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

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

SECOND TRIANNUAL INTERIM STATUS REPORT
ON THE B.H. IMPLEMENTATION PLAN

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INTRODUCTION AND OVERVIEW

DCFS, with Plaintiffs and the Expert Panel, hereby submits this Second Triannual Report to the Court regarding the projects identified in the Implementation Plan. The reporting period for the Second Triannual Report addresses the time period generally from February through March 2017.[1] As the Court likely is aware, Director Sheldon has announced his resignation effective June 15, 2017.[2] Despite this change, the Implementation Plan is a binding court order and is not directly impacted by the appointment of a new DCFS director. DCFS has assured the Expert Panel and the Plaintiffs of its commitment to the programs and initiatives it has undertaken through the Implementation plan.

While some progress toward DCFS's reform goals has been made since February, 2017, Plaintiffs and the Experts have significant concerns about the next phase of work required under the Implementation Plan. The Plaintiffs and the Expert Panel have provided separate submissions to the Court outlining those concerns.

Detailed Status Report

The following provides the detailed report regarding the various initiatives that DCFS has undertaken pursuant to the Implementation Plan.

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[1]The deadline for filing the First Triannual Status Report to the Court was extended, and it accordingly covered the period of approximately September 2016 through February 2017. The parties and the Expert Panel agreed that, the second report would cover a shorter time frame and would be filed now so that future reports would be back "on track" to cover a true "triannual" period. It is anticipated that the third triannual report to the Court will cover information for the period April 1 through July 31, 2017.

[2] DCFS General Counsel Lise T. Spacapan has been named the Interim Director while a nationwide search for a new Director is conducted. DCFS Associate Deputy Director Pete Digre, who has been instrumental in the actual execution of Implementation Plan also remains at DCFS.

I. Application of Implementation Science to the Implementation Plan:

Utilize principles of Implementation Science to develop, implement, evaluate and modify initiatives outlined in the B.H. Implementation Plan.

1. Project Goals / Target: This Court's Order of July 11, 2016 [Dkt. 527] provides for DCFS's retention of the National Implementation Research Network (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.

2. Status Report: There was significant delay in finalizing the contract with Dr. Metz. The contract was executed effective February 14, 2017 and DCFS provided logic models to Dr. Metz regarding the projects in the Implementation Plan on or about February 10, 2017.

Dr. Metz provided a virtual presentation to DCFS on April 5, 2017, regarding Supporting Sustainable Implementation of Research Evidence in Child Welfare. Exhibit A, PowerPoint by Metz for Child Welfare Association. Dr. Metz has emphasized that for a system like Illinois, in which the vast majority of services are provided through private providers, it is important to work closely with those providers in developing and then co-implementing the type of practice model change that DCFS has committed to undertake. Given the present stage of DCFS's implementation efforts, Dr. Metz stated that a significantly more intensive effort to involve POS providers is needed.

3. Revised Targets / Goals: DCFS, the Expert Panel and the Plaintiffs are attempting to schedule an in-person meeting with Dr. Metz to further discuss implementation science and teaming issues with respect to the B.H. Implementation Plan. During the next reporting period, DCFS will develop a set of strategies with Dr. Metz to improve implementation of the initiatives in the Implementation Plan and a timeline for execution of those strategies.

II. Overarching Outcome Measures

1. Project Goals / Target: The Implementation Plan requires DCFS to measure safety, permanency and well-being of class members and to monitor changes in both the quality and quantity of services and supports to class members and their families. The metrics DCFS will use for measuring safety and permanency are the same measures used in the national Child and Family Service Reviews (CFSR), and the measures for well-being are based on a matrix developed by the Child Welfare Advisory Sub-Committee. Implementation Plan, pp. 4-7.

2. Status Report:

Validation of Safety, Permanency and Stability Measures. DCFS originally set June 2017 as its anticipated date to complete full validation of the safety, permanency, and stability measures. Validation is ongoing for the exiting dashboards for the safety, stability and permanency measures and DCFS staff continue to finalize the validation of the overarching measures to meet the revised July 2017 deadline.

Integration of CANS DATA. In the last Report, DCFS stated its intent to begin tracking as many well-being measures as possible. At present, DCFS is in the process of consolidating the CANS application, which will allow better tracking of CANS data on child wellbeing.

DCFS also set the deadline for integrating CANS data relative to the well-being measures into the SACWIS system in the first quarter of FY18 (i.e., July through September 2017). DCFS is currently working with DCFS executive leadership to develop a plan to prioritize the work for integrating the CANS data.

IM CANS. DCFS was to decide whether to implement the Illinois Medicaid (IM) CANS before the current reporting period. DCFS has decided to proceed with that implementation. DCFS DoIT/OITS staff have engaged with stakeholders regarding implementation of the IM

CANS and are currently identifying short term and longer range plans to consolidate CANS processes on one application. Exhibit B, Four Month Status Report, IT Projects.

Prioritization for Mindshare. By April 30, 2017, DCFS, working with the Expert Panel and Plaintiffs, was to develop a prioritization of the different B.H. projects for completion and incorporation into Mindshare and a timeline by program stating when the data for the program and associated dashboards will be up and running on Mindshare. The Expert Panel had planned to discuss the prioritization of Mindshare dashboards with the parties at its April 5 – 6, 2017 meeting, but there was not time available at the April 2017 meeting. DCFS has not yet provided a plan for review or consideration by the Experts or Plaintiffs, but is working on the prioritization of the dashboards in the Mindshare platform and will develop the prioritization during the next reporting period.

In the interim, DCFS has continued to develop dashboards in the Mindshare platform. Dashboards went live for several B.H. related projects, including the IB3 waiver and Family Finding. Other dashboards, including SAFE Families and Regenerations, remain in various stages of development. Exhibit B, Four Month Status Report IT Projects.

Validation of CANS Data. DCFS agreed to validate information from the CANS using a variety of other data in the CWAC wellbeing matrix. A work plan has been developed to implement the validation work, which is currently scheduled to begin in July 2017 and end in December 2017. Key steps in the validation process include:

ACTIVITY	RESPONSIBLE	DESCRIPTION	TARGET DATES
Training in New Measures	IA/ Erikson	Statewide Training in the DECA	May 8-9, 2017
Utilization –New Measures	IA	IA incorporates the measures into assessment process	Start: July 5, 2017
Data Management	OITS/ Objective Arts/ NU	Build a database to enter new measures for	**Approval:** May 1, 2017 **Completion:** June 15, 2017

		analysis of well-being data	**Use:** July 1, 2017
Data Analysis:	JPA/ NU	***Includes the CANS, and all measures that will be in use/ can be accessed for FY '18***	**Plan Complete:** June 15, 2017 **Data Analysis:** 1st& 3rd Quarters of FY '18 **Initial Findings:** 3rd Quarter of FY '18
CANs-Full Use Target -200 Immersion Site Casework Staff	IA/ Harms/ NU	Immersion Sites will receive enhanced implementation support for the optimal use of the CANS in practice-requires 3-months	**Pre-work:** May 1, 2017 **Start:** June 1, 2017 **Completion:** Dec. 2017

Exhibit C, Immersion Site Four Month Status Update.

ISBE Data Integration into SACWIS: In the last report, DCFS noted that representatives from the OITS, Legal Services, and Operations were meeting in Springfield on February 14, 2017, to identify barriers in obtaining the ISBE data and developing a plan to obtain the needed data. That meeting was held and it was determined that the barrier to this initiative is determining how education data can be added to SACWIS without requiring manual matching of ISBE records with the DCFS records. Exhibit B, Four Month Status Report, IT Projects.

Expansion of Access to the Mindshare Website Within DCFS. Immersion Site Directors and project managers already have access to the Mindshare Website. Training for additional DCFS staff is underway as the Mindshare dashboards are developed. To date, the project managers are being trained as the dashboards for their projects are being developed.

Private Provider Access to Mindshare. DCFS previously reported that a security protocol must be developed to allow outside providers to access the Mindshare website. Facilitating such access will be critically important under the practice model that DCFS is preparing to implement in the Immersion Sites. However, DCFS is currently reviewing and exploring how this security protocol will be developed and then implemented.

3. Revised Targets / Goals:

Validation of Safety, Permanency and Stability Measures. DCFS continues to anticipate that the safety, permanency, and stability measures to be fully validated by July 2017.

Integration of CANS Data. Consolidation of the CANS application was anticipated to be completed by September, 2017. The anticipated deadline to integrate CANS data into SACWIS (during the first quarter of FY 2018) is no longer realistic. By the next reporting period, DCFS will have developed a plan identifying the steps needed for the integration to occur and a timeline for completion of those steps. The adjusted anticipated deadline for the integration is the fourth quarter of FY 2018; however, meeting that deadline assumes that DCFS is able to secure necessary IT support, either internally or through contracting.

With respect to development of the wellbeing matrix, DCFS and outside providers (OITS/ Objective Arts/ Northwestern University) obtained final approval of the plan for development of a database to enter the new measures for analysis of the wellbeing data on or about May 1, 2017. It is anticipated that the new database will be completed by June 15, 2017 and operational by July 1, 2017. The Juvenile Protective Association and Northwestern will complete a data analysis of the wellbeing data by June 15, 2017 and the initial findings will be issued by the end of the third quarter of Fiscal Year 2018.

IM CANS. The IM CANS will be implemented by March 2018.

Prioritization for Mindshare. The Implementation Plan states the following: "While internal positions are being established and filled, there will be some transitional activity including a contract with MindShare and with Eckerd. MindShare will collaborate with the Division of Quality Assurance, the Division of Strategic Planning and Innovation, and the Illinois Department of Innovation and Technology (DoIT). Contracts began in September 2015

and will be in place until January 2018 to assist with the transition and to provide additional assistance." Amended and Revised B.H. Implementation Plan, [Dkt. 531] p. 50. The contract with Mindshare began in September 2015 and is in place through January 2018. At the present time, DCFS is exploring the possibility of developing a replacement for the Mindshare platform using POWERBI and MS SQL server engines in house. DCFS recently hired a Victor O. Johnathan, MBA, PMP as its Chief Information Officer, who will be involved in the exploration of the development of the possible replacement for the Mindshare platform. DCFS anticipates that a decision regarding the Mindshare platform will be made within the next reporting period and that a transition plan will be developed once that decision is made. Plaintiffs are concerned about the viability of DCFS's plan to replace Mindshare by January, 2018, as set forth in their separate submission.

ISBE Data Integration into SACWIS. DCFS anticipates that student records from ISBE will be available in SACWIS during the next reporting period. The ISBE records will be input into SACWIS. The next step will be for DCFS to work to develop aggregate reports from the individual records. Aggregate reports will be used for data analysis.

Expansion of Access to Mindshare Website within DCFS. This has been completed.

Private Provider Access to Mindshare. DCFS is still evaluating whether security concerns can be addressed. Decisions regarding whether access can be given will be made during the next reporting period.

III. Implementation of Specific Recommendations of the Expert Panel

A. Panel Recommendation #1:

Institute a children's system of care demonstration program that permits POS agencies and DCFS sub-regions to waive selected policy and funding restrictions on a trial basis in order

to reduce the use of residential treatment and help children and youth succeed in living in the least restrictive, most family-like setting. (Implementation Plan, pp. 7-25).

The Implementation Plan identifies four initiatives DCFS is pursuing in response to Recommendation # 1. The first is the Therapeutic Foster Care Pilot initiative. The second is the Case Management Entity pilot. The remaining two are programs targeted to the needs of "dually involved youth" – the Regenerations pilot and Pay for Success. Each of these programs is discussed individually below.

B. Panel Recommendation #1: Therapeutic Foster Care Pilots

1. Project Goals / Target: The Implementation Plan calls for DCFS to select private agencies to implement evidence-based or evidence-informed therapeutic foster care programs over the next five years. The goal of the TFC pilot is to determine whether outcomes for youth served in the TFC pilot programs are equal to or better than those for youth who meet the clinical criteria for residential treatment and are placed in residential treatment. Implementation Plan, pp. 8-13. At least 60% of the youth served in TFC licensed homes are to be age 12 and older. Implementation Plan, pp. 8-9.

DCFS set a two-year goal for the recruitment and licensure of therapeutic foster parents and placements. The original goal included placement of a minimum of 40 children and youth in licensed TFC homes at the end of the "first contractual year" (meaning April 2018) and placement of a minimum of 100 children and youth at the end of the "second contractual year" (meaning April 2019).

2. Status Report:

Development and Service Contracts. Two agencies participating in the pilot asked DCFS to extend the initial development contracts due to recruitment and model implementation challenges, which postponed the delivery of services for several months. The development

contract with LSSI was extended on February 3, 2017 and the development contract with CHAID was extended on January 20, 2017. The development contracts for both LSSI and CHAID were extended to June 30, 2017. DCFS has twice provided JCFS with the extension on the development contact, but the contract has not yet been provided to DCFS. Service contracts for FY17 are in place for all providers in this pilot.

The third agency that originally was participating in the pilot – Children's Home & Aid ("CHAID") has chosen to refocus its work and is developing an alternative relative care model that focuses on strengthening and training relatives in crisis intervention and de-escalation techniques to care for challenging youth. Given CHAID's current approach, CHAID is no longer a part of the pilot as such, but DCFS will work with and continue to monitor CHAID's program in conjunction with the TFC pilot. Exhibit D, Four Month Status Report, Therapeutic Foster Care.

DCFS has added Youth Outreach Services (YOS) as an official participant in the pilot through a contract executed on March 1, 2017. YOS intends to provide therapeutic foster home placements under the Therapeutic Foster Care Oregon Model (TFCO), which LSSI is also using. Exhibit D, Four Month Status Report, Therapeutic Foster Care. Exhibit D, Four Month Status Report, Therapeutic Foster Care.

TFC Placements. DCFS revised its timeline for serving youth through the TFC pilot. The revised timeline called for placing a minimum of 40 children and youth in licensed TFC homes by April 1, 2018 and to have a minimum of 100 children and youth placed in TFC homes by April 1, 2019, with at least 60% of the youth served in the age group of 12 and older.

As of May 1, 2017, two youth (ages 10 and 12) have been placed through LSSI's program, one 15-year-old has been placed through JCFS' program, and one 16 year-old has been

placed through YOS. No youth have been placed with CHAID due to modifications made to the model they are currently implementing.

TFC Foster Parent Recruitment. LSSI trained a total of 20 families in the Therapeutic Foster Care Oregon Model during the month of February. After the training, LSSI ruled out four families as not being appropriate for the model. LSSI has identified 10 families/ homes that are projected to be licensed, trained, and certified in the TFCO model by April 30, 2017. LSSI currently has 25 families in the pipeline for licensure. Exhibit D, Four Month Status Report Therapeutic Foster Care Pilot. Families must be trained, licensed, and certified under TFCO to accept youth. At present, a total of 12 LSSI homes are available for placement and five homes already have youth placed in the homes.

JCFS continues to have two homes in the licensure/certification process. At present, a total of one JCFS home is available for placement or is already serving a child.

YOS has one home that is in the process of renewing its license and one foster home that is in the process of becoming licensed. Both homes must be certified and trained, which is projected to be completed by the next reporting period. At present, YOS has a total of two homes available for placement or are already serving a child.

TFC Referrals and Eligibility. During March 2017, four youth were referred to the YOS program. Of the four youth, YOS has accepted two youth in their program as of April 2017. Exhibit D, Four Month Status Report, Therapeutic Foster Care. Those two youths were placed in the homes in May 2017; one youth was placed on May 10, 2017 and the other youth was placed on May 25, 2017.

DCFS is attempting to address several issues with the referral process for the TFC pilot. Originally, the pilot limited eligible youth based on how they scored on the Child and Adolescent

Intensity Instrument (CASII). First Triannual Interim Status Report on the B.H. Implementation Plan (corrected) [Dkt. 538], p. 19. A CASII is required for each youth being considered for the TFC pilot and is completed either during a CIPP staffing or by request to the DCFS Clinical Division. A youth is eligible for the TFC pilot if they score a 5 on the CASII.

LSSI has had difficulty identifying youth six to 14 years of age in the correct legal county with the necessary score on the CASII for the LSSI program. To address this challenge, DCFS has partnered with the TRPMI pilot to identify such youth, as the TRPMI pilot also requires administration of CASII to determine a level of care. To date, however, none of the youth in the TRPMI pilot meet the age or county criteria for the available LSSI homes. Exhibit D, Four Month Status Report, Therapeutic Foster Care.

In addition, as of April 2017, eligibility for the TFC pilot has been expanded to include youth in residential treatment facilities with the requisite score of a five on the CASII. LSSI will target youth between six and 14 years of age who have been in residential treatment for 30 to 60 days for completion of a CASII. The DCFS Central Matching Unit, along with the TFC pilot manager, has requested additional resources from the DCFS Clinical Division to complete the CASIIs. This assistance will be provided on an ongoing basis.

The TFC Project Manager also has been working with the DCFS Central Matching Unit to identify youth who are targeted to move from one residential facility to another, youth in psychiatric hospitals and youth who are identified through the current CIPP and other staffing processes to increase the pool of referrals. Exhibit D, Four Month Status Report, Therapeutic Foster Care. These youth also will be eligible for the TFC pilot if they have the requisite CASII score.

The TFC Steering Committee considered, but rejected, changing the eligibility criteria for the pilot to a lower CASII score.[3]

3. Revised Targets / Goals:

Expansion and Service Contracts. Service contracts for the agencies participating in the TFC pilot are in place through Fiscal Year 2017 and are in process of being distributed and executed for Fiscal Year 2018. The Expert Panel is concerned about the current contract negotiations and rate setting process underway for this service, which have delayed finalizing contracts and reimbursing agencies for their contract expenses. The TFC contract development and approval process reflects what the Expert Panel has observed as a pervasive Departmental problem executing timely contracts that secure, maintain, and individualize needed services for families and children with challenging emotional and behavioral needs.

TFC Placements. The revised placement goals and timeline for the TFC pilot remains as stated in the prior Report to the Court -- a minimum of 40 children and youth in licensed TFC homes by April 1, 2018 and to have placement of a minimum of 100 children and youth by April 1, 2019, with at least 60% of the youth served in the age group of 12 and older. JCFS expects to have ten youth served and eight homes licensed and certified by September 30, 2017; YOS expects to have four youth and six homes licensed and certified by September 30, 2017; and LSSI expects to have 26 youth served and 30 homes licensed and certified by September 30, 2017.

TFC Foster Parent Recruitment. By the next reporting period, DCFS will have requested and obtained foster parent recruitment plans from all participating agencies. DCFS

[3]This change would have impacted the current evaluation plan since a revision of the comparison group would be required.

will continue to monitor closely the progress of the three agencies to recruit and certify TFC foster homes to meet these revised deadlines.

TFC Referrals and Eligibility. DCFS will continue to monitor the referral and eligibility process to ensure timeliness in the decision and placement process. The current referral and eligibility process for TFC provides that a youth will be identified either through the CIPP process, the DCFS Central Matching team, or on occasion, from the DCFS Clinical Division after a staffing. Once the youth has been found eligible for the TFC pilot, information is requested from the potential agencies for consideration. The agencies have five to seven days to make a determination if they can then accept the youth and provide an appropriate placement. DCFS has worked diligently to streamline this process from two weeks to the five to seven day window and continues to monitor this process for other necessary adjustments.

The DCFS Project Manager receives monthly recruitment efforts from each agency in order to monitor the mechanism for recruitment of potential foster parents/ families.

C. Panel Recommendation #1: Care Management Entity

1. Project Goals / Target:

The planned goals for the Care Management Entity (CME) pilot include: increasing non-traditional, community-based behavioral health supports; faster step-downs for youth in congregate care settings (i.e., 15% of enrolled youth to step down six months after enrollment and another 15% to step down 12 months after enrollment); treating youth and family voice and choice as primary factors in permanency planning and mental health/behavioral health interventions; reduction in youth experiencing elevations in level of care (i.e., youth being placed in specialized foster care or congregate care settings); increased placement stability at the traditional foster care level (i.e., fewer lateral moves); high service-intensity youth receiving

necessary behavioral health supports and services in their home and community settings; decreased psychiatric hospitalization; and increased permanency.

The CME pilot, which is administered though CHOICES, began in February 2014 and was scheduled to continue through June 30, 2017. The goal of the pilot was to serve 200 youth annually and 600 youth during the course of the pilot. DCFS committed to identifying a comparison group for the evaluation by December 2016 and to completing an interim evaluation by March 2017. Implementation Plan, p. 19.

2. Status Report:

Extension of the Pilot in FY18: Assuming that a managed care program is implemented for the children in DCFS' care beginning as of FY 2019, the Choices program will be replaced and/or essentially mooted by that managed care program. DCFS accordingly has determined that the CME model should remain in pilot status during Fiscal Year 2018. DCFS and pilot staff were to develop a plan for continuing service provision (e.g., contract renewals, new contracts) to youth in the pilot upon the conclusion of the pilot period. The original plan contemplated developing targets and timeframes to accomplish the transition from a pilot project to an ongoing care management model. This will not be completed since the decision was made to keep the Choices program in pilot status for Fiscal Year 2018 pending the anticipated move to a statewide Managed Care Organization program for youth in care beginning in FY 2019.

DCFS is in the process of revising the program plan with Choices to address issues regarding aftercare services, disenrollment (discharge) expectations and outcome data.[4] Additional changes will include the requirement for aftercare services and maintaining youth in

[4] For example, under the current revised program plan, youth who transition to a transitional living plan or independent living arrangement will no longer be considered "successful disenrollments," and instead will remain enrolled in the CME pilot for at least nine months post-placement to ensure stability.

the CME until permanency is achieved and DCFS is no longer the legal guardian of the youth. Additional revisions may also be required. Exhibit E, Four Month Status Report, Care Management Entity Pilot Update.

Children Served. The initial plan for the CME estimated an average census of 200 youth in care throughout the pilot. That target was not met. The CME pilot had served 350 youth in care through March 31, 2017. As of April 28, 2017, 157 youth in care were being served in the CME pilot. Exhibit E, Four Month Status Report, Care Management Entity Pilot Update April 2017. It is anticipated that a monthly census of approximately 160 youth will be served through the CME pilot during FY 2018.

In the pilot, the percent of children stepped down from congregate care within six months of enrollment was 1% (1 youth), compared to an expected 15%, and an additional 7% (5 youth) stepped down within seven to twelve months, compared to an expected 15%. Altogether, 8% of enrolled youth stepped down from congregate care, compared with an expected 30% within the identified timeframes.

Between January and April 2017, there was a reduction in the rate of hospitalization for children who received mobile crisis response services (from three youth hospitalized in January, 2017 to two in February, 2017, and none in March, 2017). Finally, during the latest reporting period, 15% of enrolled youth remained in a stable living arrangement (e.g. pre-adoptive home, foster home, home of relative or home of fictive kin) for at least 12 months or achieved permanency within 12 months of enrollment in the CME pilot, compared to the goal of 80%.

Addressing Program Barriers. DCFS previously committed to improving support for the CME pilot during this reporting period and to addressing service gaps and deficiencies in the pilot. Thereafter, DCFS was to track the extent to which its actions with DCFS regional staff,

community stakeholders and providers had a positive outcome on the services provided to youth in the pilot and the outcomes they achieve.

Meetings involving DCFS, POS, and CME were conducted on February 24, 2017, April 29, 2017, and May 30, 2017. In addition, the DCFS Project Manager and Project Supervisor for the CME pilot held teleconferences with CME administration on March 30, 2017, April 11, 2017 and April 14, 2017. The meetings and discussions focused on identification of service gaps, decision-making in Child and Family Team Meetings, and performance expectations. Exhibit E, Four Month Status Report, Care Management Entity Pilot Update April 2017.

DCFS has identified Lynda Petrick, Agency Performance Team Supervisor, as a champion of the CME pilot. Her role will be to facilitate communication between POS agencies, DCFS and Choices staff as well as to immediately address performance issues that may arise within POS partner agencies. Deborah Keen, DCFS Behavioral Health Specialist, has also been connected to the CME pilot. Her role will be to assist with frontline case issues that arise in the CME/child welfare partnership and to identify and address barriers to service implementation.

In addition, DCFS and CME Administration met and agreed to focus on placement development and resolution of non-consensus issues. While the meeting did not result in specific services for the CME to develop, they were told to establish relationships with community partners who could be called upon to develop a service tailored to a child's needs. For example, there are universities and mental health centers accessible within the four-county area. Connections with social work, psychology, and education departments could yield a group of potential providers of services for families. In addition, the CME was instructed to link with their local child welfare partners to assess what these partners viewed as priority services for children on their caseloads. They are to build services around these recommendations. This is being

monitored through the monthly Choices-Child Welfare meetings and case discussions. The placement development issue revolved around what Choices could do, as a non-licensing agency, to help recruit foster parents with both DCFS and POS agencies. By the time of the meeting between DCFS and CME Administration, Choices already had met with the CYFS foster parent recruitment group (which includes current and prospective foster parents). At that meeting, Choices was able to provide information on how the Choices program could offer supports for youth and foster parents in the home environment. Choices is scheduling similar meetings with other private agencies, such as Children's Home + Aid and LSSI. Additionally, the DCFS Project Manager and Project Supervisor informed Choices that a broader community stakeholder group, including groups such as CASA, educational providers, community businesses and law enforcement, also needed to be developed. Choices agreed to prioritize the development of the community stakeholder group in FY 2018.

To address the placement resource and development issue, the CME pilot will collaborate with the TRPMI pilot. DCFS identified 14 youth in the CME pilot who have been placed in residential treatment facilities for more than 12 months and who overlap both the CME and TRPMI pilots. These youths will be prioritized by the CME for appropriate placements. At least three youth have been staffed under this collaboration.

These staffings were not CFTMs, but were clinical reviews that involved residential treatment facility administration, the child welfare supervisor or program administrator, and the Choices Care Coordination supervisor / Clinical Director. The three youth were identified due to non-consensus within the CFTM regarding step-down from a residential treatment facility. Following the clinical reviews, which included administrative representation from the provider members, the recommendations and tasks to transition from congregate care were communicated

back to the Child and Family Teams meetings. CFTMs were convened for each youth on April 11, 20-17, April 18, 2017 and April 25, 2017. Before concise transition plans could be identified, the CFTMs were advised to address the most pressing barriers first such as, reluctance of adoptive parents to have youth return home, logistical challenges to aiding a parenting teen who has children placed far from her, and specific supports to improve transitioning a youth to a grandparent with minimal resources. The Choices Project Supervisor and Deanne Muehlbauer (from the University of Illinois Chicago) will be scheduling follow-up to the original clinical reviews to review the cases and determine progress with the listed action items.

Moving forward, TRPMI staff will provide additional support to the CME by completing clinical reviews on youths who experience issues surrounding clinical preparedness for discharge or lack of placement resources. Exhibit E, Four Month Status Report, Care Management Entity Pilot Update.

On the issue of "non-consensus," DCFS is implementing changes to address situations where a permanency worker does not agree with the decisions made at the CFTM (e.g., decisions to step a youth down, or not step a youth up to a higher level of placement). Such situations were resulting in delay. Going forward, in situations with disagreement, a CME/child welfare supervisory conference and a final decision by the Clinical Administrator will be completed within ten work days. Exhibit E, Four Month Status Report, Care Management Entity Pilot Update.

Foster Parent Recruitment and Improved Communication. DCFS committed to implementing improved communication to foster parents regarding the services available through the CME. Pilot staff were to develop a plan with specific targets and timeframes to increase the number of new and existing foster homes in the pilot project area prepared to and

capable of providing step-down placements for youth with more challenging needs. To do so, Choices met with the foster parent group at one private agency and scheduled meetings with other foster parent groups from other agencies. At these meetings, Choices will explain the additional supports it can provide to youth and to foster parents as a youth is stepped down from residential care.

Court Outreach. DCFS promised to undertake additional outreach with the judge in Vermillion County to provide an overview on the CME pilot, to solicit feedback from the judge and other stakeholders, and to identify supports for serving youth from Vermillion County in community-based settings. That occurred on April 4, 2017. Judge DeArmond provided positive feedback regarding performance of the CME pilot and child welfare staff. He was pleased with the performance of Choices staff and the supports they provided while working with child welfare staff and families. Judge DeArmond did not identify any corrective action items. He did, however, inquire about supports and services for parents with developmental disabilities and how those supports and services could be used to help impacted families.

Enhancement to the Mobile Crisis Response Process: The service of a mobile crisis response team to assess youth undergoing a behavioral health crisis has been offered through the CME Pilot since April 2016. Data continues to demonstrate that this service deflects youth from psychiatric hospitalization. Exhibit F, January 2017 Data, February 2017 Data and March 2017 Data. In March 2017, 17 DCFS youth were screened for psychiatric hospitalization. Eleven of those youth were not enrolled in Choices and six were enrolled in Choices. All of the Choices youth were able to be deflected from a hospitalization.

To enhance this service, beginning in April 2017, youth and families who receive mobile crisis response services will also receive in-home supports within 12 hours or crisis screening to

help prevent re-escalation and the need for additional crisis screenings. Exhibit E, Four Month Status Report, Care Management Entity Pilot Update.

Pilot Evaluation. The target date for evaluation of the program through Fiscal Year 2017 has been delayed to September 2017.

3. Revised Targets / Goals:

Extension of the Pilot. During the March and April 2017 teleconferences, DCFS advised Choices Administration that the program would remain in pilot status during FY 2018. A review of the program plan in April 2017 led to the clarification of expectations regarding permanency and the work that was expected to be completed by the CME, such as remaining involved with a family until legal permanency was achieved and not discharging a family when they appeared stable. These requirements regarding permanency are being incorporated into the program plan for FY 2018.

Children Served. The goal for FY 2018 is for Choices to maintain a monthly census of 160 children.

Addressing Program Barriers. The CME will hold a child welfare stakeholders' meeting at least once a month, where DCFS, private agency and CME administrations can discuss current challenges and work collectively to address those challenges. The first of these meetings occurred on February 24, 2017. In April 2017, DCFS determined that monthly meetings would occur and the DCFS Project Manager and DCFS Project Supervisor are the point persons for meeting organization, documentation and reporting outcomes. The DCFS Project Manager is currently discussing the monthly meeting protocol with participating stakeholders. DCFS will also be working with the CME pilot to ensure the CME provides data regarding

children enrolled in the Choices pilot that is more consistent with the DCFS overarching outcome measures such as permanency and placement stability.

For placement resource and development, the collaborative process has already begun.[5] The DCFS Project Supervisor will continue to identify youth for collaboration with the TRPMI pilot. By July 1, 2017 the DCFS Project Supervisor and Behavioral Health Specialist Deborah Keen will schedule staffings for identified youth, create plans for involving the CFTM in the decision-making process, and develop action steps.

The CME Administration will be responsible for arranging and/or developing the needed services and supports for each youth. The Choices Provider Relations Team is responsible for developing resources and DCFS regularly monitors the Choices provider network. For youth in residential treatment facilities enrolled in Choices, the Choices Provider Relations Team must work to develop the appropriate resource for the step-down placement. DCFS monitors this on a monthly basis through Choices reports to the DCFS Project Supervisor. Behavioral Health Specialist Deborah Keen will also serve as a real time prompt to complete assigned development tasks for each youth.

Transition to Managed Care Program. The DCFS Project Manager is convening internal DCFS meetings to discuss the child welfare role clarification during partnership with a managed care organization. An initial meeting was held in May 2017 to present the idea of preparing for the larger change to a statewide MCO. At the initial meeting, the idea was presented to develop archetypes of children and families served by DCFS and private agencies so

[5]The initial steps occurred in March 2017, when the DCFS Project Supervisor identified three youth enrolled in Choices placed in residential treatment facilities that were also part of the TRPMI pilot. The three youth were given clinical reviews and the action steps in those reviews are being reviewed. Another youth who was newly referred to Choices and is placed in a residential treatment facility that is closing will have a TRPMI review in June 2017 to assist with step-down planning.

there is clarity regarding what children and families really look like, the paths cases may take, and where the managed care overlay becomes apparent.

As additional meetings are scheduled, the Project Manager will include the Expert Panel, plaintiffs' counsel and other DCFS division representatives. General topics for discussion at those meetings will include decision-making for services to meet the unique needs of child-welfare involved families, communication between the MCO and the child welfare staff and the manner in which conflicts will be resolved.

DCFS acknowledges that all work for children and families must be centered within the Child and Family Team and be family-driven. The lessons learned from the Choices pilot include the fact that the child welfare staff and MCO need to both know and acknowledge who will do what for a family and that the decisions need to be driven by the family. Other lessons learned include the need for consolidation of activities, guidelines for payment of services, and collaboration. These areas will also be the topics of ongoing discussions as the MCO process continues to roll out.

Foster Parent Recruitment and Improved Communication. The Choices role for foster parent recruitment is for Choices to "sell" the program supports it can offer to current and prospective foster parents. Choices has committed to attending similar meetings with other private agencies. Choices has also been instructed by DCFS project management staff to create additional opportunities to reach out to potential foster parents.

Court Outreach. DCFS staff will schedule meetings with court personnel from Champaign, Ford and Iroquois counties involved in the CME pilot. DCFS project management staff will work with DCFS legal staff to schedule meetings with courts in Champaign, Ford, and Iroquois counties during the next reporting period.

Enhancement to Mobile Crisis Response. The enhancement to the Mobile Crisis Response was initiated in April 2017. The enhancement included the addition of the 12-hour post deflection response by the Choices clinical staff to provide support to the youth and the foster parent. To evaluate this enhancement, those families who receive the post-deflection response will be tracked to determine if they experience a reduction in subsequent crisis calls and fewer hospitalizations.

Pilot Evaluation. Mark Arber is the identified researcher from the University of Illinois, Urbana-Champaign and he has been provided with guidelines for the comparative research as well as access to the child care information. One challenge to be addressed in the next reporting period is the acquisition of information on youth in comparison counties and the plan to address that will be developed in the next reporting period.

D. Panel Recommendation #1: Regenerations Pilot Project for Dually-Involved Youth at Cook County Juvenile Detention Center

1. Project Goals / Target:

The Regenerations pilot is designed to provide placements and intensive services to DCFS youth in care who are also involved in the juvenile justice system and are ready for release from the Juvenile Temporary Detention Center (JTDC). Implementation Plan, pp. 20-22. The program provides traditional mental health services, care coordination, foster care services (if needed) and individualized home and community based services through a wraparound philosophy. Id. The program goal was to serve 65 youth. There was no deadline specified in the Implementation Plan for reaching that level of service, however the pilot was scheduled to be completed in June 2017 (See report page 32). Implementation Plan, p. 21. The Regenerations pilot is a collaborative effort with the JTDC, Cook County Juvenile Probation, Lutheran Child and Family Services (LCFS), Youth Advocate Programs (YAP), and the University of Illinois at

Chicago (UIC). See Exhibit G, Regenerations Pilot Project for Dually-Involved Youth at Cook County Juvenile Detention Center Four Month Status Report, April 28, 2017; Exhibit H, DCFS Regenerations RUR/Pilot Logic Model 4-28-2017.

2. Status Report:

Program Conversion. Beginning in February 2017, DCFS was to implement specific strategies to ensure that the service data and the billing data for youth served through the pilot project are reconciled. The billing and service data has not been reconciled. DCFS is still in the process of addressing this matter by reviewing specific cases that have billing discrepancies. The Regenerations pilot was to be moved from a pilot project to an ongoing DCFS program upon completion of the pilot in June 2017. That process has been started and will require contract adjustments with LCFS and YAP.

Foster Parent Recruitment. LCFS had provided DCFS with a plan for expansion of the foster parent resources necessary for the program. First Triannual Interim Status Report to the Court on the B.H. Implementation Plan, Exhibit O, LCFS Foster Parent Recruitment Plan. That plan, which places increased emphasis on fictive kin and enhanced family finding strategies, has been reviewed and is being revised based on feedback provided at the April 2017 monthly Regenerations Implementation Team meeting.

Program Refinement. Within the last reporting period, LCFS and YAP have refined their case management and advocacy approach within the pilot. LCFS hired a Wraparound consultant in April 2017. The consultant was retained to develop a wraparound model customized to the Regenerations pilot. YAP hired an additional program director and three additional advocates. There has been an increase in the frequency in communication among

LCFS, YAP, and DCFS, which has resulted in improved consensus building and problem solving.[6]

In the last reporting period, there were indications that post-placement child and family team meetings (CFTM) are not being conducted as frequently as expected. The goal was to average 0.35 CFTMs per month. During the last reporting period, the CFTM data came in well below the goal, peaking at .08 CFTMs per month. The consensus during implementation team meetings was that reports of CFTMs that were facilitated may have been taking place but were not entered into SACWIS in a timely manner. Given that Chapin Hall utilizes the post-placement CFTMs to evaluate the fidelity of the wraparound philosophy, this was an important issue to remedy. To address this through continuous quality improvement, Chapin Hall has produced weekly data reports that are presented at monthly implementation meetings to review the reporting for certain evaluation outputs (e.g., CFTMs, Advocate Hours, Parent/Child/Sibling visits) compiled from SACWIS or SharePoint databases. Providers review these changes to troubleshoot circumstances where this data was not entered (e.g., child on run, in detention, in residential treatment). This review provides the opportunity for providers to maintain compliance with their program staff to be more diligent in entering data within SACWIS and SharePoint in a timely and accurate manner.

[6] This has assisted the agencies in quickly responding to issues. A recent case example highlights why response without delay is significant. An 18-year-old female Regenerations client, who is the parent of an infant child, went to a police station to report an attempted abduction. While at the police station, the police held the 18-year-old client on an alleged violation of probation and her infant child was subsequently taken into temporary custody. Immediate intervention by LCFS and YAP lead to the release of the youth and to reunification with her infant within a number of hours. Both the youth and her child were then placed with a foster family. This immediate response prevented the youth from being involved in the criminal justice system.

Recently, there has also been an increase in residential placements of youth pursuant to court orders. Exhibit G, Four Month Status Report, Regenerations This impacted the Regeneration pilot's ability to place youth in community-based settings with relatives or foster parents. This may limit the ability to evaluate the effectiveness of the intensive advocate support and wraparound services provided through the Regenerations pilot since many of the wraparound set of services that are utilized as part of the Regenerations pilot cannot be provided to youth placed in residential care and there may not be a sufficient number of youth placed in settings other than residential care who meet the criteria for the pilot to evaluate the effectiveness of the services provided through Regenerations.

Program Data. During this reporting period, DCFS implemented specific strategies to ensure the accurate and reliable submission and tracking of service data for youth assigned to the Regenerations pilot. All providers now use a coordinated protocol for staff that ensures timely data submission to SharePoint and SACWIS databases. In addition, in April 2017, DCFS and the Cook County Juvenile Court entered a data sharing agreement. The Cook County Juvenile Court will provide historical data to DCFS and Chapin Hall on youth similar to the youth in the Regenerations pilot in order to formulate a baseline and comparison group. This data will considerably contribute to the assessment of whether or not the pilot project is effective. Currently, Chapin Hall provides data reports at the monthly Regenerations Implementation Team meetings. This allows real-time feedback to the Implementation Team regarding process measures associated with the fidelity of the pilot's service model.

Dashboard. DCFS has identified specific data outputs and outcomes for reports regarding the Regenerations pilot and finalized the data collection methods for this information. DCFS has identified three key metrics, based on the input of the B.H. Expert Panel, and

identified an additional nine metrics. All the metrics are contained in Table 1 to the Four Month Status Report. Regenerations data were to be incorporated into the Mindshare platform by the date of this Report, and DCFS anticipated that it would begin tracking outcomes for the children who have been served to date, with a particular focus on stability and safety.

Program Evaluation. DCFS anticipates that Chapin Hall will perform the comparative data analysis needed to evaluate the pilot by October 2017. Exhibit G, Four Month Status Report, Regenerations Pilot.

Additional Contracts. In the last reporting period, DCFS was in the process of developing contracts for other agencies to provide similar services to dually involved youth: Youth Outreach Services, National Youth Advocate Program, Youth Advocate Program and Childserve. Those contracts have been executed. It was anticipated that these agencies would begin providing services by the date of this Report. Service delivery has begun.

3. Revised Targets / Goals:

Program Conversion. For FY 2018, YAP will contract with DCFS directly as an independent contractor. YAP will continue to provide intensive advocate support for Regenerations clients, but will also expand to service other youth in care outside of the pilot. YAP's intensive advocacy support is needed for all dually involved youth, not just youth being released from detention. YAP will be available to Childserve, NYAP and YOS as needed. In addition, DCFS caseworkers or dually involved specialists will be able to refer dually involved youth to a YAP advocate with the approval of the Statewide Dually Involved Administrator. YAP has hired additional staff to handle an increase in the number of youth served within the next fiscal year. Exhibit G, Four Month Status Report, Regenerations Pilot Project.

LCFS NYAP, YOS, and YAP will contract with DCFS directly as an independent contractor for FY 2018.

Foster Parent Recruitment. Only LCFS and YOS have submitted foster home recruitment plans. LCFS has submitted a draft recruitment plan in June 2017 and the plan projects 20 new homes by the conclusion of FY 2018. LCFS began recruiting in June 2017. YOS submitted a foster parent recruitment proposal in May 2017, which is under review. If it is approved and adopted, YOS projects to have 10 TFC homes by the conclusion of FY 2018.

Program Refinement. The Wraparound consultant retained by LCFS will provide recommendations by June 30, 2017, and the Project Manager will implement recommended protocols/processes within two weeks thereafter. DCFS will monitor this progress through regular meetings and data reviews.

To address the failure to submit timely and accurate data for program data metrics such as CFTMs, Chapin Hall will continue to produce weekly data reports that are presented at monthly implementation meetings to provide the opportunity for providers to ensure compliance with their program staff to be more diligent in entering data within SACWIS and SharePoint. To address the problems arising from the increase in residential placements of youth pursuant to court orders, DCFS and Regenerations are developing enhanced coaching and supervision for case managers to better prepare them for court hearings.

The enhanced training will be developed by August 2017, and coaching for all case managers and advocates who are a part of the Regenerations pilot will take place by September 2017. During the monthly dually involved stakeholders meeting with Judge Toomin, the presiding judge over delinquency court, the Statewide Dually Involved Administrator and Project Manager will provide updates on the Regenerations pilot and will communicate DCFS's

concerns regarding residential placement orders and the impact on service delivery. The goal of this process is to increase confidence amongst the judiciary in the Regeneration pilot to encourage supportive judicial decisions. DCFS will also host a collaborative learning and integration meeting in August 2017 with the other service providers assisting with the RUR and dually involved population. The objective of the meeting will be to share lessons learned thus far from Regenerations, provide technical assistance to the additional service providers, and set expectations for FY 2018.

Improvement of Data Management. The next major data goal will be to utilize historical data from the JDTC to develop a comparison group. Chapin Hall evaluators will use the historical data related to youth in care detained and released from the JDTC to compare to the reported metrics within the pilot. Chapin Hall is currently determining what metrics can provide a side by side comparison given the data collected from JDTC. A comparison data sample will be available by October 2017.

Dashboard. The date for development of the Regenerations dashboard in Mindshare is not yet determined, but it is anticipated that this dashboard will be in the development phase by October 2017 either with the assistance of Mindshare, the assistance of other outside consultants or a platform developed internally by DCFS .

Additional Contracts. Beginning on July 1, 2017, three additional service providers (YOS, NYAP and YAP) will serve dually-involved youth who are RUR at the JDTC or dually involved. These providers will not become part of the Regenerations pilot, and instead will supplement the pilot. Although LCFS and YAP are the main parts of the Regenerations pilot, there are limitations to placement resources that are needed from other agencies. The additional agencies are expected to develop between nine and 14 more specialized/dually involved foster

home beds within the next six months. DCFS's goal is to develop a broader range of expertise and resources to youth in and out of the pilot.

E. Panel Recommendation #1: Illinois Pay for Success Pilot for Dually-Involved Youth

1. Progress Goals / Target:

The Illinois Pay for Success Pilot is designed to reduce recidivism and to increase placement stability, educational achievements and employment opportunities for youth dually involved in the child welfare and juvenile justice system. Implementation Plan, pp. 22-25. The pilot was to be funded through a social impact bond, by which private funds are used to pay for the pilot services. DCFS would not have an obligation to pay for services delivered through the pilot unless it is clearly demonstrated that the services had a statistically significant impact on the outcomes of the youth enrolled in the program. Implementation Plan, pp. 22-23.

2. Status Report:

Funding. CCN completed a fundraising period that set a goal of raising $17 million by March 31, 2017. Because that goal was not met, CCN extended the deadline for its fundraising goal to July 31, 2017. The funds are intended to cover the projected cost of the pilot for four years of treatment (through September 2021) and three years of evaluation.

Youth Served. There are 25 youth currently receiving services as part of the pilot. CCN has capped enrollment at no more than 25 youth in Cook, Lake, Franklin and Jefferson counties through the completion of the current fundraising period.

Program Refinement. DCFS previously identified two issues with the program that had to be addressed: 1) communication issues and referral pathways for caseworkers to partner with a Wrap Facilitator; and 2) CCN's concerns regarding the UIRs (Unusual Incident Report) which resulted in delays in inputting into the UIR system because caseworkers and data entry staff were

not timely completing the UIRs. This resulted in CCN getting delayed referrals of youth who had UIRs and may be eligible for the program. DCFS saw this as a system-wide issue and has replaced the UIR system with the Significant Event Reporting System which reports this information directly through the SACWIS system where CCN can access it more easily. The replacement of the UIR system with the Significant Event Reporting System alleviates the delay in referrals that had been experienced previously.

The Operations Committee believes that the UIR issue has been resolved in the last two months, when DCFS changed the from the UIR system to the Significant Event Reporting System. The Significant Event Reporting system is linked to SACWIS and provides more timely updates to significant events that occur during a youth's case.

To address the communication and referral pathway issue, CCN developed a protocol for contact between CCN management and management with the assigned private agency to promptly address the inadequate communication between the Wrap Facilitator and caseworkers. Exhibit I, Illinois Pay for Success Pilot for Dually-Involved Youth, Four Month Status Report, April 30, 2017.

Dashboard. The CCN dashboard is operational, but still requires some validation. Exhibit J, CCN Intake Dashboard (data through 3/31/2017).

3. Revised Targets / Goals:

Funding. Securing funding is an ongoing challenge. Both DCFS and the Governor's Office have provided support to CCN in their fundraising presentations. If CCN's fundraising goal is not met, DCFS at the least will enter into contracts to continue serving youth assigned to the pilot. DCFS will also consider renegotiating the contract during the next reporting period.

Youth Served. The current goal is to serve 800 youth in the treatment group and 800 youth in the control group over four years.

Program Refinement. While services to youth continue through the program, DCFS will monitor to ensure that the change to the Significant Event Reporting system has addressed the UIR reporting issue since significant events are linked in the SACWIS system and provided in a more timely manner. In addition, DCFS and CCN will monitor the communication issues identified above regarding referral pathways through monthly review by the Operations Committee with CCN regarding response time from the field when referrals are made.

Dashboard. The Pay for Success dashboard has been developed but not fully completed or validated. It is anticipated that the completion of this dashboard and validation will occur during the next reporting period.

Program Evaluation. Because the purpose of the ramp up phase was to develop and work out system-related issues, the University of Michigan will not be evaluating the program performance during the ramp up phase.

Panel Recommendation #2:

Create four "immersion sites" of small geographic areas that coincide with judicial circuits to fully build, test and implement a core practice model that puts children and families at the center of service planning and builds community and home-based services for children and their families. (Implementation Plan at pp. 25-38).

4. Project Goals / Target:

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

puts children and families at the center of service planning and builds community and home based resources to service children and families. DCFS intends to use Immersion Sites as the center of its transformation to improve safety, permanency and stability outcomes.

To date, the immersion site process has started in four cities: Lake County, St. Clair County, the Rock Island area (including Rock Island, Whiteside, Mercer, and Henry counties), and the five "Mount Vernon area" counties (Clay, Hamilton, Jefferson, Marion, and Wayne).

Figure 1 charts the caseflow dynamics for each of the immersion sites extending back to fiscal year 1981. The data illustrate that three of the four sites experienced peak caseload growth in the mid-1990s as foster care removals (entry cohorts) outpaced discharges (exit cohort). The rise occurred statewide (see Figure 2) and was attributed at the front-end to the cocaine epidemic that precipitated the mass removal of substance exposed infants from parental custody and a general inattention at the back-end to permanency planning options for children in long-term kinship care.

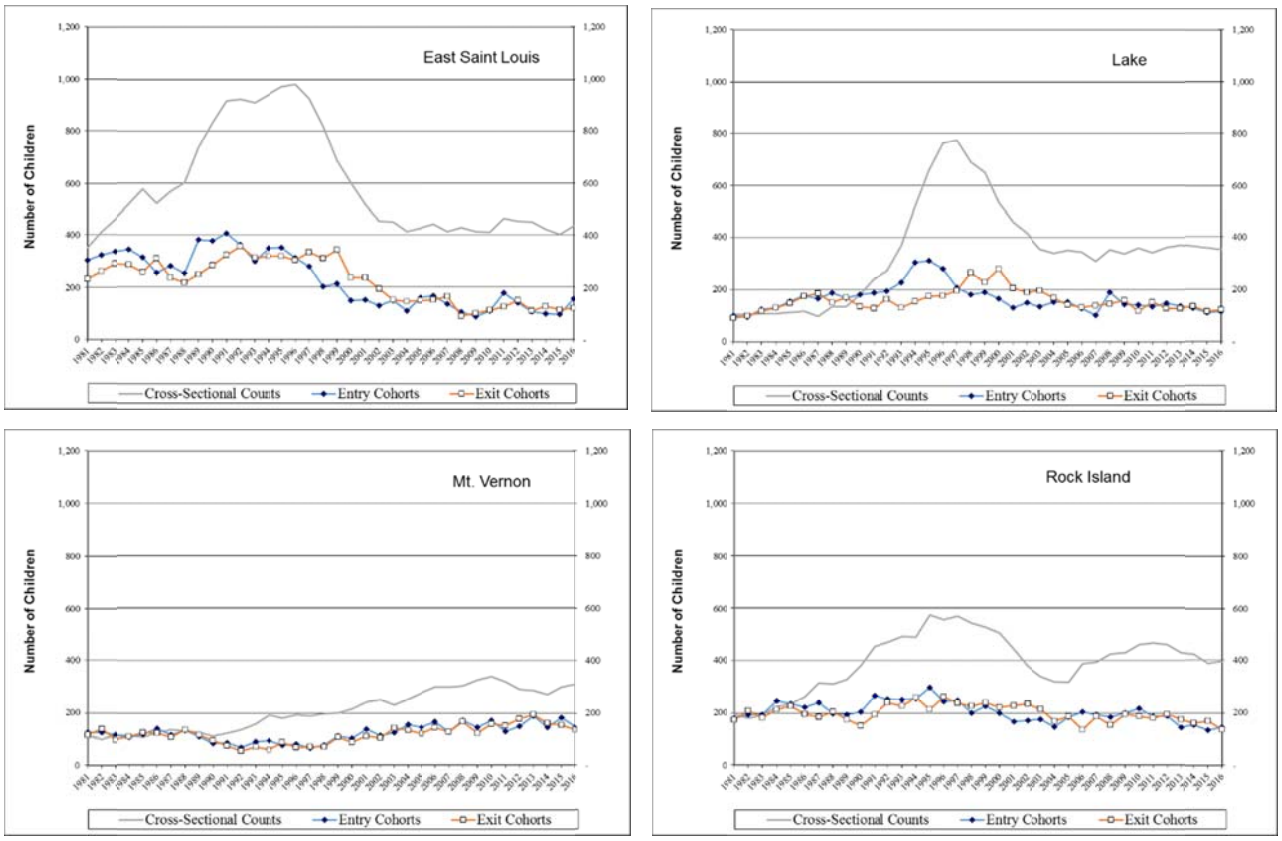


Figure 1.—Caseflowdynamics, FY1981-2016, Immersion sites

The percentage of children residing kinship foster homes swiftly increased between 1986 to 1995 in Illinois from 27% to 57% of out-of-home placements before a combination of front-end Home-of-Relative (HMR) reforms and back-end permanency initiatives reduced the percentage to under 40%. Since the mid-2000s, the number of active kinship foster care cases has hovered around 6,500 children. This leveling off of the HMR caseload has been accompanied by a leveling off of the population of children in foster family care, group homes, and residential care. As illustrated in Figure 2, the size of the Illinois foster care population stabilized at an equilibrium level of approximately 15,000 children. Since 2008, the number of children who are discharged each year from foster care match the number of children who are taken into foster care.

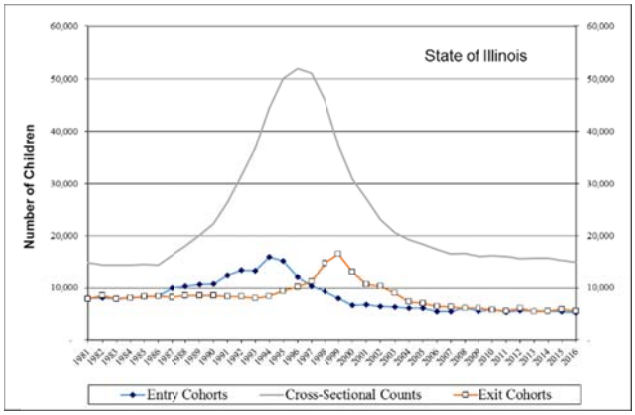


Figure 2.—Caseflow dynamics, FY1981-2016, Illinois

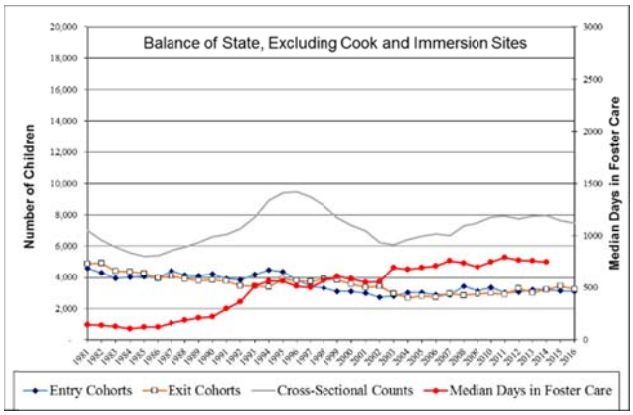
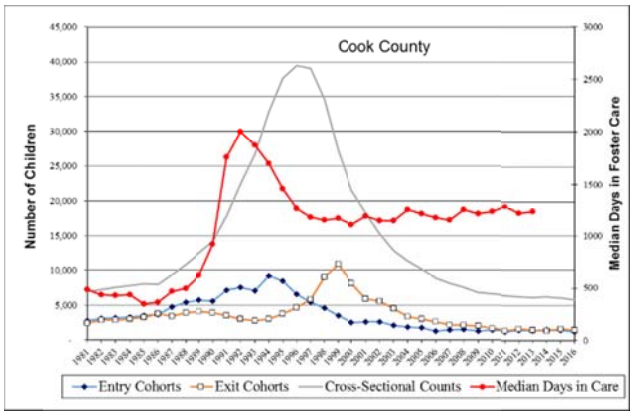


Figure 3.—Caseflow dynamics and median days in care FY1981-2016, Cook County and the Balance of State

There are two contrasting opinions on the stabilization of the foster care population in



Illinois. The first, which is the opinion of the Expert Panel and the parties, is that the child welfare system retains children unnecessarily and far too long in foster care. This is particularly true for children who are taken into foster care in Cook County, where half the children are still in foster care after 1,200 days or 40 months. Cook County consistently registers among the longest median lengths of stay compared to a national average of 14 months. Even though the median length of stay in the balance of Illinois is shorter than in Cook County, it has been steadily rising and at 750 days or 24 months, downstate counties retain children in foster care longer than 1,150 out of the 1,250 U.S. counties for which there are comparable measures.

An alternative opinion is that lengthier stays in foster care in Illinois appropriately reflect the clinical needs of the children who are taken into foster care and the challenging circumstances their families must overcome in order to regain custody. Because Illinois children are removed from their parents at far lower levels than children in other states (Illinois and Virginia are tied for the fewest removals per capita), the reasoning goes that children stay in care because good casework practice dictates that these children should remain in care in order to receive the specialized care and trauma-informed treatment they need.

In order to test the comparative merits of these two alternative opinions, the parties agreed to the creation of four "immersion sites" of small geographic areas that coincide with judicial circuits to fully build, test and implement a core practice model that puts children and families at the center of service planning and builds community and home-based services for children and their families.

DCFS identified the key components to the process as:

(i) training and coaching of all DCFS and private agency staff in the new Family-Centered, Trauma-Informed, Strength-Based Practice Model practice model for service delivery (referred to here as "FTS");
(ii) implementation of a new "Model of Supervisory Practice" or "MoSP;"

(iii) integration of its Quality Assurance Division and Monitoring Divisions in the immersion sites in order to implement a new, Quality Service Review Process (QSR);
(iv) development of community and home based services for children and families and securing Title IV-E waivers to fund same;
(v) refinement of a data tracking system to measure outcomes for children;
(vi) revision of coverage areas for DCFS offices to align them with the boundaries of the State's judicial circuits; and
(vii) decentralization and internal, DCFS structural changes to improve case flow and day-to-day operational processes.

Program Evaluation. The independent evaluation, which is required by the IV-E waiver demonstration, will test whether the implementation of the core practice model and accompanying systemic reforms improve upon safety, permanency and stability outcomes. Two sorts of comparisons will be drawn for rendering these summary assessments: 1) within-site, historical comparisons and 2) contemporaneous, cross-site comparisons with matched geographical areas.

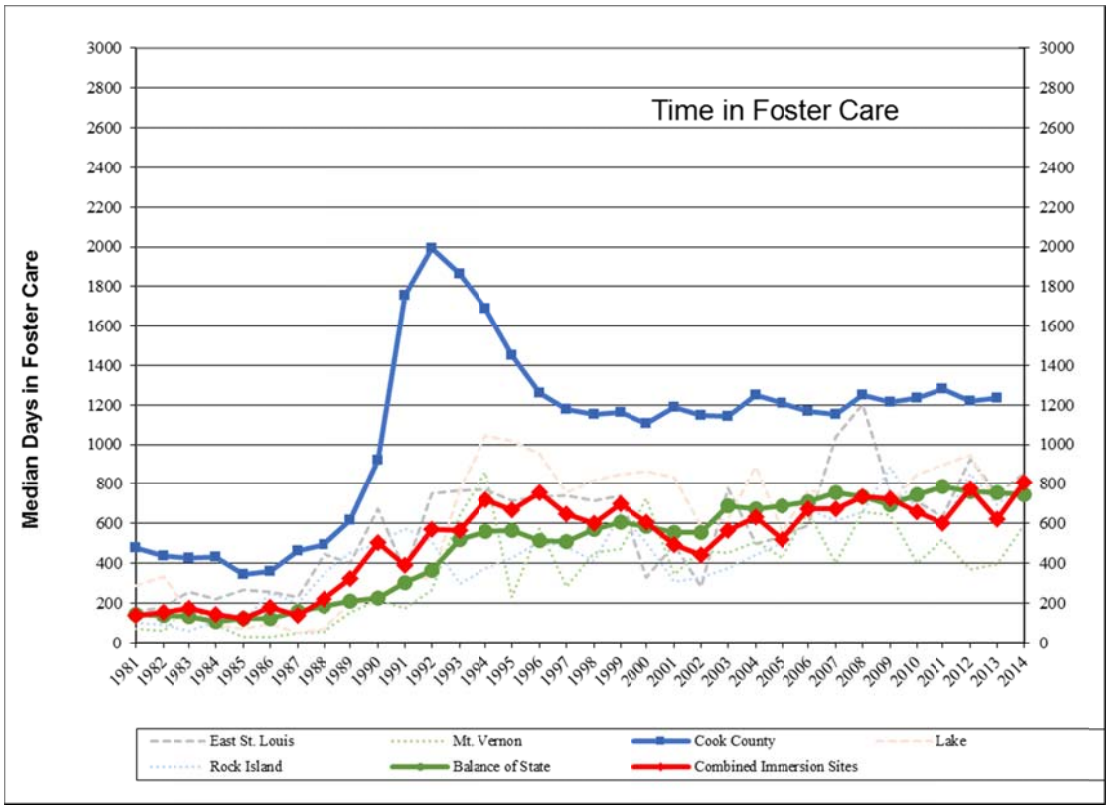


Figure 4—Median Days in Foster Care, FY1981-2014, Immersion Site, Cook County and Balance of State

For example, Figure 4 shows that the median days that children in all four immersion sites remain in foster care track closely the trend line observed for the balance of the state outside of Cook County. Combining the data for all four immersion sites helps smoothen the trend lines that jump around when plotted separately for each site. One of the indicators of success is whether as a result of the roll-out of the core practice model and accompanying systemic reforms, the median length of stay in the immersion sites can be shorted to between 400 and 450 days, which is more in line with national levels. In addition, contemporaneous comparisons can also be drawn by comparing length of stay to a comparable sample of counties from the balance of state.

DCFS continues to track data on a statewide, regional and Immersion Site basis for the following outcomes: maltreatment in foster care, repeat maltreatment, child and family team meetings, supervised and unsupervised visits, family reunification within five and 12 months, permanency within 12 months, total permanency achievements by month and year to date, permanency within 12 months, total permanency achievements by month and year to date, placement moves, time to achieve family reunification and intact service levels. Exhibit K, Outputs and Overarching Outcomes: State, Regions and Immersion Sites May 1, 2017.

