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February 15, 2019

The Honorable Jorge L Alonso
United District Court for the Northern District of Illinois
219 S. Dearborn Street
Chicago, IL 60604

Case: 1:88-cv-05599

Dear Judge Alonso:

A change in administration offers an opportunity to take stock of where things stand under the *B.H.* Consent Decree. We recognize the Department's efforts to ensure that class members receive the services they need and to improve children's outcomes. Unfortunately, the Department's efforts are not producing the desired changes in or additions to DCFS's services, much less the intended results. In fact, things seem to be getting worse in several important ways. And despite the inclusion of more data in the Department's Sixth Triannual Report, there continues to be an alarming lack of analysis of its implementation efforts that is then being used to inform and then guide needed course corrections or the development of new strategies.

A summary assessment of the current status of children and youth in DCFS custody can be inferred from an examination of the overarching outcomes that the Department, Expert Panel, and plaintiffs agreed to use to "monitor changes in both the quality of, and capacity to provide, services and support for children and families in the Illinois child welfare system (Amended and Revised Implementation Plan, Document # 531, 9/28/2016, p. 4).

The paramount obligation of a child welfare department is to ensure the safety of the children it takes into its protective custody. The expectation is that the rate of maltreatment of children and youth in DCFS care should be trending downward, and preferably far below the national threshold established by the federal government for the Child and Family Service Review (CFSR). As shown in Figure 1, the maltreatment rate has been climbing, opposite to the desired direction, since the second half of 2014. After rising above the national standard in 2016, it briefly declined but has since risen above the national standard once again.

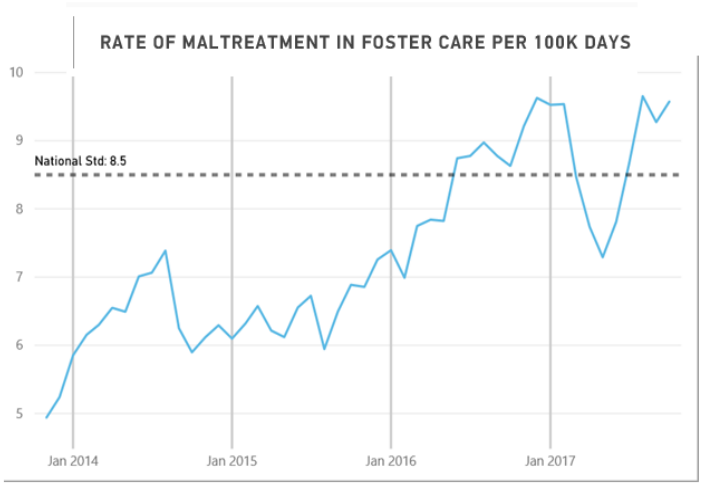


Figure 1. -- Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?
Source: *DCFS PowerBI dashboard 2/5/2019.*

Even though the rise in maltreatment may not be directly attributable to the documented difficulties that the Department has had in meeting the needs of children with psychological, behavioral or emotional challenges, it can be anticipated that remedying these difficulties should also contribute to making DCFS a safer environment for all children and youth in care.

The second indicator that the parties agreed to track is the percentage of children who are reunified with their families or discharged to permanent homes within one year of their removal into state custody. The trend line suggests that permanency rates have plummeted during 2017. However, the Expert Panel hesitates to interpret this apparent fall-off in performance as "real," especially since the data included in the 6th Triannual Report suggest that removals during the latest federal fiscal years may not have been tracked for a full 12 months. But even if we were to ignore the data reported after January of 2017, both the chart and the data included in the 6th Triannual Report indicate virtually no change in permanency rates. This lack of progress extends back well before the federal court approved the Department's Implementation Plan in 2016. The Expert Panel commented on this troubling "stasis" of the system in its Letter to the Court dated 10/30/2017 (Document # 565, p 16):

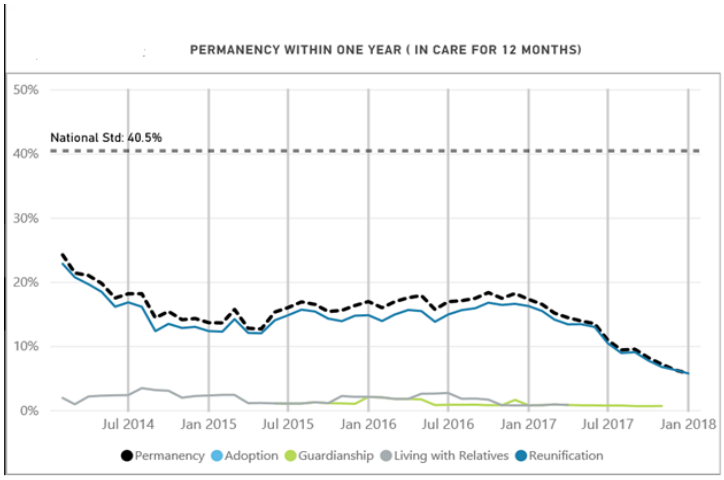


Figure 2. -- Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care?
Source: *DCFS PowerBI dashboard 2/5/2019*

"The system has stabilized at a median length of stay that is the longest in the nation (see Figure 3). Quite simply, too many children are growing up in foster care in Illinois and for far too long. The fact that the stasis of the system has persisted since the early 2000s in Cook County and longer in the balance of state, in spite of (or because of) changes in political and DCFS leadership, is one of the major reasons that a supplemental implementation plan was required in order to disrupt this unhealthy equilibrium. As Sabel and Simon (2004) note, a federal court's involvement is warranted whenever public institutions have chronically failed to meet their constitutional obligations, and the normal processes of political accountability (elections and administrative appointments) have proved inadequate for solving the problem. DCFS repeatedly has shown it cannot change the current dynamic without a consent decree."

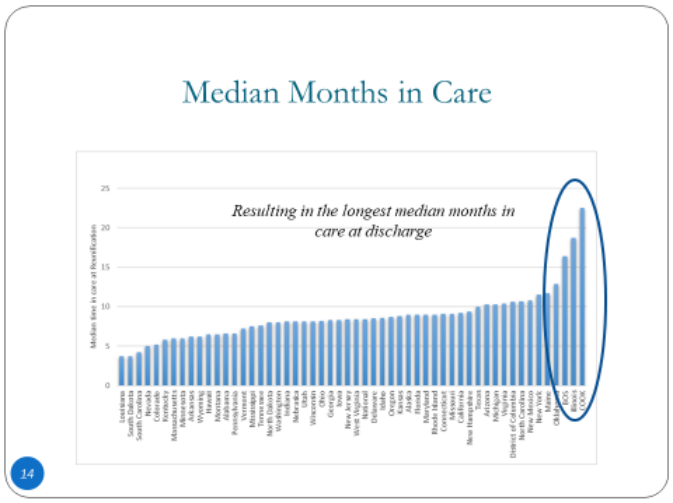


Figure 3. -- Illinois registers longest median months in foster care in the nation, 2016

The fact that the Department has not shown any appreciable progress in reducing inordinately long lengths of foster care stay under the current Implementation Plan is particularly problematic. Implementation science tells us that lack of success may be attributable to: 1) the absence of evidence-supported interventions to effect the desired change; 2) insufficient integrity in the implementation of otherwise effective interventions; or 3) lack of an enabling context to translate adequately implemented interventions into meaningful change. The Expert Panel finds that all three of these deficits have been hampering progress under the *B.H.* Consent Decree. This is why we strongly supported the Court's urging that DCFS involve the National Implementation Research Network (NIRN) in the implementation of the plan. This is why we emphasized it in our recommendations to the Court, which the Court included in its Order dated 10/20/2015 (Document #507), that DCFS develop, in partnership with one or more of its University partners, a results-oriented accountability system that improves regular and timely access to available data, develops new measurement systems to monitor implementation integrity, evaluates intervention effectiveness in accomplishing intended results, and adapts program modifications flexibly when results are contrary to expectations. Further, we recommended, and the Court included in its order, the following requirement:

> The Department shall prepare interim Status Reports for submission to the Expert Panel and Plaintiffs regarding the status of its implementation efforts to achieve compliance and the efficacy of those efforts. The reports should include, at a minimum: 1) the steps that the Department has taken for addressing system barriers and for rolling-out and assessing the fidelity of the Department's implementation of its proposed practice model and identified evidence-based

> interventions; 2) the results of its formative evaluation and any summative evaluations of impacts following the guidelines in the Children's Bureau's "Framework" publication and using appropriate comparison groups and one or more of the 26 key metrics and other measures; and 3) the various quality service reviews undertaken for ensuring that children are being fully served as intended and learning when specific initiatives should be sustained, discontinued, or revised when the desired goals are not being achieved.

The Expert Panel finds that the Department has not followed through on its pledge to involve NIRN in the implementation of the plan. We find ludicrous its claim in the latest draft of the 6th Triannual Report that it has retained NIRN 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. We have spoken to a representative from NIRN, who has indicated that the Department has conferred with the organization no more than 10 hours during all of 2018. This is far from what the Expert Panel envisioned as sufficient engagement. We suspect the Court would agree. On several occasions we attempted to create the conditions for expanding NIRN's involvement by urging that NIRN consultation time be increased minimally to 25% of the NIRN director's time. But each of these overtures was rebuffed.

It is the Expert Panel's opinion that without greater guidance from implementation experts, without the creation of a results-oriented accountability system internal to DCFS, and without a firm commitment to adhere to the guidelines established in the U.S. Children's Bureau's "Framework" for "ensuring that children are being fully served as intended and learning when specific initiatives should be sustained, discontinued, or revised when the desired goals are not being achieved" (Document # 507, p. 4), progress will not be made in bringing DCFS into compliance with the *B.H.* Consent Decree. Many thoughtful studies of Consent Decree management have reached these same conclusions.

Just to clarify, the problem is not a lack of data, but the inadequate study of data. The current report is data rich (perhaps too rich in our estimation), but study and (as a corollary) action poor. The simple fact is that when the Department engages in the full Plan, Do, Study, Act (PDSA) cycle, progress is made. Witness, for example, the successes, discussed in the 6th Triannual Report, of the Illinois Birth-Thru-Three (IB3) project in boosting rates of permanence 53% for children under the age of 6 in Cook County. According to the principles of the "experimentalist" approach, DCFS should be scaling-up this initiative to determine if the positive results are replicable in downstate Illinois. But no plans for such an undertaking are discussed in the 6th Triannual Report. The Department appears to be stuck in the same rut we identified in our original Report of the Expert Panel filed 7/23/2015 (Document # 490, p. 4).

> The Department has not adopted a sustainable model of practice which incorporates evidence-supported, evidence-informed, and promising practices. Evidence-supported practices, such as subsidized guardianship for older youth, have fallen into disuse. Evidence-informed practices, such as performance-based contracting, are not fully implemented with fidelity to the proven

> design. Promising practices, such as home-based, "wrap-around" mental health services, are carefully developed but summarily discarded after a change in leadership. Many innovations are rushed into production and scaled-up with insufficient forethought given to evaluating their impacts on desired outcomes and determining whether the program actually worked. The end result is a "flavor-of-the month" approach to endorsed treatments and a system of practice that is shaped by crises, practitioner preferences, tradition, and system expediency.

While effort has been expended with respect to projects outlined in the Implementation Plan, the most recent Triannual Report reveals the absence of an overarching DCFS plan and structure for managing the implementation of its efforts to comply with the Consent Decree. Likewise, there is an apparent absence of any "big picture" analysis of where things stand, what needs to happen next, and the apparent abandonment, without explanation, of any number of purportedly planned implementation activities. Our observations about the status of the system in October of 2017 (Document #565, p. 10) have relevance for the challenges the Department continues to face in achieving compliance with the Consent Decree:

> Caseworkers, supervisors and other departmental regional administrative staff assigned responsibility for these youth are being asked to undertake planning and service implementation activities for youth with some of the most challenging behavioral health needs in the context of communities where the specialized treatment services many of them need either do not exist at all or have not been successfully individualized in the past to address similar youths' needs. Dr. Testa wrote to Mr. Digre, "[w]e understand the Department's desire to increase the outputs from all of the B.H. projects including the perceived need to do something quickly in the hopes that it disrupts the system-wide stasis we have been observing over the last decade. However, we've been down this road before with little tangible evidence of whether these initiatives truly worked and improved the situations for children…. So let's make sure we're not simply 'flailing' about and instead make sure we walk away with tangible evidence of how the process worked, to what effect, and what inferences can be drawn about how the lives of children have improved as a result of the initiative." (Email to Pete Digre on July 27, 2017).

