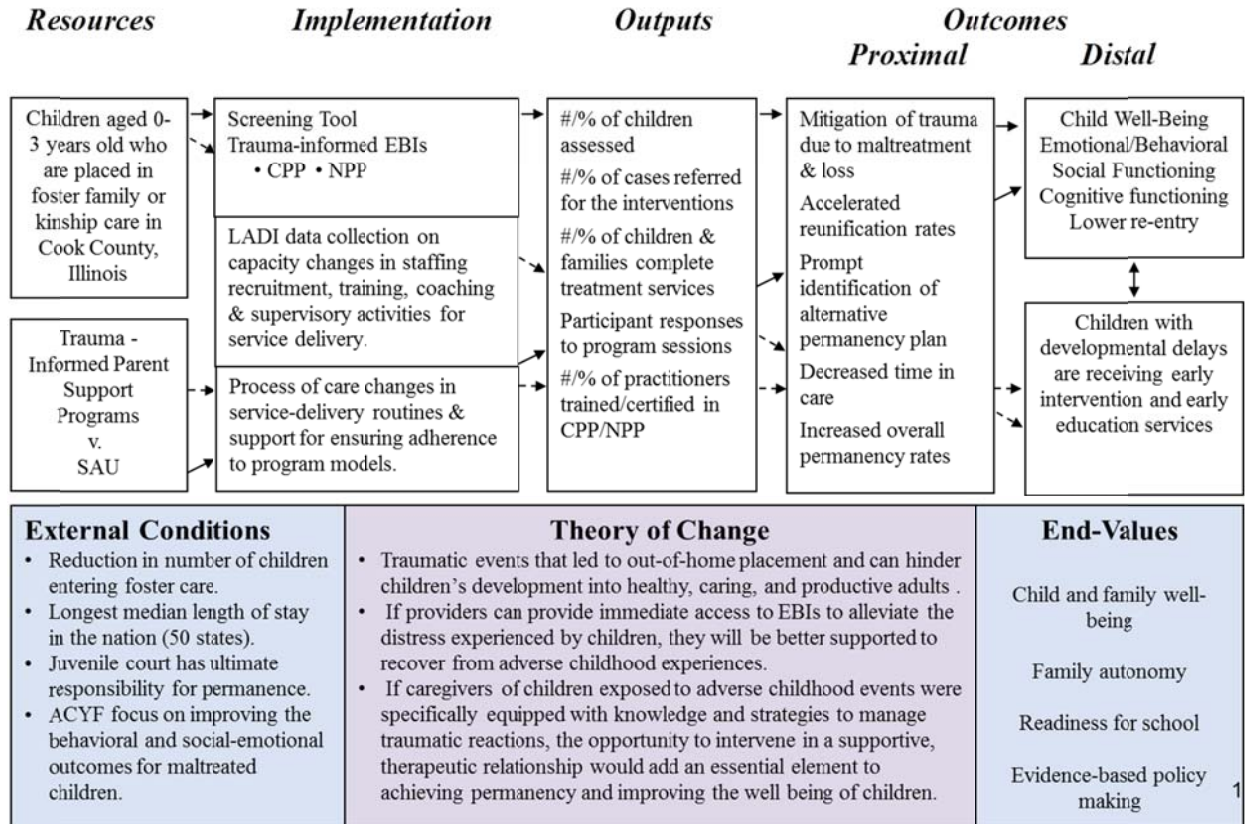
The sampling plan is designed to optimize the representativeness of the target population of foster infants and toddlers in Cook County, Illinois (external validity) and to permit valid inferences to be drawn about the impact of the intervention on safety, permanency and wellbeing outcomes (internal validity). The external validity of the samples is ensured by assigning all eligible children in Cook County to the demonstration. The sample includes infants, toddlers and preschoolers who entered foster care between July 1, 2013 and June 30, 2015 and stayed in state custody for at least 45 days. Excluded from the demonstration are children who were discharged prior to 45 days or were assigned to agencies that were not allocated to the intervention or comparison agency clusters. Illinois estimates that rotational assignment will distribute 1,560 children into the intervention group and 1,040 into the control group over the duration of the demonstration.

The PICO Question

The targeting of infant, toddlers and preschoolers together with the selection of two evidence-based interventions and focus on the improvement of permanence and wellbeing led to the following research question that can be answered through rigorous evaluation:

<p>P - Target POPULATION about which you wish to draw inferences</p> <p>I - INTERVENTION to be evaluated</p> <p>C - COMPARISON to the intervention</p> <p>O - Expected primary and secondary OUTCOMES to be achieved</p>	<p>Will Illinois children aged birth through three years old, who are placed in foster care in Cook County, (P) experience reduced trauma symptoms, increased permanence, reduced re-entry, and improved child well-being (O) if they are provided CPP or NPP programs (I) compared to similar children who are provided IV-E services as usual (C)?</p> <p>Logic Model</p> <p>The IB3 demonstration background and context, theory of change, target population, interventions, outcomes, and allocation method for approximating the comparison (counterfactual) treatment for evaluation and cost-neutrality calculations are summarized in the logic model depicted below.</p>
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The logic model depicted below overlays on top of the PICO question the hypothesized mediating casual pathways that link populations (**P**), interventions (**I**), and comparison (**C**) services as usual (SAU) to the services, procedures, and outputs that impact the proximal and distal outcomes (**O**). Immediately below the causal model are placeholders for the description of the problems, historical background, and policy context examined during the Identify & Explore phase. These external conditions are not under the direct control of change agents, but nonetheless influence the implementation of programs and constrain their capacity to achieve the desired outcomes. Next are the theory of change and relational assumptions that are posited to effectuate the desired changes. Finally there are the general end values for reconciling diverse outcomes for evaluating the ultimate worth of the change.



II. Background

Provide a short introduction to the plan that summarizes the problem(s) the Department is attempting to address.

The Child and Family Services Improvement and Innovation Act (CFSIIA) states that all applicants must demonstrate that the proposed project is designed to accomplish one or more of the following goals:

- Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth.
- Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth.
- Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.

Even though a waiver demonstration may touch on some or all of these objectives, it is good practice to identify one of the goals as the primary outcome the agency wishes to attain and to consider the others as secondary outcomes. In selecting a primary outcome, it is best to identify those areas that exhibit the greatest potential for improvement. This can be done by comparing where Illinois ranks nationally on a variety of outcome indicators.

Out-of-home placement rates:

Nationally Illinois ranks 27th highest among all States and the jurisdictions of the District of Columbia and Puerto Rico. At 5.7 foster children per 1000 children under 18 years old, there appears to be some room for improving Illinois' standing on this measure. Currently Georgia registers the lowest out-of-home placement rate at 2.7 per 1000 children. This is below the 3.0 per 1000 goal that Casey Family Program has set for the nation as a whole by year 2020.

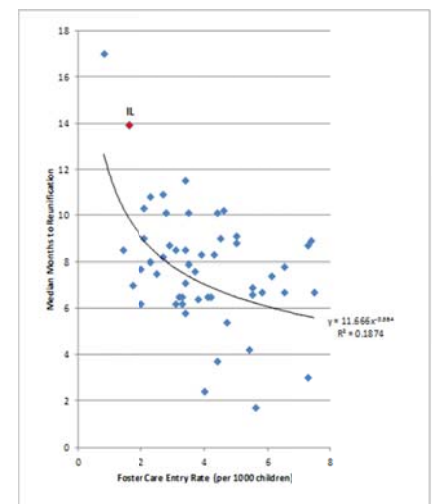
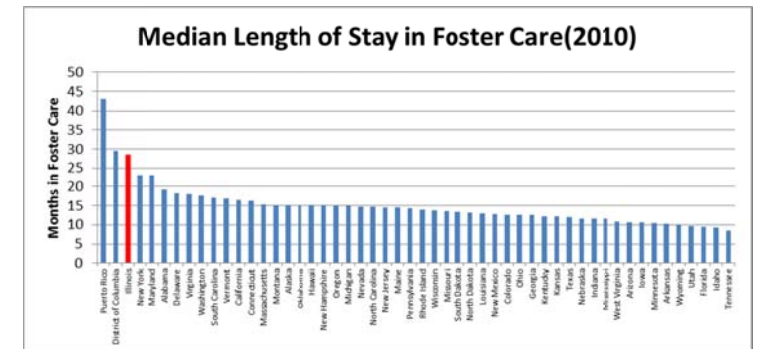
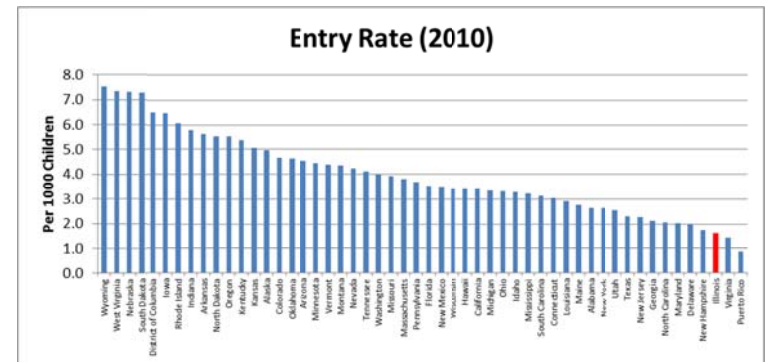
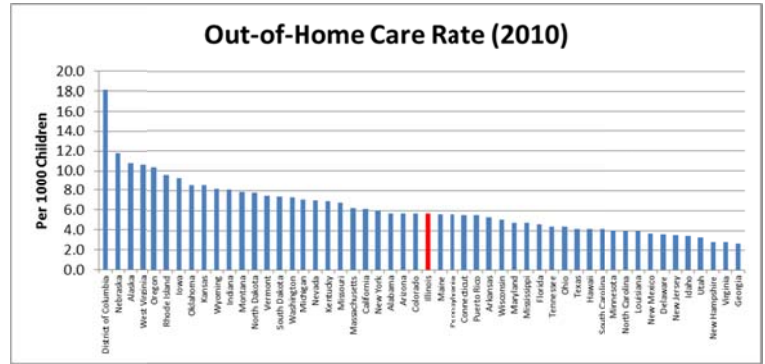
Entry Rate: The reason for Illinois' middle-of-the-pack standing on out-of-home rates doesn't appear to arise from where it ranks on children's entering foster care. At 1.6 removals per 1000 children, Illinois is third lowest in the nation and well below Georgia's rate of 2.1 per 1000.

Time in Foster Care: The factor that appears to contribute the most to Illinois' ranking on out-of-home care is the much longer time children spend in foster care. Illinois ranks 3rd highest in the nation at 28.6 months—the longest median length of stay of any State in the nation. This longer length of stay is related to the fewer number of children Illinois brings into care. The lower the

entry rate, the more challenging and the less easy are cases to reunify. This is borne out by the chart below that illustrates the correlation between low entry rates and longer times to reunification.

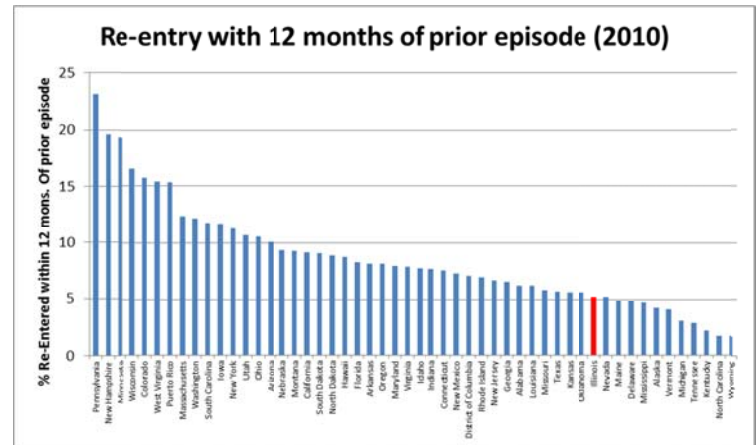
Correlation between Entry Rate and Time to Reunification:

The best fitting regression curve indicates that the median times to reunification tend to fall the more children are taken into care per 1000 children in the population. The challenges that States like Illinois face, which turned the corner on high removal rates in the mid-1990s, is how best to deal with the underlying complexity of cases that inhibit their exiting the foster care system quickly. Of related significance is the fact that Illinois ranks 3rd highest in regards to the percentage of children who enter foster care at ages zero to three years old.



Nearly one-half (47%) of children who are placed into foster care are aged three or younger. Because these early years set the stage for all that follows, they hold the greatest danger for long-term damage and the greatest potential for successful intervention.

Re-entry Rates: Another indicator of the special needs of very young children is their higher risks than average of re-entry into foster care after they've been reunified (Wulczyn et al., 2011). Even though Illinois' overall re-entry rate among all age groups is at the lower end of the national distribution, the higher rates of re-entry among the very youngest age group indicates a need for more effective evidence-based interventions for children after they are discharged from state care back to parental custody.



This summary reinforces DCFS's selection of mitigating the trauma of maltreatment and loss among very young child victims; accelerating family reunification when advisable; quickly locating alternative permanency options when reunification is no longer possible; and providing post-reunification services to ensure that infants with developmental delays are receiving early intervention and early education services.

To address these issues, Illinois is using title IV-E funds flexibly to provide one of two evidence-based and developmentally informed interventions to targeted children and their caregivers in an effort to improve attachment, reduce trauma symptoms, prevent foster care re-entry, improve child well-being, and increase permanency for children in out-of-home placement:

1. **Child Parent Psychotherapy (CPP)** is a dyadic (caregiver and child) therapeutic intervention for children aged 0–5 who have experienced one or more traumatic events and as a result are experiencing behavior, attachment, or other mental health problems. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a means for restoring the child's sense of safety, attachment, and appropriate affect.
2. **Nurturing Parenting Program (NPP)** is a curriculum-based psycho-educational and cognitive-behavioral group intervention that seeks to modify maladaptive beliefs that contribute to abusive parenting behaviors and to enhance parents' skills in supporting attachments, nurturing, and general parenting. The state will implement a version of NPP known as the Nurturing Program for Parents and Their Infants, Toddlers and Preschoolers (NPP-PV) that is focused specifically on the biological parents of children aged 0–5. In addition, the state will use a version of the NPP designed for foster caregivers of children aged 0–5 known as the NPP-Caregiver Version (NPP-CV).

For each of the above-mentioned interventions, the selection of participating children and families is determined by an enhanced developmental screening protocol implemented

through the state's Integrated Assessment or Early Childhood Program. The enhanced screening protocol includes the Devereux Early Childhood Assessment for Infants and Toddlers, the Infant Toddler Symptom Checklist, and the Parenting Stress Inventory. These protocols supplement the screening protocols used by the state prior to the demonstration, which include the Denver II Developmental Screening tool, the Ages and Stages Questionnaire, and the Ages and Stages: Social and Emotional assessment instrument. The enhanced screening protocol is used to determine a child's level of risk for trauma symptoms (categorized as low, moderate, and high risk) and the subsequent service recommendation. Generally, high-risk cases are referred to CPP, moderate-risk and low-risk cases are referred to NPP. Based on a variety of factors, such as the mental health status of the biological parent(s) and whether or not children are currently symptomatic, certain children assessed as high risk are referred immediately to CPP and others are referred to NPP services prior to CPP.

III. Theory of Change

Discuss any modifications of the theory of change about why a program or intervention is proposed to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised outcomes chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

The IB3 Theory of Change is predicated on the assumption that improvements in parenting competencies will enhance early brain development and provide the responsive parenting environment that will allow children to be returned to parental custody, and is summarized as:

- Traumatic events that led to out-of-home placement and can hinder children's development into healthy, caring, and productive adults.
- If caregivers can provide immediate access to EBIs to alleviate the distress experienced by children, the children will be better able to recover from adverse childhood experiences.
- If caregivers of children exposed to adverse childhood events were specifically equipped with knowledge and strategies to manage traumatic reactions, the opportunity to intervene in a supportive, therapeutic relationship would add an essential element to achieving permanency and improving the well-being of children.

There are two noteworthy changes to the Logic Model that was originally proposed in the IB3 Evaluation Plan. The number and percentage of practitioners certified in EBIs replaces the number and percentage of practitioners rated as adequate on NIRN Implementation Tracker instrument. Also the central role of the Cook County juvenile court in effecting permanency plans is highlighted as an external condition that moderates the capacity of child welfare agencies to attain waiver demonstration goals.

The results of the Process Study indicate that the IB3 Demonstration achieved adequate levels of implementation integrity with respect to program coverage, differentiation, exposure, adherence, and participant responsiveness. Between July 1, 2013 and June 30, 2015, 964 children were assigned to the IB3 demonstration. Almost 90% were screened for developmental risk using enhanced screening tools. Rotational assignment resulted in a fairly balanced allocation of the assigned cases to intervention agencies (51%) and comparison agencies (49%). Even though higher than expected proportions of children screened as high risk resulted in a waiting list for intensive dyadic (parent-child) interventions, referrals to small group, Nurturing Parenting Program accommodated much of the need for services. Only 19% of high risk cases and 32% of moderate risk cases were not referred to at least one modality of IB3 intervention.