Health data will also be tracked for yearly EPSDT and dental checkups. Exhibit K, Outputs and Overarching Outcomes: State, Regions and Immersion Sites May 1, 2017, pp. 1, XX-XX. Historical data indicate that compliance for these checkup drops, however as children get older. Additional requirements for review of health information have been added to the review protocols for the Agency Performance Teams reviews of private agencies. Exhibit K, Outputs and Overarching Outcomes: State, Regions and Immersion Sites May 1, 2017. If

meaningful improvements can be observed across several indicators in comparison to both historical data and comparable counties, a case for rolling-out the core practice model to another set of immersion sites will be strengthened. If no improvements are observed by the time of the roll-out to the second set of immersion sites, however, attention will either turn to other potential solutions or reconsideration of whether current levels of observed performance are actually consistent with best practice.

The Implementation Plan set the following target dates: finalization of Title IV-E waiver by September 2016 (now complete), presentation of a Summit in October 2016 to announce the new Core Practice Model (now complete), finalization of the QSR tool by November 2016 (finished late); completion of QSR training by January 30, 2017 (incomplete), and pilot use of the QSR process in at least one immersion site by February 1, 2017 (complete).

DCFS originally projected that it would take until September, 2017 to complete the process in the first four Immersion Sites, and roll-out to additional sites was to occur on a regular basis with a target state-wide completion date of 2019.

5. Status Report:

Roll-Out to New Immersion Sites. The timeline for expansion to new Immersion Sites has not yet been revised. Rolling out the model to the next set of immersion sites, even before the evaluation of the initial roll-out has been completed, will strengthen the overall evaluation. However, it remains unclear whether the completion date of September 2019 will be met.

FTS Training and Implementation. Critical to the success of any pilot initiative is assuring that a sufficient proportion of the intended recipients actually receive the desired intervention. Ninety-seven percent of the staff in the Immersion Sites completed FTS training. Make-up sessions are being offered on a rotating basis between Immersion Sites for the staff that

did not complete the FTS training and for newly hired staff. Four Month Status Report Update Immersion Sites; Four Month Status Report Update Core Practice Model. A web-based, self-directed version of FTS training is currently in development and will replace the makeup sessions in the future.

DCFS identified staff in the Immersion Sites who needed a more limited version of the FTS training and those staff completed the abbreviated self-directed version of FTS training. Ninety-four percent of the staff identified completed the abbreviated self-directed training through March 31, 2017. The following shows the completed FTS classroom trainings by Immersion Site:

Total targeted CLASS ROOM participants [4]	458	
Total participants who have completed FTS CLASS ROOM training	446	97.38%
Total participants registered for upcoming CLASS ROOM training	0	0.00%
Total participants not completed or not registered for CLASS ROOM training	12	2.62%
Total participants scheduled for SELF DIRECTED learning - NON RESIDENTIAL [5]	59	
Total participants completed SELF DIRECTED learning - NON RESIDENTIAL	56	94.92%

Procedure 315 Training. As of March 30, 2017, 100% of permanency and adoption staff, including supervisors and managers in the immersion sites have completed training in revised Procedure 315.

Makeup sessions are being offered for this training as well, on a rotating basis between Immersion Sites, to account for newly hired staff and staff who need make-up sessions.

MoSP Training. The delivery date for the Model of Supervisory training was November, 2017, but has been pushed to December, 2017. The training will include a combination of classroom training and individual coaching. Initial presentation of the training in Immersion sites is currently scheduled to begin in December. A training schedule will be developed during the next reporting period.

CFTM Training. Significant delay was encountered in finalizing and executing the contract with CWG. The contract was finally signed on April 10, 2017. Under this contract, CWG will provide both training and coaching for the CFTM and the QSR processes.

CWG has completed the CFTM curriculum, including a "Preparing and Facilitating Child and Family Team Meetings Illinois Department of Children and Family Services Trainer Manual" and a "Preparing and Facilitating Child and Family Team Meetings Illinois Department of Children and Family Services Participant Workbook."

DCFS and CWG developed a plan for moving forward on the CFTM training and coaching. CWG consultants and Immersion Site directors met in May 2017 to analyze local data and develop a one day Leadership Summit for each Immersion Site for the broader child welfare community to explain the importance of the CFTM training and the role of the QSR process in overall quality improvement. CWG staff aligned specific trainers and coaches in each Immersion Site. During June 2017, the one day Leadership Summits are scheduled in each Immersion Site. The first round of CFTM training will commence in July or August 2017 in each Immersion Site.

QSR Training and Implementation. The CWG contract also provides for training and support for the QSR process. CWG recommends that the training be done in parts: an initial training, participation in an on-site review and, after the conclusion of three on-site reviews with

the participation of a CWG mentor, additional advanced training that will prepare them to become a mentor/trainer in the QSR process going forward. Exhibit C, Four Month Status Report, Immersion Sites.

The current goal is to have a total of eight QSR reviewers who are able to complete independent QSR reviews and are then able to train and mentor other staff to complete the QSR process. To date, DCFS has hired four dedicated QSR reviewers, one headquartered in each Immersion Site. The QSR process includes case sampling for each review, identification of case-stakeholders for in-person interviews, review of case documentation, rating of the case and worker on the specific case. Exhibit XX, Four Month Status Report, Immersion Sites.

Service Provision. Contracts for lead agencies in each of the Immersion Sites were finalized and executed in April 2017. The lead agencies are: United Methodist Children's Home in the Mount Vernon Immersion Site, Lessie Bates Davis in the East St. Louis Immersion Site, Bethany in the Rock Island Immersion Site and NiCASA in the Lake County Immersion Site. Exhibit C, Four Month Status Report, Immersion Sites.

The contracts provide for delivery of intensive and in-home evidence based services within the Immersion Sites. Each contract is premised on wrap-around principles and contains flexible funding for the development of individualized services and supports to meet the needs of individual families. Each Immersion Site program was taking referrals by the first week in June. Training in an evidence-based wraparound principles was also completed during the first week in June. The flexible funding provided and the community networks supporting each program make it possible to engage a wide array of individualized services for families and their children, such as emergency housing through the now de-centralized Norman funds; support services for substance abuse, mental health, domestic violence; and family support services such as child

care, home aides and parent education. Family needs and strength are defined through the CFTM process and the lead agency providing the service array is responsible for responding to the defined needs identified in the CFTM. Exhibit C, Four Month Status Report, Immersion Sites.

IV-E Waiver. The Administration for Children and Youth asked DCFS to provide a detailed plan for implementation of the IV-E waiver by April 2017. DCFS has submitted that detailed plan. The Waiver has been granted and the additional funding and flexibility is built into the DCFS budget.

Office Realignment. DCFS developed a plan to align regional and field offices with judicial circuits. It was anticipated that the plan would be ready for review by the Director and for union negotiations by March 31, 2017. That has not yet occurred.

Restructuring and Decentralization. DCFS continues to work on structural issues to better align with practice goals and expectations in the Immersion Sites.

DCFS committed to "retooling" the Integrated Assessment process, to transformation of the CIPP process into the CFTM process, and to delegation of the placement matching process to teams in the Immersion Sites by April 30, 2017, and further committed to developing a plan for statewide implementation by the end of the current reporting period. Discussions with CWG led to the conclusion that the exact role of Integrated Assessment and how it fits with the CFTM training and coaching going forward requires more study.

6. Revised Targets / Goals:

Roll-Out to New Sites, DCFS is planning to hold its Second Annual Transformation Summit on August 8, 2017 to August 10, 2017 in Springfield, Illinois. The theme of the Summit is "Pursuing Permanency: Cultivating, Maintaining and Supporting Lifelong Connections."

Exhibit L Save the Date PDF document. However, it is still too early to roll out the Immersion Site process in any additional locations, and it also is still too early to state with confidence whether statewide rollout by September 2019 is realistic. DCFS will consult and work collaboratively with the Expert Panel and Plaintiffs regarding any adjustments in the timeline for adding new Immersion Sites for the remainder of the state.

FTS Training and Implementation. This has been completed in the four initial Immersion Sites, as over 97% of DCFS and private agency staff have been trained. Makeup sessions will be made available for staff that still require training and a web-based training will be developed for future training.

Procedure 315 Training. All staff in the Immersion Sites have completed this required training.

MoSP. The MoSP training is projected to begin in December 2017.

Child and Family Team Training. The Immersion Site directors and staff from CWG will meet by the end of May 2017 to complete a data analysis and develop Leadership Summits for community stakeholders in each Immersion Site regarding the importance of and the plan for implementing CFTM training in each site.

The Leadership Summits that must precede CFTM training will be held by the end of June 2017. Initial CFTM training will commence in July 2017 and run through August 2017. The initial training will include 18 supervisors and six coach candidates and the training will include both education and observation. Exhibit C, Four Month Status Report, Immersion Sites. The training plan includes training coaches who will be trained to facilitate CFTMs, to coach CFTMs and then to become Master Coaches and Trainers for other DCFS and provider agency staff. The goal is to develop the initial coach candidates into Master Coaches by December

2017. Master coaches will be approved to develop additional cohorts of supervisors and coaches and to provide the CFTM training to additional staff. Exhibit C, Four Month Status Report, Immersion Sites.

The second round of CFTM training is scheduled to commence in September 2017. This schedule is subject to modification based on the progress of round one CFTM trainees.

Quality Service Review Process. The four dedicated QSR reviewers will conduct a second round of QSR reviews with the CWG mentors in June 2017 after they complete a refresher training with CWG on June 1-2, 2017. A second group of new QSR reviewers are scheduled to begin training in August 2017. DCFS will work closely with CWG to make any needed adjustments to this schedule.

Service Delivery. With lead agency contracts now in place for each Immersion Site, the DCFS Clinical Division will guide development and implementation of in-home services. The Clinical Division has provided consulting in the development of each Immersion Site's service array. DCFS is building service level expectations into each of the lead agency contracts. The Immersion Site Directors will be responsible for identifying gaps in available services. Service gaps will be identified and solutions developed through the ongoing stakeholders planning process which is active in each Immersion Site.

Realignment of Office Areas. The plan for realignment has been completed but not yet executed. When Interim Director Spacapan takes office she will be briefed and decisions will made as to the next steps that need to be taken with regard to the realignment plan.

Restructuring and Decentralization. During the next reporting period, DCFS will work intensely with the CWG staff to develop a plan, including a timeline and action steps to fully align the Integrated Assessment process into the Child and Family Team process and to

integrate clinical staff into that process. In that same timeframe, the CIPP assessment and planning process will be progressively transitioned into the CFTM process as the CFTM training and coaching is implemented. The Central Matching Unit is currently delegated to the Immersion Sites and will be fully integrated into the CFTM process as the CFTM training and coaching proceeds. Full implementation of integration of the matching process into the CFTMs will be completed as the CFTM training and coaching process achieves its goal of creating a total of 96 CFTM facilitators, master coaches and coaches in December 2017.

Clinical staff will be engaged in cases where youth experience more complex behavioral and emotional problems from the very beginning of the case and will remain involved with the CFTM. These assessments will drive the development of individualized plans and the delivery of needed services for youth with serious mental health and behavioral needs.

Program Evaluation. Details of the outputs and proximal and distal outcomes are stated in considerable detail in the status report on Immersion Sites. A few highlights include outputs such as deepening worker knowledge of the family centered, trauma informed and strength based framework which is the foundation of the DCFS practice and deepening worker understanding of the path to permanency enhanced by new opportunities, such as family finding, state subsidized guardianship and fictive kin. In addition, a plan will be developed during the next reporting period to address the apparent failure to timely provide EPSDT screenings and dental care to older youth. This plan will be implemented in the Immersion Sites.

F. Panel Recommendation #3:

Fund a set of permanency planning initiatives to improve permanency outcomes for adolescents who enter state custody at age 12 or older either by transitioning youth to permanent homes or preparing them for reconnection to their birth families reaching adulthood. (Implementation Plan, pp. 38-42).

DCFS is pursuing two initiatives in accordance with this Recommendation – the Fictive Kin/ State Funded Guardianship, and Family Finding. Figure 5 updates the statewide permanency chart for older youth, which was included in Report of the Expert Panel that was submitted to the Court in July of 2015. It was the opinion of the Expert Panel that the permanency options made available to adolescents who were unable to reconnect with their birth families were either too few or insufficiently explored by DCFS. Recent data show an uptick in the percentage of older children who are returned to their parents' homes. This is a welcomed change. On the other hand, the Report of the Expert Panel showed that less than 3% of adolescents who entered DCFS at age 12 or older were discharged to permanent guardianship arrangements within 5 years of case opening. Two years later, the update data show that the percentage has declined even further to 2%. This compares to 7% that was the norm during the mid-2000s. Placement of older youth in adoptive homes has also declined. Even though more should be done to find adoptive homes for older youth in care, the termination of parental rights (TPR) and reassignment of legal responsibilities to another set of parents have always been a difficult transition for older youth to accept.

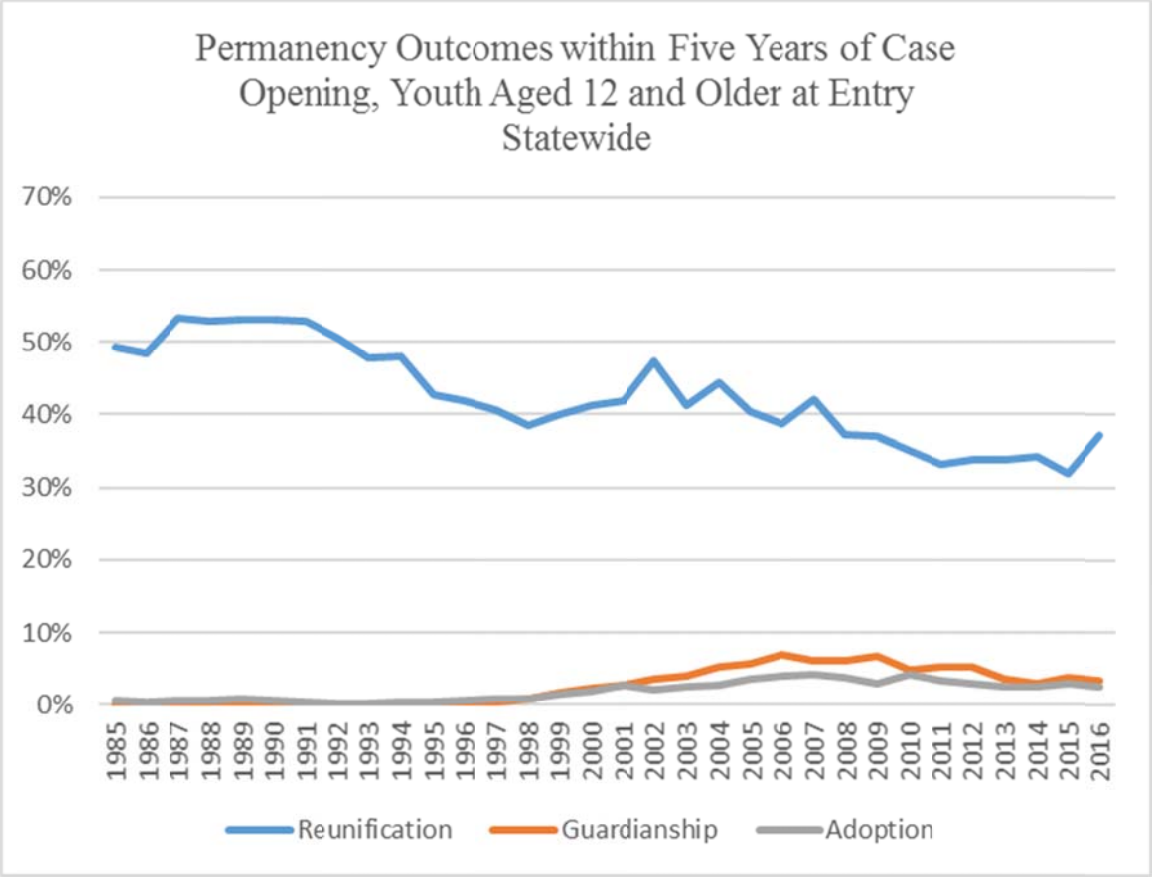


Figure 5—Permanency Outcomes within Five Years of Case Opening, Children Aged 12 and older at Case Opening

Regular teleconference calls regarding the status of B.H. projects with DCFS project managers, the Expert Panel, and the parties have reinforced the need for expanding the permanency options available to older youth. One of the explanations for the decline in the use of subsidized guardianship was the restriction of eligibility for federal kinship guardianship assistance to only youth in licensed kinship care. Prior to the enactment of the federal Fostering Connections Act in 2008, guardianship assistance was available to all kinship caregivers regardless of their licensing status as well as to non-related foster parents. The changes to the State Funded Guardianship Program and the redefinition of relatives to include current foster parents if the youth has been in the home for one year and has developed a family-like

connection will restore these permanency options to families. Each initiative is discussed separately below.

G. Panel Recommendation # 3: Amended Definition of "Fictive Kin"

1. Project Goals/Target

The Implementation Plan contemplates that amendments to expand the definition of fictive kin will improve permanency options and lead to improved well-being. DCFS committed to updating its administrative rules with the expanded definition of fictive kin after January 1, 2017, which was the effective date of the statutory change to the Children and Family Services Act. Implementation Plan, pp. 39-40.

2. Status Report:

DCFS is currently engaged in rulemaking for DCFS Rules 300, 301, 302, 304, 309, 315, 328, 337, 338, 359 and 402, which includes the updated definition of fictive kin. The First Notice period was completed on April 3, 2017 and DCFS received no comments on the proposed changes. DCFS is proceeding in Second Notice and anticipates this will be completed within approximately 60 days. Exhibit M, Four Month Status Report Amended Definition of Fictive Kin and Expanding State Funded Guardianship.

Training on revised Procedure 315, Permanency Planning, includes training on the expanded definition of fictive kin. All immersion site permanency and adoption staff have completed Procedure 315 training. Additional staff throughout the state are also engaged in revised Procedure 315 training, which was scheduled for completion by May 31, 2017. Exhibit M, Four Month Status Report Amended Definition of Fictive Kin and Expanding State Funded Guardianship.

DCFS continues to track placements with fictive kin. As previously reported, from January 1, 2015 to December 31, 2016, there were 1236 youth placed with fictive kin. From

January 1, 2017 to May 1, 2017, 650 youth statewide have been placed with fictive kin, with 37 of those placements made after February 28, 2017. At the present time, DCFS is unable to identify how many of the 650 fictive kin placements made through May 1, 2017 are attributable to the expanded definition of fictive kin. However, DCFS is currently developing business rules which will be able to identify those fictive kin placements due to the expended definition of fictive kin. Exhibit M, four Month Status Report Amended Definition of Fictive Kin and Expanding State Funded Guardianship.

3. Revised Targets / Goals:

Tracking Outcomes. DCFS will continue tracking placements and outcomes of youth in fictive kin homes to monitor for safety, stability and permanency. The mechanism for tracking youth in fictive kin is a dashboard in the Mindshare platform. Safety and permanency will be measured by no moves being recorded for those youth who have been placed in the home of fictive kin. The permanency for those youth will be tracked via discharge to either home of parent/home or home of guardian of home of adoptive parent where a previous home fictive kin was recorded. Any placement move from fictive kin will be provided in a report for regional review and follow-up for stability.

Training – Procedure 315. The completion date for DCFS training on Procedure 315 has been revised. Per the DCFS Training Division, there are approximately 160 staff that still need to be trained and some newly hired staff who will also need this training. Based on this information, the anticipated timeline for completion is June 30, 2017. The anticipated date for the self-directed web based training for investigative and intact staff is also June 30, 2017.

Data Collection. Project management staff are working on clarification and completion of business rules and data elements for Family Finding and state-funded guardianship/Kin Gap.

Once those rules and data elements are completed, the project managers will review them with the Expert Panel to ensure that the appropriate information is being collected.

H. Panel Recommendation # 3: Expanding State Funded Guardianship

1. Project Goals/Target: The Implementation Plan contemplates that DCFS will amend its administrative rules to expand the eligibility for state funded guardianship. DCFS committed to completing the amendments by December 2016. Implementation Plan, p. 39.

2. Status Report: DCFS is currently engaged in rulemaking for DCFS Rule 302.410 which includes the expanded definition of state funded guardianship. The First Notice period was completed on April 17, 2017 and DCFS received no comments on the proposed rule change. DCFS is proceeding to Second Notice and anticipates this will be completed within approximately 60 days. Exhibit M, Four Month Status Report Amended Definition of Fictive Kin and Expanding State Funded Guardianship, p. 1

Effective April 1, 2017, Administrative Case Review (ACR) staff are required to implement questions during every ACR to assure that state-funded guardianship is being pursued for all eligible youth 12 years of age and older where the goals of return home and adoption have been ruled out. Information on the responses will be included in the ACR feedbacks and the ACR reporting system. Eventually, data will also be collected through the dashboards of the Mindshare platform.

Initial data from the ACR system, as an example, indicates that state funded guardianship is being pursued for youth in eleven of 16 applicable child cases reviewed where a child is placed in a non-licensed relative home and in 15 out of 19 cases in which the youth was placed in a licensed non-relative home during the ACR process in April 2017. State funded guardianship should have been pursued for all of those cases but was not because the question of

whether state funded guardianship was not being asked at the ACR in all cases where a youth might be eligible. To address this, effective July 1, 2017, the question of whether state funded guardianship is being pursued with be asked at ACRs for all youth age 12 and older who have permanency goals other than adoption. Previously, the question of whether state funded guardianship was being asked only for those youth age 12 and older who have a goal of guardianship. To be eligible, youth also must be placed in a non-licensed or licensed relative home. Siblings under the age of 12 who are placed in the same home as an eligible youth are also afforded the state funded guardianship option. Exhibit M, Four Month Status Report Amended Definition of Fictive Kin and Expanding State Funded Guardianship.

DCFS previously committed to developing a dashboard in the Mindshare platform that will allow program managers to be able to identify youth eligible for specific subsidies, such as the state funded guardianship program, in order to move them to permanency. To date, the dashboard has not been developed and no target completion date has been set.

3. Revised Targets / Goals:

Completion of the rulemaking process for state funded guardianship should be completed by July 31, 2017. Commencing in this reporting period, regular monthly reports will be generated on youth eligible for state funded guardianship and the KinGAP program. Exhibit M, Four Month Status Report Amended Definition of Fictive Kin and Expanding State Funded Guardianship. Youth eligible for the programs will be identified by a review of the youth's age, permanency goal and type of living arrangement. The monthly reports will contain identifying information regarding the youth in care, including the age of the youth, the type and date of the current placement, the current permanency goal and the date the current permanency goal was set. Cases with potential eligibility for state funded guardianship and KinGap will be identified

by ACR reviewers, Adoption Specialists and Agency Performance Team staff. ACR still send an alert or critical notice to the assigned caseworker, supervisor, regional adoption supervisor and regional agency performance staff. Adoption staff, along with agency performance staff, will be responsible for addressing eligibility for guardianship with the assigned caseworker and supervisor.

The Mindshare dashboard for state-funded guardianship and KinGAP will be completed during the next reporting period and the date for the completed validation of the dashboard will be determined once the dashboard has been finalized. The finalization of the dashboard in the Mindshare platform will eliminate the need for multiple monthly reports.

Tripling the percentage of youth who attain permanence after entering foster care at ages 12 and older from its current level to 6% at the end of an entry cohort's third year in foster care is a reasonable goal. Work will commence on achieving this object first in the immersion sites.

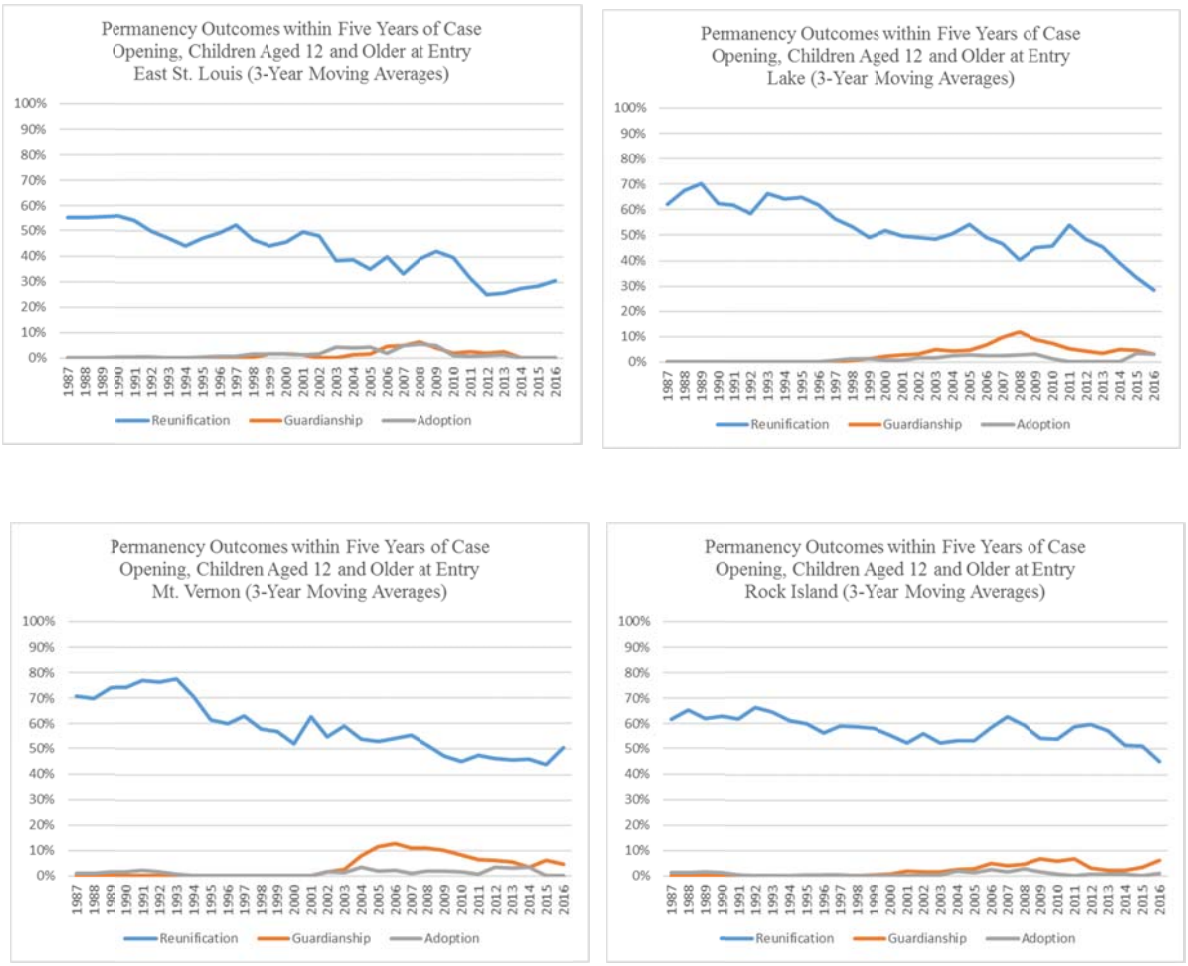


Figure 6 Permanency Outcomes for Children Aged 12 and Older at Entry into Foster Care, Immersion Sites

Figure 6 compares the permanency outcomes within five years of case opening for youth who entered care at ages 12 years old and older in the four immersion sites. The utilization of subsidized guardianship has fallen off in all immersion sites, with the exception of Rock Island. In spite of the slight uptick in reunification rates in East St. Louis and Mt. Vernon, the overall trend has been downward in all immersion sites. As a result, the percentage of youth who turn 18 years old while in care has doubled in all immersion sites from 15% in the 1980s to 30% in the 2010s. As the prospects for legal permanence diminish sharply for youth who attain majority age while in care, the chances that these young folks will age out of care without the support of a

permanent family is highly probable. Some of these former youth in care will find their way safely back to their families of origin, but a substantial fraction will experience bouts of homelessness, fall prey to sexual trafficking, or end up in toxic relationships. For these reasons, it is extremely important to prevent these adverse experiences to the extent possible by embedding youth in relationships of both relational and legal permanence before they reach the age of majority,

I. Panel Recommendation # 3: Family Finding

1. Project Goals/Target: One of the initiatives DCFS is undertaking to ensure that no youth ages out of foster care without some permanent family connection is Family Finding. The Implementation Plan requires DCFS to implement specific "family finder" strategies as part of permanency planning for adolescents who do not have an obvious reunification plan. Implementation Plan, p. 40. The goal of DCFS's Family Finding strategy is to improve permanency outcomes for all youth by identifying family that can serve as potential placements, supports or resources for youth. Implementation Plan, pp. 40-42. Per DCFS procedures, a goal of "independence" should never be assigned to children under the age of 16 years old. But even for older children, the independence goal should be used sparingly. It is extremely difficult for youth to establish and maintain lifelong supports and connections on their own, even after family finding activities have taken place. Thus every effort should be made to explore adoption and subsidized guardianship options with a youth's current caregiver or identify through family finding efforts other individuals who are willing to make a permanency commitment as a legal guardian to whom the youth can look to for guidance, encouragement, and membership as they transition to adulthood.

DCFS committed to revising its rules and procedures to enhance family finding efforts on all levels. Family finding efforts are to be conducted for all children and youth entering care with

a return-home goal. The revised rules and procedures will require all child protection, intact and permanency staff to seek out non-custodial parents, relatives and fictive kin when placing a child or youth.

DCFS further committed to requiring Permanency Achievement Specialists within each DCFS region to conduct family finding tasks, and that these Specialists would be available to both DCFS and private agency staff to provide technical assistance on complex or difficult cases to identify barriers to permanency through methods of file mining, family meetings, trainings or other assistance. The self-directed web-based training for Family Findings began in March 2017 and is available to DCFS staff, private agency staff, and administrators via the DCFS Virtual Training Center. The web-based training currently is a component part of the Foundations training for new permanency staff, and will be included in the Foundations training for child protection staff as well.

Additionally, the Plan states that ACR staff will flag cases where family finding is not occurring or where there is a barrier to permanency so that DCFS and private agency staff can be made aware of the issues and take steps to rectify the problems.

No dates for the above commitments were specified in the Implementation Plan. During the next reporting period, DCFS will set target dates for accomplishing these objectives now that is has a concrete plan.

2. Status Report:

Refocused Efforts on Youth 12 and Older. In the prior Report, DCFS committed to refocus its family finding efforts on adolescents with emotional and behavioral health in order to locate additional placements or supports for those children. DCFS has identified youth over the age of 12 to determine whether any family finding activities were completed for the child.

Relying on DCFS form 151-H or through a case note, DCFS has identified 698 youth out of 31,547 youth to date who have had family finding activities documented in their case files through the DCFS 151-H form or through a case note. This data was pulled from all youth who entered care at age 12 or who became 12 years of age or older from July 2010 to April 30, 2017. Exhibit N, Four Month Status Update, Family Findings. DCFS has a number of strategies to address those cases where no family findings efforts are documented. For those youth, when an ACR is held on the case, the ACR reviewer will send a feedback to the assigned caseworker and supervisor. A feedback is a narrative report used by the ACR to provide case status information in relationship to permanency, safety and well-being of the children in care and their families. There are three types of feedbacks:

1) The Monthly Feedback which is a written summary of the status of a case after it has been administratively reviewed. The Monthly Feedback documents that DCFS policy is being followed, that there is a plan for permanency, that the youth's needs are being met and that the youth are safe while in the custody of DCFS;
2) The Monthly Feedback with Alert issues is a written summary of a lack of needed services to children and/or families and/or unmet needs that jeopardize a child's safety, well-being and/or timely achievement of permanency. The alert feedback is also used to address specific issues that have not risen to a critical level, but need the attention to present the issue from rising to a critical level. The alert feedback is designed to address moderate risk issues requiring further action and resolution by the worker and supervisor.
3) The Critical Feedback is a written summary of issues where there is a violation of DCFS rules, procedures or policies, laws or court orders that endanger the safety,

well-being and/or permanency of children and youth for whom DCFS is responsible, including neglect of a child's mental health, medical or safety needs.

4) The interim Feedback is a written narrative indicating the status of resolution for a previously identified critical issue. This feedback is only written on cases following an interim ACR which is required within one to three months following identification of a critical issue. This interim feedback is to help ensure that the critical issue is being address for resolution expeditiously.

DCFS project management staff will also provide reports to Regional Administrators for cases in their region who have had no family findings work completed. The Regional Administrators will review the reports and provide them to assigned caseworker and supervisory staff to ensure that the family findings work is being completed.

Mindshare Dashboard. DCFS staff completed work on the Family Finding dashboard in the Mindshare platform. Exhibit N, Four Month Status Update, Family Findings. That dashboard, which still requires validation, went live on April 14, 2017. The dashboard encompasses all youth in care, however, specific measures for youth ages 12 and older are being reviewed and validated. Those specific measures include: the number of youth ages 12 and older with noted relative or fictive kin supports; the type of living arrangement where the youth resides, such as placement with relatives (HMR), fictive kin (HFK) or home of relative (HMP), after family finding efforts were completed; the length of stay in each type of placement (indicating stability) and legal permanency type. Exhibit N, Four Month Status Update, Family Finding.

Inclusion of Family Finding in ACR. Effective April 1, 2017, ACR staff are required to ask questions at every ACR to assure that family finding activities have been completed. This

information will be contained in ACR feedbacks and in the ACR reporting system. Initial data indicates that family finding activities, through a review of the case by the ACR reviewer, were completed in 632 of 864 applicable child cases that had an ACR review in April 2017. Exhibit N, Four Month Status Update, Family Findings.

Webinar Training. On March 2, 2017, the Family Finding webinar training was released. It is mandatory on-line training for all child protection and permanency staff and supervisors. As of April 28, 2017, 1,045 staff completed or are in process of completing the training. Exhibit N, Four Month Status Update, Family Finding.

Procedure 315 Training. DCFS began offering training on Procedure 315 in its revised format, which addresses family findings issues, in December 2016. A separate, self-directed web based training on Family Findings, which provides an overview of the family finding philosophy and direction on how to complete and record family findings activities, was implemented in March 2017 on the DCFS Virtual Training Center. DCFS previously anticipated that by May 31, 2017, all permanency staff would have completed the training. During the next reporting period, DCFS will report on whether that goal was met.

3. Revised Targets / Goals:

Refocused Efforts on Youth 12 and Older. DCFS is currently completing the plan for refocusing its family findings efforts for youth in care who are ages 12 and older. This plan will be completed by the end of June 2017.

Efforts Addressed to Remaining Youth. The B.H. Expert Panel suggested inclusion of the 0-3 population to family finding/sub guardianship/expanded KinGap. The Mindshare dashboard will have fiscal year entry cohorts, so DCFS will be able to review if the youth who are entering care have family finding activities completed. These dashboards encompass all

youth in care regardless of their age. The reports will permit data sorting by DCFS region, POS agencies and DCFS offices. It will also allow for the isolation of the targeted population of those youth over the age of 12 and those youth ages 0-3.

Mindshare Dashboard. DCFS will complete validation of the Family Finding dashboard by June 30, 2017. A meeting is scheduled for June 8, 2017 to discuss finalization and determine if other business rules are required since family finding, fictive kin and state-funded guardianship were combined into one project as they are interrelated. These were combined after review by the B.H. Expert Panel and the decision that family finding is an activity that will help assist in the identification of relative or fictive kin, which may lead to permanency through the state funded guardianship and KinGap options for youth.

Inclusion of Family Finding in ACR. Family finding questions were added to the ACR review packet effective April 1, 2017. These reports will be sent to the Regional Administrators to be disseminated to both DCFS permanency staff as well as POS permanency staff. This information will also be sent via feedback system described above. The DCFS Regional Administrators will be responsible to ensure staff are completing the family findings work in accordance with DCFS procedures

Webinar Training. The target date for completion of the Webinar training has been extended to June 30, 2017. The web-based training is now a part of Foundations training for all permanency/placement staff/and will remain on the VTC for all other disciplines.

Procedure 315 Training. The target date for completion of this training has been extended to June 30, 2017.

J. Panel Recommendation #4:

Retain an organizational consultant to aid DCFS in "rebooting" a number of stalled initiatives that are intended to address the needs of children and youth with psychological,

behavioral or emotional challenges" (Implementation Plan, pp. 42-43). Recommendation #4 addresses two points - DCFS reorganization, and "rebooting" stalled initiatives intended to meet the needs of specific youth. DCFS identified two initiatives that needed to be "rebooted." DCFS's reorganization and those two programs – Birth to Three (IB3) and Safe Families for Children (SFC) – are discussed below. In addition, DCFS identified various IT projects, including updating or expanding certain information systems and applications and implementing a data analytics system intended to alert investigators of children at exceptionally high risk of serious harm, as part of its response to this Recommendation. Those projects are also addressed below.

K. Expert Panel Recommendation # 4: Reorganization

1. Project Goals / Target: The Implementation Plan called for DCFS to create a high level unit with cross-organization authority to develop an implementation plan, manage the implementation and resolve system barriers. It also noted that the organizational consultant should evaluate the organizational structure and culture of DCFS; the effectiveness of DCFS' policies, procedures and programs; the effectiveness of DCFS's leadership and managerial structure and function and to assess the supervisory functions of the agency. Implementation Plan at pp. 42-43.

2. Status Report: Director Sheldon has announced his resignation effective June 15, 2017. DCFS General Counsel Lise T. Spacapan has been named the Interim Director. The Governor's Office has advised that a nationwide search for a new Director will be undertaken.

3. Revised Targets / Goals: None at this time.

L. Panel Recommendation # 4: Illinois Birth Thru Three (IB3)

1. Project Goals / Target:

The Illinois Birth Thru Three (IB3) is a five-year federal demonstration project that began in 2012 which DCFS will complete within the original timeframe specified in the terms and conditions of its IV-E waiver agreement with the federal government. The project provides two evidence-based interventions, singly or in combination – Child Parent Psychotherapy (CPP) and Nurturing Parenting Program (NPP) – to parents and children in Cook County, regardless of Title IV-E eligibility, in order to reunify children with their parents more quickly and reduce the risk of re-entry to the child welfare system. Implementation Plan, pp. 22-26.

2. Status Report: DCFS still intends to complete the pilot by September 30, 2018, and seek renewal of the waiver for an additional year. The target number of children to be served through the program is 2,400. Since the last reporting period, an additional 50 children were added to the program, which increases the total to 1,816. It is anticipated that another 580 children will be enrolled when the 5-year enrollment period ends on June 30, 2018. Exhibit O, Four Month Status Report: Illinois Birth Through Three Project, p. 1.

Loss of Credentialed Staff. DCFS previously noted that one challenge to the program was that participating agencies were having difficulty retaining credentialed staff. The project now employs a CPP consultant who can support linking newly hired staff with Learning Collaboratives as well as provide support as they gain experience. Similarly, the statewide expansion of NPP will allow for ongoing training of new providers. The program is now fully staffed.

Lack of Engagement by Birth and Foster Parents. Another difficulty with the program has been encountered due to a lack of engagement by some birth and foster parents. DCFS developed a model of on-site field support for participating agencies, with a support specialists assigned to each agency. The specialists were on-site on a monthly basis to provide

coaching and support. In addition, specific offices and agencies were targeted for case status reviews[7] and permanency plans for IB3-involved families. These services continue and will be expanded. The primary lesson has been that it is important to distinguish parental compliance with IB3 services from progress in all domains addressed by the service plan. Key parent risk/safety factors (rooted in trauma history) and level of progress in addressing these concerns including: mental health, substance abuse, domestic violence, housing, and low or unstable income were the common barriers that continued to adversely impact permanency.

A significant issue for the program has been a lack of engagement by participants. In the last reporting period, DCFS committed to providing a 10% increase in the implementation support for this program, and that support was to be provided for 10 agencies providing casework services to children enrolled in the IB3 program. This increased commitment was intended to improve engagement in the program. The additional support DCFS promised was provided.

There are currently three Nurturing Parenting Program (NPP) groups for birth parents and all provider agencies are fully staffed. NPP is one of the evidence-based interventions upon which the waiver is premised. A total of 54 parents have completed the service during Fiscal Year 2017. Exhibit O, Four Month Status Report: Illinois Birth Through Three Project, p. 1. There is also a NPP in process for foster parents. A total of 27 foster parents have completed an NPP program during Fiscal Year 2017. Of the 104 foster parents that have completed NPP, 48% completed during the current fiscal year. The program attributes this to efforts of the implementation team to engage agencies to commit to enhancing outcomes for this population.

[7] The focus of these reviews is permanence, and the case under review is used to help illustrate and discuss parent / foster parent engagement and the available evidence-based interventions that should be undertaken.

The strategy for developing foster parent engagement is the addition of an on-site support specialist for each agency that provides coaching and other supports. Exhibit O, Four Month Status Report: Illinois Birth Through Three Project, p. 1.

DCFS has implemented a continuous quality improvement plan in a further effort to increase the engagement rates for foster and birth parents served by the two agencies with the lowest engagement rates. Exhibit O, Four Month Status Report: Illinois Birth Through Three Project, p. 2. The first phase of Child Parent Psychotherapy Continuous Quality Improvement meetings has taken place. Exhibit O, Four Month Status Report: Illinois Birth Through Three Project, p. 1. Data demonstrates that current engagement rates (of natural or foster parents or both?) vary across the providers from a low of 41% to a high of 82%. Data demonstrate that current engagement rates of natural and foster parents has substantially improved with a mean of 71%. The Support of the CPP consultant and the development of specific CQI plans for CPP will continue.

3. **Revised Targets / Goals:** Permanency outcomes have finally begun to improve for the better for the intervention group compared to the comparison group. The most notable difference is the higher combined rate of reunification or placement into subsidized guardianship with kin in the intervention (+8.8 percentage points), which exceeds the statistical threshold of significant difference ($p < .010$). Excluding guardianships, however, the difference in reunification rates (+5.0 percentage points) drops below the conventional threshold of significance but still is trending in the desired direction ($p < .132$). The higher rate of guardianship in the intervention group is offset to some extent by a higher rate of adoptions in the comparison group, which narrows the difference in overall permanency rate to +4.4

percentage points. While not statistically significant, the difference is trending in the expected direction ($p < .143$).

Despite these improvements, only 25% of the 268 infants and toddlers who were screened and referred to IB3 interventions during fiscal year 2014 had been reunified with their parents or permanently placed through adoption or guardianship after 24 months in care. This constitutes only a marginal improvement over historical baselines and falls far short of the desired goal of closing the permanency gap with downstate counties. Historical data show that children who enter care between the ages of birth through 3 years old in Cook County spend an excessive amount to time in DCFS custody compared to similarly aged children who enter care in downstate counties. There is a 20 percentage-point gap in permanency outcomes between Cook County and downstate counties, which emerges after three years since case opening. Even though the gap narrowed during the mid-2000s due largely to a surge in adoptions of infants and toddlers, the gap has widened again in recent years.

Based on historical trends, the likelihood that this permanency gap can be closed by reunifying children with their birth family after the third year in foster care is extremely slim. Less than 6% of infants and toddlers reunify with their birth families after 36 months in care. This is true for children in both Cook County and Downstate counties. The slim chances of reunification after an extended period of out-of-home care is borne out by over 50 years of permanency planning research. Concurrent planning should in some cases continue, but permanency goals must begin to shift toward adoption and guardianship by the end of a child's third year in care. Therefore, the IB3 quality improvement team will be offering support to the 10 intervention agencies that provide casework services to children enrolled in the IB3 program in an effort to improve engagement of relative caregivers and foster parents in IB3 services.

To support further improvement in permanency outcomes, Dr. Steve Budde, Juvenile Protection Association, initiated a reunification viability review of cases with a special focus on families who completed the parenting programs but have not received their children back into their custody. Supervisors have reported that the review has been helpful in support of case conceptualization and permanency planning. Three hundred cases will be used to test the new protocol to assess the viability of alternative permanency options for children enrolled in the IB3 interventions.

M. Recommendation # 4: SAFE Families for Children (SFC)

1. Project Goals / Target: The core objectives of SFC include deflection of youth from child welfare custody, child abuse prevention, and family support and stabilization. As noted in the First Interim Triannual Report to the Court, the program cannot be evaluated until there are a total of 475 families in the control group and 475 families in the comparison group. Due to low engagement, DCFS has reexamined and modified the process for engaging families in SFC so that the evaluation can be completed. SFFC has been in place in northern Illinois for over ten years and was expanded statewide in October 2015, but even after that participation in the program has lagged behind expectations. Implementation Plan, pp. 44-46.

2. Status Report:

In the last reporting period, DCFS committed to continue making individual contact with families referred to the program in order to increase engagement and participation. For the month of February, referrals were down to only 4 families (compared to 12 and 11, respectively, for the prior months of December and November. But current projections are that referrals for March will match the earlier levels, but still are below the desired target of 20 new families per month.

DCFS has fixed one major implementation glitch that was discovered during the pilot evaluation phase. There have been no duplicate assignments of cases to intervention and comparison groups since June of 2016. Unfortunately, the problem of identical cases being assigned independently by DCFS and SFC to different assignment groups has not been ameliorated. DCFS attempted to solve the problem by giving "read-only" access of the SACWIS assignment screens to SFC. This appeared to solve one of the reasons for the cross-overs of cases from comparison to intervention conditions. SFC was able to stop accepting referrals from already assigned cases by checking the SACWIS randomizer in advance. However, it was discovered that calls were being made to SFC prior to workers' making the assignment in SACWIS. As a result, two of the referrals since March 1, 2017 have resulted in mixed assignments because DFCS workers completed the case assignment in SACWIS *after* the call was made to SFC (which randomized the case on its own). In the hopes of eliminating the "dueling randomizers," Mike Ruppe and Nora Harms-Pavelski met with one of the Expert Panel members in April to explore the possibility of allowing SFC access privilege to use the SACWIS randomizer. This proved to be too drastic a departure from confidentiality rules so DCFS proposed another potential solution.

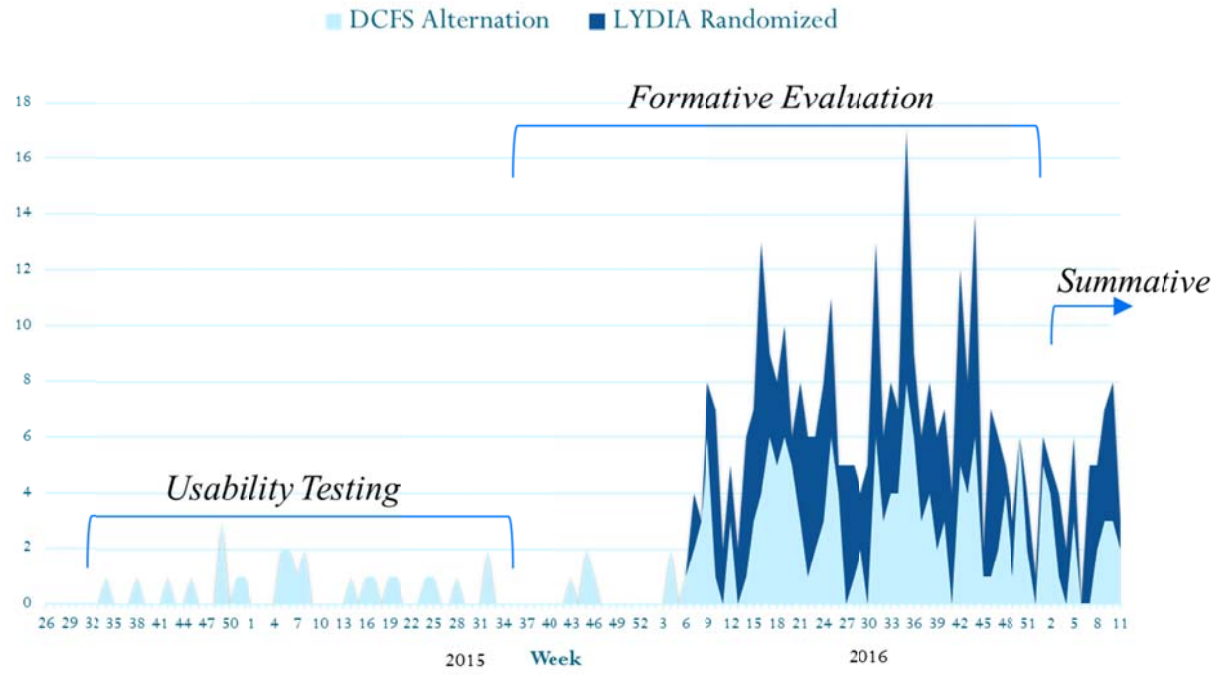
The current plan in the works is that SFC will not activate its own randomizer when a call is made directly to them within the hours of 8 am to 4:30 pm. Instead, a DCFS has identified a staff person whom SFC can call during work hours who will have access privileges to activate the randomizer. After hours, the SF randomizer will still be available for use and will override any assignments made by DCFS.

Another implementation problem has been the lack of follow-though on families assigned to the intervention group for whom DCFS has indicated in SACWIS that the family has agreed to

accepting SFC hosting services. Since the first triannual report was submitted, only one-half of the families (50%) who agreed to hosting services were put in contact with SFC. DCFS has arranged for the Associate Deputy for Child Protection to be informed of DCFS staff who were not responding to Safe Families inquiries regarding the status of referred families, so that appropriate action could be taken. This process is in place and a tracking mechanism is being developed to track this information.

DCFS also committed to have developed a method for tracking family engagement, whether to create a referral form to assist with tracking, and whether and how expansion of the program will be needed to better serve children in the first four Immersion Sites.

Referrals for the period August 2014 through February 2017 are shown below:



3. Revised Targets / Goals:

It is anticipated that if the DCFS plan to centralize the referral and allocation process can be implemented, that the change along with continued oversight of DCFS staff's responsiveness

by the Associate Deputy for Child Protection and SFC's continued practice of making individual contact with families will boost family participation in SFC hosting services sufficient to meet or exceed the target of 60 families per quarter.

By the end of the next reporting period, DCFS will either have implemented the modification of the referral / randomization process *or* will have developed and implemented alternative measures to increase participation in this program. Further action clearly is required, as the current strategies have not resulted in a material improvement. Since February 17, 2017, DCFS has only been able to restore the number of referrals from DCFS investigators to SFFC to its prior, inadequate volume of 11 families per month. Exhibit P, SAFE Families Four Month Status Report.

N. Panel Recommendation # 4: Information Systems

1. Project Goals / Target:

The Implementation Plan requires DCFS to take a number of steps to enhance or replace data systems to generate more timely, accurate and complete data.

Short term goals, with a targeted completion between March and September 2017, include enhancement of the existing SACWIS system to accept educational data provided by ISBE and unusual incident reporting from private agencies, as well as improvements in mobile technology through a mobile application for caseworkers, on-line foster parent licensing application, and a tablet application for licensing site inspections. Implementation Plan, pp. 48-52.

Long-term goals, with a targeted completion date of September 2019, are replacement of the existing SACWIS system, and implementation of predictive analytics. Implementation Plan, pp. 48-52. Regarding predictive analytics, DCFS committed to establishing an internal team in OITS to bring reporting needs and data analytics into a centrally managed organization. In the

short term, DCFS elected to use Mindshare as the platform for its data analytics. This product allows DCFS to merge and analyze data from multiple environments and produce reports for more informed decision making in a dashboard format. Ultimately, DCFS intends to establish a statewide enterprise data analytics platform ("Enterprise IT") to reduce reliance on external entities to collect and analyze data to drive outcomes. Implementation Plan, pp. 49-51. Achievement of that goal is not anticipated until December 2018.

2. Status Report:

Replacement of SACWIS: Subsequent to the approval by U.S. Department of Health and Human Services Administration for Children and Families of DCFS' Planning Advance Planning Document, DCFS issued a request for proposal (RFP) for a feasibility study to replace SACWIS with a "Comprehensive Child Welfare Information System." On March 16, 2017, a bidder's conference was held. On March 21, 2017, vendor questions were due and on March 27, 2017, DCFS published responses to vendor questions. The RFP closed on April 11, 2017 and DCFS is in the process of a two-phase scoring model. DCFS remains on target for a July 1, 2017 start date for the contract on the feasibility study. Exhibit Q, Four Month Status Report, CCWIS RFP, p. 1. However, DCFS' current contract with an outside consulting group, Five Points, is set to expire on June 30, 2017. Five Points has provided critical technical support and expertise DCFS needs to oversee and evaluate the feasibility study. DCFS is currently evaluating various options with respect to the consultants employed by Five Points in an attempt to ensure that this initiative is not jeopardized.

Mindshare. The contract with Mindshare began in September 2015 and is in place through January 2018. B.H. Implementation Plan. At the present time, DCFS is exploring the possibility of developing a replacement for the Mindshare platform using POWERBI and MS

SQL server engines in house. DCFS recently hired a Victor O. Johnathan, MBA, PMP as its Chief Information Officer, who will be involved in the exploration of the development of the possible replacement for the Mindshare platform. DCFS anticipates that a decision regarding the Mindshare platform will be made within in the next reporting period and that a transition plan will be developed once that decision is made. Plaintiffs remain concerned regarding the expiration of the Mindshare contract, as set forth in their separate submission.

Short Term Improvement of Existing SACWIS: The Significant Event Report system was launched on February 24, 2017 and provides automated functionality in SACWIS. The Significant Event Report system captures significant occurrences that impact child and youth serviced by DCFS. Exhibit B, Four Month Status Report, IT Projects, pp. 1-2. Training of DCFS staff and private agency staff has begun but is not yet complete.

In the last reporting period, DCFS had regular contact with staff from the State Board of Education to further explore how education data maintained by the Illinois State Board of Education can be integrated into SACWIS. Those discussions are ongoing. To date, a solution for performing that integration has not been finalized. The remaining hurdle is developing a means for integration that does not require manual matching of records from ISBE.

Mobile Applications: On April 19, 2017, DCFS released version 2 of the Case Access mobile app. Updates include a new and improved user interface, industry standard design, android compatibility and auto-rotate enhancement for keyboard users and a larger photo display. Exhibit R, Announcement April 18, 2017, Mobile app version 2 to be released 4/19/17. Data reflects improvement in the timeliness of case note and photo data entry. Data as of March 31, 2017 show that the average baseline time for a child protection specialist to enter a case note in SACWIS was 7 days and the mobile app has decreased that time to one day; the average

baseline time for a child welfare specialist to enter a case note in SACWIS was 14 days and the mobile app has decreased that time to half a day. Exhibit B, Four Month Status Report, IT Projects, pp. 4.

DCFS also created an on-line licensing application for foster homes. A controlled roll-out of the licensing application commenced which includes DuPage, Bloomington, McLean, Livingston, Peoria, Tazewell and Woodford counties. DCFS staff continue to work on the controlled roll-out of the licensing application and DCFS has received 38 online applications to date. Exhibit B, Four Month Status Report, IT Projects, pp. 4.

Predictive Analytics

The predictive analytics project developed by Mindshare, which tracks information from nine areas of practice and analyses that data to identify investigations with the highest probability of serious injury for children aged 0 to 8 known to DCFS, is up and running. DCFS anticipated that a reporting mechanism would be built into the Eckerd / Mindshare portal to allow the sharing of data with DCFS Administration, Regions, and Teams. That has not occurred..

DCFS has not yet decided whether to expand the predictive analytics model to intact family cases. If that expansion occurs, DCFS anticipates that the work can be done with current Eckerd staff within DCFS, and that the expansion could be available beginning in FY 18.

3. Revised Targets / Goals:

Replacement of SACWIS. DCFS has awarded the CCWIS Feasibility Study contract to a vendor and the project work will commence on July 1 2017. DCFS intended to receive support from an outside contractor, Five Points, to assist with the feasibility study. The DCFS's contract with Five Points ends on June 30, 2017, and DCFS will determine how to proceed.

Short-Term Improvement of Existing SACWIS. DCFS has implemented the Significant Event Report system into SACWIS. This new system replaces the prior Unusual Incident Report system. Training of DCFS and private agency staff began in the last reporting period and has been completed.

The target completion date for the second short-term improvement of SACWIS – the integration of ISBE data by October, 2017 – may not be met. DCFS has determined that these records can be loaded based on a manual matching process. In addition, critical technical expertise and support for this project presently is being provided by outside consultants from Five Points. As discussed above, DCFS' contract with Five Points expires on June 30, 2017, and it may not be possible to renew that contract.

Mobile App for Caseworkers – By the next reporting period, DCFS will have developed and implemented a plan for identifying caseworkers who are not using the mobile app and for providing the additional support those caseworkers need to adapt to this changed technology. In addition, DCFS will develop a process for evaluating whether supervisors' practices should be modified as the new technology is routinely used in the field. DCFS uses a computer application to monitor progress and other issues.

Mobile App for Licensing. Roll-out of the mobile app for licensing continues. A schedule for the roll out will be completed in the next reporting period.

Predictive Analytics. By the next reporting period, DCFS will determine whether the predictive analytics program will be expanded to include intact family services and will develop a plan for any such expansion. The Mindshare contracts began in September 2015 and will be in place until January 2018. The Implementation Plan contemplated that Mindshare would provide short term transitional assistance in developing dashboards to view key outcomes in real time.

Before expiration of the Mindshare contract, DCFS may be a in a position to bring this function in-house. DCFS is considering that and other potential options.

O. Panel Recommendation #5:

Restore funding for the Illinois Survey of Child and Adolescent Well-Being (ISCAW) that uses standardized instruments and assessment scales. (Implementation Plan, p. 53).

1. Project Goals / Target: The Implementation Plan contemplated restoration of funding for the ISCAW well-being study, which would be a point-in-time study of the

The well-being study was to replicate most of the methods of the Illinois Child Well-Being Year 3 launched in 2004, with additional new features including: updated methods to enhance caseworker participation and increase caseworker response rates, and a brief measure of child life satisfaction to enhance measurement of positive child well-being. Implementation Plan, p. 53. The report is projected for the second quarter of 2018.

2. Status Report: The Survey Research Laboratory of the University of Illinois at Chicago is developing the protocol for the study and the Institutional Review Board application. The information in the protocol and application will include: a description of all sampling procedures, communication plans for contact and recruitment of participants, development of procedures for study interviews, preparation of all instruments, descriptions of methods for preparation and protection of data files, descriptions of methods to provide for human subject protections and plans for analysis and dissemination of study results.

The protocol will be reviewed by the University of Illinois Chicago Institutional Review Board on June 15, 2017. An agreement was reached which provides that the University of Illinois Chicago Institutional Review Board will have primary review of the study protocol.

In addition to the above work, decisions were made regarding study participants. The sample will include 500 to 600 children and youth will be drawn from youth in care on June 30,

2017. The sample will include those children and youth in non-permanent substitute care placements for a minimum of three months and will only include one youth and child per caregiver. Exhibit V, Four Month Status Report, ISCAW.

3. Revised Targets / Goals: Data analysis is currently scheduled to commence in the first quarter of FY2018 and occur from July to September 2017. It is anticipated that the final report will be available during the third quarter of FY 2018.

P. Panel Recommendation #6:

Develop and implement a new plan for monitoring residential and group home programs, utilizing external partners. (Implementation Plan at p. 53).

1. Project Goals / Target: The goals set out in the Implementation Plan were for DCFS, with the University of Illinois at Chicago and Northwestern University, to develop a redesigned residential monitoring program, the goal of which is to increase the safety of youth placed at residential treatment facilities and to enhance the effectiveness of the residential services provided at the residential treatment facilities. As described in the Implementation Plan, the program called for development of regional multi-disciplinary monitoring teams that would assess residential programs' effectiveness utilizing multiple data sources and inputs. Residential monitoring teams were to have been identified and training was to have begun by December 2016. Implementation Plan, Exhibit YY [Dkt. 531-51]. DCFS partnered with Northwestern University and the University of Illinois at Chicago to develop an improved monitoring system – the Therapeutic Residential Performance Management Initiative (TRPMI). Chapin Hall was selected as the evaluator for this initiative. The TRPMI pilot is designed to enhance youth treatment, progress and well-being as well as to effectively monitor, evaluate and promote therapeutic residential program effectiveness.

2. Status Report: A comprehensive plan for the Therapeutic Residential Performance Management Initiative (TRPMI) was developed. Exhibit S, Summary: Develop and Implement a New Plan for Monitoring Residential and Group Home Programs, dated April 30, 2017; Exhibit T, DCFS TRPMI Logic Model (updated 3/30/17) and Outcomes Table (updated 3/2/2017).

The Three Pilot Teams. The TRPMI pilot calls for three TRPMI teams. Two TRPMI teams were implemented on January 9, 2017. The first team is responsible for monitoring 11 program groups (made up of 34 programs from five residential treatment providers located in the Northern Region. The second team is responsible for monitoring nine program groups (made up of 19 programs from seven residential treatment programs) located in the Southern Region. The last TRPMI pilot team, which is for Cook County, was implemented as of March 1, 2017, 30 days ahead of schedule. This team is responsible for monitoring six program groups (made up of six programs from five residential treatment providers. With implementation of this team, the TRPMI pilot will be monitoring service provision to nearly half of youth in residential treatment programs in Illinois.

Staffing. As implementation of TRPMI proceeds, DCFS has concluded that current team composition may be inadequate to address the full scope of the work, especially with respect to the activities associated with individualized and intensive discharge planning. Consequently, early indications are that TRPMI teams are overextended and some of the traditional monitoring activities focusing on agency compliance issues and effectiveness require greater attention. The TRPMI Steering Committee has agreed that a third Clinical Specialist should be added to the Cook TRPMI Team.

None of the three TRPMI teams are fully staffed. A total of six Clinical Specialist positions are vacant (two FTE per team). Additional vacant positions include 1.5 CQI Specialist positions (.50 FTE per team) and one statewide QI Specialist. A variety of full time and part-time temporary staff who are "borrowed" primarily from the DCFS Clinical Division are in place on the Southern TRPMI team and the Northern TRPMI team to function as Clinical Specialists while the permanent staff are being hired. There are approximately five temporary FTEs (consisting of eight individuals).