As DCFS moves ahead under new leadership, more rigorous analysis of why it has not made more progress toward compliance under the existing Implementation Plan seems warranted. The attached report from one of the Implementation Plan's initiatives (Therapeutic Residential Performance Management Initiative) provides the type of information, analysis and recommendations that will be helpful in determining where things actually stand, analysis of why there has not been more progress and ideas about what needs to happen next with respect to a number of the challenges faced by DCFS. It is important that DCFS provide the same level of thoughtful reporting on how things are actually going, identify the specific problems, provide detailed analysis of why things are not working and plans, or at least ideas, for how to make things better. DCFS's attempt to edit out this type of content in earlier TRPMI reports (as opposed to simply specifying its position regarding content with which it disagreed) is both disturbing and consistent with our observation that the Department prefers to stick to reporting

activities without providing or inviting analysis and discussion about how implementation is really working and what needs to be done to improve it.

We appreciate the Court's continued commitment to ensure that members of the B.H. class receive the services that address their underlying needs and achieve the levels of safety, permanence and well-being the B. H. Consent Decree entitles them. We stand ready to provide more details at the parties' next appearance in Court on February 28, 2019.

Respectfully submitted,

Marci White

Mark Testa
Spears-Turner Distinguished Professor

TRPMI External/University Supplementary Submission
B.H. v Walker May-September 2018 Triannual Report
Deann Muehlbauer (UIC), Alan Morris (UIC), Neil Jordan (Northwestern)
February 10, 2019

Introduction

In the summer of 2018, external TRPMI staff and faculty from UIC and Northwestern University (TRPMI university partners, and sometimes referred to as TRPMI in this report) and DCFS attempted to resolve several issues associated with the BH monthly status and triannual reports submitted to the Court and other relevant parties pursuant to the BH Consent Agreement. At that time, the monthly status reports were written and submitted to DCFS by the TRPMI university partners; the triannual reports include collaboration with Chapin Hall. The TRPMI university partners were concerned to discover that the content that we had produced for these reports was subsequently edited by DCFS, and critical data elements and contextual narrative were deleted. These edits were made without an opportunity for joint consultation or discussion with TRPMI so that both parties could achieve a consensus regarding the final submitted version. It should be noted that UIC and NU repeatedly requested that DCFS and TRPMI collaborate on a solution that satisfied all parties.

In accordance with our understanding of the original intent to utilize external partners in the TRPMI pilot, we maintained that it was in a position to provide objective assessment and feedback to all TRPMI stakeholders about the successes and challenges associated with the TRPMI pilot. Accordingly, transparency and an opportunity for the external partners to provide uncensored feedback would facilitate our ability to provide constructive input and maximize the value of our participation in the pilot. TRPMI intended to continue providing data to inform our observations and, where possible, propose potential solutions. Further, TRPMI recognized that at times the data and analysis may be discouraging and evoke discomfort. However, along with indicators of progress, it was our belief that only via the identification and quantification of problems and barriers that meaningful intervention and remedies could be generated.

Additionally, there appeared to be differing perspectives regarding the focus and role of TRPMI and, as a result, lack of consensus regarding the scope of the reports to the Court. Our position, congruent with the mandate delineated by the BH expert panel, described in the TRPMI Implementation Plan, incorporated into the TRPMI Logic Model, and consistent with expectations identified in the residential provider's program plans, was that in addition to monitoring the residential programs themselves, TRPMI was directed to identify system level barriers and problems that impact youth, families, and agencies involved in the pilot. These included the facilitation of appropriate transitions of youth back to the community and developing a permanency pathway for these youth. Accordingly, it followed that several TRPMI initiatives associated with these goals involved coordination and collaboration with DCFS staff beyond the Monitoring Division as well as POS stakeholders. Further, it was our view that data and analysis pertaining to

these issues fall within the TRPMI scope and, when available, should be included in the monthly and triannual reports. While it was not clear to us that DCFS is consistently aligned with this assessment of TRPMI's charge, TRPMI met with DCFS leadership to begin clarifying scope.

As discussions about the reports have been somewhat contentious with some issues remaining unresolved, several months ago UIC/NU presented a proposal to DCFS in an attempt to resolve these ongoing concerns. TRPMI recommended limiting our submissions to DCFS to a presentation of updated metrics that have been included in the monthly and triannual reports to date. Concurrently, UIC/NU would separately prepare an addendum to the report that includes additional metrics and discussion providing context, recommendations, and barriers encountered implementing the TRPMI pilot, as well as identification of critical system concerns and problems. These would focus on issues regarding the safety, treatment, and well-being of youth involved in the residential system as well as those that impact effective and timely transition of youth back to the community. This option would allow DCFS to submit their report to the Court while also enabling UIC/NU to submit our portion independently.

On July 30, 2018 TRPMI was informed by DCFS that they accepted our proposal going forward. This is UIC and Northwestern's second supplementary report. We are hopeful that this process strengthens our collaboration and partnership in the service of youth and families involved in the residential treatment system.

In the following pages, this report addresses four areas: (1) TRPMI Activities and Initiatives, (2) TRPMI Implementation Barriers, (3) Critical System Barriers Impacting Residential Youth/Families, and (4) Issues Regarding the TRPMI Pilot Evaluation. Within each area are several subsections. Updates to the subsections are italicized for topics addressed in previous reports.

TRPMI Activities & Initiatives

TRPMI Completion of Child and Adolescent Service Intensity Instruments (CASIIs)

TRPMI staff complete CASIIs for designated youth (i.e., youth not making adequate treatment progress or those with complicated discharge plans or barriers). This instrument, developed by the American Academy of Child & Adolescent Psychiatry, provides valuable information for individualized treatment discharge planning. During the reporting period, 36 CASIIs were completed. By April 2018, TRPMI staff completed CASIIs for about half of the designated youth in TRPMI sites. Because TRPMI lacks the capacity to complete CASIIs for all TRPMI designated youth, TRPMI continues to focus the use of CASIIs for (1) youth with a discharge plan of home of parent or home of relative, or (2) youth with other discharge plans who will need additional services or resources after stepdown.

Current Update:

Between April and December, TRPMI staff completed CASIIs for 59 designated youth. To ensure consistency across the 3 TRPMI teams, the fidelity process was re-evaluated and

strengthened to better achieve scoring reliability and more targeted and individualized recommendations pertaining to the youth/family during the transition and community re-entry process. Accordingly, TRPMI modified its fidelity tool and process and continued to conduct regular meetings with TRPMI staff completing CASIIs. As was indicated in the last triannual supplemental submission report, the fidelity process addresses several priorities including ensuring that the CASIIs were strength-based and included the input and perspective of both youth and families. One issue that was reported previously concerned the amount of time staff devoted to completing CASIIs. TRPMI greatly reduced reporting of information otherwise available to stakeholders and streamlined the process significantly, thus providing greater focus on the key findings and recommendations. TRPMI has begun developing changes to how CASIIs will be administered; these changes will be reported in the next triannual supplement submission report.

Communication Protocol

In an effort to address pervasive systemic barriers to effective treatment planning, TRPMI developed the Communication Protocol during spring 2017 to engage multiple stakeholders in solving time-sensitive problems that impact individual youth. The goal of the Communication Protocol is to establish a sense of urgency, promote accountability and transparency in communication, and provide individualized support to youth and youth planning teams. The Communication Protocol was initially implemented without a great deal of fidelity, and TRPMI subsequently determined that the Communication Protocol required revision. During Implementation Subcommittee Meetings in February, March, and April 2018, the protocol was reviewed and simplified. The TRPMI Steering Committee approved the revised version on April 25 and agreed that a D-Net announcement should be completed to inform the workforce.

Current Update:

TRPMI has continued implementation of the Communication Protocol with mixed results. In some cases, including one particularly notable situation, the DCFS chain of command has been slow to respond and generally not cooperative. However, the most significant barrier to full implementation of the Communication Protocol has been the reluctance of TRPMI team members to utilize the protocol according to the guidelines. TRPMI believes that this reluctance partially stems from team members' worries that use of the protocol will jeopardize their working relationships with stakeholders. This supports TRPMI's impression that a strong culture of conflict avoidance exits with the DCFS system. This is especially true when the Communication Protocol identifies solutions that will require collaboration with DCFS divisions other than Monitoring. Related to this, TRPMI staff are aware of the high caseloads and priorities of the permanency worker workforce, have empathy towards the permanency workers, and accept that the permanency workers are unable to meet all expectations. Accordingly, TRPMI staff do not believe the Communication Protocol will be effective when an overloaded permanency worker is involved. TRPMI will continue implementation of the Communication Protocol, providing focused supervision and coaching as well as tracking.

Youth Experience of Care Survey

Beginning in April, TRPMI initiated a partnership with Traditional Monitoring (i.e., the DCFS Monitoring Division leadership and staff assigned to residential programs in all non-TRPMI areas) and the DCFS Youth Advisory Board (YAB) to revise the Youth Experience of Care Survey. TRPMI representatives attended YAB meetings in all 4 DCFS regions during April to collect feedback directly from youth regarding the questions on the Youth Experience of Care Survey. The YAB recommendations were then incorporated into a revised survey, which the TRPMI Implementation Subcommittee reviewed in late April. Subcommittee members agreed that a smaller group should convene to finalize the revisions and then present the survey to the Statewide YAB for approval at their May meeting. TRPMI values this developing partnership with the YAB, and TRPMI representatives plan to continue attending monthly Regional YAB meetings.

Current Update:

A Youth Experience of Care Survey instrument was finalized for youth over age 12. In partnership with the YAB, youth in both the TRPMI and Traditional residential programs were surveyed during October and November. Analysis of the data has been completed and a report regarding findings will be disseminated in February. Additionally, a subcommittee of TRPMI and Traditional Monitoring has developed two alternative surveys for youth under 12 and those with cognitive limitations. Currently, these surveys are being piloted. TRPMI anticipates that the final versions of these surveys will be administered beginning in March 2019.

TRPMI Involvement in Child and Family Team Meetings (CFTMs)

After 12 months, TRPMI concluded that its strategy to promote development of CFTMs for all youth had not been effective. Consequently, TRPMI developed a new, more targeted initiative, titled the Home of Parent (HMP)-CFTM project, in partnership with the DCFS Operations Division. The goal of the HMP-CFTM project is for TRPMI staff to support permanency workers in establishing CFTMs for youth newly admitted to residential care with a return home goal and living in close proximity to their parents. Specific families and youth for the project were identified in March. The next step required DCFS Monitoring to make arrangements with DCFS Operations to contact the permanency workers for those youth and families, which was still in progress on April 30. Once those contacts are made, TRPMI plans to engage the permanency workers to help plan CFTMs for these youth.

Current Update:

The HMP-CFTM project proceeded, also with mixed results. TRPMI plans to complete a "Lessons Learned" document that will include a description of the results. In general, the leadership of Northern Region placement and immersion site managers supported this initiative, and TRPMI was able to provide support to Northern Region permanency workers to implement CFTMs for some of the identified youth. However, TRPMI was not able to promote sustained development of CFTs and ongoing CFTMs for most of the identified youth. The predominant barrier involved a lack of family-centered practice and engagement as well as only partial implementation of the CFTM model.

In addition, participation in CFTMs conducted outside of the HMP-CFTM initiative by TRPMI staff has decreased over the last several months. It appears that the majority of CFTMs do not successfully engage family members/youth or include meaningful discharge and transition planning. Although TRPMI recognizes that residential staffings are a poor proxy for CFTMs, TRPMI team members frequently feel it's necessary to prioritize participation in residential staffings for the purpose of ensuring that transition and discharge planning occurs.