Even though rotational assignment resulted in a well-balanced allocation of children to intervention and comparison conditions according to indicators of risk and need prior to removal, differences in the local ecologies of communities served by intervention and comparison agencies and DCFS offices resulted in some systematic imbalances with respect to ethnicity, kinship care, and case management by DCFS offices. Data analysis included appropriate statistical control for these differences. Linear, logistic, and hazards regression models yielded similar sets of findings with respect to the proximal permanency outcomes of return home (including trial visits), family reunification, and legal permanence. The intervention effect, however, was confined to children initially placed in non-kinship homes under the case management of voluntary agencies. Even though children initially placed with kin demonstrated higher return home rates than children placed with non-kin, the advantage was the same regardless of whether they were assigned to intervention or comparison agencies. Further, higher return home rates among children assigned to DCFS offices in the comparison group (Cook County South region) than intervention offices (Cook County Central and North regions) resulted in a sign reversal of the intervention effect for children under DCFS case management.

Predictive margins of program exposure within the restricted sample of children placed in non-kinship home under voluntary agency case management showed an increased return home rate for cases that completed or were still attending IB3 programs compared to drop-outs, no shows, or children assigned to comparison agencies. The highest return home rate was registered among non-referred cases, which includes cases that reunified quickly before a referral could be made as well as cases rated as low risk.

IV. Implementation Status

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

The Illinois Birth through Three Demonstration [IB3] has completed year 3 of full implementation. As we end this reporting period, there are currently 1,503 children referred to the demonstration and there is an even distribution of those cases across intervention and comparison agencies. The assessment processes and the associated algorithm for determining risk resulting from trauma exposure is one of the most substantial innovations of the demonstration.

Each of the IB3 interventions report substantial progress at the close of the year. The team involved in the Nurturing Parenting Program for foster caregivers [NPP-CV] has undertaken extraordinary measures to address engagement challenges which have been detailed in previous reports. These include orientation sessions involving program alumni as well as home outreach, and monthly calls to families with high risk IB3 children. The CV program increased utilization by 42%! We end the year with 33 foster parents completing the program. While this number is still low, the engagement efforts that were required to secure this census reflects the overall need to align the organization to support the expectations for foster parent involvement and to address the barriers that they face. We have been working to partner on daycare supports [a primary barrier] for foster parents and plan to implement this in FY '17.

The retention rate for NPP-PV for our birth parents improved from FY '15. Rates were comparable across the 2 providers [44 & 47%] in FY '15. The final data for FY '16 reflects rates of 61 and 49%. Of those that complete, close to 30% [29%-actual] were fathers reflecting our ongoing commitment to the role of fathers. NPP-PV continues to serve predominately high risk families [55%] as is true for CV.

The CPP report for the end of the fiscal year indicated 55 families are engaged in the intake process or actively engaged across the 5 providers. This data reflects tremendous progress given we ended last fiscal year with a capacity of 47 and only 23 active cases. 17 referrals were made in the month of June, 2016 which reflects the transition by the agencies to new contract models and bringing on new clinicians.

Contracts: This report will detail substantial progress in addressing threats to the implementation process. Insufficient staffing and contract models that were not viable for the provider agencies have been addressed thanks to the commitment by the DCFS administration to fully support and fund the demonstration. Negotiations with Budget and Finance resulted in substantial changes to the contracts for both interventions. We end the year with increased capacity for both IB3 interventions. We also end the year with searches underway for additional staff for IB3. The positions will enhance our capacity for implementation support, data entry and assessments.

The report will detail considerable progress in Continuous Quality Improvement the resulting from the enhanced availability of client data through the IB3 database. The partnerships between program staff and evaluation staff have resulted in more robust and valid data. We are already seeing the benefits of providing data to foster care agencies within the intervention group as well as the IB3 providers of CPP and NPP.

Field Support: Demonstrations require implementation support to achieve the organization change that the demonstration seeks to accomplish. As we end the first full year of implementation support we are pleased with the efforts of the team to gain access and engage the placement agencies. Their work has been embraced and their monthly meetings have become a part of program operations in some sites. The efforts have been largely [although not exclusively] targeted to foster care staff. There will be an enhanced focus on licensing staff in the coming year. The team involved in implementation support met their goals for the year for agency engagement.

Communications: The IB3 video revision was completed during this period. The updated video can be found at: https://www.youtube.com/watch?v=laAG0fwb_Pk.

We are pleased to report significant progress in communicating program and evaluation findings to national audiences. The training section of the report will detail a recent webinar conducted for the National Child Welfare Workforce Institute on Thursday 6/9/16 by Drs. Tate and Mann. There are also plans to present aspects of the IB3 assessment processes as well as the benefits of program and evaluation partnerships at Zero to Three and NCCAN during the fall. In each presentation, IB3 strives to normalize implementation challenges in order to support program design and development efforts utilizing EBIs within child welfare settings.

Overall, IB3 is pleased to report a successful 3rd year. The experience of the past 3 years provides the leadership team with clear direction to enhance our outcomes for year 4. We feel we have the resources that are needed to accomplish our goals. Perhaps most important to our success, we have deepened our commitment and collaboration with our partner agencies who share our goals.

V. Outputs

Discuss the extent to which intervention components were delivered as intended (outputs). Describe the numbers and proportion of the target population that received the intended intervention content (reach), the amounts of intervention content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation). Also describe the unique features of the intervention, which make it distinguishable from business as usual, and the extent to which the comparison group didn't receive similar features of the intervention (differentiation).

As detailed in the IB3 Logic Model, the primary project outputs include:

- #/% of children assessed
- #/% of cases referred for the interventions
- #/% of children & families complete treatment services
- Participant responses to program sessions
- #/% of practitioners trained/certified in CPP/NPP

Children assessed: As indicated in the Logic Model, a key component of the waiver demonstration is the Department's use of enhanced developmental screening tools at case intake to classify children into high, moderate, and low risk groups. Of the 964 children assigned to the IB3 demonstration during state fiscal years 2014 and 2015, over 90% of assigned children (N = 879) were assessed for trauma and other functional impairments as of December 31, 2015 (see Table 6). The remaining 9% (N = 85) were coded as unassessed for a variety of reasons, including a delay in data entry as well as the transfer of case management responsibilities outside of the Cook County service area before screening could commence.

Number and Percentage of Children Assessed

Fiscal Year		Unassessed (A)	Assessed (B)	Total (C)
FY14	Count	29	439	468
	Row%	6%	94%	100%
FY15	Count	56	440	496
	Row%	11%	89%	100%
TOTAL	Count	85	879	964
	Row%	9%	91%	100%

Usability testing of the risk assessment algorithm during the Develop and Test phase of initial implementation and formative evaluation helped to spot early problems and correct them before the demonstration moved into the Compare and Learn phase of full implementation and summative evaluation (Akin, Bryson, Testa, Blase, McDonald & Melz, 2013). The determination was made during usability testing that children who lacked recorded assessments were missing at random due primarily to delays in data entry. As these completed assessments were entered into the database, the distribution of cases among risk categories stayed relatively constant. This suggests that ignoring the remaining 85 missing assessments and another 8 cases, which were coded as screened but no risk assessment was recorded in the IB3 database, won't seriously bias the analysis of program coverage.

Cases referred: The table below shows remarkably good balance for the 871 cases with known risk determinations (chi square = 1.25, 3 *df*, $p < .741$). The worry that was expressed in prior reports that an awareness of assignment group may be inflating the risk scores of children assigned to the intervention group is no longer a source of concern with the larger sample. Another issue examined during usability testing and formative evaluation was the much higher than expected proportion of children rated at high to moderate risk. Originally it was anticipated that the combined proportions of high to moderate risk children would be less than 50 percent of all children screened. Table 7 shows that the combined proportions of children in the moderate to high risk categories total 87%. This larger than expected combined rating was driven largely by the documentation of trauma exposure and symptomology as obtained through Integrated Assessment and the use of the Child and Adolescent Needs and Strengths (CANS). The larger than expected rating does not pose a particular threat to the validity of the evaluation because the need is distributed equally between the two assignment groups. However, it has posed a problem for implementation integrity because a smaller than desired fraction of high risk cases were able to be served within the allotted waiver resources.

Referrals to CPP Program for Intervention Children Assessed as High Risk

Quarter of Case Opening		Referred to CPP				Not Referred to CPP
		CPP Only	NPP-PV & CPP	NPP-CV & CPP	NPP-PV, NPP-CV & CPP	
Q3-2013	Count	12	1	3	2	10
	Row%	43%	4%	11%	7%	36%
Q4-2013	Count	13	2	1	0	9
	Row%	52%	8%	4%	0%	36%
Q1-2014	Count	1	7	0	2	16
	Row%	4%	27%	0%	8%	62%
Q2-2014	Count	2	9	3	1	33
	Row%	4%	19%	6%	2%	69%
Q3-2014	Count	1	3	0	2	44
	Row%	2%	6%	0%	4%	88%
Q4-2014	Count	0	0	1	1	29
	Row%	0%	0%	3%	3%	94%
Q1-2015	Count	0	0	0	0	29
	Row%	0%	0%	0%	0%	100%
Q2-2015	Count	0	0	0	0	20
	Row%	0%	0%	0%	0%	100%
TOTAL	Count	29	22	8	8	190
	Row%	11%	9%	3%	3%	74%

Children and families who completed treatment: Referral to a program does not guarantee that participants receive the full dosage of services as intended. As shown in Table 10, 40% to 50% of referrals to the CPP and NPP-PV programs did not complete the full course of treatment. On the other hand, a majority of referrals did complete treatment or were still attending the program. Particularly noteworthy is the fact that completion rates were highest for birth parents enrolled in NPP-PV. The lowest completion rates were registered among caregivers who were referred to the NPP-CV program. Only one-fifth of NPP-PV referrals completed the program as intended.

Program Completion Status by Program Type and Risk Level

Program Type	Completion Status		Risk Level		Total
			High	Moderate	
CPP	Completed or Attending	Count	32	8	40
		Col.%	48%	67%	51%
	Non-Completion	Count	35	4	39
		Col.%	52%	33%	49%
	TOTAL	Count	67	12	79
		Col.%	100%	100%	100%
NPP-PV	Completed or Attending	Count	70	30	100
		Col.%	57%	54%	56%
	Non-Completion	Count	53	26	79
		Col.%	43%	46%	44%
	TOTAL	Count	123	56	179
		Col.%	100%	100%	100%
NPP-CV	Completed or Attending	Count	30	12	42
		Col.%	23%	19%	22%
	Non-Completion	Count	101	52	153
		Col.%	77%	81%	78%
	TOTAL	Count	131	64	195
		Col.%	100%	100%	100%

Participant responses to sessions: In order to assess participant responsiveness to the IB3 demonstration, researchers at Chapin Hall at the University of Chicago conducted focus groups and interviews with selected professional staff and individual parents and foster caregivers who were referred to IB3 services. The focus groups were conducted separately with the following staff: IB3 continuous quality improvement (CQI) team, intervention agency caseworkers, legal representatives, Integrated Assessment (IA) screeners, CPP providers and NPP providers.

Parents and foster parent interviews were conducted to collect detailed information on the individual experiences of subjects referred to the IB3 programs. Interviews were conducted with parents and foster parents who were identified as eligible for IB3 services. The interviews included both engaged and non-engaged subjects. For purposes of the study, non-engaged subjects were defined as those parents and foster caregivers who were assigned to the intervention group but had not completed IB3 services and were not actively participating in IB3 services at the time of the interview recruitment. A brief summary of key findings is as follows:

- Core IB3 program services are being very well-received *when* parents and foster caregivers participate in services.

- Logistics and communication are the primary barriers regarding engagement and participation of both parents and foster caregivers in IB3 services.
- Program communication is the primary issue affecting staff (caseworkers mainly) perceptions of the program and its interventions. The CQI team identified caseworkers to be the most important in terms of communication and creating buy-in amongst the parents/foster parents. However, feedback from caseworkers suggests they knew the least about the services/interventions.
- The CPP waitlist was identified across most focus groups as an issue and cause for concern.
- Interview participants expressed general frustration and fatigue with regard to IDCFS service expectations. This seems to significantly impact their follow-up with IB3 as well as other IDCFS services.

VI. Proximal Outcomes

Use the table provided below to report progress in attaining the proximal outcomes. The Outcomes listed should match those detailed in the Logic Model. In the “Significance and Explanation of Difference,” briefly describe whether the differences are trending in the expected direction.

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
Mitigation of trauma due to maltreatment and loss			
Accelerated reunification rates			
Prompt identification of alternative permanency plan			
Decreased time in care			
Increases overall permanency rates			
<i>Returned to parental custody</i>	9.7, 48	6.4%, 30	Permanency rates for the intervention group exceed the corresponding rates for the comparison group.
<i>Reunified & case closed</i>	5.6%, 28	3.8%, 18	
<i>Reunification, adoption or guardianship</i>	6.3%, 31	4.7%, 22	

VII. Distal Outcomes (if applicable to the reporting period)

Use the table provided below to report progress in attaining the distal outcomes. The Outcomes listed should match those detailed in the Logic Model. In the “Explanation of Status,” briefly describe whether the differences in the long-term outcomes, which were intended to result from the intervention, are in alignment with expectations.

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Child well-being			
Emotional / behavioral			
Social functioning			
Cognitive functioning			
Lower re-entry			

It is too early in the project to examine distal outcomes. These will be determined later in the project, and will involve results from a survey to be conducted by the Survey Research Laboratory at the University of Illinois at Chicago. The survey will be piloted in the fall of 2016, and executed starting in January, 2017.

VIII. Other Consequences

Describe any unexpected issues or concerns that impacted either positively or negatively (ex. leadership or organizational changes, exogenous factors beyond the agency's control) the Department's ability to implement or evaluate the plan.

- **Availability of program data**

Overall progress in IB3 Continuous Quality Improvement [CQI] has been significantly enhanced by the availability of program data through the IB3 database. Staff have participated in excel training with several evaluators in order to develop their technical skills in manipulating information using PIVOT tables. The partnership also allows us to validate data and identify emerging threats to data integrity. IB3 staff continues to identify and resolve minor errors in the IB3 database. While the research is very time intensive, the problems that have been identified are now much more subtle and reveal the increased capacity of our team.

For the past 3 months, we have produced monthly program summaries which are shared with the evaluation team at monthly evaluation meetings. The availability of program data has been useful for CQI in 3 areas: field support with foster care agencies, feedback to intervention agencies and for identification of questions / issues that we attempt to work through with the evaluation team.

- **Engagement of foster parents**

The IB3 Waiver team realizes the IB3 demonstration is an innovation that is asking foster parents to engage in ways that not only have they not previously been asked to do. However, the surrounding child welfare system is not sufficiently prepared to support foster parents in this area. We are very clear that this challenge calls for more systemic change and alignment in management efforts.

- **Contracting/ Resources**

IB3 engaged in considerable efforts to revise CPP contracts. As we noted previously, across the 5 provider agencies, the total yield on contract allocations for FY '15 was only 29%. This was untenable to the providers and to their boards; in fact providers have indicated that this only covered 42-48% of their costs. CPP

contracts for FY '17 will utilize an actual cost model and providers will continue to bill Medicaid. CPP agencies will be allotted 7.5 FTEs for CPP and they are scaling up to meet that capacity. The CPP capacity for FY '17 is 106 cases.

IB3 staffing will increase in FY '17. The roles of implementation support specialists will increase by 2-FTEs and the Quality Improvement Technician will add 1-FTE on the UIUC contracts. These roles will enhance our capacity for implementation support, NPP referrals and data entry. In addition to support the substantial increases in the IB3 population, there are 2-FTE screening positions and one clerical support position on the Erikson contract to support screening and assessment.

IX. Plan Revisions

Describe what the Department learned from the results, successes, and challenges of the reporting period and what changes (programmatic, evaluative or organizational) will be made based on these lessons.

IB3 is currently in Year 4 of operations. The IB3 theory of change is predicated on the assumption that improvements in parenting competencies will enhance early brain development and provide the responsive parenting environment that will allow children to be returned to parental custody. One of the mechanisms that is critical to responsive parenting is empathy with the normal developmental needs of children. This can be particularly challenging when caring for pre-verbal children who express their needs by crying or signaling through non-verbal cues. Fortunately as a species humans are innately equipped to respond appropriately, but sometimes signals get crossed. Personal trauma experiences, insecure attachments relationships in one's own childhood, and antiquated child-rearing advice that is no longer valid can interfere with the proper protection, care, and discipline of children. Both CPP and NPP are evidence-based interventions that attempt to improve caregivers' abilities to interpret, value, and respond sensitively to the normal developmental needs of children. The IB3 demonstration relies on the Adolescent and Adult Parenting Inventory (AAPI-2) to measure the degree to which such goals are being achieved.

At the end of the reporting period, 201 parents and 74 substitute caregivers had completed baseline assessments of their parenting and child rearing attitudes. Of the parents, 70% were mothers and 30% were dads. Of the caregivers, 75% were females and 25% were males. The distribution of subscale responses for both parents and caregivers indicate a generally higher level of risk compared to general population norms. Approximately 16% of the general population scores in the high risk range compared to 25% of parents and caregivers in the IB3 sample. There is one exception to the rule, however. Fewer parents and caregivers in the IB3 sample score in the high risk range (less than 10%) compared to general population norms on attitudes toward corporal punishment. Very few parents and caregivers endorse hitting, spanking, and slapping of children as appropriate ways of disciplining children.