Step-Down and TRPMI Involvement in CFTs. One of the goals of the TRPMI program is to identify youth who are ready or approaching readiness for stepdown, to improve step-down decision-making and planning, and to assist in securing appropriate step-down placements. To complete these functions, TRPMI staff typically collaborate with the youth and relevant stakeholders (including case management, residential and immersion site staff) individually and in the context of staffings to complete comprehensive planning

Another goal of the TRPMI pilot is to promote the development of CFTMs to replace the staffing process as the driver of discharge planning. Because few CFTMS have been convened to date for youth with the completed CASIIs (i.e., priority youth), TRPMI staff encourage treatment teams to start taking small steps toward identifying potential CFTM members to assist in expediting and convening the CFTMs. To support these efforts, a draft Communication Protocol/Procedure was developed on February 22, 2017, and was tested in March, 2017. The Communication Protocol is intended to provide a means of effectively communicating, coordinating, collaborating and problem-solving within CFTMs to promote effective and timely transition and discharge planning. The protocol was tested with four Choices youth current placed in TRPMI residential programs (during the end of March and early April) and whose

teams were not in consensus regarding critical discharge planning decisions. Debriefing occurred with the CHOICES and TRPMI teams and both provided positive feedback regarding the use of the Communication Protocol. TRPMI will continue to follow the youth to assess effectiveness of the protocol. DCFS has decided to roll out the protocol, and a roll-out plan is under development for the three pilot sites.

TRPMI intends to eventually develop processes to monitor youth stability and wellbeing post-discharge to confirm the effectiveness of the discharge planning process.

TRPMI teams completed 61 CASIIs through March 2017 and anticipated an additional 33 would be completed in April 2017 for a total of 94 CASIIs. Targets have been established for completed CASIIs in May and June 2017.

3. Revised Targets / Goals:

Staffing. Permanent positions for six full-time clinical specialists, one quality improvement specialist, and one statewide quality improvement manager have been approved and posted at Northwestern University. Hiring is anticipated by June 30, 2017. Once these positions are filled, all teams will be fully staffed according to the original staffing design.

Now that the hiring process is well underway, an overall evaluation of staffing resources will be completed based on lessons learned during the initial implementation period. The third Clinical Specialist that was approved by the Steering Committee for the Cook County team will be included in the evaluation. It is anticipated that any revision to the staffing planning based on the resource evaluation will require approval by DCFS. The TRPMI team will complete the evaluation and present a plan to DCFS by July 1, 2017.

Step-Down and TRPMI Involvement in CFTs. In this reporting period, in addition to implementation of the Communication Protocol, more focused efforts to schedule and convene

CFTMs will be initiated. There may be multiple reasons why CFTMs are not currently being convened more frequently, if at all. TRPMI staff and residential teams are now partnering with CIPP staff, which facilitate the CFTMS to increase the number of CFTMs being convened. This will include partnering with the CIPP program to assign facilitators who will assist in planning and facilitating the initial CFTM and a limited number of subsequent CFT meetings. This partnership will be tested in May 2017 with a small number of youth who require development of CFTMs.

Dashboard. The TRPMI SharePoint team is working on a CASII data collection function for release in early June 2017. A CASII status dashboard and a CASII recommendations data collection function are currently under development and are expected to be delivered in early July 2017**.**

Another dashboard showing Congregate Care youth information is currently being designed in collaboration with the DCFS OITS team using the Mindshare application**.**

Program Evaluation. At the suggestion of the BH experts, the critical program outputs[8] that presently are being tracked and monitored will be refined so that the tracking process is more manageable. To ensure fidelity to the TRPMI program design is maintained, however, some [output metrics will be reclassified and treated as process indicators.[9]

The plan for evaluating TRPMI is in the process of being modified. The initial plan for evaluating the TRPMI pilot was to use a cross-sectional pre-test / post-test design with calendar year 2016 (CY16) defined as the baseline year (pre-test) and calendar year 2018 (CY18) defined as the post-test year. Due to the changes in monitoring residential facilities, the feasibility of

[8] A program output is the product or deliverable produced by a program activity.
[9] A process indicator is the unit of service or program activities delivered.

adopting an interrupted time series design is being explored. Interrupted time series designs are commonly used to examine change in outcomes during a period of time preceding a program or policy change and a similar period of time after such a change. Adopting this design will allow evaluators to better control for changes over time that are independent of the TRPMI intervention. It will also allow more flexibility in defining a baseline time point or points, which should allow the evaluation design to more accurately reflect the implementation milestones (i.e. hiring of full time clinical staff). The Expert Panel supports this change in evaluation design.

Once the Interrupted Time Series design is fully adopted by the pilot leadership, Chapin Hall will provide data regarding the effectiveness of the pilots – accounting for implementation milestones that may impact outcomes – on a quarterly basis with a one quarter lag. Upon successful completion of the pilots, the TRPMI strategies will be used to build the internal capacity of DCFS staff to effectively monitor the safety, well-being and permanency of youth receiving residential treatment. The TRPMI monitoring model will then be implemented statewide.

A time frame for rollout of the pilot statewide remains uncertain at this time. A timeframe will be developed based on the development of DCFS' internal capacity to monitor residential programs, either independently or in partnership with outside specialists.

IV. Communication Plan: Implement a Defined Communication Plan with the B.H. Expert Panel and Plaintiffs' attorneys. (Implementation Plan, p. 55).

1. Progress Goals / Target: A Communication Plan, entered by the Court on September 28, 2016 [Dkt. 530], provides for bi-weekly conferences with the Expert Panel and the Parties, during which the pilots and programs identified in the Implementation Plan are discussed. The plan provides for DCFS to provide a monthly report to the Expert Panel and Plaintiffs' Counsel which details the specific steps that have been taken in actual implementation

of each initiative set forth in the Implementation Plan, the actual results achieved, any barriers that exist and strategies to eliminate or resolve the barriers, and an evaluation of program results. The Plan also provides for DCFS to make efforts proactively to share information "beyond that which directly relates to the specific initiatives described in the Implementation Plan" that nevertheless is significant.

Additionally, DCFS staff participate in quarterly meetings with the Office of the Cook County Public Guardians office. A DCFS representative with knowledge of the status of the B.H. Implementation Plan will attend those meetings to address issues with the B.H. Implementation Plan and status updates. The next quarterly meeting is scheduled for June 14, 2017.

2. Status Report: During this reporting period, all required telephone conferences and meetings have been held. DCFS is of the view that there are no communications issues. Plaintiffs disagree. In their view, though communication has improved, communication issues continue to arise.

First, there continue to be instances in which the Experts have flagged a potential problem or issue and have asked questions, but have not received timely response (or any response at all) to those inquiries.

Further, in Plaintiffs' view, DCFS (i) has shown a growing tendency to use the improved level of communication with the Experts as a means to relinquish decision-making to the Experts in the first instance; (ii) DCFS has failed to acknowledge developing problems in a timely manner and only discloses those issues when they have reached crisis proportion; and (iii) information DCFS has provided in recent meetings regarding the failures in the investigation process, a new (and untested) program for accelerating investigation closures, and investigator

caseloads was, at best, materially incomplete. Plaintiffs' views on these issues are set forth more fully in their Additional Submission, which is filed contemporaneously herewith.

Revised Targets / Goals: DCFS will continue in its efforts to comply with all requirements of the Communication Plan.

V. Project for a Target Group of Children and Youth/Enhanced IPS Program Beyond Medical Necessity Pilot

1. Progress Goals / Target

In the September 28, 2016 Implementation Plan, DCFS committed to a pilot targeted to serve fifty (50) children and youth from Cook County who are in psychiatric hospitals beyond medical necessity (BMN). Fifty (50) youth were to be served, and 100 youth were to be used for two comparison groups of 50 youths each.

As of September, 2016, when the Court entered the Implementation Plan, the logic model for this pilot had not been refined.

The BMN pilot was scheduled to begin in September 2016 with a review of five cases and scheduled to be operational in November 2016. Amended and Revised Implementation Plan, pp. 56-57.

2. Status Report:

Contract Modification and Hiring. In the last reporting period, DCFS committed to amendment of its current contract with Kaleidoscope for intensive stabilization services. The amendment was to allow Kaleidoscope to hire additional staff, including positions for Stabilization Consultants. The position was posted in January 2017. Initially, there were very few candidates due to the requirement of a master's level degree, child welfare experience and the salary range. DCFS agreed to increase the salary range. On May 14, 2017, the first Stabilization Consultant began employment at Kaleidoscope. Interviews for the second

Stabilization Consultant position are ongoing. Exhibit U, Four Month Status Report, Target Group of Children and Youth in Psychiatric Hospitals beyond Medical Necessity Pilot, p. 1.

Children Served. It previously was agreed that until Stabilization Consultants were retained, no more than three youth would be served through the pilot.[10] As those positions are filled, additional youth will be served. It was anticipated that by April 30, 2017, at least five new youth would be assigned to the pilot. The goal regarding the number of children to be served in this project has not yet been determined and is dependent on the completion of the hiring process.

3. Revised Targets / Goals

Contract Modification and Hiring. Kaleidoscope intends to add a Stabilization Consultant for every 5 to 8 children added to the pilot. The target is to hire two additional Placement Stabilization Consultants in FY 2018 and potentially to add two additional Placement Stabilization Consultants in the future. The Stabilization Consultants must receive training in the Child and Family Team process.

Children Served. The goal regarding the number of children to be served in this project has not yet been determined and is dependent on the completion of the hiring process. The current goal is for five to ten youth to be assigned to every Placement Stabilization Consultant who is hired. The three current youth in care are transitioning to the newly hired Placement

[10]There are three youth assigned to the pilot. The first youth was initially recommended for a residential placement, but a home-based setting with the previous foster parent's adult sisters was located. Despite the work of the Kaleidoscope, the youth has been re-hospitalized twice since Kaleidoscope's involvement. Kaleidoscope continues to work very closely with the family ensuring that all needed supports are in place. A second youth has done well since his discharge from the psychiatric hospital. Due to his stability and successful service delivery, Kaleidoscope is no longer servicing this case. The third youth was placed in a relative home from the psychiatric hospital. There was a change in the child welfare specialist assigned to the case after the hospitalization. Exhibit U, Four Month Status Report, Target Group of Children and Youth in Psychiatric Hospitals beyond Medical Necessity Pilot, p. 1.

Stabilization Consultant and she will be assigned an additional two to seven youth. With the two additional hires, ten to 20 youth will be assigned to this pilot.

Program Enhancement. DCFS is enhancing processes under the pilot. Kaleidoscope will be invited to CIPP staffings in Cook County for all youth who are psychiatrically hospitalized to allow intervention to occur as soon as possible and Kaleidoscope will attend their first CIPP on June 5, 2017. Participation in the CIPPs will be randomized. At this time, participation occurs when a CIPP occurs on a particular day (randomized) with the youth's identification number ending with an odd number. DCFS is using the month of June to determine if this is a good process to determine the amount of youth eligible for this pilot. If the future research shows that Kaleidoscope's participation in the staffing and service delivery supports the pilot's Theory of Change, then the intent would be to expand the program to include most (or all) CIPPs. DCFS anticipates having all necessary research regarding the pilot by December 2017.

As of March 3, 2017, DCFS will also enhance board payments for the caregivers as needed while receiving case management from an agency that does not have a specialized contract. Exhibit U, Four Month Status Report, Target Group of Children and Youth in Psychiatric Hospitals beyond Medical Necessity Pilot. DCFS will be able to back date this rate to the relative caregivers that were already involved in the pilot to the date of placement.

Finally, control and comparison groups have been better defined. Assignment to the pilot will be random and will be determined according to the last digit of the youth's DCFS ID number and the day that the youth's CIPP occurs. Kaleidoscope is scheduled to attend its first CIPP on June 5, 2017. Chapin Hall, Kaleidoscope and DCFS representatives have agreed that the control and comparison group will be formalized with a July 1, 2017 date to ensure that the

identified assignment will reflect a good portion of youth that Kaleidoscope will be able to provide services for.

Dashboard. The dashboard in the Mindshare platform has not yet been finalized. That will occur during the next reporting period. The additional time was necessary for DCFS to better define the pilot. Chapin Hall's involvement has also assisted in better defining outcomes.

Pilot Completion and Evaluation. At this time, DCFS anticipates that the pilot will be in effect until the end of fiscal year 2019 (June 30, 2019). The formal evaluators for this project are still not identified however Chapin Hall is currently being explored as an option. DCFS will have the evaluator identified by the next reporting period.

EXHIBIT A

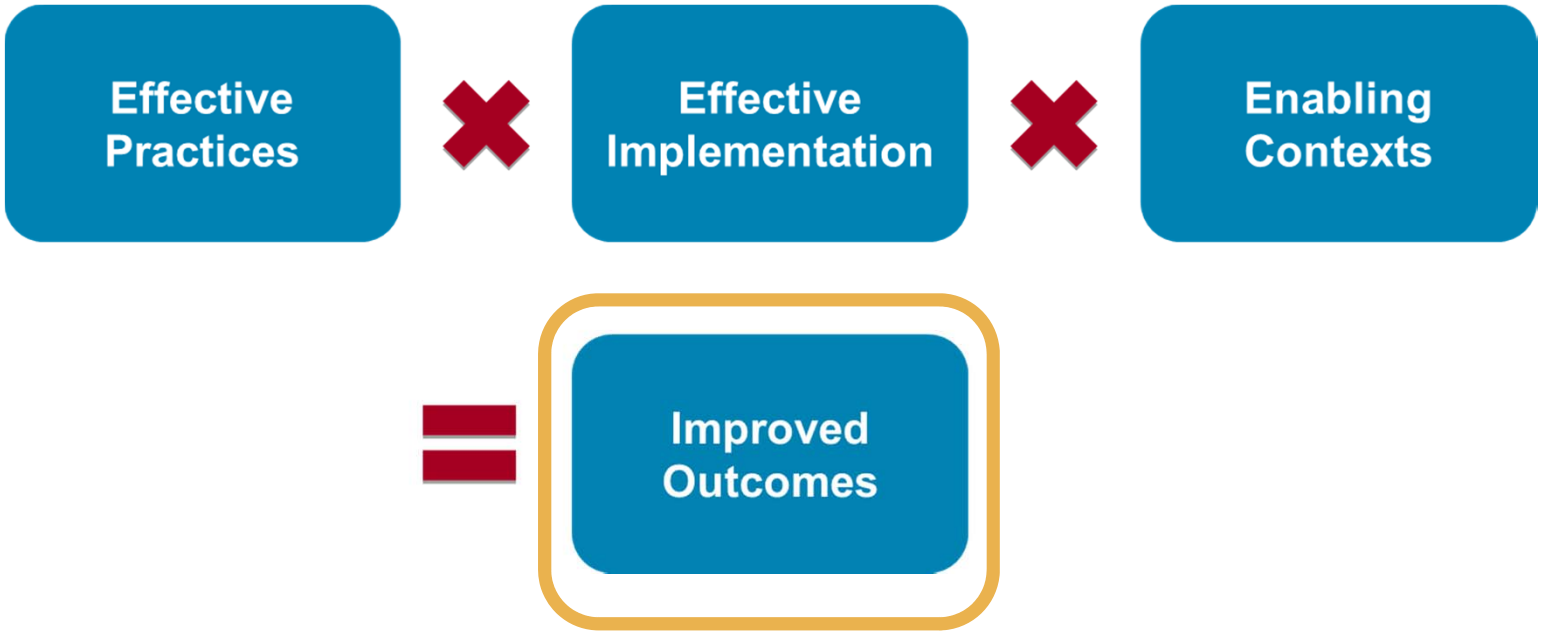
Supporting sustainable implementation of research evidence in child welfare

Allison Metz, Ph.D.
Director and Senior Scientist

Child Welfare League of America
National Conference
March 29–31, 2017

nirn National Implementation Research Network

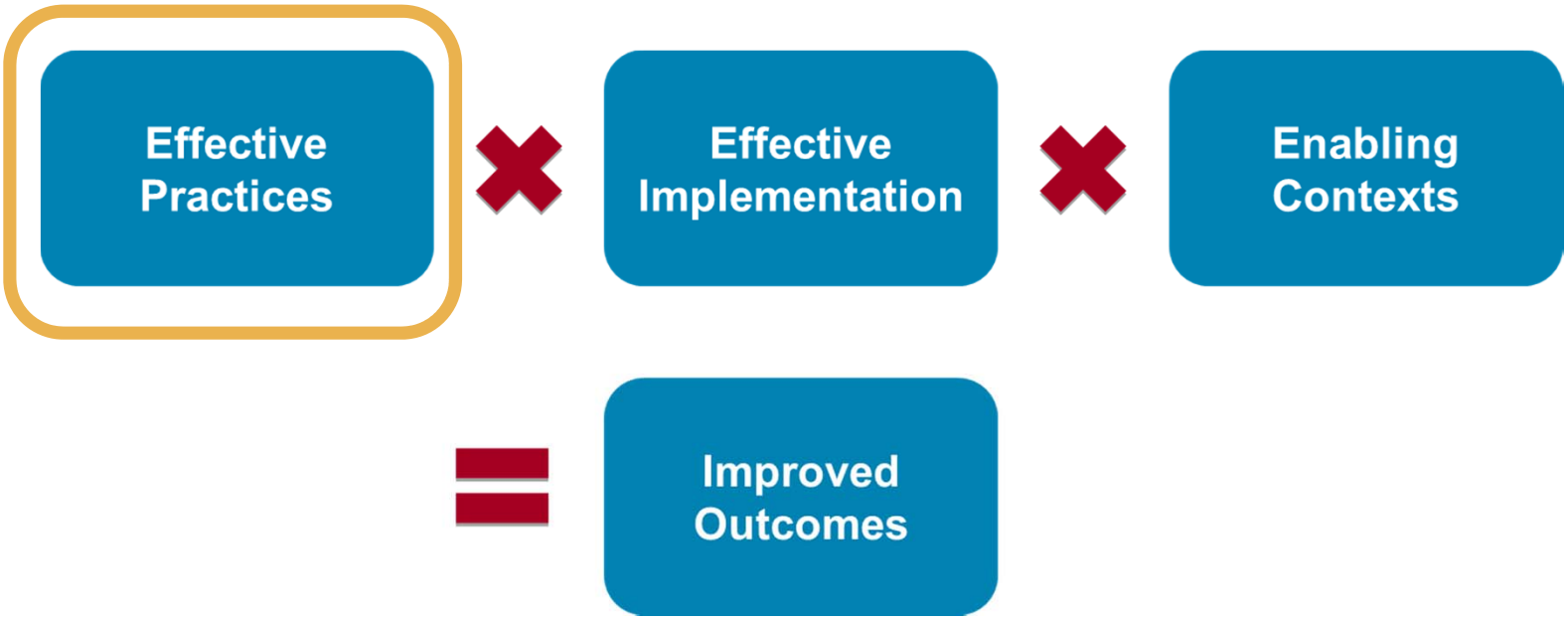
Active Implementation



Improved Outcomes

- Safety
- Permanency
- Well being

Active Implementation



Effective Practices

- What works, for whom, why, and in what circumstances?

- Whose practice are we supporting?

Effective Practices

- What works, for whom, why, and in what circumstances?
- Whose practice are we supporting?

Contextual fit is the match between the strategies, procedures, or elements of an intervention and the values, needs, skills and resources of those who implement and experience the intervention.

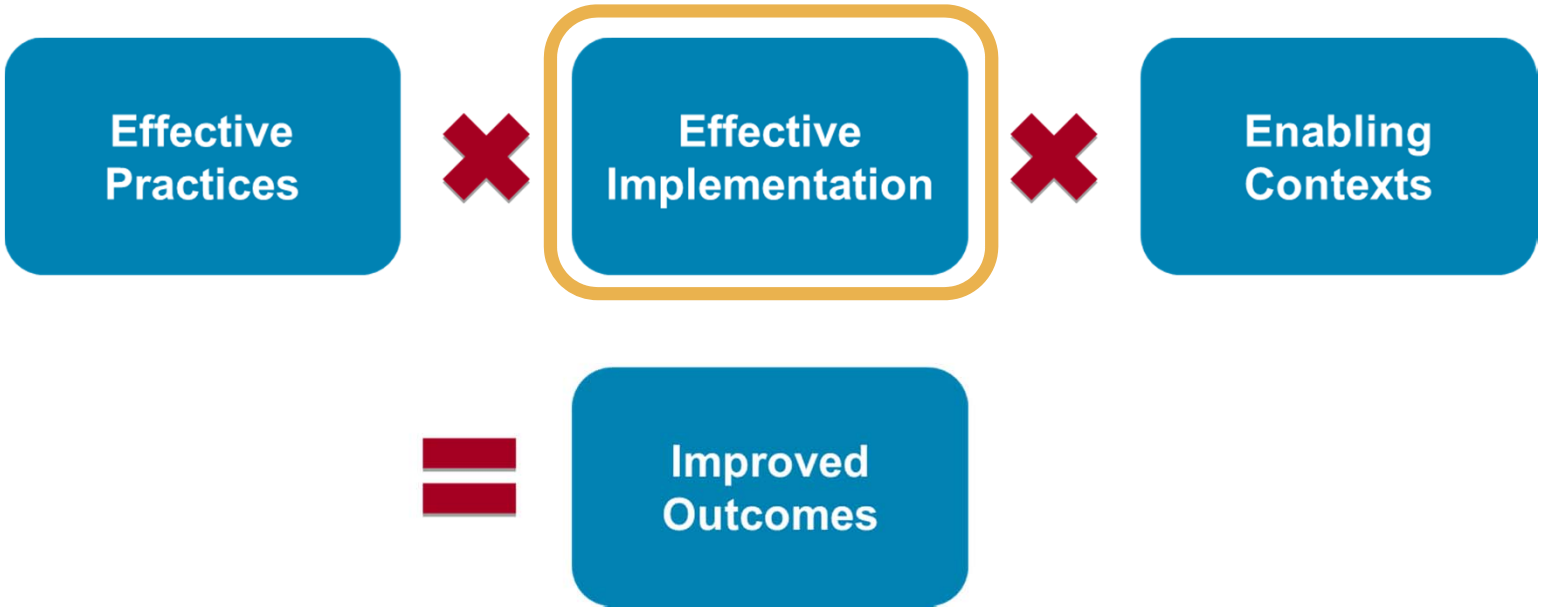
(Horner, Blitz & Ross, 2014)

Effective Practices

- What works, for whom, why, and in what circumstances?
- Whose practice are we supporting?

- Aligning child welfare practices with implementation of evidence-based practices
- Developing understanding of the theoretical underpinnings for change
- Training and coaching within and across systems

Active Implementation



Strategies and Supports

Effective Implementation

- Developing visible supports
- Transitioning supports

Effective Implementation

- Developing visible supports
- Transitioning supports

Supports throughout the system and for multiple programs

- Competency Supports
- Organizational Supports
- Leadership Supports


What does Prena need to support her practice?

- ✓ **Competency Supports**
- ✓ **Organizational Supports**
- ✓ **Leadership Supports**

Fidelity Assessment

Systems Intervention

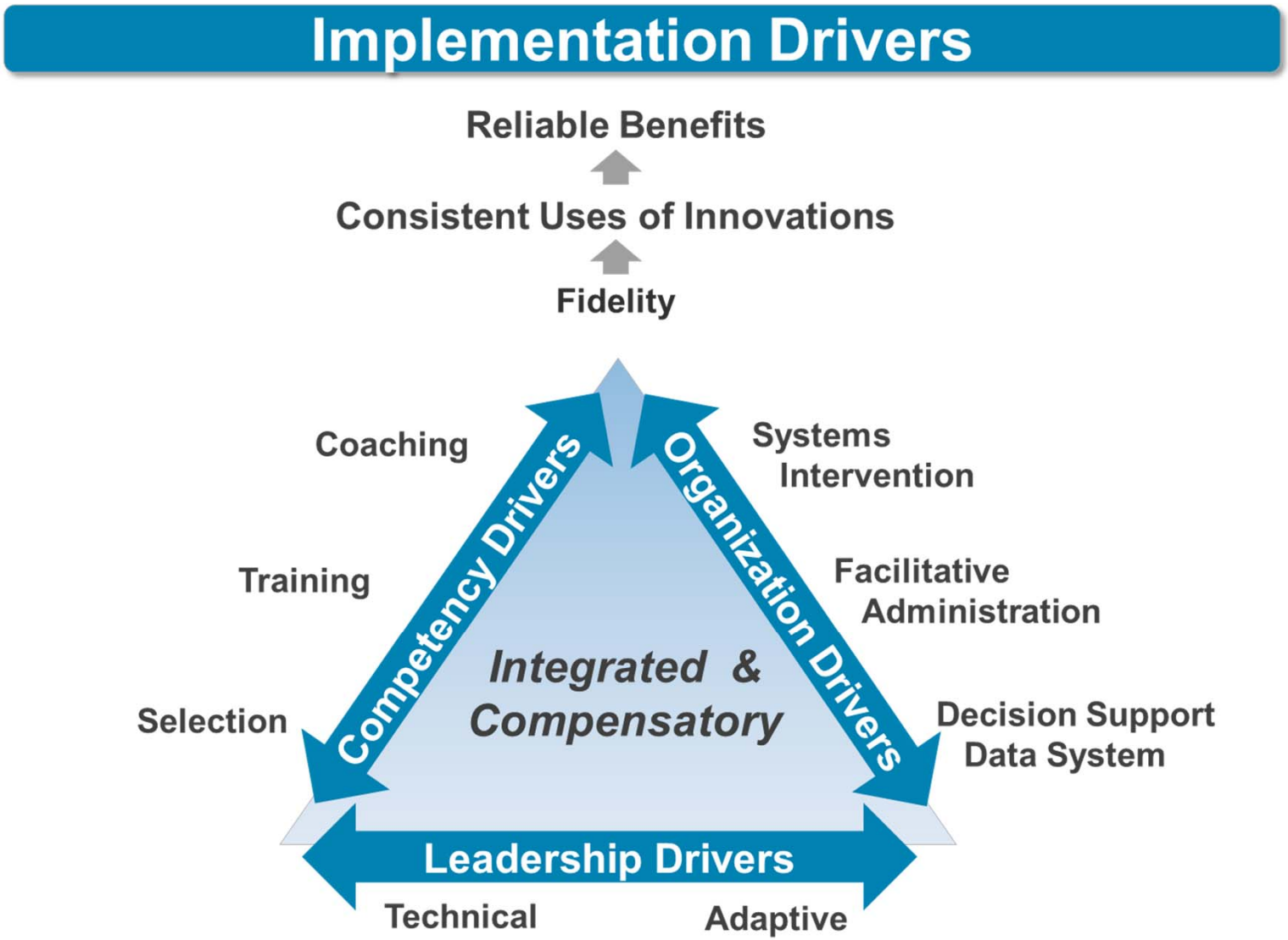
Coaching Process

Facilitative Administration

Training Process

Decision Support Data Systems

Selection Process


Implementation Drivers
Reliable Benefits
Consistent Uses of Innovations
Fidelity
Coaching
Training
Selection
Competency Drivers
Systems Intervention
Facilitative Administration
Decision Support Data System
Organization Drivers
Integrated & Compensatory
Leadership Drivers
Technical
Adaptive

Active Implementation

Enabling Contexts

VALUE: Implementation is a *collaborative* act

Collaboration leads to:

- Knowledge and evidence that is more implementable
- Infrastructure that brings research evidence and implementation closer together
- Attention to local needs and increased relevance and impact of implementation activity
- Enhance the capacity and capability of implementation

Enabling Contexts

- Collaboration and Teams
- Communication and Learning

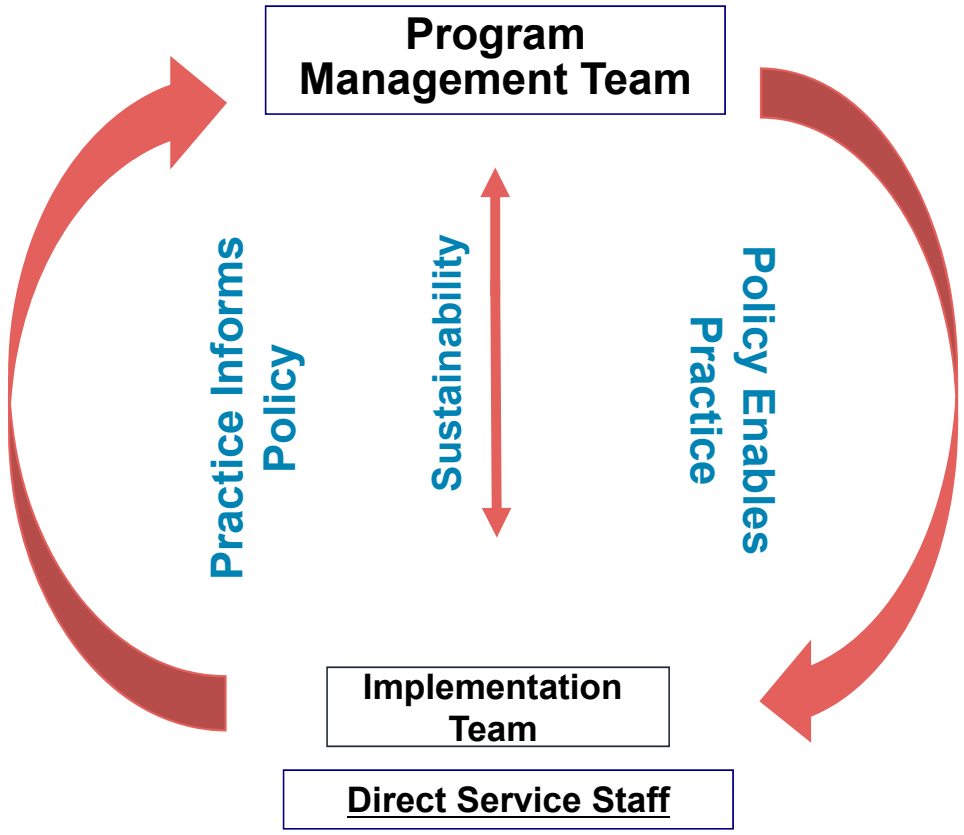
Enabling Contexts

- Collaboration and Teams
- Communication and Learning

Working in complex systems requires the engagement and influence of multiple stakeholders.
This requires a different kind of leadership- moving from solo heroes to collaboration and teamwork.

Communication & Learning

Enabling Contexts

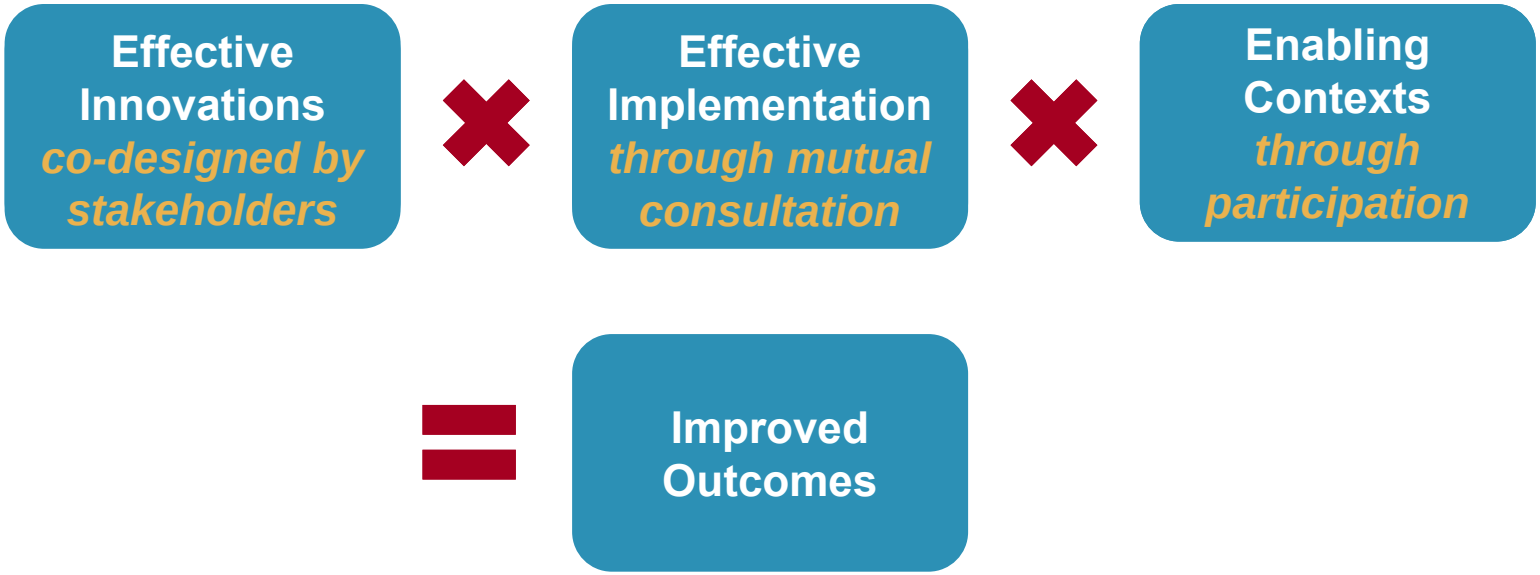


Enabling Contexts

Co-Creation and Implementation Science

- The problem with the “gap” theory – there is not an empty space; stakeholders’ knowledge populates the gap
- Co-creation for public services refers to the active involvement of stakeholders in all stages of the production process resulting in a shared body of usable knowledge across scientific, governance, and local practice boundaries

Implementation Science and Co-Creation



Summary

Improved outcomes requires focusing implementation effort on:

- Effective Practices
- and Effective Implementation
- and Enabling Contexts

This includes…

- Developing supports throughout the system, and for multiple programs
- Transitioning those supports from *innovation* to *new way of work*
  (keywords: scaling, sustaining, improving, integrating data)
- Valuing and actively facilitating and collaboration/co-creation

For More Information

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www.scalingup.org
www.implementationconference.org


GIC 2017: Toronto, Canada
Expanding Implementation Perspectives: Engaging Systems
• Pre-Conference: Sick Kids, Peter Gilgan Centre for Research and Learning June 19, 2017
• Main Conference: Sheraton Centre Hotel June 20-21, 2017
Save The Date!
GIC Global Implementation Conference

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

EXHIBIT B

I. Plan

DCFS intends to implement several changes to the current SACWIS application while it evaluates a potential migration to a Comprehensive Child Welfare Information System (C.C.W.I.S.) It will also deploy innovative technology in the field to improve business process efficiency and service delivery.

II. Background

Currently DCFS has numerous software applications that reside outside of the SACWIS environment. This is not atypical among State Child Welfare agencies around the country. Initial system designs were developed years ago, business processes change, agencies priorities fluctuate from administration to administration, integration opportunities present themselves, newer technology collides with legacy systems, and the lack of strategic and enterprise vision all drive this national challenge.

III. Theory of Change

DCFS has made a deliberate decision to retire several of its legacy systems and doing so, has presented an opportunity to integrate these function in the current SACWIS application. DCFS also sees this as an opportunity to better prepare itself for a potential migration to a CCWIS environment understanding that it is easier to migrate from a few systems than several.

IV. Implementation Status

DCFS Office of Information Technology (OITS) staff, in partnership with Department Program/Business offices has identified key business functions that are currently performed outside of SACWIS. Opportunities for streamlined case management functions are available. Opportunities for improved data sharing with other state agencies are possible as well.

These business functions include:

- Unusual Incident Reporting (UIRs)
- Child Adolescent Needs and Strength Assessment Tool (CANS)
- Illinois State Board of Education (ISBE)
- Online Licensing Application
- Case Access Mobile Application
- Tablet Application for Licensing Inspections

Significant Event Reporting (Formerly Unusual Incident Reporting UIR)

Significant Event Reporting was launched on 2/14/17 with enhanced practice procedures (P331) and automated functionality in the Department's core case management system (SACWIS). The SACWIS user base was expanded to include residential facility providers, foster care licensing, day care licensing and other Department and POS stakeholders responsible for recording significant events.

Significant Event Reporting is the process that captures significant, sometimes traumatic occurrences that impact children and youth served by the Department. (These are reports formerly known as Unusual Incident Reports.) Additionally, this process is used to capture significant events that involve Department licensed facilities, including day care providers, as well as staff employed by the Department or Purchase of Service (POS) Agencies, Department licensed facilities and caregivers. Significant events in Illinois child welfare include child and youth events, and personnel, caregiver and facility related events. Child

and Youth Significant Events include allegations of abuse and neglect, reports of missing or abducted children and youth, and child and youth incidents such as:

- Encounters with Law Enforcement;
- Behavior Related Incidents;
- Sexualized Behavior;
- Medical/Psychiatric;
- Injury Related Incidents;
- Identification of a Pregnant or Parenting Children and Youth in Care;

Key Benefits of Implementation

Significant Events require immediate reporting for abuse/neglect and missing events. Child/youth incidents are also required to be reported immediately during business hours, however when the occurrence is outside of normal business hours, the "immediate" reporting requirement will occur at the beginning of the next business day. All incidents that are required to be reported immediately to the State Central Register/Hotline (SCR) or Child Intake Recovery Unit (CIRU) shall be reported immediately upon learning of the incident regardless of the time or day. In the previous practice the UIR was required in addition to abuse/neglect reports and reports of missing child/youth events. This created duplicate processes for staff and resulted in duplicate data.

Significant events are visible immediately on a SACWIS monitoring log as well as on the caseworker and supervisor desktop. The immediate reporting timeline allows for quicker responses to child and youth events and immediate notification to involved staff at field service, management, monitoring and executive levels. Often in the past key staff had not been notified in a timely manner and required interventions were not employed. For example, in instances where a child or youth had experienced an arrest or involvement with law enforcement the DCFS Office of the Guardian was not notified in time to provide legal representation. Now the immediate visibility will allow for this.

Significant event disposition as defined in procedures section 331.190 now allows for the disposition activity to occur in one place. As noted, previously the final disposition could not be entered on the Illinois Outcomes platform. The SACWIS functionality captures all aspects of significant event reporting as in current practice. Immediate reporting, streamlined systems and functionality allows for dispositions to occur more timely. The enhanced process and improved automation supports safety, permanency and wellbeing in that reports are more timely (previously required within 7 days, now required within 24 hours) and notifications are immediate, in real time upon system report entry. Additionally, all stakeholders with responsibility are able to view the incidents in SACWIS and with proper assignment security may link into the case to view other pertinent information.

Child Adolescent Need and Strengths/CANS

CANS data relative to child wellbeing will be addressed through CANS development in SACWIS and migration of all internal CANS assessors from disparate systems to the SACWIS case management system/automated case file record. DCFS DoIT/OITS staff have been engaged with stakeholders around plans for implementing the Illinois Medicaid (IM) CANS. Currently OITS staff and key stakeholders are identifying short and longer range plans to consolidate CANS processes on one application and establish implementation goals.

The Department is working through the Governance process to prioritize CANS among other critical initiatives. At this time, a formal implementation schedule has not been established, however the CANS process is a Department priority that will be addressed along with other key projects.

Illinois State Board of Education (ISBE)

The Department continues to work with ISBE on viewing child education information for the children served by DCFS. The Department has received a data feed from ISBE for several years but this only contains school enrollment information and does not contain child education information. The current Department effort with ISBE is to view the education information for the children in care by utilizing a web service provided by ISBE. This process involves ISBE making a connection between a list of DCFS children to the ISBE population of children. In the event individual child records cannot be matched between DCFS and ISBE a manual match process will be required by staff within the Department. Conversations between ISBE and DCFS will continue in attempt to alleviate manual processes and in effort to provide critical child wellbeing data to the Department.

Online Licensing Application

This online application is designed to assist with determining eligibility of interested parties applying for foster care licenses and replacing the paper application form required by the licensing office. Data will be captured online, routed to the appropriate offices for processing and assist with communicating expectations to the public reducing incomplete submissions, paperwork and follow up calls.

Key Benefits of Implementation

Benefits of this application are the initial step to providing 24/7 access for foster care licensing candidates. As the State moves toward a paperless and electronic organization, tools like online applications and client/provider portals will be necessary to keep up with the increased demand and inquiries while maintaining same amount of support staff. Since its release in late 2016, several offices have been instructed and trained to direct inquiring parties to a link which asks eligibility questions to "pre-vet" candidates and allow eligible parties to create a User Name and Password in order to complete an online form. Applicants have up to 60 days to complete this form. Once completed, submissions are sent to the respective processing staff to continue the licensing application process. Below are some statistics that show the number of inquiries and completed forms thus far.

# of inquiries stopped by vetting questions = 1
# of inquiries advancing onto the application = 88
# of applications for traditional foster home = 62
# of applications for relative foster home = 7
# of pending applications 15 days = 3
# of pending applications 30 days = 0
# of pending applications 45 days = 3
# of pending applications expired 60 days = 20
# of completed applications for traditional foster home = 33
# of completed applications for relative foster home = 5
# of completed applications = 38

Completed By County Counts
Traditional Foster Home Adams = 1
Traditional Foster Home Champaign = 1
Traditional Foster Home City of Chicago = 1
Traditional Foster Home Cook = 1
Traditional Foster Home DuPage = 19
Traditional Foster Home Kane = 2

Traditional Foster Home Kendall = 1
Traditional Foster Home McLean = 3
Traditional Foster Home Ogle = 1
Traditional Foster Home Will = 2
Traditional Foster Home Winnebago = 1
Relative Foster Home Cook = 1
Relative Foster Home DuPage = 2
Relative Foster Home Tazewell = 1
Relative Foster Home Will = 1

Case Access Mobile Application

As of January 12, 2017, **all** (approx. 950) DCFS operations direct service staff; including Child Protection Specialists and Supervisors and Child Welfare Specialists (permanency and intact) and Supervisors have been provided iPhones with access to DCFS email/calendar/contacts and the Case Access mobile app. The device and mobile app combination provides workers with immediate access to supervisors and/or emergency personnel, the ability to document contacts and upload investigation/child photos to SACWIS in real time and web conferencing access in the field.

The Department is working through the Governance process to develop policies to support Mobile Partner Access for external agencies.

Key Benefits of Implementation

- Significant improvement in timeliness of case note and photo data entry.

  Note timeliness statistics:
  Monthly mobile usage reports (as of **3/31/17***)
  CWS note avg. time to entry
  - BASELINE AVG. - 14 days
  - REPORT PERIOD AVG. - 0.5 day
  CPS note avg. time to entry
  - BASELINE AVG. - 7 days
  - REPORT PERIOD AVG. – 1 day

  Photo timeliness statistics:
  Department policy requires youth in care photos to be updated once every 365 days. Current average age of youth in care photo as of 3/31/17 is: **194 days**

- Improvements in overall productivity, communication with supervisor, access to caseload and timely documentation.
  The iPhone and mobile app provide numerous opportunities for social workers to creatively increase productivity while "working mobile." Convenient and timely access to coworkers, clients and data provide the means to expedite decisions on child safety and add value to existing processes.

- Mobile app usage continues to increase over time

  The Department monitors real time data analytics to inform our mobile strategy and ongoing development efforts. We continue to prioritize paired customer and product development to iteratively improve an indispensable product.

Monthly data comparisons:

December 1 2016 vs. March 31, 2017
- Visits Over Time
Increase from 6,336 to 7, 494

December 2016 vs. April 2017
- Avg. Visit Duration
Increase from 15 min/16 sec to 17 min/22 sec

Tablet Application for Licensing Inspections

The Department continues to work the contracted party (T.C.C.) to develop an App which will be available on tablet devices used by licensing field staff. It will allow field staff to capture data, document findings, and generate compliance notices. This initiative will reduce the need to complete lengthy paper forms currently used, duplicate entry, improve data timeliness and service delivery. Development is underway and the workgroup meets on average bi-weekly. The exact deployment date is still to be determined and will take place following the required system integration to the State's central licensing system (IMSA) and appropriate User Acceptance Testing (UAT.)

V. Outputs

Significant Event Reporting (Formerly Unusual Incident Reporting UIR)

This function was transitioned from the IL Outcomes and NOMAD Systems to SACWIS effective 2/14/17. Procedures 331 were revised an implemented 2/14/17. Full implementation included current SACWIS users (POS and DCFS CWS staff) as well as non-SACWIS users in residential facilities, licensing staff in DCFS and POS agencies, executive staff and other non-case carrying staff.

Child Adolescent Needs and Strength Assessment Tool (CANS)

CANs will be prioritized and developed in SACWIS. Once implemented the reliance on external system will be reduced and SACWIS will include more child centric data, as CANS assessment data is currently not part of the SACWIS record.

Illinois State Board of Education (ISBE)

The Education Passport/ISBE project will be prioritized and will include enhanced data sharing with the Illinois State Board of Education and enhancing the current Education Profile in SACWIS.

Online Licensing Application

This online application is designed to assist with determining eligibility of interest parties applying for foster care licenses and replacing the paper application form required by the licensing office. Data will be captured online, routed to the appropriate offices for processing and assist with communicating expectations to the public reducing incomplete submissions, paperwork and follow up calls.

Case Access Mobile Application

App can be loaded on any iOS device allowing case management and investigative staff to enter case notes and take pictures while in the field. This data will be loaded directly into SACWIS reducing the need for duplicate entry and more timely data entry.

Tablet Application for Licensing Inspections

This App is being developed by a third party (T.C.C.) and is under the direction and management of

DCFS licensing staff. It will allow field staff to capture data, document findings, and generate compliance notices. This initiative will reduce the need to complete lengthy paper forms currently used, duplicate entry, improve data timeliness and service delivery.

Proximal Outcomes

Proximal Outcome (per Proximal Outcome in Logic Model)	***Intervention Group (%, N)***	***Comparison Group (%, N)***	***Significance and Explanation of Difference***
Unusual Incident Reporting/Significant Events • Business Requirements • Database Management/Application Development • UAT • Training • Communication • Go Live	Not Applicable	Not Applicable	Completed 2/14/17
Child Adolescent Needs and Strength Assessment (CANS) • Business Requirements • Database Management/Application Development • UAT • Training • Communication • Go Live	Not Applicable	Not Applicable	Expected completion TBD
Illinois School Board of Education • Business Requirements • Database Management/Application Development • UAT • Training • Communication • Go Live	Not Applicable	Not Applicable	Expected completion TBD

Online Licensing Case Application • Business Requirements • Database Management/Application Development • UAT • Training • Device Purchase and Deployment • Communication • Go Live	Not Applicable	Not Applicable	Completed 10/31/16
Case Access Mobile Application • Business Requirements • Database Management/Application Development • UAT • Training • Device Purchase and Deployment • Communication • Go Live	Not Applicable	Not Applicable	Completed 01/31/17
Tablet Application for Licensing Inspections • Business Requirements • Database Management/Application Development • UAT • Training • Device Purchase and Deployment • Communication • Go Live	Not Applicable	Not Applicable	Expected Completion Date: 8/31/17

VI. **Distal Outcomes**

Distal Outcome (per Distal Outcome in Logic Model)	***Intervention Group (%, N)***	***Comparison Group (%, N)***	***Explanation of Status***
Significant Event Reporting/*Formerly Unusual Incident Report*	Not Applicable	Not Applicable	Ongoing within SACWIS releases post 2/14/17

enhanced reporting and functionality			
Enhanced/individualized incident monitoring views for specialty divisions/units such as licensing, TPSN, legal, etc.	Not Applicable	Not Applicable	Ongoing within SACWIS releases post 2/14/17
Critical Event Reporting/Mobile Access	Not Applicable	Not Applicable	Ongoing within SACWIS releases post 2/14/17

VII. Other Consequences

As of the last report DCFS IT staff were being absorbed into a new state agency, Department of Innovation and Technology (DoIT). The State of Illinois IT transformation may impact DCFS' access to necessary resources. Releasing new tools and enhancements to staff always requires effective change management and communication. Additionally since last report staff retirements have created vacancies that are being managed by acting Department staff with other full time responsibilities. There are impending union strike concerns and contingency planning underway that would greatly impact IT deliverables.

VIII. Plan Revisions

No change planned at this time.

EXHIBIT C

BH Four Month Status Report

Immersion Sites

April 30, 2017

Narrative updates and changes in plans for April 30 are blue, italicized and underlined.

1. **Implementation Plan and Month by Month Implementation Status Progress:**
    a. **Through an Immersion Site process the safety, permanency, stability and wellbeing outcomes for DCFS children and youth will be improved. The immersion process was initiated with four sites covering approximately 11% of the DCFS caseload in August, 2016. Sequentially other Immersion Sites will be developed until the new model of practices, processes and services array are in effect statewide.**
    b. **The first four Immersion Sites are the Mount Vernon area (5 adjacent counties), East St. Louis/St. Clair County, the 14th Judicial Circuit centered in Rock Island, and the 19th Judicial Circuit of Lake County.**
    c. **The Immersion Site process has the following components:**
        i. **Extensive training and coaching in a new model of practice called "FTS" for family centered, trauma informed and strengths based. The FTS implementation details are in the Logic Model and Status Update for FTS.**
        ii. **The FTS training and coaching will be integrated with Paul Vincent's Child Welfare Group's Quality Service Review (QSR) processes to ensure that parental engagement and child and family teams are well established through the training and coaching.**
        iii. **Extensive training and coaching for supervisors in the Model of Supervisory Practice (MoSP).**
        iv. **Quality assurance and monitoring to ensure that the new FTS practice model is fully implemented in the Immersion Sites. The implementation details are in the Logic Model and Status Updates for Quality Assurance. The QA process will be integrated with Paul Vincent's Child Welfare Group's QSR process to ensure that parental engagement and child and family teams are fully implemented in the Immersion Sites.**
        v. **Development of an intensive and immediately available array of in home evidence supported services for parents, caregivers and children and youth. The service array will include flexible funding so that any services that are needed to achieve permanency can be purchased.**
        vi. **To create additional funding flexibility in providing the immediately available intensive array of in home evidence based services DCFS has secured Title IV-E waiver authority to use funds that were**

formerly restricted to out of home care to provide that array of in home services.

vii. **Improving the case flow and day to day operational process by changing rules, policies, practices and operational procedures which have proven to be ineffective or redundant, and which hinder achieving permanency outcomes for children and youth.**

viii. **Making structure changes in the DCFS organization to increase integration and remove further barriers to achieving better outcomes.**

ix. **Piloting decentralization of some current central office functions such as matching children with placements (Central Matching), provision of emergency housing funds to families and youth at risk of homelessness, Agency Performance Team which monitors case management, and case opening (Case Assignment and Placement Unit) in order to determine if efficiencies and a more effective case flow can be achieve through local management in the regions and field offices.**

x. **Reorganizing the DCFS field office structure around Judicial Circuits to better align its operations with the Juvenile Court.**

d. **Major milestones achieved during August include:**

i. **Field office, personnel and contract data gathered for each Immersion Site.**

ii. **Immersion Site Director Position was established, interviews were conducted and Immersion Site Directors were initially selected and are under final vetting.**

iii. **The FTS in person training module was completed.**

iv. **An outcome data tracking system for Immersion and comparison sites was designed including:**

1. **Data set for trend lines for key outputs and proximal and distal outcomes defined.**
2. **Data base defined and planned with outcome and failure alerts for BH class kids including shelter over 60 days, step down, BMN (in psychiatric hospitals beyond medical necessity) and RUR kids (in detention beyond their release date and parents or caregivers have refused to take custody).**

v. **Listening visits were held in all sites with focus on organizational, resource and procedure/process challenges. Discussions were conducted with Judges (East St. Louis Judges' meeting deferred to September), DCFS front line personnel, private child welfare agency leaders and front line personnel, counseling and services providers, foster parents, children and youth and biological children. Dates for these visits were as follows:**

1. **August 3-4: Mount Vernon**
2. **August 9: East St. Louis**

3. **August 18: Rock Island**
4. **August 24 : Lake County**

vi. **During the August listening visits many important barriers to permanency were uncovered which will lead to plans to resolve them to improve outcomes. A few of the several dozen commonly cited were:**

1. **Ineffective and untimely processing of adoption and guardianship subsidy documents.**
2. **Lack of a readily available and effective array of intensive and in home evidence supported services for parents and children and youth.**
3. **Constant changes in caseworkers leading to discontinuity in service delivery and lack of consistent support and an effective casework relationship for children, youth and families.**
4. **Difficulties in obtaining consent for critical care needs such as oral surgery.**
5. **Complaints of a lack of partnership and team work between foster parents, biological parents and caseworkers.**
6. **Child and family teams not being used for case assessment, planning and ongoing service delivery. This is leading to disconnects between assessment findings, plans developed and services actually delivered.**

vii. **Initial decentralization began with the establishment of a pilot for the matching process and the case opening process in the Southern Region including covering the Immersion Sites of Mount Vernon and East St. Louis.**

viii. **Planning was initiated to align the field office and regional boundaries with the Judicial Circuits.**

ix. **Plans were developed with Paul Vincent's Child Welfare Group to align the FTS training and coaching and the Quality Assurance process with the Quality Services Review.**

x. **IV-E Wavier discussions were engaged with the federal Children's Bureau to obtain a waiver to use out of home care funds for the intensive array of in home services.**

e. **In September the following milestones were achieved:**

i. **Immersion Site Directors were recruited and hiring decisions were made with an October 3 start state established for each.**

ii. **Lessons learned from the listening visits were consolidated into major priorities. Plans to solve one, the disbursal of cash for housing through the Norman process, were developed. Others were deferred to detailed case flow process mapping process training October 5 and 6.**

iii. **The Casey Family Services Foundation designated a team to lead the Immersion Site Directors in a process mapping process on October 5 and 6.**
iv. **A method to track cohorts from the Immersion Sites defined and cohort tracking development began.**
v. **Performance dashboards were defined and construction initiated with a target date of December 1.**
i. **The reorganization of DCFS field offices around Judicial Circuits will commenced with overall direction, plans and barriers developed.**
ii. **Additional FTS training modules will be completed specifically on-line FTS overview FTS training for managers, Judges and other stakeholders.**
iii. **The IV-E Waiver application was developed for federal consideration with an October review and submission goal.**
iv. **Decentralized pilots for placement matching, and case opening, were expanded from the Southern Region to the Northern and Central regions for their Immersion Sites.**

f. **In October the following milestones were achieved:**
i. **The Casey Family Services Foundation completed business process and life of case reviews with the Immersion Site Directors to identify opportunities to improve processes and organization by eliminating unnecessary processes and simplifying the organization.**
ii. **Immersion Site Directors developed stakeholder planning groups to develop designs for these models of intensive arrays of in home care guided by wraparound principles.**
v. **An October 17-19 "Summit" Conference with Judges, DCFS front line personnel, private child welfare agency leaders and front line personnel, counseling and services providers, foster parents, children and youth, and biological parents publically launched the Immersion Site training and coaching and provide extensive information on the FTS/QSR/MoSP content and the Immersion goals and outcomes. Specific FTS and CFTM training and Immersion Site information was provided for Immersion Site stakeholder leaders on October 17 in a pre-Summit meeting. The Summit included Mega-Sessions regarding the FTS model and the CFTM process stakeholders.**
vi. **In person FTS training for managers and support personnel was implemented in late October.**
vii. **Paul Vincent's Child Welfare Group developed an Illinois version of the Quality Services Review to use in our Quality Assurance efforts. These will be real onsite interviews of actual participants, for example in the child and family team, to ensure that the model of practice is fully embedded and followed with fidelity in day to day operations. Draft QSR model was finalized on November 1 and 2.**

viii. **Initial plans were developed and implemented to eliminate the major process barriers and redundancies which hinder the achievement of permanency.**

ix. **The IV-E Waiver was submitted to the Federal Government on October 31, and the Waiver has now been approved.**

g. **In November the following milestones were achieved:**

i. **Kick off events were held in each Immersion Site to initiate all activities including the FTS training and coaching, the planning for the implementation of an intensive array of in home services, the process modifications to eliminate redundancies and barriers to permanency, the organizational simplifications, and other Immersion Site components.**

1. **Integrated POS and DCFS teams were engaged in each Immersion Site.**
2. **A Stakeholders Planning Group was developed in each Immersion Site.**

ii. **The FTS model of practice and coaching team began continuously and progressively training all service personnel in person and all administrative and support personnel via the online module.**

iii. **A child and family team online module was completed with Paul Vincent's staff which provides practical information on how to conduct a child and family team. Final product is under review.**

iv. **Plans were developed to amend the Paul Vincent group's budget to provide a team of national expert coaches to support our in-field coaching experts in the Immersion Sites.**

v. **The Quality Assurance tools embedding the principles of the Quality Services Review were developed with Paul Vincent's group. The DCFS QSR reviewers were recruited and hired.**

vi. **Each Stakeholder Planning Group developed an approach to the provision of an intensive array of in home wrap around services.**

vii. **Discussions were held with ACF Commissioner who indicated likely approval of the IVE Waiver. The Waiver will provide additional resources which can be targeted on development of the intensive array of family based in home services.**

viii. **Staff were trained in each Immersion Site in both the matching process and case assignment and placement processing. Process is active in Mount Vernon (whole Southern Region), East St. Louis, and Rock Island (Peoria sub-region), and was planned for mid-January in Lake County.**

ix. **Local organizational integration and better alignments will be completed.**

1. **Immersion Site Directors are leading teams that integrate child protection, permanency, intact, monitoring, clinical,**

licensing, purchase of service case management to better integrate child welfare services.

2. **Stakeholder's Planning Groups are established to design the intensive array of services and to improve processes.**
3. **Planning began to align DCFS services around Judicial Circuits.**
4. **Initial recommendations to improve processes were vetted including:**
    a. **Elimination of the 2017 Matching form.**
    b.
    c. **Sharing foster home development efforts and new homes recruited between private providers and DCFS resource development.**
    d. **Replacing the Percentage of Referral Opportunities process for making foster care placements with a Child and Family Team driven "best placement" process.**

x. **Both cohort tracking aligned with the overarching outcomes was developed.**
1. **Mindshare cohort tracking was established which can track both the Immersion Site counties, the State as a whole and any comparison counties defined in terms of outcomes.**
2. **A baseline for permanency achievement was established for each of the Immersion sites using 2016 data to track improvements in attaining permanency against 2017.**

h. **In December, January and February the following milestones were achieved and goals were updated for March and April:**
i. **P315, Child and Family Team Meeting, Child and Family Team Coaching, Family Centered, Trauma Informed and Strengths Based (FTS) and MoSP training and coaching.**
1. **Core Practice Model: Family-Centered, Trauma-Informed, and Strength-Based (FTS) Practice.**
    a. **The Core Practice Model: Family-Centered, Trauma-Informed, and Strength-Based Practice training was delivered from November 2016 until January 2017 in the four current Immersion Sites.**
    b. **Make-up classes were scheduled for February to ensure that small number of staff who did not yet attend or who missed all of the available sessions will have the opportunity to now attend.**
    c. **Make-up sessions were scheduled monthly starting in March 2017 on a rotating basis between Immersion Sites to account for new staff hired after the full rollout of training was completed. The number of participants**

within each immersion site who have completed this training to date is listed in the chart in the outputs and outcomes section.

d. An abbreviated self-directed version of the training was established during the rollout of these trainings for managerial and support populations who did not need the full training. The content of this training centers on Illinois Family-Centered, Trauma-Informed, and Strength-Based practice. This training specifically outlines all three aspects of the practice model and discusses how they interact together along with Race-Informed Practice to encompass how staff should be engaging and working with children, youth and families. The number of participants within each immersion site who have completed this training to date is listed in the chart in the outputs section.

2. P315 Training

a. P315 Training was initiated within the Immersion Sites in January 2017. The P315 training covers several central BH concerns including family finding, fictive kin and expanded state subsidized guardianship. The targeted timeframe for completion was March 31, 2017.

b. Statewide Operations worked with Monitoring and the Office Professional Development to ensure that permanency and adoptions staff, supervisors, and managers complete the training before the end of March 2017 with make-up sessions being offered into April 2017.

c. Investigations staff were offered a self-directed module online regarding their role and responsibilities in Emergency Shelter Care process which go live in March 2017.

d. The number of participants within each immersion site who have completed these trainings to date is listed in the chart in the outputs and outcomes section.

3. Child and Family Team Meeting Training;

a. The Child Welfare Group informed DCFS that a final curriculum for the training portion of this learning process will be made available by 2/28/17. The content of the Child and Family Team Meeting training and coaching will be provided by the consulting group as their proprietary curriculum and model.

i. **Previous curriculum used by the consulting group in other jurisdictions has been provided to Illinois.**
ii. **The content focuses on ways to engage and prepare families for an effective child and family meeting, and then how to effectively facilitate the meeting in such a way as to ensure that the family and youth feel supported and empowered.**
iii. **The curriculum from previous jurisdictions is in alignment with Illinois' Family-Centered, Trauma Informed and Strength Based practices.**

b. **The Office of Professional Development prepared to launch the first cohort of trainings in conjunction with the consultants in March following a Leadership Summit in each immersion site. Coaching will commence two weeks after the training.**
c. **In preparation, the Office of Professional Development staff began meeting with immersion site stakeholders and agency executive to begin explaining the training and coaching process while encouraging the identification of supervisors and staff who will participate in the first cohort.**

4. **Child and Family Team Meeting Coaching Trainings are targeted to begin within Immersions Sites in March 2017.**
   a. **The Office of Professional Development has begun engaging with agencies within the Immersion Sites during the month of February 2017 to prepare them for the upcoming training and to allow agencies to begin identifying staff they desire to attend the first cohort of the trainings. The expectation is that the first group of supervisors will achieve "facilitator" status by July 2017 and then "coach" status by September 2017.**
   b. **Further targeted outcomes include that by November 2017, a core staff will achieve "Master Coach" status, 96 supervisors will achieve "coach" status, and 96 workers will achieve "facilitator" status. By December 2017, the 96 supervisors will be able to finish developing the remainder of the workers into "facilitator" status.**
   c. **The first Staff will be certified to provide the training without the consultant group by September 2017.**
   d. **Following November 2017, "Master Coaches" will be certified to develop cohorts of supervisors in future**

immersion sites into "coaches" on average of every 14 weeks per cohort of supervisors.