TRPMI Training

TRPMI provided training for staff that primarily focused on development and implementation of new initiatives. These initiatives included best practice guidelines for discharge planning, a new intervention for addressing runaway behavior, and policy and procedure for critical TRPMI activities (e.g., conducting on-site agency observations). These trainings provided a foundation for development of a formal TRPMI procedure manual addressing standard operating procedures.

TRPMI provided additional training for the purpose of enhancing the knowledge base of TRPMI staff. These included training in the Therapeutic Crisis Intervention (TCI) model and financial support programs for youth, flexible funding available to families, and the process for placing youth in mental illness transitional living programs.

Current Update:
TRPMI increased its internal training activities during the last several months. TRPMI held 2 all-staff meetings and also completed 1-hour training sessions with all staff every other week. The foci of training has included QI approaches such as the Plan-Do-Study- Act (PDSA) process, the Six Core Strategies for Reducing Seclusion & Restraint Use, and Northwestern University's recent training on the ThinkTrauma model. Training has also addressed implementation of new initiatives and discussion of TRPMI's expectations and procedures for daily operations. These training topics are further reinforced in the weekly TRPMI Team Meetings conducted separately by each TRPMI team.

TRPMI also trained the Traditional Monitoring staff regarding the Runaway Protocol Initiative. In addition, TRPMI provides ongoing consultation to Traditional Monitoring staff regarding the Runaway Protocol Initiative as well as the Youth Experience of Care Survey, including issues related to data management.

TRPMI Provider Meetings

In February 2018, TRPMI held meetings with residential providers in each of the TRPMI pilot regions in order to solicit feedback and develop recommendations for refining TRPMI operations. Data were gathered via a written satisfaction survey as well as focused group discussion. Representatives from all the TRPMI providers (except Catholic Children's Home) participated, and 14 satisfaction surveys were returned. The overarching themes identified from the meetings and surveys are listed below and sorted into strengths and areas that need improvement. TRPMI shared these findings with the TRPMI Steering Committee, TRPMI Implementation Subcommittee, and the TRPMI

Advisory Committee. Consistent with the quality improvement (QI) philosophy embedded in the TRPMI implementation plan, TRPMI has been discussing ways to potentially address the suggested areas of improvement.

Strengths:

- Information provided in the TRPMI Team Activity Reports (TARs) effectively addresses quality of care issues, and feedback is usually balanced and objective. In particular, providers indicated that these reports were clinically informed and often provided specific information regarding staff interventions. Several providers reported that they use the information for staff training purposes.
- Providers reported that TRPMI is supportive and collaborative regarding feedback on residential programming and development and review of QI plans. Providers also noted that TRPMI additionally provides thoughtful guidance regarding input at staffings, CFTMs, and with difficult cases.
- Providers indicated that TRPMI frequently provides advocacy in addressing system barriers.
- CASIIs provide an overall snapshot of the youth and provide a useful synthesis of youth information in one place. Providers reported that CASIIs are most helpful for hard to place youth or youth who are transitioning out of residential placements.

Areas needing improvement:

- Providers indicated that TRPMI can sometimes feel compliance-driven and similar to Traditional Monitoring and Licensing. Several stakeholders recommended further clarification of TRPMI's monitoring role.
- Providers reported that TRPMI is not always able to provide timely resolution of system barriers, if at all.
- Providers suggested that administrative meetings should be streamlined as they can be lengthy and information is sometimes redundant.
- The dates and times of milieu visits are sometimes predictable and completed TARs are not always submitted timely to the providers. Additionally, several providers recommended more specific description of staff actions and activities on the TARs as well as increased overnight milieu visits.

Current Update:
During this reporting period, TRPMI initiated several efforts to both maintain activities characterized as TRPMI strengths as well as address those indicated as areas needing improvement. Regarding the latter issues TRPMI has:

- *Made significant efforts to clarify TRPMI's role and the implementation processes related to new initiatives. This includes collaborating with Chapin Hall to modify the TRPMI logic model (this will be more fully address later in the report).*
- *Explored mechanisms for residential providers on the TRPMI Advisory Committee to communicate more effectively with both TRPMI and Traditional Monitoring; many non-TRPMI providers have expressed interest in TRPMI initiatives and activities.*
- *Continued to vigorously and creatively advocate for addressing system barriers that impact youth in residential treatment programs. These barriers continue to be extremely challenging, and TRPMI plans to meet regularly with DCFS regional*

leadership to facilitate greater traction on addressing these barriers.

- *Restructured TRPMI's preparation for provider administrative meetings and better clarified the meeting agenda and meeting reporting process.*
- *Ensured that provider observations are tracked such that they occur at days and times specific to TRPMI's assessment of provider functioning and individualized monitoring plan.*
- *Continued administrative review of site visit observation reports to ensure they include clinical recommendations, which providers have reported to be very helpful, and compliance issues critical to residential program operations.*

Runaway Reduction Initiative

Approximately 10 years ago, in partnership with a provider workgroup, UIC developed the "Youth Missing from Care: Guidelines for Residential Treatment Facilities and Group Homes". These proposed guidelines were designed to inform residential providers in their development of runaway protocols to address prevention, assessment, and treatment planning. Subsequently, DCFS has required providers to address the six domains identified in these guidelines, a requirement included in each provider's program plan.

The UIC guidelines document was developed because residential program runaway behavior was identified by all stakeholders as a serious and widespread problem. TRPMI has determined that this requirement for providers to develop strategies and protocols that address the six domains has not been consistently implemented. It should be noted that the runaway problem remains a critical concern as the DCFS Illinois Outcomes Agency Aggregate Report indicated that there were approximately *4,500 reported instances of runaways* from Illinois residential programs in FY17. The actual number of runaways is likely higher due to under-reporting by some residential programs; as part of TRPMI's routine monitoring, several agencies indicated that for many years they have not reported runaways consistent with DCFS reporting requirements. It should be noted that frequently youth who runaway from residential programs engage in highly unsafe behaviors including criminal violations, sex trafficking, substance abuse, and reckless endangerment of themselves and others. Consequently, TRPMI has prioritized addressing this issue.

In April, 2018 TRPMI initiated a QI project to review each provider's runaway protocol to (1) assess the protocol's consistency with the runaway guidelines and DCFS policy, and (2) determine whether the provider is using an effective assessment process that identifies youth at risk to run as well as those assessed as potentially dangerous or vulnerable while on unauthorized absence. Additionally, TRPMI has developed a process to evaluate each provider's implementation of the protocol with respect to prevention and individualized planning. The goals of this QI project include: (1) achieving greater fidelity in reporting runaways, (2) assisting providers in establishing clear, consistent guidelines for staff with respect to the 6 domains, (3) helping providers establish a way to effectively assess youth at high risk of runaway and those who are highly vulnerable and dangerous during run episodes, because many of these youth will

require individualized treatment planning, and (4) reducing providers overall runaway rate.

This project builds on TRPMI's prior highly successful experiences consulting, with several residential providers with severe runaway problems. For these agencies, the rate of runaway behavior decreased over 80%, and local law enforcement reported a significant positive impact on the surrounding community. The runaway initiative attempts to generalize this impact to the broader residential provider group. This process is informed by implementation science findings, consistent with refinements in TRPMI's overall approach to new initiatives and logic model design (see below).

Current Update:

TRPMI has initiated a review of TRPMI providers' runaway protocols to ensure that each domain has been addressed. This review process consists of an initial protocol review, followed by TRPMI feedback, and subsequent protocol revisions by the provider. Next, TRPMI conducts on-site reviews of implementation of the protocol to help ensure that staff are aware of the expectations and can operationalize them accordingly. Additionally, provider agencies utilize a systematic assessment of youth, using the UIC Runaway Assessment and Treatment Planning Tool or another approved method, to identify youth with risk to run as well as those who also can be considered potentially vulnerable or dangerous while on run. TRPMI prioritizes review of treatment planning efforts for these youth and will track runaway rates for all youth in each program as well as for this subgroup of youth especially at risk (assuming DCFS agreement to support revisions to the existing data system).

With strong support from DCFS leadership, TRPMI recently met with Traditional Monitoring staff to assist them in implementing this initiative across all Illinois residential agencies serving DCFS youth. TRPMI developed review and assessment tools to assist in this process, and we also provided training about the Runaway Reduction Initiative to Traditional Monitoring staff. TRPMI continues to provide ongoing consultation with respect to this effort. Traditional monitoring implementation will proceed in a stepwise manner, initially focusing on a subgroup of providers served by Traditional Monitoring to identify barriers and further refine their processes. This initiative was guided by the small test of change approach discussed below.

<u>Initiated a Small Tests of Change Approach</u>

TRPMI and Chapin Hall collaborated to revise the TRPMI Logic Model using a small test of change approach combined with a Plan-Do-Study-Act approach. This approach better reflects the realistic nature of implementation of system level changes over time and is informed by implementation science, specifically acknowledging the stages of implementation defined by the National Implementation Research Network (NIRN). These phases include Exploration, Installation, Initial Implementation and Full Implementation (Fixsen et al 2010). An advantage of this approach is that it provides TRPMI with a framework for developing, scaling up, and eventually transferring new initiatives to Traditional Monitoring.

TRPMI Implementation Barriers

Data Systems

A summary of the current status of the TRPMI data system development is below. Following the summary, the historical context and current efforts are described. Additionally, a detailed description of the scope of the work and issues/recommendations is provided.

Summary

- **Data system development stopped after October 2018.**
  The initial release of the TRPMI data system occurred in October 2018. Although TRPMI provided guidance to the Illinois Department of Information Technology (DoIT) and DCFS Office of Information Technology Services (OITS) for the next data system release, DoIT/OITS has not continued its work on the TRPMI data system. The lack of further data system development is concerning because the initial release represents only ~1/3 of the system's envisioned functionality, as will be described in the scope of work section below.
- **Development and use of a reliable and consistent data system has been a central focus for TPRMI operations support and quality improvement since the original DCFS Request for Information for Therapeutic Residential Treatment Services in 2015.**
  From its outset, the TRPMI Pilot was designed to be data driven, in contrast to previous monitoring efforts. Accordingly, all parties including DCFS, the B.H. Expert Panel, and DCFS's university partners - Northwestern University and the University of Illinois/Chicago - identified an effective data system as a central component of this effort, and this key element has been included in every TRPMI planning document.
- **TRPMI has been able to produce some actionable information using Microsoft Office applications.**
  TRPMI has been able to produce some actionable information from the Youth Experience of Care surveys administered across the state using Microsoft Word, Microsoft Excel, and the recently introduced PowerBI data manipulation and visualization tool. An excerpt of this information is provided below.
- **The TRPMI data system continues to experience implementation barriers and issues with DCFS and DoIT collaboration, and TRPMI offers recommendations for addressing these issues and barriers.**
  Further progress has been stymied due to a variety of operational and inter-divisional barriers. Current status and issues preventing further progress will be detailed below, followed by a set of recommendations that TRPMI believes will renew the collaboration between TRPMI, DCFS, and DoIT.
- **The TRPMI pilot should be considered in the "<u>initial implementation</u>" stage (NIRN) for purposes of BH Implementation progress reporting and evaluation.**
  The data system is conceptualized to be the foundation for all TRPMI operations. The poor progress and current immobilization with respect to development has prevented the TRPMI pilot from effectively moving forward on multiple fronts and

achieving positive outcomes. It is TRPMI's position that until the data system is substantially operational, the pilot will remain in the initial implementation stage.