Key process and outcome findings are summarized below and reflect information reported by the state in semi-annual progress reports submitted through January 30, 2016 and the Interim Evaluation Report was submitted in April, 2016.

Process Evaluation Findings

The results of the process study of the enhanced developmental screening process showed exceptionally good coverage of the intended target population of children. Approximately 87% of all children under age 4 years old who entered foster care in Cook County during fiscal years 2014 and 2015 were assigned to the demonstration. Of the 964 assigned children, almost 90 percent of children assigned to IB3 were screened for risk using the enhanced screening tools. Approximately 56 percent were determined to be at high risk, 31 percent were determined to be at moderate risk, and the remainder were determined to be at low risk or were deferred for further assessment. The proportion of children determined to be at high risk was greater than expected and the need for CPP has exceeded provider capacity. A waiting list for CPP services began in the third quarter of the demonstration. By fiscal year 2015, all new referrals to CPP essentially stopped due to the lengthening waiting list. The lack of CPP availability resulted in increased NPP referrals. Two-thirds of cases that were enrolled in the demonstration during 2015 were referred to either NPP-PV or NPP-CV.

- Completion rates for CPP and NPP-PV were deemed respectable, with over one-half of birth parents completing all 16 weeks of NPP-PV and one-half of CPP participants completing or still attending the 52-week CPP program. However, only 22 percent of the caregivers referred to NPP-CV completed the program. Interviews with foster caregivers identified logistical barriers, such as child care and transportation, and skepticism/disagreement about foster parents' need for parenting training as key factors hindering participation in NPP-CV.
- The LADQ was used to assess the comparability of agencies in the intervention cluster and control cluster. The LADQ was completed by 16 of the 17 agencies participating in the demonstration in February and March 2013. On balance, responses to the LADQ suggested that the two clusters of agencies are comparable on most dimensions of service delivery and agency capacity. For example, although more intervention agencies reported a loss of staff within the past 12 months at statistically significant levels due to funding reductions than control group agencies, the clusters of agencies both averaged the same annual staff turnover rate (approximately 20 percent).
- Interviews and focus groups with parents, foster parents, and service providers were conducted to assess participant responsiveness to the IB3 demonstration. Some of the key findings from these interviews and focus groups are:
 - Core IB3 program services are very well received when parents and foster caregivers participate in them.
 - Logistics and communication are the primary barriers to engagement and participation of both parents and foster caregivers in IB3 services.
 - Communication is the primary issue affecting staff (primarily caseworkers') perceptions of the program and its interventions. Feedback from caseworkers suggests that they know the least about the IB3 services/interventions compared to other providers (e.g., CQI team members, legal representatives, and NPP and CPP service providers).
 - Caregiver interview participants expressed general frustration and fatigue with regard to DCFS service expectations. This seems to significantly impact their follow-up with IB3 as well as other DCFS services.

Outcome Evaluation Findings

Rotational assignment resulted in a well-balanced allocation of children to intervention and comparison conditions according to indicators of risk and need prior to removal, differences in the local ecologies of communities served by intervention and comparison agencies and DCFS offices resulted in some systematic imbalances with respect to ethnicity, kinship care, and case management by DCFS offices.

- The examination of pre- and post-test differences in scores on the AAPI-2 for parents and caregivers who completed the NPP program (n=171) indicates there was substantial improvement in parenting competencies among program participants. There were moderate to strong improvements in four out of the five parenting and child rearing behaviors assessed, with the strongest improvements found in levels of parental empathy. However, the probability of returning home was found to be low even for children whose caregivers or parents completed the NPP program and scored as low risk at post-test: only 1 out of 10 children were returned home.
- In light of the exceptionally long lengths of stay of foster children in Cook County (less than 10% have exited state custody since the start of the demonstration), only three types of proximal permanency outcomes could be reliably compared: return home rates regardless of whether state custody was relinquished (i.e., includes trial home visits); reunification rates with case closure; and permanency rates which encompass reunification, adoption, and legal guardianships. Only the return home rate showed a marginally significant association ($p < .10$) with assignment to the intervention cluster of agencies in the expected direction of improved permanence. The other two proximal outcomes were also in the expected direction but the observed difference was not large enough to rule out chance error.
- For those children initially placed in non-kinship family settings under the case management of voluntary/non-DCFS agencies, children in the intervention group were more likely to return home than children in the control group. Children initially placed with kin had higher return home rates than children initially placed with non-kin regardless of whether they were assigned to the intervention or control group. Children in the intervention group that were placed in kinship homes that were managed by DCFS were less likely to return home than similar children in the control group. These results suggest that the effects of the IB3 interventions are not uniform across different populations and settings.
- In regard to length of placement, a graph of smoothed hazards rates showed flat levels after two years in foster care for cases assigned to comparison agencies but sharply rising rates for children assigned to intervention agencies. If this pattern continues into year three of the demonstration, it is very likely that the intervention effect on reunification rates will strengthen during this critical period of judicial oversight when decisions are made about alternative permanency plans for the children..
- The state's evaluation team has completed a preliminary analysis of the association between rates of children returning home and the types of involvement parents and caregivers have had with the IB3 interventions (i.e., whether caregivers completed/were still attending the program, dropped out, were "no shows"; or were in the control group).

Results indicate that a significant association between types of involvement with IB3 interventions and rates of return home was limited to the subgroup of children that were initially placed in non-kinship family settings under voluntary agency management. Children in this subgroup were marginally more likely to return home if caregivers had completed or were still attending an IB3 program compared to children whose caregivers had dropped-out, were no shows, or were in the control group ($p=.066$). The pattern of association between IB3 exposure and odds of returning home provide promising evidence of a positive impact of IB3 programs, at least for this subgroup of children. There may, however, be other unmeasured characteristics that are linked to both service completion and returning home (e.g., caregiver compliance) that explain the apparent association.

Cost Study Findings

The total cost of services for the IB3 intervention group from July 1, 2013 to December 31, 2015 was \$11,483,272. On a per-child basis, an average of \$18,315 was spent on the care and case management of 627 intervention cases. If these same children had been assigned to the control group, it is estimated that the cost per child would have averaged \$16,586 – the average difference of \$729 per child reflects the additional costs of providing the IB3 interventions and associated case management expenditures. Total intervention costs were lower than projected because of contractual challenges concerning CPP, with only 29 percent of the obligated funds for fiscal year 2015 invoiced by the five CPP providers.

The remaining 10 quarters of the evaluation will continue to track the progress of the children who were assigned to the IB3 intervention group. In addition to monitoring the implementation integrity of the demonstration, a major investment will be made in surveying the well-being of children in both comparison and intervention groups. In this way, we hope to capitalize on the rigor of the evaluation design and strengthen the evidence-base for what works to promote the safety, family permanence, and well-being of children during their most sensitive years of development.

Please See the Appendix for a Summary of Lessons Learned from IB3.



Appendix: Lessons Learned from IB3

Overview: The IB3 waiver is a model that interacts with all parts of the complex child welfare system. The design parallels “business as usual” and enhances those typical practices with trauma and developmentally informed assessments and interventions. Stakeholders are usually supportive of the design of the model and view it as an appropriate strategy for addressing the needs of very young children that enter the child welfare system after experiencing early adversity. Given the model interacts with so many parts of the system, many of the most significant lessons learned by IB3 involve systemic barriers and the need to continually engage in implementation supports for all parts of this complex bureaucracy.

1) Every aspect of an intervention requires implementation support:

The program structured supports for each aspect of the intervention. Supports ranged from training, ongoing meetings/ consultation and field coaching. IB3 designed supports to assist caseworkers in getting children and families into the interventions provided by the waiver. Training and ongoing consultation is available to the integrated assessment program and to clinicians providing the interventions. Strategies for ongoing support require continual reassessment and ongoing attention. For example, initial training of intervention agency staff was well attended and well received. Staff attrition in child welfare requires ongoing training and IB3 provided this through a self-directed webinar. This was not successful and IB3 returned to providing in person staff training.

While our targeted support of caseworkers was high, we provided less support to our clinical interventions beyond regular meetings. Each of the agencies that provides CPP has a consultant and 3/5 also employed a trainer of the model. Initial support included regular group meetings for peer sharing which also included the 3 trainers. At the end of year 2, two of those trainers left the employment of their agencies. Each of the 5 agencies experienced some level of staff attrition and it became clear that the project would need to sponsor consultation and training through the acquisition of a CPP trainer. Most of the challenges that are encountered will continually need to be re-evaluated.

2) The interface between casework and everything else (treatment providers, care coordination, the courts, etc....) requires attention and support:

The degree to which any agency or specific provider attempts to operate within a system of care approach is critical to successful case outcomes. Unfortunately, the system has not uniformly achieved this standard and therefore, cases can become mired in communication failures, unnecessary redundancy and failures to coordinate between service providers.

IB3 found this to be a critical challenge in the Nurturing Parenting Program {NPP} which includes a home coaching component. The prevailing wisdom of the effectiveness of home coaching over generic parent education is clear across providers. Unfortunately, if a new caseworker is not aware of this component of NPP, parent coaching referrals can inappropriately be initiated creating an unnecessary burden through service duplication for families.

Implementation support often requires a combination of communication strategies, skill development and problem solving that considers the interface of each component of the system. IB3 began to collaborate with the STEP field support program in year 2 and we hope to fully engage all IB3 intervention agencies in field support during year 3. The efforts to promote care coordination are beyond the direct scope of IB3 and yet, supporting established practices [i.e. child and family team meetings] is within the purview of STEP. Our providers of Child Parent Psychotherapy [CPP] have uniformly begun to request staffings at case opening to open communication between parties in the case and seek agreements regarding the focus of treatment. When the practice of CFTM's includes providers this action would not be initiated by treatment providers.

3. The system will resist and puts up barriers at every step and every attempt when implementing an innovative program:

There is an inherent cynicism about change efforts that stymie the most well intended/ designed programs. Staff may not question the overall merits of the intervention but they may resist the additional work or even deviations from the norm particularly if they believe this is a temporary inconvenience that will likely be abandoned with time, new leadership or yet another discovery of the next great solution to the problems that are readily acknowledged by all. Viewing resistance as normative is extremely critical for the staff that must encounter and challenge resistance. The expectation of resistance removes the blame and potential for counterproductive interactions with the parties that are pushing back against the change efforts.

- ***Reflection, support, talented staff, administrative commitment and perseverance will be required!***

The IB3 program is housed within the Office of Child Well Being which exemplifies relationship-based reflective practice. Difficult conversations regarding bias, implicit and explicit power and collaborative practices are the hallmark of the work. System change is overwhelming and collegial support is essential at every level and for all roles. Data is a powerful ally in viewing progress realistically. Ultimately we celebrate small successes and encourage one another as we conquer new obstacles.

- **Every role expectation/ requirement for all parties within program must be clearly delineated, trained, and supported:**

Innovations by definition are bringing change to systems that are designed to resist change. A key feature of IB3 is providing support for access to IB3 interventions to the intervention agencies. These supports are intended to expedite referrals, support caseworker engagement in making referrals and to maintain access with intervention providers. While all of these activities are designed to be *supportive*, in the absence of appropriate training they can be perceived as *threatening* because they encroach upon the role and responsibilities of the caseworker. Resistance is usually easily overcome with experiences with the IB3 staff.

4. The innovation will be challenged by all areas of the system that are underdeveloped i.e. foster parent support:

We provide virtually no support to foster parents, particularly kin and efforts to do so are resisted

and contradicted. Training, recruitment and monitoring functions are the primary areas of focus for our foster parents.

The focus on foster parent supports in IB3 takes on two primary innovative elements. Foster parents are the focus of an 8-week version of NPP and they are often the primary parties who begin the CPP interventions with identified children in their care. NPP is far more than a training requirement for foster parents. It offers home coaching and peer support for the challenges of fostering children with complex needs. Likewise, CPP requires full engagement in a psychodynamic therapeutic approach for the foster parent and the child. Designing these interventions runs contrary to the system's mental models for the requirements of foster parents and therefore IB3 has had to engage in a number of training, coaching and direct engagement of foster parents with less success than we hoped for.

Initial resistance is often directly from the foster parents who do not understand the expectations for participation in IB3 interventions. They report a number of barriers that will require the full support of the child welfare system. These include:

Innovations by definition are bringing change to systems that are designed to resist change.

- **Logistic barriers** associated with the requirement to support children in participating in a range of services i.e. EI, medical appointments, visits, or other counseling;
- **Life stressors:** Foster parents are families that face their own developmental family life crises (e.g. care for elder parents, medical crises, problems associated with their own children and relationships or lack of social supports).
- **Resources:** Foster parents are often limited by transportation and child care challenges that often prohibit their participation in interventions.

Foster parents are extremely grateful for supportive services once barriers can be overcome. The overall lack of supports for foster parents has limited the ability of IB3 to address needs that may emerge of the NPP groups. This is often reflected in normal family life crises that are exacerbated if a parent fears monitoring related sanctions from the system rather than supports for addressing the problem. It has also severely hampered engagement.

5. The balance between the expectations of support vs. compliance:

Implementation is not the same as executing a contract. The contract monitors with IB3 are also program administrators. Contract issues become implementation problems to be solved.

6) Utilization of evidence based interventions will require system changes in practice, technology, quality assurance and contracting:

Finance structures that deliver "units of service" tend to not deliver outcomes, provide adequate

capacity or support effective interventions. Evidence based practices yield outcomes that are tied to competencies of the model. The shift to competency-based practice requires:

- Data systems that can track unique model outcomes;
- Staff training
- Re-designing contracts to specify unique outcomes tied to models;
- Communication to the courts of new ways of viewing client progress.

7) You will need more resources than you think:

IB3 is currently seeking a trainer and consultant for CPP. This position is designed to support ongoing initial training and implementation of the model. The need for this position was not anticipated in a region where CPP trainings are frequently available and trained providers were readily available at the outset of the launch of the demonstration. By year 2, capacity issues became apparent and reached crisis level by the end of year 2.

As the program continues to grow, staffing levels for each component should also be increasing but this is not the case. In spite of the cost savings of this demonstration, to-date the program has not been able to access the savings to address identified programmatic needs.

8) Strong communications strategies are needed:

IB3 created pamphlets, a video, and took our program on the road. By the end of year one, we saw a shift from the field who often proclaimed, "IB-*what!*" to a beginning grasp of the program and its components.

EXHIBIT OO



Safe Families for Children

Fact Sheet

Call: 1-855-240-6604

Safe Families for Children (SFFC) hosts vulnerable children and creates extended family-like support for desperate families who have nowhere else to turn. Through a community of devoted volunteers motivated by compassion, children are kept in a safe and loving home with the ultimate goal of returning with their parents.

Volunteer Approval Process and Ongoing Support: Fingerprint Background check (same background check as foster parents), references, home assessment, home safety inspection, training based on Foster Pride, ongoing monthly education via webinars, and quarterly support group meetings.

Monitoring: Children are monitored in the host home consistent with foster home monitoring (e.g. after first 48 hours, weekly during the first month).

Length of Stay: Average length of stay is 45 days with ranges from 2 days to 2 years

Ages: New born infants through parenting teens. Some host families will take the parent and child.

Discharge: 90% return to parents or a relative.

Parental Mentoring: The relationship between the host family and placing parent may continue (if the parent desires this) even after the children are returned home.

How to explain Safe Families to a placing parent?

- Going to a Safe Family home does not mean the child is going to foster care.
- Parent retains rights and decision making. A parent can change his/her mind.
- Host families do not get paid for caring for the children and cover all costs.
- All host families have had background checks and home assessments.
- The host family can be considered like an aunt/uncle (extended family).
- A family coach will be available to help them get the resources they need.
- Parents certainly can visit their children and have regular phone contact.

Why a parent should consider Safe Families?

- SFFC provides parents space and time to make necessary changes.
- All host families are volunteers. They don't get paid for caring for children.
- SFFC is not involved in adoption. The intention is to return children to better supported parents.
- If parent is interested, a continued relationship with the Host family can be established after placement has ended.
- A family coach is available to help the parent get back on his/her feet. Other volunteers are available to help in areas such as mentoring, transportation, and etc.
- Parents can easily request the host family to help out again. They often will have the host family's phone number.
- DCFS investigators have stated that SFFC provides a compassionate and supportive tone to families in crisis.

Who to refer...

- A parent whose safety/risk issues can be resolved in 6 months or so.
- A parent who needs to complete drug treatment, mental health care, hospitalization, domestic violence, etc
- Children who do not have severe behavioral problems.
- Neglect, risk of harm, no fault dependency, excessive corporal punishment, etc.
- Cases where more time is needed to assess allegation but the children are better off in a safe place.
- When no relatives are available or when relatives are not the best option.

Referral Process

1. After assessing a case, the determination is made that the child needs to be in a safe place outside the home (edge of care).