5. **Model of Supervisory Practice:**
    a. **Model of Supervisory Practice is a combination of both in-classroom training along with individual coaching. The content of the training and coaching centers on expectations for supervision and supervisory guidance in child welfare.**
    b. **The content is divided into four aspects of supervisory practice: Administrative, Developmental, Supportive, and Clinical. Supervisory guidance includes aspects of all four. Currently, the Model of Supervisory Practice is formatted to be delivered as four separate 1.5 day modules with a single coaching session following each of the four modules.**
    c. **With ongoing clarity being received from the consulting group regarding the requirements of the Child and Family Team Meeting training and coaching process, the Office of Professional Development began work on consolidating the Model of Supervisory Practice into less modules and a shortened delivery. Coaching will still occur between the modules. The training and coaching will be targeted to occur following the first cohort's completion of the Child and Family Team Meeting training and coaching.**
    d. **The estimated timeframe for Model of Supervisory Practice to begin will be in November/December 2017 and will involve all child welfare supervisors.**

ii. **Quality Assurance based on the Quality Services Review model:**
1. **Four Immersion Site reviewers were hired and began work. They are supported by four additional QA staff, one for each of the Immersion Sites.**
2. **The QSR instrument was finalized and the reviewers were trained on January 19-20 and the initial QSR reviews were initiated in late January.**
3. **Four rounds of review of the QSR pilot reviews were planned to be conducted by the Child Welfare Group in February, March, and April to ensure that the QSR reviewers are doing their work with fidelity to the QSR standards.**
4. **Advanced QSR training will be conducted in March.**
5. **The QSR reviewers will have regular debriefings and case reviews with the Child Welfare Group experts to progressively increase their skill in facilitating QSR reviews.**

6. **By May we hope to have eight highly skilled QSR reviewers who have the expertise to do the work and develop new reviewers.**

iii. ***Delay in Child and Family Team Meeting Training and Coaching and QSR Training and Implementation: It was determined by the State Procurement Officer that DCFS should not simply increase the Paul Vincent Child Welfare Group's contract. It was suggested that there may be competing bidders which raised the possibility of a many month Request for Proposals process. Extensive discussion was held with the State Procurement Office and the DCFS lawyers and it was concluded that it was appropriate to sole source the contract but that a public posting sole source procedure would be followed to ensure that no other firm wished to bid on this contract. This process delayed the award of the contract to April 10. On April 26 a planning meeting was held to finalize the implementation target dates forward. The a summary plan forward is in the April 30 update.***

iv. **Planning for the Intensive Array of Services began:**

1. **The intensive array of in home services entered the contract development stage in each Immersion Site. The goal was to have a contract program plan and budget in place for each site by March 1 with an implementation date of April 1. *In April below you will note that the contract negotiations extended into April with all four contracts being awarded by April 30.***
2. **Each program is based on the principles of intensive, evidence supported, and both clinical and anti-poverty services, flexible funding, Medicaid maximization, integrated care coordination, rapid response, and in home and community and not in office services organized in an evidence supported wrap around model.**
3. **The DCFS Clinical Division continues to provide consultation and oversight of the development and implementation.**
4. **Each site has well developed approaches which are being finalized in contract program plans:**
    a. **Mount Vernon is developing a lead agency approach integrating supervised reunification, Nurturing Parent Training, Intensive Placement Support for both intact and reunifying families, 24/7 emergency response and the intensive Multi-Systemic Therapy program.**
    b. **Lake County is developing an intensive wrap around approach involving ARC (Attachment and Regulation Competency), Motivational Interviewing, Triple P parent training and 24/7 emergency access.**

c. **Rock Island is working with the community mental health agency to expand its capacity to provide prompt in home stabilization for families in crisis and to reunify children and youth in placement with their families.**
d. **East St. Louis is working with two well established agencies to provide a full continuum including both clinical and anti-poverty care and services. This includes a settlement house with a strong anti-poverty history and considerable experience with the old DCFS Local Area Network approach and one of our more clinical child welfare providers.**
e. ***There were some changes in these program plans as the contracts were finalized. The final programs are described in April below.***

v. ***Delay in the Implementation of the Intensive Array of Services in each Immersion Site: The contracting process which includes considerable interaction and negotiation between the lead agencies, the Immersion Site Directors and the DCFS contracts and legal units has taken about one month longer than anticipated. In addition there were changes in lead agencies in two of the sites as the chosen lead agencies realized that they could not fulfill the requirements of serving as wrap around facilitator. While initial program plans were developed as planned in both March and April the final lead agency wrap around contract awards were deferred until late April to allow time to work out contracts and program plans what were consistent with DCFS rules and procedures and met the requirements for wrap around facilitation by the lead agency. Details common to each of the program plans are discussed in the April section below.***

vi. **The initial process improvements to eliminate barriers and redundancies were implemented and a second priority group was planned. A large group of recommended process improvements are being implemented. Examples completed follow:**
   1. **In Mount Vernon an Adoption Lab with DCFS adoption leaders working directly in one location with private agency adoption workers to complete paperwork avoids the back and forth that is taking months and completes the process in a couple of days. DCFS has several hundred adoption and guardianship subsidies in backlog due to overly complex, redundant and unresponsive processes*. Due to its success this project has been expanded statewide.***
   2. **Funding authorizations for housing support for homeless families has now been delegated to private case management agencies in each Immersion Site.**

3. **In Mount Vernon and East St. Louis multiple page forms are being consolidated or eliminated, some are many pages in length with little value added.**
4. **In Lake County the "percentage of referral opportunities case rotation" assignment of new cases among private agencies has been improved by a team process which places children in the best placement for them and not the next placement on the rotation.**
5. **In Lake further evolution is being planned to share foster homes among foster care agencies and disconnect case management from service provision which would avoid the necessity of changes in case management. This may be coupled with private agency sharing of foster homes and a centralized recruitment program.**
6. **In Mount Vernon phones will be provided for parents who do not have one (quite common) so that they can create an immediate relationship with foster parents when their children are removed and talk to their children in the foster home to provide assurance.**
7. **In Lake County DCFS recruited foster homes will be shared with the private agencies so homes can be more quickly licensed.**
8. **In each Immersion Site new processes are being planned to ensure immediate engagement of parents in a child and family team at the family's first entry into services.**
9. **Waiver of a rule which prevented DCFS and other State employees from becoming DCFS foster parents is being issued.**
10. **In Rock Island all adoptions in process are under review and the Adoption Specialist is going from private agency to private agency to coach and help workers complete the process.**
11. **In Rock Island all 0-6 year old children are being reviewed to ensure expedited reunification or adoption.**

vii. **Increased organization integration and simplification will be achieved.**

1. **All DCFS components including private agency case management programs are working regularly in each site as a more integrated team and are developing the intensive services array, the process improvements and the decentralized approaches described here.**
2. **Case management monitoring by APT (Agency Performance Team) has been transferred to Regional direction to ensure better integration of public sector and private sector case**

flow and quality of work. This means that the DCFS regions and the Immersion Sites now have full responsibility for the entire child welfare continuum including both state employees and private agency programs. Program policy and monitoring support for the regions operational efforts has been aligned with the clinical program centrally.

3. **Plans are being developed and will be fully implemented by April to integrate the Integrated Assessment, Matching Process, CIPP, Regional Clinical and clinical specialists into the local Child and Family Team Meeting process in the Immersion Sites. Clinical staff will be engaged in the more complex behavioral and emotional problem cases from the beginning to the end of the life of the case. The goal is to ensure that Integrated Assessment recommendations are fully vetted with parents and children, fully realized in plans that the children and parents own, and fully implemented through the service goals and plans. *Plans have been developed and the implementation will proceed with the implementation of the Vincent Child and Family Team Meeting training and coaching contract. Juvenile Courts and caseworkers rely heavily on the work of the Integrated Assessor which is not a resource generally available in other states so how to best align it with the CFTM needs study. Due to the complexity of fully aligning Integrated Assessment with the CFTM process the Vincent Child Welfare Group has decided to first focus on existing cases to allow further time to study the best way to maximize the extensive resources of Integrated Assessment with the parental and youth empowerment process of the CFTM process. CIPP will be fully integrated into the CFTM process and the CIPP facilitators will be trained as master coaches. Clinical staff will be readily available whenever needed by the CFTM.***
4. **Matching, case assignment and placement and provision of emergency housing funds for families and youth at risk of homelessness has been decentralized.**
    a. **A process to allow the Immersion Sites to provide emergency cash for housing to keep high risk families and youth in housing has been implemented in each Immersion Site.**
    b. **The placement matching process and the case assignment and opening process have also been implemented in each Immersion Site.**
    c. **Field offices and regions will be aligned with Judicial Circuits. A plan is under development to align regions**

and field offices with Judicial Circuits and discussions with the Union are being established to resolve any local staff reassignments. Once the plan is finalized in March implementation will begin in aligning our field offices and regions with the Illinois Judicial Circuit areas. As the Immersion process is completed in each Circuit a DCFS Circuit Administrator will be appointed to provide the key point of leadership in the Circuit to ensure that the gains and results of the Immersion process are maintained and enhanced.

d. ***Change to c. above: The plan to align DCFS with Judicial Circuits has been completed but implementation has been deferred to later in the Spring to allow sufficient time for leadership review and labor union negotiations.***

e. Clinical residential monitoring has begun in the Immersion Sites and in Cook County. Youth at high risk are being identified and referred to the Immersion Site Director to make sure they receive a necessary array of intensive wrap around care.

viii. Additional February/March Plans and Results: Assessment, Corrections and Enhancements, and Further Implementation Plan Development.

1. **In February we will complete an assessment of our efforts to date and include in our February monthly update report our assessment of the effectiveness of the results of each component and the whole process and any corrections or enhancements of the implementation Plan needed.**
2. **The overall goals of the Immersion Sites will continue as defined above.**
3. **Particularly important will be making a determination of the time requirements to maximize the effectiveness of the Immersion Process and to fully embed it into day to day practice in a sustainable way. DCFS has learned from Paul Vincent and his Child Welfare Group that our initial plan of four month sequential Immersion Sites was much too ambitious to attain sustainable outcomes from the Immersion Process. As you will note above the final component of our training, the MoSP may not be completed until Winter, 2017. Future Immersion Sites will benefit from all the training, coaching, reviewing and other tools which have been produced in our first Immersion Site process which should significantly speed up the process. DCFS will have considerable experience by February and, with the Child**

Welfare Group's support, should be able to determine how long an immersion process takes to achieve maximum improved outcomes.

4. **Therefore we will be able to adjust our plans and lay out a realistic timeline for the balance of the state. When this is completed a detailed plan forward will be developed and submitted to the Court correcting the past assumptions in the Implementation Plan.**
5. ***Correction to 2 and 3 above: The delay in the Vincent Child Welfare Group contract and the planning for Union negotiations for the conversion of our Field Office structure to Judicial Circuits have made it impossible to firmly state with certainty specific dates in which DCFS will move forward into the second and subsequent rounds of Immersion Sites. DCFS' consultations with the Vincent CWG have highlighted the significant length of time needed to train stakeholders, improve child welfare practice in a sustainable way, and develop and sustain the array of intensive home and community-based services youth need. The Department, in collaboration with the Expert Panel and Plaintiffs' counsel will come to a conclusion as to the best path forward by June 30.***
6. **The Output and Outcome data was refined by ensuring its alignment with CFSR business rules. The University of Illinois Child and Family Research Center, Chapin Hall and DCFS business rules will each be aligned with CFSR business rules to ensure consistency in measurement.**
7. **Monthly tracking of both CFSR and actual numbers of permanencies compared to the baseline year of calendar 2016 are being tracked to demonstrate progress or the lack thereof so that prompt corrective action can be taken. Results are being published in our monthly reports to the BH Experts. Tracking of permanencies will be provided by Immersion Site, Regions and Statewide. Tracking the actual numbers comparing 2016 to 2017 has begun.**
8. **Child well-being indicators have been added to our monthly reports using the CANS and E-Health systems beginning in this January update. For January only Immersion Site data is looked at but it will be expanded to the Regions and Statewide in going forward.**
9. **Before doing this we would like to discuss with the Experts exactly which data they see as most valuable and how often they would like it tracked. Well-being data will be progressively enhanced until the full CWAC Well Being matrix is incorporated in March. *A change was made to use the***

CWAC Well Being Matrix to validate CANS data. This process is scheduled for July. We are using CANS to report on the wellbeing of DCFS children on a continuing basis. Details are in April Overarching Outcomes section.

10. **However, DCFS has much more capacity to provide data to understand and respond to the behavioral, emotional and health care needs of its children and youth and intends to go well beyond the CWAC matrix.**
11. **One of the key issues is the credibility of the CANS data since it reflects caseworker judgements. DCFS has developed an approach to validate the fidelity of the data and review it with the BH Experts. This approach is explained in the Four Month Status Report under April.**
12. **DCFS has produced some excellent baseline data for the well-being of children on a statewide basis. This is included in two documents which are provided entitled "Well Being of Children and Adolescents with Special Health Care Needs in the Child Welfare System" and "DCFS/POS/Congregate Care Teen Outcomes". A brief summary of some of the highlights of these studies is included in section 9 below.**

i. **March and April Implementation Plans Update and Results Achieved**
   i. **Extensive training and coaching in a new model of practice called "FTS" for family centered, trauma informed and strengths based. The FTS implementation details are in the Logic Model and Status Update for FTS:**
      1. ***The FTS training was completed in each of the Immersion Sites with 97.4% participation. The details are included in the outputs section attached. Several of the few non-participants were from Whiteside County where our Immersion Site crosses DCFS regional boundaries. Additional make up sessions will be held to pick up the 12 stragglers.***
      2. ***P315 training which covers the important BH initiatives of family finding, state subsidized guardianship and fictive kin was completed with 100% participation in the Immersion Sites. The details are included in the outputs section below.***
      3. ***Child and Family Team Meeting Training: Paul Vincent's group finished the CFTM training curriculum and transmitted it to DCFS.***
      4. ***As discussed above the Vincent contract for CFTM training and coaching and QSR implementation was awarded on April 10 and initial implementation plans were developed on April 26 involving the Vincent group, the BH Experts and DCFS leadership.***

5. ***The following is a summary plan based on discussions with the Vincent CWG. It is subject to change as the CWG is able to make staff available and as additional lessons are learned in the implementation process.***
6. ***The summary plan forward for CFTM training and coaching is as follows:***
    a. ***May 2017:***
        i. ***Vincent CWG consultants will work with the Immersion Site Directors to analyze local data and to develop one day Leadership Summits for the broader child welfare community in each Immersion Site.***
        ii. ***The CWG will complete their plan to align specific trainers and coaches with each site.***
    b. ***May/June 2017: Leadership Summits to orient the child welfare community to the CFTM concept and process will be held in each Immersion Site.***
    c. ***June/August 2017: The first round of training and coach development will be initiated in each site. 18 supervisors and six coach candidates will be involved in each site for a total of 24 in each site. The training will involve both education and observations. Coaches will learn to first facilitate the CFTM process and then to train and to coach.***
    d. ***August/September 2017: The second round of training and coach development begins.***
    e. ***December 2017: By December the first round of coaches should be ready for designation as Master Coaches which will empower them to create new facilitators and provide the CFTM training.***
    f. ***Master Coaches" will be approved to develop additional cohorts of supervisors both in the current and future immersion sites into "coaches" on average of every 14 weeks per cohort of supervisors.***
    g. ***December 2017: The Model of Supervisory Practice will be targeted to occur within the current immersion sites following the completion of the first cohort of supervisors becoming child and family team meeting "coaches."***
    h. ***The Vincent CWG will work with DCFS to enhance this work plan based on the knowledge gained as Round One is implemented.***

ii. **The FTS training and coaching will be integrated with Paul Vincent's Child Welfare Group's Quality Service Review (QSR) processes to ensure that parental engagement and child and family teams are well established through the training and coaching.**

1. ***The following is a summary plan based on discussions with the Vincent CWG. It is subject to change as the CWG is able to make staff available and as additional lessons are learned in the implementation process.***
2. ***Training is in two-parts: initial and advanced. Prior to participating in an on-site review, reviewers must receive the initial training. At the conclusion of three on-site reviews with an expert CWPPG mentor, the reviewer will participate in an advanced training in preparation for eventually becoming a mentor/trainer of the QSR process.***
3. ***The on-site review consists of:***
    a. ***Case sampling for each review***
    b. ***Identifying case stakeholders for interviews***
    c. ***Scheduling in person interviews***
    d. ***Reviewing the case documentation***
    e. ***Completing the interviews, initially with a mentor, until the time when the mentor determines the reviewer is competent to review independently***
    f. ***Rating the case and completing data entry***
    g. ***Writing the case summary***
    h. ***Debriefing with the supervisor and worker for the case***
4. ***Four dedicated QSR reviewers have been hired and are headquartered in each Immersion site. Their initial training has been completed, as well as the pilot on-site review. Four additional QSR reviewers are tentatively scheduled to begin late Spring/Early Summer. The goal is to have a total of eight qualified QSR reviewers that are able to (a) successfully review independently, (b) mentor new reviewers and (c) ultimately provide training on QSR to build capacity.***
5. ***The data base has been completed and is ready for case rating entry and reporting.***
6. ***Summary Timeline:***
    a. ***May 2017: Revise review instrument from lessons learned during the pilot***
    b. ***May/June2017: Provide refresher training for reviewers who received round one course in January and debriefing among reviewers***
    c. ***June/July 2017:***
        i. ***On-site round review #2 and #3 for current QSR reviewers and debriefing among reviewers***

ii. ***QSR Training for New QSR Reviewers***
iii. ***On site review #1 for New QSR reviewers***

d. ***July/August 2017:***
   i. ***Advanced training for Existing QSR reviewers***
   ii. ***Evaluation of reviewers readiness for independent reviews.***
   iii. ***First Quarterly presentation of QSR aggregated findings and trends***
   iv. ***On site review #2 for new QSR reviewers***

e. ***August/September 2017:***
   i. ***QSR Training for private agency QA staff***
   ii. ***Onsite review #3 for New QSR Reviewers***
   iii. ***Evaluation of New QSR Reviewers for independent reviews***
   iv. ***Existing QSR reviewers mentor four private agency QA staff in their onsite #1 review***
   v. ***Advanced training for New QSR Reviewers***

f. ***September/October 2017: Evaluate progress of reviewers for additional training and/or mentoring***

iii. **Extensive training and coaching for supervisors in the Model of Supervisory Practice (MoSP).** ***Please see i.j. above. MoSP training has been deferred to Winter to better align it with our work to develop supervisors as CFTM coaches.***

iv. **Quality assurance and monitoring to ensure that the new FTS practice model is fully implemented in the Immersion Sites. The implementation details are in the Logic Model and Status Updates for Quality Assurance. The QA process will be integrated with Paul Vincent's Child Welfare Group's QSR process to ensure that parental engagement and child and family teams are fully implemented in the Immersion Sites.** ***Details are outlined in ii. above.***

v. **Development of an intensive and immediately available array of in home evidence supported services for parents, caregivers and children and youth. The service array will include flexible funding so that any services that are needed to achieve permanency can be purchased.**

1. ***Contracts for each of the lead agencies to provide the intensive and immediately available array of in home evidence supported service were awarded in April. Each is based on wrap around principles and has considerable flexible funding so that individualized plans can be developed for each family based on their individualized needs. Each Immersion Site Intensive Array shares these common requirements:***

a. ***Driven by the family participation in the CFTM in defining their own needs and strengths.***
b. ***Availability of services for emergency family and child situations.***
c. ***Services of sufficient intensity to provide safety depending on the level of imminent and/or pending danger.***
d. ***Engagement of the parents and youth in the child and family team meeting process consistent with the QSR principles.***
e. ***Provision and oversight over the delivery of the array of services including access to and linkages with substance abuse, mental health, domestic violence, peer support and anti-poverty services.***
f. ***Use of evidence supported services where ever available.***
g. ***Claiming Medicaid or family insurance as the first payer and using DCFS funds only when these are not available.***
h. ***Providing wrap around services with fidelity to a recognized model consistent with care coordination processes.***
i. ***Making flexible funding readily available when the individualized needs of the family dictate its usage.***

2. ***Lead agency performance incentives***
   a. ***If the lead agency can demonstrated success in 80% of its cases and an actual increase in numbers of families and children achieving permanency in the immersion site, and an actual increase in the number of youth stepped down from residential care in the immersion site the lead agency will be eligible for an incentive bonus.***
   b. ***The bonus shall be $1000 for each family reunification, family preservation, adoption or guardianship which is successfully maintained for six months.***
3. ***United Methodist Children's Home is the lead agency in the Mount Vernon Site, Lessie Bates Davis is the lead agency in East St. Louis, Bethany is the lead agency in the Rock Island Judicial Circuit, and NiCASA is the lead agency in Lake County.***

vi. **To create additional funding flexibility in providing the immediately available intensive array of in home evidence based services DCFS has secured Title IV-E waiver authority to use funds that were formerly restricted to out of home care to provide that array of in**

home services. ***As cited above the federal Department of Health and Human Services awarded the IV-E Waiver to DCFS in January. The waiver allows DCFS to use funds that were formerly solely for residential and foster care and related case management and use it for providing intensive in home wrap around services. The immediate benefit of the Waiver was an additional 13 million in federal funds which would have otherwise not been received by DCFS due to a declining residential population. This enhances DCFS's capacity to provide the intensive array of services as described above and other family supportive services which enable reunification and family preservation. The required IV-E Waiver Plan was submitted to the federal government in April.***

vii. **Improving the case flow and day to day operational process by changing rules, policies, practices and operational procedures which have proven to be ineffective or redundant, and which hinder achieving permanency outcomes for children and youth.** ***The results are discussed above and examples are re-summarized below:***

1. **In Mount Vernon an Adoption Lab with DCFS adoption leaders working directly in one location with private agency adoption workers to complete paperwork avoids the back and forth that is taking months and completes the process in a couple of days. DCFS has several hundred adoption and guardianship subsidies in backlog due to overly complex, redundant and unresponsive processes*****. Due to its success this project has been expanded statewide where it is one factor which is leading to a significant increase in adoptions.***
2. **Funding authorization for housing support for homeless families has now been delegated to private case management agencies in each Immersion Site.**
3. **In Mount Vernon and East St. Louis multiple forms are being consolidated or eliminated, several of them many pages in length with little value added.**
4. **In Lake County the "percentage of referral opportunities case rotation" assignment of new cases among private agencies has been improved by a team process which places children in the best placement for them and not the next placement on the rotation.**
5. **In Lake further evolution is being planned to share foster homes among foster care agencies and disconnect case management from service provision which would avoid the necessity of changes in case management. This may be coupled with private agency sharing of foster homes and a centralized recruitment program.**

6. **In Mount Vernon phones will be provided for parents who do not have one (quite common) so that they can create an immediate relationship with foster parents when their children are removed and talk to their children in the foster home to provide assurance.**
7. **In Lake County DCFS recruited foster homes will be shared with the private agencies so homes can be more quickly licensed.**
8. **In each Immersion Site new processes are being planned to ensure immediate engagement of parents in a child and family team at the family's first entry into services.**
9. **Waiver of a rule which prevented DCFS and other State employees from becoming DCFS foster parents is being issued.**
10. **In Rock Island all adoptions in process are under review and the Adoption Specialist is going from private agency to private agency to coach and help workers complete the process.**
11. **In Rock Island all 0-6 year old children are being reviewed to ensure expedited reunification or adoption.**

viii. **Making structure changes in the DCFS organization to increase integration and remove further barriers to achieving better outcomes*. The following were discussed above and amplified here:***

1. ***All DCFS components in each Immersion Site including private agency case management programs are working together in each site as a more integrated team and are developing the intensive services array, the process improvements and the decentralized approaches described here. DCFS leaders meet each two weeks with an Immersion Site Child Welfare Advisory Committee to resolve problems and answer questions.***
2. ***Case management monitoring by APT (Agency Performance Team) has been transferred to Regional direction to ensure better integration of public sector and private sector case flow and quality of work. This means that the DCFS regions and the Immersion Sites now have full responsibility for the entire child welfare continuum including both state employees and private agency programs. Program policy and monitoring support for the regions operational efforts has been aligned with the clinical program centrally.***
3. ***Plans have been developed to integrate the Integrated Assessment, Matching Process, CIPP, Regional Clinical and clinical specialists into the local Child and Family Team Meeting process in the Immersion Sites. Clinical staff will be***

engaged in the more complex behavioral and emotional problem cases from the beginning to the end of the life of the case. The goal is to ensure that Integrated Assessment recommendations are fully vetted with parents and children, fully realized in plans that the children and parents own, and fully implemented through the service goals and plans. These new processes will be implemented with the roll out of the Vincent Child and Family Team Meeting training and coaching process. Juvenile Courts and caseworkers rely heavily on the work of the Integrated Assessor which is not a resource generally available in other states so how to best align it with the CFTM needs study. Due to the complexity of fully aligning Integrated Assessment with the CFTM process the Vincent Child Welfare Group has decided to first focus on existing cases to allow further time to study the best way to align the extensive resources of Integrated Assessment with the parental and youth empowerment process of the CFTM process. CIPP will be fully integrated into the CFTM process and the CIPP facilitators will be trained as coaches. Clinical staff will be readily available whenever needed by the CFTM.

4. ***Clinical residential monitoring has begun in the Immersion Sites and in Cook County. Youth at high risk are being identified and referred to the Immersion Site Director to make sure they receive a necessary array of intensive wrap around care.***

ix. **Piloting decentralization of some current central office functions such as matching children with placements (Central Matching), provision of emergency housing funds to families and youth at risk of homelessness, Agency Performance Team which monitors case management, and case opening (Case Assignment and Placement Unit) in order to determine if efficiencies and a more effective case flow can be achieve through local management in the regions and field offices.** ***Matching, case assignment and placement and provision of emergency housing funds for families and youth at risk of homelessness have been decentralized to the Immersion Sites. A process to allow the Immersion Sites to provide emergency cash for housing to keep high risk families and youth in housing has been implemented in each Immersion Site. The placement matching process and the case assignment and opening process have also been implemented in each Immersion Site. As cited above APT has been regionalized.***

x. **Reorganizing the DCFS field office structure around Judicial Circuits to better align its operations with the Juvenile Court.** ***A plan has been developed to align regions and field offices with Judicial***

Circuits and discussions with the Union are required to resolve any local staff reassignments. Once negotiations are finalized implementation will begin in aligning our field offices and regions with the Illinois Judicial Circuit areas in the Immersion Sites. As the Immersion process is completed in each Circuit a DCFS Circuit Administrator will be appointed to provide the key point of leadership in the Circuit to ensure that the gains and results of the Immersion process are maintained and enhanced. Details will be discussed with the experts and plaintiffs by June 30.

xi. *Assessment of Results and Further Implementation of Immersion Sites*

1. *Establishment of the Second Round of Immersion Sites Aligned with the Conversion of the Field Office Structure to Judicial Circuits:*
    a. *The delay in the Vincent Child Welfare Group contract and the planning for Union negotiations for the conversion of our Field Office structure to Judicial Circuits have made it impossible to firmly state with certainty specific dates in which DCFS will move forward into the second and subsequent rounds of Immersion Sites.*
    b. *DCFS' consultations with the Vincent CWG have highlighted the significant length of time needed to train stakeholders, improve child welfare practice in a sustainable way, and develop and sustain the array of intensive home and community-based services youth need.*
    c. *The Department, in collaboration with the Expert Panel and Plaintiffs' counsel will come to a conclusion as to the best path forward by June 30.*
2. *Overarching Outcome Measure Tracking and Analysis: Statewide, Regional and Immersion Site.*
    a. *With the completion of several Mindshare dashboards DCFS is now reporting overarching outcome indicators by state, region and immersion site.*
    b. *In addition DCFS is reporting actual numbers (not percentages or ratios) comparing permanency results for 2016 compared to 2017 by state, region and immersion site.*
    c. *These results are being trended to determine if progress is being made in improving results for safety, permanency and well being.*
    d. *These results and an analysis of the trends are included in both the Immersion Site Outputs and*

Outcomes and also in the Overarching Outcomes section of the BH Four Month Status Report.

3. ***Child Well Being Tracking***
    a. ***Health Care: DCFS has abundant data on the health care of its children and this is included in the Outputs and Outcomes section for both the Immersion Sites and also the Overarching Outcomes sections of the Four Month Status Report.***
    b. ***Emotional and Behavioral Development: The DCFS CANS system which is maintained by Northwestern University provides extensive information on the emotional and behavior development of DCFS children. This data is also included and analyzed in both the Immersion Site and the Overarching Outcomes sections of the Four Month Status Report.***
    c. ***Validation of CANS- CWAC Well Being Committee Implementation Plan: The initial cans is entered by the Integrated Assessor who develops the initial psycho-social assessment of the child and the family. From that point on the CANS is updated each six months by the Case Worker. Since it is updated by the Case Worker the question as to its validity has been raised. DCFS and CWAC worked together to develop and approach to validate the integrity of the CANS data. A work plan to implement this approach has been developed and will be implemented this Summer. Dr. Kim Mann is leading the effort to use the CWAC Well Being Committee's plan to do this validation. This effort will be organized this Spring and implemented in July. Integrated Assessment will provide the validation testing. The details are in the chart below:***

ACTIVITY	RESPONSIBLE	DESCRIPTION	TARGET DATES
Training in New Measures	IA/ Erikson	Statewide Training in the DECA	May 8-9, 2017
Utilization –New Measures	IA	IA incorporates the measures into assessment process	Start: July 5, 2017
Data Management	OITS/ Objective Arts/ NU	Build a database to enter new measures for analysis of well-being data	**Approval:** May 1, 2017 **Completion:** June 15, 2017 **Use:** July 1, 2017
Data Analysis:	JPA/ NU	***Includes the CANS, and all measures that will be in use/ can be accessed for FY '18***	**Plan Complete:** June 15, 2017 **Data Analysis:** 1st & 3rd Quarters of FY '18 **Initial Findings: 3rd Quarter of FY '18**
CANs-Full Use Target -200 Immersion Site Casework Staff	IA/ Harms/ NU	Immersion Sites will receive enhanced implementation support for the optimal use of the CANS in practice-requires 3-months	**Pre-work:** May 1, 2017 **Start:** June 1, 2017 **Completion:** Dec. 2017

d. ***Education: DCFS has educational data on each individual child but it comes in a format which cannot be aggregated and therefore analyzed as a whole. The DCFS Director has written the Illinois State Board of Education and requested that the information be provided in a form that can be analyzed.***

2. **Background:**
   a. **IL DCFS has one of the longest lengths of stays in non-permanent care in the country. The 2010 federal Child and Family Services Review data indicated that Illinois is in 50th place of 50 states for the length of time it takes for a child to achieve permanency. Last place among the states is totally unacceptable for the well-being of Illinois children.**
   b. **DCFS has strong unions and provider networks. Most staff and providers are eager for better outcomes but some resist efforts to change.**
   c. **Neither DCFS nor its provider network has a consistent model of practice that uses the considerable emerging research in trauma care and the ultimate importance of a secure and healthy attachment to a consistent and committed adult.**
   d. **High turnover among POS case workers creates case discontinuities as do ill-conceived organizational processes, rules and procedures.**

e. **Overreliance on residential care and a lack of an array of intensive in home services results in many unnecessary deep end placements with poor results.**
f. **Lack of focus on families and their strengths and little understanding of trauma and attachment leads to children being unnecessarily placed and extensive lengths of stay.**
g. **Both the overly complex processes and non-integrated and highly centralized organization components create multiple barriers to achieving better outcomes.**
h. **The DCFS field and regional offices are not well aligned with the Judicial Circuits leading to less than optimal working alliances with the courts.**

3. **Theory of Change:**
   a. **The Quality Service Review concepts, which we have embedded in our FTS practice model enhancements, has proven to be effective in improving case work practice and outcomes in several states.**
   b. **Considerable evidence supports the effectiveness of intensive evidence based or supported wrap around family based services to resolve problems so that children and youth can live in families who are committed to them for life.**
   c. **Attachment and trauma theory has generated abundant evidence that the safety and security of a permanent home with consistent and committed adult parents or mentors improves self-regulation and executive function and the ability for children and youth to live in families.**
   d. **Case work is negatively impacted by a plethora of unnecessary procedures and by an overly complex and unaccountable organizational structure which if simplified would release considerable energy for improved practice.**
   e. **Since the court is the ultimate permanency decision maker alignment with the Judicial Circuits is critical for a close working alliance.**
4. **Implementation status: *Implementation status is included under the planned goals and milestone above in the Plan section.***
5. **Outputs and Outcomes are provided in the Outputs and Outcomes section attached. They are provided both for the Immersion Sites and also for the DCFS Regions and Statewide. Since the Outcomes are statewide this section will also be included for the Overarching Outcomes.**

EXHIBIT D

FOUR-MONTH STATUS REPORT TEMPLATE

Project Name: Therapeutic Foster Care Pilots

Report Period: February, March, April 2017

May 1, 2017

I. Summary

Summarize the progress that has been made in meeting the Revised Targets/Goals reproduced below from the latest Triannual Interim Status Report (submitted May 1, 2017).

Youth Outreach Services (YOS) was identified to replace CHASI. The Department executed a contract with Youth Outreach Services (YOS) on March 1, 2017 to implement the Therapeutic Foster Care Oregon Model (TFCO). The target population are dually involved youth ages 12-17 in Cook and Northern Regions. YOS has agreed to also accept youth that are dually involved. The eligibility criteria that youth must meet to participate in the pilot will be consistent with the Departments Therapeutic Foster Care pilot. The agency has a total of 4 therapeutic foster homes. The therapeutic foster parents were already licensed with YOS and are now trained in therapeutic foster care and ready to take youth.

During the month of March the Department referred 4 youth to the YOS program. YOS interviewed 2 youth (1 youth in Detention, 1 youth stepping down from residential) and are coordinating the Child and Family Team Meetings for both to discuss admission, services and transition. YOS is currently coordinating interviews with the remaining 2 youth. All youth scored a 5 on the CASII instrument. YOS has accepted two youth into their program. For the month of April, 2 more youth have been referred to the YOS program. These are only recent referrals and they are currently reviewing informational packets. According to the agencies tracking information they have one home that is in the process of renewing their license and one foster home that is in the process of becoming license. YOS had one female youth the age of 16 placed in a TFC home.

YOS is also participating in the Pay for Success pilot. The YOS therapeutic foster homes will be filled on a first come first served basis between the Department therapeutic foster care pilot and the Pay for Success pilot.

During the month of February the Department referred 2 youth to Jewish Child and Family Services for placement in a therapeutic foster home. One youth, placed in the shelter and the second youth stepping down from residential treatment. Both youth scored a 5 on the CASII. JCFS accepted the youth in the shelter into the program however the youth decided to be placed in a home with another agency.

JCFS accepted the youth stepping down from residential treatment. Staff at JCFS participated in a treatment team meeting at the residential facility where a plan was developed to transition the youth into the therapeutic foster home. The model requires the foster parent to participate in 7 different trainings over a 14 week period after the youth is placed in the home. This model also requires pre-placement visits, 1 day visit and 2 overnight visits. The youth and foster parent participated in 1 day visit and 3 overnight visits prior to placement. The youth was placed on 03-13-2017 in the JCFS therapeutic foster home. A JCFS treatment team member will check in on the foster parent daily to reinforce techniques learned in training and to make sure that the foster parent and youth are working well together. AS of April, JCFS has not developed any additional foster homes for the

TFC pilot program. According to their tracking documents, the agency currently has 2 homes in the licensure/ certification process. The age of the one female youth placed is 15 .

Lutheran Social Services of Illinois (LSSI) trained a total of 20 families in the Therapeutic Foster Care Oregon Model during the month of February. After the training, LSSI ruled out 4 families because they felt that based on the training they were no longer appropriate. LSSI identified 10 families/ homes that would be ready to accept youth by April 30, 2017. During the month of March the Department referred 4 youth to the LSSI program. Of the four youth, 1 was denied because LSSI did not have a home that would take the youth. The other youth was accepted by a different agency. LSSI is reviewing the information for the other youth to determine which foster homes that would be most appropriate. As of April LSSI had a total of 13 referrals from the department. They have recently accepted 2 referrals. One placement of a youth is scheduled to take place on Friday April 28, 2017. The youth that is scheduled to be placed on 4/28/17 10 year old male. The second youth that has been accepted and is awaiting placement is a 12 year old female. LSSI has reported 25 families in the process of being licensed.

During the month of February, CHASI was asked to develop a model of Therapeutic Foster Care utilizing relative homes. CHASI's original proposal that was accepted by the Department included the utilization of relative homes, to strengthen and train relatives in crisis intervention and de-escalation techniques to care for challenging relative youth with the goal of achieving permanency in that home. During the assessment and planning phase of the pilot, in consultation with the BH Expert it was decided that therapeutic foster homes should be traditional homes only. Despite this change CHASI continued participation in the pilot. However, CHASI continued to push back on this decision. They requested to place a youth in a fictive kin home with the intention of working with the fictive kin to achieve permanency in the therapeutic foster home. CHASI's ideology as well as definition of therapeutic foster care, were not aligned with the Department's pilot. As a result CHASI was asked to develop relative therapeutic foster homes. CHASI will no longer participate in the pilot. However the Department will monitor the program at some measure (that measure has been decided to date).

II. Revised Targets / Goals

The agencies have asked DCFS to extend the initial development contracts, and DCFS expects to do so for a limited additional period. DCFS has sent service contracts to the three agencies; two of the agencies have executed those contracts and the third agency signed and submitted the service contract to DCFS on March 31, 2017. The service contracts will extend until the end of Fiscal Year 2017.

The revised timeline for the TFC pilot is to have a minimum of 40 children and youth in licensed TFC homes by April 1, 2018 and to have placement of a minimum of 100 children and youth by April 1, 2019, with at least 60% of the youth served in the age group of 12 and older.
DCFS will continue to monitor closely the progress of the three agencies to recruit and certify TFC foster homes so that DCFS can meet the deadlines set forth in the Implementation Plan.

DCFS will take the steps necessary to ensure that TFC services are developed by these or other providers or programs. If DCFS determines it will not be able to meet the targeted number of 40 TFC placements by the estimated April 1, 2018 date, DCFS, in consultation with the Expert Panel

and Plaintiffs' counsel, will revise the TFC placement goals for this pilot and will explore alternative options, with these or other providers or programs, for development of TFC homes in the targeted areas.

III. Problem Formulation

Provide brief descriptions of the problem(s) and program(s) that is/are being implemented to address the problem(s). Include a brief description of the comparison group or benchmarks against which comparisons will be made, e.g. control group, historical cohort, neighboring counties, or target goals.

Identifying youth between the ages of 6-14 in the correct legal county with a score of 5 on the CASII for the LSSI program has been difficult.

The Therapeutic Foster Care pilot partnered with the TRPMI pilot to identify youth. Both pilots require that a CASII instrument be completed to determine level of care. Instead of competing for the limited resources of the Department both pilots decided to partner to step youth down from residential into therapeutic foster homes, specialized or adolescent foster care. The TRPMI pilot needs homes for youth that are ready for step down, which the therapeutic foster care pilot can provide and the therapeutic foster care pilot needs the CASII to be completed to determine eligibility.

The TRPMI pilot developed a list of youth in residential treatment on phase II ready for step down that require a CASII instrument be completed. Many of the youth on the list did not meet the county or age criteria for the homes currently available for the therapeutic foster care pilot. In the month of April it was agreed upon to also look at the youth on phase I. This would allow us to examine youth and increase the pool of potential candidates for the TFC pilot.

I requested additional resources from the clinical division to complete the CASII instrument. I have been working with Central Matching to identify youth for the pilot. We have decided to target youth between the ages of 6-14 who have been in residential treatment for 30-60 days on Phase I for completion of the CASII. In addition we will be taking a look at youth that have been targeted to move from one residential facility to another (lateral move). Central Matching has also reviewed youth who are in the hospital beyond medical necessity and youth who have been recommended for TFC through the CIPP and other staffing processes.

There has also been discussion regarding accepting a lower CASII score as the criteria. The therapeutic foster care pilot was designed to provide youth with an alternative to restrictive residential treatment. If we accept a lower CASII score the comparison group would no longer be Youth in residential vs. Youth in therapeutic foster care, because a CASII score lower than 5 does not meet the criteria for residential. As a result we have decided to move forward with the plan to target youth between the ages of 6-14 who have been in residential treatment for 30-60 days on Phase I and youth that have been targeted to move from one residential facility to another (lateral move). This conversation will be revisited in the future should it prove necessary.

The Department has identified 3 youth on Phase I in residential treatment.

IV. Program Outputs

Use the table below to report data on the relevant amounts of program outputs, e.g. number of children, families, foster homes, offices, that are expected to be reached or delivered by the program. The numbers and percentages should identify the counts and proportions that received the intended

program content (reach), the amounts of program content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation).The specific Outputs listed should match those detailed in the Logic Model.

Include comparable data on outputs against which comparisons will be made using the reference group identified above under Problem Formulation. Under the "Significance and Explanation of Difference," briefly describe whether the differences are trending in the expected or opposite direction.

Since program outputs are related to TFC implementation and fidelity monitoring, there is none to report in the "Comparison" column.

Program Outputs ***(per Outputs in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Significance and Explanation of Difference***
# of youth referred to TFC	Total: 23 • CHASI: 1 • JCFS: 3 • LSSI: 13 • YOS: 6	N/A	
# of TFC youth with completed CASII for TFC referral	Total: 100% • CHASI: 1 • JCFS: 3 • LSSI: 13 • YOS: 6	N/A	
# of youth accepted in TFC	Total: 5	N/A	
# of youth placed in TFC	Total: 2	N/A	
# of TFC inquiries	Total: 124 • CHASI: 17 • JCFS: 28 • LSSI: 78 • YOS: 1	N/A	
# of TFC licensed homes	Total: 40 • CHASI: 0 • JCFS: 3 • LSSI: 33 • YOS: 4	N/A	
# of TFC homes completed TFC training	Total: 36 • CHASI: 0 • JCFS: 3 • LSSI: 36 • YOS: 0	N/A	
# of TFC certified homes	Total: 14 • CHASI: 0	N/A	

Program Outputs ***(per Outputs in Logic Model)***	***Program*** ***(%, N)***	***Comparison*** ***(%, N)***	***Significance and Explanation of Difference***
	• JCFS: 3 • LSSI: 7 • YOS: 4		
# of filled TFC homes (and reasons)	Total: 1 • CHASI: 0 • JCFS: 50% • LSSI: 20% • YOS: 25%	N/A	
% of TFC certified homes retention	None to report	N/A	
Duration of TFC homes' availability to accept youth	None to report	N/A	
% of TFC parent check-in (daily/weekly/other methods) completed	None to report	N/A	
# of CFTM per TFC youth	None to report	N/A	
% of TFC youth receiving family therapy and trauma-informed therapy	None to report	N/A	
% of TFC youth completing/dropping out of (and reasons) family therapy and trauma-informed therapy	None to report	N/A	
# of placement moves	None to report	N/A	
% TFC youth with biological family involvement in CFTM	None to report	N/A	
% TFC youth with discharge parent resources (TBD) developed	None to report	N/A	
% TFC program fidelity – developer or DCFS-specific (TBD)	None to report	N/A	
% TFC fidelity – FFTA Core Standards	None to report	N/A	

V. Proximal and Distal Outcomes

Use the table provided below to report progress in attaining the proximal and distal outcomes (if available at the time of the report). The Outcomes listed should match those detailed in the Logic Model. In the "Explanation of Status," briefly describe whether the differences in the outcomes, which were intended to result from the intervention, are in alignment with expectations.
Since TFC referral began in February 2017, there are no proximal/distal outcomes to report.

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
Proximal Outcomes (TFC vs. Residential)			
P01: Caseworker perception of foster parent/ permanent parent engagement	None to report	None to report	
P02: Youth perception of meaningful adult connections	None to report	None to report	
Distal Outcomes (TFC vs. Residential)			
D01: # of runaways, detentions, and hospitalizations	None to report	None to report	
D02: # of runaway days, detention days, and hospitalization days per placement (TFC/residential) day	None to report	None to report	
D03: % permanency achieved, by type	None to report	None to report	
D04: Time until permanency (after decision to place/not place in TFC)	None to report	None to report	
D05: Functioning and trauma	None to report	None to report	
Unintended Consequences			
U01: TFC becomes integrated into IL continuum of care as an alternative to residential care and a pathway towards youth permanency	None to report	None to report	
U02: Decreased number of youth placed in residential care statewide	None to report	None to report	

VI. Theory of Change Revisions

Discuss any modifications of the theory of change about why a program or intervention is expected to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

VII. Overall Assessment

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

The Department executed 2 service contracts, the third agency signed and returned their contract to the Department on March 31st which is an accomplishment. The Department can begin to refer youth, agencies can accept and place youth in therapeutic foster homes.
The placement of one youth in the JCFS foster home in March was a significant accomplishment for the TFC pilot. This step down placement has provided significant insight. Residential facilities view pre-placement visits between the youth and foster parent as necessary and standard protocol. The JCFS model includes pre-placement visits but the TFCO model does not include pre-placement visits. This may be prove to be an issue. We have to continue to educate the residential providers about the various models. In addition, according to the residential transition protocol the residential treatment center continues to provide treatment, which may interfere with the models. In this case it was decided that the residential treatment team would not continue treatment but would work with JCFS to transition the treatment to JCFS.

The addition of Youth Outreach Services and their 4 trained therapeutic foster homes has significantly increased the total number of available therapeutic foster homes which allowed the Department to begin referring youth sooner. YOS has one youth placed.

The Department developed a SharePoint to begin tracking outputs such as youth referred, denied and accepted into the pilot. These are output that are included on the logic model. In addition, the Department developed a recruitment tracking spreadsheet that the agencies submit the 1st and 15th of the month to track and monitor progress with recruitment. The Department and Chapin Hall are working with the agencies to develop systems for tracking the additional outputs. The Department is also establishing weekly calls with JCFS, YOS, and LSSI to discuss referrals, status updates, potential homes, and any other concerns. Time frames have also been discussed for when a referral is made to an agency, how long the agency has to make a determination on that particular referral.

The overall challenge has been recruitment of appropriate therapeutic foster homes and the unrealistic timeframes given to do so. It has proven to be a significant challenge to find foster parents that are willing to take youth with such high needs. Historically, the Department/POS has prioritized placement with relatives. We seek relative placement before all else. We have spent significant resources licensing relatives and very little time and resources in foster parent recruitment. This has created the systemic issue of a lack of traditional foster homes and placements in the community for youth, which has led to youth remaining in residential for longer than needed. The therapeutic foster care pilot was developed to determine if it is a viable alternative to residential treatment. But I think the systemic need for homes has and will continue to impact this pilot.

EXHIBIT E

FOUR-MONTH STATUS REPORT TEMPLATE
Project Name: Care Management Entity Pilot

I. Summary

Summarize the progress that has been made in meeting the Revised Targets/Goals reproduced below from the latest Triannual Interim Status Report (submitted February 17, 2017).

The meeting between DCFS Administration and the CME Administration on 02-24-17 provided the opportunity for frank dialogue regarding the CME performance. It is clear the CME exhibits strong performance points involving the use of the child and family team as the venue to produce change in a family system; high fidelity wraparound to address the unique needs of children; and Mobile Crisis Response (MCR) to reduce hospitalization of youth for psychiatric reasons. During the February meeting, it was agreed that Choices would implement a 12-hour response time to follow up with youth who had been deflected from hospitalization.

The new Project Manager and Project Supervisor conducted teleconferences with Choices Administration on 03-30-17; 04-11-17; and 04-14-17. These teleconferences focused on program plan requirements, practice updates, and renewed discussion of performance expectations. A meeting to bring together DCFS Administration, POS Administration, and Choices Administration was held on 04-19-17. Discussion topics included role clarification, decision-making in child and family teams, and addressing emergent cases in a timely manner. A case discussion was led by the Project Manager; issues connected to alert and critical ACR feedbacks were also discussed.

In addition to introducing Lynda Petrick (APT Supervisor) as a champion of the pilot, the Project Manager is also connecting Deborah Keen, Behavioral Health Specialist, to the pilot. She has experience in casework practice, supervision, guiding child and family teams and clinical practice. She will serve as an additional quality control guide for the pilot.

Renewed Focus on Stepdown Placements: The collaborative discussion with the Therapeutic Residential Performance Management Initiative (TRPMI) did occur on 03-13-17 and TRPMI work has begun. On 03-29-17, contact was initiated by the TRPMI team for those Choices youth placed in RTCs within the TRPMI coverage area. Three of the youth were staffed using the communication protocol, which is being piloted by TRPMI, on 04-06-17 and 04-07-17.

Court Outreach: The Project Manager, Supervisor, Regional Administrator, and regional APT supervisor met with Judge DeArmond of Vermilion County on 04-17-17 to discuss the CME pilot's role in child welfare cases, and any challenges or successes that have been observed with youth who are enrolled with the CME. The Judge offered positive feedback regarding the work he has seen in his courtroom involving both the CME and child welfare professionals. Work continues in order to proceed with similar court meetings in Champaign, Ford, and Iroquois counties.

Pilot Status: DCFS Administration determined the Choices model will remain in pilot status as the final data analysis has not been completed and will not be done until after the new fiscal year starts. In light of the State's movement to managed care in FY 19, it is unclear if Choices would be the CME providing services. It is logical to maintain the work in pilot status and implement practice revisions to prepare for managed care.

Program Plan Revision: The CME has experienced drift from the original program plan, specifically as it pertains to aftercare services, disenrollment (discharge) expectations, and outcome data. As we complete the FY18 contract and program plan for the CME, these revisions will be added.

II. Revised Targets / Goals

Addressing Barriers to Success: The new Project Manager and Supervisor requested assistance from DCFS Associate Director Pete Digre to clarify expectations about supporting the CME pilot with DCFS state level and regional administrative staff. The DCFS Associate Director as well as other state level DCFS Leadership were able to have a meeting with the CME, on 02-24-17, to explore barriers and supports that the CME needed to address. Some of these things included poor step down rates for youth in congregate care settings, data reporting, plateaued growth of the Provider Network, and the strained relationships between the CME and other local community agencies who often work with DCFS and youth with behavioral health needs. Lynda Petrick, Agency Performance Team Supervisor, was identified as the regional support for the CME pilot and will be one of the champions of the pilot. The DCFS administration stated that a clear message would be sent to POS and DCFS permanency teams regarding collaboration with the CME on creative placement resources for youth in care. The meeting provided a space where the CME pilot administration could express concerns regarding systemic challenges that they are experiencing and get direction from the DCFS Administrators about what has worked in other areas with similar challenges. Some of the challenges that were reported were the lack of permanency worker buy-in to the CFTM model, lack of foster homes to step youth down to or place instead of a higher level of care, instances of non-consensus that delay the team in moving forward with tasks and interventions for the youth, to name a few. The CME stated that they were successful with community integration and would implement those strategies in the CME pilot area. The DCFS Administrators also made their expectations of the CME pilot very clear as it pertained to improving outcomes around permanency as a whole. The CME has expressed some ideas about the way in which they can re-allocate resources to the home and community settings to better meet the unique needs of the youth and families that they serve.

Renewed Focus on Step-Down Placements and Barriers: As part of the efforts identified above regarding resource development, a renewed focus will be placed on youth enrolled in the CME who are placed in residential treatment facilities and need a step down placement. There have been approximately 40 youth in residential care for more than 12 months and 14 of them overlap between the CME and the Therapeutic Residential Performance Management Initiative (TRPMI) to move youth out of residential into more home and community based settings. Through this collaboration, additional supports will be available to Child and Family Teams to address the barriers they are experiencing with moving youth out of residential care. The youth will be prioritized based on disagreements about clinical preparedness for step down, lack of step down placement resources or if the youth's CFT is in non-consensus around level of service intensity or service provision. Moving forward, additional support will be given to the CME by the TRPMI BH Initiative to address some of the specific barriers by completing clinical reviews on youth who have roadblocks or challenges around clinical preparedness for discharge or the lack of a placement resource. For teams that appear to be in non-consensus about what needs to happen with a youth, the CME project manager will complete a non-consensus review to give definitive direction around what the team should be working on next. The non-consensus review process, for service intensity and type of service, will now have the same time frame expectations. The prior program plans reflected different time frames, but these have been brought into alignment. The CME/child welfare supervisory conference and the final decision by Clinical Administration (if the supervisory discussion does not resolve the conflict) will be completed within 10 work days. It is intended that the child's sense of time will be honored and service conflicts resolved as quickly as possible.

Pursuing Step-Down Placements: The CME needs to follow through on "selling" the supports that can be offered to caregivers when youth are stepping out of congregate care. This includes addressing reluctance or concern about caring for a youth with elevated needs. Often CME and child welfare efforts will cease when a caregiver expresses hesitation agreeing to accept a placement. A dialogue must occur and the caregiver asked specifically what framework needs to be established in order to care for the youth, day and night. Caregivers who have declined should be revisited and asked these questions as well.

Court Outreach: The goal of meeting with Judge DeArmond in Vermilion County was met. During the meeting on 04-17-17, the judge provided positive feedback regarding the performance of the CME and child welfare staff. Additional efforts are being made to engage the court systems in Champaign, Ford, and Iroquois counties as well.

Transition from Pilot Status: During the next reporting period, the Department, along with pilot staff, will develop plans for continuing the services (e.g., contract renewals, new contracts), along with targets and timeframes to accomplish practice revisions based upon lessons learned in the first 2 ½ years of the pilot.

It has been determined by DCFS that the CME will remain a pilot for the next fiscal year. The contract renewal for this particular CME provider has taken place but it only covers FY 18. There is some uncertainty about who will be the provider for the CME at the beginning of FY19.

CME Evaluation: The target date for full evaluation completion of the CME pilot remains in September 2017. In order to consistently check progress, the benchmarks that have been set for many of the expected outcomes of the CME pilot that directly specify permanency achievement and placement stability and will be reported monthly while the other benchmarks will be reported on a quarterly basis.

Program Plan Revision: Program plan changes will include updating processes that have been difficult to interpret or follow due to systemic barriers or protocols currently in place. For example, youth who transition to TLP or ILO living arrangements will no longer be considered "successful disenrollments". Instead, they will remain enrolled for at least 9 months post-placement to ensure stability. After discharge, these youth will also be given the ability to re-refer themselves for care coordination should they struggle in any life domain that creates a challenge for functioning independently. Other examples of changes in the program plan include aftercare services that the CME historically has not been able to provide due to lack of consent; a shifting away from duplicative tasks between the care coordinator and the caseworker, and maintaining youth in the CME until permanency is achieved and DCFS is no longer the guardian (i.e., not discharging a youth based upon presumptive stability or permanency). It is expected that as further review of the program plan occurs, there will be additional areas that will be revised.

Health Care: The priority of reaching health care benchmarks for youth in care appeared to have diminished for the CME, but there is now greater emphasis placed on meeting these benchmarks and addressing deficiencies.

Monthly Data Reports: The CME provides monthly, quarterly, and yearly reports. Because these reports do not always plainly show rates of step down and stability (despite efforts of the Project Manager and Supervisor to address the situation), linkage with a representative of the DCFS Quality Enhancement team has been requested. The goal is to demonstrate for Choices data collection staff how to best organize the information collected by the CME.

III. Problem Formulation

Provide brief descriptions of the problem(s) and program(s) that is/are being implemented to address the problem(s). Include a brief description of the comparison group or benchmarks against which comparisons will be made, e.g. control group, historical cohort, neighboring counties, or target goals.

The CME pilot continues to work on building more creative supports and services to encourage permanency for children in family care settings as well as youth stepping down from congregate care settings. The Project Manager and Supervisor are working specifically with Choices to guide them regarding expectations for effectively wrapping a youth with intense behavioral health needs and traumatic responses. This addresses their difficulty using residential placements as short term stabilization resources as well as stepping down from a congregate care setting into a community/home based setting. The goal is to be able to provide interventions for the highest-needs youth in the area and create an 80% stabilization rate for those in traditional foster care and specialized foster care. Additionally, there is to be an increase in congregate care step downs - 15% within 6 months of enrollment and 15% within 7-12 months of enrollment.

IV. Program Outputs

Use the table below to report data on the relevant amounts of program outputs, e.g. number of children, families, foster homes, offices, that are expected to be reached or delivered by the program. The numbers and percentages should identify the counts and proportions that received the intended program content (reach), the amounts of program content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation).The specific Outputs listed should match those detailed in the Logic Model.

Include comparable data on outputs against which comparisons will be made using the reference group identified above under Problem Formulation. Under the "Significance and Explanation of Difference," briefly describe whether the differences are trending in the expected or opposite direction.

Program Outputs ***(per Outputs in Logic Model)***	***Program*** ***(%, N)***	***Comparison*** ***(%, N)***	***Significance and Explanation of Difference***
Youth served this month	From January through March 2017, 209 youth were served, including 50 new referrals and 62 discharged youth.		Youth served ranged from -6% ages 0 to 5, - 27% ages 6 to 11, -30% ages 12 to 15, -23% ages 16 to 17, -13% ages 18 to 21.
Reduce percentage of psychiatric hospitalization for enrolled youth	MCR Data: -January 2017 shows that 4 youth in care enrolled in the CME were screened and of	~50%	

	the 4, 3 were hospitalized for a 75% rate of hospitalization for that month. -February shows 8 youth in care enrolled in the CME were screened a total of 11 times, with 2 of those screening resulting in a hospitalization, for a rate of 18.2%. -March 2017 shows 6 youth in care enrolled in the CME were screened a total of 8 screenings in the month of March 2017. None of those screenings resulted in hospitalizations		

V. Proximal and Distal Outcomes

Use the table provided below to report progress in attaining the proximal and distal outcomes (if available at the time of the report). The Outcomes listed should match those detailed in the Logic Model. In the "Explanation of Status," briefly describe whether the differences in the outcomes, which were intended to result from the intervention, are in alignment with expectations.

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
# of youth who achieved permanency	Reunification with Biological Parent: n=17 Adoption: n=1 Subsidized Guardianship: n=4		To Date- Reunification: 38 Adoption: 5 Subsidized Guardianship: 5

What percent of children have stepped down from congregate care to a less restrictive setting within 6 months and within 7-12 months of their enrollments	During this reporting period, 1% (1 youth) stepped down from a congregate care setting within 6 months; 7% (5) youth stepped down within 7-12 months	1-6 months of enrollment= 15% 7-12 months of enrollment= an additional 15%	In this reporting period, there were a total of 68 youth in a congregate care setting, most of which had no movement.
80% of enrolled foster children in traditional foster care, home of relative, or fictive kin placements will remain stable (i.e., in their current placement) for at least 12 months from their date of enrollment (unless permanency is achieved sooner)	In this reporting period 85 youth were placed in a traditional foster home, home of relative, or fictive kin placement. N= 13 (15%) remained stable or achieved a path to a permanent home for at least 12 months.	Goal is 80%	27 (32%) youth have been stable in their placement for 7-11 months. 20 (24%) youth have been stable in their placement for 4-6 months. 16 (19%) youth have been in the same placement for 1-3 months. 9 (11%) youth were in placements for less than 30 days.
80% of enrolled foster children in specialized foster care will remain stable, (i.e., in their current placement) for at least 12 months from their date of enrollment (unless they are moved to a less restrictive placement or permanency is achieved sooner).	During this reporting period 27 youth were placed in specialized foster care. N=7 (26%) youth remained stable for at least 12 months.	Goal is 80%	7 (26%) youth have been stable in their placement for 7-11 months. 8 (30%) youth have been stable in their placement for 4-6 months. 3 (11%) youth have been stable in their placement for 1-3 months. 2 (7%) youth has been placed in a specialized foster home for less than 30 days.

VI. Theory of Change Revisions

Discuss any modifications of the theory of change about why a program or intervention is expected to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

The review of the CME pilot, through examination of case management as well as discussions with CME administration and child welfare providers, shows there is a need for clarification of expectations for specific performance areas. For example, if communication and decision-making surrounding C/FT non-consensus for youth in congregate care is spelled out and a solution developed to resolve conflict about the decision, then the youth will be able to move from that care level more quickly.

Within the System of Care principles and high fidelity wraparound, there is significant power given to the Child and Family Team to make important decisions regarding the treatment approaches and supports that a youth and family receive. It is not suggested that any one person on the team holds more power than the other. However, as this has been implemented within the CME pilot, there are circumstances where one team member can delay planning just by disagreeing with issues such as where a youth should be placed, or when a youth is prepared to move out of a congregate care setting. It has been determined that there has to be one authority figure who is able to "break the tie" or make a final decision. The Project Manager will be this authority is executed. For example, if most of a Child and Family Team are in consensus about reducing a youth's level of care, but one team member is not, then the Project Manager will be responsible for deciding the level of care for the youth and will provide direction to the team so that the planning can move forward. Similarly, the TRPMI team will also serve as a conduit for addressing Child and Family Team non-consensus in a residential setting in order to prevent delay in decision making (and ensure there is actually an active team).

A successful CME framework is dependent upon collaboration between the CME and child welfare providers. When collaboration is fractured, there can be delays in service delivery and permanency. Therefore, if steps are taken to repair these fractures through open discussion and learning from past practice (positive and negative), then service interventions should improve. This is being addressed through enhanced investment of DCFS staff in the collaboration process and consistent, guided meetings to bring out barriers that might previously have remained tacit but impacted how families were served.