The Historical Context for Development of the Data System

From the beginning -- and well before the establishment of the TRPMI pilot -- the critical importance of developing a reliable and effective data system has been a central focus with respect to our monitoring proposal. Both the Department's 2015 RFI as well as proposals generated by UIC and NU highlighted this key element. In fact, UIC's response to the RFI addressed the need for a technology-based monitoring program referencing the BH Expert Panels recommendation for "targeted areas of metric utilization and quality focus". UIC noted:

> …UIC assumes the Department will continue to utilize underperforming programs as long as there is a severe bed shortage and an immature outcomes program. Consequently, significant investments in both staff and technology are necessary in the foreseeable future for any program charged with providing the necessary oversight, support and technical assistance required to, at a minimum, ensure the safety and security of young people.

Additionally, UIC's 2015 RFI response also pointed to deficiencies in DCFS's existing data systems:

> ….the Department's current data systems cannot be relied upon to adequately supplement the current monitoring process, nor can it provide an adequate framework for a more sophisticated data system as suggested by the RFI." As a remedy, UIC advocated for the development of outcome measures delineated in the SAMSHA Building Bridges Initiative, and the Department has recently agreed that the Building Bridges framework could support implementation of the therapeutic residential procedures. *However, this strategy will require intensive efforts to develop new data systems. Unfortunately, UIC has not yet seen the Department dedicate resources that would indicate it prioritizes development of enhanced residential outcomes* (italics added).

It should be noted that of the 19 specific RFI questions posed by DCFS, 14 were related to metrics, technology, or predictive analytics. In fact, while UIC's response to the RFI concurred with DCFS regarding the critical role of data and technology, UIC also stressed the importance of including monitoring activities to supplement metrics, such as onsite observations and consultation. It is very concerning that despite DCFS's initial clear assessment that the development of a critical data capability was the primary (and largely exclusive) focus of an improved monitoring program, TRPMI's data system development has not been adequately supported by DCFS.

Finally, TRPMI notes that impending DCFS changes in response to the Family First legislation will also require improvements to DCFS's existing data systems. Recommendations from DCFS Family First workgroups planning these changes indicate the need for timely and consistent performance measures, utilization of Power BI technology, and integration with SACWIS, and they also emphasize the need to minimize

data tracking inefficiencies. The TRPMI data system is closely aligned with these mandates and should provide the flexibility to incorporate modifications as they arise over the course of Family First implementation.

TRPMI understands that the residential system directly impacts approximately 950 youth, who comprise a distinct minority of the ~15,000 children and youth in the DCFS system. Consequently, there may be concerns about using a disproportionate amount of DCFS resources for these youth. TRPMI contends, however, that residential youth are the most significantly impacted by mental health issues frequently associated with trauma, which requires a disproportionate allocation of services, supports, and resources. Consequently, we maintain that their treatment and oversight also require a more robust data system to support these efforts – a position that has been acknowledged by all parties but needs to be sufficiently supported at this juncture.

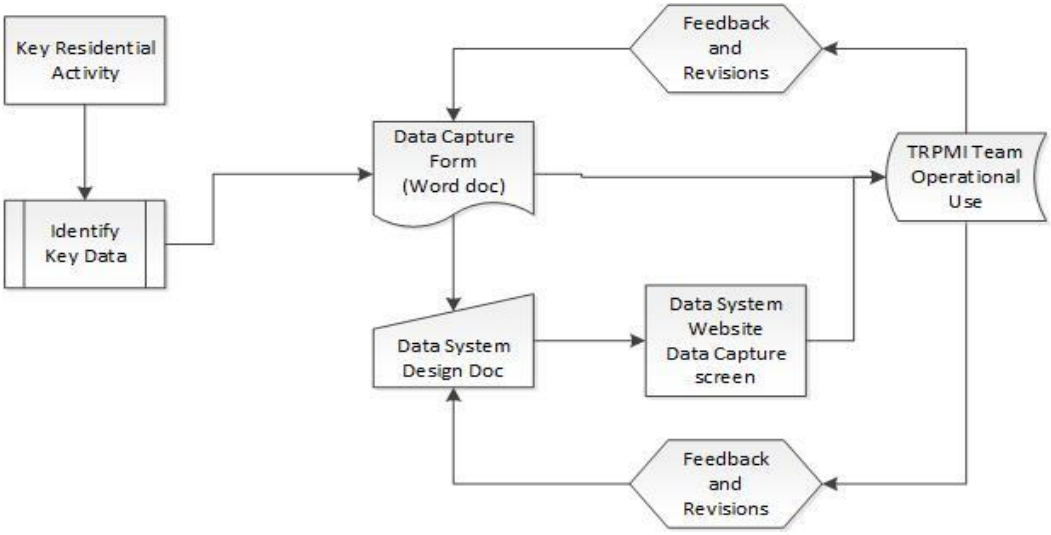
Current Efforts

TRPMI has been engaged in a data system development process that has been replete with interruptions, lack of follow through, and multiple levels of approval that has significantly delayed progress. Implementation has been delayed for months by setbacks related to OITS support redirected to address other priorities, as well as competing OITS directives and approaches. These issues have been the subject of dozens of discussions with DCFS, many TRPMI Steering Committee meetings, and multiple reports to the court related to TRPMI barriers.

Furthermore, even TRPMI's ability to rely on existing enterprise data systems for critical monitoring information has been significantly degraded in recent months due to serious problems with data fidelity across these systems. Consequently, not only has TRPMI been unable to gain traction and momentum on the data systems in development, but the existing systems cannot be reliably used any longer to support TRPMI's everyday monitoring work. For example, the TRPMI Runaway Reduction Initiative (described above) has been hindered by problems with the accuracy of runaway data in DCFS's existing enterprise data systems. While TRPMI was initially able to develop a few critical reports associated with this effort, over the past few months TRPMI no longer has that capacity because the Department's data and reporting capabilities are seriously flawed. TRPMI has repeatedly raised this issue with DCFS leadership, but we are unaware of any meaningful efforts to address the issue. Although TRPMI continues to carry out all other routine TRPMI monitoring activities, our ability use data to focus our activities towards youth and residential agencies are partially limited by the lack of valid and reliable runaway data from existing systems.

It should be noted that there was a period when TRPMI worked in a highly collaborative and effective fashion with DoIT. This was during the initial phase of TRPMI data system development in 2018, when TRPMI and DoIT staff worked together to improve design and development processes. As diagrammed below, the data system design process that TRPMI and DoIT implemented involved a synthesis of current operations, lessons learned, and best practices into key activities from which critical data are captured. Specifically, the process began by using Word document forms for data capture; these forms were designed to allow for data extraction to Excel. TRPMI team members used

these forms and provided valuable feedback to improve content and effectiveness. Once the forms were tested in the field, the design team used them as working artifacts to guide the design of an equivalent data capture form in the data system. This process was used to design the data system components (i.e., CASII, Child & Family Team Meeting worksheets, data entry pages) that have been deployed.

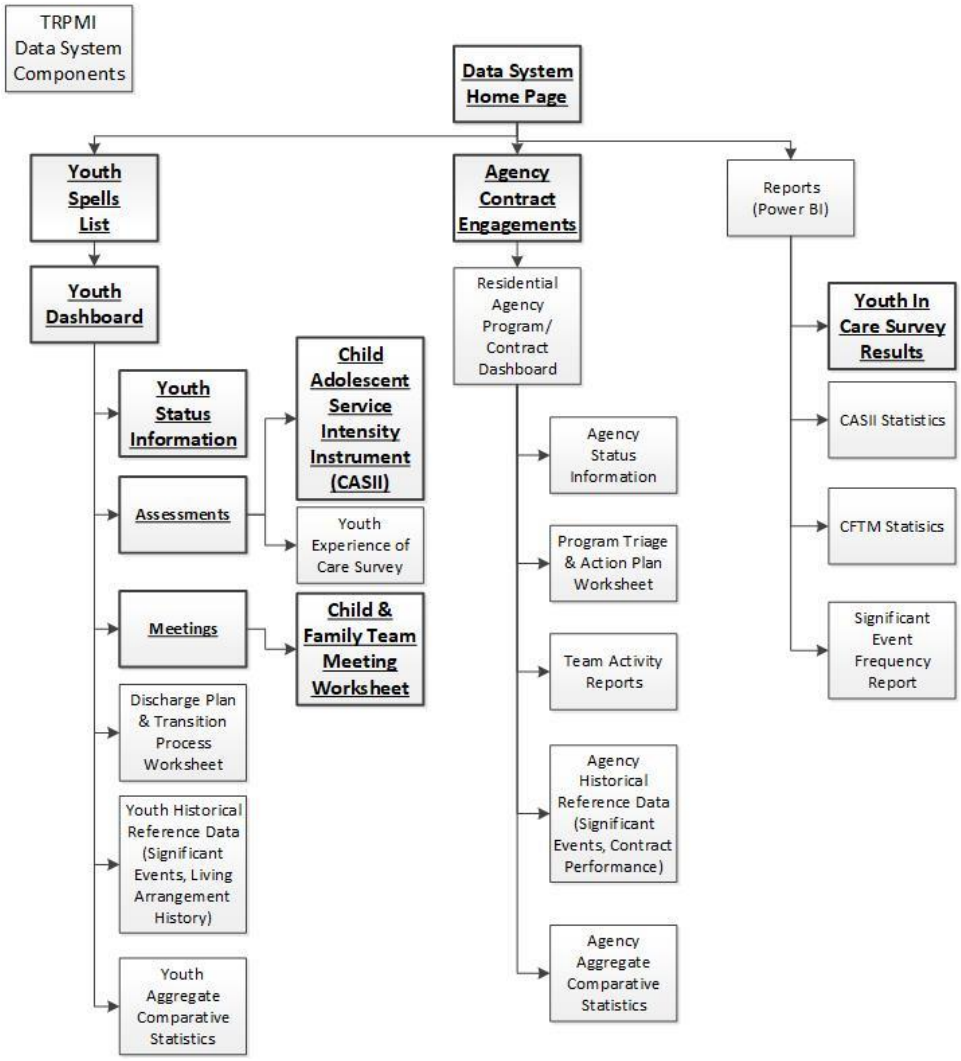


This effective approach to collaboration between TRPMI and DoIT programmers was interrupted upon deployment of the first phase of the TRPMI data system, as described in the Scope of Work section below. Specific examples of these interruptions and barriers are provided in the Issues and Recommendations section below.

TRPMI Data System Scope of Work

The TRPMI pilot project integrates best practices in child welfare, lessons learned in the field, and the experience of DCFS and its university partners (UIC, Northwestern and Chapin Hall), with the objective of improving monitoring, quality, and outcomes of residential care. The data system is being built to support the daily work of TRPMI monitors and to provide aggregate data that track and assess implementation of best practices as well as barriers. It is designed to provide a "one-stop shop" for collecting and integrating data pertaining to youth and residential programs, using dashboards to organize information.

The diagram below provides an overview of the scope of implemented and proposed components of the data system. The **bold and underlined** items in the diagram represent functions that have been implemented and deployed in the live data system. The other items in the diagram are currently undergoing design and pilot testing, or have been envisioned to be a future component of the data system.



TRPMI has also begun using Microsoft PowerBI for data exploration and reporting, starting with the recently administered Youth Experience of Care Survey, which integrated feedback from over 500 youth in TRPMI and non-TRPMI residential placements. The diagram below shows an example of analyses for youth in placements monitored by TRPMI.

Note that this effort was performed using Microsoft Office tools – Word, Excel, and PowerBI – and does not depend upon the TRPMI data system. TRPMI has recently gained access to the DCFS database environment, including SACWIS and TRPMI data. However, the documentation necessary to understand how these data are organized (e.g., data dictionary, table relationships) does not exist, **which severely limits the usability of these critical data**. If TRPMI receives guidance and documentation on the content of these databases, TRPMI is well positioned to develop and produce additional reports to illuminate a variety of aggregate youth behaviors, aiding the process of analysis and providing a channel for residential agencies to make data-driven choices on service offerings and improvements for their youth in care. Based on our experience throughout the TRPMI pilot, **we are not optimistic that we will receive the necessary supports to produce data reports as originally envisioned.**

Issues and Recommendations

1. Lack of progress on existing IT work - Significant Event Frequency Report
    a. The Significant Event Frequency Report (SEFR), used by TRPMI to track serious safety-related incidents, is meant to show the count of Significant Events for all youth under the care of a selected residential agency contract for a selected date range. Several calculation errors have been discovered during the past several

months, including bed day counts and counts of runaway episodes, when compared with the raw data contained in SACWIS.

b. Runaway count calculation errors were discovered and captured in 4 examples going back to August 2018. These examples were reviewed with DoIT in December. However, these errors have not been fixed.

c. Bed day calculation errors were also discovered in August 2018 and reviewed with DoIT in December. These errors have also not been fixed.

d. **Recommendation**: *DoIT should provide*
   i. Specific status and plans on correcting the SEFR,
   ii. Timeframes and due dates at the start of other TRPMI tasks, and
   iii. Status on all TRPMI tasks on a weekly basis.