2. Determine if there are other family members available or not.
3. If none are available and the case appears to be appropriate for Safe Families, you can see if the parent would be open to participating in Safe Families if they are eligible. See notes on “appropriate referrals” how to explain SF to a parent.
4. If no other options are available, contact supervisor who will go into SACWIS and click on the randomizer to see if Safe Families is an option.
5. Or... call 1-855-240-6604 and Safe Families intake will randomize it to see if it’s eligible. Safe Families will need some basic information about the case. Provide a brief description of the situation, expected length of stay, when placement is need, and any special needs (allergies, medical needs) that a host family should be made aware of. If placement is needed immediately, please inform the Intake Worker and someone will be dispatched.
6. If SF determines that the case is appropriate for services and the parent agrees, SF will begin to locate a host family.
7. While that is occurring, have the parent complete the SF intake forms. They are in your packet. You can also access them at www.safe-families.org.
8. If a parent has more questions, feel free to have them speak directly to the intake person.
9. Once a home is located, arrangements will be made to pick up the child.

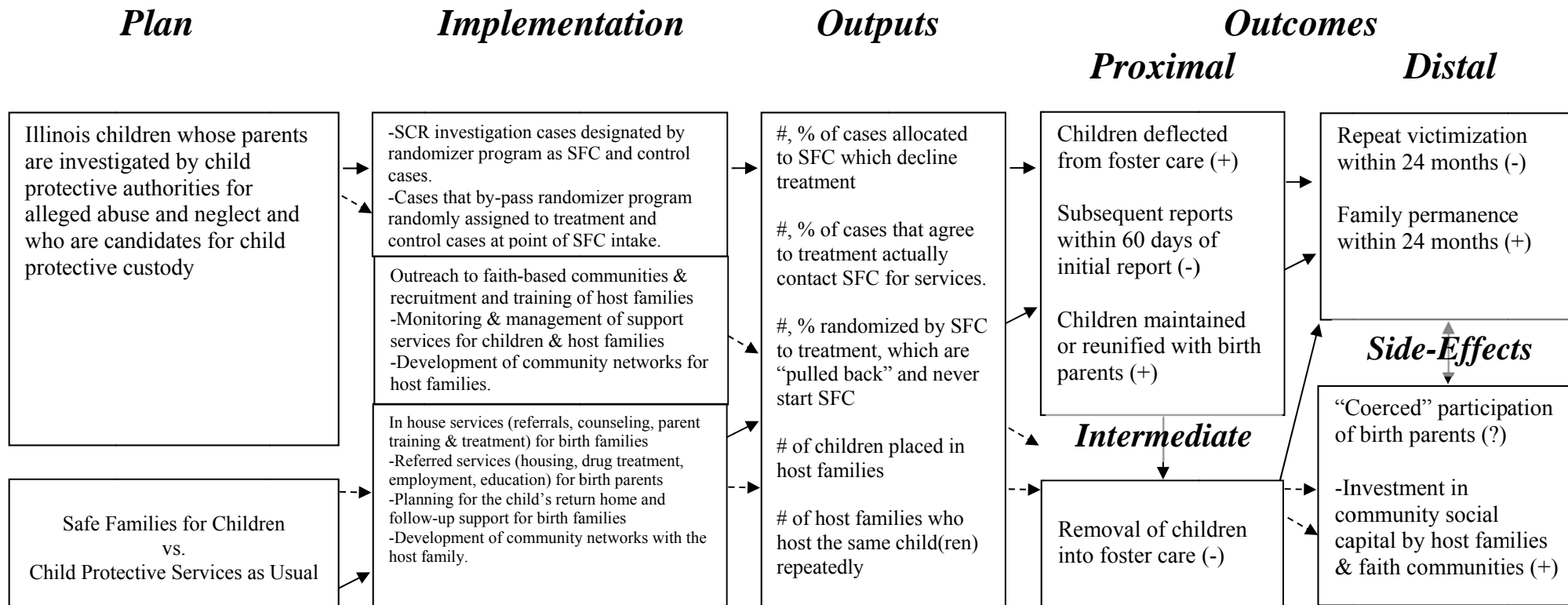
FAQs

- **Can host families take children with medical complexities?** Yes, but it depends on the skill and availability of families
- **Who will be my main contact?** A family coach assigned to the case.
- **Will siblings be kept together?** Not always. It depends on the availability of host families.
- **Can a parent stay with their children in a host family home?** Occasionally.
- **Can workers visit children in host family homes?** Yes, or meet at a central location to visit.
- **Can Safe Families respond immediately to a crisis?** Yes. Please let us know how soon a placement is needed
- **Once placed with a host family, do children ever get moved?** Yes, occasionally. If a host family cannot continue to care for a child, another family will be located. Approval from a placing parent will be sought.
- **Will school aged children be able to stay in their current school?** Not always. We always try.
- **What happens if the parent requests their children back?** The worker will be notified for direction.
- **Do all host families and parents stay in relationship after return home?** It depends on the parent’s wishes.
- **Can a parent reuse Safe families?** Yes, as many times as needed as long as it’s not being abused. The parent can call directly.
- **If a child needed to return to Safe Families, will they go to the same host home?** Yes, if they are available.
- **If DCP decides to take custody, can the child remain with a host family?** Yes, if DCFS is interested (fictive kin)

Questions?

Contact David Anderson at (773) 659-0037 or danderson@lydiahome.org, jwhitfield@safefamilies.net

EXHIBIT PP

Logic Model Template: Safe Families for Children**External Conditions****Theory of Change****End-Values**

<p>-Lengthy stays in foster care after removal</p> <p>-Lack of compliance by parents with case plans</p> <p>-Procedural delays in adjudication process slowdown reunification</p> <p>-Faith-based communities are an untapped resource for voluntary host families</p>	<ul style="list-style-type: none"> • Birth parents will voluntarily place children with a host family. • Provision of resources and support to birth parents helps reduce crises and chronic problems. • Social isolation can be minimized through the creation of bridging social capital networks. • Trained volunteer host families can provide a supportive network and resources for birth parents. • Reduction of social isolation will decrease child maltreatment and improve parent and child functioning. 	<p>Family autonomy</p> <p>Child well-being</p> <p>Family permanence</p> <p>Child safety</p> <p>Community solidarity</p> <p>Budgetary efficiency</p>
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> FOUR-MONTH STATUS REPORT TEMPLATE

The template outlines the content of the four-month Implementation Plan Status Reports. The Sections of the Status Report should adhere to the structure of the Logic Model. Both qualitative and quantitative updates should be provided in each section on progress, results, and barriers.

I. Plan

Project the number of population units (children, families, office) that are expected to be reached by the intervention subdivided into the intervention group and comparison group(s) against which comparisons will be made. Include further demographic and clinical subdivisions of the group(s), which might moderate the intervention's impact.

To perform the evaluation of the program, a total of 750 families are needed; 475 families are needed via referral from DCFS. The control group will also need 475 families that came to the attention of Safe Families from other ways other than the randomizer through DCFS and Safe Families. The population is those families whose parents are investigated by child protection for abuse and neglect and are candidates for protective custody. There is no further clinical or demographic breakdown of this group.

II. Background

Provide a short introduction to the plan that summarizes the problem(s) the Department is attempting to address.

The Department wanted to look at the efficacy of a low cost, "non-threatening" program for families such as Safe Families in preventing removals into foster care, reducing the occurrence of child maltreatment, and the incidence of safe and stable reunification to birth families. As resources become more difficult and limited to obtain each year, a program such as Safe Families, based in communities which relies on community support, with host homes and ongoing support systems for families is the wave of the future. The Department wanted to determine if this type of low cost alternative program can be a positive support to the families of Illinois.

III. Theory of Change

Discuss any modifications of the theory of change about why a program or intervention is proposed to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised outcomes chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

There have been no modifications to the theory of change at this time as to why this intervention is proposed to work.. This research project actually began October, 2014. Referrals have been lower than expected and the sample size too small to draw statistically valid conclusions, but there are some baseline characteristics that provide a possible profile of Safe Family users: "A" sequence allegations of

inadequate shelter, supervision, environmental neglect , or substantial risk of abuse involving homes with children under six who have experienced a subsequent oral report or maltreatment or have been taken into protective custody and placed in foster care. Again this will need to be continually assessed and this is a preliminary finding based on a small sample.

Baseline Characteristics

Characteristics	Allocated Cases (N = 26)	Child Cases (N = 45)	Allegations (N = 75)
% A sequence reports	58%	56%	47%
% Referrals from Cook County	35%	29%	35%
% Not substantiated for maltreatment	27%	24%	29%
Mean age at report		5.9 years old	6.3 years old
% Male		58%	54%
% African American		51%	39%
% Inadequate shelter/environmental neglect			41%
% Substantial risk of abuse			31%
% Inadequate supervision			19%
% Miscellaneous harms			9%

IV. Implementation Status

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

As reported earlier, the referrals via the investigative randomizer have been lower than expected. In discussion with the evaluators, it was thought this may be a result of a lack of education regarding the Safe Families program and reluctance by the child protective investigator to utilize the randomizer for fear the family would be assigned to the control group and not able to receive Safe Family Services. In response, DCFS and Safe Families have worked together touring the state and providing information and education regarding the Safe Families program, referral process and benefits of the program. A second randomizer was also implemented within the Safe Families program that could be utilized when investigators would not "flip the switch" for the randomizer within the investigations. 120 referrals were wanted each quarter, but it has been a struggle to get those numbers. Again in discussion between DCFS and the evaluators, the goal was set at 60 families per quarter and to extend the evaluation period by two years. Referrals have begun increasing but challenges still remain: Those referral made via the randomizer within the investigation are rarely completed-the families do not "make it" to Safe Family services, among the case referred via the Safe Families randomizer, 40% are not followed through, also in those cases randomized by Safe Families, 10-15% of children are taken into custody in a very short time span, which Safe Families has no control over, and finally, in referrals randomized by Safe Families, many do not

appear to have children at risk of harm of removal. To meet these current challenges, educating field staff is again a focus, but now addressing specific DCFS offices with none to few referrals and including front line staff in the information sessions. Also while referrals were not followed through by either cases randomized at the investigative level or through the secondary randomizer at Safe Families, there was greater follow up at the Safe Families randomizer. As such the educational sessions are focusing on the utilization of the Safe Families randomizer. It is thought that possibly talking to a person at Safe Families is providing a personal, intimate touch which is resulting in higher follow through rather than just pushing a button in an investigation. DCFS, Safe Families and the evaluators continue to watch this and the referral numbers. Reports from both randomizer are placed on the Sharepoint site for Safe Families monthly and evaluated to determine next steps. This is ongoing. Having the reports on a regular basis has been a success in terms of being able to assess immediately and address problem areas with referrals.

V. **Outputs**

Discuss the extent to which intervention components were delivered as intended (outputs). Describe the numbers and proportion of the target population that received the intended intervention content (reach), the amounts of intervention content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation). Also describe the unique features of the intervention, which make it distinguishable from business as usual, and the extent to which the comparison group didn't receive similar features of the intervention (differentiation).

As of this writing, between both randomizers, 205 referrals have been received. Not all referrals followed through with Safe Families Services as reported earlier. At this time we do not have significant samples to make determinations, just speculation and supposition. However, we may be able to develop a profile of the best "candidate" for these services based on the information received which is also identified earlier within this report. This program is being evaluated by a professional evaluator at the request of DCFS. They maintain all evaluative information at this time. The evaluation period began in 2014 and will continue to 2018. It is known that as of September 30, 2015, none of the children whose families accepted services have been removed to foster care

VI. **Proximal Outcomes**

Use the table provided below to report progress in attaining the proximal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the "Significance and Explanation of Difference," briefly describe whether the differences are trending in the expected direction.

<i>Proximal Outcome (per Proximal Outcome in Logic</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
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<i>Model)</i>			
Children deflected from Foster Care	205 referrals	Not available at this time	Not available at this time
Subsequent reports within 60 days of initial report			
Children maintained or reunified with birth parent		Not available at this time	Not available at this time

VII. Distal Outcomes (if applicable to the reporting period)

Use the table provided below to report progress in attaining the distal outcomes. **The Outcomes listed should match those detailed in the Logic Model.** In the “Explanation of Status,” briefly describe whether the differences in the long-term outcomes, which were intended to result from the intervention, are in alignment with expectations.

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Repeat victimization within 24 months	205 referrals	Not available at this time	Not available at this time
Family permanence within 24 months		Not available at this time	Not available at this time
...			

VIII. Other Consequences

Describe any unexpected issues or concerns that impacted either positively or negatively (ex. leadership or organizational changes, exogenous factors beyond the agency’s control) the Department’s ability to implement or evaluate the plan.

The consequences/unexpected outcomes were identified and addressed above. Based on prior referral rates to Safe Families it was not thought that referrals would drop significantly once a randomizer was placed within the investigation. Steps have already been taken to meet that challenge and others identified and the evaluation of Safe Families continues. The evaluation period has been extended for 2 years and the number of referrals per quarter has dropped to 60 to assist in meeting the unexpected consequence of the randomizer.

IX. Plan Revisions

Describe what the Department learned from the results, successes, and challenges of the reporting period and what changes (programmatic, evaluative or organizational) will be made based on these lessons.

As reported above, this is an evaluation project of the efficacy of the Safe Families program in reducing the incidence of children removed to foster care, reduced maltreatment and increased stability and support to birth parents upon reunification. The evaluation period began October 2014 and with the extension will

go to 2018. It is hoped we will find this program is a low cost alternative to foster care and expensive services utilized now and will provide better outcomes in reunification, child stability, maltreatment reduction and placement in foster care.

EXHIBIT QQ

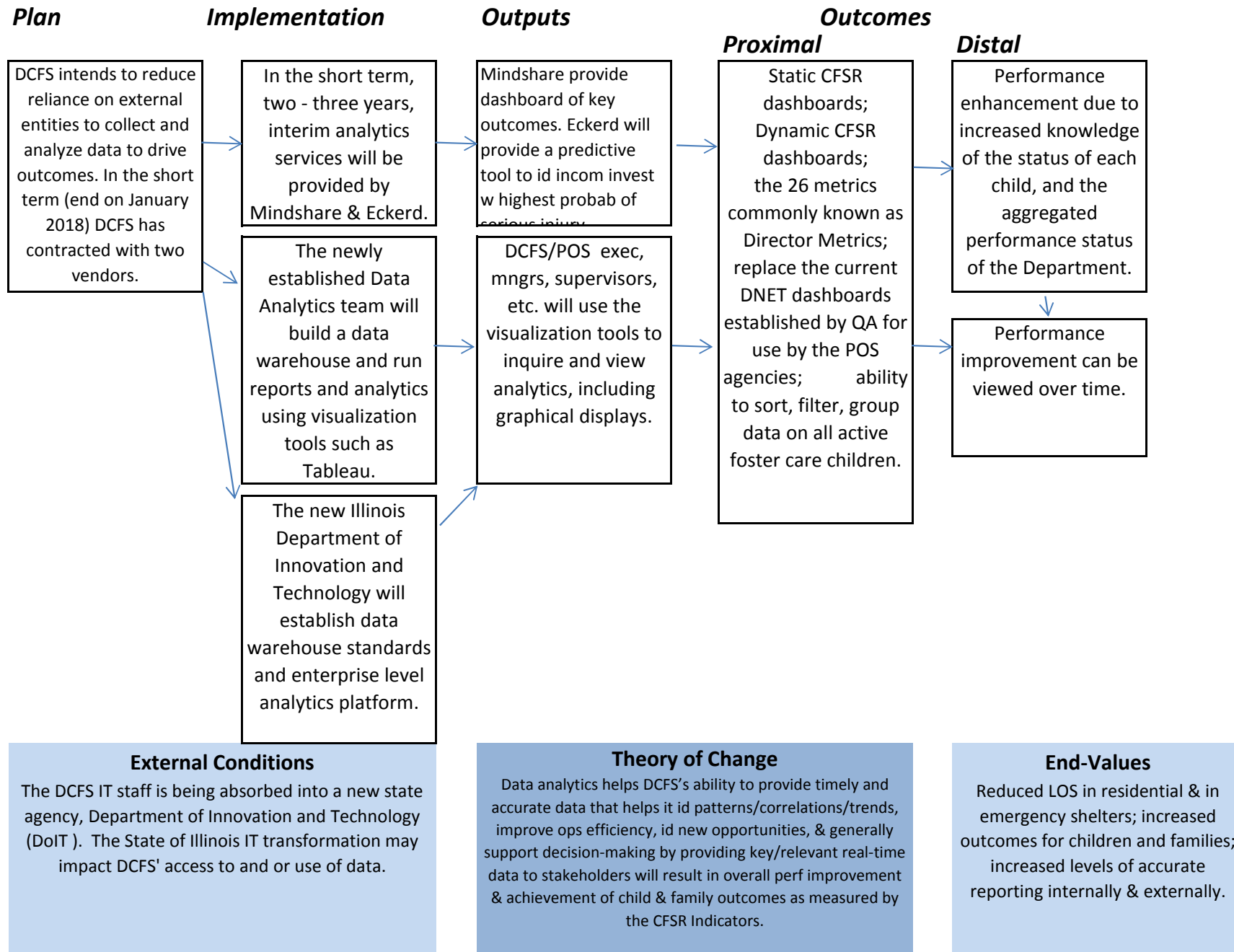


EXHIBIT RR

DRAFT Predictive and Data Analytics BH Status Report by R Lizcano

August 31, 2016

I. Plan

DCFS intends to reduce reliance on external entities to collect and analyze data to drive outcomes. In the short term (by January 2018) DCFS has contracted with two vendors. End Values will result in reduced Length of Stay (LOS) in residential and in emergency shelters; increased positive outcomes for children and families; and, increased levels of accurate reporting internally and externally.