VII. Overall Assessment

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

There are six key areas where program changes or modifications have been initiated this quarter. These areas include: improving the working relationships between the CME and child welfare staff through organized meeting times, guided discussion, and case analysis; clarifying roles and who has responsibility for final decision-making; addressing challenges to the step down of youth in congregate care by utilizing the communication protocol within the TRPMI pilot; narrowing the non-consensus process time frames (making it shorter) to address service type and intensity issues; reinforcing program plan guidelines for pilot enrollment to the point of legal permanency for children (and extending pilot involvement for youth who have moved to ILO/TLP) as well as following through on after-care expectations; creating a 12-hour clinical response post-hospital deflection.

Creating positive working relationships between the CME pilot provider and the extended community is also a priority and will be a focus for the next quarter. In particular, developing a true stakeholder group outside of child welfare is integral to the "community embedding" identified as a

necessity for the CME work to move forward. Foster caregivers, school systems, law enforcement, businesses, and other providers in the area are to be invited to the able to discuss care for children. The meeting held on 04-19-17 was a much needed step forward to unify family service partners, but the next step is needed. In order to improve practice efficacy and enhance critical thinking of team members, specific cases managed by DCFS and private agencies have been and will continue to be used as examples of what the CME/child welfare agency collaborative process should look like. The addition of the APT Supervisor (Lynda Petrick) and Behavioral Health Specialist (Deborah Keen) as part of the Department's management plan for the CME affords more immediate address of conflict, an opportunity to observe the C/FT process in real time, and expedient feedback regarding performance.

The CME will host a child welfare stakeholders' meeting at least once a month, where DCFS, POS and Choices administrations can come together to transparently discuss any challenges experienced in the pilot and collectively work to address these challenges in an urgent and effective manner. A success of this pilot remains the Mobile Crisis Response, which has essentially maintained the psychiatric hospitalization rate below 50% for youth enrolled in the pilot. This is supported by the 12-hour crisis support by the CME. Researchers are now linked to the pilot and are able to address the data analysis requested by the Department. They will examine not only the overarching measures attached to the BH plan, but also longitudinal stability of children post-discharge from the Choices program.

Efforts of the CME to clearly show the community and caregivers what the wraparound process can offer, and adapting/negotiating care plans for children who require some level of complex care, need to be the standard and not the exception. This is the core strength of the CME and the Choices pilot group will be brought back to this point.

EXHIBIT F

January 2017

	Non-Choices Enrolled DCFS Youth	Choices Enrolled DCFS Youth	TOTAL
Number of Unique Youth	13	4	17
Hospitalizations	8	3	11
Crisis Screenings	15	4	19
Hosp Rate	53.3%	75.0%	57.9%

Recidivism			
	Non-Choices Enrolled DCFS Youth	Choices Enrolled DCFS Youth	TOTAL
Number of Youth with Recidivism	2	0	2
Total Number of Hospitalizations	0	0	0
Total Number of Screenings	5	0	5
Hosp Rate	0.0%	0.0%	0.0%

February 2017

	Non-Choices Enrolled DCFS Youth	Choices Enrolled DCFS Youth	TOTAL
Number of Unique Youth	8	8	16
Hospitalizations	4	2	6
Crisis Screenings	13	11	24
Hosp Rate	30.8%	18.2%	25.0%

Recidivism			
	Non-Choices Enrolled DCFS Youth	Choices Enrolled DCFS Youth	TOTAL
Number of Youth with Recidivism	3	5	8
Total Number of Hospitalizations	4	2	6
Total Number of Screenings	6	10	16
Hosp Rate	66.7%	20.0%	37.5%

March 2017

	Non-Choices Enrolled DCFS Youth	Choices Enrolled DCFS Youth	TOTAL
Number of Unique Youth	11	6	17
Hospitalizations	7	0	7
Crisis Screenings	12	8	20
Hosp Rate	58.3%	0.0%	35.0%

Recidivism			
	Non-Choices Enrolled DCFS Youth	Choices Enrolled DCFS Youth	TOTAL
Number of Youth with Recidivism	3	3	6
Total Number of Hospitalizations	3	2	5
Total Number of Screenings	7	8	15
Hosp Rate	42.9%	25.0%	33.3%

EXHIBIT G

FOUR-MONTH STATUS REPORT SUMMARY

Project Name: Regenerations Pilot Project for Dually-Involved Youth at Cook County Juvenile Detention Center

The purpose of this four-month status report is to provide a comprehensive update to internal and external stakeholders invested in reducing the number of youth in care that are detained at the Cook County Juvenile Temporary Detention Center (JTDC), particularly youth that are detained beyond their scheduled released date. The Regenerations Pilot Project is designed to address this identified problem through a collaborative effort with the JTDC, Cook County Juvenile Probation, Lutheran Child and Family Services (LCFS), Youth Advocate Programs (YAP), and the University of Illinois at Chicago (UIC), using a Wraparound philosophy to provide traditional mental health services, care coordination (e.g., Wraparound, the service), and other home and community based services.

A. From July 1, 2015 (e.g., Pilot inception) through March 24, 2017 (e.g., end of the current reporting period), 69 youth have participated in the Pilot.
    1. Of these 69 youth, 54 were admitted to the Pilot in FY16 and 15 were admitted to the Pilot in FY17.
    2. Of the 54 youth admitted to the Pilot in FY16, 3 were discharged in FY16, 5 were discharged in FY17, and 46 are still enrolled as of 3/24/17.
    3. Of the 15 youth admitted to the Pilot in FY17, 2 were discharged in FY17 and 13 are still enrolled as of 3/24/17.

B. Of the 69 youth who have been served by the Pilot since its inception, 66 youth were served for at least some part of FY17 (e.g., the 69 youth ever served minus the 3 youth admitted to and discharged from the Pilot in FY16).

C. The current 4-month status report will provide information about this group of 66 youth.
    1. Output reporting will be based on fidelity data entered into SharePoint or SACWIS on or after 7/1/16.
    2. Outcome reporting will be based on data entered into SharePoint or contained in CYCIS on or after a youth's date of entry to the Pilot.

D. The pilot had some challenges with timely and accurate data entry during the first year of implementation. Now, the pilot has captured historical data going back to the inception of the program.

E. 12 pre/post placement outputs, 4 proximal outcome, and 2 distal outcome metrics are reported in the current four-month status report.

F. The Regenerations Pilot Project incorporated bi-monthly case review meetings to address any barriers to achieving placement stability with challenging RUR cases. This is in addition to monthly Regeneration Implementation Team meetings that focus on progress towards achieving logical model outputs and outcomes. There are two outputs that evaluate parent/ sibling/ and child visits that will be merged into one metric. The two metrics evaluated pre and post placement visits. It would be more efficient to tally overall visits. This is the same for evaluating metrics related to pre and post provisions for the use of flex funds

G. The intensive care coordination effort between the case management and advocacy support appears to prove to have an impact on the safety, stability, and well-being of youth within the pilot project. 2 youth lives were saved due to the efforts of responding swiftly to circumstances that would have led to harmful outcomes immediate if collaboration on these cases did not occur. 39 of the 66 youth have been matched with family or family-like settings. 22 of the 39 youth had 2 or less moves since being placed.

H. There is still much work to be done in order to evaluate recidivism rates and decrease juvenile justice involved youth within DCFS care.

EXHIBIT H

DCFS Regenerations RUR/Pilot Logic Model 4-28-2017

Plan

The Regenerations/RUR Pilot will work with new and existing DCFS wards, 12-18 years old, who are detained at the JTDC and on the RUR list or who are released directly from the JTDC to shelter care

Regenerations RUR/Pilot

vs.

Service as Usual (Historical Comparison Group)

Implementation

Pre- and post-placement implementation coordinated and provided by CIPP, LCFS, and YAP

Wraparound philosophy (WP)

Wraparound services:

- Traditional mental health services (MH)
- Care coordination (CC)
- Flex funds (FF)
- Other home and community based services (CB)

Ongoing data collection on fidelity to Wraparound philosophy and Wraparound services

Outputs

Pre-Placement

1. Completion of CASII (CC)

Post-Placement

2. Level of adherence to Wraparound philosophy based on WFI-EZ (WP)
3. Timely submission of Individualized Service Plan (ISP) (CC)
4. Completion of SDQ for ISP and YCS (CC)
5. Per ISP, provision of:
   - ◊ In-home supports (CC)
   - ◊ Access to educational and recreational activities (CB)
   - ◊ Crisis intervention and its coordination (CC)
   - ◊ Placement stabilization services (CC)
6. CFT meetings and CFT composition (CC)
7. Frequency of CASII following placement (CC)
8. Ave. # of hours advocates spend with youth (CC)
9. Ave. # of supported/non-supported work hours (CC)
10. Enrollment in school (CB)

Throughout Pilot

11. Provision of flex funds when appropriate (FF)
12. Ave. # of parent/child/sibling visits (CB)

Outcomes

Proximal

1. Fewer days in JTDC after mandatory release date
2. More discharges to, days in, and in family or family-like setting
3. Fewer placement moves
4. Fewer discharges to and days in residential care

Distal

1. Improved youth well-being
2. Improved family connections
3. Improved youth school and work engagement
4. Reduced youth recidivism

Unintended Consequences

1. Overall decrease in juvenile justice involvement among DCFS youth in care

Background

- Societal (e.g., poverty, racism)
- Family (e.g., lack of resources, lack of involvement)
- Child (e.g., mental illness, school problems)

Theory of Change

Youth in JTDC are at-risk for being detained beyond their release date, discharged to residential care when residential care is not necessary, and staying in residential care longer than necessary. In the context of a Wraparound philosophy and the CMCS and SAMHSA (2013) informational bulletin, federal projects have demonstrated that in addition to traditional mental health services, youth outcomes are improved by also providing 1) Intensive care coordination (often called Wraparound service planning/facilitation), 2) Family and youth peer support services, 3) Intensive in-home services, 4) Respite care, 5) Mobile crisis response and stabilization, 6) Flex funds, and 7) Other home and community based services.

End-Values

The goal of the regenerations pilot/theory of change will be to improve conditions for youth in terms of well-being, school and work engagement, and increase the likelihood that they will remain in stable family-like settings and not return to the juvenile justice system.

EXHIBIT I

FOUR-MONTH STATUS REPORT

Project Name: Illinois Pay for Success Pilot for Dually-Involved Youth

Date submitted: 4/30/2017

I. Summary

During the fundraising period, past four months, they have 25 youth in their treatment group covering Cook, Lake, Franklin and Jefferson Counties. They have requested and been granted an extension to the fund raising period until July 2017. We expect by mid-May to know the status of the fund raising which will determine when they will re-open their referral pathways.

II. Revised Targets / Goals

The Conscience Community Network LLC (CCN) is in the midst of a fundraising period and has set a goal of raising $17 million by July 2017. Those funds are intended to cover the projected cost of the pilot for four years of treatment (through March 2021) and three years of evaluation. CCN will not enroll any more than 25 youth in Cook, Lake, Franklin and Jefferson counties until after the fundraising deadline has passed.

If CCN's fundraising goal is not met, DCFS will consider entering into appropriate contracts to continue serving youth already receiving services as part of the pilot. The Department will also consider renegotiating the contract during the next reporting period. CCN is a network among some of the state's largest providers, and DCFS recognizes that the formation of a provider network with which it could contract for needed services has potential as a model for the Department to bring together key providers under a single contract to provide specific services, or services for small, but targeted populations (e.g., youth with sexually aggressive behaviors, youth involved in human trafficking, parenting teens, dually-diagnosed youth, youth on the autism spectrum).

On the assumption that work with CCN will continue in some form, DCFS and CCN will continue to work to address the problems identified in the ramp up phase regarding communication issues and referral pathways. CCN played an integral part of identifying concerns in our UIR (unusual incident report) and as a result the Department has revamped the entire reporting system. CCN has developed a protocol tool for their management to reach out to management of the agency with case management responsibility to work together in the pilot and rectify the communication issues.

III. Problem Formulation

They have a control group that has been established through a randomizer and will be evaluated by the U of Michigan.
Securing the funding continues to be a challenge and has recently been given support from DCFS administration and the governor's office in their fund raising presentations.

IV. Program Outputs

Since we are in the fund raising period (started in January 2017) minimal outputs can be recorded. As stated early the project has given the Department feedback on systems issues, created their own database, established clear written protocols, established and communicate throughout our system the referral pathways and with the Department have an Executive and Operations Committees developed to govern the project.

Program Outputs ***(per Outputs in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Significance and Explanation of Difference***
Youth receiving wraparound	All 25 youth		
Program Output 2			

V. Proximal and Distal Outcomes

Use the table provided below to report progress in attaining the proximal and distal outcomes (if available at the time of the report). The Outcomes listed should match those detailed in the Logic Model. In the "Explanation of Status," briefly describe whether the differences in the outcomes, which were intended to result from the intervention, are in alignment with expectations.

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
Proximal Outcome 1			
Proximal Outcome 2			
Distal Outcome 1			
Distal Outcome 2			
Etc.			

VI. Theory of Change Revisions

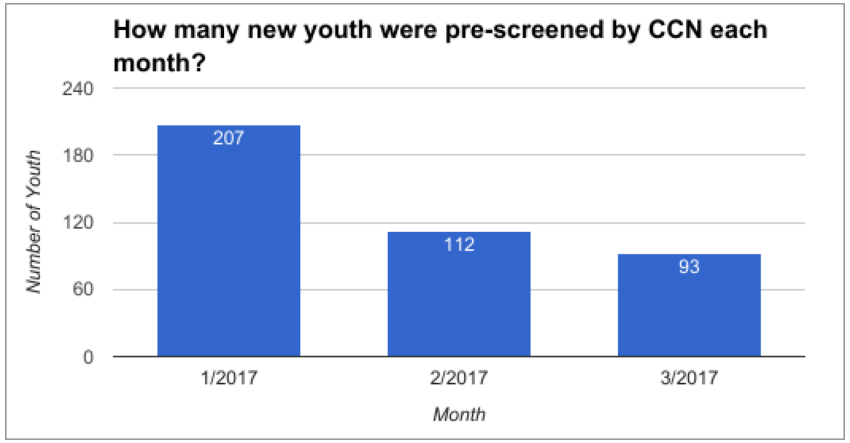
No revisions to theory of change

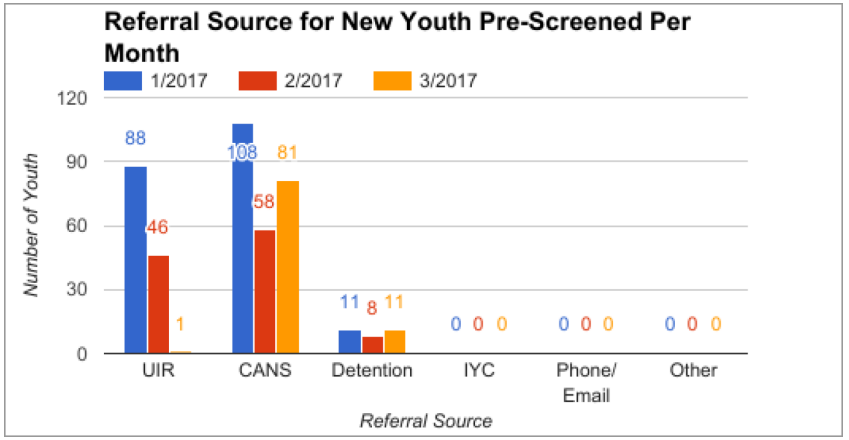
VII. Overall Assessment

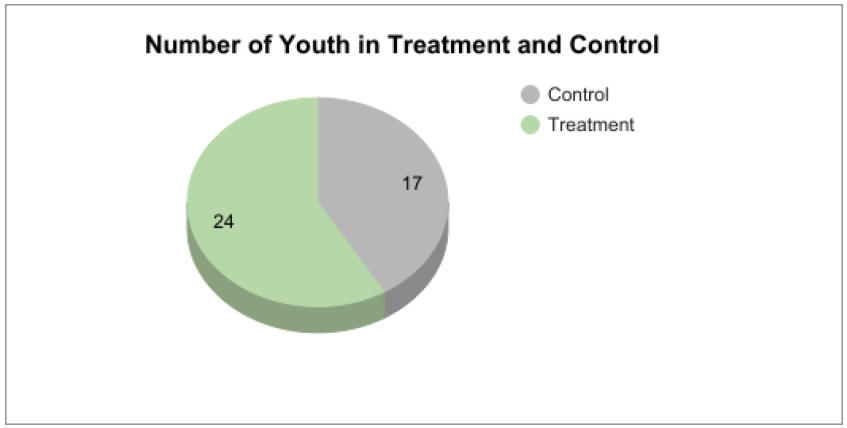
Stepped down three youth from residential during their ramp up phase and have establish clear systems for all referral pathways. PFS gave critical feedback to DCFS to help us improve our UIR system.

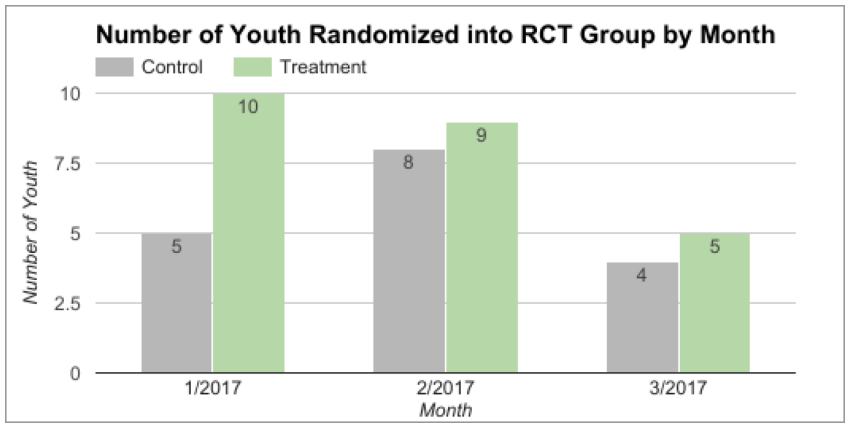
EXHIBIT J

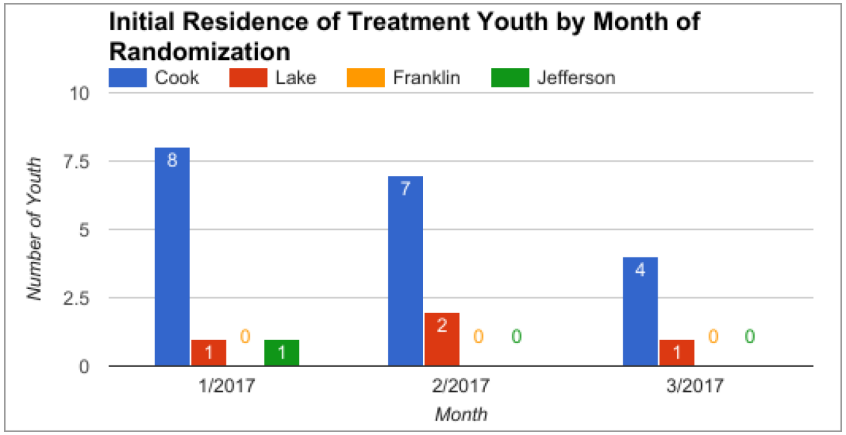
CCN Intake Dashboard (includes data through 3/31/17)











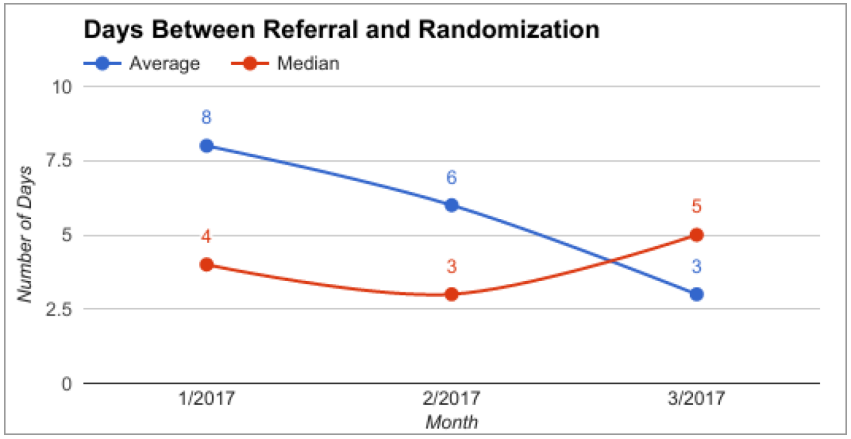


EXHIBIT K

Outputs and Overarching Outcomes: State, Regions, and Immersion Sites

May 1, 2017

1. **Permanency improved in February and March. The details are on pages 29-35. Some of the highlights are:**
    a. **Statewide total permanency is up from 973 in the first quarter of calendar 2016 to 1030 in calendar 2017. This is being driven by large increases in February and March.**
    b. **Adoptions were lagging but shot way up in March bringing the first quarter of calendar 2017 total to 335 as compared to 299 the first quarter of 2016.**
    c. **Every region showed some improvement as did each of the immersion sites except Rock Island which is going to need special attention.**
2. **Pages three through five demonstrate:**
    a. **That the immersion sites have completed their FTS and 315 training as expected (page three).**
    b. **That statewide we do OK with family visitation, about one visit per 30 days, but we do much better in the immersion sites with 2-3 visits average in 30 days. I will get regional breakouts in the future.**
3. **Pages 6-15 have the classical CFSR indicators. These are 12 month entry cohorts so progress emerges slowly. The problem with the CFSR indicators is both that they are slow to reveal progress and that they do not recognize a good deal of the permanency results. For example if a child is reunified or adopted after 37 months the permanency indicators which are 12, 24 and 36 month cohorts would not pick that child up as a success. This is why we also track the total actual numbers (pages 29-35). In summary:**
    a. **Abuse in foster care is trending down a little (good) (page 6).**
    b. **Permanency within 12, 24 and 36 months is trending down a bit with no progress evident (not good) (page 7-13). I am hopeful that the actual increased numbers off February and March will begin to reverse this trend in future 12 month entry cohorts as discussed above.**
    c. **Placement stability has improved (page 14-15).**
4. **Well Being**
    a. **Health:**
        i. **Simply stated we do OK in getting regular yearly full EPSDT checkups for children under two (90.2%) and not to bad up to age five (86.6%). After that there is a decline with, for example, 6-12 year olds only getting their annual checkups 79% of the time and 13-21 year olds only getting annual checkups 65% of the time (pages 16-20).**
        ii. **Annual dental checkups have similar results to medical checkups.**
        iii. **We have rewritten all of the contract program plans to focus on this more strongly and APT has added this to their POS review protocols.**

b. **Development: CANS has outstanding data and the highlights are analyzed on pages 21-24. High points include:**
    i. **Development: We do well with young children but this declines for school age children and adolescents.**
    ii. **Trauma Stress Symptoms: All age groups demonstrate a significant decline in trauma symptoms during their time with DCFS.**
    iii. **Emotional Needs: Improvement at all age levels but greatest for younger children.**
    iv. **Social Functioning: Consistent improvement for all age groups.**
    v. **Strengths: Consistent positive trajectory for all age groups.**
    vi. **We do some good work and with analysis of the potential lessons here could do even better.**
    vii. **The plan for CANS validation is discussed in the Four Month Status Report.**
c. **Education: No aggregable data is available and the Director has written ISBE asking that this be corrected.**

5. **Residential: Charts are included demonstrating the decreases we have achieved in residential care, shelter care and juvenile justice confinement (pages 36-37).**

Training in Rule 315 and FTS:

Total All Immersion Sites	**Manual count as of 3/30**
Total Target Population	219
Total population who have completed P315 training	219/100%
Total population registered for upcoming P315 training	0
Total population not completed or registered	0

Total All Immersion Sites		
Total targeted CLASS ROOM participants	458	
Total participants who have completed FTS CLASS ROOM training	446	97.38%
Total participants registered for upcoming CLASS ROOM training	0	0.00%
Total participants not completed or not registered for CLASS ROOM training	12	2.62%
Total participants scheduled for SELF DIRECTED learning - NON RESIDENTIAL	59	
Total participants completed SELF DIRECTED learning - NON RESIDENTIAL	56	94.92%

Frequency of supervised & unsupervised family visits:

Statewide	
Supervised Visits per 30 Days in Care	0.94
Unsupervised Visits per 30 Days in Care	0.09

East St. Louis	Number of Visits
Supervised Visits	
0	84
1-50	221
51-100	64
101-200	44
201+	14
Visits/30 Days in Care	2.03

Unsupervised	Number of Visits
0	308
1-20	88
21-100	28
100+	3
Visits/30 Days in Care	0.27

Mt. Vernon	Number of Visits
Supervised Visits	
0	44
1-50	153
51-100	74
101-200	52
201+	6
Visits/30 Days in Care	2.82

Unsupervised	Number of Visits
0	248
1-20	60
21-100	20
100+	1
Visits/30 Days in Care	0.19

Lake	Number of Visits
Supervised Visits	
0	59
1-50	168
51-100	55
101-200	49
201+	12
Visits/30 Days in Care	1.81

Unsupervised	Number of Visits
0	269
1-20	46
21-100	25
100+	3
Visits/30 Days in Care	0.16

Rock Island	Number of Visits
Supervised Visits	
0	49
1-50	179
51-100	69
101-200	94
201+	16
Visits/30 Days in Care	3.07

Unsupervised	Number of Visits
0	298
1-20	62
21-100	33
100+	14
Visits/30 Days in Care	0.39

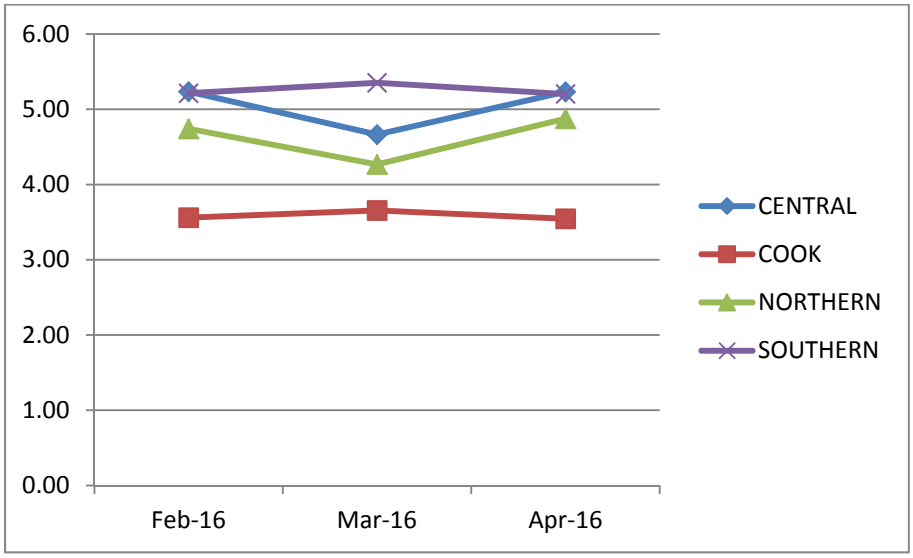
Safety

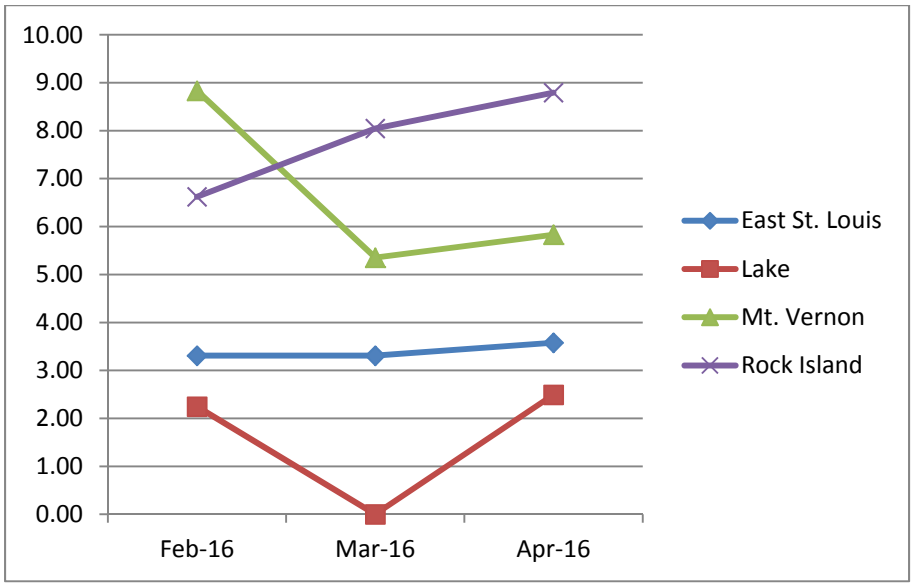
Of all children in foster care during a 12-month period, what is the rate of victimization per 100,000 days of foster care?

Average of Rate Per 100,000 Days	Calendar Year			
Region	2014	2015	2016	Grand Total
CENTRAL	5.64	5.78	4.06	5.16
COOK	3.66	2.29	3.54	3.16
NORTHERN	7.14	5.07	5.19	5.82
SOUTHERN	3.73	7.78	3.34	4.94
Grand Total	**4.95**	**4.69**	**3.99**	**4.55**

Average of Rate Per 100,000 Days	Calendar Year			
Region	2014	2015	2016	Grand Total
East St. Louis	0.54	5.62	1.84	2.62
Lake	4.49	1.21	1.76	2.50
Mt. Vernon	3.07	10.09	6.60	6.69
Rock Island	1.55	6.97	10.58	6.41
Grand Total	**2.32**	**5.98**	**5.28**	**4.54**

Trends for Victimization Cohorts ending in 2017





Permanency and Stability

Permanency in 12 months for children entering foster care: ***Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care?***

Children in the 2015 Cohort represent data followed up until March 2017, the most up-to-date permanency data available.

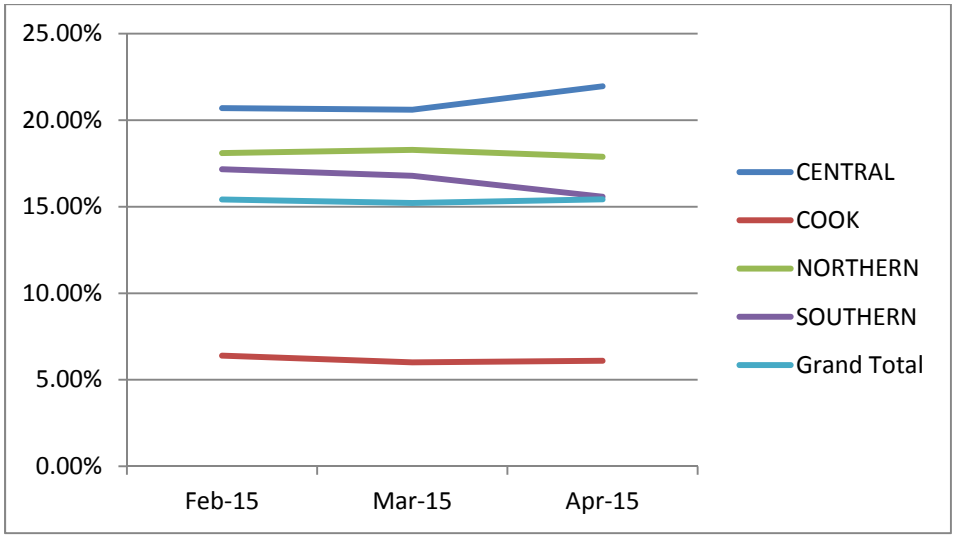
Count of dschW12	Cohort								
	2013*		2013 Total	2014**		2014 Total	2015***		2015Total
Region	N	Y		N	Y		N	Y	
CENTRAL	83.85%	16.15%	100.00%	83.20%	16.80%	100.00%	78.04%	21.96%	100.00%
COOK	94.88%	5.12%	100.00%	91.36%	8.64%	100.00%	93.91%	6.09%	100.00%
NORTHERN	85.40%	14.60%	100.00%	80.85%	19.15%	100.00%	82.12%	17.88%	100.00%
SOUTHERN	79.17%	20.83%	100.00%	76.69%	23.31%	100.00%	84.42%	15.58%	100.00%
Grand Total	**86.19%**	**13.81%**	**100.00%**	**84.02%**	**15.98%**	**100.00%**	**84.58%**	**15.42%**	**100.00%**

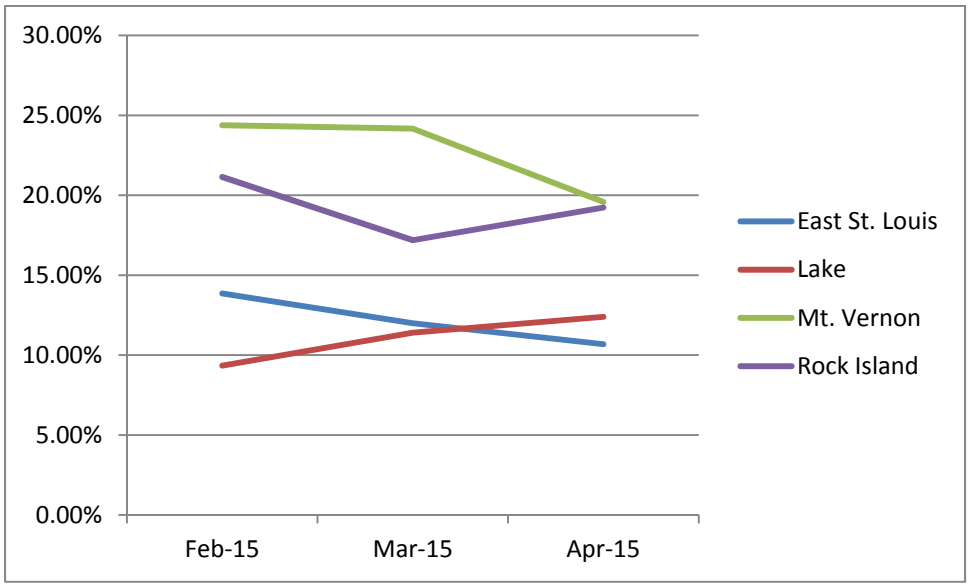
Count of dschW12	Cohort								
	2013*		2013 Total	2014**		2014 Total	2015***		2015* Total
Immersion Site	N	Y		N	Y		N	Y	
East St. Louis	84.85%	15.15%	100.00%	83.33%	16.67%	100.00%	89.32%	10.68%	100.00%
Lake	88.99%	11.01%	100.00%	93.39%	6.61%	100.00%	87.60%	12.40%	100.00%
Mt. Vernon	72.55%	27.45%	100.00%	69.29%	30.71%	100.00%	80.42%	19.58%	100.00%
Rock Island	85.71%	14.29%	100.00%	89.04%	10.96%	100.00%	80.77%	19.23%	100.00%
Grand Total	**82.14%**	**17.86%**	**100.00%**	**83.51%**	**16.49%**	**100.00%**	**84.10%**	**15.90%**	**100.00%**

*Children Entering Care from April 01, 2013 to March 31, 2014
**Children Entering Care from April 01, 2014 to March 31, 2015
***Children Entering Care from April 01, 2015 to March 31, 2016

Trends for permanency in 12 months for cohorts ending in 2017 - Dates indicate the beginning of cohort.

April 2015 data point is identical to above numbers, March and February represent the same data for cohorts beginning one and two months earlier, respectively. This provides a smaller month-over-month trend, compared to year-over-year presented above.





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

Children in the 2016 Cohort represent data followed up until March 2017, the most up-to-date permanency data available. In contrast to the above tables, cohort names represent the *time period of interest* for this table, i.e., the 2016 Cohort represents permanencies achieved between April 2016 and March 2017.

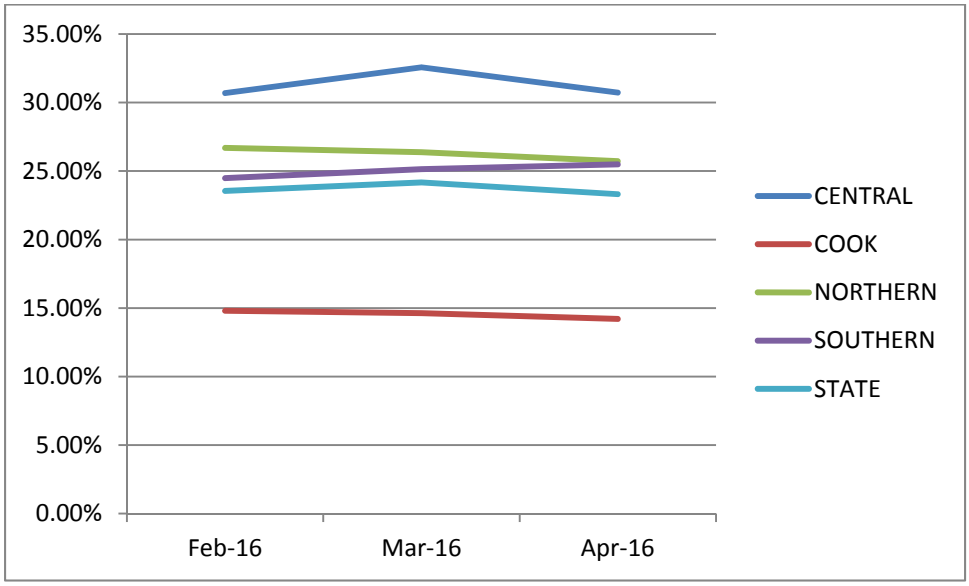
Count of dschW12 for Youth in Care 12-23 Months	Cohorts						
	2015*		2015 Total	2016**		2016 Total	Grand Total
Region	N	Y		N	Y		
CENTRAL	66.47%	33.53%	100.00%	69.28%	30.72%	100.00%	
COOK	85.79%	14.21%	100.00%	85.79%	14.21%	100.00%	
NORTHERN	73.88%	26.12%	100.00%	74.29%	25.71%	100.00%	
SOUTHERN	67.42%	32.58%	100.00%	74.52%	25.48%	100.00%	
Grand Total	**74.12%**	**25.88%**	**100.00%**	**76.69%**	**23.31%**	**100.00%**	

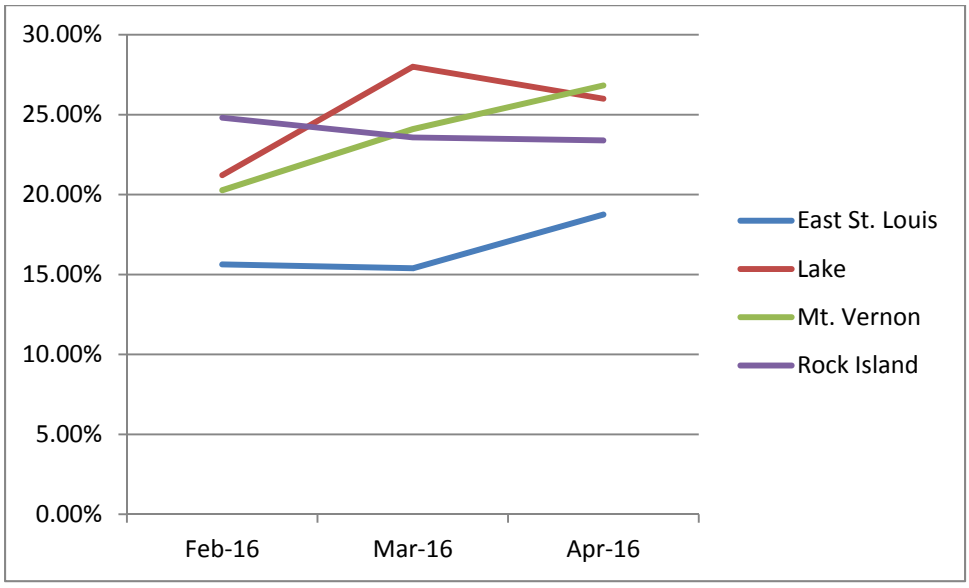
Count of dschW12 for Youth in Care 12-23 Months	Cohorts						
	2015*		2015 Total	2016**		2016 Total	Grand Total
Immersion Site	N	Y		N	Y		
East St. Louis	80.56%	19.44%	100.00%	81.25%	18.75%	100.00%	
Lake	85.14%	14.86%	100.00%	74.00%	26.00%	100.00%	
Mt. Vernon	52.69%	47.31%	100.00%	73.17%	26.83%	100.00%	
Rock Island	68.37%	31.63%	100.00%	76.61%	23.39%	100.00%	
Grand Total	**70.33%**	**29.67%**	**100.00%**	**75.95%**	**24.05%**	**100.00%**	

*Children Active on April 01, 2015 (Entering Care from April 01, 2013 to March 31, 2014)
**Children Active on April 01, 2016 (Entering Care from April 01, 2014 to March 31, 2015)

Trends for permanency in 12-23 months for cohorts ending in 2017

April 2016 data point is identical to above numbers, March and February represent the same data for cohorts beginning one and two months earlier, respectively. This provides a smaller month-over-month trend, compared to year-over-year presented above.





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

Children in the 2016 Cohort represent data followed up until March 2017, the most up-to-date permanency data available. Cohort names represent the time period of interest for this table, i.e., the 2016 Cohort represents permanencies achieved between April 2016 and March 2017.

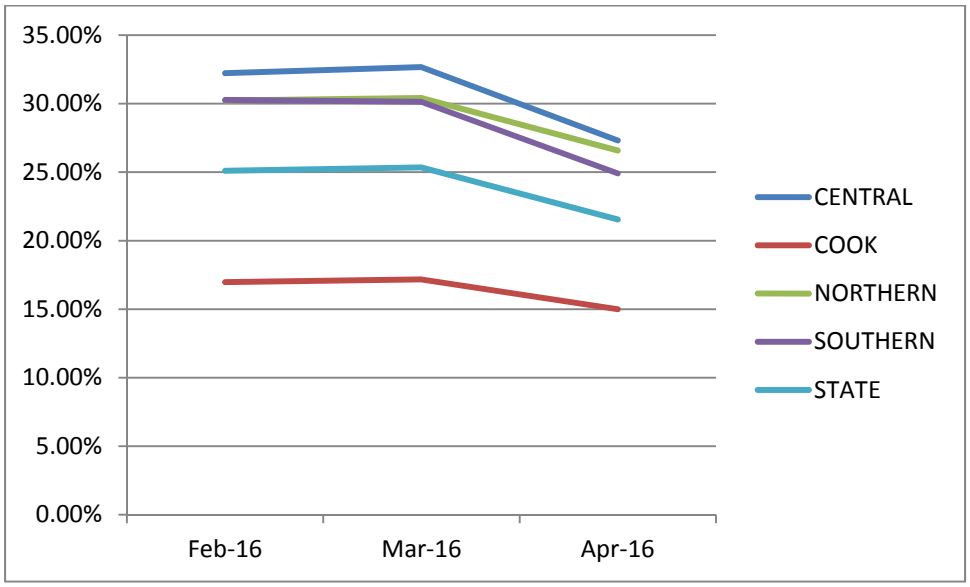
Count of dschW12	Cohorts						Grand Total
	2015*		2015 Total	2016**		2016 Total	
Region	N	Y		N	Y		
CENTRAL	65.99%	34.01%	100.00%	72.68%	27.32%	100.00%	
COOK	83.20%	16.80%	100.00%	85.00%	15.00%	100.00%	
NORTHERN	70.18%	29.82%	100.00%	73.42%	26.58%	100.00%	
SOUTHERN	67.29%	32.71%	100.00%	75.09%	24.91%	100.00%	
Grand Total	**74.24%**	**25.76%**	**100.00%**	**78.45%**	**21.55%**	**100.00%**	

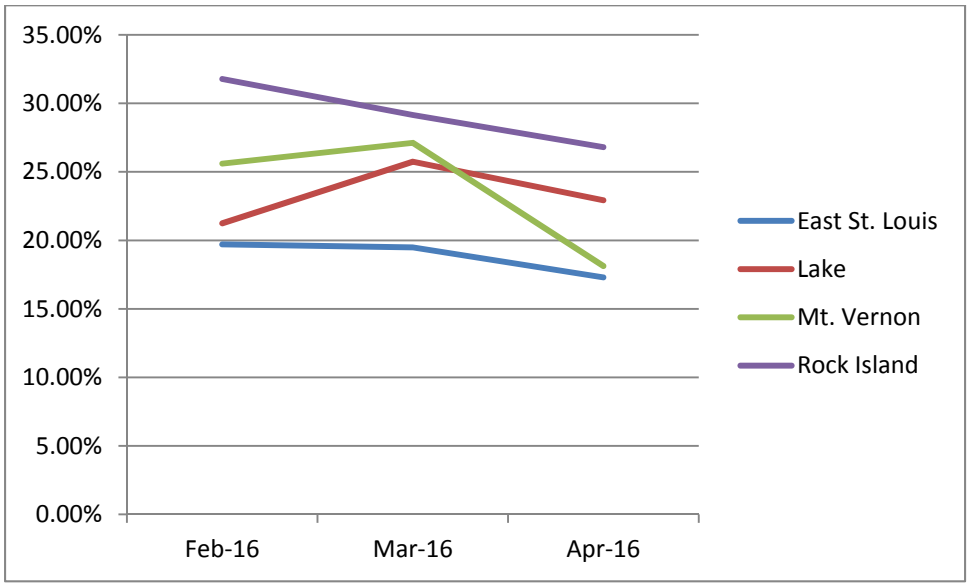
Count of dschW12	Cohorts						Grand Total
	2015*		2015 Total	2016**		2016 Total	
Region	N	Y		N	Y		
East St. Louis	77.30%	22.70%	100.00%	82.71%	17.29%	100.00%	
Lake	77.08%	22.92%	100.00%	77.07%	22.93%	100.00%	
Mt. Vernon	61.67%	38.33%	100.00%	81.88%	18.13%	100.00%	
Rock Island	66.10%	33.90%	100.00%	73.20%	26.80%	100.00%	
Grand Total	**71.33%**	**28.67%**	**100.00%**	**78.23%**	**21.77%**	**100.00%**	

**Children Active on April 01, 2015 (Entering Care before April 01, 2012)*
***Children Active on April 01, 2016 (Entering Care before April 01, 2013)*

Trends for permanency for 24 to 36 months for cohorts ending in 2017

April 2016 data point is identical to above numbers, March and February represent the same data for cohorts beginning one and two months earlier, respectively. This provides a smaller month-over-month trend, compared to year-over-year presented above.





Re-entry to foster care in 12 months: ***Of all children who enter foster care in a 12-month period who discharged within 12 months to reunification, living with a relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?***

Mindshare is currently troubleshooting errors on the page for this measure that prevent reporting for this update.

Placement Stability: ***Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?***

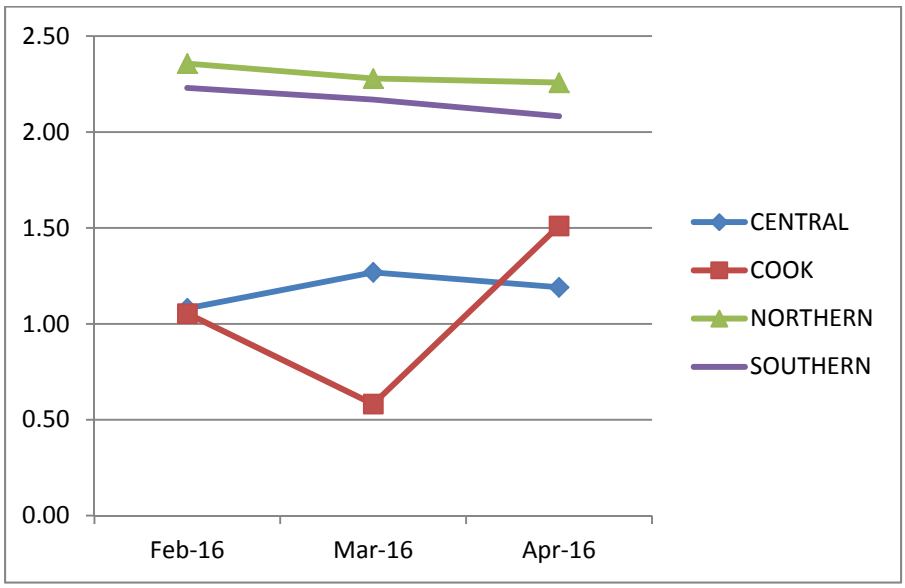
Average Moves/1000 Days in Care	Cohort			
Region	2014*	2015**	2016***	Grand Total
CENTRAL	1.76	1.51	1.41	1.57
COOK	2.43	2.27	1.75	2.21
NORTHERN	2.30	1.99	2.00	2.11
SOUTHERN	2.54	1.76	1.53	1.91
Grand Total	**2.20**	**1.88**	**1.63**	**1.92**

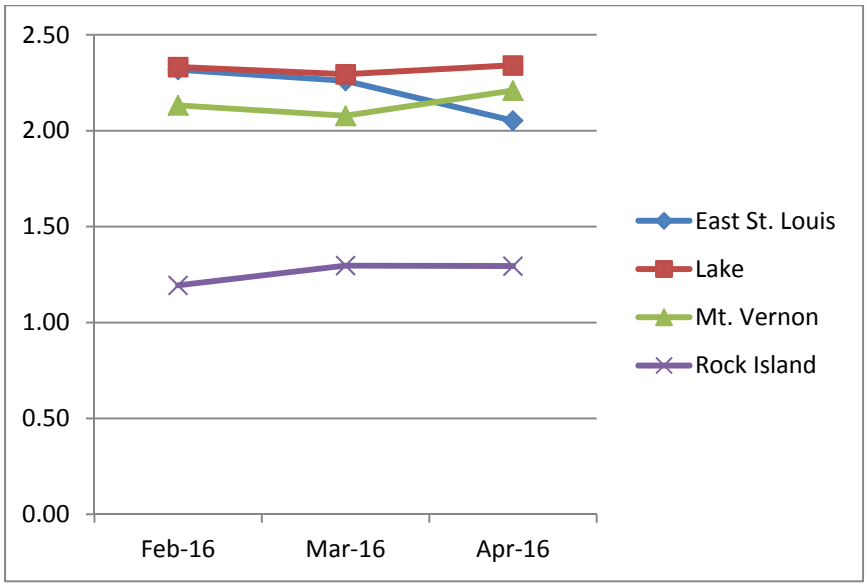
Average Moves/1000 Days in Care	Cohort			
Immersion Site	2014*	2015**	2016***	Grand Total
East St. Louis	2.15	3.02	2.05	2.38
Lake	1.99	2.62	2.34	2.29
Mt. Vernon	2.64	1.58	2.21	2.09
Rock Island	1.73	1.01	1.29	1.37
Grand Total	**2.10**	**2.02**	**1.95**	**2.02**

***Children Entering Care from April 01, 2014 to March 31, 2015**
****Children Entering Care from April 01, 2015 to March 31, 2016**
*****Children Entering Care from April 01, 2016 to March 31, 2017**

Trends for placement stability cohorts ending in 2017

April 2016 data point is identical to above numbers, March and February represent the same data for cohorts beginning one and two months earlier, respectively. This provides a smaller month-over-month trend, compared to year-over-year presented above.





Wellbeing

EPSDT, Dental, and Seasonal Flu Vaccination Compliance

Basic Health Data by Age Breakouts
Statewide Statistical Summary
As Of: 4/24/17

**(Indicates service date of 1/31/2016 or greater)*
***(Indicates flu season immunization date of 08-01-2016 or greater)*

Statewide - Youth in Care - Age Breakouts	Total # Cases	% Yearly EPSDT*	% Yearly Dental Preventive Services*	% Yearly Seasonal Flu Shot **
15mo - 23mo* **	336	90.18%	N/A	**See 6mo-2yo range*
6mo - 2yo* **	1959	**See 15mo-23mo range*	N/A	55.18%
3 - 5yo	3070	86.61%	74.10%	36.52%
6 - 12yo	4809	78.77%	78.85%	32.43%
13 - 21yo	5170	65.24%	68.22%	26.82%

Notes: This report only includes child cases that have been opened for 3 months or longer.

*****EPSDT measure for children under 2 yrs of age: Includes only children currently age 15 months thru 23 months of age who came into care prior to one month of age and have remained in care throughout the reporting period.**

*****Flu measure for children 2 yrs of age and younger: Includes only children who turned 6 months of age prior to the start of the current flu season (August 1st).**

Regions:

Notes: This report only includes child cases that have been opened for 3 months or longer.

*****EPSDT measure for children under 2 yrs of age: Includes only children currently age 15 months thru 23 months of age who came into care prior to one month of age and have remained in care throughout the reporting period.**

*****Flu measure for children 2 yrs of age and younger: Includes only children who turned 6 months of age prior to the start of the current flu season (August 1st).**

Youth in Care - Ages 6mo to 2 years				
Region	Total Youth Ages 15mo - 23mo***	% With 5 or more EPSDT Visits	Total Youth Ages 6mo - 2yo***	% Yearly Seasonal Flu Shot**
Central Region	116	93.97%	606	56.77%
Cook Region	118	83.05%	636	52.83%
Northern Region	58	89.66%	388	55.93%
Southern Region	44	100.00%	329	55.93%
Totals	**336**	**90.18%**	**1959**	**55.18%**

Youth in Care - Ages 3 to 5 years				
Region	Total # Cases	% Yearly EPSDT*	% Yearly Dental Preventive Services*	% Yearly Seasonal Flu Shot**
Central Region	889	86.95%	75.93%	32.09%
Cook Region	1067	84.54%	74.60%	40.94%
Northern Region	530	87.74%	79.62%	35.47%
Southern Region	584	88.87%	65.41%	36.13%
Totals	**3070**	**86.61%**	**74.10%**	**36.52%**

Youth in Care - Ages 6 to 12 years				
Region	Total # Cases	% Yearly EPSDT*	% Yearly Dental Preventive Services*	% Yearly Seasonal Flu Shot**
Central Region	1392	78.45%	79.38%	31.18%
Cook Region	1671	78.46%	76.84%	34.43%
Northern Region	934	80.73%	82.87%	29.76%
Southern Region	812	77.71%	77.46%	33.50%
Totals	**4809**	**78.77%**	**78.85%**	**32.43%**

Youth in Care - Ages 13 to 21 years				
Region	Total # Cases	% Yearly EPSDT*	% Yearly Dental Preventive Services*	% Yearly Seasonal Flu Shot**
Central Region	1221	68.80%	74.04%	29.92%
Cook Region	2370	58.44%	60.93%	24.92%
Northern Region	885	73.11%	78.64%	24.75%
Southern Region	694	72.19%	69.60%	30.57%
Totals	**5170**	**65.24%**	**68.22%**	**26.82%**

Immersion Sites:

Notes: This report only includes child cases that have been opened for 3 months or longer.

*****EPSDT measure for children under 2 yrs of age: Includes only children currently age 15 months thru 23 months of age who came into care prior to one month of age and have remained in care throughout the reporting period.**

*****Flu measure for children 2 yrs of age and younger: Includes only children who turned 6 months of age prior to the start of the current flu season (August 1st).**

Youth in Care - Ages 6mo to 2 years*				
Immersion Site	Total Youth Ages 15mo - 23mo***	% With 5 or more EPSDT Visits	Total Youth Ages 6mo - 2yo***	% Yearly Seasonal Flu Shot**
East St. Louis	3	100.00%	47	68.09%
Lake	6	83.33%	55	61.82%
Mt. Vernon	9	100.00%	43	39.53%
Rock Island	6	100.00%	42	47.62%
Totals	**24**	**95.83%**	**187**	**55.08%**

Youth in Care - Ages 3 to 5 years				
Immersion Site	Total # Cases	% Yearly EPSDT*	% Yearly Dental Preventive Services*	% Yearly Seasonal Flu Shot**
East St. Louis	90	88.89%	74.44%	42.22%
Lake	72	86.11%	76.39%	34.72%
Mt. Vernon	50	90.00%	82.00%	18.00%
Rock Island	78	89.74%	74.36%	32.05%
Totals	**290**	**88.62%**	**76.21%**	**33.45%**

Youth in Care - Ages 6 to 12 years				
Immersion Site	**Total # Cases**	**% Yearly EPSDT***	**% Yearly Dental Preventive Services***	**% Yearly Seasonal Flu Shot****
East St. Louis	125	86.40%	80.00%	46.40%
Lake	123	83.74%	79.67%	24.39%
Mt. Vernon	101	77.23%	78.22%	21.78%
Rock Island	146	85.62%	80.82%	26.03%
Totals	**495**	**83.64%**	**79.80%**	**29.90%**

CANS Wellbeing Measures

Young Child (0 - 5yo) Module Scores At Integrated Assessment and Two Years
All Youth (N = 4,921)
IA dates between July 1, 2009 and November 29, 2016

PROPORTION ACTIONABLE MODULE SCORES				
	Integrated Assessment	Two-Year Follow Up	Percent Change	Significance*
Developmental Needs	7.3	5.5	25.5	0.000
Young Child Developmental Needs	9.1	3.9	56.5	0.000
Physical Health	6.7	3.6	45.9	0.000
Young Child Physical Health	7.6	4.7	37.7	0.000
Young Child Traumatic Stress Symptoms	6.4	1.6	74.6	0.000
Young Child Emotional Strengths	64.9	98.0	50.9	0.000
Young Child Emotional Needs	2.7	1.1	59.6	0.000
Young Child Risk Behaviors	0.5	0.2	53.1	0.000
Young Child Strengths	59.4	64.9	9.3	0.000
Young Child Social Functioning	2.1	1.7	20.6	0.005
Young Child Social Behaviors	1.3	0.7	48.1	0.000
*Paired T-Test.				

Middle-Child (6 - 12yo) Module Scores At Integrated Assessment And Two Years
All Youth (N = 2,145)
IA Dates Between July 1, 2009 and November 29, 2016

PROPORTION ACTIONABLE MODULE SCORES				
	Integrated Assessment	Two-Year Follow Up	Percent Change	Significance*
Developmental Needs	6.2	6.4	3.8	0.660
Mid-Childhood Social Functioning	15.8	7.0	55.5	0.000
Physical Health	4.1	2.4	42.7	0.000
Mid-Childhood Traumatic Stress Symptoms	20.5	8.2	60.2	0.000
Mid-Childhood Emotional Strengths	56.3	88.8	57.8	0.000
Mid-Childhood Emotional Needs	11.6	6.8	41.6	0.000
Mid-Childhood Risk Behaviors	3.9	2.6	33.8	0.000
Mid-Childhood Strengths	58.1	62.5	7.6	0.000
Mid-Childhood Social Functioning	12.2	8.5	30.1	0.000
*Paired T-Test.				

Adolescent (13 - 18yo) Module Scores At Integrated Assessment And Two Years
All Youth (N = 2,078)
IA Dates Between July 1, 2009 and November 29, 2016

PROPORTION ACTIONABLE MODULE SCORES				
	Integrated Assessment	Two-Year Follow Up	Percent Change	Significance*
Developmental Needs	6.3	7.7	22.4	0.992
Adolescent Social Functioning	36.1	23.1	36.1	0.000
Adolescent Physical Health	6.1	4.3	28.8	0.000
Adolescent Traumatic Stress Symptoms	27.8	11.8	57.4	0.000
Adolescent Emotional Strengths	46.0	76.4	66.1	0.000
Adolescent Emotional Needs	22.3	12.1	45.7	0.000
Adolescent Risk Behaviors	15.9	9.0	43.5	0.000
Adolescent Strengths	59.1	60.7	2.9	0.007
Adolescent Social Functioning	23.9	13.2	44.7	0.000
*Paired T-Test.				

Description of Results:

Child and Adolescent Needs and Strengths (CANS) assessments are collected on all youth who come into care. The tool is meant to capture and share a synthesis of multiple sources of information and perspectives into a format that can guide case and service planning, in addition to assisting with critical decision making utilizing change over time data. Completing the CANS in consistent intervals over-time allows for the on-going evaluation of the strengths and needs of the children and caregivers.

The above analyses use the Integrated Assessment CANS, completed by independent screeners at case opening as an initial time point. Any CANS completed near the date marking the completion of a youth's second year in care are used as the second time point. Those assessments are generally completed by caseworkers, outpatient therapists, or Intensive Placement Stabilization (IPS) clinicians serving the case.

Numbers in the first two columns of the table represent the "Percent Actionable Items". Actionable is defined as a '2' or '3' rating on the CANS assessment. The important takeaway of reporting on actionable items, is that an intervention or service is needed to address the item. Which means that components of our child welfare system needs to jump into action to ameliorate the need.

The percentage is a proportion representing the number of youth receiving a CANS assessment who are rated 2 or 3. For example, in the first table, Young Child (0-5), 7.3% of Developmental Needs items are rated as actionable. The difference between the two time points is then compared using a Paired T-Test to calculate the statistical significance of any change.

Using CANS item scores for analysis allows for capturing the "what" of a child's case, not the "why". The "what" is a moment in time assessment of their level of need or strength. As a result, the below conclusions are general inferences that can be taken

about how children in the system do over time receiving support from our child welfare system, as their family members attempt to regain custody of their children. Case-level information about the services received during the time period between IA CANS and the 2 year CANS is unknown in this analysis. However, factors such as service provision, skill level of providers, geography, family visitation, change in placements, and a number of other factors are required in order to understand the "why" of any change found.

Conclusions and Future Directions:

Developmental Needs: Trends across age groups show improvements among Young Children that are not present in Middle-Childhood or Adolescence. Results suggest that Young Children's needs are being identified and addressed more successfully than in Middle-Childhood or Adolescent cases.

> **Future exploration: Non-significant change in older youth suggest that improved identification of problems, improved services, or training in Middle-Childhood and Adolescent development may be effective ways of improving outcomes.**

Physical Health: Needs among Young Children and Middle-Childhood show stronger improvements than in Adolescence. Further analysis can explore whether the difference is statistically significant. All age-groups begin with a similar level of need, suggesting that Adolescent youth can improve as much as the other age groups.