2. Delays in Work Request Process

After deployment of the initial set of data system components in October 2018 (see **bold and underlined** items in the data system scope diagram above), further data system development has been halted due to significant delays in the work request process:

a. TRPMI is now required to submit a new Enterprise Service Request (ESR) for each request for a new set of data system components, which, in turn, requires DCFS Deputy Director approval, followed by DCFS/DoIT Governance Board evaluation for prioritization and assignment.
   - One ESR request (access to significant event data) was requested in October 2018 and finally resolved in January 2019.
   - **TRPMI must essentially re-litigate the need for additional data system features and functions in each ESR.**

b. TRPMI expects to submit several more ESRs to fully cover the scope of data system functionality, including, but not limited to:
   - Enhancements to enable the data system to be used by both TRPMI and Traditional Monitoring for all residential agencies across the state.
   - Data capture and reporting in support of the Runaway Reduction Initiative
   - Discharge Plan & Transition Process worksheets
   - Integration of youth reference data (e.g., significant events), living arrangement history, and trends and comparative statistics
   - Agency/Program Dashboard
   - Agency/Program Triage Evaluation worksheets
   - Team Activity Reports worksheets
   - Agency reference data (e.g., significant events, contract performance, aggregate trends, and comparative statistics)

c. Limited DoIT resources available for development. The initial phase of the data system development involved a dedicated and talented DoIT developer, which allowed for a high degree of responsiveness and concentrated work. Since the initial phase, TRPMI has not had consistent access to any DoIT resources much less the dedicated DoIT developer who initially worked with TRPMI.

d. **Recommendations**:
   i. *TRPMI must make the most of each ESR so that each ESR includes a comprehensive set of new functions, thus reducing the number of data system ESRs that need to go through the governance process.*
   ii. *DCFS and DoIT must then agree to commit resources for a longer term (6-9 months) to implement each ESR's requested functionality.*
   iii. *DoIT should continue to use an iterative/agile approach to the development process with TRPMI, which worked very successfully in the implementation for TRPMI Phase I. This would apply to all new ESRs and allow TRPMI to address bug fixes in the current implementation.*

3. Limited access to technical resources – staff and documentation
   a. Microsoft PowerBI preliminary work is characterized by slow progress, with no DCFS or DoIT resources to call on for coaching or technical support.
   b. DCFS has made no technical documentation available to allow TRPMI to understand what is contained in the wide variety of DCFS databases just recently made available for direct access.
   c. DCFS has not made available current documentation on content, field definitions, table relationships in the BI-SACWIS database.
   d. Far too many DCFS databases are overloaded with under/unutilized and often duplicative data. Due to the narrow focus of most departmental needs, there is no thought and little capability to provide for data sharing and collaboration.
   e. **Recommendations:**
      i. DoIT Data Warehouse must be a top priority to provide a reliable, well documented data environment where data consumers can work directly with data to produce reports
      ii. DoIT should provide documentation (e.g., data dictionaries, data table relationship diagrams) on DCFS databases, particularly:
         1. SACWIS – significant events, runaways, and SCR hotline calls
         2. TRPMI – the data tables that underpin the TRPMI data system itself
      iii. DoIT should provide technical assistance (coaching, training) on the various databases to enhance TRPMI's ability to make use of the data.
      iv. DCFS/DoIT/TRPMI should establish a PowerBI User Group to allow for the exchange of data analysis and reporting methods and techniques as they specifically relate to DCFS youth in care data.

<u>Personnel/Staffing</u>

All TRPMI Clinical Specialist and Quality Improvement Specialist positions, which are UIC and Northwestern contract positions, were completely filled as of April 2, 2018. In January, DCFS got the go-ahead from Illinois Central Management Services to create a new position to replace the Northern Region Team Coordinator, who had been on leave since July. This position was filled in August 2018. It should be emphasized that long-

term vacancies in the Team Coordinator positions are especially concerning because they significantly limit TRPMI's capacity to fully implement the TRPMI pilot.

The original DCFS Southern Team Coordinator resigned in November 2017. A DCFS replacement was hired in March 2018, but this person retired in July 2018, leaving the position again vacant. DCFS has been recruiting a replacement since July, but the position remains open. The TRPMI Field Services Manager, who is based in Chicago, has been serving as the acting Southern Team Coordinator. Given the considerable distance between Southern Region and the Chicago area, it is very difficult for TRPMI leadership to effectively manage this team in the absence of a permanent team coordinator.

A Southern Region Clinical Specialist resigned effective August 2018. The other Southern Region Clinical Specialist resigned December 2018. These are NU positions, and a search is underway to identify qualified applicants. It should be noted that recruiting qualified clinical staff is a challenge throughout the Southern Region. Additionally, a NU Clinical Specialist in the Northern Region is currently on maternity leave.

TRPMI continues to be relatively under-resourced with regard to the number of team staff carrying out day-to-day responsibilities of the pilot. Several agencies require resource-intensive monitoring due to youth safety and treatment concerns, and stepped up TRPMI involvement in several other programs would be indicated if resources allowed. For example, TRPMI would like to enhance ongoing monitoring efforts by conducting systematic youth or staff interviews at agencies with identified safety concerns and related issues as was done at several programs during the last reporting period. These interview processes were highly labor-intensive and required teams to spend several days on-site at each agency. The information gleaned from these interviews was extremely valuable and will likely guide monitoring efforts for the foreseeable future. Further, the individual focus on youth (e.g., permanency, transition planning, youth connections, Child and Family Teams), which is an essential part of TRPMI's mandate, continues to require significantly more resources than were originally projected and allocated. Finally, development and implementation of new initiatives, and addressing critical issues such as youth runaway, require significant resources, not the least of which is related to highly intensive efforts associated with preparation of reports to guide our activities due to the lack of an effective data system. Accordingly, as currently staffed, TRPMI is unable to meet all system, youth, and agency needs as originally proposed. TRPMI continues to recommend revisiting the TRPMI staffing plan with DCFS to reassess the possibility of expanding the number of TRPMI clinical specialists statewide.

Collective Bargaining Grievance

In 2018 AFSCME and DCFS agreed that the TRPMI pilot would continue with the understanding that the parties meet every 90 days to discuss the pilot's status and that additional discussions will also occur in the event DCFS desires to increase or decrease the number of monitoring positions. During this period, TRPMI learned that DCFS staff on the TRPMI teams expressed concern that DCFS monitoring positions could be impacted if the TRPMI pilot is successful. As a result of these concerns, TRPMI

recognizes that there exists a potential conflict of interest with respect to TRPMI monitors, most of whom are employed by DCFS, and their role in implementing a successful pilot. Further, TRPMI has learned that DCFS staff on the Southern Team, as well as some residential providers, believed that the TRPMI pilot would be concluding shortly due to the grievance. While the temporary resolution of the grievance should help clarify these issues, in our view these ongoing concerns have especially impacted the functioning of the Southern Team. TRPMI and DCFS Monitoring leadership have been discussing ways to remedy these issues.

Current Update:

In January 2019 TRPMI was asked to respond to AFSCME's inquiry regarding use of mandatory overtime and expectations for in-person meetings. At this juncture TRPMI is unaware of the nature of these additional AFSCME concerns or other issues. TRPMI has indicated to DCFS a willingness to address and discuss issues raised by AFSCME that may arise during the pilot.

DCFS Endorsement of TRPMI to Stakeholders

Another notable barrier to successful TRPMI implementation relates to ongoing challenges in collaborating with DCFS divisions other than Monitoring, as well as other stakeholders. Several critical TRPMI initiatives require cooperation and coordination with a variety of additional stakeholders, both within and outside DCFS. TRPMI recognizes the many challenges inherent in these kinds of collaborations across stakeholders and silos within the DCFS system. From TRPMI's perspective, it is apparent that many stakeholders perceive that the Department is ambivalent with respect to the TRPMI initiative. For example, following a considerable period of reluctant cooperation with TRPMI, one residential provider shared that they were informed that TRPMI was incentivized to "find problems" in order to justify our existence! Accordingly, TRPMI continues to recommend a formal or informal endorsement of TRPMI by DCFS leadership to enhance TRPMI's credibility with other DCFS stakeholders and promote mutual accountability. TRPMI plans to attend DCFS regional meetings in the near future to facilitate collaboration. We continue to recommend that DCFS leadership endorse our participation and collaboration.

Critical System Barriers Impacting Residential Youth/Families

The TRPMI teams, as well as the Traditional Monitoring staff, are stymied by longstanding systemic barriers that have significantly impacted effective and efficient treatment and outcomes for youth and families involved in the residential system. Several of these barriers are so critical and pervasive that their impact often overwhelms monitoring and provider efforts to enhance residential program effectiveness. In several cases, conditions directly impacted by these barriers are worsening. While some of these barriers are related to the residential service system itself, other barriers are associated with coordination with other parts of the DCFS and POS structure as well as with community placements, supports, and services.

As stated above, TRPMI believes that these barriers are among the most significant factors that negatively impact the safety and well-being of youth treated in the residential service system, and their impact cannot be overstated. Extraordinarily long lengths of stay (among the longest in the nation), violations of youth's rights related to extended periods in highly restrictive environments despite the recommendations of treatment teams, limited access to critical services, and inadequate attention to permanency pathways for these youth (which, in part contribute to Illinois having the longest time to permanency in the nation) are all artifacts of these problems.

While disagreement exists regarding TRPMI's role with respect to identifying and quantifying the impact of these barriers when possible and partnering around solutions, TRPMI maintains that it is critical to highlight these concerns. In our view, by limiting TRPMI activities to those of Traditional Monitoring, and absent sufficient attention to these system issues, the pilot will, in effect, be confined to working around the margins and will limit the pilot's impact.

In an effort to better document the scope and magnitude of these problems and propose solutions, TRPMI has begun to track and analyze recurring residential- and system-related barriers that impact youth step-downs to community based settings, including availability of placements and essential community based supports and services for youth and families. For the most part, TRPMI has experienced the same system and TRPMI pilot implementation barriers as indicated in previous monthly status and triannual reports.

Several challenges that have been identified by TRPMI, and others associated with residential program options and agency functioning appear to be worsening. These are described below.

Workforce Crisis – Residential and Permanency Worker

Residential Workforce

Serious workforce limitations are associated with extremely high staff turnover rates for many agencies forced to compete for staff in an increasingly strong economy. This is particularly deleterious as programs strive to meet state and federal expectations with respect to incorporating relatively sophisticated trauma informed milieu operations, individualized treatment, and other evidence based practices into their program model. This requires additional training and the acquisition of a complex skill set for all staff. Workforce limitations with respect to retention and recruitment severely impede this process. Use of temporary staff and utilization of high rates of overtime are widely prevalent and contribute to unsafe and counter therapeutic environments. Additionally, agencies consistently report that growing expectations (including TRPMI's) to facilitate youth connections and the development of a permanency pathway further strain the capacity of programs to maintain in-house programming and safety while -- at the same time -- expending limited resources to address additional expectations. Additionally, TRPMI has received anecdotal reports of serious difficulties finding qualified professional mental health therapists in the Southern Region, in particular.