II. Background

DCFS has a need to better understand their current and desired state by utilizing Predictive Analytics, Data analytics, ad hoc reporting and FOIA responses

III. Theory of Change

Data analytics helps DCFS's ability to provide timely and accurate data that helps it identify patterns/correlations/trends, improve ops efficiency, identify new opportunities, & generally support decision-making by providing key/relevant real-time data to stakeholders will result in overall perf improvement & achievement of child & family outcomes as measured by the CFSR Indicators.

IV. Implementation Status

Short Term

While positions are being established and filled, there will be some transitional activity including recent procurements for select vendors to provide interim services. They will collaborate with the Division of Quality Assurance, the Division of Strategic Planning and Innovation and DoIT. Their contracts will be in place until January 2018 to help with the transition and to provide additional assistance.

Long Term (Beyond 18 Months)

The State of Illinois is establishing a state-wide enterprise data analytics platform ("Enterprise IT"). Enterprise IT is currently under review by the State CIO's office and the Health and Human Services Innovation Incubator's (HHSi2) office. DCFS will continue to work closely with the state's CIO to adopt an interoperable Health and Human Services framework that will be conducive to data sharing and integrated service delivery across state agencies.

V. Outputs

Mindshare:

Will provide dashboards for each level of staff from Caseworker to Director. This solution will use embedded metrics to present actionable intelligence to front line as well as Administrative staff

Eckerd for Predictive Analytics:

The development of a predictive model that will be used to identify those incoming investigations with the highest probability of serious injury or death.

DRAFT Predictive and Data Analytics BH Status Report by R Lizcano

August 31, 2016

VI. Proximal

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (%, N)</i>	<i>Comparison Group (%, N)</i>	<i>Significance and Explanation of Difference THIS HEADING IS NOT APPLICABLE contains dates</i>
Static CFSR Dashboards	Not Applicable	Not Applicable	Data Validation is underway this is expected to be an ongoing effort.
Ability to sort and filter	Not Applicable	Not Applicable	In use now on all dashboards
Mindshare ICARE Portal with out of box functionality in production <ul style="list-style-type: none"> Dedicated Hardware, configured and racked Dedicated Domain Name Installed and Accessible Approved and Signed Security Certificate, installed and operational Dedicated Portal, configured and accessible Account profiles for initial and pre-defined users – readied for login and daily use Functional dashboards based on default measure definitions 	Not Applicable	Not Applicable	Completed
Mindshare: Establish role-based user groupings for defining dashboards and reporting levels of abstraction are as follows: Executive, Area Administrator, Supervisor, Team, Worker	Not Applicable	Not Applicable	Estimate 11/1/16

DRAFT Predictive and Data Analytics BH Status Report by R Lizcano

August 31, 2016

Proximal continued:

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (%, N)</i>	<i>Comparison Group (%, N)</i>	<i>Significance and Explanation of Difference THIS HEADING IS NOT APPLICABLE contains dates</i>
Eckerd Development of the Model a) Execution of a data sharing agreement and establishment of the necessary data sharing protocols so that the Eckerd/Mindshare Team have access to the Department's SACWIS data.	Not Applicable	Not Applicable	Completed
Eckerd Development of the Model b) The development of the predictive model that is used to identify those incoming investigations with the highest probability of serious injury or death.	Not Applicable	Not Applicable	Initial prediction delivered 5/16/16, widened prediction with new problem statement in development as of 8/30/16
Eckerd Development of the Model c) Research on the Department's current Child Protective Investigations model to determine the critical practices, when done to standard; provide the best opportunity for reducing the probability of a poor safety outcome for a child.	Not Applicable	Not Applicable	Initial prediction delivered 5/16/16, widened prediction with new problem statement in development as of 8/30/16
Eckerd Development of the Model d) Utilizing the results of the predictive model and the results of the practice research, develop a set of questions that will be used by Department staff to review those investigations with the highest probability of a poor safety outcome.	Not Applicable	Not Applicable	Delivered 5/16/16,
Eckerd Development of the Model e) Development of a web-based secure portal that will present to the Department Quality staff the cases to be reviewed, the review questions to be answered, the documentation and tracking of any follow-up activities required of the investigator and data for analysis.	Not Applicable	Not Applicable	Delivered 5/16/16
Eckerd Model Deployment a) Provide access to the portal.	Not Applicable	Not Applicable	Delivered 5/16/16,
Eckerd Model Deployment b) Provide the Department QA Team a Program Guide on how to use the model.	Not Applicable	Not Applicable	Delivered 5/16/16
Eckerd Model Deployment c) Conduct training for Department staff that will be conducting the reviews and for management staff that will be overseeing the process.	Not Applicable	Not Applicable	Delivered 5/16/16, training will be ongoing

DRAFT Predictive and Data Analytics BH Status Report by R Lizcano

August 31, 2016

I. Distal Outcomes

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (%, N)</i>	<i>Comparison Group (%, N)</i>	<i>Explanation of Status THIS COLUMN CONTAINS EXPECTED DATES</i>
Eckerd Provide quarterly fidelity monitoring of the review process	Not Applicable	Not Applicable	Initial Fidelity Review conducted 8/30/16 and will be ongoing quarterly
Eckerd Provide on-going hosting and user support for the portal.	Not Applicable	Not Applicable	Estimated Completion Jan 2017
Dynamic CFSR Dashboards	Not Applicable	Not Applicable	Data Validation is underway, finalized by Jan 2017
Mobile Apps Available.	Not Applicable	Not Applicable	Estimated Completion Jan 2017
Director's Metrics	Not Applicable	Not Applicable	Estimated Completion Jan 2017?
DNET QA Dashboards	Not Applicable	Not Applicable	Estimated Completion April 2017

II. Other Consequences

The DCFS IT staff is being absorbed into a new state agency, Department of Innovation and Technology (DoIT). The State of Illinois IT transformation may impact DCFS' access to and or use of data in anticipated timeframes.

III. Plan Revisions.

No change planned at this time.

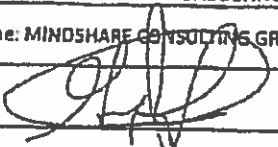
EXHIBIT SS

**STATE OF ILLINOIS
CONTRACT
DEPARTMENT OF CHILDREN AND FAMILY SERVICES**

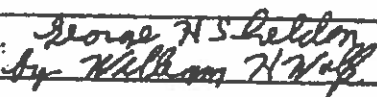
CDC: CON Program Name: ICARE Contract #: 5469579016

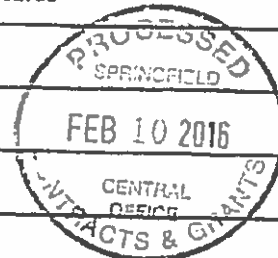
CONTRACT SIGNATURES

VENDOR NAME: MINDSHARE CONSULTING GROUP

DCFS Name: MINDSHARE CONSULTING GROUP	Address: 3853 NORTHDAL BLVD
Signature: 	City, State ZIP: TAMPA, FL 33624
Printed Name: Greg Povolny	Phone: 813-949-3293 x221
Title: Chief Executive Officer	Fax: 813-949-3483
Date: 2-3-16	Email: gpovolny@mindshare-technology.com
Dept. of Human Rights Public Contract #: 5469579016	DUNS #: 826757044

STATE OF ILLINOIS

Agency: IL Department of Children and Family Services	Address: 406 E Monroe St.
Director Signature:	City, State ZIP: Springfield, IL 62701
Printed Name: George H. Sheldon	Phone: (217) 785-3930
Title: Director	Fax: (217) 782-3796
Date:	
Designee Signature: 	Date: 2-5-16
Printed Name: William Wolfe	Phone: (217) 785-3930
Designee's Title: Deputy Director	Email: William.Wolfe@Illinois.Gov
<p>If this Contract is in the amount of \$250,000 or more in a fiscal year, or order against a master contract in the amount of \$250,000 or more in a fiscal year, this Contract shall not be binding and enforceable until it is also approved and signed in writing by the Chief Legal Counsel and the Chief Fiscal Officer of the Department in accordance with 30 ILCS 105/9.02.</p>	
DCFS Chief Legal Counsel Signature: <i>See attached</i>	Date:
Printed Name:	
DCFS Chief Financial Officer Signature: <i>See attached</i>	Date:
Printed Name:	





Statement of Work

1. Scope of Services

Services

ICARE will be the interim solution which will provide the Agency with individual dashboards for each level of staff from Caseworker to the Director. This system will be utilized to correct the lack in reporting and data availability that is currently hindering performance until the Enterprise Statewide Platform can be implemented. This will be an Outcome Driven Hosted Business Analytics Tool which is specifically designed for improvements in Child Welfare Practice.

The ICARE solution will use embedded metrics to present actionable intelligence to caseworkers and Investigators as well as Administrative Staff. The intent is that this tool will drive practice and ensure timeliness and accuracy of information and instant access to areas of risk that include compliance and out of compliance situations as it relates to State Statutes and Department guidelines.

Individual Dashboards will be provided and allow for customization. A summarized view should give an at-a-glance look as well as have drill down capability to the lowest entity. Each staff member should also be given the ability to create and share Ad-Hoc Dashboards as needed. Daily actionable items and real time metrics should always be available.

The Mindshare will be required to provide a tool that is easy to use, is outcome driven with indicators, has the ability to set goals with actionable items and see the progress towards that goal. It is expected that the time to market will be 30 days for the initial delivery of key dashboards as agreed upon by the department and the Mindshare. Training should be provided for a period of 90 -180 days. Support hours must be 24/7/365. SLAs will be established as agreed upon by the Department and the Mindshare.

The dashboards/reports are associated to the following seven service areas: Foster Care, Home of Relative, Intact, Intake, Investigation, Residential Treatment, and Specialized Foster Care.

The following solution requirements should be met by the Mindshare. These solution requirements relate to the deliverables in section 2. The solution must:

- use embedded metrics to present actionable intelligence to identified service areas
- provide customizable dashboards
- provide a summarized at-a-glance view with drill-down capabilities to the lowest entity
- provide the ability to create and share Ad-Hoc Dashboards as needed
- provide the ability to document and track actionable items
- provide metrics on-demand and available at all times
- provide the ability to create automated standard federal reports (e.g., AFCARS, NCANDS, NYTD)
- provide the ability to share Standard Federal Reporting measures
- provide obtainable logic and rules in a readable fashion
- provide auditing and statistical mechanisms to determine metrics on usage

Illinois Department of
DCFS
 Children & Family Services

Statement of Work

2. Deliverables

Category	Deliverable	Timeframe
Data Collection	Data feed to be established between OITS and Mindshare	3 Days
Preliminary Activities	Hold sessions to gain agreement and understanding for the meaning of the dashboards	7 Days
Preliminary Activities	Provide a process that produces an analysis summary for determining classification type for each identified dashboard/report. Example classification types include the following: <ul style="list-style-type: none"> • Doable – Business process, system, and data exist to produce the desired dashboard • Development Needed – System development changes doable in the desired timeframe • Business Process Changes Needed – Staff can be taught in the desired timeframe • Data Quality Issues – Data isn't accurate enough to produce meaningful results • Undoable – Data and/or system doesn't exist to produce the desired dashboard 	7 Days
Preliminary Activities	Produce a traceability listing for the dashboards/reports in the addendum to the following Seven Service Areas: Foster Care, Home of Relative, Intact, Intake, Investigation, Residential Treatment, and Specialized Foster Care	7 Days
Preliminary Activities	SLAs will be established	7 Days
Development/Implementation	ICARE Portal with out of box functionality in production Dedicated Hardware, configured and racked Dedicated Domain Name Installed and Accessible Approved and Signed Security Certificate, installed and operational Dedicated Portal, configured and accessible Account profiles for initial and pre-defined users – readied for login and daily use Functional dashboards based on default measure definitions (dashboards as defined in Addendum A and depending on availability supporting data)	30 Days
Development/Implementation	Establish statewide and regional dashboards, with drill-downs based on role, as defined in Addendum A	30-60 days
Development/Implementation	Establish role-based user groupings (or otherwise agreed upon during the first week of the engagement) for defining dashboards and reporting levels of abstraction are as follows: Executive, Area Administrator, Supervisor, Team, Worker	60 days
Development/Implementation	Establish statewide and regional dashboards, with drill-downs based on role, as defined in Addendum B	60-120 Days
Development/Implementation	Mobile Apps Available	120-180 Days
Support	Helpdesk support to be on-going for length of contract	On-Going

*The Department reserves the right to change priority within the defined scope of work. Deliverables and Timeframes may be adjusted as agreed upon between the Department and the vendor.



Statement of Work

Addendum A

The following list of dashboards/reports is in scope:

1. Executive MyDash to give high level view of dashboards included in this addendum.
2. Median length of stay for children in congregate care
3. Percent of children in congregate care who are under age 12
4. Percentage of children who have clinical assessments completed prior to and during residential care stay
5. Ratio of planned to unplanned exits
6. Percentage of referrals to residential care are clinically appropriate (*assessment indicates high need AND high risk*)
7. Degree of clinical change is achieved during residential care (*as measured by periodic assessment*)
8. Average length of sustained favorable discharge
9. Average wait time to placement in residential care
10. Proportion of providers are using clearly articulated and/or evidence-based intensive treatment approaches
11. Average wait time to placement after residential care
12. Percentage of sibling groups remaining intact
13. Percentage of children transferred to residential care from a specialized foster care placement
14. Median Length of Stay for Children Reunified
15. Percent of Children Entering Out-of-Home Care Reunified within 12 Months
16. Median Length of Stay for Children Adopted
17. Percent of Children in Out-of Home Care for 24 Months or More Who Achieved Permanency
18. Average length of time from commencing a ICPC case till completion
19. Total number of available step-down family placements
20. Total number of available wrap-around service options to prevent placement in residential treatment
21. Total number of youth assessed by case workers for step-down from residential treatment
22. Total number of case workers with youth in residential treatment beyond "medical necessity"
23. Total number of youth in residential treatment for more than 6, 12, and 18 months
24. Average wait time for Hotline
25. Average of the percentage of calls returned
26. Percentage of mandated reporter calls not referred for investigation (MCNRT)
27. Percentage of reports issued by the Hotline resulting in substantiated finding

*DCFS will provide Mindshare with the data from the following additional systems to allow for the completion of the above dashboards.

- Illinois Outcomes
- Psychiatric Hospital Tracking
- ACR

**Complete and accurate business definitions, supporting data and respective data explanations are pre-requisites for dashboard completion and signoff.



Statement of Work

Addendum B

Priority Outcomes for the Bureau of Operations

1. Child Safety and Well Being—Data measured by CERAP compliance, mandate compliance, safety plan monitoring, and percentage of SOR's
2. Return Home Achievement of Minors Particularly between the ages of 0 and 6 years
3. Sibling Visitation
4. Parent/Child Visits
5. Court Compliance in Investigations, Permanency, and High Risk Intact/Intact
6. Increase in Percentage of Providers in the Communities in which our clients actually reside
7. Increase of foster homes for children between the ages of 0-2 (hard to place babies and kids being potty trained) and teenagers
8. Increase of amount of foster children that are actually placed within the same community as their home in which they were removed
9. ACR compliance but just as important documentation supporting client input in the service/treatment plan—Client Input = Better Outcomes
10. 30 day completion compliance rate for investigations when ratios of 9:1 are enacted
11. 60 day completion rate/Undetermined Rate of less than 5% for the State and Regions and Overdue Investigative Rates/Percentages
12. Staff Morale needs to be measured ongoing to take affect at 6 month and 12 month intervals. Higher the morale hopefully will lead to better performance measures for our clients
13. Amount of time to open a case once service needs are identified. This includes handoff, transitional visit, and paperwork being processed by CAPU. The less time the better as clients are more engaged in the beginning of an investigation to address the presenting problem etc.
14. Increase the percentages and rates of successful case closing for youth in DCFS care that age out or have independence goals.
15. Body charts being included on 100% of all investigations on allegation 11—Many death cases with bad outcomes do not have a current body chart in the record at the time of the bad outcome
16. Ensuring timely medical compliance for our DCFS wards at 24 hour screenings and three week follow up
17. Increase graduation rates and grade level promotions for our DCFS wards
18. Reduced rates of probation non-compliance and Juvenile Justice violations/incarcerations of our DCFS Wards
19. Percentage of Protective Custodies that DCFS is awarded temporary custodies on – The higher the percentage the better
20. Percentage of intact cases that the remain home goal is achieved

The premise to all of the above is that these objectives and goals are all interrelated and tied together. The better we do in the above areas will lead to better outcomes for our staff, agency, and will greatly benefit most of all our clients. The above also take the premise that it is not just about numbers and being efficient but it needs to be quality driven for the ultimate success of our families that DCFS services.

*Complete and accurate business definitions, supporting data and respective data explanations are pre-requisites for dashboard completion and signoff.