> **Future Exploration: Statistical significance of the difference in change between the three age groups should be explored further. Additionally, the greater autonomy of Adolescents and the effect that has on their physical health should be explored.**

Traumatic Stress Symptoms: All age groups showed statistically significant improvement. Of interest is the trend of higher initial needs as children are older, coupled with decreasing rates of improvement. This is unexpected, as high initial need would suggest more room for improvement among older youth. It is possible that traumatic stress symptoms are more difficult to identify in very young children, and are instead rated under "Temperament"-related items.

> **Future Exploration: Service provision and the impact of the independence of older youth on service provision may explain differences in improvement. Case-level information on services and their trauma lens can inform this question. It is possible that this group of items is also impacted by environmental factors such as placement stability and relationships with caregivers.**

Emotional Needs: This group of items shows the same trend as Traumatic Stress Symptoms, greater improvement among Young Children, despite lower rated needs at Integrated Assessment. Reasons for the trend may be the same.

> **Future Exploration: Similar to Traumatic Stress Symptoms, a case-level understanding of the services, specifically therapy, being provided will inform this trend and present options for improvement. It is possible that this group of items is also impacted by environmental factors such as placement stability and relationships with caregivers.**

Social Functioning Needs: Trends show consistent improvement across age groups despite large differences at Integrated Assessment. Findings suggest services and environmental factors successfully reduce social functioning needs at all ages.

Strengths in the context of this report, and the CANS as a tool are different in their desired directionality of change. The aim is an *increase* in "usable strengths", as opposed to a reduction in actionable needs. Emotional Strengths and Social Functioning Strengths show consistent positive trends in all age groups, suggesting quality services for youth and sufficient training for the field. This is in line with the Department's larger mission of being strengths-based, finding and building the strengths of youth in care rather than focusing exclusively on needs.

It's important to note that the number of actionable adolescent risk behaviors at time of IA CANS are significantly higher than the other age ranges. One of the department's primary objectives is to provide safety for the adolescents we serve. There is a strong reduction of actionable risk behaviors after having been in care for two years. The reduction of actionable risk behaviors suggests that our system of support is having a strong positive impact on these adolescents. It would be interesting to look at the number of UIR's for this cohort and see if the reduction of actionable items aligns with UIR data.

Final thought: This data set speaks to how over time the needs and strengths of children and adolescents change over time with "business as usual." The changes and intentionality of providing quality services within the immersion Sites allows for evaluation over time of those services and how they may positively impact the reduction of needs and enhance the strengths of the children and families we serve.

Current Living Arrangements

Type Living Arrangement	Count of Current Living Arrangement
Armed Service Duty	4
CILA	26
College/University Scholarship	12
Deceased	6
Detention	123
Foster Home Adoption	946
Foster Home Boarding	899
Foster Home Private Agency	2481
Foster Home Specialized	1988
Group Home	159
Home of Adoptive Parent	16
Home of Fictive Kin	642
Home of Parent	771
Home of Relative	5955
Hospital/Healthcare Facility	135
Independent Living Only	336
Inst Rehabil Service	8
Institution DCFS	1
Institution DMH	2
Institution DOC	46
Institution Private	818
Job Training Program	1
Nursing Care Facility	34
Other	13
Private Guardianship Home	1
Transitional Living	385
Unauthorized Home of Parent	30
Unauthorized Placement	110
Unknown Cont Contact	14
Whereabouts Unknown	150
Youth Emergency Shelters	3
Youth in College	97
Grand Total	**16212**

% goal of reunification

Southern

	N	%
Reunification in 5 Months	166	6%
Reunification in 12 Months	1264	49%
Guardianship	82	3%
Adoption	353	14%
Independence	313	12%
Other	420	16%
Total	2598	

Central

	N	%
Reunification in 5 Months	240	5%
Reunification in 12 Months	1735	39%
Guardianship	192	4%
Adoption	837	19%
Independence	561	13%
Other	908	20%
Total	4473	

Cook

	N	%
Reunification in 5 Months	259	4%
Reunification in 12 Months	1718	28%
Guardianship	592	10%
Adoption	783	13%
Independence	1432	24%
Other	1263	21%
Total	6047	

Northern

	N	%
Reunification in 5 Months	131	4%
Reunification in 12 Months	1135	38%
Guardianship	184	6%
Adoption	541	18%
Independence	411	14%
Other	620	21%
Total	3022	

State

	N	%
Reunification in 5 Months	796	5%
Reunification in 12 Months	5852	36%
Guardianship	1050	7%
Adoption	2494	15%
Independence	2717	17%
Other*	3230	20%
Total	16139	

* A larger number of youth than previous updates do not have a goal listed in Mindshare, this is being explored

East St. Louis

	N	%
Reunification in 5 Months	74	17%
Reunification in 12 Months	166	38%
Guardianship	10	2%
Adoption	49	11%
Independence	84	19%
Other	56	13%
Total	439	

Mt. Vernon

	N	%
Reunification in 5 Months	17	5%
Reunification in 12 Months	153	48%
Guardianship	23	7%
Adoption	27	8%
Independence	42	13%
Other	59	18%
Total	321	

Lake

	N	%
Reunification in 5 Months	17	5%
Reunification in 12 Months	151	42%
Guardianship	20	6%
Adoption	35	10%
Independence	55	15%
Other	84	23%
Total	362	

Rock Island

	N	%
Reunification in 5 Months	12	3%
Reunification in 12 Months	190	46%
Guardianship	21	5%
Adoption	51	12%
Independence	54	13%
Other	82	20%
Total	410	

Permanency Achievement by Type and Month Comparing Baseline 2016 with 2017

There was a increase in permanency achievement in February and March and in the first quarter of 2017 compared to 2016, from 973 to 1030. This was true statewide, in each of the regions and in three of the four Immersion Sites.

Total Exits Statewide

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	26	38	100	79	132	136	61	47	6	6	325	306
Feb	14	34	92	99	113	157	58	49	8	9	285	348
Mar	31	25	97	157	166	138	61	49	8	7	363	376
Apr	24		98		142		59		3		326	
May	23		122		213		61		3		422	
Jun	49		187		168		57		6		467	
Jul	21		80		161		60		4		326	
Aug	24		139		199		43		11		416	
Sep	35		154		181		57		8		435	
Oct	34		118		128		52		1		333	
Nov	27		173		123		47		4		374	
Dec	41		161		146		45		5		398	
Total	349	**97**	1,521	**335**	1,872	**431**	661	**145**	67	**22**	**4,470**	**1,030**
Percent	8%		34%		42%		15%		1%			

East St. Louis

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	1	0	4	2	0	2	0	2	0	0	5	6
Feb	0	0	1	1	1	9	3	1	0	0	5	11
Mar	0	0	1	0	1	6	2	1	1	0	5	7
Apr	1		3		1		2		0		7	
May	0		0		4		3		0		7	
Jun	0		5		3		2		0		10	
Jul	0		1		1		2		0		4	
Aug	0		6		1		1		0		8	
Sep	0		6		1		0		0		7	
Oct	3		0		3		0		0		6	
Nov	0		6		0		0		0		6	
Dec	0		4		1		3		0		8	
Total	5	**0**	37	**3**	17	**17**	18	**4**	1	**0**	**78**	**24**
Percent	6%		47%		22%		23%		1%			

Lake

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	1	0	4	2	3	1	1	0	0	0	9	3
Feb	0	10	4	5	1	2	0	0	0	0	5	17
Mar	0	0	2	2	0	3	2	0	0	0	4	5
Apr	0		0		2		1		0		3	
May	0		4		10		0		0		14	
Jun	0		1		6		0		2		9	
Jul	1		1		3		6		0		11	
Aug	0		4		5		2		0		11	
Sep	3		3		3		0		0		9	
Oct	3		2		1		0		0		6	
Nov	0		4		6		1		1		12	
Dec	2		3		5		0		0		10	
Total	10	**10**	32	**9**	45	**6**	13	**0**	3	**0**	**103**	**25**
Percent	10%		31%		44%		13%		3%			

Mt. Vernon

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	0	5	2	4	2	3	3	2	0	0	9	14
Feb	0	2	1	1	7	1	4	0	0	0	5	4
Mar	0	2	2	0	0	5	2	1	0	0	4	8
Apr	0		0		8		0		0		3	
May	0		0		3		1		0		14	
Jun	0		0		3		3		1		9	
Jul	0		0		5		0		0		11	
Aug	1		0		5		0		1		11	
Sep	3		1		7		0		0		9	
Oct	0		3		3		0		0		6	
Nov	0		0		4		0		0		12	
Dec	0		1		6		0		0		10	
Total	4	**9**	10	**5**	53	**9**	13	**3**	2	**0**	**103**	**26**
Percent	5%		12%		65%		16%		2%			

Rock Island

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	0	0	2	2	9	7	0	1	0	0	11	10
Feb	0	0	2	0	10	3	1	0	0	1	13	4
Mar	0	0	3	3	2	6	1	1	0	0	6	10
Apr	0		1		6		1		0		8	
May	0		11		7		1		0		19	
Jun	5		0		2		1		0		8	
Jul	0		5		1		1		0		7	
Aug	0		2		7		1		1		11	
Sep	0		1		6		1		0		8	
Oct	0		5		2		0		0		7	
Nov	3		1		6		1		0		11	
Dec	0		10		12		1		0		23	
Total	8	**0**	43	**5**	70	**16**	10	**2**	1	**1**	**132**	**24**
Percent	6%		33%		53%		8%		1%			

Central

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	10	5	23	31	67	56	16	13	3	1	119	106
Feb	2	4	39	51	47	78	8	10	0	0	96	143
Mar	5	5	42	66	74	48	11	13	3	2	135	134
Apr	4		37		57		9		1		108	
May	3		33		72		11		0		119	
Jun	14		45		64		17		2		142	
Jul	2		26		56		12		1		97	
Aug	8		60		95		12		5		180	
Sep	13		46		57		11		4		131	
Oct	5		49		61		11		0		126	
Nov	9		52		42		15		3		121	
Dec	8		48		69		13		2		140	
Total	83	14	500	148	761	182	146	36	24	3	1514	383
Percent	5%		33%		50%		10%		2%			

Cook												
Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	3	15	27	19	17	26	28	23	2	2	77	85
Feb	9	13	19	15	27	31	31	27	2	5	88	91
Mar	13	7	16	35	38	30	32	20	2	4	101	96
Apr	16		33		27		33		1		110	
May	12		47		51		33		0		143	
Jun	18		58		27		28		1		132	
Jul	13		19		40		31		0		103	
Aug	8		24		31		25		4		92	
Sep	12		35		46		34		0		127	
Oct	18		29		28		31		0		106	
Nov	9		30		34		19		1		93	
Dec	27		42		13		18		0		100	
Total	158	35	379	69	379	87	343	70	13	11	1272	272
Percent	12%		30%		30%		27%		1%			

Northern

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	7	3	31	17	27	25	9	6	1	3	75	54
Feb	3	15	23	24	25	29	11	5	5	3	67	76
Mar	2	10	25	40	31	29	8	9	2	1	68	89
Apr	3		17		30		11		1		62	
May	8		26		59		7		3		103	
Jun	8		48		50		2		2		110	
Jul	6		20		42		12		2		82	
Aug	4		26		42		3		1		76	
Sep	6		44		37		7		3		97	
Oct	7		22		21		7		0		57	
Nov	4		54		21		7		0		86	
Dec	6		37		29		7		0		79	
Total	64	28	373	81	414	83	91	20	20	7	962	219
Percent	7%		39%		43%		9%		2%			

Southern

Month	Guardianship		Adoption		Home of Parent		Other		Home of Family		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Jan	6	15	19	12	21	29	8	5	0	0	54	61
Feb	0	2	11	9	14	19	8	7	1	1	34	38
Mar	11	3	14	16	23	31	10	7	1	0	59	57
Apr	1		11		28		6		0		46	
May	0		16		31		10		0		57	
Jun	9		36		27		10		1		83	
Jul	0		15		23		5		1		44	
Aug	4		29		31		3		1		68	
Sep	4		29		41		5		1		80	
Oct	4		18		18		3		1		44	
Nov	5		37		26		6		0		74	
Dec	0		34		35		7		3		79	
Total	44	20	269	37	318	79	81	19	10	1	722	156
Percent	6%		37%		44%		11%		1%			

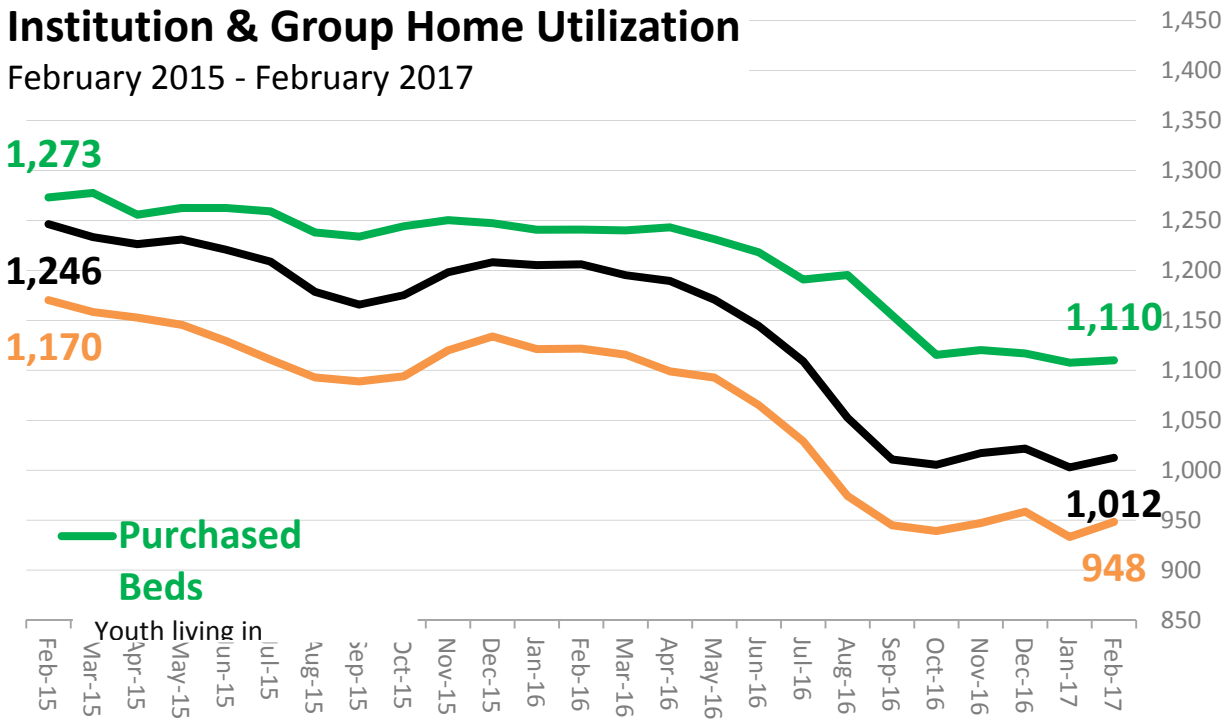
Intact Family Services:

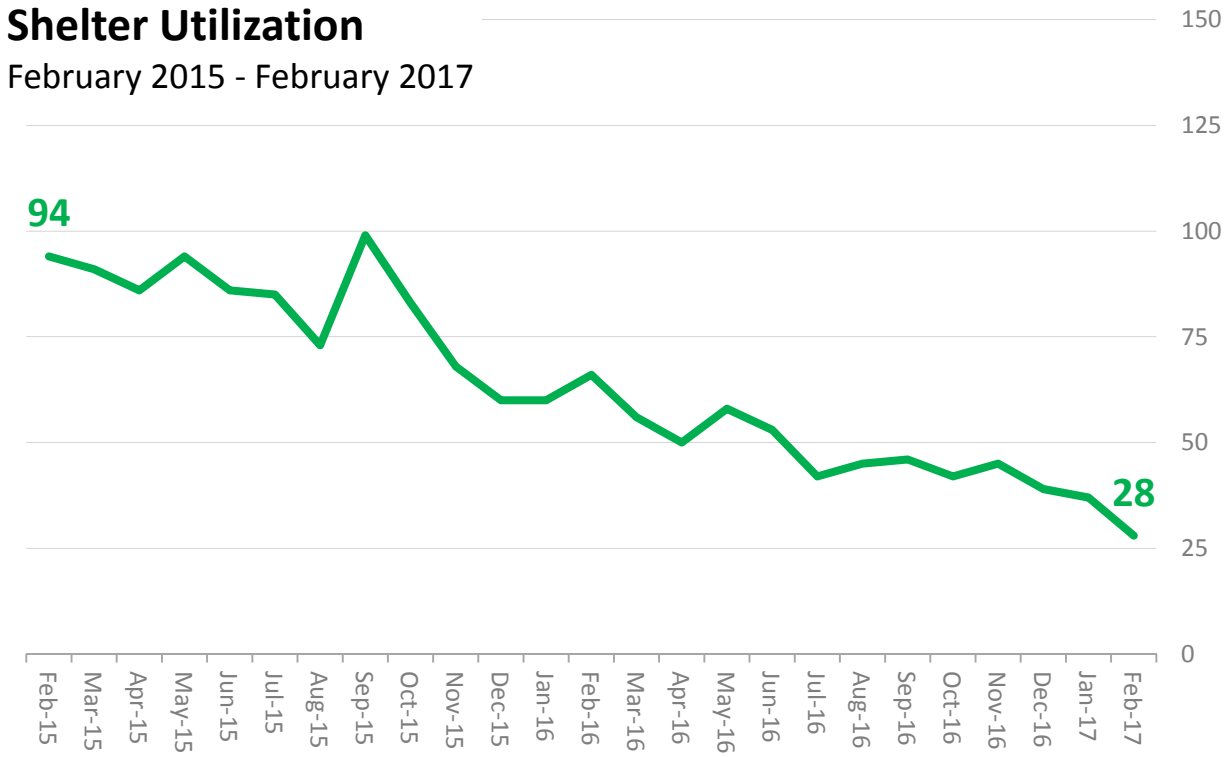
In FY16, IFS served approximately 6063 families statewide.

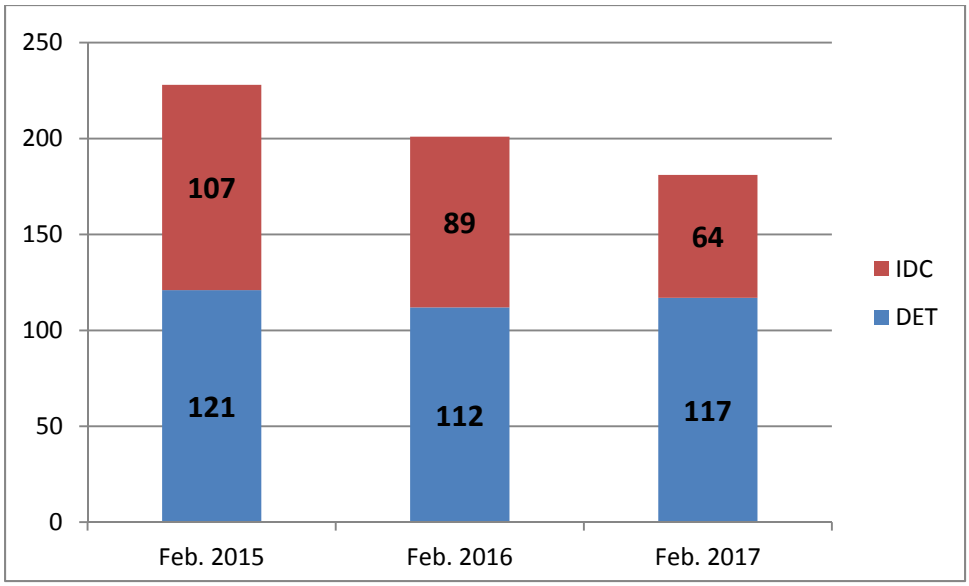
95% of families are referred for intact services as a result of abuse or neglect. The remaining 5% are referred from unfounded reports or court orders. During FY16, 88.2% of families remained intact during the service period and 95.68% did not re-open in the subsequent 12 months. 90.84% did not experience maltreatment during the service period; 93.26% did not experience maltreatment in the subsequent 6 months.

As of March 17, 2017, 5,884 children and 4193 adults were being served in 2473 intact families by POS providers. There are currently 2644 IFS cases statewide including those served by DCFS.

DCFS usage of residential, shelter, correctional and detention facilities has declined significantly and is currently about 950 for on-going residential care, 25-33 for shelter care and 181 for correctional and detention.



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150
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Feb. 2015
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IDC
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EXHIBIT L

SAVE THE DATE!

2017 Illinois Child Welfare Transformation Summit

The tentative dates and location for this year's summit are –

Tuesday, August 8 through Thursday, August 10, 2017 in Springfield, Illinois.

We are excited to announce this year's theme, "**Pursuing Permanency:** Cultivating, Maintaining, and Supporting Lifelong Connections."

We will be announcing more details on the D-Net and the Virtual Training Center as further details become available.

If you thought last year was phenomenal, you are in for a treat at this year's summit!

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Illinois Department of DCFS Children & Family Services

EXHIBIT M

FOUR-MONTH STATUS REPORT TEMPLATE

Project Name: Amended Definition of "Fictive Kin" and Expanding State Funded Guardianship

Date submitted: 5/01/17

I. Summary

On January 1, 2017 the Illinois law expanding the definition of 'fictive kin' became effective; rulemaking is in process, 1st notice period ended April 3, 2017, no comments were received from the public, and we are proceeding to 2nd notice period. At this time we are waiting on a fiscal review from our DCFS budget office and then the Governor's Office of Management and Budget (GOMB), once this is complete, we will file at 2nd notice and this is the review completed by the Joint Committee on Administrative Rules (JCAR) within 45 days.

On August 24, 2016 Policy Guide 2016.09 was issued to immediately update Rule 302.410 on expanding state funded guardianship, rulemaking for 302 is also in process and the 1st notice period ended April 17, 2017, no comments were received so we are preparing for 2nd notice.

Training on fictive kin and expanded state funded guardianship is included in P315 and effective April 1, 2017, ACR implemented questions geared to assure that State funded guardianship is being pursed for eligible youth 12 years of age or older by permanency staff where Return Home and Adoption have been ruled out. AND This will be done at every review. This information will be contained in the feedbacks as well as available in the ACR reporting system. There were some functional issues with the implementation of the new questions surrounding family finding efforts, however it has been resolved. Data received from ACR indicates State funded guardianship is being pursued for a youth 12 years of age or older placed in a non-licensed relative home in 11 of the 16 applicable child cases reviewed during the month of April. Additionally, there is evidence that State funded guardianship is being pursed for an eligible youth 12 years of age or older placed in a licensed non-relative home in 15 out of 19 cases reviewed. State funded Guardianship was also considered for a sibling under the age of 12 placed in the same home with an eligible youth 12 years of age or older in 34 of the 40 applicable cases. Data also indicates there is evidence that in youth age 12 and over is connected to a relative/fictive kin relationship for support in 414 of the 530 applicable cases.

II. Revised Targets / Goals

DCFS will continue tracking placements and outcomes of youth in fictive kin homes to determine if there is increased stability and permanency from January 2017 forward.

Procedure 315 training for DCFS and POS staff is in force. Currently there has been 1848 staff either enrolled or have completed training. Training is scheduled through May of 2017. Additional meetings are currently being held to develop an abbreviated version of Procedure 315. This will be a web based self-directed training specific to the job specialty for child protection and intact staff and their respective supervisors as Fictive Kin is a component of Family Finding. The curriculum is anticipated to be available in June of 2017.

DCFS is developing a dashboard in the Mindshare platform that will allow program managers to be able to identify youth eligible for specific subsidies like the state funded guardianship program in order to move them to permanency. The new dashboard in Mindshare will capture youth eligible for KinGap and Expanded Subsidized State funded Guardianship Programs and the outcomes for eligible youth. Youth eligible for Expanded Guardianship will meet age and placement criteria, have a legal status code of Adoptive Rights, Surrender Both Parents, or Guardianship. They will have a permanency goal of Independence, Cannot Be Provider For in a Home Environment, or Guardianship.

The target date for development of the Mindshare dashboard will be determined by the Expert Panel and Parties. Once that is in place, DCFS will review those youth who may be eligible for the new state funded guardianship program. Once those youth are identified, their names will be provided to their assigned case manager and supervisor to explore if the youths' current permanency goal should be changed to state-funded guardianship. The permanency worker and supervisor will document the discussion and will change the goal when appropriate.

DCFS Regional Administrators, through regular staff meetings and other staffings, will work to ensure that all staff are advised of the expanded eligibility for state-funded guardianship that cases are reviewed to determine eligibility for state funded guardianship, and that caseworkers are discussing the revised eligibility criteria with all eligible families. A staff meeting in the Central Region in scheduled for February 17, 2017, Southern Region is scheduled in early March 2017 and the Northern region is scheduled for February 27, 2017. The Cook County Meeting with Regional Administrator will be held by the end of March 2017. Fictive Kin will also be addressed at each regional meeting.

Although State funded expanded guardianship questions were added to the Administrative Case Review (ACR) packet, due to technical issues, the questions were not populating correctly and information was not collected on applicable cases at each review. This has been resolved. It is anticipated that monthly reports will be generated on youth in the targeted population in regards to eligibility for both state funded guardianship and the KinGAP program. During the next reporting period, ACR staff will be instructed to raise the issue of eligibility for state funded guardianship during each ACR and to document that discussion in their feedback. The ACR staff will additionally discuss with the permanency staff the youth's current placement type and determine if Fictive Kin was explored as a placement option.

III. Problem Formulation

Youth lingering in care, where return home and substitute care pending termination of parental rights have been ruled-out, can now obtain permanency and remain in home-like placement setting, and provided long-term stability

IV. Program Outputs

Expanded Guardianship:
As of **05/01/17** there are:
2,576 youth with goals of Adoption
1,458 with goals of substitute care pending termination

999 with goals of guardianship
Of the 999 with guardianship goals, 389 of them are youth that are 12 and older

Information from an Independence report provided by Jeremy Harvey reveals that there are 2,871 youth in the state with a goal of Independence. Of the 2,871, there are 203 youth under 16 years old (15.99):
46 are in home of relatives or parents;
75 are in foster homes;
70 in group home, hospitals, or residential
9 are unauthorized

These cases should be reviewed to see if state funded guardianship or KinGap is appropriate for these youth as it will provide them with support and life-long connections and more importantly, permanency in a home-like setting.

Fictive Kin
As of 5/1/17, **650** youth statewide have been placed with fictive kin. This is an increase of 37 cases from 2/28/17.
375 have a goal of return home
44 have a goal of adoption
28 have a goal of guardianship
135 have a goal of Independence

Fictive Kin Placements by age:
30 youth Age 15
54 youth Age 16
62 youth Age 17
Total placed in HFK -146

Program Outputs ***(per Outputs in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Significance and Explanation of Difference***
More youth in home-like placement setting with life-long connections			
Youth remain in their community			
Increase in permanency			
Greater stability in placement and less likely to have multiple moves			

V. Proximal and Distal Outcomes

Proximal/Distal Outcome (per Outcomes in Logic Model)	*Program (%, N)*	*Comparison (%, N)*	*Explanation of Status*
More placements available for youth through fictive kin allowing them to remain in home-like setting in their community			
Greater stability ; less placement changes			
Increase in achieving permanency			
Life-long connections for youth			
Increased well-being			

VI. Theory of Change Revisions

Youth in care should be returned home to parents. When that is not possible the service needs of the youth and caregiver's ability to obtain services and provide a long-lasting supportive/loving connection for youth must be considered carefully. If parental rights cannot be terminated based on a finding of unfitness and best interests, then guardianship with a relative may provide the most stable-home-like setting. Lowering the age for youth to be eligible to 12 years of age for state funded guardianship provides more youth the opportunity for to achieve permanency.

Similarly by expanding the definition of fictive kin to include current foster parents if the youth has been in the home for 1 year and has developed a family-like connection, converts this to a relative home and youth can achieve permanency through subsidized guardianship via Kin Gap.

Both of these options ensure youth have life-long connections, in a home-like setting in their community, and provide more stability, enhanced permanency and well-being

VII. Overall Assessment

Challenges: rule-making and training of staff have been slow**;** the need to review current goals and placement types for youth in care will be time-consuming very important for older youth in particular. Mindshare will assist with much of this

Success: Permanencies are steadily increasing. Engaging the ACR reviewers to ask questions on current goal and placement type is significant to ensure caseworkers are considering available options and securing life-long, family-like connections for our youth; 650 youth have thus far been placed in fictive kin placements with 146 between the age of 15-17 (23%) and 28 have goals of guardianship (4.3%).

EXHIBIT N

Project Name: Family Finding Project
Date submitted: 4/28/17

I. Summary

Family Finding activities are required for all youth in the Illinois Foster Care system. Family Finding is a tool that aides in assuring life-long connections for youth. Relative or Fictive Kin who are identified can provide a variety of supports to the children and family ranging from visits, mentoring, transportation, attending special events or providing placement when children must be removed from living with their parents. Locating and engaging these supports aids in DCFS meeting the overreaching goals of the Department to provide safety, well-being, stability and permanency for youth. While connections for all youth are essential in meeting the mission of child welfare practices within Illinois, it is particularly important for youth ages 12 and older who have no identified supports or placement resource. Even further, it is important to look at a subset of that population, youth who are 12 and older with emotional or behavioral needs that cause a necessity for congregate care placements.

Since the filing of the Triannual Interim Report in February, concentrated efforts have focused on identification of the target population and future data collection. Operations' staff worked with the Department of Information Technology to formulate business rules and is in the process of validating those measures for the Mindshare Family Finding Dashboard. This process has been successful in identification of errors in data which facilitated the changing of business rules, as well as other legends that will need to be added to effectively capture data that will show outputs and outcomes for Family Finding activities. The Family Finding Dashboard went live on April 14th, 2017. This dashboard has entry of care cohorts that displays all youth entering care in that fiscal year. The dashboard encompasses all youth in care in order to review family finding regardless of their age; however, specific measures for those youth over the age of 12 are being reviewed for purposes of this report. These measures include: the number of youth ages 12 and over with noted relative or fictive kin supports; the type of living arrangement where the youth resided if placement with relatives (HMR), fictive kin (HFK) or home of relative (HMP) were achieved after family finding efforts were completed; the length of stay in each type of placement (indicating stability) and legal permanency type. Once Mindshare is fully validated and functional, we will have the capacity for review of efficiency of these efforts within the immersion site as well as if the youth identified through the Therapeutic Residential Performance Management Initiative (TRPMI) pilot. The TRPMI historically encompass youth who have been identified as having emotional or behavioral needs.

The total population of youth who are over 12 have been isolated (beginning FY 10/11 to present) There have been 698 youth to date who have been noted to have Family Finding activities completed. This has been documented by a 151-H case note completion stating a notification of identified support has been sent, or the entry of a case note indicating an individual who has agreed to provide support to a youth. With the changes in Mindshare business rules, we anticipate the isolation of those 12 year old youth who require placements that support a youth experiencing emotional or mental health issues.

Training of Procedures 315 continues to be a focus, as this is being provided to both DCFS and Purchase of Service permanency staff. Currently, there have been 1,848 staff enrolled or have completed training. Training is scheduled through May of 2017. Additional meetings are currently being held to develop an abbreviated version of Procedure 315. This will be a web based self-directed training specific to the job specialty for child protection, intact staff and their respective supervisors as Family Finding is also a requirement by staff for this population. The curriculum is anticipated to be available in June of 2017. Family Finding is the conduit to locating fictive kin and relative placement upon entry into foster care, as well as those family or fictive kin that may be able to provide other informal or natural supports.

The Webinar VTC training for Family Finding was released on March 2, 2017 and is a required on-line training for all staff and supervisors within permanency and child protection. To date, there have been 1,045 staff who have either completed or are in the process of completing the on-line training. This training provides the philosophy of Family Finding and in-depth explanation of required activities.

Information has been disseminated through multiple regional meetings to regional program managers and permanency achievement supervisors advising of the process in order for referrals to Permanency Achievement Specialists (PAS) to be made when there is a youth who does not have documented supports, is in need of step down resource options, has specialty circumstances (BMN youth, IYC/DET youth) and cases where assigned permanency workers require technical assistance in Family Finding efforts. The inclusion of other BH projects that intersect Family Finding will continue to be assessed.

Effective April 1, 2017, Administrative Case Review (ACR) implemented questions geared to assure that family finding activities have been completed by permanency staff in regards to the youth. These questions will be asked at every review and will include discussion on initial family finding activities, ongoing activities, as well as determining if family finding tasks have been completed or if the youth experienced a disruption in placement. This information will be contained in the feedback reports and will also be available in the ACR reporting system. Initially, there were some functional issues with the implementation of the new questions surrounding family finding efforts; however, it has been resolved. Data received from ACR indicates Family Finding activities were completed upon each placement change in 632 of the 864 applicable child cases reviewed during the month of April. Additionally, there is evidence that the youth age 12 and over is connected to a relative/fictive kin relationship for support in 414 of the 530 applicable cases.

II. Targets / Goals

The current goal is by the end of the next reporting period, DCFS will have the live Family Finding Mindshare dashboard available with all necessary revisions completed. Along with the Family Finding Mindshare dashboard being validated, additional legends are being added to assure that identified outputs/outcomes can be gained. This includes youth who are age 12 or older and youth 12 or older who have identified emotional and behavioral needs.

The location of supports for this population will be tracked through the dashboard. The outputs, proximal and distal outcomes will be measured.

Training of Procedures 315 will continue with permanency staff from both DCFS and the Purchase of Services agencies. This training will continue through May of 2017. The creation and implementation of an abbreviated version of 315 will also be available and provided to intact and investigation staff. The completion of the VTC Family finding training became available on March 3, 2017 and is a mandatory training for all direct services staff (investigation, intact and permanency staff) and their respective supervisors. The original timeframe for completion was April 30, 2017; however, this will be extended as approximately only one half of staff have completed to date. It will remain available for newly hired staff on the VTC. There is also discussion on adding a Procedure 315 component to Foundations training for new staff.

Family Finding questions were added to the Administrative Case Review packet; however, due to technical issues, the questions were not populating correctly. Working with the Office of Innovation Technology Services unit, it is anticipated that monthly reports will be generated on youth in the targeted population in regards to family finding efforts that have been verified to have been completed by permanency staff.

Family Finding will continue to work with other BH initiatives to seek ways in which those initiatives and family finding intersect and support one another.

Permanency Achievement Staff will continue to provide technical support on cases upon referral, specifically if requested, to assist locating supports within the targeted population.

Problem Formulation

The major concern in regards to Family Finding has been the inability to provide data that will substantiate family finding activity completion and the effectiveness of those efforts. The completion of the Family Finding Mindshare dashboard will allow information in regard to the target goals to be measureable in a meaningful manner. There is no control group for this project as all youth receive family finding. However, the group of youth who will be followed for BH inclusion is the subset of youth over the age of 12 and youth who are over the age of 12 who have identified mental or emotional needs that create a need for congregate care placements. The breakdown of youth in congregate care is still in process. This will be noted by their current placement type. This data is anticipated to be available with the changing of the business rules that have been requested of Mindshare.

Once the validation of the Dashboard data has been completed, data can be retrieved and reviewed. It will provide a clear picture of those youth who do not have identified connections. This will allow for identification of these youth and the ability to have a plan for concentrated efforts to be provided. The creation of a dashboard to specifically look at measure, assure the data is valid and that it answers the questions that are posed in the logic model have been challenging. It involves a joint effort with permanency staff and the Department of Innovation Technology Services to work hand in hand to review the data, logic model and requested outputs/outcomes. Included in this report, as well as the data set

attachments, are preliminary numbers of Family Finding activities, outputs and outcomes. The validation of this dashboard remains in process and these numbers are subject to change with edits in business rules that will concrete the data being provided.

III. Program Outputs

The data below is under validation; however, the current preliminary numbers display for all youth ages 12 and over who have entered care since July 1, 2010 to April 25th 2017, the number of relatives identified (as evidenced by # of 151-H). It is important to note that the function of adding a note to capture the number of 151-H being sent is a fairly new functionality in SACWIS, therefore; it is thought the number of relatives identified is actually higher. The increase of natural/informal and formal supports is measured by SACWIS entry of relatives who have been identified and have agreed to provide those noted supports. A relative can choose the type of support or supports that they are committed to provide. They have the option to provide multiple types of supports for the same youth. The identification to denote a relative versus a non-relative support to the children or family is being explored with Mindshare; hence, there is no data available to show the increase in relative versus non relative support. It is hopeful that with the completion of Procedure 315, the release of the web based abbreviated version of 315 for DCP and intact staff, along with the VTC Family Finding training, that data supporting the completion of family finding activities steadily increases. The more relatives or supports that can be identified and engaged to support a youth and family, the more likely that positive outcomes will be observed within the data.

Program Outputs ***(per Outputs in Logic Model)***	***Program*** ***(%, N)***	***Comparison*** ***(%, N)***	***Significance and Explanation of Difference***
Increase in identification of relatives.	359 Relatives identified.		There are a total of 698 youth identified to have had Family Finding activities. *These youth have had Family Finding activities noted in SACWIS and are currently placed in relative/fictive kin care
Increase of natural, informal, and formal supports.	1,188 Formal 2,209 Informal 1,365 Natural		There are a total of 698 youth identified to have had Family Finding activities. *These youth have had Family Finding activities noted in SACWIS and are currently placed in relative/fictive kin care
Increase of relatives committed to ongoing relationships.	Not yet available. Efforts are in process with Mindshare to provide.		

IV. Proximal and Distal Outcomes

The validation process assisted in the identification of the data elements necessary to gain meaningful outcomes from Family Finding Activities. Continued validation efforts are still in progress; however, this is the preliminary data available. Of the 698 youth who have been identified to have family finding, 56% of those youth either are or have been placed in relative care. 43% of those youth have spent their entire length of stay (LOS) in relative care. 9% of those youth have achieved legal permanency. These youth have obtained permanency either through Adoption(9%), Family(2%), Guardianship(8%), Other(9%) or Parent(72%). The discharge type at this time shows the majority of youth who have had Family Finding activities completed return to home of parent at a significantly higher rate than other types of permanency. It is also important to note that Family Finding, although is a core good child welfare practice, the functionality of collecting this data is in its infancy. Noteworthy is that the requirement to record these efforts within the SACWIS case record is recent with the revisions and training of Procedures 315. It is anticipated that with the continued Procedure 315 training, both in person and web based for all staff, regardless of their discipline, that Family Finding activities will increase and will lead to better outcomes for permanency for our youth.

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program*** ***(%, N)***	***Comparison*** ***(%, N)***	***Explanation of Status***
Proximal Outcome – Increase in relative or fictive kin placement	56% or 388 youth placed in relative/fictive kin placement.		56% of youth with FF compared to 38% of youth overall were at some time in the case placed with relatives. There are a total of 698 youth identified to have had Family Finding activities. *These youth have had Family Finding activities noted in SACWIS and are currently placed in relative/fictive kin care.
Proximal Outcome – Stability with relative or fictive kin placement	43% of the 698 youth have their total LOS in relative/fictive kin placement.		Youth with FF spent 43% of their LOS in relative care vs. 26% of relative care to LOS for all youth. There are a total of 698 youth identified to have had Family Finding activities. * These youth have had Family Finding activities noted in SACWIS and are currently placed in relative/fictive kin care.
Proximal Outcome – Discharge from more restrictive environment.	Not yet available. Efforts are in process with Mindshare to provide		

Distal Outcome –Discharge to legal permanency.	9% or 64 youth have achieved legal permanency.		There are a total of 698 youth identified to have had Family Finding activities. * These youth have had Family Finding activities noted in SACWIS.
Distal Outcome – Identification of lifetime connections	Not yet available. Efforts are in process with Mindshare to provide		
Distal Outcome-Increase in Well-Being	Not yet available. Efforts to identify benchmarks of well-being are being explored.		

V. Theory of Change Revisions

-Relatives will agree to care for their own family.
-Parents empowered to engage in placement process by providing relatives/fictive kin.
-Paradigm shift for courts to supporting relatives/fictive kin placements.
-Paradigm shift for courts supporting quicker reunification to parents when safety factors have been mitigated.
-Philosophical change of traditional foster parents that reunification is the goal and support Family Finding efforts and possible move of children to relatives homes.
-Philosophical change of traditional foster parents to understand that permanency through reunification, guardianship, or adoption is the ultimate goal for youth in care.

VI. Overall Assessment

Challenges that have been incurred are a lack of data in regards to the targeted population on for the BH implementation of Family Finding. It was difficult to identify a clear population for concentration of review as Family Finding is an activity that will be provided to all youth in care. A delay in the completion on training of Procedures 315, as well as the completion of the VTC Family Finding webinar also provided for significant challenges.

Successes in this endeavor include over 1,800 staff that have been trained or are registered for training on Procedures 315. Over 1,000 staff have completed the webinar for Family Finding. The Mindshare Dashboard for Family Finding is live; however, still undergoing validation. The collaboration between the permanency administration and the Department of Innovation Technology Services has been on-going to validate and flush out business rules to assure that the outputs and outcomes can be garnered. Partnerships with other BH initiatives have been stablished and will continue to grow as Family Finding activities become implemented by staff.

Moreover, 64 youth have achieved permanency that had Family Finding efforts completed. It is the hope of the Department that the identification and engagement of the supports to the

youth and family will continue into their legal permanency. Although the identification of supports while a youth in care is important, their support continues to be paramount to the youth's on-going stability past the Department of Children and Family Services involvement.

EXHIBIT O

FOUR-MONTH STATUS REPORT TEMPLATE

Project Name: Illinois Birth Thru Three Project

Date submitted:

I. Summary

Illinois's IB3 waiver demonstration serves caregivers and their children aged birth through three years old, who are placed in foster care in Cook County, regardless of title IV-E eligibility. There have been 50 children added to the program since the last reporting period for a total of 1,816. There is no change in the balance in assignment to the intervention and control groups since the last reporting period [48%-Intervention and 52% Control]. Contract planning for FY '18 is in progress. There are no changes anticipated in the Nurturing Parenting Program contracts. Two agencies need to be expanded for Child Parent Psychotherapy [CPP] in order to accommodate the IB3 cases that will be assigned the Safe Babies Court Team pilot.

There are 3 Nurturing Parenting Program groups underway for birth parents at this time. All 3 NPP provider agencies are now operational. Referrals for fathers remain high at 33%. 54 parents have completed the service this fiscal year which reflects a retention rate of 72%.

There is a group in process for foster parents [NPP-CV with 9 participants]. 27 foster parents have completed the program during the current fiscal year. The retention rate for foster parents is 55%. The program continues to focus on engagement in services for foster parents. The implementation support team continues to highlight "the foster parent challenge" with data and case reviews, particularly in permanency updates where the foster parent may be the permanency goal.

The first phase of Child Parent Psychotherapy [CPP] CQI meetings have taken place. Two agencies clearly identified areas of focus for the consultant and 2 are still in review. All four agencies have received engagement data to support defining their unique plans for CQI. Engagement and fidelity strands will be focal for all agencies. The program completed a 6-month analysis of client engagement for CPP. The CQI team has been reporting engagement on a monthly basis for some time, but this is the first attempt to review these outcomes over time. This will be a standard tool for CQI and it has been provided to the CPP consultant. The program will also look back at historical data for FY' 16 in preparation for the annual contract monitoring visits. Data discussions are a standard practice for these reviews.

Dr. Steve Budde {Juvenile Protection Association} reviewed the viability project for the IB3 team. 300 cases will be used in this month to test the new protocol which supports case planning for permanency. Supervisors are reporting that it is helpful in support of case conceptualization and permanency planning.

Staff development is underway to move 2 staff into new leadership roles for IB3. There is also a search to replace one Implementation Specialist.

II. Revised Targets / Goals

The Department will complete the pilot of engagement activities as scheduled. Implementation support staff will provide support for 10 agencies that provide casework services to children enrolled in the IB3 program by 10% in an effort to improve engagement. It is anticipated that improvement is most likely and needed in the areas serving foster caregivers which include: Child Parent

Psychotherapy [CPP] and the Nurturing Parenting Program for Foster Caregivers [CV].

III. Problem Formulation

Even though Illinois's overall re-entry rate among all age groups is at the lower end of the national distribution, the higher rates of re-entry among the very youngest age group indicates a need for more effective evidence-based interventions for children after they are discharged from state care back to parental custody.

To address these issues, Illinois is using title IV-E funds flexibly to provide one of two evidence-based and developmentally informed interventions to targeted children and their caregivers in an effort to improve attachment, reduce trauma symptoms, prevent foster care re-entry, improve child well-being, and increase permanency for children in out-of-home placement.

IV. Program Outputs

Program Outputs ***(per Outputs in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Significance and Explanation of Difference***
Program Output 1-CPP	Mean for engagement = 55.8% Mean for successful case closure =26%	0	Engagement rates vary across the 4 providers from a low of 41% to a high of 82%; Successful closures also range from 45%-18%. The focus of CQI is bringing the 2 below standard agencies to the mean.
Program Output 2-NPP-PV	Successful completion for those enrolled across the 2 agencies reporting data are not comparable at 49 & 59%.	0	One agency has a new facilitator and the variation in experience is likely contributing to the differences noted this month.
Program Output 3-NPP-CV	Successful completion for those enrolled for FY' 17 is 44%.	0	A class completed this month with 11/13 enrolled completing or 85%.

V. Proximal and Distal Outcomes

Use the table provided below to report progress in attaining the proximal and distal outcomes (if available at the time of the report). The Outcomes listed should match those detailed in the Logic Model. In the "Explanation of Status," briefly describe whether the differences in the outcomes, which were intended to result from the intervention, are in alignment with expectations.

The following proximal outcomes are based on MINDSHARE data as of April 29, 2017 for the cohorts of Cook County children who entered foster care during fiscal years 2014 and 2015 and were screened for referral to the IB3 interventions.

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program*** ***(%, N)***	***Comparison*** ***(%, N)***	***Explanation of Status***
Proximal Outcome 1- permanency up to 12 mons.	FY' 14 Cohort [4.5%] FY '15 Cohort [6.3%]	FY' 14 Cohort [2.5%] FY '15 Cohort [4.6%]	*Trending as expected.* FY' 14 Cohort [N= 268] FY '15 Cohort [N=253]
Proximal Outcome 2- permanency 12-23 mons.	FY' 14 Cohort [9.0%] FY '15 Cohort [9.5%]	FY' 14 Cohort [10.9%] FY '15 Cohort [11.1%]	
Proximal Outcome 2- permanency after 24 mons.	FY' 14 Cohort [23.5%] FY '15 Cohort [7.5%]	FY' 14 Cohort [18.3%] FY '15 Cohort [3.6%]	
Distal Outcome 1			IB3 evaluation of distal outcomes planned for FY '18.
Distal Outcome 2			

VI. Theory of Change Revisions

The program is in year- 4 of operations and there are no changes indicated in the theory of change.

VII. Overall Assessment

Mindshare data for IB3 continues to be valid.

All staff with CQI and implementation support roles are working with clear data to support agency engagement in the improvement of outcomes.

EXHIBIT P

FOUR-MONTH STATUS REPORT TEMPLATE
Project Name: SAFE Families for Children Project

I. Summary

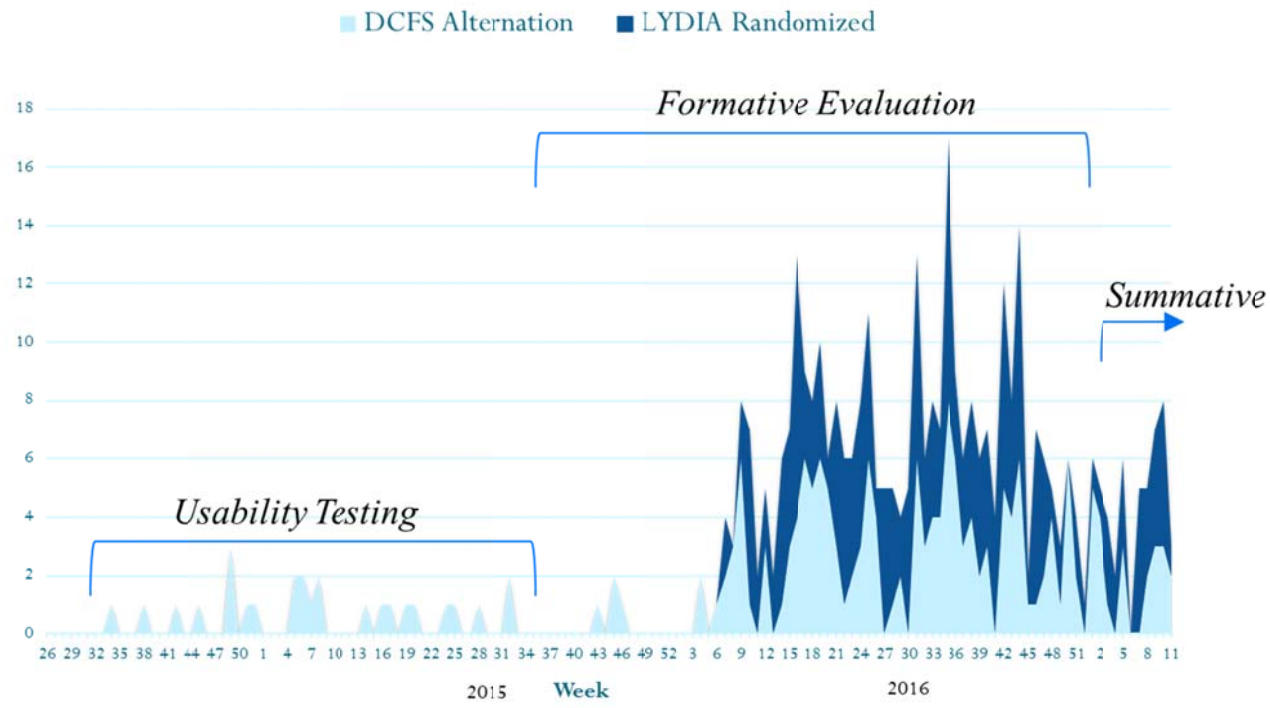
Summarize the progress that has been made in meeting the Targets/Goals that were specified in the latest Triannual Interim Status Report to the Court.

Since the submission of the First Triannual Interim B.H. Status Report on February 17, 2017, the number of referrals from DCFS investigators to Safe Families for Children (SFC) rebounded from a low of 4 families in February to its usual monthly volume of 11 families in March. Assignments during the first two weeks of April suggest that referrals will again reach this monthly volume, but it is important to acknowledge that these monthly totals amount to only one-half the quarterly volume needed to evaluate the impact of the program. Discussions are currently underway with SFC to centralize the allocation process so that SFC referrals that bypass the DCFS automated alternation system (aka. randomizer) can be assigned directly by SFC staff using the same DCFS automated mechanism. Permissions will need to be granted in order for SFC to have read/write access to SACWIS. The combined direct and indirect referrals should be sufficient to meet or exceed the target of 60 families per quarter.

Usability Testing: The SFC pilot program began accepting referrals back in August of 2014. Since that time, the program has undergone usability testing, which involved an implementation study of 26 SFC referrals through September 30, 2015. The purpose of usability testing was to check the integrity of the key implementation and automated evaluation processes that DCFS developed in cooperation with SFC for assigning, referring and linking families to routine administrative data. The results showed that the pilot was falling short of its original target of 120 referrals per quarter, which statistical power analysis indicated was needed to reach the desired sample size of 940 family cases within two years. It was agreed that if DCFS took active steps to increase the use of the automated randomizer, the pilot could begin the next phase of initial implementation and formative evaluation.

Formative Evaluation: In spite of efforts to increase the use of the randomizer, which included personal conversations by the DCFS Project Manager with each area administrator in Cook and Northern regions and e-mails to all child protection supervisors in Cook and Northern regions to remind them of the requirement to consider SFC families as a resource for children, referrals only slightly increased during initial implementation through March of 2016. In response to the March 30th biannual report to the Arnold Foundation (sponsor of the evaluation), the funding for the evaluation was put on hold for two quarters until the pilot could show substantial progress towards attaining a revised goal of at least 60 family cases per quarter (one-half of the original goal). To help achieve these totals, the SFC pilot was expanded statewide. In addition, the SFC demonstration was named as a pilot project under the BH Implementation Plan that was filed with the United States District Court for the Northern District of Illinois Eastern Division in February of 2016. As a result of these changes, use of the DCFS automated alternation system spiked starting the 4th week of 2016 (see Figure 1). When combined with the direct referrals that were randomized by SFC at intake, the total number of referrals exceeds the quarterly target of 60 families.

Figure 1.—Safe Families for Children Referrals: August, 2014 thru March, 2017



II. Goals and Revised Targets

Specify the current goals and any revised targets that will be addressed in the next Triannual Interim Status Report to the Court.

The results of the formative evaluation that concluded on December of 2016 suggest that the evaluation of the SFC program should proceed to full implementation and summative evaluation for non-Cook counties effective January 1, 2017. The inclusion of Cook County in the summative evaluation will be postponed until the proportion of intervention families that actually receive SFC hosting services reaches 33% and the percentage of cross-overs from comparison to receive the SFC hosting services declines to less than 3%. The output indicators presented in Table 1 below show that both Cook and non-Cook regions need to take corrective active to achieve these revised goals, but the implementation problems are especially acute in Cook County.

The research project will be pre-registered for a summative evaluation using the Open Science Framework (OSF) Standard Pre-Data Collection Registration template. SFC administrative staff will continue to make individual contact with families referred to the program for the purpose of increasing family engagement and participation. Effective February 1, 2017, Associate Deputy for Child Protection is informed of the names of DCFS staff who do not respond to Safe Families inquiries regarding the status of a referred family so that proper action is taken. A meeting is being set for May of 2017 with the independent evaluators, SFC staff and DCFS to consider the possibility of granting SFC read/write access to SACWIS in order to centralize the allocation process and address implementation problems regarding non-participation by DCFS staff, current issues, needs for continued education and efforts surrounding expansion. At this time, it will be decided whether it

is feasible to re-program the DCFS alternation procedure, using Arnold funding, in order to achieve true randomization of families.

III. Problem Formulation

Provide brief descriptions of the problem(s) and program(s) that is/are being implemented to address the problem(s). Include a brief description of the comparison group or benchmarks against which comparisons will be made, e.g. control group, historical cohort, neighboring counties, or target goals.

SFC is a promising program to prevent child abuse recurrence and removal into state protective custody by recruiting and overseeing a network of host families with whom parents can voluntarily place their children in times of need. Developed by LYDIA, a Chicago-based social service agency, SFC is currently operating in over 40 local sites across the U.S. Despite its wide diffusion, the efficacy of the program has never been tested in a rigorous fashion. In 2013, the DCFS IRB approved a low-cost RCT evaluation of the SFC program, which could provide credible evidence of the program's efficacy in preventing removals into foster care, reducing the recurrence of child maltreatment, and contributing to safe and stable reunification with birth families.

The evaluation will answer the following well-built PICO (population, intervention, comparator, and outcome) research question: Are Illinois children whose parents are investigated by child protective authorities for alleged abuse and neglect (population) less likely to enter the child welfare system (primary outcome) and more likely to avert subsequent abuse/neglect episodes and to be maintained in or reunified with their birth families (secondary outcomes) if they are referred to SFC's host families network (intervention) as compared to children from similar families who are served through child protective services as usual (comparator)?

In order to generate credible data to answer the PICO question, a randomized encouragement design was developed that could be sufficiently powered and implemented with integrity to withstand threats to the four types of validity identified by Shadish, Cook & Campbell (2002): statistical, internal, external, and construct validity. A randomized encouragement study is a type of RCT in which units (e.g. individuals, families or organizational clusters) are allocated to a comparison group or to an intervention condition that is intended to induce compliance with a recommended course of treatment.

The pilot relies on two methods to allocate families to intervention and comparison groups. The first is the automated alternation routine initiated by DCFS investigators when they determine that the case they are investigating is appropriate for referral to SFC. The alternation routine operates as follows: After the IDCFS investigator and supervisor agree that a family is an appropriate candidate; the supervisor activates a "hyperlink" (referred to as the "randomizer" by IDCFS staff). The hyperlink allocates alternately the recommended case to the intervention or comparison group. The supervisor gets a response immediately upon clicking the hyperlink that indicates whether or not the investigator may approach the family about participating in the SFC program or whether the family must be taken into protective custody or referred to another program or service. All supervisors from all investigative teams across the state have access to the alternation function.

The second method is a back-up randomization procedure that SFC developed to allocate referrals that by-pass the DCFS randomizer. The back-up routine is as follows: SFC referrals that by-passed the DCFS alternation procedure are entered into a spreadsheet, which runs a macro to assign the case to the intervention and comparison group based on a random sequence of assignment categories. After the case has been assigned, additional case information is added to the spreadsheet, which lists referral date, parent's name, the DCFS identification number, and whether the referral was initiated by a DCFS investigator or an intact family services worker.

Tests of statistical equivalence conducted during usability testing and formative evaluation indicate that both allocation procedures were successful in balancing the baselines characteristics of both the intervention and comparison groups prior to SFC referral.

IV. Program Outputs

Use the table below to report data on the relevant amounts of program outputs, e.g. number of children, families, foster homes, offices, that are expected to be reached or delivered by the program. The numbers and percentages should identify the counts and proportions that received the intended program content (reach), the amounts of program content received by each of the participants (dosage), and whether these amounts are adequate, marginally adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation). The specific outputs listed should match those detailed in the Logic Model, which should be attached to the report as an Appendix. Include comparable data on outputs against which comparisons will be made using the reference group identified above under Problem Formulation. Under the "Significance and Explanation of Difference," briefly describe whether the differences are trending in the expected or opposite direction.

The key program outputs are boldfaced in the SFC Logic Model (Appendix A) and listed in Table 1 below. Even though it is desirable for at least 70% of the families, who are allocated to the SFC program, to agree to accept services, the observed proportions of acceptances in both Cook and non-Cook regions are minimally adequate. Unfortunately, the proportion of accepters who are put into contact with SFC services is only one-half. Efforts to improve the proportions of follow-throughs by providing SFC staff with "read-only" access to follow-up with investigators have not resulted in higher follow-through rates. SFC staff have had difficulty contacting some of the investigators in order to connect with the families. It is anticipated that by the next reporting period, DCFS will have determined additional ways for tracking family engagement and will have determined whether there is a need to create a specific referral form to assist with tracking.

Another problem that lowers the number of follow-throughs are "pull-backs" after contact is made. This can occur because relatives agree to care temporally for the children or child protective custody must be taken immediately for safety reasons. A randomized controlled trial can accommodate "pull-backs" so long as the proportion doesn't rise too far above 10%. Unfortunately, pull-backs are running 23% or higher in both Cook and non-Cook regions.

The far greater threat to the validity of the evaluation is the excessive numbers of "cross-overs" that are occurring in Cook County, which is a lesser but still significant problem in the non-Cook regions. The problem refers to comparison cases who violate their assigned treatment plan and "cross-over" to receive the intervention. The large percentage of children who crossed-over to the intervention appears to have arisen from duplicate assignments by both DCFS and SFC as well as some miscommunications between staff. Nonetheless, the possibility of deliberate subversion of the experimental design cannot be ruled out. Cross-overs reduce the difference between the intervention and comparison groups in treatment-receipt rates, which makes it very difficult to render a valid summary judgment of the impact of the pilot program.

Table 1. —Key Program Outputs

Program Outputs (per Outputs in Logic Model)	*Region*	*Program (%, N)*	*Comparison (%, N)*	*Significance and Explanation of Difference*
%, # of DCFS referrals that accept treatment	Cook	63.6%, 66	NA, 60	One-half to two-thirds of families allocated to SFC agreed to hosting. The desired is 70%. The comparison is not offered treatment.
	Non-Cook	47.4%, 38	NA, 43	
%, # of accepters who contact SFC	Cook	53.8%, 21	NA, 16	Only one-half of the families that accepted SFC hosting services made contact with SFC. Many of the "No Shows" resulted from lack of follow-through by DCFS investigators. Despite allocation to the comparison, DCFS investigators made direct contact with SFC on 27 families.
	Non-Cook	44.4%, 8	NA, 11	
%, # of SFC contacts that were "pulled back" by investigators.	Cook	23.8%, 5	NA, 0	A quarter of SFC contacts are subsequently "pulled-back" because relatives agree to care temporally for the children or the children needed to be taken immediately into child protective custody for safety reasons.
	Non-Cook	25.0%, 2	NA, 0	
%, # of children who are hosted by SFC families	Cook	19.8%, 19	27.1%, 26	27.1% of comparison cases "crossed-over" to the intervention in Cook. This was greater that the % of the intervention group that was hosted. Therefore, the experiment is "broken" and SFC cannot be properly evaluated in Cook County. Even though there are crossovers in non-Cook regions, a greater proportion of the intervention cases were hosted, which permits a "diluted" effect to be estimated.
	Non-Cook	20.3%, 13	10.7%, 9	

Sources: Program data based on monthly allocation spreadsheets provided by DCFS and contact and hosting information supplied by Safe Families for Children.

V. Proximal and Intermediate Outcomes

Use the table provided below to report progress in attaining the proximal, intermediate, and distal outcomes (if available at the time of the report). The outcomes listed should match those detailed in the Logic Model. Under the "Explanation of Status," briefly describe whether the differences in the outcomes, which were intended to result from the intervention, are in alignment with expectations.