Although workforce issues in residential programs are a nationwide problem, workforce challenges are particularly acute in Illinois. The DCFS per diem rate for residential programs has remained stagnant for many years while the costs of providing residential treatment continue to rise. While some agencies can partially compensate through fundraising, the overall situation is already at a crisis point. It should be noted that several states with mature systems of care provide significantly higher per diem rates for residential programs (e.g., New Jersey) than in Illinois, even after adjusting for cost of living differences. Many Illinois residential agencies have developed creative approaches to hiring and maintaining staff, and TRPMI has partnered with programs to highlight these activities as critical components of their QI efforts. For each program, review of vacant positions, use of overtime and temporary staff, and efforts to lessen the impact of turnover on safety and programming are routine agenda items. However, these efforts can only have a limited impact given the current context. TRPMI understands that the Child Welfare Workforce Act (Senate Bill 2628) was recently enacted by the Illinois legislature and establishes a task force intended to address this issue. TRPMI strongly supports these efforts because the ability of any initiative to provide safe and effective treatment for youth will be significantly limited until workforce issues are addressed.

Current Update:

In an effort to address the residential workforce crisis, DCFS instituted a retention bonus for staff working directly with youth in residential programs. While this bonus was a positive step, it is insufficient for fully addressing the workforce problem. TRPMI has recommended that providers begin reporting staffing vacancies by job type as part of the provider monthly reports to TRPMI and DCFS. Currently this information is not provided in a manner that allows for quantifiable data reports and analysis. If implemented, the proposed modifications will allow TRPMI to track vacancy percentages for each agency and across the system to better inform discussion around this serious problem.

Permanency Worker Workforce

TRPMI is aware of longstanding problems related to collaboration between permanency workers and residential providers around a multitude of issues pertaining to youth in residential programs. More recently, TRPMI has initiated several projects aimed at enhancing youth connections to families and significant adults, implementing child and family teams, and developing and implementing complex transition plans for challenging youth. Consequently, TRPMI has gained a better understanding of some of the issues associated with caseworker involvement and collaboration.

TRPMI was gratified to find that collaborations with DCFS administrators regarding these initiatives were productive in terms of initial planning efforts. However, it quickly became apparent that there exist severe caseworker shortages, particularly in some areas of the state. For example, TRPMI was told that teams designed to function with 5 permanency workers are attempting to manage with only 2 permanency workers. These shortages, identified by multiple DCFS administrators, result in permanency workers being overwhelmed and not able to adequately balance the multiple responsibilities of their job. Key elements of the DCFS practice model that are the basis of several of the

TRPMI initiatives require permanency workers to prepare for CFTMs, identify and engage adults who may comprise a youth's support system, and take the time to collaborate and play a key role in implementation of transition plans and post-discharge supports and services. It is clear that there are currently insufficient permanency staff resources to carry out all of these expectations.

The underpinnings of these significant caseworker shortages likely differ between POS and DCFS staff. For example, POS caseworkers are much more likely to leave their job entirely, while DCFS staff frequently change positions within DCFS, with staff often transitioning to other types of roles and duties. According to DCFS administrators, retirement also plays an important role in caseworker shortages. While TRPMI recognizes that this issue is clearly outside the scope of the pilot to address, it is essential to underscore the impact of these shortages on planning and implementation of activities that are central to the mission of residential providers. Given the complexity and multiple challenges that youth in residential care and their families present, active involvement on the part of the permanency worker is vital. The outcomes of youth in residential programs and their families are unlikely to substantially improve until this problem is adequately addressed.

Given these severe shortages, TRPMI staff (as well as residential provider case managers) have "filled in" for permanency staff in cases where lack of worker involvement is especially concerning with respect to impact on the youth and family. Obviously, this is a last resort, as it can cause role confusion and discord between permanency workers and TRPMI staff; however, it should be noted that in some situations, permanency workers welcome this assistance.

Current Update:

Shortages and turnover of permanency workers continue to impact residential youth in terms of worker continuity and demands. TRPMI continues to be informed anecdotally that caseloads of 30 or more youth are not uncommon. Permanency workers are also under pressure to improve CFSR outcomes, so the tasks associated with these outcomes are prioritized above other duties.

Residential Service System Deficits

There exists a lack of adequate residential treatment options for the most challenging youth who often present with severe mental health and behavioral problems and increasingly, juvenile justice involvement. Without addressing this deficit, referrals to out of state programs will likely increase over time – a practice that has had negative consequences for Illinois youth in the past. Additionally, limitations of existing residential programs play a significant role in youth matriculating through a revolving door of residential placements and create unsafe conditions in residential programs. TRPMI has observed that many programs are unprepared to successfully treat and manage significant numbers of these especially challenging youth. As an initial step in an effort to further inform this discussion, TRPMI plans to quantify and report the proportion of residential youth dually involved in the juvenile justice system in each TRPMI residential program.

TRPMI conducted an initiative that should facilitate discussion and planning for potential solutions associated with these residential service system deficits. During January and February 2018, TRPMI fielded a survey with Illinois residential providers, DCFS leadership, DCFS and NU staff involved in matching and placement of youth in residential programs, Office of the Cook County Public Guardian, and other stakeholders to systematically identify critical gaps in the Illinois residential services system that have been long discussed by stakeholders. Analysis of the close-ended questions was completed in March, and the analysis of the open-ended questions was completed in August. TRPMI shared preliminary results with the Steering and Advisory Committees in February and March, respectively, and presented findings at a DCFS statewide summit in May.

Survey results indicated:

- Youth that represent the most significant challenges to existing residential providers presented with severe behavioral problems, runaway behaviors, and traumatic stress symptoms.
- In response to the question regarding the most critical additional program supports that would help providers safely and effectively treat these youth, areas most often endorsed related to enhanced staff resources, staff retention, and qualifications of staff.
- 65% of respondents agreed that the Illinois residential service system should include a secure care component, with 14% disagreeing and 22% unsure. Qualitative responses indicated that the primary advantages of having secure care available were to ensure youth safety and promote treatment engagement. According to the qualitative data, the primary disadvantage was the potential for misuse related to admission criteria and oversight. Also, the development of a coordinated continuum of services was highly recommended.
- Regarding the question pertaining to system of care features that would significantly enhance residential programs' ability to effectively stabilize these youth, respondents most often endorsed greater availability of step down placements, greater emphasis on family engagement, and more effective child and family teams.

Informed by the survey results, TRPMI has also reviewed the residential program array in New Jersey, North Carolina, and Maryland -- three states with mature systems of care -- to better understand the range, scope, and funding of their residential services systems. Despite the fact that these states have a vastly more effective and comprehensive system of community based services and supports, they also have a broader range of residential treatment options that are better resourced and supported than is the case in Illinois. For example, New Jersey has 7 types of residential and group homes, 2 types of substance abuse residential and group homes, and 4 types of residential and group homes serving ID/DD youth. New Jersey has implemented a subacute inpatient program. At the most intensive end of their residential continuum, the per diem rate (inclusive of Medicaid), is $882, well over twice what Illinois pays its “severe” in-state providers, and accordingly, these programs have a significantly higher direct care staffing ratio of 1 staff person per 2 youth in care whereas the highest staffing direct care staffing ratio in DCFS’ Illinois residential programs is 1 staff person per 3 youth in care. North Carolina also has a range

of options that include several settings specifically designed as secure care. Maryland has a rigorous RFP vetting process that helps ensure that prospective programs have the capacity and ability to effectively serve these challenging populations, a deficit TRPMI identified in a previous Lessons Learned report regarding Illinois. TRPMI believes that these states have addressed the problems Illinois stakeholders delineated in the survey, and TRPMI encourages DCFS to initiate ongoing discussions with representatives from these jurisdictions to inform future planning efforts.

As our data system allows, TRPMI plans to review existing data regarding the high proportion of youth in the DCFS residential system who experience lateral or "step up" movement within residential treatment, discharges to runaway and detention, and discharges to out-of-state residential programs, which typically occur because of a lack of appropriate services in the Illinois system, to more fully inform this analysis.

TRPMI hopes that these activities will assist DCFS in developing a strategy and vision for resource planning. TRPMI continues to participate in DCFS's ongoing meetings in which some potential new residential programs are discussed.

Current Update:

- *Placement of youth in out of state programs, primarily secure care, is trending upward. New program development is occurring at a slow pace, and DCFS reports that existing residential providers are not expressing a substantial interest in opening new programs to serve youth with complex needs. TRPMI understands that an RFP is being considered by DCFS, which was a TRPMI recommendation in 2016.*
- *TRPMI did not complete its plan to quantify and report the proportion of residential youth dually involved in the juvenile justice system in each TRPMI residential program. However, TRPMI was alerted to this issue when working with one moderate program for mentally ill youth in the Southern Region experiencing high levels of runaway and involvement with law enforcement. This agency reported that approximately half of the current youth admitted to the program had previous involvement in the juvenile justice system. TRPMI will continue to look for a data source to analyze this issue on a system level.*

<u>Community Resource Limitations</u>

Consistent with the rationale for the MB lawsuit and the HFS Better Care Illinois 1115 Waiver, adequate access to and availability of necessary supports and services for youth with significant mental health and behavioral challenges is a significant problem. There is a scarcity of the community-based, evidence-based services and supports outlined in the CMS/SAMSHA Informational Bulletin, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*, across Illinois available to youth in the child welfare system. For example, although intensive placement stabilization (IPS) services are available for youth in community-based placements, TRPMI has been informed that many TRPMI youth who are stepping down have behavioral health needs beyond what IPS was designed to provide. The CASII assessments conducted by TRPMI staff corroborate these assessments – many youth who stepdown from residential treatment require an intensity of clinically informed services

that is far beyond that which is currently available through IPS or other community mental health resources. Consequently, many youth who stepdown from residential are at considerable risk for failing their community placement and requiring more restrictive treatment again. Similarly, access to these resources, if available to youth and families, would play a key role in providing timely and effective intervention that would help avoid reliance on residential treatment in the first place. Furthermore, the inadequate access to care coordination, critical for integration of service delivery and problem solving for youth with complex behavioral and emotional needs served in the community, is a significant deficit. Finally, while DCFS supports the provision of flexible funds to support family-based placements, bureaucratic impediments often create lengthy delays in approving and transmitting flexible funds to caregivers. It is critical that these problems are effectively addressed, as individualized supports and services for youth in family-based placements are likely to be recommended more frequently through the CFTM process.

Another concern regarding sufficient availability of community mental health resources is the impact of the new Medicaid managed care requirements for child welfare system youth on access to community mental health services. Beyond being informed that the implementation of Illinicare for Illinois child welfare system youth has been postponed repeatedly, TRPMI has received very little information about how Illinicare will be implemented. TRPMI had hoped there would be participatory planning and clarity provided during the roll out. Given the critical role that community mental health services play in ensuring successful residential stepdown, TRPMI specifically requested via the Steering Committee an opportunity to be included in the Illinicare planning process to provide input. Additionally, TRPMI has recommended that Dr. Michael Naylor, a UIC child and adolescent psychiatrist and former member of the BH expert panel, be consulted in this regard because his knowledge of the needs of DCFS youth with severe emotional disturbances would be invaluable in Illinicare implementation planning. To date, neither TRPMI nor Dr. Naylor has been involved in discussions regarding these issues, nor has TRPMI received information about potential community-based supports and services that will be provided or how these supports and services will be financed under the new managed care model. Finally, it appears that plans to address the community services and supports are also being considered as part of the Family First implementation activities. TRPMI is concerned that there appears to be a lack of coordination between the Family First planning, Medicaid managed care, and the BH expert panel with regard to these critical issues. In some areas, TRPMI believes conflicts exist between the Family First plans and the BH panel's recommendations and priorities.

Foster Care System Crisis

At the urging of DCFS leadership and the expert panel, UIC and NU TRPMI leadership, in partnership with Chapin Hall, reviewed TRPMI data to identify barriers youth and families experience when transitioning from TRPMI residential programs. Barriers were grouped into three categories and the frequency of occurrence was estimated. Potential solutions were identified for each barrier. This report was submitted in December 2017 to the TRPMI Steering and Advisory Committees for review and discussion. To date, TRPMI is unaware of any substantive follow-up activities taken by DCFS regarding these

recommendations. This inaction is especially troubling in light of the foster care crisis that exists in relation to both capacity and ability to address the needs of this population.