Statement of Work

Investigations

1. 24 Hour mandate compliance
2. CERAP Compliance
3. Data Entry into SACWIS
4. Compliance on Safety Plan Monitoring
5. Good Faith Attempt Follow up
6. Percentage of investigations completed within 10, 30, and 60 days
7. Percentage of Cases that are Overdue or Undetermined in the Region
8. Protective custodies that are approved by the ASA office and by the Judge
9. Percentage of investigations that become SOR reports while the current sequence is still pending

Child Protection

1. Overdues
2. Missed mandates
3. Completion time frames
4. Investigations at 55 days with no extension
5. Ward Investigations
6. Child care worker Investigations
7. Good faith attempt contacts for child victims with time frames
8. Ceraps with child victims seen and time frame
9. Safety plans and 5 day monitoring
10. Supervision activities and dates
11. Abuse Investigations for victims age 6 and younger
12. Protective custodies taken with date, time, child victims, outcome
13. Facility reports-residential, foster care (including HMR), day care
14. Worker activity over the life of an investigation

Intact/High Risk

1. Weekly Visits and in person contact compliance
2. Cases closed in less than a year
3. Cases closed six months or less
4. Cases open one year or more
5. Initial social history compliance
6. Social History Update Compliance
7. Service Plan Compliance

Intact

1. Geographic location of intact referrals (community, county, field office all acceptable) by month giving a year to date total
2. Disrupted cases
3. Caseload capacity report
4. Case closing
5. Identified case dynamics (This would allow us to identify service needs in what geographic locations and responsiveness of services)



Statement of Work

6. Court involved cases
7. Safety plans
8. SORs by agency
9. Cases reopened within 1 year
10. Frequency of contact with family
11. Completion of IA and Service plan –Timeliness

Placement

1. Sibling visit compliance
2. ACR Compliance
3. Court attendance/compliance
4. Parent/child visit compliance
5. Permanency outcome percentages as it relates to Return Home, Adoption, and Guardianship
6. Percentage of older youth that successfully reach independence goal
7. Title IV Eligibility Compliance for federal funds
8. Service Plan Compliance
9. Integrative Assessment Compliance
10. Compliance with Parent/Child visitation with court
11. Child and Family Team Meetings

*Complete and accurate business definitions, supporting data and respective data explanations are pre-requisites for dashboard completion and signoff.

EXHIBIT TT

08/29/2016 Dear Colleagues,



On July 28, 2016, the inaugural cohort of the *Success!* Academy celebrated their graduation from the program. Members of the first cohort participated in 10 sessions focused on enhancing and building knowledge and skill sets, understanding how organizations work, communicating effectively, good decision making, increasing effectiveness, managing people well and problem solving. The program is supported by a grant through the Casey Foundation. Congratulations to the first cohort of the *Success!* Academy!

Robin Albritton is Cook County manager for the Division of Quality Assurance and Research. She has an extensive 22+ years of experience in child welfare which includes: foster care, intact family services and child protection. She has an appreciation for both sides of the spectrum in child welfare as an administrator and direct service worker. Robin continues to advocate for social justice in her day-to-day work as she wants all children to self-actualize into healthy, happy and productive contributors to society.

Tamela Atwood has been with DCFS for almost 23 years and has served in various roles throughout her career. In addition to her professional accomplishments, Tamela is a board member of the Champaign County Child Advocacy Center and volunteers at Home Sweet Home, a homeless shelter in Bloomington; and GiGi's Play House, a Down syndrome awareness center. She is invested in the DCFS mission and is constantly looking for creative and innovative ways to achieve agency goals. Tamela strives to end disparity in the system and to better serve every child who DCFS encounters.

Tanya Carriere is area administrator for the Specialized Unit in Cook County Child Protection. She has worked with DCFS for the past 27 years in the areas of: foster care, intact family services and child protection. Tanya has also worked as an adjunct professor at Governors State University School of Social work where she taught field integrative seminar classes. Tanya says the *Success!* Academy has taught her that "success is not an accident. It is hard work, perseverance, learning, studying, sacrifice and most of all love of what you're doing."

Mary Beth Corrigan is a statewide public service administrator who started out at DCFS nearly 22 years ago as a child welfare worker. She is committed to providing children with an optimal early education learning experience. Mary Beth has been instrumental in creating and facilitating a number of cross site trainings statewide, made enhancements to the joint cooperative agreement between DCFS and Head Start/Early Head Start and is developing new joint cooperative agreements that will meet the needs of our children and families.

Twana Cosey is the statewide resource and recruitment administrator for DCFS. She began her career in social work with the DCFS nearly 22 years ago as a child welfare specialist and was promoted to various positions thereafter. Currently, Twana is the project manager for the Therapeutic Foster Care Pilot. Twana enjoys implementing pilot projects which provide the department with an opportunity to assess new and creative approaches to serving children and families.

Shirley Davis-Barsh is a public service administrator in Contracts and Grants. For the past 10 years, Shirley has been instrumental in assisting under-graduate and graduate social work students further their education by providing clinical supervision to enable them to become licensed professionals. She has had the honor and privilege to serve as a foster parent via traditional and home of relative foster care for several years. Her passion continues to be grounded in the well-being of all children and their families.

Ashley Deckert is a child protection supervisor at the Urbana Field Office. In 2007, she started out her career as a foster care caseworker and shortly after joined DCFS in the area of Intact Family Services. This opportunity allowed Ashley to continue her passion of working to positively impact children and their families. She is actively involved in her community and shows a real passion for family-centered, trauma-informed and strengths-based practice.

Jen Florent brings more than two decades of experience in communications, public relations and journalism to her role of Public Information Officer III with DCFS. In her role, Jen is responsible for contributing to the strategic communications plan to advance the department's mission, vision and values to staff, the public and the children and families served by DCFS. Based in Springfield, Jen has developed a wide network of media and professional contacts by which to target audiences in the capital city and communities across the state.

Jeremy Harvey has 20 years of lived experience in the Illinois foster care system. Throughout his academic career he assisted DCFS in the training of caseworkers and foster parents, with a focus on teen issues and life after foster care. Early in his professional career he trained attorneys, caseworkers and youth on education, housing, employment and other opportunities and services DCFS offered. Currently, Jeremy works in the Strategic Planning and Innovation Division. Jeremy says he is "proud to work for the Department of Children and Family Services" and is "so excited about helping shape the future of child welfare in Illinois."

Angela Hassell is the downstate field service manager for Residential Monitoring. She has 20 years of experience in child welfare starting her career in the private sector as a case manager and working within the Champaign school district before transitioning to DCFS. She has been with DCFS for more than 15 years and has worked as a child welfare specialist, paired team supervisor and a placement supervisor in Central Region. As an agent for change, Angela has served in her community on various committees and boards to address substance abuse and to enhance educational opportunities for youth and those in post-secondary education.

Justin Hegy is a labor relations specialist for DCFS. He has a diverse background in public administration consisting of public policy research, advocacy and in-depth labor relations work within state government. Justin believes children's safety is a core responsibility of government and says "we must take this moral obligation seriously. I will continue to push positive change to help drive the success of the Illinois Department of Children and Family Services."

Luke Hinds is a budget analyst in the Division of Budget and Finance, located in Springfield. He started at DCFS in the role of reimbursement officer in the Client Payment Unit, where he gained valuable experience communicating directly with foster and adoptive parents and POS agencies, learning first-hand the perspectives of the providers. He currently focuses on the operations side of the budget and maintains a strong sense of fiduciary responsibility to the children and families that DCFS serves.

Alisha Hodge is a Central Region administrative case reviewer. She has 19 years of social work experience, beginning her career in the private sector then transitioning to DCFS in 1999. Throughout her career with DCFS, Alisha has been involved in numerous special assignments and initiatives, including the Central Region Transformation Team, addressing racial disparities for children of color in child welfare.

Kelly King is the statewide adoption program monitor. She is very passionate and dedicated to her work and continues to seek out the best ways to assist children in DCFS care. Kelly strives to speak up for those that do not have a voice. Her current career interests include continuing to work in the child welfare system and clinical studies.

Ron Krueger is a public service administrator in the Office of the DCFS Guardian in Chicago. Professional development and networking activities during Ron's 23 years with DCFS include active involvement on Aunt Martha's Youth Service's board and the board of the Aurora University School of Social Work. Ron is part of a family that adopted a former DCFS youth. In addition, Ron was a specialized foster parent. These experiences, in particular, have helped him develop different perspectives and remain committed to the youth DCFS serves.

Norma Navarro Machay began her career with DCFS as a student intern in 1991. Soon after graduating, she was hired as a Spanish-speaking social service trainee in Cook County. Through the years she has served as Spanish-speaking child welfare specialist, child protection specialist and currently serves as a senior public service administrator. Norma is also an adjunct faculty member in the Department of Social and Behavioral Sciences at Joliet Junior College.

Scott Manuel joined DCFS in 2002 as a contractual administrative law judge. He then transitioned to DCFS Legal where, for the next several years, he served as litigation counsel focused on administrative appeals. In 2012, Scott rejoined the Administrative Hearings Unit as deputy chief ALJ. While at DCFS, it has been Scott's pleasure to work with such dedicated staff and colleagues. He prides himself of finding solutions to problems and working together.

Mario Martinez is a public Service administrator in the Division of Child Protection. The majority of Mario's work experience has focused on helping to improve the lives of children in the area of child welfare. In addition to his work at DCFS, he has worked in the areas of child protection and placement in the state of Wisconsin. Mario's long-term goal is to continue to make progress in his career with DCFS.

Kevin Walsh is the Cook County administrator for Education and Transition Services in the DCFS Division of Child Well-Being. He began his career at DCFS in 1993 and currently oversees programs that aim to improve educational outcomes for youth in care and to assist older youth in preparing for independence. During his tenure in Clinical Services, his work experiences and assignments included: serving at the Juvenile Court-Help Unit, the Clinical Placement Review Team and Regional Clinical and as a clinical screener for the pilot phase of the Integrated Assessment program.

Quincy Washington is a public service administrator in the Office of Field Audits, Budget and Finance Division. Prior to joining DCFS, Quincy had an extensive career in corporate banking and a thriving military career having served in the United States Army for 26 years. It is Quincy's goal to assist in the process of unifying the entire department around financial data and build better interdepartmental relationships to make smarter and faster business decisions.

Susan Webster is the special counsel to the DCFS guardianship administrator. After spending 15 years as a civil litigator in a private law firm, Susan made a personal decision to work in public service and chose Illinois DCFS. Currently, Susan manages the personal legal issues for all youth in care, statewide and provides legal counsel to the DCFS guardianship administrator. Throughout her legal career, she has trained and mentored other attorneys and frequently presented continuing legal education.



Front Row (Left to Right): Ramina Velez; Wendi Wilkins; Twana Cosey; Robin Albritton; Brooke Taylor; Ashley Deckert; Kelly King; Director Sheldon; Alisha Hodge; Norma Navarro Machay; Quincy Washington; Jen Florent; Tamela Atwood; Mary Beth Corrigan; Shirley Barsh; Mario Martinez; Scott Manuel; Susan Webster; Monico Whittington-Eskridge; Carolyn Ross

Back Row (Left to Right): Tanya Carriere; Angela Hassell; Jeremy Harvey; Luke Hinds; Kevin Walsh; Ron Krueger; Sheryl Carter Negash (Casey Foundation); Justin Hegy

EXHIBIT UU

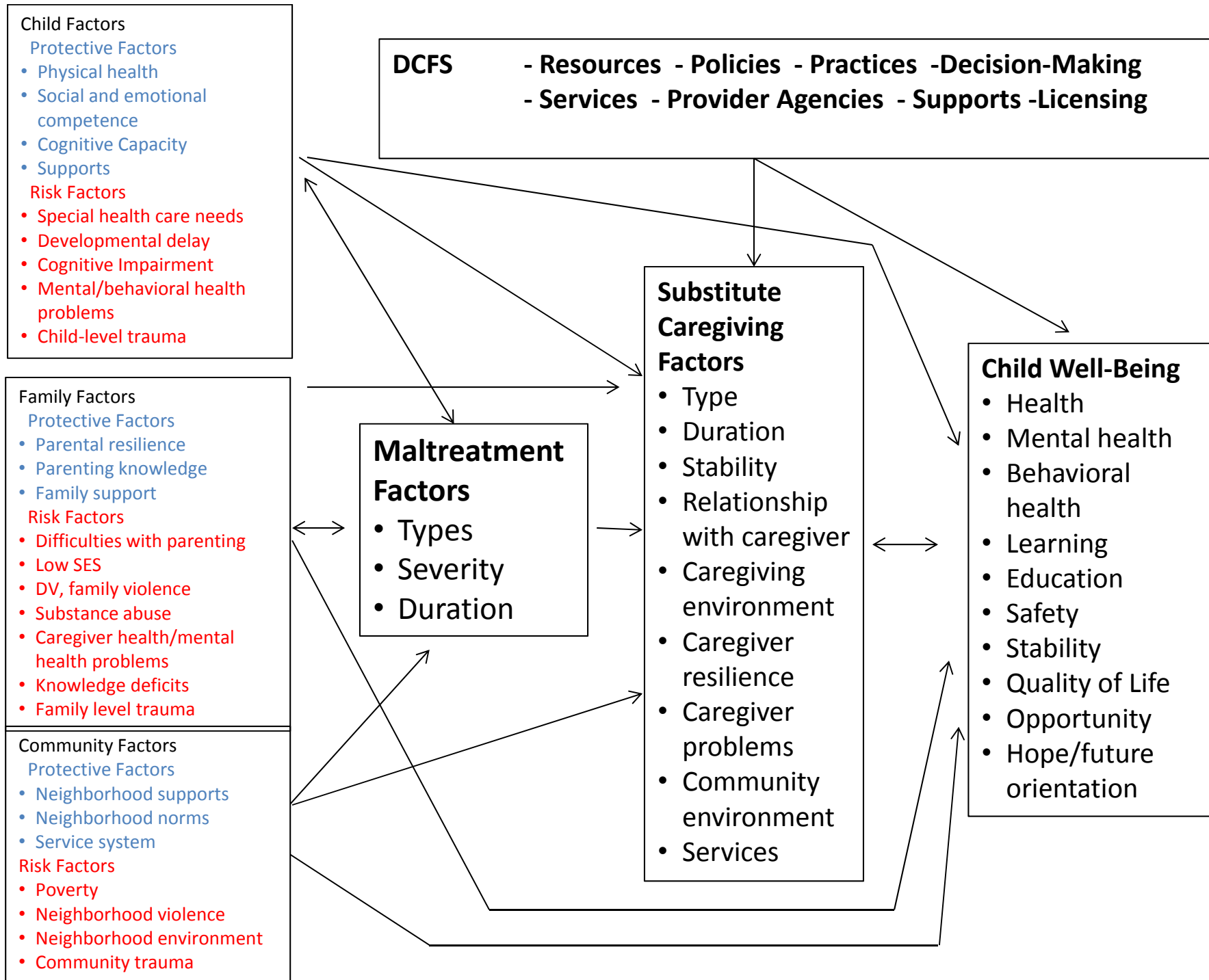


EXHIBIT VV

Illinois Child Well-Being Study

Progress Report

September 1, 2016

At a meeting August 19, 2016 the Steering Committee for the Illinois Child Well-Being Study 2017 reached consensus on all major elements of the methodology for the study. The well-being study will be a point-in-time study of the well-being of the population of children in open placement cases as of a selected date during FY2017. It will replicate most of the methods of the Illinois Child Well-Being Year 3 launched in 2004, with additional new features:

- Updated methods to enhance caseworker participation and increase caseworker response rates
- A brief measure of child life satisfaction to enhance measurement of positive child well-being

The team is also exploring opportunities to enrich the well-being study by supplementing primary data collection with data on the sample from other sources, including Child and Adolescent Needs and Strengths Scale (CANs); Trauma Comprehensive Version collected during the Integrated Assessment; health data in SACWIS; education data from the Illinois State Board of Education (ISBE); and placement data from the DCFS Integrated Database. Any use of these data sets will take time to develop, and will postdate primary data collection for the study to enable the most timely possible implementation of the study.

The study operations team from the Children and Family Research Center at the University of Illinois at Urbana-Champaign and the Survey Research Laboratory at the University of Illinois at Chicago is preparing for study implementation in 2017. Upcoming activities include finalizing the details of the research methodology so that a final budget can be estimated, and communicating with the DCFS Guardian to develop consent procedures for child participation in the study. We have developed a preliminary timeline for project activities, which is presented in Table 1. This timeline is subject to many factors that make precise dates difficult to pinpoint, including contracts, data use and data sharing agreements, and IRB approvals. How long each of those processes take will ultimately drive when data collection can begin.