The key proximal and intermediate outcomes are boldfaced in the SFC Logic Model (Appendix A) and listed in Table 2 below. The purpose of formative evaluation is to ascertain whether the observed differences in proximal and intermediate outcomes between the intervention and comparison groups are trending in the expected direction. The data presented in Table 2 indicate that children assigned to the intervention group were more likely to be deflected from protective custody

and less or no more likely to be removed into foster care after allocation than children assigned to the comparison group. The pattern was most pronounced in the non-Cook regions of the state with those differences trending toward statistical significance.

Table 2. —Key Proximal and Intermediate Outcomes

Proximal/Intermediate Outcomes ***(per Outcomes in Logic Model)***	***Region***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
%, # of children deflected from protective custody	Cook	84.3%, 70	78.7%, 59	Both Cook and non-Cook regions show higher rates of deflection from protective custody in the intervention group, but only the difference in non-Cook regions is trending toward statistical significance.
	Non-Cook	95.5%, 63	75.9%, 60	
%, # removed into foster care	Cook	22.9%, 22	18.8%, 18	Both Cook and non-Cook regions show lower rates of removal in the intervention group, but only the difference in non-Cook regions is trending toward statistical significance
	Non-Cook	41.7%, 35	12.5%, 8	
%, # of subsequent oral reports	Cook	25.0%, 24	16.7%, 16	In spite of the lower rates of removal into foster care, the children allocated to the intervention group experienced no statistically significant higher risk of subsequent oral reports of maltreatment than children allocated to the comparison group.
	Non-Cook	18.8%, 12	17.9%, 15	

Sources: Protective custody calculated from data supplied by Chapin Hall at the University of Chicago. Removal into foster care and subsequent oral reported were calculated from the spreadsheets downloaded from the Mindshare dashboard developed to track key performance indicators for the SFC pilot project.

VI. Theory of Change and Revisions

Discuss any major modifications of the theory of change about why a program or intervention is expected to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

The theory of change that undergirds the logic of the SFC is similar to allied interventions such as alternative response and diversion to kinship care. Each of these efforts attempts to help families in need by offering a non-authoritarian response to family problems. The major difference between SFC and CPS as usual is that families retain legal custody and voluntarily place their children with SFC host families whereas if safety concerns warrant the children's removal, CPS must take legal custody and place the children in licensed foster care or approved kinship homes. The voluntary nature of the SFC hosting arrangement is posited to be a critical factor that contributes to the success of the program. The arrangement is intended to foster cooperation, reciprocal exchange, and mutual trust between birth parents and the host family. Families share decision-making authority, and SFC volunteers and paid staff serve as case coordinators for the birth parents and the host families. Additional volunteers may be recruited to help both sets of families in other ways, such as providing

transportation assistance, child care, moral support, and job search assistance. After the hosting arrangement has ended, the goal is for the two families to remain in contact and hopefully sustain the "bridging social capital" that was built up between them. Because of the legacy of trust and reciprocity that was forged between the two families during their shared care of the child, the expectation is that the supportive arrangement will continue after the children are reunified with their birth family.

Observations made during initial implementation and formative evaluation indicate that DCFS investigation staff, particularly in Cook County, may be diverging from fidelity to the SFC model in potentially unhelpful ways. It appears that some DCFS investigators may view SFC as a temporary holding spot until they are able to gain sufficient evidence to justify removal of the children. This is not the purpose of SFC, and there is additional concern that removing children who are in a voluntary hosting situation may not satisfy the urgent and immediate requirement for removal. The high rate of cross-overs in Cook County suggest that SFC is not being utilized as intended in Cook County. This contributes to the equivalent removal rates of children in Cook County, regardless of assignment group. The opposite pattern observed across the non-Cook regions, where children in the intervention group are deflected from protective custody and foster care at significantly higher rates than the comparison group, further reinforces the concern that the intervention is being inappropriately implemented in Cook County. There are other implementation problems that will need to be addressed, such as the low rate of follow-through for families who have agreed to accept the intervention (no-shows).

SFC staff have reported resistance from DCFS staff to the use of the randomizer. Their argument is that DCFS needs to help each family. Some regions have refused to use Safe Families because some families are alternately allocated to CPS as usual. It is an odd philosophy that withholds help from all families because a randomized half are offered business as usual. Further SFC staff received feedback from a DCFS supervisor that his investigators do not use SFC anymore because they do not want to randomize cases. He finds the study unethical since children unable to go into hosting because of a 'no' then have to be screened in. The problem with this ethical objection is that there is insufficient evidence to indicate that SFC is truly an intervention that "helps" each family. In fact, there are some indications from the Cook County pilot that participation in SFC may be putting children at greater risk of family disruption. There is a long history of practices that were deemed promising based on expert judgement, which later turned out not to have the positive impact that people hoped. More distressing, there are widely implemented interventions that turn out to have harmful impacts once properly evaluated. *Scared Straight* is a notable example. Conversely, there are many examples of randomized experiments that demonstrate the benefits and worth of promising practices and helped change federal law. The Illinois subsidized guardianship experiment is a notable example. The whole philosophy of the BH Implementation plan is first to learn whether a promising program truly works before rolling it out to all families. By showing whether or not SFC truly improves safety and preserves families compared to similar families that receive CPS as usual, the state will acquire the evidence needed to justify expansion of the program or, if the evidence shows no positive impact, look for other ways to help families.

VII. Overall Assessment

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

The overall assessment is that there is sufficient evidence to warrant proceeding to full implementation and summative evaluation for non-Cook counties effective January 1, 2017. The formative data indicate that the number of referrals are continuing to reach quarterly targets. Further,

the Mindshare dashboards show that children assigned to the intervention group were more likely to be deflected from protective custody and less or no more likely to be removed into foster care after allocation than children assigned to the comparison group. The pattern was most pronounced in the non-Cook regions of the state with those differences trending toward statistical significance. The formative results also argue against proceeding to full implementation and summative evaluation for referrals made in Cook County until the proportion of intervention families that actually receive SFC hosting services reaches 33% and the percentage of cross-overs from comparison to receive the SFC hosting services declines to less than 3%. Reaching these milestones increases the likelihood that an internally valid estimate can be generated of the impact of SFC on preventing the removal of children into foster care, avoiding repeat maltreatment, and ensuring that children remain safely under the case of their parents for at least two years. In the meantime, the research project will be pre-registered for a summative evaluation in non-Cook regions using the Open Science Framework (OSF) Standard Pre-Data Collection Registration template.

Appendix A

Safe Families For Children Logic Model

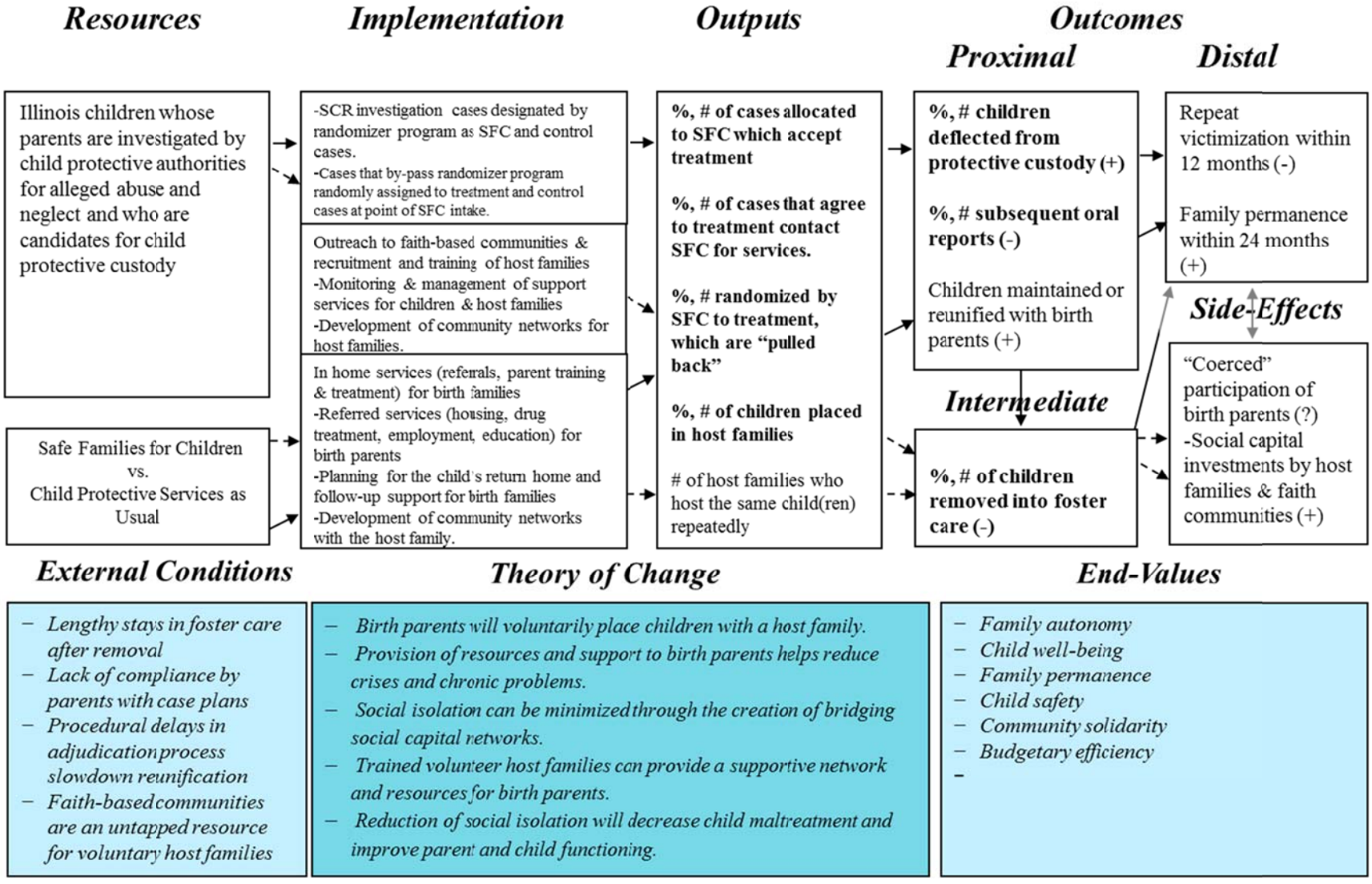


EXHIBIT Q

Information Technology (IT)/CCWIS RFP BH Status Report by V Jonathan

April 4, 2017

I. Plan

DCFS intends to evaluate and potentially take advantage of the recently released Federal Rule for States to migrate from a Statewide (or Tribal) Automated Child Welfare Information System TACWIS/SACWIS environment to a Comprehensive Child Welfare Information System (CCWIS).

II. Background

Originally developed in 1993, the Department of Health Human Services released TACWIS/SACWIS regulations which defined large systems that maintained all of the functions for child welfare workers to record and manage Foster Care and Adoption cases. Earlier this year, a federal rule was released providing the ability for states to move to Comprehensive Child Welfare Information System (CCWIS.) The transition provides states more flexibility to design systems tailored to their needs. The rule promotes data sharing with other agencies, requires data quality, reduces mandatory functional requirements, and allows agencies to build system based on their needs. Although DCFS doesn't have approved SACWIS application, it does maintain most of the case management functionality in a single system referred to as "SACWIS." It also manages much of its accounting and case opening/closing processes in two legacy systems referred to as MARS/CYSIS.

Currently DCFS has numerous software applications that reside outside of the SACWIS environment which is not atypical among State Child Welfare agencies around the country. Initial system designs were developed years ago, business processes change, agencies priorities fluctuate from administration to administration, integration opportunities present themselves, newer technology collides with legacy systems, and the lack of strategic and enterprise vision all drive this national challenge.

III. Theory of Change

As Director Sheldon and leadership aggressively seek ways to improve the system of care, DCFS needs to maintain agile in its work process. Technology to support modern practice of Child Welfare and general work processes will be a requirement. In order to do this, systems will need to be nimble, easier to maintain, and have the ability to integrate with other systems and agencies across the Health and Human Services verticals.

IV. Implementation Status

Short Term

A feasibility study evaluating and documenting the work process within the system of care "as is" and "to be" should be performed. This study will be used to generate the requirements for a Request for Proposal (RFP) to migrate to a CCWIS environment.

DCFS intends to leverage internal and external resources to manage this initiative. Funding from the Federal government is available for these efforts using a Planning Advanced Planning Document (PAPD) will be submitted to ACF. If approved, DCFS can receive 50% funding.

**Update 10/7/16
Members of DCFS met with Dian Carrol of ACF to discuss approach of transitioning to a CCWIS state. Follow up meetings internal with DCFS will occur within the month of October to initiate necessary paperwork.

**Update 11/4/16
PAPD is in final draft form pending internal review of DCFS Leadership and is anticipated to be signed by Director Sheldon by 11/9/16 or sooner then sent to ACF. Anticipated response by ACF will be by mid-January 2017. DCFS will begin creating the RFP for vendors to manage the feasibility study with an anticipated release date of February 2017 or sooner.

**Update 12/9/16
PAPD was submitted to ACF and approved by Commissioner Lopez on 11/28. DCF will proceed with the development of an RFP for the feasibility study. RFP is expected to be released in January 2017.

**Update 01/13/17
DCFS is finalizing the RFP to perform a feasibility study with an anticipated completion date on or before January 31, 2017. ACF has reviewed and submitted suggested changes.

**Update 02/13/17
DCFS has finalized the RFP to perform the feasibility study and will be submitted to ACF for final review by February 15, 2017. ACF will perform a final review and approval within the next 30-60 days before DCFS can post for responses by the vendor community.

**Update 4/4/17
DCFS has received approval from ACF of the RFP for the feasibility study and the solicitation has been published. The bidder's conference took place on 3-16-17. The Vendor questions were due by 3-21-17 and the department published the responses to these questions on 3-27-17. The bid opening date is scheduled for 4-11-17. There will be a two phase scoring model, the responsiveness and an oral presentation phase. We are on track for the target contract start date of 7-1-17.

Long Term (Beyond 18 Months)

Upon completion of the feasibility study and business requirements phase, DCFS intends to create and release a Request for Proposal (RFP) for the new CCWIS platform.

V. Outputs

Planning Advanced Planning Document – develop and submit PAPD to the federal government. This document should include DCFS intent to perform a feasibility study and development of a RFP with the intent to request 50% funding.

Request for Proposal – the proposal should include the business requirements needed to support DCFS vision of system of care including by not limited to case management, supporting mobility, integration to other state systems and third party applications, data analytics, geographic information systems, reporting, assessment tools, unusual incident reporting, provider systems, client portals, etc.

VI. Proximal

Proximal Outcome (per Proximal Outcome in Logic Model)	*Intervention Group (%, N)*	*Comparison Group (%, N)*	*Significance and Explanation of Difference THIS HEADING IS NOT APPLICABLE contains dates*
Planning Advance Planning Document (PAPD) • Meet with other states to discuss approach • Develop PAPD • Submit to Federal Government	Not Applicable	Not Applicable	Expected Completion Date 1/1/17. Update – Completed by 11/9/16
Feasibility Study/Develop Request for Proposal • Identify Internal Staff • Identify External Resources • Develop Schedule for Statewide Review • Meet with Policy/Operations to develop "to be" model. • "As is" vs. "to be" analysis • Develop RFP based on new business needs for CCWIS platform	Not Applicable	Not Applicable	Expected completion 4/1/18

I. Distal Outcomes

Distal Outcome (per Distal Outcome in Logic Model)	*Intervention Group (%, N)*	*Comparison Group (%, N)*	*Explanation of Status THIS COLUMN CONTAINS EXPECTED DATES*
Release Request for Proposal	Not Applicable	Not Applicable	Expected Completion by 10/1/18

II. Other Consequences

The Planning Advance Planning Document the DCFS IT staff is being absorbed into a new state agency, Department of Innovation and Technology (DoIT). The State of Illinois IT transformation may impact DCFS' access to necessary resources. Other contingencies include funding availability.

III. Plan Revisions.

No change planned at this time.

EXHIBIT R

04/18/2017 Mobile app version 2 to be released 4/19/17

*To preview v2 updates, watch the **updated video demos*** or review the **SACWIS App User Guide v2*** available on the mobility website.*

This significant update introduces:

- A ***new*** and ***improved*** user interface
- Industry-standard design
- Intuitive navigation
- Standard controls
- Android compatibility (to support future Mobile Partner Access)
- Auto-rotate enhancement (landscape orientation now supported) for Bluetooth keyboard users and larger photo display

The SACWS app will automatically be removed and the new Case Access app will be pushed to all DCFS iPhone 6S+ devices at approximately **noon on 4/19/17**. If your device does not automatically receive the new app, you can conveniently install it from the DCFS App Store.

You will be required to enter your user name (network ID) and current mobile app password for initial log-in. If you have Touch ID configured on your device, the app will automatically prompt and offer to setup touch login for **subsequent** logins. If you don't remember your current mobile app password, please contact the Help Desk to reset it.

If you experience any issues with this update or need additional assistance, please contact our Help Desk via email or call 1-800-610-2089. You can also reach out to your local mobile super user* for help. Thank you!
links will take a few moments to load.

EXHIBIT S

4-MONTH STATUS REPORT

Develop and Implement a New Plan for Monitoring Residential and Group Home Programs

Date submitted: April 30, 2017

I. Revised Targets / Goals

Evaluation

- The initial plan for evaluating the TRPMI pilot was to use a cross-sectional pre-test / post-test design with calendar year 2016 (CY16) defined as the baseline year (pre-test) and calendar year 2018 (CY18) defined as the post-test year. Due to the evolving nature of the implementation plan, however, the TRPMI Evaluation Sub-Committee is currently examining the feasibility of adopting an interrupted time series design. Interrupted time series designs are commonly used to examine change in outcomes during a period of time preceding a program or policy change and a similar period of time after such a change. Adopting this design will allow evaluators to better control for changes over time that are independent of the TRPMI intervention. It will also allow more flexibility in defining a baseline time point or points, which should allow the evaluation design to more accurately reflect the implementation milestones (i.e. hiring of full time clinical staff). The B.H. experts have expressed support for this change in evaluation design. The next 4-month report will likely reflect these changes.
- It would be unwise to anticipate that the outcomes of the pilot would adequately support a statewide rollout that is grounded in strengthening DCFS' internal capacity to solely monitor residential programs. Given the scope and complexity of the intervention, it may not be realistic to integrate TRPMI strategies into DCFS operations in the foreseeable future.
- At the suggestion of BH experts, the number of critical program outputs are currently being identified and the total number will be reduced to a more manageable number. However, the pilot teams will continue tracking some of the outputs as process indicators as necessary to ensure fidelity and manage team activities.

TRPMI Activities

- Focused efforts to schedule and convene CFT meetings will be initiated in April. This will include partnering with the CIPP program to assign facilitators who will assist in planning and facilitating the initial Child and Family Team meetings and a limited number of subsequent CFT meetings.
- The Communication Protocol was tested in March 2017 and a decision was made to proceed with full implementation. An implementation plan is under development and implementation is projected to start in May 2017.
- As implementation proceeds, the team composition may be inadequate to address the full scope of the work, especially with respect to the activities associated with individualized and intensive discharge planning. Consequently, early indications are that TRPMI teams are stretched and some of the traditional monitoring activities focusing on

agency compliance issues and effectiveness require greater attention. Presently, the Steering Committee agreed that a third Clinical Specialist should be added to the Cook TRPMI Team. When the permanent team members are in place, an overall evaluation of resources will be necessary.

Staffing

- Permanent positions (6 FTE Clinical Specialist, 1 FTE QI Specialist and 1 FTE Statewide QI Manager) have been approved and posted at NU since the last status report. We anticipate hiring into those positions by the end of June 2017.

Data Systems

- A plan was put in place to expand the team developing the data system (i.e., SharePoint) essential for tracking TRPMI activities and generating reports. Additionally, a new MindShare report is being designed (i.e., column list for the Congregate Care dashboard) by the TRPMI team in conjunction with OITS. Although the report was targeted to be completed by April 15, 2017, it's still pending. We hope to have it completed in May.

II. Problem Formulation

Provide brief descriptions of the problem(s) and program(s) that is/are being implemented to address the problem(s). Include a brief description of the comparison group or benchmarks against which comparisons will be made, e.g. control group, historical cohort, neighboring counties, or target goals.

Introduction

In July 2015, the BH Expert Panel report noted several concerns with the internal capacity of DCFS to monitor and evaluate therapeutic residential programs. The Panel recommended that DCFS enlist the assistance and guidance of external partners to develop a more effective residential and group-home monitoring program. As a result, DCFS partnered with Northwestern University and the University of Illinois at Chicago to develop an improved monitoring system – the Therapeutic Residential Performance Management Initiative (TRPMI). Chapin Hall was selected as the evaluator for this initiative.

Plan & Implementation

The TRPMI was originally designed to effectively monitor, evaluate and promote therapeutic residential program effectiveness. Although enhanced, the design was similar to the primary goals of the previous monitoring program. It was determined in early January 2017 by the Department, Plaintiffs and Expert Panel that the primary focus of the pilot should be to monitor youth and their progress from a clinical perspective in addition to the regulatory monitoring to ensure program compliance. A comprehensive, revised plan for the pilot was developed as the TRPMI pilot was initially implemented on January 9, 2017 in the Northern and Southern Regions. The revised plan addresses the safety, well-being and clinical outcomes of youth in residential facilities *in addition* to a review of the facilities themselves. Specifically, the TRPMI is clinically driven, trauma-informed and team oriented with a focus on utilizing continuous quality improvement (CQI) methods and addressing organizational culture and climate. The activities of the TRPMI teams include:

- Identifying effective practices for transitioning youth from therapeutic residential programs so that youth are stable and thriving in their step down placement.
- Addressing issues and barriers, both within residential programs and the larger service system, to improve outcomes.
- Conducting reviews and administering surveys and tools to collect data on a variety of program- and youth-specific indicators.
- Engaging relevant stakeholders to improve youth connections, build/enhance child and family teams, encourage youth voice and develop post discharge supports.

Critical to the success of the TRPMI will be its ability to collaborate with Therapeutic Residential Providers and other BH initiatives including Immersion Sites, Therapeutic Foster Care, FTS Practice Model, Case Management Entity/Choices, Regenerations, Pay for Success and Family Finding and Engagement.

TRPMI was implemented in Northern and Southern regions on January 9, 2017 and now includes 22 program groups (made up of 77 programs from 17 different residential treatment provider agencies in the Northern, Southern and Cook Regions). When fully implemented, the staff assigned to TRPMI teams will consist of internal and external staff, and include a Team Coordinator, Clinical Specialists, Monitors, and a Quality Improvement Specialist under the direction of a TRPMI Manager.

Evaluation

The intervention is the TRPMI and the comparison intervention is business-as-usual (BAU) monitoring. The evaluation of the three pilot regions currently consists of three phases: baseline year (CY16), implementation year (CY17), and post-implementation year (CY18). Chapin Hall collected baseline survey data (CY16) on all residential treatment providers, including those in the three pilot regions. During the implementation year (CY17), TRPMI will be implemented in the three pilot regions, in which process and implementation data will be collected to guide implementation. Data collected by the TRPMI teams will be used to inform the evaluation. During the post-implementation year (CY18), a follow-up survey will be conducted. In addition, outcomes data leveraged from administrative data will be analyzed to compare outcome changes from the baseline year to the post-implementation year (CY16-CY18) between the 22 program groups in the pilot regions vs. the 26 program groups not in the pilot regions.

Upon successful completion of the pilot, the TRPMI strategies will be used to build the internal capacity of DCFS staff to effectively monitor the safety, well-being and permanency of youth receiving residential treatment. The TRPMI monitoring model will then be implemented statewide.

III. Program Outputs

Use the table below to report data on the relevant amounts of program outputs, e.g. number of children, families, foster homes, offices, that are expected to be reached or delivered by the program. The numbers and percentages should identify the counts and proportions that received the intended program content (reach), the amounts of program content received by each of the participants (dosage), and whether these amounts are adequate, marginally

adequate, or inadequate (e.g. due to attrition, drop-outs, or unsatisfactory participation).The specific Outputs listed should match those detailed in the Logic Model.

Include comparable data on outputs against which comparisons will be made using the reference group identified above under Problem Formulation. Under the "Significance and Explanation of Difference," briefly describe whether the differences are trending in the expected or opposite direction.

The primary program outputs are included in the following table. As noted in section II, the number is critical program outputs are being reduced to a more manageable number. Outputs indicated between #8 - #11 in the table are likely to be eliminated.

Program Outputs ***(per Outputs in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Significance/ Explanation of Difference***
1. Number of Youth Assigned to the TRPMI pilot, by pilot site	<u>January 2017</u> Northern: 136 Southern: 152 Total: 288 <u>February 2017</u> Northern: 150 Southern: 162 Total: 313 <u>March 2017 (3/20/17)</u> Cook: 171 Northern: 150 Southern: 162 Total: 483	NA	NA
2. # and % of priority youth with completed CASII assessments (include targets and target dates)	<u>January 2017</u> 4 CASIIs completed (1%) <u>February 2017</u> 23 CASIIs completed (7%) <u>March 2017 (3/20/17)</u> 34 CASIIs completed (8%) <u>Targets</u> April 2017: 33 May 2017: 30 June 2017 30	NA	NA

3. # and % of priority youth for whom CFT members have been identified and notified and initial CFT date **SET** (e.g., Youth, family/kin, permanency worker, supervisor, caregiver, TR program, other supports)	<u>Projected April 2017</u> CFTM Scheduled: 45 CFTM Conducted: 39 <u>Projected May 2017</u> CFTM Scheduled: 37 CFTM Conducted: 31 <u>Projected June 2017</u> CFTM Scheduled: 32 CFTM Conducted: 27	NA	NA
4. % of youth whose permanency worker regularly visits	Data not available	NA	NA
5. # and % of priority youth, by category: e.g., pilot site, by Immersion Site, by TFC service area, by Choices involvement, by Regenerations	Data not yet available for all categories. # Immersion Site Youth: Cook Team: 18 Northern Team: 16 Southern Team: 29	NA	NA
6. # and % of Priority Youth for whom Initial CFT has occurred; strengths and needs identified and documented in an individualized plan	Projected April 2017: 34 Projected May 2017: 27 Projected June 2017: 24	NA	NA
7. % of youth receiving post-discharge services as indicated (redefined as receiving services outlined in individualized plan)	Data not yet available	NA	NA
8. % of TR programs demonstrating fidelity to key elements of TR procedures	Data not yet available	NA	NA
9. % of TR programs that adopt and implement EBPs with fidelity	Data not yet available	NA	NA
10. % of TR agencies that demonstrate fidelity to CQI Metrics	Data not yet available	NA	NA
11. Develop a TRPMI DNET page	Data not yet available	NA	NA

IV. Proximal and Distal Outcomes

Use the table provided below to report progress in attaining the proximal and distal outcomes (if available at the time of the report). The Outcomes listed should match those detailed in the Logic Model. In the "Explanation of Status," briefly describe whether the differences in the outcomes, which were intended to result from the intervention, are in alignment with expectations.

CY2016 outcomes between Program (TRPMI Pilot) vs. Comparison (Non-TRPMI Pilot) are reported in the following table. Survey data is collected one time per year and administrative data (e.g., CYCIS, RTOS) is available for reporting with an approximately ninety-day delay. Therefore, data are only available through CY2016 as of this reporting period.

Though outcome values are reported separately for the Program and Comparison groups and differences exist between the groups, these differences are not a result of the TRPMI pilot as these data reflect baseline outcomes in the calendar year prior to TRPMI implementation. Therefore, it is noted in the explanation of status column in the table below – intended for a description of data trends – that we do not hypothesize differences between the intervention and comparison groups for the period reflected in this report.

Data are reported for each proximal, intermediate, and distal outcome as indicated by the TRPMI logic model and as defined by TRPMI operational definitions for each outcome. Outcomes include youth safety, permanency, and well-being, as well as program-level incorporation of youth voice, best practices and trauma-informed services, family engagement, and improvements to organizational climate and culture. Baseline outcome data are derived from a number of different sources, including the Chapin Hall baseline survey of therapeutic residential provider staff adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009) along with scales of *Safety Climate* (Zohar, 1980), *Safety Organizing* (Vogus & Sutcliffe, 2007), and *Psychological Safety* (Edmondson 1999), and administrative data from SACWIS, CYCIS, Illinois Outcomes, and RTOS databases.

Many of the TRPMI outcomes are measured in a number of ways. For example, some outcomes are measured by both survey and administrative data. Others may be measured by multiple variables derived from administrative data, each from different sources. The purpose of this strategy is to provide a more robust perspective of changes to program and youth functioning. For each outcome listed in the table below, we provide CY2016 baseline values for each measure of the outcome, along with some summary operational information to inform interpretation. For example, Proximal Outcome 1: *Improve program-level metrics related to youth safety*, is measured by data provided by Northwestern University from the RTOS database, and from data collected via the baseline survey of residential providers conducted by Chapin Hall in CY2016. The administrative data measures allegations and absence of maltreatment for youth in residential treatment and the survey measure captures use of safety practices related to youth in residential treatment.

Measures derived from administrative data were operationalized according to variables available in existing administrative databases and are reported according to the definitions associated with each respective database. Or, if data transformation occurred, those changes are indicated in the summary definitions for individual metrics of TRPMI outcomes. Attempts were made, when possible, to align operational definitions for measures with those used by other DCFS pilots and programs. For example, as a measure of youth well-being, TRPMI adopted the operational definition of well-being developed by the DCFS Child Welfare Advisory Committee (CWAC). This definition includes measures of Social Functioning Strengths and Social Functioning Behaviors derived from the Child and Adolescent Needs and Strengths (CANS) assessment instrument items. Therefore, the TRPMI operational definition of child well-being is consistent with other definitions and is multi-faceted and is made up of a number of aspects of youth well-being including cognitive functioning, physical

health, emotional/behavioral functioning, and social functioning.

Measures derived from survey constructs are reported as proportion scores for each of the twelve constructs that make up the residential provider survey: *Child and Family Voice, Communication, Continuous Quality Improvement, Cultural Competence, Family Engagement, Restraint and Seclusion, Strategies and Interventions, Transition Planning, Treatment Planning, Unusual Incident Reporting, Youth Safety Practices*, and *Youth Decision-Making*. Proportion scores are attained by summing and calculating item scores as a proportion of the total possible score for items characterizing each construct. Possible proportion scores range from 0 (no items met) to 1 (all items met). Scores closer to 1 indicate higher ratings for that construct.

As outlined previously in the example of Proximal Outcome 1, use of RTOS data allow us to examine percentage and overall number of allegations of maltreatment (Program Group = 11%, 91; Comparison = 9%, 89), and the percentage of absence of maltreatment for youth in the two groups (Program Group = 89%; Comparison Group = 91%). Survey data provide a proportion score of residential provider perception of the use of *Youth Safety Practices* (Program Group = .80; Comparison = .77). When combined, these measures provide a robust view of youth safety metrics. All other outcome measures included in the table below should be interpreted similarly.

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
Proximal Outcome 1: Improve program-level metrics related to **youth safety**	• **Youth Maltreatment** (Northwestern University RTOS data on allegations and absence of maltreatment): - Allegations of maltreatment = 11%, 91 - Absence of maltreatment = 89% • **Youth Safety Practices** (Chapin Hall survey). Average Proportion Score = 0.80 (SD=0.31)	• **Youth Maltreatment** (Northwestern University RTOS data on allegations and absence of maltreatment): - Allegations of maltreatment = 9%, 89 - Absence of maltreatment = 91% • **Youth Safety Practices** (Chapin Hall survey). Average Proportion Score = 0.77 (SD=0.34)	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Proximal Outcome 2: Improve program-level metrics related to **youth well-being**	• **School Attendance** (Northwestern University RTOS Data on school attendance per 6-month periods prior to RTOS evaluations in CY16): - Average attendance of 86.2% among 480 residential treatment spells with valid attendance data in	• **School Attendance** (Northwestern University RTOS Data on school attendance per 6-month periods prior to RTOS evaluations in CY16): - Average attendance of 89.3% among 497 residential treatment spells with valid attendance data in	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups

Proximal/Distal Outcome (per Outcomes in Logic Model)	*Program (%, N)*	*Comparison (%, N)*	*Explanation of Status*
	CY16 (average school days attended days/average school days scheduled). • **Youth Immunizations** (DCFS Office of Health Services immunization compliance data). Among youth in the 841 TR placements in CY16: - EPSDT screening (69.0% compliant) - Dental preventive services (87.5% compliant) - Flu shot (66.8% compliant, out of 835 eligible youth) - TDap (93.5% compliant, out of 799 eligible youth) - Meningococcal (94.2% compliant, out of 789 eligible youth) - HPV (68.4% compliant, out of 768 eligible youth) • **Youth Well-Being** (Chapin Hall CANS data): Below we report the percentage actionable per item among non-missing scores (i.e., a score of "2" or "3"), using the first CANS after youth entered TR placement. Scores are reported for each domain below as follows: (% actionable, out of # non-missing CANS records).	CY16 (average school days attended days/average school days scheduled). • **Youth Immunizations** (DCFS Office of Health Services immunization compliance data). Among youth in the 1,104 TR placements in CY16: - EPSDT screening (78.6% compliant) - Dental preventive services (86.2% compliant) - Flu shot (68.4% compliant, out of 1,101 eligible youth) - TDap (91.9% compliant, out of 1,011 eligible youth) - Meningococcal (93.2% compliant, out of 1,002 eligible youth) - HPV (70.0% compliant, out of 992 eligible youth) • **Youth Well-Being** (Chapin Hall CANS data): Below we report the percentage actionable per item among non-missing scores (i.e., a score of "2" or "3"), using the first CANS after youth entered TR placement. Scores are reported for reach domain below as follows: (% actionable, out of # non-missing CANS records).	

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***

	<u>Cognitive Functioning</u>
	- Developmental Needs (age 0-5 only):
	  - Developmental/Intellectual (16.6%, 596)
	- Young Child Developmental Needs (age 0-5 only):
	  - Motor (1.2%, 166)
	  - Sensory (5.4%, 166)
	  - Communication (3.6%, 165)
	- Social Functioning Behaviors
	  - School Achievement (32.2%, 578)
	
	<u>Physical Health</u>
	- Medical/Physical Health:
	  - Medical (16.1%, 596)
	  - Physical (1.9%, 596)
	- Young Child Physical Health (age 0-5 only):
	  - Failure to Thrive (0.6%, 165)
	  - Birth Weight (0.6%, 161)
	  - Substance Exposure (16.8%, 173)
	
	<u>Emotional/Behavioral Functioning</u>
	- Traumatic Stress Symptoms:
	  - Adjustment to Trauma (44.0%, 596)
	  - Re-Experiencing (19.6%, 596)
	  - Avoidance (27.5%, 596)
	  - Numbing (17.1%, 596)
	  - Dissociation (8.2%, 596)
	- Emotional/Behavioral Strengths:
	  - Optimism (32.9%, 592)
	- Emotional/Behavioral Needs:
	  - Psychosis (7.7%, 596)
	  - Attention/Impulse
		<u>Cognitive Functioning</u>
		- Developmental Needs (age 0-5 only):
		  - Developmental/Intellectual (22.0%, 669)
		- Young Child Developmental Needs (age 0-5 only):
		  - Motor (15.4%, 26)
		  - Sensory (19.2%, 26)
		  - Communication (21.4%, 28)
		- Social Functioning Behaviors
		  - School Achievement (26.3%, 647)
		
		<u>Physical Health</u>
		- Medical/Physical Health:
		  - Medical (7.5%, 669)
		  - Physical (1.9%, 669)
		- Young Child Physical Health (age 0-5 only):
		  - Failure to Thrive (0.0%, 23)
		  - Birth Weight (8.7%, 23)
		  - Substance Exposure (33.3%, 30)
		
		<u>Emotional/Behavioral Functioning</u>
		- Traumatic Stress Symptoms:
		  - Adjustment to Trauma (52.5%, 669)
		  - Re-Experiencing (24.2%, 669)
		  - Avoidance (38.9%, 669)
		  - Numbing (24.4%, 669)
		  - Dissociation (12.3%, 669)
		- Emotional/Behavioral Strengths:
		  - Optimism (40.4%, 668)
		- Emotional/Behavioral Needs:
		  - Psychosis (11.1%, 669)	

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
	(58.9%, 596) - Depression (37.4%, 596) - Anxiety (28.9%, 596) - Oppositional (45.6%, 596) - Conduct (22.8%, 596) - Substance abuse (14.7%, 596) - Attachment (31.4%, 596) - Eating Disturbance (3.2%, 596) - Affect Dysregulation (42.3%, 589) - Behavior Regressions (12.5%, 585) - Somatization (4.3%, 586) - Anger Control (57.3%, 595) - Select Risk Behaviors: - Suicide Risk (15.8%, 596) - Self-Mutilation (12.4%, 596) - Other Self Harm (12.8%, 596) - Danger to Others (41.3%, 596) - Sexual Aggression (6.9%, 596) - Runaway (33.7%, 590) - Delinquency (16.4%, 590) - Judgment (40.7%, 595) - Fire Setting (1.9%, 571) - Sexually Reactive Behaviors (11.9%, 596) <u>Social Functioning</u> - Social Functioning Strengths: - Interpersonal (42.4%, 595) - Relationship Permanence (46.2%, 584)	- Attention/Impulse (52.5%, 669) - Depression (45.1%, 669) - Anxiety (36.4%, 669) - Oppositional (40.4%, 669) - Conduct (23.1%, 669) - Substance abuse (10.3%, 669) - Attachment (35.9%, 669) - Eating Disturbance (4.5%, 669) - Affect Dysregulation (39.3%, 666) - Behavior Regressions (11.9%, 665) - Somatization (5.3%, 665) - Anger Control (47.9%, 668) - Select Risk Behaviors: - Suicide Risk (15.3%, 669) - Self-Mutilation (12.0%, 669) - Other Self Harm (12.3%, 669) - Danger to Others (26.3%, 669) - Sexual Aggression (10.8%, 669) - Runaway (29.7%, 666) - Delinquency (14.1%, 665) - Judgment (49.0%, 664) - Fire Setting (2.1%, 655) - Sexually Reactive Behaviors (13.8%, 669) <u>Social Functioning</u> - Social Functioning Strengths: - Interpersonal (50.8%, 668) - Relationship Permanence (56.3%, 668)	

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***

	- Family (52.2%, 596)
	- Social Functioning Behaviors:
	  - Social Functioning (41.3%, 596)
	  - School Behavior (36.9%, 583)
	  - Social Behavior (26.7%, 591)
	- Social Functioning Behaviors (Adolescence):
	  - Intimate Relationships (30.2%, 169)
	- Young Child Social Behaviors (age 0-5 only):
	  - Curiosity (2.4%, 164)
	  - Playfulness (3.6%, 165)
	
	<u>Elements that Can Affect Well-Being</u>
	- Family (51.8%, 593)
	- Living Situation (33.2%, 596)
		- Family (52.0%, 669)
		- Social Functioning Behaviors:
		  - Social Functioning (48.3%, 669)
		  - School Behavior (29.4%, 646)
		  - Social Behavior (34.2%, 666)
		- Social Functioning Behaviors (Adolescence):
		  - Intimate Relationships (43.7%, 270)
		- Young Child Social Behaviors (age 0-5 only):
		  - Curiosity (9.5%, 21)
		  - Playfulness (9.5%, 21)
		
		<u>Elements that Can Affect Well-Being</u>
		- Family (58.3%, 666)
		- Living Situation (32.0%, 669)	

Proximal Outcome 3: Improve metrics related to **<u>youth voice</u>**	• **Child and Family Voice** (Chapin Hall survey): Average Proportion Score = 0.71 (SD=0.32) • **Youth Decision Making** (Chapin Hall survey): Average Proportion Score = 0.67 (SD=0.32)	• **Child and Family** Voice (Chapin Hall survey): Average Proportion Score = 0.67 (SD=0.35) • **Youth Decision Making** (Chapin Hall survey): Average Proportion Score = 0.63 (SD=0.34)	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Proximal Outcome 4: Improve metrics related to **<u>TR providers' use of TR best practices</u>**	• **Treatment Planning** (Chapin Hall survey): Average Proportion Score = 0.82 (SD=0.28) • **Strategies and Interventions** (Chapin Hall survey): Average Proportion Score: 0.82 (SD=0.29) • **Cultural Competence** (Chapin Hall survey): Average Proportion Score = 0.75 (SD=0.31) • **Continuous Quality Improvement** (Chapin Hall survey): Average Proportion Score = 0.73	• **Treatment Planning** (Chapin Hall survey): Average Proportion Score = 0.78 (SD=0.30) • **Strategies and Interventions** (Chapin Hall survey): Average Proportion Score: 0.79 (SD=0.32) • **Cultural Competence** (Chapin Hall survey): Average Proportion Score = 0.72 (SD=0.34) • **Continuous Quality Improvement** (Chapin Hall survey): Average Proportion Score = 0.70	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
	(SD=0.31) • **Restraint and Seclusion** (Chapin Hall survey): Average Proportion Score = 0.76 (SD=0.32) • **Restraint and Seclusion** (Northwestern University RTOS Data on Restraint and Seclusion): - Average number of restraints = 1137 - Average number of seclusions = 134 • **Child and Family Voice** (Chapin Hall survey): Average Proportion Score = 0.71 (SD=0.32) • **Communication** (Chapin Hall survey): Average Proportion Score = 0.69 (SD=0.36) • **Transition Planning** (Chapin Hall survey): Average Proportion Score = 0.68 (SD=0.35) • **Unusual Incident Reporting** (Chapin Hall survey): Average Proportion Score = 0.68 (SD=0.36) • **Unusual Incident Reporting** (Northwestern University RTOS Data on UIRS): - Rate of Occurrence-Restraint (IO1): (IO1/Spells)*100 = 138.15 - Rate of Occurrence-Seclusion (IO2): (IO2/Spells)*100 = 16	(SD=0.35) • **Restraint and Seclusion** (Chapin Hall survey): Average Proportion Score = 0.73 (SD=0.35) • **Restraint and Seclusion** (Northwestern University RTOS Data on Restraint and Seclusion): - Average number of restraints = 1516 - Average number of seclusions = 444 • **Child and Family Voice** (Chapin Hall survey): Average Proportion Score = 0.67 (SD=0.35) • **Communication** (Chapin Hall survey): Average Proportion Score = 0.66 (SD=0.38) • **Transition Planning** (Chapin Hall survey): Average Proportion Score = 0.65 (SD=0.36) • **Unusual Incident Reporting** (Chapin Hall survey): Average Proportion Score = 0.63 (SD=0.39) • **Unusual Incident Reporting** (Northwestern University RTOS Data on UIRS): - Rate of Occurrence-Restraint (IO1): (IO1/Spells)*100 = 153.75 - Rate of Occurrence-Seclusion (IO2): (IO2)/Spells)*100 = 45	
Proximal Outcome 5: Improve metrics related to **TR providers' use of EBPs**	• **Use of EBPs** (Chapin Hall survey). Item responses range from 1 (Never) to 5 (Always): Average Item Score =	• **Use of EBPs** (Chapin Hall survey). Item responses range from 1 (Never) to 5 (Always): Average Item Score =	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
	4.62 (SD = 0.69)	4.60 (SD = 0.66)	the program and comparison groups
Proximal Outcome 6: Improve metrics related to **TR providers' use of trauma-informed services**	• **Use of trauma-informed services** (Chapin Hall survey) Item responses range from 1 (Never) to 5 (Always): Average Item Score = 4.56 (SD = 0.71)	• **Use of trauma-informed services** (Chapin Hall survey) Item responses range from 1 (Never) to 5 (Always): Average Item Score = 4.61 (SD = 0.67)	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Proximal Outcome 7: Improve program-level metrics related to **family engagement**	• **Child and Family Voice** (Chapin Hall survey): Average Proportion Score = 0.71 (SD=0.32) • **Family Engagement** (Chapin Hall survey): Average Proportion Score = 0.70 (SD=0.32) • **CFTM** (MindShare dashboards MP6 and M02): - In CY16, 841 youth received TR from TRPMI Pilot providers. Among these 841 youth in TR placements, 815 were active in DCFS care as of 4/23/17 and/or entered DCFS care since FY2010. Of these 815 youth in TR placements currently active in DCFS care, on average there was 1.75 CFTM (SD=2.80 CFTMs) in the lifetime of the cases dating back to case opening (note that the current MindShare dashboard MP6 only counts CFTMs by entry cohort and dashboard M02 does not count CFTMs for non-active DCFS cases, or CFTMs during a specific period of time, e.g., during a specific residential placement).	• **Child and Family Voice** (Chapin Hall survey): Average Proportion Score = 0.67 (SD=0.35) • **Family Engagement** (Chapin Hall survey): Average Proportion Score = 0.67 (SD=0.35) • **CFTM** (MindShare dashboards MP6 and M02): - In CY16, 1,104 youth did not receive TR from TRPMI Pilot providers. Among these 1,104 youth in TR placements, 1,069 were active in DCFS care as of 4/23/17 and/or entered DCFS care since FY2010. Of these 1,069 youth in TR placements currently active in DCFS care, on average there was 1.67 CFTM (SD=2.67 CFTMs) in the lifetime of the cases dating back to case openings (note that the current MindShare dashboard MP6 only counts CFTMs by entry cohort and dashboard M02 does not count CFTMs for non-active DCFS cases, or CFTMs during a specific period of time, e.g., during a	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
		specific residential placement).	
Proximal Outcome 8: Improve metrics related to **TR provider organizational culture and climate**	• **Safety Climate** (Chapin Hall survey). Item response options range from 1 (Not at All) to 5 (To a Very Great Extent): Average Item Score = 4.09 (SD = 0.70) • **Safety Organizing** (Chapin Hall survey). Item response options range from 1 (Not at All) to 5 (To a Very Great Extent): Average Item Score = 3.88 (SD = 0.85) • **Psychological Safety** (Chapin Hall survey). Item response options range from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree): Average Item Score = 5.01 (SD = 1.13)	• **Safety Climate** (Chapin Hall survey). Item response options range from 1 (Not at All) to 5 (To a Very Great Extent): Average Item Score = 4.11 (SD = 0.71) • **Safety Organizing** (Chapin Hall survey). Item response options range from 1 (Not at All) to 5 (To a Very Great Extent): Average Item Score = 3.90 (SD = 0.79) • **Psychological Safety** (Chapin Hall survey). Item response options range from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree): Average Item Score = 5.01 (SD = 1.05)	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Intermediate Outcome 1: Increase % of **TR discharges to family- and fictive kin caregivers**	• **Negative (NDR), Favorable (FDR), and Sustained Favorable Discharge (SFDR)** (Northwestern University RTOS data): - NDR = 14.9 - FDR = 30.4 - SFDR = 23.6 • **Discharge to Family and Fictive Kin** (Chapin Hall Administrative data): - In CY16, 841 TR placements that belonged to the TRPMI Pilot providers - 461 of 841 TR placements were active as of 12/31/16. - Of the remaining 380 TR placements that ended, 159 (41.8%)	• **Negative (NDR), Favorable (FDR), and Sustained Favorable Discharge (SFDR)** (Northwestern University RTOS data): - NDR = 14.5 - FDR = 33.7 - SFDR = 28 • **Discharge to Family and Fictive Kin** (Chapin Hall Administrative data): - In CY16, 1,104 TR placements did not belong to the TRPMI Pilot providers - 600 of 1,104 TR placements were active as of 12/31/16. - Of the remaining 504 TR placements that ended, 174 (34.5%)	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
	were discharged to family- and fictive kin placements.	were discharged to family- and fictive kin placements.	
Intermediate Outcome 2: Decrease % of **youth discharging from TR who re-enter TR**	• **TR Re-Entry** (Chapin Hall Administrative data): - In CY16, 841 TR placements belonged to the TRPMI Pilot - 461 of 841 TR placements were active as of 12/31/16 - Of the remaining 380 TR placements that ended, 134 (35.3%) returned to a TR placement within 6 months.	• **TR Re-Entry (**Chapin Hall Administrative data): - In CY16, 1,104 TR placements belonged to the TRPMI Pilot - 600 of 1,104 TR placements were active as of 12/31/16 - Of the remaining 504 TR placements that ended, 171 (33.9%) returned to a TR placement within 6 months.	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Intermediate Outcome 3: Reduce **number of days from Phase 2 list entry to TR discharge**	• **Days on Phase 2** (Northwestern University RTOS data): Average number of days= 186.9	• **Days on Phase 2** (Northwestern University RTOS data): Average number of days= 178.2	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Distal Outcome 1: Reduce number of **days youth in out-of-home care spend in TR**	• **Residential Treatment Spells** (Northwestern University RTOS data): Number of residential treatment spells = 823 • **TR Placement Days** (Chapin Hall Administrative data): - In CY16, there were 515,959 out-of-home care days among youth who had a TR placement - There were 841 TR placements that belonged to the TRPMI Pilot that totaled 165,346 TR placement days - Thus, on average there were 320.5 TR placement days per 1,000 out-of-home care	• **Residential Treatment Spells** (Northwestern University RTOS data): Number of residential treatment spells = 986 • **TR Placement Days** (Chapin Hall Administrative data): - In CY16, there were 515,959 out-of-home care days among youth who had a TR placement - There were 1,104 TR placements that did not belong to the TRPMI Pilot that totaled 229,813 TR placement days - Thus, on average there were 445.4 TR placement days per 1,000 out-of-home care	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups

Proximal/Distal Outcome ***(per Outcomes in Logic Model)***	***Program (%, N)***	***Comparison (%, N)***	***Explanation of Status***
	days in CY16 (i.e. (165,346/515,959)*1,000=320.5).	days in CY16 (i.e. (229,813/515,959)*1,000=445.4).	
Distal Outcome 2: Reduce number of **TR placements among youth in out-of-home care**	• **Out-of-Home Care** (Chapin Hall Administrative data): - In CY16, there were 841 TR placements that belonged to the TRPMI Pilot - The total number of out-of-home care days among youth who had a TR placement were 515,959 days - Thus, on average there were 1.6 TR placements per 1,000 out-of-home care days in CY16 (i.e. (841/515,959)*1,000=1.6).	• **Out-of-Home Care** (Chapin Hall Administrative data): - In CY16, there were 1,104 TR placements that did not belong to the TRPMI Pilot - The total number of out-of-home care days among youth who had a TR placement were 515,959 days - Thus, on average there were 2.1 TR placements per 1,000 out-of-home care days in CY16 (i.e. (1,104/515,959)*1,000=2.1).	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups.
Distal Outcome 3: Reduce number of **youth in TR placements**	• **Youth in TR Placements** (Northwestern University RTOS data): Number of youth in residential placements = 768	• **Youth in TR Placements** (Northwestern University RTOS data): Number of youth in residential placements = 897	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Unintended Outcome 1: Post-discharge **stability of discharges from TR** may change	• **Post-discharge living arrangements** (Northwestern University RTOS data): - Number of negative living arrangements after discharge = 784 - Number of favorable living arrangements after discharge = 888 - Number discharged youth admitted/re-admitted to more restrictive residential settings, including hospitalization (other than for stabilization of less than 30 days) = 40	• **Post-discharge living arrangements** (Northwestern University RTOS data): - Number of negative living arrangements after discharge = 1227 - Number of favorable living arrangements after discharge = 1107 - Number discharged youth admitted/re-admitted to more restrictive residential settings, including hospitalization (other than for stabilization of less than 30 days) = 48	• None, since these are CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups
Unintended Outcome	• **TR Providers** (Chapin	• **TR Providers** (Chapin	• None, since these are

Proximal/Distal Outcome (per Outcomes in Logic Model)	*Program (%, N)*	*Comparison (%, N)*	*Explanation of Status*
2: Number of **TR providers** may change	Hall Administrative data): - TR providers were designated by the TRPMI Implementation Team using Provider IDs and Contract IDs. From 1/1/16-12/31/16, there were 841 TR placements that belonged to the TRPMI Pilot.	Hall Administrative data): - TR providers were designated by the TRPMI Implementation Team using Provider IDs and Contract IDs. From 1/1/16-12/31/16, there were 1,104 TR placements that did not belong to the TRPMI Pilot.	CY16 baseline values, there is no associated hypothesis about the differences between the program and comparison groups.

V. Theory of Change Revisions

Discuss any modifications of the theory of change about why a program or intervention is expected to work. List any additional connections that need to be made, which link the problems and needs being addressed with the actions the Department has taken or will need to take to achieve desired outcomes. This section may include a revised chain of "if-then" or "so that" statements, which modify the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions.

The Theory of Change requires further review and revision to effectively guide ongoing implementation efforts. The implementations activities need to be tied to outputs and processes. This mapping will also facilitate design of the SharePoint data system. TRPMI anticipates completing this process by June 2017.

Of note, during this reporting period, the Implementation Team – as directed by the BH expert panel – has revised outputs included in the TRPMI logic model in order to further refine and operationalize definitions for reporting purposes. As a result of this task, outputs have been identified as *Primary* or *Contributing* outputs and new outputs were proposed for inclusion in the logic model. More recently, the recommendation was made to reduce the number of outputs. Final decision making should be completed in May 2017.

Additionally, the evaluation subcommittee completed the task of finalizing the definition for the unit of analysis for the evaluation. As a result of this effort, the TRPMI pilot now defines the unit of analysis by program group, rather than by agency. According to this new definition, the TRPMI pilot is comprised of 22 selected program groups made up of 77 programs from 17 different residential treatment provider agencies licensed to serve DCFS youth in care in the three TRPMI regions. For example, the Allendale agency in the Northern Region contains four program groups (Allendale Lake Villa, Allendale Benet Lake, Allendale North Chicago, and Allendale Group Homes) made up of fourteen individual units. Programs were assigned to program groups according to program type and geography. The comparison group is comprised of 26 program groups made up of 103 programs from 26 agencies. As a result of this task, the logic model was amended to reflect the unit change to program groups Appendix 2. Agency program groups are detailed in the Logic Model-Appendix 3.

Finally, in an effort to rigorously account for the phased implementation of the TRPMI pilot, the evaluation sub-committee is currently considering adapting the evaluation design, as described in Section I, to an interrupted time series design. This design change will allow for measurement of change over time, taking into account a series of critical implementation milestones that may impact outcomes. By applying an interrupted time series design, we will conduct difference-in-difference testing to assess change from pre- to post-implementation with a concurrent comparison group, but will also be able to conduct sensitivity tests for each implementation milestone (i.e. hiring of full time clinical staff) to determine the relative impact of each aspect of the program as it is implemented. This design strategy will more adequately meet the needs of this pilot to evaluate individual aspects of the program, as well as to view effect of the program overall in comparison to usual monitoring services.

VI. Overall Assessment

Discuss significant successes and challenges with implementing the plan during the reporting period in the following areas: staff/provider recruitment and selection, training, supervision and coaching, performance assessment, data systems, administrative supports, and external partnerships.

Successes are noted in the summary section. In addition, informal feedback from a wide variety of stakeholders have indicated enthusiastic support for the TRPMI pilot. Residential providers indicated during the April advisory committee meeting that the monitoring observation reports are useful and clinically informed. The providers also commented that the TRPMI is "shining light" on long-standing system issues and barriers.

Several critical issues/obstacles, noted below, have adversely impacted the pilot rollout in important areas, preventing it from gaining momentum and achieving an optimal level of results.

Data Systems

Tracking implementation of TRPMI processes for treatment and discharge planning, and effective coordination across stakeholders requires new integrated information systems that can be accessed by all involved (i.e., SharePoint). Development, access and training with respect to these information systems has commenced with support from DCFS and NU. Additional resources have been temporarily allocated to the pilot to expedite development of an information system (utilizing SharePoint) to track progress for individual youth, communicate across key stakeholders and efficiently identify barriers. NU has hired a part time manager to assist and coordinate development. However, development of the SharePoint site has so far been incomplete in terms of structuring new and existing work processes as needed to assign staff resources, assess implementation fidelity and generate meaningful data/reports.

Efforts to pull together dedicated and skilled staff resources to constitute the development team are underway. While we were hopeful that this newly configured team would make significant strides quickly to provide essential and fundamental support to TRPMI staff, one of these individuals with significant expertise was reassigned to other duties. Progress on SharePoint development will therefore be slower and manual data tracking by the teams will be necessary. The TRPMI requests that additional, dedicated staff resources are added to the team. Otherwise, several important pilot projects will be impeded such as rollout of the communication protocol. Furthermore, the goal of using SharePoint to coordinate activities across stakeholders will also be delayed for the foreseeable future.

Further, due to changes in the Department's Significant Events Reporting system (i.e., transition reporting from RTOS to SACWIS), the pilot teams lost capacity for systematically monitoring youth incidents. As both the TRPMI staff and residential providers become increasingly proficient in the new SER process, some of this capacity will be regained; however, reporting is no longer directly linked to SER entries, making analysis more challenging than was previously the case. Finally, the remaining

RTOS functionality was under-going repair and the quantity and quality of data available to TRPMI teams was limited. The repairs were completed in early April.

Staff/Provider Recruitment & Selection and Supervision & Coaching

Given the dual focus for the pilot on both agency performance, and youth treatment and discharge planning -- involving significant coordination and collaboration with key system stakeholders -- the implementation plan addressed the need to hire two Clinical Specialists for each of the three pilot teams. These positions required contract approval and development from both DCFS and NU. In the interim, clinical staff from the DCFS Clinical Division were detailed to the teams pending completion of the NU hiring process.

While the temporary staff have assisted in pilot activities, there have been challenges in many cases with respect to supervision and oversight of these staff, union rules regarding travel, role clarification, etc. As the contracting process has slowly moved forward, the TRMPI Manager and Team Coordinators have been overburdened as they struggle to build positive morale necessary for heightened advocacy, and testing creative and innovative approaches. Thus far, we have not been able to optimize the benefits we hoped for through a team-based approach. Additionally, the QI staff positions, critical for developing protocols and processes, managing data and providing guidance to the TRPMI teams have not been filled due to the same delays in contract and approval processes. While the implementation lessons learned will better equip us to train and coach the permanent staff, we are concerned that our high-performance expectations for the pilot teams may be unrealistic in the near term.

Note that when we agreed to roll out the pilot with temporary staff, we were assured that permanent staff would be on board within two months (i.e., early March 2017). At this juncture, NU's contract has been approved by DCFS since the last report NU has posted the positions. We project that the new staff will be on board in June 2017.

External Partnerships

We recognize that effective discharge planning involves close cooperation, and support across all stakeholders involved with each youth. Development of effective Child and Family Teams, identification and access to transition and post discharge supports and services are often highly complex and challenging tasks. In our view, a major system wide problem in this regard is a pervasive and long-standing inability or unwillingness to address conflict or disagreements between parties in a productive manner. Consequently, clearly holding participants accountable for ensuring that critical tasks are completed, addressing problems early on in order to avoid lengthy delays in the planning process, addressing lack of consensus situations, and addressing the "chain of command" in the event that preliminary efforts fail are inherent obstacles with respect to this problem.

In an effort to better address this critical issue, TRPMI has developed a communication and problem identification process (i.e., Communication Protocol) that has been well received, tested and discussed with key stakeholders as noted above. TRPMI plans for full implementation of the protocol in June 2017. It will be critical that key leaders in the Department and POS agencies fully endorse and support the protocol.

Administrative Supports - Clarification of Roles, Authority and Responsibility

The TRPMI team has experienced confusion and lack of clarity regarding the relationship of the TRPMI pilot to DCFS monitoring comparison group. Issues related to reporting structure, independence of the TRPMI teams, lines of communication and coordination are problematic at times. It is our opinion that TRPMI staff, as well as stakeholders, need greater clarity regarding these issues.

Initial discussions with DCFS leadership have been promising; however, ongoing intervention by DCFS leadership will be necessary to fully resolve these concerns.

Performance Assessment - Impact of Residential Programs at Risk

A considerable amount of time has been devoted to closely monitoring the operations of several TRPMI programs assigned to both the Northern and Southern TRPMI teams. Monitoring of these struggling programs and providing consultation regarding fundamental safety issues requires the teams to disproportionately allocate resources. TRPMI staff report that managing the dual responsibilities (i.e., traditional monitoring, expediting effective discharge dispositions for youth) may require additional resources across the teams. Once the permanent staff are on board, TRPMI will be in a better position to assess the need for additional resources. To illustrate this issue, the chart below delineates the intensity of each team's monitoring efforts regarding the agency function.

Agency Monitoring Plans					
Team	Agency	Census 3/31/17	Regular Monitoring	Enhanced Monitoring	Intensive Monitoring
Cook	CHASI Rice	35	XX		
	Ibukun	5	XX		
	Lawrence Hall	43	XX		
	Threshold's	23	XX		
	UCAN	65	XX		
Northern	Allendale	79			XX
	Arden Shore	7	XX		
	Little City	16		XX	
	Lutherbrook	30		XX	
	One Hope United	18			XX
Southern	Catholic Children's Home	10		XX	
	Caritas - Bosco	23	XX		
	Egyptian - Circle of Hope	4			XX
	Five Star Industries	3	XX		
	Hoyleton	39	XX		
	One Hope United Hudelson	33	XX		
	Spiro (UMCH)	13	XX		
	TCI	37		XX	

EXHIBIT T

PLAN

The target population for the redesigned Therapeutic Residential (TR) monitoring program, now called the Therapeutic Residential Performance Management Initiative (TRPMI), is TR program groups[a] in Illinois serving youth in DCFS care (n = 48). The TRPMI Pilot will include 22 TR program groups: [b]

1. Allendale Lake Villa (Lake, IS)
2. Allendale Benet Lake[c] (NIS)
3. Allendale North Chicago (Lake, IS)
4. Allendale Group Homes (Lake, IS)
5. Arden Shore (Lake, IS)
6. St. John Bosco (St. Clair, IS)
7. Catholic Children's Home (Madison, NIS)
8. Rice (Cook, NIS)
9. Egyptian (White, NIS)
10. Five Star Industries (Perry, NIS)
11. Hoyleton (Washington, NIS)
12. Hoyleton Group Home (Marion, IS)
13. Ibukun (Cook, NIS)
14. Lawrence Hall (Cook, NIS)
15. Little City (Cook, NIS)
16. Lutherbrook (DuPage, NIS)
17. One Hope United Northern (Lake, IS)
18. One Hope United Hudelson (Marion, IS)
19. Thresholds (Cook, NIS)
20. Transitional Center, Inc. (St. Clair, IS)
21. UCAN (Cook, NIS)
22. UMCH (Jefferson, IS)

The intervention is the TRPMI.