Current Update:

TRPMI maintains that the deficits in the foster care system are fueling potentially inappropriate residential admissions. TRPMI providers are increasingly reporting that some youth recently admitted to their programs do not require residential treatment. The first chart below indicates that during the 3 month period between October and December 2018, 22 of the 79 (28%) youth admitted to TRPMI programs were new to DCFS care and their first placement was in a residential facility. Furthermore, 14 of these 22 youth had no family finding completed, 4 of these 22 youth had initial family finding completed without follow up, and the remaining 4 youth received comprehensive family finding services. Because these youth are new to care, timely and effective family finding along with CFTM supports and services may have helped avoid the need for residential placement for some of these youth. Furthermore, 13 of the 15 youth (87%) not new to care who were admitted to residential treatment following psychiatric hospitalization were hospitalized after a foster care disruption. Additionally, TRPMI has observed an increasing trend in the number of youth admitted to residential programs due to dependency. The second chart below indicates that the case type at opening for 22 of the 79 (28%) youth admitted during the same period was dependency, most of whom were "hospital lock outs."

Previous Living Arrange of Youth Admitted to TRPMI Programs October - December 2018			
Previous LIVAR	# Youth	% Youth	1st Placement Residential*
Foster Home Specialized	8	10%	NA
Foster Home Relative	3	4%	NA
Foster Home Fictive Kin	1	1%	NA
Foster Home Traditional	1	1%	NA
Hospital Facility Psychiatric	31	39%	16
Shelter	8	10%	3
Detention/DOC	11	14%	1
Group Home	2	3%	NA
RTC	11	14%	NA
UAP	1	1%	NA
Home of Parent	2	3%	2
Total	79	100%	22
**previous living arrangement either psychiatric hospital, detention, shelter or home of parent*			

Case Type at Opening Youth Admitted October-December 2018		
Case Type	# Youth	% Youth
Abuse	4	5%
Child Behavior Problem	7	9%
Court Ordered Neglect	4	5%
Dependent	22	28%
Neglect	40	51%
Unknown	2	3%
Total	79	

Matching

TRPMI continues to observe significant delays in the time it takes for a youth to be matched and appropriately placed, especially for youth with a plan for discharge to foster care. It should be noted that a youth is referred to the matching process *once the treatment team/CFT has determined that the youth is ready for discharge,* at which point the treatment team/CFT begins seeking a post-discharge placement and accompanying services. The lengthy delays between initiation of the matching process and actual discharge as noted below, results in youth lingering in highly restrictive residential facilities for lengthy periods, which for many youth generates a sense of hopelessness and ultimately iatrogenically exacerbates symptomatic behavioral manifestations.

In the previous triannual supplement submission report, TRPMI reviewed youth who had been recently discharged. Of the 78 youth in the matching process on April 30, 2018:

- 33 were discharged between May and July 2018; for 10 of the 33 youth (30%), the actual discharge date occurred at least *9 months after initiation of the matching process.* 45 of the 78 youth (58%) who were in the matching process as of April 30, 2018 were not discharged from their residential program as of the end of July 2018.
- Most youth with long wait times were waiting for a foster care placement. In April, foster care was the identified discharge living arrangement for 33 youth (including 2 youth waiting for relative foster care). However, the discharge plan for several of these youth changed to another level of care due to the lack of foster homes willing to accept them.

Current Update:

A similar analysis was completed for youth positively discharged from TRPMI programs in 2018. As noted below, 15 of 33 (45%) youth who discharged to a foster care placement waited at least 6 months following treatment completion to move to a foster care placement. The proportion of youth who waited at least 6 months following treatment completion to stepdown to either TLP (13 of 45) or within residential/GH (10 of 35) was 29%. It should be noted that several of the youth who stepped down within residential/GH were initially waiting for foster care.

Matching Times by Living Arrangement Type for Discharged Youth in 2018							
	Time in Matching - # Youth						
Step Down LIVAR	0-3 months	3-6 months	6-9 months	9-12 months	12-18 months	more than 18	Total
Foster Care	5	13	8	5	1	1	33
TLP	24	8	7	3	2	1	45
Residential/GH - Step Down	17	8	3	1	4	2	35
Total	46	29	18	9	7	4	113
	41%	26%	16%	8%	6%	4%	100%

In the previous triannual supplemental submission report, TRPMI reported 45 of the 78 youth (58%) who were in the matching process as of April 30, 2018 had not been discharged from their residential program. As of July 29, 2018, 19 of those 45 (42%) youth had waited at least 9 months for a stepdown placement.

Current Update:

TRPMI reviewed matching delays for youth currently in residential placement (as of 1/14/19). The chart below indicates that 33 of 75 (44%) of youth in the matching process had been waiting at least 6 months following treatment completion; 21 of these 33 (64%) youth are waiting for a foster care placement.

Matching Times by Living Arrangement Type for Current Youth (as of 1/14/19)							
	Time in Matching - # Youth						
Step Down LIVAR	0-3 months	3-6 months	6-9 months	9-12 months	12-18 months	more than 18 months	Total
Foster Care	9	14	9	4	7	1	44
TLP	4	4	2	0	0	0	10
RTC/GH - Step Down	4	4	3	1	3	1	16
RTC Lateral or Step Up	1	2	1	0	1	0	5
Total	18	24	15	5	11	2	75
	24%	32%	20%	7%	15%	3%	100%

Although these current data and the data from the previous report were analyzed a bit differently, there is no evidence that the lengthy discharge delays are improving, and youth continue to languish in restrictive residential environments long past completion of treatment.

Taken together, the data regarding matching along with the data regarding residential admissions strongly indicate foster care capacity and capability are insufficient to meet the needs of youth with complex behavioral and mental health needs. Several of the recommendations delineated in TRPMI's December 2017 report to the TRPMI Steering and Advisory Committees directly addressed the foster care issue. Selected recommendations from this report are highlighted below, and TRPMI recommends immediate attention regarding further development in these areas.

1. *Establish a lead agency pilot model, using case rates, with a competent residential agency that has an out-of-home service continuum, including case management*

responsibility. The lead agency could subcontract for some services, as a single provider may not initially have the capacity to provide a service array that includes home and community-based services.

2. *Develop and implement effective Child & Family Teams. DCFS needs to clarify expectations and clearly communicate this policy. (While there has been development in this area, DCFS should identify and address weaknesses in the implementation process.)*
3. *Make peer supports available for families, caregivers, and youth. Peer services available to caregivers should provide in-home, trauma-informed consultation.*
4. *Develop and implement planned and crisis respite services for stepdown caregivers.*
5. *Develop and implement training on how to develop crisis prevention plans.*

Residential Discharge Practice

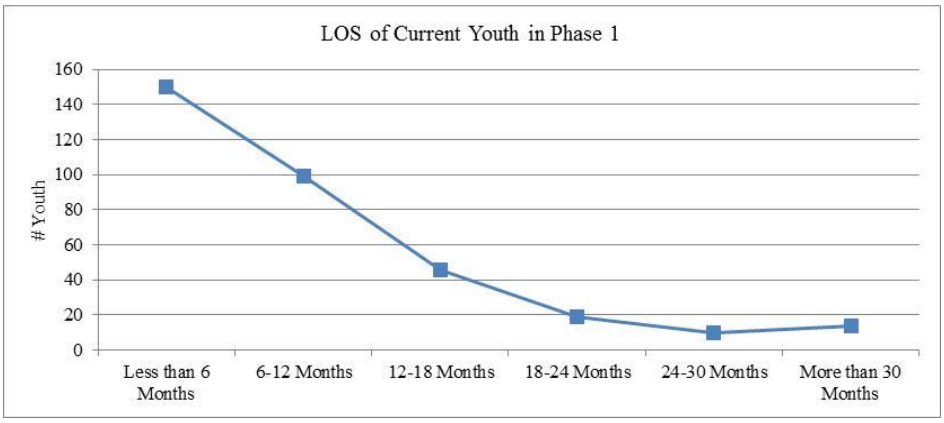
TRPMI and other stakeholders have been concerned about long lengths of stay for youth in residential treatment. As the chart below indicates, 102 of 456 (22%) of youth in residential agencies monitored by TRPMI have been in their current residential treatment program for at least 18 months, as of 1/14/19. (Please note that an analysis using an admission or discharge cohort would show a longer average length of stay.)

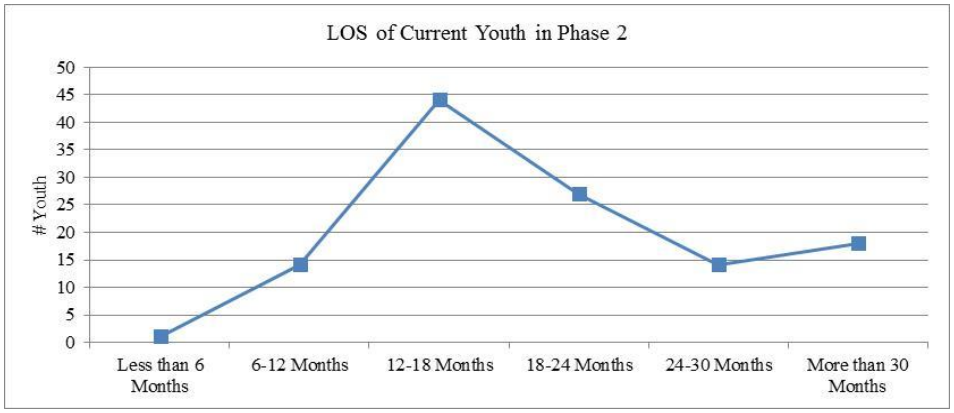
Length of Stay of Current Youth (1-14-19)								
TRPMI Team	Agency	Less than 6 Months	6-12 Months	12-18 Months	18-24 Months	24-30 Months	More than 30 Months	Total
Cook	CHASI Rice	5	13	6	5	3	1	33
	Ibukun	1	1	2	1	0	0	5
	Lawrence Hall	9	12	9	3	2	3	38
	Thresholds	10	4	5	5	1	1	26
	UCAN	14	19	11	11	1	1	57
	Cook	39	49	33	25	7	6	159
Northern	Allendale	38	18	25	5	1	2	89
	Arden Shore	2	3	0	1	0	0	6
	Little City	1	1	1	0	1	11	15
	One Hope United Northern	7	8	4	0	0	0	19
	Northern	48	30	30	6	2	13	129
Southern	Catholic Childrens Home	2	3	1	1	0	1	8
	Five Star Industries	0	0	0	1	1	1	3
	Hoyleton	11	2	8	5	7	7	40
	One Hope United Hudelson	10	6	7	2	0	0	25
	Spero Family Services	12	4	4	0	1	0	21
	St. John Bosco Children's Cente	9	7	4	2	4	2	28
	Transitional Center	20	12	3	4	2	2	43
	Southern	64	34	27	15	15	13	168
	Total	151	113	90	46	24	32	456

While there are many factors that impact length of stay, several are associated with residential discharge practices specific to Illinois. TRPMI believes that a primary driver in this regard is the Phase I and Phase II framework for transition and discharge planning. TRPMI field staff have observed that in actual practice, significant transition and discharge planning activities are not initiated until youth "complete" treatment during Phase I. Once a youth's team determines that the youth has completed treatment and is

ready for discharge, the youth is moved to Phase II. For youth who do not have an identified discharge resource, the matching process is initiated in Phase II. As noted above, the matching process is frequently very lengthy, and many youth remain in Phase II for several months or even a year or more.