Table 1

Anticipated Activities and Dates--Preliminary

ACTIVITY	DATE
Finalize Research Design, Budget	10/17/16
Letter of intent due from DCFS to UIC; SRL development begins	11/01/16
Finalize Data Use/Data Sharing Agreements	01/31/17
Sample files due to SRL	02/10/17
Submit IRB applications	02/15/17
Earliest anticipated caseworker data collection	04/15/17
Caseworker data collection end date	06/30/17
Foster parent data collection end date	08/30/17
Child data collection end date	10/31/17
Caseworker deliverables ready	08/31/17
Foster parent deliverables ready	10/31/17
Child deliverables ready	12/23/17

EXHIBIT WW

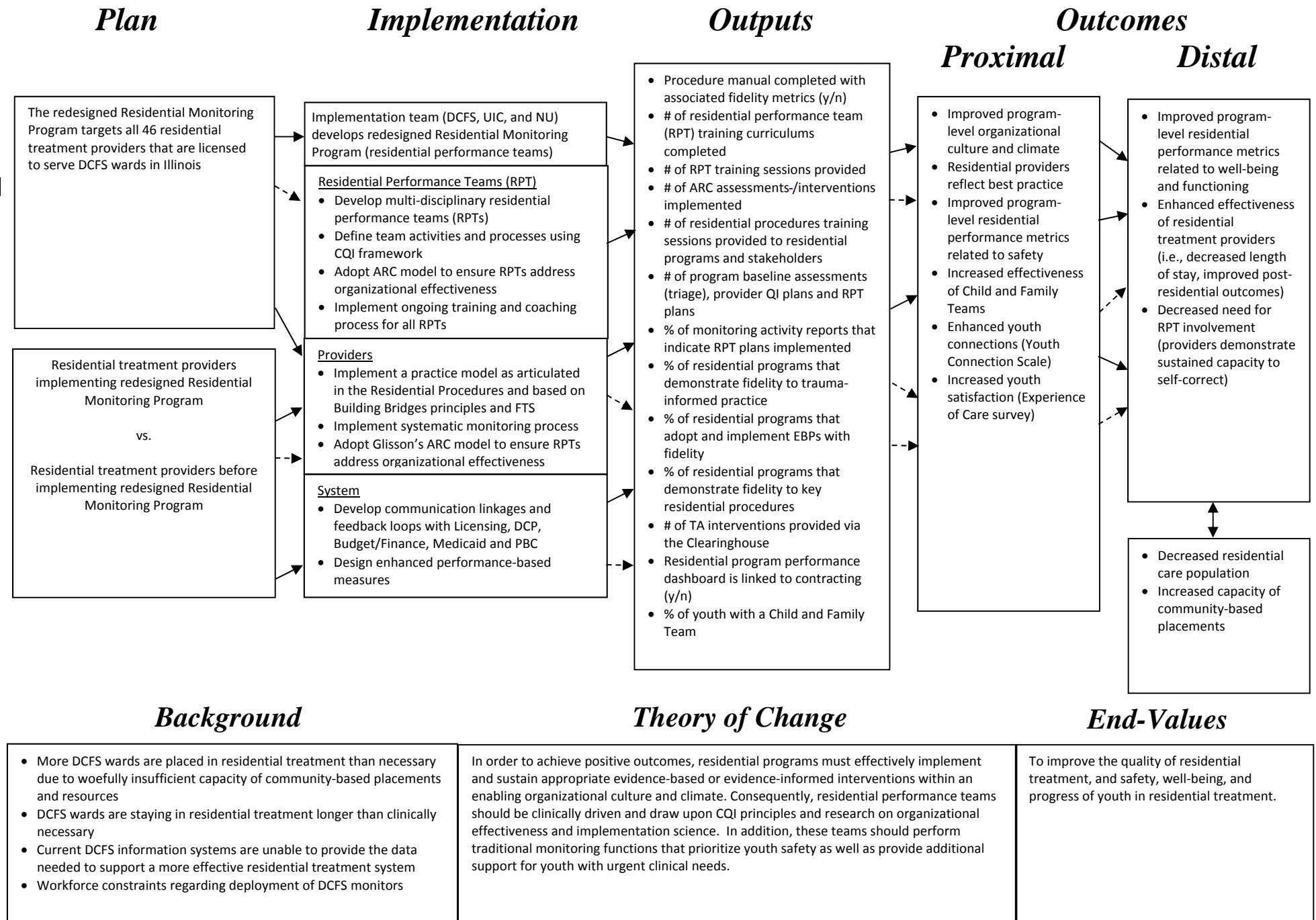


EXHIBIT XX

DCFS RESIDENTIAL MONITORING REDESIGN 4-MONTH STATUS REPORT

September 2, 2016

I. Plan

The redesigned Residential Monitoring Program targets all 46 residential treatment providers that are licensed to serve DCFS wards in Illinois.

Intervention Group: Residential treatment providers implementing the redesigned Residential Monitoring Program.

Comparison Group: Residential treatment providers prior to implementation of the redesigned Residential Monitoring Program.

II. Background

The July 2015 BH Expert Panel report noted several concerns with the internal capacity of DCFS to monitor and evaluate programs and services for the youth in its care. Particular concerns and recommendations were made regarding DCFS' monitoring of youth in group homes and residential treatment centers. The expert panel noted:

- (1) DCFS wards are staying in residential treatment longer than clinically necessary;
- (2) More DCFS wards are placed in residential treatment than necessary due to insufficient capacity of community-based placements and resources;
- (3) clinical expertise, especially related to the milieu management of youth with severe emotional and behavioral problems, is not a job requirement for residential monitors;
- (4) an inability of residential monitors to identify poorly functioning programs;
- (5) a lack of viable problem resolution strategies available to monitoring;
- (6) a dearth of high end treatment options that led to DCFS continuing to use inadequate treatment programs that are unable to maintain the safety and well-being of youth in their care.
- (7) Current DCFS information systems are unable to provide the data needed to support a more effective residential treatment system

Resultantly, the BH Expert Panel recommended that DCFS enlist the assistance and guidance of external monitors and engage some of its university partners to develop a results-oriented accountability residential monitoring system. DCFS partnered with Northwestern University and the University of Illinois at Chicago (Redesign Team) in March 2016 to develop a tiered residential monitoring system that incorporates a new performance and outcomes based measurement system to monitor implementation integrity, evaluates intervention effectiveness

in accomplishing intended results, and adapts program modifications flexibly when results are contrary to expectations.

III. Theory of Change

In order to achieve positive outcomes, residential programs must effectively implement and sustain appropriate evidence-based or evidence-informed interventions within an enabling organizational culture and climate. Consequently, residential performance teams should be clinically driven and draw upon CQI principles and research on organizational effectiveness and implementation science. In addition, these teams should perform traditional monitoring functions that prioritize youth safety as well as provide additional support for youth with urgent clinical needs.

IV. Implementation Status

Beginning in March 2016, the Redesign Team assessed the strengths and weaknesses of the current residential monitoring process and solicited stakeholder feedback. The Redesign Team surmised that the primary determinants of child-level outcomes in residential treatment include:

- (1) Safety
- (2) Quality of Clinical Programs
- (3) System Factors

Chapin Hall also disseminated a baseline survey to all group home and residential treatment center staff. The results of the survey are pending.

On August 19, 2016 the Redesign Team delivered to Director Sheldon a description of its proposed residential monitoring redesign plan along with information about proposed personnel resources and an implementation timeline (see attached). The proposal has been submitted to the Illinois Children and Family Services Advisory Council for comment.

Next Steps

Once the plan is approved, the Redesign Implementation Team (DCFS, UIC, and NU) will meet to develop the redesigned Residential Monitoring Program. Initial activities will include:

- outlining the roles of the internal and external monitors,
- determining the components of the current and interim process that will transition into the new monitoring system,
- reviewing and revising tools used in monitoring, including corrective action plans,
- ascertaining training needs and the resources for training, and
- identifying the measures needed to assess the safety and clinical outcomes of youth and the quality of treatment programs.

The redesigned Residential Monitoring Program implementation activities also include:

- Residential Performance Teams (RPT)
 - Develop multi-disciplinary residential performance teams (RPTs)
 - Define team activities and processes using CQI framework
 - Adopt ARC model to ensure RPTs address organizational effectiveness
 - Implement ongoing training and coaching process for all RPTs
- Providers
 - Implement a practice model as articulated in the Residential Procedures and based on Building Bridges principles and FTS
 - Implement systematic monitoring process
 - Adopt Glisson's ARC model to ensure RPTs address organizational effectiveness
- System
 - Develop communication linkages and feedback loops with Licensing, DCP, Budget/Finance, Medicaid and PBC
 - Design enhanced performance-based measures

V. Outputs

- (1) Procedure manual completed with associated fidelity metrics (y/n)
- (2) # of residential performance team (RPT) training curriculums completed
- (3) # of RPT training sessions provided
- (4) # of ARC assessments/interventions implemented
- (5) # of residential procedures training sessions provided to residential programs and stakeholders
- (6) # of program baseline assessments (triage), provider QI plans and RPT plans
- (7) % of monitoring activity reports that indicate RPT plans implemented
- (8) % of residential programs that demonstrate fidelity to trauma-informed practice
- (9) % of residential programs that adopt and implement EBPs with fidelity
- (10) % of residential programs that demonstrate fidelity to key residential procedures
- (11) # of TA interventions provided via the Clearinghouse
- (12) Residential program performance dashboard is linked to contracting (y/n)
- (13) % of youth with a Child and Family Team

VI. Proximal Outcomes

- (1) Improved program-level organizational culture and climate
- (2) Residential providers reflect best practice
- (3) Improved program-level residential performance metrics related to safety
- (4) Increased effectiveness of Child and Family Teams
- (5) Enhanced youth connections (Youth Connection Scale)
- (6) Increased youth satisfaction (Experience of Care survey)

VII. Distal Outcomes

- (1) Improved program-level residential performance metrics related to well-being and functioning
- (2) Enhanced effectiveness of residential treatment providers (i.e., decreased length of stay, improved post-residential outcomes)
- (3) Decreased need for RPT involvement (providers demonstrate sustained capacity to self-correct)
- (4) Decreased residential care population
- (5) Increased capacity of community-based placements

VIII. Other Consequences

System Barriers

- Inadequate service array to support youth and families in home-based living arrangements
- Policy framework does not promote family-focused services or development of effective Child and Family Teams
- Workforce capacity issues
- Fragmented data systems
- Expand/enhance youth & family related data collection/reporting
 - Evaluations: CFT , Youth Connect, Youth Experience Survey, CANS
 - Integrated Assessment, CWS Admin Case Review, CIPP, RTOS
- Integrate facility/agency data collection/reporting
 - Triage data – fiscal, operating budget, agency review, PBC
 - Facility Observation Reporting
- Remove barriers to inter-department/inter-agency data sharing
 - DCFS: Licensing, DCP, Financial, Medicaid
 - HFS, DJJ, DHS
- Improve analysis and reporting capability to extract value from existing data

IX. Plan Revisions

None to report at this time.

EXHIBIT YY

RESIDENTIAL MONITORING REDESIGN PROJECT WORK PLAN

I. September 2016

A. Residential Performance Teams

- 1) Staffing plan completed (including budget)
- 2) Current job descriptions revised and develop new job descriptions
- 3) Request and receive hiring approval (DCFS & NU) and post positions
- 4) Develop and initiate plan for completing the RPT manual
 - Identify current processes/forms to be revised and/or updated to be consistent with residential procedures standards
 - Identify new processes/forms
- 5) Develop strategy for cross system collaboration
- 6) Explore EBPs to guide organization capacity building efforts (i.e., Glisson's ARC model) and select EBP to implement

B. Interim Monitoring Plan

- 1) Continued testing of youth Experience of Care Survey
- 2) Ongoing revision of residential program QI plans
- 3) Develop Monitoring (RPT) Plans and implement for all "pilot" agencies
- 4) Develop documentation procedures for agency status reports
- 5) Begin collecting lessons learned

C. Data Systems

- 1) Assessment of data systems and work plan development
 - UIR redesign
 - PBC measures
 - On-line, residential agency/program dashboard
 - Monitoring data systems (RTOS)
 - Predictive analytics
 - Data systems aligned with residential procedures to document residential service episode
 - DCFS systems integration
 - DHS DMH DAT-STAT system

D. Residential Procedures

- 1) Complete final draft of residential procedures

- 2) Complete work plan for implementation (phases 1, 2 & 3) and ensure commitment of residential procedures committee
- 3) Initiate phase 1 of implementation plan

E. Enhanced Performance Outcomes

- 1) Identify providers to join work group
- 2) Convene work group meeting bi-weekly and develop work plan

F. TA Clearinghouse

- 1) Design needs assessment survey tool delineate key areas of TA/training needs
- 2) Administer survey to DCFS Monitoring, Clinical, UIC, Providers, CCA

II. October 2016

A. Residential Performance Teams

- 1) Conduct interviews for new positions and make offers
- 2) Continue to complete work on RPT manual according to plan
- 3) Initiate strategy for cross system collaboration
- 4) Develop RPT staff training plan
- 5) Initiate cross system collaboration strategy
- 6) Complete EBP (organizational capacity building) contracting process

B. Interim Monitoring Plan

- 1) Complete testing of youth Experience of Care Survey
- 2) Ongoing revision of residential program QI plans
- 3) Ongoing implementation and revision of Monitoring (RPT) Plans
- 4) Complete monthly agency status reports
- 5) Ensure all lessons learned applied to RPT design process

C. Data Systems

- 1) Implementation of work plan

D. Residential Procedures

- 1) Complete phase 1 implementation plan
- 2) Initiate phase 2 implementation plan

E. Enhanced Performance Outcomes

- 1) Identify providers to join work group
- 2) Convene work group meeting bi-weekly and develop work plan

F. TA Clearinghouse

- 1) Analyze survey results to delineate key areas of TA/training needs
- 2) Begin querying providers regarding training capacity, types of training (e.g., presentations, on-site consultation)
- 3) Begin assessing capacity within DCFS Training, UIC and Clinical regarding existing training expertise and capacity

III. November 2016

A. Residential Performance Teams

- 1) Complete interviews for new positions and make offers
- 2) Continue to complete work on the RPT manual according to plan
- 3) Complete strategy for cross system collaboration
- 4) Develop RPT staff training curriculums
- 5) Begin EBP (organizational capacity building) training process

B. Interim Monitoring Plan

- 1) Complete interim monitoring plan
- 2) Transition to RPT model

C. Data Systems

- 1) Implementation of work plan

D. Residential Procedures

- 1) Continue phase 2 implementation plan

E. Enhanced Performance Outcomes

- 1) Bi-weekly meeting to develop enhanced performance outcomes

F. TA Clearinghouse

- 1) Complete assessment of all training resources
- 2) Vet TA/training resources
 - Establish criteria and process including planning for sustaining learning over time
 - Complete vetting process
 - Develop resources list (distinguish between paid and unpaid)
- 3) Establish budget
 - Project the demand for training (i.e., quantity, types)
 - Establish a fee structure for providers including a sliding scale
 - Project total training costs using the resource list and needs assessment data
- 4) Create a payment mechanism

d. December 2016

A. Residential Performance Teams

- 1) Establish RPT teams
- 2) Complete RPT manual
- 3) Implement RTP training plan
- 4) Develop schedules for completing systematic monitoring process and initiate
- 5) Initiate implementation of EBP (organizational capacity building)

B. Data Systems

- 1) Implementation of work plan

C. Residential Procedures

- 1) Complete phase 2 implementation plan
- 2) Initiate phase 3 implementation plan

D. Enhanced Performance Outcomes

- 1) Bi-weekly meeting to develop enhanced performance outcomes

E. TA Clearinghouse

- 1) Develop referral process for RPTs to request TA/training
- 2) Begin providing TA/training through the clearinghouse

EXHIBIT ZZ

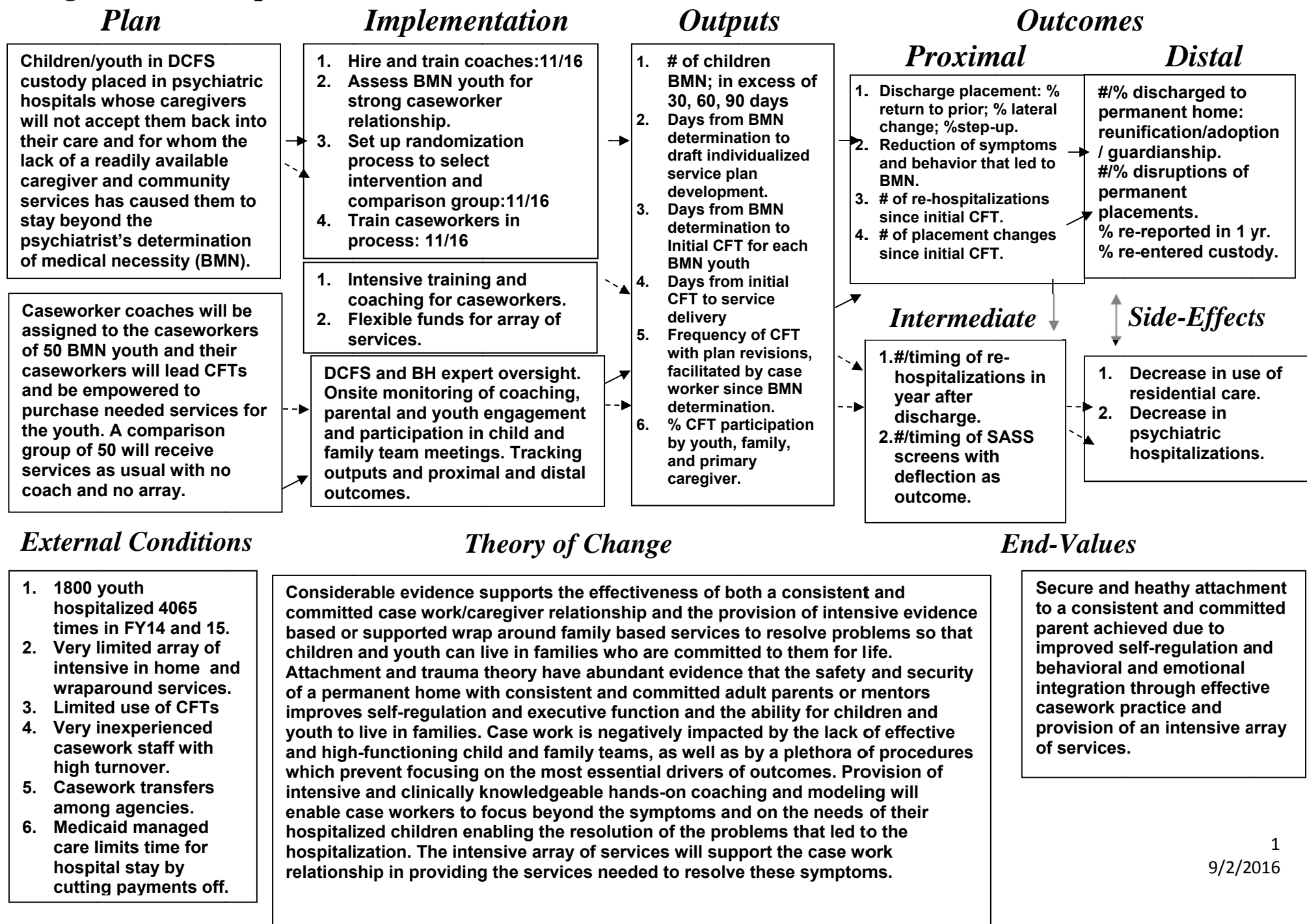
Logic Model Template**BMN PROJECT**

EXHIBIT AAA

**BMN Pilot Project
September 1, 2016**

I. Plan

- a. **Population:** The population of this pilot will be DCFS children and youth in psychiatric hospitals in Cook County who remain beyond medical necessity (BMN). The youth have been determined BMN by a psychiatrist at the hospital. These youth are BMN by virtue of their parent's or caregiver's refusal or inability to care for them.
- b. **Intervention:**
 - i. Caseworker Coaches will be assigned to the caseworkers of 50 BMN youth with whom the caseworker has been assessed to have a strong relationship.
 - ii. The coaches and case workers will be empowered to purchase, secure and tailor services to meet the individualized needs of the youth.
 - iii. Two comparison groups of 50 will receive services as usual with no coach and no expanded array of intensive evidence based services beyond what is customarily available. One comparison group will be youth who have a strong relationship with their caseworker, but the caseworker will not be assigned a coach. The second comparison group will be BMN youth who are assessed not to have a strong relationship with their caseworker.
 - iv. If the project is unable to identify 50 BMN youth with strong caseworker relationships, the Department will consider including youth in residential settings awaiting discharge who have a strong caseworker relationship (see IV b below).
 - v. The coaches will work directly with the caseworker in the field, modeling, teaching, and practicing in order to improve assessment, engagement, and individualized planning with the Child and Family Team as the hub of decision-making, service planning and progress assessment.
- c. **Coach to Caseworker Ratio:** Coaches will have a small coach to caseworker ratio (approximately 1:5-10 (the specific ratio will be fixed based on experience as the pilot proceeds), enabling a greater degree of relationship-building with the case worker and continuous contact with the clinical, community, and operations service providers.
- d. **Child and Family Team:** The CFT will be built around the family and youth and include everyone who is important in the life of the youth, including the coach, case manager, his or her supervisor, the parents, the family, the youth's allies and mentors, service providers, caregivers, clinicians, and the youth him/herself. The CFT's mission will be to understand the family's strengths and needs in order to develop an overall assessment and individualized service plan for the youth and the family, including specifying the services and supports the youth and the family need. The CFT will meet at least monthly and continue from the first contact with the youth and family to permanency.
- e. **Intensive Preparation for Caregivers:** Parents, foster parents, relatives, fictive kin, and residential personnel who are caring for the intervention group will receive specialized coaching and training in remediation of trauma, addressing trauma behavioral symptoms, and achieving a secure

- and healthy attachment with each youth.
- f. **Assessment:** The CFT will be involved in on-going assessment, including the collection and analysis of information about the youth and family's strengths and needs. This will begin immediately upon identification of the youth as BMN and continue to the identification of the youth and family's needed services and supports, and follow through with service delivery until permanency is achieved. The information will be collected and analyzed within the context of the CFT in order to best engage the youth and family in decision-making and to tailor services to the child and family's needs and capabilities.
 - g. **Engagement:** The coach will ensure that the casework relationship with the youth and family considers culturally sensitive, strengths-based approaches to best engage the family as part of the CFT. Engagement is the foundation on which trust is built. It requires listening and empathic understanding in a respectful, attuned and responsive manner to elicit and build upon the strengths of the youth and family in order to include the youth and the family in decision-making regarding solutions to the youth's and family's challenges.
 - h. **Individualized Planning and an Array of Intensive Services that Address Causes not Symptoms:** The coach and case worker will be empowered to develop and access a total service array including but not limited to: occupational therapy, parent training/psychoeducation programs; Intensive Placement Stabilization (IPS) services; specialized and evidence-supported clinical services such as CPP, MST, ARC, TARGET and others; developmental disability services; transition to adulthood services; and training and assistance with housing and cash. Flexible funds will be used to provide necessary care and services (including natural supports and non-traditional services) which are not readily available through current and other service providers. Care will be taken to use the CFT process to gain an understanding of the underlying family systems, trauma, and other conditions that may have led to the behavior necessitating the youth's hospitalization(s), rather than addressing that behavior in isolation.
 - i. **Procedural Waivers:** All procedural requirements which limit access to existing services will be selectively waived as necessary for this experimental approach so that maximum flexibility in service provision geared toward optimal effectiveness can be achieved. Procedural requirements that limit development, access, or use of other services will also be selectively waived as necessary.
 - j. **Family Based Care:** The coach will work with the case worker to support locating, securing, implementing and tailoring service delivery as well as monitoring the child's wellbeing, all in conjunction with the CFT. All attempts will be made to keep the youth in a family setting with the first priority being their own family with intensive wraparound support and community-based services, secondly relatives or fictive kin, third therapeutic or specialized foster care, and finally, residential care if the child's needs and the community's need for safety cannot be met in a community setting. Residential care will only be an option if nothing else works for the child, not necessarily when nothing else works for the family.
 - k. **Establishment of the Comparison Group and the Assessment Process to select youth for the Comparison and Intervention Groups:**
 - i. As described in Section IV below comparison and intervention

- groups will be established to determine the effectiveness of this intervention. Critical to this process will be the development of an assessment process so that youth who have a strong connection to a current caseworker can be selected for the intervention group.
- ii. For each BMN youth, the strength and meaningfulness of his/her caseworker relationship will be assessed.
 - iii. Youth with a strong caseworker relationship will then be randomly assigned to the intervention or comparison/control group. 50 BMN children will be randomly allocated to the intervention group and another 50 will be allocated to normal case management and services as usual in the control group.
 - iv. Youth without a strong caseworker relationship will be assigned to a second comparison group (no limit on number). The 2 control groups will receive normal case management and services as usual.
 - v. The planned selection process is described in more detail in II d below and will be further developed with the BH experts.
- I. Continuous Review and Planning Improvements: Ensuring that the youth and family's plan is effectively driving successful outcomes requires continuous adjustment and enhancement to get the right care and services in place at the right time. As such, the CFT will meet monthly and review whether the plan for the youth is achieving stability and permanency for the youth and family, as well as emotional and educational development for the youth. The CFT will review the family and youth's status, service progress, and the appropriateness of the goals and services in meeting the youth and family's needs in order to determine if a modification is necessary. When modifications are needed, the services and supports will be reexamined, the plan will be adjusted, and changes will be implemented based on those reassessments.
- m. Sustained Transition from DCFS Involvement: With the support of the coach the CFT and the case worker will be responsible for a well-planned transition out of DCFS custody in active partnership with the family and the youth. The transition will be driven by the achievement of a permanent home and involve a careful assessment of risk, making sure that reliable transitional formal and informal supports are in place and that both the youth and the family have additional help available when new developmental needs emerge, both in the ordinary course and in crisis situations. 24/7 help will be available in a crisis and within one day when problems emerge. These supports will be in place before the transition in the form of a support plan.
- n. Implementation Timeline:
- i. September:
 - 1. Approach agreed to by BH Experts and court.
 - 2. Completion of the review of the five cases leads to further enhancements of the plan and the Logic Model.
 - ii. October:
 - 1. Coaching Vendor(s) established.
 - 2. Review of five cases completed to support program design and training.
 - 3. Logic Model and Detailed Implementation Plan finalized.

4. Training established for coaches, case workers and caregivers.
 5. Measures for outputs, proximal, intermediate and distal outcomes finalized.
- iii. November:
1. Coaches hired.
 2. Coaches trained.
 3. Procedures for CFT and access to wrap around and other community-based services established.
 4. Output and outcome measurement process established.
 5. Randomization methodology established. In addition to above parameters, siblings and parents will be allocated to the same group as the intervention youth.
 6. Method (e.g., questions, simple tool, interview guide) for assessment of caseworker relationship to differentiate those with a strong connection to their case worker and those that do not have a strong relationship.
 7. Flexible funds and any necessary procedural waivers established.
 8. Proximal and distal outcomes for BMN cases finalized.
- iv. December: Test cases selected (3-5) and caseworker coaches, with an assigned caseworker, begin child and family assessments, family engagement/developing a therapeutic alliance, culminating in an initial CFT meeting led by the coach and in an initial individualized service plan for the BMN youth, to include individualized community support services, specialized treatment interventions, flexible funds, necessary policy waivers, and ongoing individualized intensive case management and support services for the child and family.
- v. January 2017: Program operational and BMN children and youth begin being randomly assigned to the intervention and comparison groups.

II. Background

- a. These youth remain in the hospital after their medically necessary discharge date due to the refusal of not only parents but also relatives, fictive kin, foster care and residential providers to provide a home for them. Families have given up on being able to care for them and providers are hesitant due to a history of behavior which endangers the youth himself/herself or others.
- b. Many of these youth have multiple hospitalizations. 1800 DCFS children were hospitalized a total of 4065 times during fiscal years 2014 and 2015. The current state of casework support and services delivery is inadequate to meet their needs, they continue to recycle through the mental hospital system demonstrating that current approaches are failing and a new approach is needed.

- c. Linda Stroud and Steve Budde have conducted initial structured interviews with key individuals involved with the children included in their project (case worker, foster parent, SASS screener, clinician at the hospital). Their early findings and recommendations mirror what the Expert Panel included in its Report and in its Recommendations to the Department, as well as the goals for the BMN project: 1) the importance of the caregiver's relationship with the child to help children heal and achieve permanency; 2) case managers need to demonstrate a more clinical and reflective approach to working with foster parents and children in crisis; and 3) case managers will assume responsibility and a leadership role in each case for actively coordinating and ensuring the provision and quality of services and supports for children in crisis and for their parents and foster parents.
- d. From the interviews and record reviews conducted so far, the interviewers have noted another key finding that it plans to explore and document more formally- when meaningful and effective relationships between the caseworker and child and/or between the foster parent and the child exist, the likelihood of the child's sustained stability and improved functioning was greater. This is not a surprise, and it reinforced that disrupting a strong and committed caseworker/child relationship has a negative impact. Based on this early finding and our discussions, the interviewers are adding specific tools to the interview protocols to assess the strength and quality of the child's relationships with the caseworker and foster parent.
- e. Also mirroring our understanding, the interview project is finding that some case managers may not feel empowered to mobilize the type and quality of care needed for children in crisis and upon discharge from the hospital. Case managers need training, coaching and support, and monitoring to assume a leadership role for care coordination, continuity of care, and communication among CFT members.

III. Theory of Change

- a. Considerable evidence supports the effectiveness of both a consistent and committed case work relationship and the provision of intensive evidence based or supported wrap around family based services to resolve problems so that children and youth can live in families who are committed to them for life, especially when the youth, family and caregivers are empowered through the use of a CFT.
- b. Attachment and trauma theory have generated abundant evidence that the safety and security of a permanent home with consistent and committed adult parents or mentors improves self-regulation and executive function and the ability for children and youth to live in families.
- c. Case work is negatively impacted by a plethora of procedures which prevent focusing on the most essential drivers of outcomes. Provision of intensive and clinically knowledgeable coaching will enable case workers to focus beyond the symptoms and on the needs of their hospitalized

children enabling the resolution of the problems that led to the hospitalization.

- d. The intensive array of services will support the case work relationship in providing the services needed to resolve these symptoms.
- e. As this process unfolds the capacity to build a consistent and committed attachment relationship is enhanced furthering a virtuous cycle of increased executive function and self-regulation.

IV. Implementation Status

a. Intervention and Comparison Model Established:

- i. Youth will be assessed to determine if they have a meaningful and committed caseworker relationship. For youth with strong caseworker relationships, they will be assigned to the following groups for this project:
 - 1. Half of the children and their assigned caseworker will be assigned to the “intervention” group, and
 - 2. Half of the children and their assigned caseworker will be assigned to the comparison group and continue to receive services “as usual.”
 - ii. Based on the outcome of the above assessment for each BMN child, *children who do not have a meaningful and committed caseworker relationship* will also be assigned to a second comparison group and continue to receive services “as usual.”
 - iii. Each caseworker will be assigned a “caseworker coach” who will work alongside the caseworker to achieve the goals and expectations included in the Department’s BMN project plan. The Department will identify a vendor(s) and/or individuals to serve as “caseworker coaches.” The coaches will be responsible for 5-10 caseworkers, providing needed hands-on and side-by-side training/skill-building, consultation, modeling, coaching, and support for caseworkers to engage families, lead effective CFTs, access and coordinate individualized community-based services, and monitor and modify services as needed.
- b. When the program is underway, the Department will consider using the same assessment process outlined above for children currently in residential settings who are in need of and waiting for community-based services. Based on the assessment of the strength and meaningfulness of the child/caseworker relationship, children will be assigned to either the “intervention” group or to the “services as usual” comparison group as described in #i, #ii and #iii above. Including children in residential settings who are in need of community-based services will enable the Department to reach a target group of 50 children more quickly and to test the impact of effective case management grounded in therapeutic relationships with another group of high-need children.

- c. Once a child/caseworker is assigned to the “intervention” group and to a coach, the caseworker’s agency (POS or DCFS) will agree to retain responsibility for the child’s case for the duration of the project, regardless of the child’s residential placement.

V. Outputs

- a. # of BMN children; in excess of 30, 60, 90 days
- b. Days from BMN determination to draft individualized service plan development.
- c. Days from BMN determination to Initial CFT for each BMN youth.
- d. Days from initial CFT to service delivery.
- e. Frequency of CFT with plan revisions, facilitated by case worker since BMN determination.
- f. % CFT participation by youth, family, and primary caregiver.

VI. Outcomes: It is expected that children served by this coaching model will maintain improved outcomes in contrast to the comparison group as follows:

- a. Proximal:
 - i. Discharge placement: % return to prior placement; % lateral change; % step-up
 - ii. Reduction of symptoms and behaviors that led to BMN
 - iii. # of re-hospitalizations since initial CFT
 - iv. # of placement changes since initial CFT
- b. Intermediate:
 - i. # and timing of re-hospitalizations in a year after discharge
 - ii. # and timing of SASS screens with deflection as outcome
- c. Distal:
 - i. #/% discharged to permanent home: reunification/adoption/guardianship
 - ii. #/% of disruptions in permanent placements
 - iii. % re-reported in 1 yr.
 - iv. % re-entered custody

The Department will use the table provided below to report past performance on the proximal outcomes for BMN children in FY15 & 16. The proximal outcomes listed should match those detailed in the Logic Model. Whether the differences are trending in the expected direction will be briefly described and explained in the “Significance and Explanation of Difference” section.

VII. Proximal Outcomes

<i>Proximal Outcome (per Proximal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Significance and Explanation of Difference</i>
Reduction of symptoms and behaviors that led to BMN			
# of re-hospitalizations since initial CFT			
# of placement changes since initial CFT			

#/% BMN 30, 60, 90 days			
Discharge placement:			
N/% return to prior placement			
N/% lateral change			
N/% step-up			
#,% re-hospitalized within 1 year			
# and timing of SASS screens with deflection as outcome			

VIII. Distal Outcomes (if applicable to the reporting period)

<i>Distal Outcome (per Distal Outcome in Logic Model)</i>	<i>Intervention Group (% , N)</i>	<i>Comparison Group (% , N)</i>	<i>Explanation of Status</i>
Youth achieve reunification with parents or guardianship or adoption with permanent caregiver. # , % discharged to permanent home: reunification/adoption/ guardianship within 1 year, 2 years			
# and % of disruptions in permanent placements			
# , % re-reported in 1 year # , % re-entered custody in 1 year			

IX. Other Consequences
Significant costs but manageable in pilot.

X. Plan Revisions
To be determined.