The length of stay distribution displayed in the first chart below is for the 338 of 456 youth (74%) currently in TRPMI-monitored residential programs who are in Phase I (as of 1/14/19). The second chart for the remaining 118 youth (26%), who are in Phase II (also as of 1/14/19). The first chart shows that 89 of the 338 Phase I youth (26%) have been in Phase I for at least 1 year. Our internal TRPMI data indicate that for most of these youth, a stepdown caregiver has not been identified. The second chart shows that 103 of the 118 Phase II youth (87%) have been in residential treatment for at least 1 year and 32 of the 118 Phase II youth (27%) have been in residential treatment for at least 2 years.





The typical way that Phase I and Phase II are currently practiced interferes with active transition and discharge planning that should start at residential admission (i.e., at the beginning of Phase I) rather than at the beginning of Phase II. There is strong anecdotal evidence that this practice significantly delays stepdown. DCFS identified this as in issue several years ago and spent considerable resources to develop residential procedures based on best practices. Implementation of these procedures could provide a catalyst for redefining overall practice. Additionally, implementing the procedures in conjunction

with other system recommendations (see pages 27-28) would lay the foundation for significantly relieving the gridlock currently experienced. TRPMI recognizes that the magnitude of change suggested by these recommendations is enormous, and benefits would not immediately be realized. However, this level of change is necessary to meaningfully impact the lives of children and families served by the residential service system.

Issues Regarding the TRPMI Pilot Evaluation

TRPMI has identified substantive issues regarding several components of the TRPMI evaluation, as indicated below.

CANS Measures

The TRPMI Evaluation Subcommittee discussed the following issues and concerns related to the CANS outcomes.

- In reviewing the TRPMI evaluation data from the September-December 2017 triannual supplemental submission report, it became clear that the current approach to measuring progress, in which average CANS domains scores across all residential youth who had a CANS administered that quarter are being compared over time, which does not adequately identify improvements. Specifically, aggregating several individual items into broader domains dilutes the impact of improvement of a single item. Consequently, the Subcommittee agreed that this approach is limited in its ability to identify observable differences. In response to this concern, the Subcommittee identified 3 alternative options for deploying CANS data to assess youth progress, and Chapin Hall produced and presented preliminary results to the Subcommittee. The Subcommittee felt the best option was to use a limited number of individual CANS items rather than domains. The Subcommittee is finalizing the list of CANS items for future evaluation reports by choosing the items most applicable to residential treatment from the list of well-being items generated by the CWAC Well-being Committee.

  Current Update:

  This issue was addressed when 9 CANS items were selected for inclusion in the evaluation as outcomes to replace the CANS domain scores. The selected CANS items include:

  1. *Adjustment to trauma*
  2. *Attention deficit/impulse control*
  3. *Oppositional behavior*
  4. *Affect dysregulation*
  5. *Anger control*
  6. *Danger to others*
  7. *Runaway*
  8. *Judgement*
  9. *Social function*

- There exist significant reporting inconsistencies among residential providers and permanency workers. There has been a lack of clarity about whether residential providers or permanency workers are responsible for completing the CANS for youth while they are in a residential treatment setting. Consequently, not all youth have a CANS administered every 6 months while in residential.

  Current Update:

  This remains an ongoing concern. In addition, residential providers will be required by Medicaid to complete a different CANS instrument – the IM CANS – which raises additional questions. At the current time, the Department has directed providers to complete the current CANS and the IM CANS. TRPMI anticipates that not all providers will complete both instruments due to redundancy and, accordingly, CANS compliance issues will likely increase beyond existing variability in CANS compliance. Additionally, a crosswalk between the two different versions of the CANS will be necessary.

- There has been no ongoing fidelity monitoring of the CANS assessment process. For example, it is unclear what proportion of the clinicians administering the CANS have current certification for administering the CANS. TRPMI is aware that DCFS recently launched a CANS certification/re-certification program to remedy this situation going forward.

  Current Update:

  This issue has not been addressed to our knowledge and poses a problem with the historical CANS date utilized in the evaluation process.

TRPMI has several recommendations to address the limitations associated with using residential CANS data as TRPMI outcome measures.

- TRPMI *concurs* with the decision to use individual CANS items rather than CANS domains as measures.

- DCFS needs to clarify who (residential providers or permanency workers) is responsible for administering the CANS to youth while they are in a residential treatment setting and how the CANS data is then incorporated into the evaluation.

  Current Update:

  This remains unaddressed, and data that identify which CANS are used and dates of the CANS used should be made available.

- It is essential when reporting CANS data (or any other data) to also include identified limitations that should be considered when interpreting the data.

  Current Update:

  The most recent evaluation report addresses some limitations but does not identify the multiple limitations associated with implementation of the CANS by DCFS. It should also be noted that TRPMI has been addressing provider reporting fidelity related to

significant events. Provider reporting fidelity varies significantly and should also be identified as a potential limitation in the evaluation of the data.

- TRPMI strongly supports DCFS's efforts to increase CANS certification and recertification among persons responsible for administering the CANS, and it will be important to include anyone who will be completing CANS for youth in residential treatment. Although future CANS data should be more reliable due to certification and recertification, TRPMI recommends that the Evaluation Subcommittee reassess the utility of using existing CANS data due to the large number of missing CANS data for many youth in residential treatment and concerns about the reliability of existing CANS data.

  Current Update:

  This remains unaddressed. However, going forward, it appears certification will be completed for those individuals completing the new IM CANS. As noted above, the lack of certification for individuals who have completed the historical CANS is of concern.

  Regarding the IM CANS, there needs to be: 1) Clarification about which CANS will be used going forward in the evaluation, 2) Resolution of the duplicative requirement that providers must complete two versions of the CANS during the transition period, and 3) A determination that completing a cross walk between the two versions of the CANS is feasible.

Additionally, in recognition that the other administrative data measures being used in the evaluation are limited in their ability to assess individual youth-level changes, the Evaluation Subcommittee has begun discussing potential supplemental evaluation measures that may better assess youth- and program-level improvements over time.

Current Update:

This has not been addressed. As noted earlier, the logic model revisions have been completed.

<u>Accounting for Case Mix</u>

The evaluation relies on the historical CANS and administrative data to identify expected trajectories based on case mix. In the past, such historical data were available for the vast majority of youth entering residential. Recently, a larger proportion of youth are directly entering residential care when they enter DCFS care. For example, TRPMI recently found almost half of the youth entering residential are new to care, which means that historical information is absent for a large portion of youth prior to their entry into the residential system. Therefore, this poses a problem with respect to the current evaluation design. The impact of this issue requires further study by the Evaluation Subcommittee.

Time Series Design

Unrelated to the evaluation measures being used, DCFS and TRPMI have different viewpoints regarding the benchmarks utilized in the TRPMI evaluation's time series design. All parties agreed that the major advantage of using the time series design is that it offered opportunities to denote critical benchmarks in the development and implementation of the pilot (e.g., distinguishing the start date of the pilot from the date at which full implementation occurs). Incorporating these benchmarks into the evaluation design allows us to more accurately contextualize changes in outcomes over time.

Since early implementation, TRPMI has consistently recommended (in Evaluation Subcommittee and Steering Committee meetings and in monthly status reports) that a pilot "ramp-up period" (i.e., partial implementation) should be identified as one of the benchmarks using criteria identified in the Steering Committee related to key personnel recruitment and implementation of key operations (i.e., status of staffing and data system), and TRPMI believes the Evaluation Subcommittee agreed to incorporate this design element. However, the DCFS January-April 2018 triannual supplemental staffing report does not acknowledge the existence of the ramp-up period. The report only acknowledges 2 post-implementation monitoring periods: one defined as the "date of the initial onset of the TRPMI implementation on January 1, 2017", and the second defined as "the date from which TRPMI was being implemented in all three regions, beginning April 1, 2017." Although these 2 time points are important ones in terms of planned stating dates, many critical elements of the TRPMI implementation plan were not in place by 4/1/17 due to notable implementation barriers that have been described in this and previous reports. These critical elements include the hiring of external Clinical Specialists and QI Specialists in the Northern and Southern Regions and having a functioning data system. To cite one example, TRPMI was unable to implement the runaway project described above until the TRPMI QI staff were hired in April 2018.

Current Update:

The most recent evaluation report identifies a pre-TRPMI monitoring period and a post-implementation monitoring period. DCFS arbitrarily set the post-implementation date, which does not accurately reflect input from the full Steering Committee, including TRPMI representatives, the expert panel, and the BH parties. Clearly, the pilot has been implemented piecemeal over time. As was discussed above, TRPMI contends that a "partial implementation" or "ramp-up" period should be designated during the period prior to implementation of the key elements of the TRPMI model.

Finally, the outcomes are designated as proximal, intermediate, distal, and unintended. The current evaluation report collapses the outcomes together and provides no definitions for proximal, intermediate, or distal in the context of the TRPMI evaluation. Additionally, there is no information describing the intended sequence of these outcomes over time. This issue is especially germane at this juncture. Informed by implementation science regarding system change, TRPMI recently adopted a "small test of change approach" using PDSA cycles, in conjunction with Chapin Hall. As a result, outcomes measured at the system level would not capture the impact of the small test of change approach. Therefore, the evaluation outcomes as they currently exist are not aligned with these changes in the logic model.

Evaluation as a Tool for Improving Practice

While many TRPMI stakeholders share the belief that the evaluation results should help inform residential practice improvements, TRPMI is concerned that the current evaluation does not leverage these opportunities sufficiently. For example, the runaway measure being used in the evaluation will have limited utility because of inconsistencies in how residential providers report runaways. Proximal Outcome 2 (PO2: decrease % of runaway days in TR) is the measure being used to evaluate runaways in the pilot.

As TRPMI has become increasingly knowledgeable about the runaway dynamics in the agencies it works with, it has become clear that this measure is fundamentally flawed. Most significantly, PO2 only captures runaway behavior of youth who are absent overnight. Of the approximately 4,500 reported runaway episodes in FY17, the vast majority did not involve youth who were absent overnight. These runaway episodes of shorter duration frequently involve youth engaging in significant risk behaviors such as criminal behavior, substance use and human trafficking. Community stakeholders, including police and elected officials, have expressed alarm to DCFS and TRPMI regarding runaways that are not being measured in the current evaluation. Consequently, these data are incomplete, and the findings presented in the report reflect an inaccurate depiction of this serious problem.

Current Update:

These issues have been partially addressed. Specifically, the evaluation going forward will capture all runaway activity. However, TRPMI's new logic model requires TRPMI to implement small tests of change. Therefore, evaluation of system-wide outcomes will obscure the specific impact of targeted implementation consistent with the current logic model. TRPMI plans to collect the majority of data for all small test of change initiatives. The evaluation should complement this process and help TRPMI determine if the small test of change is an effective approach.

With respect to the issues identified above (i.e., CANS measures, case mix, time series design, Significant Event reporting fidelity and the evaluation design as a tool for improving practice), we recommend that the Evaluation Subcommittee assess the impact of these issues and reach a consensus about how to include consideration of their impact in future triannual reports.

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

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

NOTICE OF FILING

To: All counsel of record.

PLEASE TAKE NOTICE that on the 15th day of February, 2019, the **Expert Panel's Submission Addressing the Sixth Triannual Interim Status Report on the B.H. Implementation Plan** was filed with the Clerk of the United States District Court for the Northern District of Illinois, Eastern Division, at the U.S. Courthouse, 219 S. Dearborn Street, Chicago, Illinois 60604.

Dated: February 15, 2019

Respectfully submitted,

By: /s/ Heidi Dalenberg

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CERTIFICATE OF SERVICE

I, Heidi Dalenberg, one of the attorneys for the Plaintiff class in the above-captioned litigation, hereby certify that on February 15, 2019, I caused the foregoing **Expert Panel's Submission Addressing the Sixth Triannual Interim Status Report on the B.H. Implementation Plan** and **Notice of Filing** to be electronically filed with the Clerk of the Court using the CM/ECF system, which will cause an electronic copy to be served on all counsel of record. In addition, I served copies of the foregoing **Expert Panel's Submission Addressing the Sixth Triannual Interim Status Report on the B.H. Implementation Plan** and **Notice of Filing** on the following individuals, who are Court-appointed experts in this matter, via email as set forth below:

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