The comparison intervention is business-as-usual (BAU) monitoring.

The effect of TRPMI on the outcomes of interest will be estimated by comparing change from baseline (CY16) to follow-up (CY18) in the 22 TR providers receiving TRPMI during the pilot time period (CY17) versus change over the same time period for the 26 TR providers receiving BAU monitoring during the pilot period.

IMPLEMENTATION

Implementation Team (DCFS, UIC, and NU)

- Develop TRPMI program (IT1)
- Develop multi-disciplinary TRPMI teams (IT2)
- Define TRPMI Team activities (IT3)
- Implement training and coaching for TRPMI Teams (IT4)

TRPMI Teams

- Prioritize discharge planning for "Phase 2" youth and other clinical interventions for youth with significant treatment problems (TT1)
- Partner with relevant BH initiatives – e.g. Immersion Sites, Family Finding, QSR, TFC (TT2)
- Implement standardized, clinically-informed monitoring interventions at program level (TT3)
- Develop individual monitoring and QI plans for TR programs (TT4)
- Conduct reviews, surveys and administer tools to collect data on youth voice, youth connections and progress in treatment (TT5)
- Implement Glisson's ARC model (TT6)
- Implement TA clearinghouse (TT7)

Providers

- Measure youth progress and well-being (P1)
- Implement practice model in alignment with TR Procedures, Building Bridges principles, and FTS (P2)
- Implement an effective CQI process (P3)
- Enhance trauma-informed treatment and implement best practices (P4)
- Adopt Glisson's ARC model (P5)

System

- Develop protocols for coordination and tracking systems between Permanency workers and TRPMI teams (S1)
- Engage and support families (e.g., CFTMs) (S2)
- Develop communication linkages and feedback loops with DCFS divisions and relevant stakeholders (S3)
- Design integrated and streamlined data and reporting systems (S4)
- Develop home and community-based supports and services (S5)
- Use data in the context of the DCFS QA's CQI Framework (S6)
- Develop mutually reinforcing TR and Foster Care performance measures (S7)

OUTPUTS

Primary

- # of youth assigned to the TRPMI pilot, by pilot site
- # of "priority" youth assigned to the TRPMI pilot
- # and % of priority youth with completed CASII assessments (Include targets and target dates)
- # and % of priority youth for whom CFT members have been identified and notified and initial CFT date SET.
- % of youth whose permanency worker regularly visits
- # and % of priority youth, by category
- # and % of Priority Youth for whom initial CFT has occurred; strengths and needs identified and documented in an individualized plan
- # and % of Priority Youth for whom an individual plan has been developed, with goals, services (type, frequency, duration, intensity), timeframes
- % of youth receiving post-discharge services as indicated (redefined as receiving services outlined in individualized plan)*
- % of TR programs demonstrating fidelity to key elements of TR procedures
- % of TR programs that adopt and implement EBPs with fidelity
- % of TR agencies that demonstrate fidelity to CQI metrics
- Develop a TRPMI DNET page

Contributing

- % of Phase 2 and youth with significant issues with action plans developed, for implementation inside the TR program
- # of youth consultations completed and interventions implemented
- % of Youth Experience of Care Surveys & Youth Connections Scales completed
- % of youth/worker engagement surveys completed
- # of wraparound plans identifying home and community based services and supports for which there is no funding
- # and type of home and community based services and supports developed and utilized
- % of Youth and Family post discharge surveys completed
- % of youth with a CFT operating with fidelity
- # of program baseline assessments (triage), provider QI plans and TRPMI team plans
- # of TR procedures training sessions provided to TR programs and stakeholders
- # of enhanced TR and FC performance measures developed and implemented
- # of presentations and collaboration sessions held with stakeholders(e.g. CWAC, GAL)
- # of focus groups conducted with internal and external stakeholders
- # of ARC assessments/interventions implemented
- # of approved Agency Behavior Treatment Plans

OUTCOMES (See Table 1 for definitions and baselines)

PROXIMAL

- Improve program-level metrics related to youth safety (PO1)
- Improve program-level metrics related to youth well-being (PO2)
- Improve metrics related to youth voice (PO3)
- Improve metrics related to TR providers' use of TR best practices (PO4)
- Improve metrics related to TR providers' use of EBPs (PO5)
- Improve metrics related to TR providers' use of trauma-informed services (PO6)
- Improve program-level metrics related to family engagement (PO7)
- Improve metrics related to TR provider organizational culture and climate (PO8)

INTERMEDIATE

- Increase % of TR discharges to family- and fictive kin caregivers (IO1)
- Decrease % of youth discharging from TR who re-enter TR (IO2)
- Reduce number of days from Phase 2 list entry to TR discharge (IO3)

DISTAL

- Reduce number of days youth in out-of-home care spend in TR (DO1)
- Reduce number of TR placements among youth in out-of-home care (DO2)
- Reduce number of youth in TR placements (DO3)

UNINTENDED

- Post-discharge stability of discharges from TR may change (UO1)
- Number of TR providers may change (UO2)

[a] See Appendix 3 for list of Illinois TR providers according to Program Groups
[b] Program Groups are designated with (County location, Immersion Site Status); IS = Immersion Site, NIS = Not and Immersion Site)
[c] Allendale Benet Lake is an out-of-state provider and is not an Immersion Site

BACKGROUND

- More youth in DCFS care are placed in TR than is necessary due to insufficient capacity of community-based placements and resources.
- Youth in DCFS care who are placed in TR stay in TR placements longer than is clinically necessary.
- Current DCFS information systems are unable to provide the data needed to support a more effective provision of TR.
- Workforce constraints regarding deployment of DCFS monitors impacts effectiveness of current TR monitoring program.

THEORY OF CHANGE

Provision of best practices within an enabling organizational culture and climate, coupled with systematic and data-driven monitoring functions – within a larger system of community based services, supports, tools, and resources – will positively impact outcomes related to improved youth safety, well-being, and voice, ultimately reducing the number of days youth spend in therapeutic residential treatment and the number of placements in therapeutic residential treatment.

END VALUES

- To improve monitoring of TR providers
- To promote TR provider quality
- To promote youth outcomes of safety, well-being, family engagement, and treatment progress.

TABLE 1. OPERATIONAL DEFINITIONS AND BASELINE VALUES FOR PROXIMAL, INTERMEDIATE AND DISTAL OUTCOMES

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
Proximal				**Implementation**	**Comparison**
PO1	Improve program-level metrics related to youth safety	An operational definition of PO1 has not been finalized, but the goal is to include the existing measure of absence of maltreatment in TR from SACWIS data and develop other appropriate measures. **NU (Jennifer and Neil):** RTOS data on allegations and absence of maltreatment.	**NU (Jennifer and Neil):** Unique Maltreatment Events = Number of maltreatment events where finalized finding was indicated and the event occurred during the youth's time in that contract. Absence of Maltreatment % = Number of unique maltreatment events divided by the total number of spells for the given contract or subgroup during the designated period of time and subtracting this percent from 100%. NOTE: In cases where incident dates are not available, report dates may be used to determine the date of a maltreatment event.	Not yet available	
		For the definition in this row, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	**Youth Safety Practices** survey construct proportion score. Construct Proportion Score: Sum score of items/35 (total possible for Youth Safety Practices construct): • Strategies/Interventions: a, e, f.ii • Restraint/Seclusion: a, c, d • Transition Planning: a.v Possible proportion scores range from 0 (no Youth Safety Practice items met) to 1 (all Youth Safety Practice items met).	Average Proportion Score = 0.80 (SD=0.31)	Average Proportion Score = 0.77 (SD=0.34)
PO2	Improve program-level metrics related to youth well-being	An operational definition of PO2 has not been finalized, but the goal is to develop, use or enhance existing measures of youth well-being in TR derived from SACWIS, Illinois Outcomes database, or other administrative data such as the school attendance measure, % youth receiving required EPSDT screenings, % youth receiving required dental	**DCFS (Theresa and MCJ):** % school attendance, by PBC provider. **DCFS (Theresa and MCJ):** % youth receiving EPSDT screenings, dental screenings, or other immunizations (influenza, Tdap, meningococcal, and HPV). Criteria include youth in care in GRH, IPA, TLP. **Chapin Hall:** Summarize CANS data of youth in residential care based on the CANS domains determined		

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
		screenings, and/or % youth receiving required immunizations. **DCFS (Theresa and MCJ):** PBC data on school attendance, **DCFS (Theresa and MCJ):** DCFS Office of Health Services immunization compliance data. **Chapin Hall:** CANS data.	by the CWAC well-being committee to represent well-being. The relevant domains are as follows: 1. Cognitive Functioning a. Young Child Developmental Needs (as applicable) b. Developmental Needs c. Social Functioning Behaviors 2. Physical Health a. Young Child Physical Health (as applicable) b. Medical/Physical Health 3. Emotional/Behavioral Functioning a. Traumatic Stress Symptoms b. Emotional/Behavioral Strengths c. Emotional/Behavioral Needs d. Select Risk Behaviors 4. Social Functioning a. Young Child Social Behaviors (as applicable) b. Social Functioning Strengths c. Social Functioning Behaviors d. (For adolescents) Intimate Relationships		
PO3	Improve metrics related to youth voice	PO3 is defined in multiple ways. For the definition in this row, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	**Child and Family Voice** survey construct proportion score. Construct Proportion Score: Sum score of items/100 (total possible for Child and Family Voice construct): • Strategies/Interventions: f.iii • CQI: d • Child and Family Voice: a, b, c.i, c.ii, c.vii d.i d.ii, e, f.iii, f.v, f.vi, g, h, I j, k • Communication: e • Transition Planning: a.i Possible proportion scores range from 0 (no Child and Family Voice items met) to 1 (all Child and Family Voice items met).	Average Proportion Score = 0.71 (SD=0.32)	Average Proportion Score = 0.67 (SD=0.35)
		PO3 is defined in multiple ways. For the definition in this row, data were compiled from a survey of TR providers conducted by Chapin Hall	**Youth Decision-Making** survey construct proportion score. Construct Proportion Score: Sum score of items/60 (total possible for Youth Decision-Making construct):	Average Proportion Score = 0.67 (SD=0.32)	Average Proportion Score = 0.63 (SD=0.34)

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
		that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	• Continuous Quality Improvement: c • Child and Family Voice: c.i, c.vii, c.i, h, I, j, k, l.i, m, n.iv • Transition Planning: a.i Possible proportion scores range from 0 (no Youth Decision-Making items met) to 1 (all Youth Decision-Making items met).		
		PO3 is defined in multiple ways. For this operational definition, the TRPMI implementation team proposes to administer the Experience of Care Survey (CASCW, 2012) to youth placed with TR providers receiving TRPMI. **Chapin Hall: Survey Data**	Not yet defined	Data were not collected in CY16. Please note that because these data will be collected as part of the TRPMI implementation, once data collection begins, data will only be available for the Intervention group.	
PO4	Improve metrics related to TR providers' use of TR best practices	For PO4, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	**Treatment Planning** survey construct proportion score Construct Proportion Score: Sum score of items/60 (total possible for Treatment Planning construct): • Treatment Planning: a, b.i, b.iii, b.iv, b.v, b.vii, b.viii, b.x, d • Child and Family Voice: f.ii, h Possible proportion scores range from 0 (no Treatment Planning items met) to 1 (all Treatment Planning items met).	Average Proportion Score = 0.82 (SD=0.28)	Average Proportion Score = 0.78 (SD=0.30)
		Chapin Hall: Survey Data	**Strategies and Interventions** survey construct proportion score.	Average Proportion Score: 0.82 (SD=0.29)	Average Proportion Score: 0.79

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			Construct Proportion Score: Sum score of items/30 (total possible for Strategies and Interventions construct): • Treatment Planning: b.iii • Strategies/Interventions: a, b, c, d, e, f.iii Possible proportion scores range from 0 (no Strategies and Interventions items met) to 1 (all Strategies and Interventions items met).		(SD=0.32)
		Chapin Hall: Survey Data	**Cultural Competence** survey construct proportion score. Construct Proportion Score: Sum score of items/35 (total possible for Cultural Competence construct): • Cultural Competence: a, b, c, d, e, f, g Possible proportion scores range from 0 (no Cultural Competence items met) to 1 (all Cultural Competence items met).	Average Proportion Score = 0.75 (SD=0.31)	Average Proportion Score = 0.72 (SD=0.34)
		Chapin Hall: Survey Data	**Continuous Quality Improvement** survey construct proportion score. Construct Proportion Score: Sum score of items/50 (total possible for Continuous Quality Improvement construct): • Continuous Quality Improvement: a, b, c, d, e, f, g h • Restraint/Seclusion: c • Child and Family Voice: f.i Possible proportion scores range from 0 (no Continuous Quality Improvement items met) to 1 (all Continuous Quality Improvement items met).	Average Proportion Score = 0.73 (SD=0.31)	Average Proportion Score = 0.70 (SD=0.35)
		Chapin Hall: Survey Data	**Restraint and Seclusion** survey construct proportion score. Construct Proportion Score: Sum score of items/25 (total possible for Restraint and Seclusion construct): • Restraint/Seclusion: a, b, c, d • Communication: d.iv Possible proportion scores range from 0 (no Restraint and Seclusion items met) to 1 (all Restraint and Seclusion items met).	Average Proportion Score = 0.76 (SD=0.32)	Average Proportion Score = 0.73 (SD=0.35)

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
		NU (Jennifer and Neil): RTOS data on restraint and seclusion	**NU (Jennifer and Neil):** **Restraint and Seclusion Calculations for Quarterly Report:** Restrictive Behavior Management x Type = Average number of applications of restrictive behavior management interventions per youth during the fiscal year, including manual restraint, seclusion and emergency administration of psychotropic medications; this data is based on UIRs reported by agencies and may be affected by reporting fidelity and reliability. Note also that not all of these interventions are available to all providers; for example, most group homes do not have seclusion rooms (if not all; reporting error may account for reports of seclusion at MGH facilities) and most providers do not have medical staff readily available to authorize/administer psychotropic medications on an emergency basis. **(I01) - Restraint of a youth in care, Manual** The youth in care was the subject of a behavior management technique involving the use of physical contact or force, characterized by arm or body holds to physically restrict the child or youth and to protect him/her from injuring self or others. Physical restraint may only be used as an intervention when a child is a threat of physical harm to self or others. (The use of physical restraint is limited to secure child care facilities, child care institutions, group homes and youth emergency shelters licensed by the Department. No other facility licensed by the Department is authorized to use manual restraint). Manual restraint or physical restraint is further defined in 89 Ill. Adm Code 384 (Discipline and Behavior Management In Child Care Facilities). **(I02) - Seclusion of a youth in care** A child or youth is removed from an area to a specifically designated room from which egress is		

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			restricted. The Department, in accordance with 89 Ill. Adm. Code 384, must approve the room that is designated as a seclusion room. Seclusion is a behavior management technique limited in its use to secure child care facilities, child care institutions, group homes, and youth emergency shelters licensed by the Department. No other facility licensed by the Department is authorized to use seclusion.		
		Chapin Hall: Survey Data	**Child and Family Voice** survey construct proportion score. Construct Proportion Score: Sum score of items/100 (total possible for Child and Family Voice construct): • Strategies/Interventions: f.iii • Continuous Quality Improvement: d • Child and Family Voice: a, b, c.i, c.ii, c.vii, c.i, d.ii, e, f.iii, f.v, f.vi, g, h, I, j, k • Communication: e • Transition Planning: a.i Possible proportion scores range from 0 (no Child and Family Voice items met) to 1 (all Child and Family Voice items met).	Average Proportion Score = 0.71 (SD=0.32)	Average Proportion Score = 0.67 (SD=0.35)
		Chapin Hall: Survey Data	**Communication** survey construct proportion score. Construct Proportion Score: Sum score of items/40 (total possible for Communication construct): • Communication: a, b, d.i, d.ii, d.iv, e. f.ii Possible proportion scores range from 0 (no Communication items met) to 1 (all Communication items met).	Average Proportion Score = 0.69 (SD=0.36)	Average Proportion Score = 0.66 (SD=0.38)
		Chapin Hall: Survey Data	**Transition Planning** survey construct proportion score. Construct Proportion Score: Sum score of items/75 (total possible for Transition Planning construct): • Treatment Planning: b.ix • Child and Family Voice: l.ii, l.iii • Communication: i.i, i.ii	Average Proportion Score = 0.68 (SD=0.35)	Average Proportion Score = 0.65 (SD=0.36)

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			• Transition Planning: a.i, a.ii, a.iii, a.iv, a.v, a.vi, a.vii, b, c, d Possible proportion scores range from 0 (no Transition Planning items met) to 1 (all Transition Planning items met).		
		Chapin Hall: Survey Data **NU (Jennifer and Neil):** RTOS data on other UIRs in addition to restraint and seclusion.	**Unusual Incident Reporting** survey construct proportion score. Construct Proportion Score: Sum score of items/21 (total possible Unusual Incident Reporting construct): Unusual Incident Reporting: a, b, c Possible proportion scores range from 0 (no Unusual Incident Reporting items met) to 1 (all Unusual Incident Reporting items met). **NU (Jennifer and Neil):** We use DCFS definitions. Please see information pasted at the end of this document. Northwestern uses ROCR (Rate of Occurrence Report) to analyze the following UIRs: B01 B02 B03 B04 C01 D02 D03 E06 F01 F02 G02 H01 I01 I02 J01 J03 J05 ROCR looks at the number of incidents per youth over a 1 year period. ROCR also aggregates these numbers to provide the number of incidents by contract. Northwestern has also analyzed the following as part of the Executive Summary: Restraint Results in Injury to a Youth in Care (D03), School- Youth in Care Suspended (F01), Sexually Aggressive Behavior by a Youth in Care Alleged (C01), Self-inflicted Injury/Wound (D02), Runaway/Missing Youth in Care (J01), and Aggressive Act or Behavior by a Youth in Care Alleged (J03). For the Executive Summary, we look at UIRs at the system level by looking at the **average # Incidents across all PBC Agencies, per Bed Year in Residential Care.** Per bed year in therapeutic residential care is calculated by looking at the number of incidents in 365.25 total bed	Average Proportion Score = 0.68 (SD=0.36)	Average Proportion Score = 0.63 (SD=0.39)

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			days (time in interruptions is not removed from total bed day count). UIR system will be downgraded over the next month: 1. After Feb 10, create UIR functionality will be disabled. 2. After March 11, edit/submit UIR functionality will be disabled. 3. Thereafter, the UIR system will be read-only The SACWIS Significant Event Reporting (SER) subsystem will replace the IL Outcomes and NOMAD mainframe UIR systems. The SACWIS SER does include a Significant Event Frequency Report, equivalent to the ROCR Contract Detail report.		
PO5	Improve metrics related to TR providers' use of EBPs	For PO5, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	Response to survey question C.c, "Youth receive services, programs, and treatments that are evidence-based or evidence-informed." Item responses range from 1 (Never) to 5 (Always).	Average Item Score = 4.62 (SD = 0.69)	Average Item Score = 4.60 (SD = 0.66)
PO6	Improve metrics related to TR providers' use of trauma-informed services	For PO6, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	Response to survey question C.d, "Youth receive services, programs, and treatments that are trauma-informed." Item responses range from 1 (Never) to 5 (Always)	Average Item Score = 4.56 (SD = 0.71)	Average Item Score = 4.61 (SD = 0.67)

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
PO7	Improve program-level metrics related to family engagement	PO7 is operationalized in more than one way. For the definition in this row, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	**Child and Family Voice** survey construct proportion score Construct Proportion Score: Sum score of items/100 (total possible for Child and Family Voice construct): • Strategies/Interventions: f.iii • Continuous Quality Improvement: d • Child and Family Voice: a, b, c.i, c.ii, c.vii, c.i, d.ii, e, f.iii, f.v, f.vi, g, h, I, j, k • Communication: e • Transition Planning: a.i Possible proportion scores range from 0 (no Child and Family Voice items met) to 1 (all Child and Family Voice items met).	Average Proportion Score = 0.71 (SD=0.32)	Average Proportion Score = 0.67 (SD=0.35)
		PO7 is operationalized in more than one way. For the definition in this row, data were compiled from a survey of TR providers conducted by Chapin Hall that included questions developed by the TRPMI steering committee for this purpose and questions adapted from the Building Bridges Initiative (BBI) assessment (BBI, 2009). For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	**Family Engagement** survey construct proportion score. Construct Proportion Score: Sum score of items/100 (total possible for Family Engagement construct): • Strategies/Interventions: a, f.iv • Child and Family Voice: a, b, c.ii, c.vii, d.i, d.ii, e, f.v, f.vi, j • Communication: b, c, d.i, d.ii, d.iv, e • Transition Planning: a.i, c Possible proportion scores range from 0 (no Family Engagement items met) to 1 (all Family Engagement items met).	Average Proportion Score = 0.70 (SD=0.32)	Average Proportion Score = 0.67 (SD=0.35)
		PO7 is operationalized in more than one way. For this operational definition, the TRPMI implementation team proposes to administer the Youth Connections Scale (CASCW, 2012) to youth placed with TR providers receiving TRPMI. **Chapin Hall: Survey Data**	Not yet defined	Data were not collected in CY16. Please note that because these data will be collected as part of the TRPMI implementation, once data collection begins, data will only be	

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
				available for the Intervention group.	
		PO7 is defined in multiple ways. This operational definition has not yet been finalized, but the goal is to use a measure of CFTM frequency and participation derived from SACWIS. **DCFS (Theresa and MCJ):** Quality CFTM as defined by DCFS (TBD) and recoded in SACWIS. MindShare to report on frequency and participation of CFTM (TBD).	**DCFS (Theresa and MCJ):** Frequency of quality participation of CFTM as defined by participation of child, caregiver, and foster parent in CFTM (TBD).	Not yet available	
PO8	Improve metrics related to TR provider organizational culture and climate	For PO8, data were compiled from a survey of TR provided conducted by Chapin Hall that included questions from Zohar's safety climate scale (1980), Vogus and Sutcliffe's safety organizing scale (2007), and Edmondson's psychological safety scale (1999). These are measures of aspects of safety culture. For the evaluation, Chapin Hall plans to re-administer the survey in CY17 and CY18. **Chapin Hall: Survey Data**	Safety climate (7 items); Item response options range from 1 (Not at All) to 5 (To a Very Great Extent)	Average Item Score = 4.09 (SD = 0.70)	Average Item Score = 4.11 (SD = 0.71)
			Safety organizing (9 items); Item response options range from 1 (Not at All) to 5 (To a Very Great Extent)	Average Item Score = 3.88 (SD = 0.85)	Average Item Score = 3.90 (SD = 0.79)
			Psychological safety (4 items); Item response options range from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree)	Average Item Score = 5.01 (SD = 1.13)	Average Item Score = 5.01 (SD = 1.05)
Intermediate					
IO1	Increase % of TR discharges to family- and fictive kin caregivers	IO1 is defined in multiple ways. For this operational definition, data were compiled by Northwestern from its RTOS database. **NU (Jennifer and Neil):** RTOS discharge data - negative discharge rate (NDR), favorable discharge rate (FDR), and sustained favorable discharge rate (SFDR).	Among discharges from 12/1/2015 – 11/30/2016, % with favorable discharge. **NU (Jennifer and Neil):** Negative discharge rate (NDR) is a PBC measure that measures negative discharge outcomes by calculating the percentage of all youth served by residential contracts who are negatively discharged during the	71% with favorable discharge (524 with favorable discharge out of 756 discharges)	

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			evaluation period. A negative discharge disposition includes discharges due to disruptions in placement (due to runaway [RNY], detention placement [DET], psychiatric hospitalization [HHF], or shelter placement [SHL] and do not return to the same contract) or youth who are placed laterally in a different agency contract at the same classification level or stepped up to a more restrictive (i.e., higher) level of residential treatment. Negative Discharge Destinations: RNY = number of youth who disrupted due to runaway. DET = number of youth who disrupted due to detention placement. HHF = number of youth who disrupted due to psychiatric hospitalization. SHL = number of youth who disrupted due to shelter placement. Lateral = number of youth in the contract who are placed laterally in a different agency contract at the same classification level. Step up = number of youth in the contract who stepped up to a more restrictive level of residential placement. Favorable discharge rate (FDR) measures the proportion of all youth served by residential contracts who are favorably discharged. Favorable discharges comprise both neutral discharge dispositions (such as to chronic residential treatment settings) and positive stepdowns to a less restrictive residential classification or non-residential settings. Sustained favorable discharge rate (SFDR) represents the proportion of all youth served who are favorably discharged during the evaluation year, and whose post-discharge placements are sustained for at least 90 days. Favorable Discharge Destinations: CIL = number of youth in the contract who stepped down to an agency-supervised community integrated		

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			living placement. FHB/P = number of youth in the contract who stepped down to a foster home through DCFS or a private agency. FHS = number of youth in the contract who stepped down to a specialized foster home. HAP/HMP = number of youth in the contract who stepped down to home of parent or home of adoptive parent. HMR = number of youth in the contract who stepped down to a home of relative placement. ILOagency = number of youth in the contract who stepped down to an agency-supervised independent living placement. ILOss (emanc) = number of youth in the contract who emancipated at age 21 from chronic residential treatment to adult supervised setting through the adult mental health system. TLP = number of youth in the contract who stepped down to an agency-supervised transitional living program. YIC = number of youth in the contract who stepped down to a youth in college program. IPA/GRH = number of youth in the contract who stepped down to a residential or group home placement of a less restrictive setting. Neutral = number of youth in the contract who discharged to a chronic residential treatment program.		
		IO1 is defined in multiple ways. For this operational definition, data were compiled by Chapin Hall using CYCIS. **Chapin Hall:** CYCIS data.	"Family- and fictive kin" placement is defined using the following living arrangement codes in CYCIS: "FHA","FHB","FHI","FHP","FHS","FHT","HMP","HMR","HRA","UAH","SGH","GDN", and "HFK". TR placement is defined using living arrangement codes "GRH" and "IPA" that are also paid living arrangements and excluding shelters (note: CYCIS data only available through 9/30/16). **Chapin Hall:** See above definition.	From 1/1/16-9/30/16, there were 579 TR placements, of which 466 TR placements were active as of 9/30/16. Of the remaining 113 TR placements that ended, 23 (20.4%) were discharged to family- and	

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
				fictive kin placements.	
IO2	Decrease % of youth discharging from TR who re-enter TR	IO2 is defined by Chapin Hall using CYCIS data. **Chapin Hall:** CYCIS data.	TR placement is defined using living arrangement codes "GRH" and "IPA" that are also paid living arrangements and excluding shelters. Re-entry is defined as leaving a TR placement and returning to a TR placement within 6 months (note: CYCIS data only available through 9/30/16). **Chapin Hall:** See above definition.	From 1/1/16-9/30/16, there were 579 TR placements, of which 466 TR placements were active as of 9/30/16. Of the remaining 113 TR placements that ended, 58 (51.3%) returned to a TR placement within 6 months.	
IO3	Reduce number of days from Phase 2 list entry to TR discharge	IO3 is defined by Northwestern using RTOS data. **NU (Jennifer and Neil) and MCJ:** RTOS data and Phase 2 data.	Average number of days of all youth from Phase 2 placement to discharge from 12/1/2015 – 11/30/2016. **NU (Jennifer and Neil) and MCJ:** Discharge Date – Phase 2 Entry Date [Please provide operational definition of entering Phase 2.]	• Average number of days for all youth = 258; • Average number of days for youth discharged to favorable placements = 252; • Average number of days for youth discharged to unfavorable placements = 292	• Programs for youth with DD who were discharged = 415 • BD (Behavior Disorder) programs had an average length of stay of 171 days
Distal					
DO1	Reduce number of days youth in out-of-home care spend in TR	DO1 can be operationalized in more than one way. For the definition in this row, DO1 is defined by Chapin Hall using CYCIS data.	Number of days youth spent in TR per 1,000 days in out-of-home care in CY16 (note: CYCIS data only available through 9/30/16). TR placement is defined using living arrangement codes "GRH" and "IPA" that are also paid living arrangements and excluding shelters.	From 1/1/16-9/30/16, there were 579 TR placements that totaled 63,962 TR	

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
		Chapin Hall: CYCIS data.	**Chapin Hall:** See above definition.	placement days. The total number of out-of-home care days for youth in these 579 TR placements were 1,369,376 days. Thus, on average there were 46.7 TR placement days per 1,000 out-of-home care days in CY16 (i.e. (63,962/1,369,376)*1,000=46.7).	
		DO1 can be operationalized in more than one way. For the definition in this row, DO1 is defined by Northwestern using RTOS data. **NU (Jennifer and Neil):** RTOS data on residential treatment spell.	Residential treatment spells during the measurement period 12/1/2015 – 11/30/2016 **NU (Jennifer and Neil):** Spell = episode of residential treatment in a given TR contract. Individual youth may accrue more than one residential spell during the fiscal year and therefore may be counted more than once.	During the measurement period, there were 1,676 residential treatment spells. Many youth may have had more than 1 residential treatment episode during the measurement period, thus the spell count is higher than the youth head count.	
DO2	Reduce number of TR placements among youth in out-of-home care	DO2 is defined by Chapin Hall using CYCIS data. **Chapin Hall:** CYCIS data.	Number of TR placements among youth in out-of-home care per 1,000 days in out-of-home care (note: CYCIS data only available through 9/30/16). TR placement is defined using living arrangement codes "GRH" and "IPA" that are also paid living arrangements and excluding shelters. **Chapin Hall:** See above definition.	From 1/1/16-9/30/16, there were 579 TR placements. The total number of out-of-home care days for youth in these 579 TR placements were	

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
				1,369,376 days. Thus, on average there were 0.43 TR placements per 1,000 out-of-home care days in CY16 (i.e. (579/1,369,376)* 1,000=0.43).	
DO3	Reduce number of youth in TR placements	DO3 is defined by Northwestern using RTOS data **NU (Jennifer and Neil):** RTOS data.	Count of youth in Residential placements on during the measurement period 12/1/2015 – 11/302016. **NU (Jennifer and Neil):** Residential Placement a placement in a Residential or Group Home contract. This definition does not include ILO or TLP contracts or shelters.	Residential youth headcount dropped from 1,152 as of 11/27/2015 to 958 as of 11/25/2016.	
Unintended					
UO1	Post-discharge stability of discharges from TR may change	There is more than one way in which UO1 can be define. Both definitions presented here were compiled by Northwestern using RTOS data **NU (Jennifer and Neil):** RTOS data.	Count of placement changes for youth discharged from Residential 12/1/2015 – 11/30/ 2016 **NU (Jennifer and Neil):** Negative LIVARS RNY = number of youth who disrupted due to runaway. DET = number of youth who disrupted due to detention placement. HHF = number of youth who disrupted due to psychiatric hospitalization. SHL = number of youth who disrupted due to shelter placement. Lateral = number of youth in the contract who are placed laterally in a different agency contract at the same classification level. Step up = number of youth in the contract who stepped up to a more restrictive level of residential placement. Favorable LIVARS CIL = number of youth in the contract who stepped down to an agency-supervised community integrated	After the 756 discharges (closed spells), 2,904 placements were recorded for those youth during that measurement period. There were 1,312 placement changes to negative living arrangements and 1,592 placement changes to favorable living arrangements.	

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			living placement. FHB/P = number of youth in the contract who stepped down to a foster home through DCFS or a private agency. FHS = number of youth in the contract who stepped down to a specialized foster home. HAP/HMP = number of youth in the contract who stepped down to home of parent or home of adoptive parent. HMR = number of youth in the contract who stepped down to a home of relative placement. ILOagency = number of youth in the contract who stepped down to an agency-supervised independent living placement. ILOss (emanc) = number of youth in the contract who emancipated at age 21 from chronic residential treatment to adult supervised setting through the adult mental health system. TLP = number of youth in the contract who stepped down to an agency-supervised transitional living program. YIC = number of youth in the contract who stepped down to a youth in college program. IPA/GRH = number of youth in the contract who stepped down to a residential or group home placement of a less restrictive setting. Neutral = number of youth in the contract who discharged to a chronic residential treatment program.		
		NU (Jennifer and Neil): RTOS data.	Of those discharged in the time period 11/30/2015 – 12/1/2016, count of youth admitted/re-admitted to more restrictive residential settings, including hospitalization (other than for stabilization of less than 30 days) **NU (Jennifer and Neil):** Class level = classification level of contract designating the treatment intensity and relative restrictiveness of the program (in terms of supervision/staffing levels, structure, permeability to the community, etc.).	Of the 227 negative discharges in the time period: a. Hospitalizations (other than psychiatric hospitalizations) are not available in	c. 28 youth were discharged to a more restrictive residential placement (step

Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value	
			Severe= severe residential treatment center Moderate = moderate residential treatment center, MGH = moderate group home Chronic= description of population served at this level, i.e. chronically mentally ill older youth typically transitioning to the adult mental health system.	the DCFS data set. b. 20 youth were admitted to a psychiatric hospitalization as their subsequent placement after discharge.	up) and another 28 were discharged due to disruptions as a result of being detained. 123 discharges were due to disruptions as a result of runaways.
UO2	Number of TR providers may change	An operational definition for this outcome has not yet been finalized. **Chapin Hall:** Chapin Hall is currently creating a crosswalk of the definition of a "TR provider" from the different provider lists we have received to date. When we have a draft crosswalk, we will need the rest of the Administrative Data Ad-Hoc Group to vet it so that we know the provider denominator of TRPMI.	Not yet defined **Chapin Hall:** TBD	Not yet available	

References for Table 1:

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Outcome type and number	Outcome as listed on the logic model	Data source	Operational definition	Baseline (CY16) Value
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Appendix 1: UIR Definitions (Updated 2/15/17)

Types of Unusual Incidents

The following is a list of the codes and corresponding descriptions of events to be recorded on the CFS 119, Unusual Incident Report Form. In reporting an unusual incident, check as many codes as apply.

(A01) - Death of a DCFS youth in care

A child dies while in the legal custody or guardianship of the Department, regardless of the cause of death and regardless of whether the child was supervised directly by the Department or a by a POS provider.

(A02) - Death of a Former youth in care

A child for whom the Department was legally responsible dies within one year after discharge from guardianship or custody of the Department.

(A03) - Death of a Non-youth in care

A child has died and the Department has current or prior involvement with the family, or a child has died in a facility licensed by the Department, such as a foster home or day care center. Current involvement may include a pending child abuse and neglect investigation or an open intact family service case. Prior involvement may include, but is not limited to, being a subject in a previous child abuse or neglect investigation, or a member of a closed intact family service case.

(B01) - Sexual Abuse of a youth in care Alleged

A child for whom the Department is legally responsible has allegedly been sexually abused by a parent or responsible caregiver, immediate family member, other person residing in the home, parent's paramour, or other person responsible for the child's welfare as defined by 89 Ill. Adm. Code 300 (Reports of Child Abuse and Neglect).

(B02) - Abuse of a youth in care Alleged

A caregiver, parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child or a paramour of the child's parent is alleged to have inflicted, caused to be inflicted, or allowed to be inflicted upon a youth in care physical or mental injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function to a youth in care.

(B03) - Sexual Assault of a youth in care Alleged

A child for whom the Department is legally responsible, has allegedly been the victim of a forceful threat and use of force in submitting to (carrying out) a sexual act by a person who is not the child's caregiver, immediate family member, other person residing in the home, parent's paramour, or other person responsible for the child's welfare. Examples include rape, attempted rape, date rape.

(B04) - Neglect of a youth in care Alleged

A child for whom the Department is legally responsible is allegedly not receiving proper or necessary nourishment, medical care or routine care.

(C01) - Sexually Aggressive Behavior by a youth in care Alleged

Sexually aggressive behavior means sexual behaviors that are intrusive or potentially harmful to others. Sexually aggressive behavior may involve children/youth who are not peers (not at the same development level) and may be accompanied by pressure or coercion to participate or the use of force, threat of harm or violence.

(C02) - Sexually Problematic Behavior by a youth in care Alleged

Sexually problematic behaviors in children and youth are sexual behaviors that are compulsive, excessive, persistent and/or inconsistent with the

child's age and development. They may include masturbation in inappropriate places; simulating sex with other children, toys, furniture or animals; or, as children become older, promiscuity, touching or fondling others (outside of play or consensual sexual activities with peers) or other boundary problems like kissing others on the lips or unwelcome, unwanted and intrusive touching.

(D01) - Accidental Injury/Wound

In the case of a wound, a youth in care has unexpectedly received an injury in which the skin or other external surface is torn, pierced, or cut through unintentional means. An injury can encompass conditions such as burns, broken bones, severe sprains etc. For either a wound or an injury to be reportable the child must have required medical attention.

(D02) - Self-inflicted Injury/Wound

A youth in care has deliberately inflicted an injury or wound upon himself or herself and direct care of the site of the injury is needed or required. Depending on the extent or severity of the injury or wound, care may be provided by the caregiver, other lay person, or a medical professional.

(D03) - Restraint Results in Injury to a youth in care

A youth in care sustained a physical injury while being restrained by a responsible caregiver. The injury must have been accidental and occurred during the course of the restraint. Physical restraint is a behavior management technique involving the use of physical contact or force, characterized by measures such as arm or body holds to protect a child from injuring himself/herself or others. Examples of injuries that are likely to occur during restraint include broken bones, bruises, bumps, strains and rug burns.

(E01) - Medication - youth in care Refusal

A youth in care refused to take his/her prescribed medication and failure to do so may jeopardize the health or well being of the child.

(E02) - Medication Dispensing Error

A youth in care received an incorrect dosage of a prescription or non-prescription (over the counter) medication, posing a risk to the child's ongoing health or well-being.

(E04) - Medical Emergency

Medical emergency means any urgent situation requiring that a child or youth be seen by a physician on-site or transported to an urgent care clinic, doctor's office or hospital emergency room for immediate treatment. Immediate medical intervention is required to address the medical problem or condition that threatens the child's health or well-being, but does not result in admission to a hospital.

(E05) - Psychiatric Emergency

A psychiatric emergency is a situation in which behaviors or symptoms arising from an emotional disturbance or mental illness place a child or youth or others at risk for harm to self or others. A psychiatric emergency requires crisis intervention by a psychiatrist or other mental health professional, in whatever setting, to reduce the risk of injury to the child or youth or to others.

(E06) - Psychotropic Medication - Emergency Administration

Psychotropic medications were administered on an emergency basis to reduce the risk of harm to the child, youth or others. All emergency psychotropic medications must be ordered by a psychiatrist and be subject to post-approval by telefax or telephone to the consent line in the Office of Guardianship Administrator, as described in 89 Ill. Adm Code 325 (Administration of Psychotropic Medications to Children for Whom the Department of Children and Family Services is Legally Responsible). In accordance with Department policies (89 Ill. Adm. Code 325 (Administration of Psychotropic Medications to Children for whom the Department is Legally Responsible), emergency medications may not continue for more than 48 hours, excluding Saturdays, Sundays and holidays. The use of chemical restraint or the introduction of medication for the express purpose of restricting a child's or youth's movement is prohibited.

(E07) - Medication - Adverse Reaction

An adverse reaction is an unanticipated and negative reaction to a medication. Symptoms may include itching, hives, dizziness, abdominal cramping or headache. Anaphylactic reaction is a life-threatening medical emergency as symptoms may include difficulty in breathing, bleeding, confusion or loss of consciousness.

(F01) - School - youth in care Suspended

A youth in care has been temporarily barred from attending educational classes and access to school facilities or school bus. "Suspension" is usually for up to 10 school days, but may be longer for safety reasons, as determined by school authorities.

(F02) - School - youth in care Expelled

A youth in care has been barred from educational classes and the use of school facilities for up to two calendar years.

(G01) - Medical Hospitalization

A medical or health problem or condition requires admission of a youth in care to a hospital for examination, observation or treatment for other than for mental health reasons.

(G02) - Psychiatric Hospitalization

An incident or episode has occurred in which a youth in care has been admitted to a hospital or psychiatric facility for examination, observation or treatment for mental health reasons.

(H01) - Crime: youth in care Detained, Arrested, Charged with or Convicted

A youth in care has been detained or taken into custody by law enforcement authorities, charged with committing a crime, or convicted of committing a criminal act as defined in the Criminal Code. A follow-up report is required in the event the youth in care is convicted.

(H02) - Crime: Foster Parent Suspected, Arrested or Convicted

A foster parent or relative caregiver is suspected of committing a crime or has been arrested or convicted of a criminal act as defined in the Illinois Criminal Code of 1961 [720 ILCS 5] (Criminal Code).

(H03) - Crime: Employee Arrested, Charged with or Convicted

A Department or purchase of service (POS) employee has been arrested, charged with or convicted of a criminal act as defined in the Criminal Code.

(I01) - Restraint of a youth in care, Manual

The youth in care was the subject of a behavior management technique involving the use of physical contact or force, characterized by arm or body holds to physically restrict the child or youth and to protect him/her from injuring self or others. Physical restraint may only be used as an intervention when a child is a threat of physical harm to self or others. (The use of physical restraint is limited to secure child care facilities, child care institutions, group homes and youth emergency shelters licensed by the Department. No other facility licensed by the Department is authorized to use manual restraint). Manual restraint or physical restraint is further defined in 89 Ill. Adm Code 384 (Discipline and Behavior Management In Child Care Facilities).

(I02) - Seclusion of a youth in care

A child or youth is removed from an area to a specifically designated room from which egress is restricted. The Department, in accordance with 89 Ill. Adm. Code 384, must approve the room that is designated as a seclusion room. Seclusion is a behavior management technique limited in its use to secure child care facilities, child care institutions, group homes, and youth emergency shelters licensed by the Department. No other facility licensed by the Department is authorized to use seclusion.

(J01) - Runaway/Missing youth in care

A runaway or missing youth in care must be reported when a responsible facility representative, a caregiver or law enforcement becomes aware that the whereabouts of a youth in care are unknown.

"Missing" means that a child or youth is absent from the residence of a caregiver or the premises of a child care facility without the knowledge or consent of the persons responsible for the child's welfare, the whereabouts of the youth are unknown, and the intent to run away has not been established.

"Runaway" means that a child or youth is absent from the residence of a caregiver or the premises of a child care facility without the consent of the persons responsible for the child's or youth's welfare, when the whereabouts of the child or youth are unknown and the intent to runaway has been established.
A child or youth must be reported as missing or having run away as soon as a search of the home or facility is completed and it is confirmed that the youth has left the home/campus without permission. The absence is to be reported even when the child or youth returns in a short period of time.

(J02) - Weapon Alleged to be in youth in care's Possession

A youth in care had in his/her possession an instrument that is capable of producing death or serious bodily injury when used for its intrinsic purpose, or that has the potential to cause serious bodily injury or endanger a life because of the way it is used, the way it is attempted to be used or the force with which it is used. The term weapon includes firearms, knives, clubs and explosive devices.

(J03) - Aggressive Act or Behavior by a youth in care Alleged

A youth in care has engaged in serious aggressive physical behavior to youth in care people, animals, property or other objects, posing a clear and present risk of injury to the child or youth or others.

(J04) - Property Damage of $50 or More by a youth in care

An incident has occurred in which the actions of a youth in care resulted in damage to the property of others and there is a potential liability claim against the Department for damages of $50 or more.

(J05) - Suicide Attempt by a youth in care

A youth in care intentionally, but unsuccessfully, attempted to take his/her own life.

(J06) - Suicide Ideation / Threat by a youth in care

A youth in care expresses or conveys to a caregiver or others a mental image of committing suicide.

(J07) - Alcohol or Substance Abuse by a youth in care Suspected

Suspected alcohol or substance abuse means that a caregiver or other person has reason to believe that a child or youth has illegally consumed alcohol; used or is using cannabis or a controlled substance (as defined by the Illinois Controlled Substance Act [720 ILCS 570]) without a physician's prescription; or is using or has used inhalants or other substances intended to have an intoxicating or hallucinogenic effect that may result in clinical dependency.

(K01) - Robbery/Burglary Occurred on Premises

Both DCFS and POS facilities must submit an Unusual Incident Report if a burglary or robbery occurs. Law enforcement must also be notified.

(K02) - Fire/Natural Disaster Damaged or Affected Facility/Home

Natural disaster means those situations caused by nature that are a significant threat of harm to the safety of employees or clients in either a Department or POS provider facility/home. Natural disasters include tornado, flood, earthquake, severe winter storms. Utility emergencies such as

gas leaks are included in this category. To be reported as an unusual incident, customary operations, routines or relationships at the facility/home must be disrupted.

(K03) - Hazardous/Physical Condition Discovered at Facility

A dangerous condition exists in a child-care facility and presents a threat to the physical well being of children, staff, or other persons at the facility. This category usually pertains to the condition of the physical plant, grounds, or to materials, implements or weapons stored in or around the facility.

(K04) - Legal Action By/Against a Child Care Facility Resulting from a Serious Incident

An incident involving a youth in care, employee of the Department or a child care facility in which legal proceedings have been, or may be, initiated against the Department or child care facility by the youth in care, employee or facility.

(L01) - Kidnapping/Abduction of a youth in care

A child or youth for whom the Department is legally responsible was seized and detained unlawfully by a person without the consent of either the caregiver or guardian.

(L02) - Pregnant or Parenting youth in care Identified

Parenting youth in care includes both females and males for whom the Department is legally responsible, regardless of whether the youth in care's child remains in the custody of the youth in care.

(L03) - Media Involvement/Media Inquiry

Media involvement or inquiry means any incident that may have media impact and is not part of a planned public announcement, education or similar effort. Media involvement or inquiries may focus on a child or youth for whom the Department is legally responsible, persons served by the Department, child care facilities licensed by the Department, staff of the Department or a POS provider or on litigation affecting a POS provider.

(L04) - Assault of a youth in care Alleged

As a result of threats, assault, and/or physical contact, a youth in care is placed in reasonable fear (apprehension) of receiving or actually sustaining great bodily harm from another individual without legal justification, e.g., was held at knife point.

(L05) - Threats Against DCFS/POS Staff or Facility, Including Bomb Threats, Firearms, or Riot/Mob Action

A threat is a communication that forewarns of the intent to inflict physical, emotional or any other harm to an individual or to subject an individual to physical confinement or restraint. Riot and/or mob action refers to situations in which two or more persons are gathered with the intent to do harm to a person or persons in a Department or POS provider building or property.

(L06) - Accident Involving a youth in care

A child for whom the Department is legally responsible has experienced an unexpected and undesirable event that poses a threat to the youth in care's physical safety and well-being. Accidents include, but are not limited to, car accidents, sports accidents, falls within a facility or during a field trip.

(L07) - Falsification of Credentials or Records

Falsification of credentials means that a job applicant or a DCFS or private agency employee submits or has submitted a job application, academic records, employment record, license or certification, or similar document to establish eligibility for employment or continued employment, or used in determining the individual's eligibility for an appointment, reassignment, promotion or leave, or other employment decisions that falsely states the qualifications or achievements of the individual.

Falsification of records or statements includes an act of misrepresentation, falsification or omission of any fact in a written or verbal communication

by a Department employee or an employee of a POS agency. Records may include client or case records, court testimony, vouchers, personnel records, and time and attendance records.

(L08) - Misrepresentation of Services or Cost of Services

Misrepresentation of services means that services were reported as having been provided to a person served by either the Department or a purchase of service provider when those services were not provided, or that the services were provided for a period of time or under conditions other than those reported. Such misrepresentation may occur in reports to the Department, the courts, auditors or others acting on behalf of the Department.

Misrepresentation of the costs of services means the actual costs to provide service were intentionally inflated to produce a larger billing or payment than one is entitled to for the services provided. Misrepresentation of the cost of services includes deliberately understating the cost of providing services in order to gain advantage in a competitive bidding situation.

(L09) - Violation of a Court Order

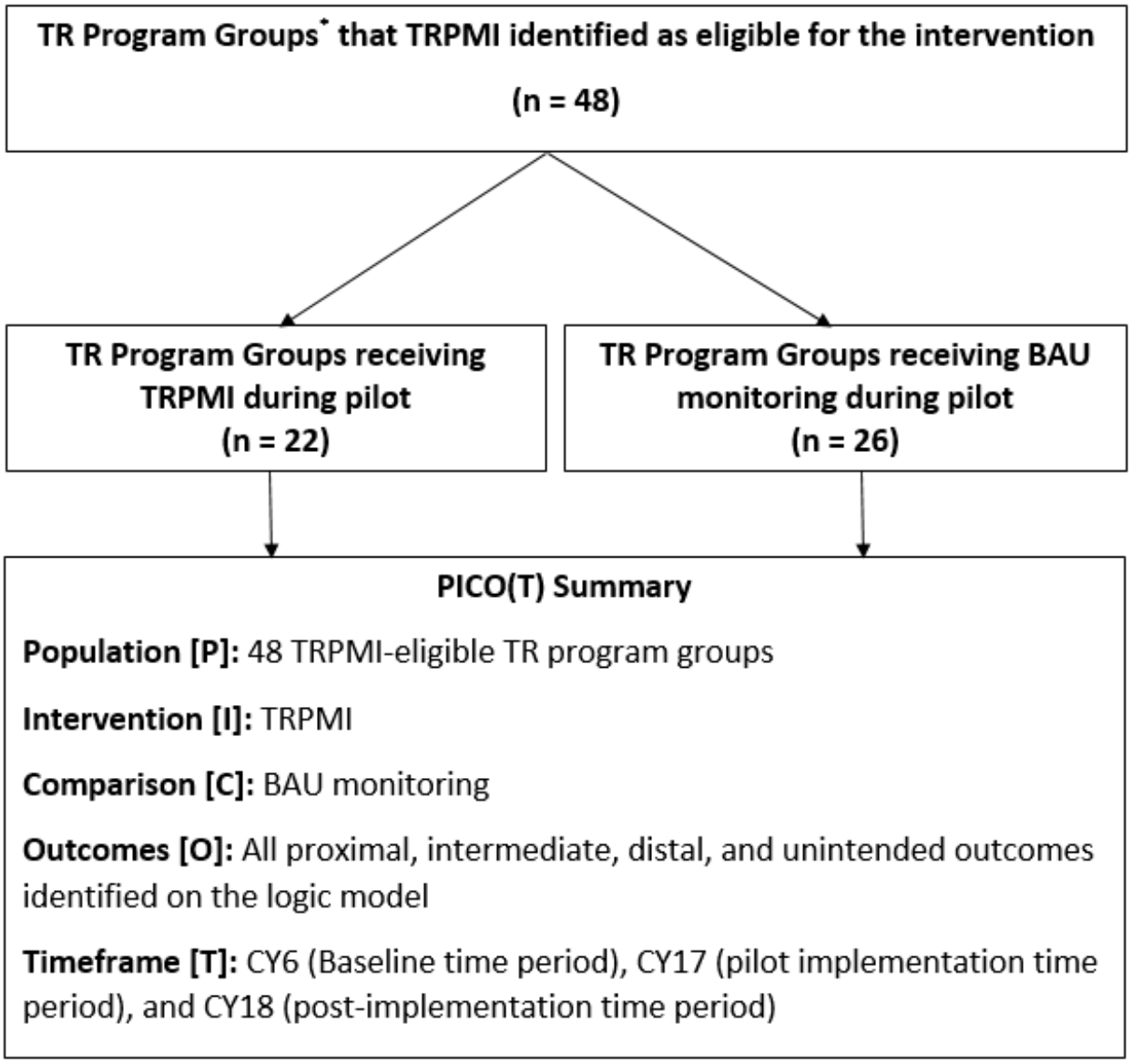
An order relating to a youth in care or Department client issued by a court, whether juvenile, criminal or civil, was violated, placing the youth in care's safety and well-being in jeopardy. Examples include violations of Orders of Protection prohibiting contact with youth in cares, failure to render court ordered services, etc.

(L10) - Report Against DCFS or POS Worker Involving a youth in care Alleged

An employee of the Department or a POS provider is alleged to have put a youth in care's safety or well-being in jeopardy. The direct child welfare services employee license of an individual who is named as an alleged perpetrator in a pending child abuse or neglect investigation may be suspended or may not be reinstated, pending the outcome of the investigation. In accordance with 89 Ill. Adm. Code 412, Licensure of Child Welfare Employees or Supervisors, if the report is indicated by the Department, the Direct Child Welfare Services Employee License Board may suspend, revoke or refuse to reinstate the license of a direct child welfare services employee unless or until the indication is reversed on appeal or administrative court review. One of the other types of unusual incidents described in this Appendix may also be deemed appropriate for submission with this type of report.

Appendix 2: Evaluation Design (Updated 3/2/2017)

FIGURE 1. EVALUATION DESIGN, OVERVIEW



*Program Group is the unit of analysis defined by agency and location

Appendix 3: TR Providers by Program Group (Updated 3/1/2017)

Provider	Program	Unit	Program Group (Evaluation Unit)	TRPMI Pilot	Surveyed?	Contract ID(s)	Provider ID(s)	AKA
Allendale Association				1	1			
	RTC Illinois	Armour East	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Shelter East	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Bush RTC	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Armour West	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Shelter West	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Shumway	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Holway	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Illinois	Lehman	Allendale Lake Villa	1	1	001301304	001301	Lake Villa
	RTC Wisconsin	Benet Lake Boys 1	Allendale Benet Lake	1	1	243996301	243996	ALLENDALE BENET LAKE
	RTC Illinois YC	St. Armand	Allendale Lake Villa	1	1	001301305	001301	Lake Villa
	RTC North Chicago	Allendale North Chicago	Allendale North Chicago	1	1	501373301	501373	ALLENDALE-NORTH CHICAGO FACILITY
	Group Homes	RHONDA ALTER	Allendale Group Homes	1	1	001300310	192854	RHONDA ALTER GROUP HOME
	Group Homes	Walter Cherry	Allendale Group Homes	1	1	001300310	110330	WALTER L CHERRY GROUP HOME
	Group Homes	BECKER GROUP HOME	Allendale Group Homes	1	1	001300310	002129	
Arden Shore Child & Family Srvs	Waukegan Grp Hm	Waukegan Grp Hm	Arden Shore	1	1	001524305	314142	Arden Shore Group Homes
Arrowhead Ranch	RTC	Group 5	Arrowhead	0	1	001583205	001583	
Baby Fold				0	1	020328611	020328	
	Baby Fold	Oak Prgm 2	Baby Fold	0	1	020328611	020328	
	Baby Fold	Spruce Prgm 3	Baby Fold	0	1	020328611	020328	
CAMPAGNA ACADEMY INC				0	1	539754403	539754	Campagna
	Residential Treatment	Cottage 4 - DD Boys	Campagna Academy	0	1	539754402	539754	
	Residential Treatment	Cottage 5 - DD Boys	Campagna Academy	0	1	539754402	539754	

	Residential Treatment	Oasis - 1 West Girls	Campagna Academy	0	1	539754401	539754	OASIS SECURE PROGRAM
	Residential Treatment	Oasis - 2 West Girls	Campagna Academy	0	1	539754401	539754	OASIS SECURE PROGRAM
	Residential Treatment	Oasis - 2 East Boys	Campagna Academy	0	1	539754401	539754	OASIS SECURE PROGRAM
Caritas Family Solutions	St. John Bosco Children's Center	St. John Bosco Children's Center	St. John Bosco Children's Center	1	1	180025704	180025	St. John Bosco Children's Center
Catholic Children’s Home	McNicholas Hm	McNicholas Home	Catholic Children’s Home	1	1	003974711, 003974712	003974	
Center for Youth & Family Solutions				0	1	512962203, 512962204	512962	GUARDIAN ANGEL HOME
	Guardian Angel Home	Edward Hall	Guardian Angel	0	1			
	Guardian Angel YC	Gill Hall	Guardian Angel	0	1			
Center on Deafness	Centerview	Centerview	Center on Deafness	0	1	489083401	500248	Centerview Residential
Chaddock				0	1		004049	
	Chaddock Boys School		Chaddock	0	0	004049507	004049	
	Chaddock Group Home		Chaddock	0	0	004048506	308658	
	Residential Treatment	Leathers Cottage	Chaddock	0	1			
	Residential Treatment	Appuhn Cottage	Chaddock	0	1			
	Residential Treatment	Wesley Cottage	Chaddock	0	1			
	Grp Hm Moderate	Appuhn Cottage	Chaddock	0	1			
	Grp Hm Moderate	Kittel Cottage	Chaddock	0	1			
Children’s Home & Aid Society				1	1	230673401	230673	DANIEL F AND ADA L RICE

	Rice Children & Family Ctr	1 East	Rice	1	1			
	Rice Children & Family Ctr	1 West	Rice	1	1			
	Rice Children & Family Ctr	2 East	Rice	1	1			
	Rice Children & Family Ctr	2 West	Rice	1	1			
Children's Home Association of Illinois				0	1	020343206, 020343207, 020343208	020343	CHAIL
	Atlantis	Atlantis Unit	Children's Home Association of Illinois	0	1			
	Challenger & Freedom Units	Challenger Unit	Children's Home Association of Illinois	0	1			
	Challenger & Freedom Units	Freedom Unit	Children's Home Association of Illinois	0	1			
	Endeavor	Endeavor	Children's Home Association of Illinois	0	1	004259242	231997	
	Enterprise	Enterprise	Children's Home Association of Illinois	0	1			
ChildServ				0	1			
	Group Home	Downers Grove	ChildServ	0		012033302	156848	CHILDSERV DOWNERS GROVE GROUP HOME
	Grp Hms	Lisle	ChildServ	0	1	012033302	243543	DR. LIND, JERRY
	Grp Hms	Naperville	ChildServ	0	1	012033302	020130	CHILDSERV / EMERGENCY GROUP HOME
	Grp Hms	Highland Home	ChildServ	0	1			
Cunningham Childrens Home				0	1	444026601	444026	
	Grp Hms	Kendall Gill Boys Group Home	Cunningham	0	1	005272612	261767	CUNNINGHAM CHILDREN'S HOME, KENDAL

								GILL
	Grp Hms	Sarah English Girls Group Home	Cunningham	0	1	005272612	005265	
	Main Campus	Goodman	Cunningham	0	1			
	Main Campus	New Hope	Cunningham	0	1			
	Main Campus	Jedi	Cunningham	0	1			
Egyptian Health Department	Circle of Hope	Circle of Hope	Egyptian	1	1	058861801	539187	
Five Star Industries	Community Grp Hm	Group Home	Five Star Industries	1	1	288605801	291415	FIVE STAR INDUSTRIES INC / GROUP HOME
Garden of Prayer Youth Center	Group Home	JUMP - Farm House	Garden of Prayer	0	1	442707304	463968	GARDEN OF PRAYER YOUTH CENTER INTENSIVE
Genesee Lake School				0	1			
	RTC Main Campus	Genesee Lake School	Genesee Lake School	0	1			
	Goup Home	Sawyer House	Genesee Lake School	0	1			
	GroupHOme	Cheryl House	Genesee Lake School	0	1			
Hephzibah Childrens Assn	RTC	Unit	Hephzibah	0	1	009410416, 312032401	182449, 312032	Hephzibah Diagnostic Shelter, 312032
Hope Institute for Children & Families				0	1			Hope Institute; Hope School
	KIDDY EXPRESSIONS DAY CARE CENTER		Hope Institute	0	0	167412502	351579	
	Community Hms	Belhaven	Hope Institute	0	0	167412502	521337	
		Grinnell	Hope Institute	0	0	167412502	510511	GRINNELL GROUP HOME
		Stockton	Hope Institute	0	0	167412502	496660	
	Community	Springwood	Hope Institute	0	1	167412502	391580	

	Hms							
	Community Hms	Heather Mill	Hope Institute	0	1	167412502	396696	
	Community Hms	Halifax	Hope Institute	0	1	167412502	359142	Halifax Drive
	Community Hms	James Street	Hope Institute	0	1	167412502	345673	
	Community Hms	Bluestem	Hope Institute	0	1		351579	
	Community Hms	Comorant	Hope Institute	0	1	167412502	339337	
	Community Hms	Lindbergh	Hope Institute	0	1	167412502	340830	
	Community Hms	Red Oak	Hope Institute	0	1	167412502	367857	
	Community Hms	Boxwood	Hope Institute	0	1	167412502	328581	Boxwood Court
	Community Hms	Claremont	Hope Institute	0	1	167412502	460516	CLAREMONT GROUP HOME
	Community Hms	Delano	Hope Institute	0	1	167412502	496661	
	Campus Group Homes	Grant	Hope Institute	0	1	167412502	498906	Grant Comm Home
	Campus Group Homes	Jefferson	Hope Institute	0	1	167412502	505287	Jefferson Comm Home
	Campus Group Homes	Kennedy	Hope Institute	0	1	167412502	505285	Kennedy Comm Home
	Campus Group Homes	Monroe	Hope Institute	0	1	167412502	515816	Monroe Comm Home
	Campus Group Homes	Lincoln	Hope Institute	0	1	167412502	516833	Lincoln Comm Home
	Campus Group Homes	Nyre	Hope Institute	0	1	167412502	514269	The Nyre House
Hoyleton Youth & Family Services				1	1	033699704	033699	532689
	Residential	Main	Hoyleton	1	1			
	Residential	Elm	Hoyleton	1	1			
	Residential	Keolling	Hoyleton	1	1			

	Residential	Skyview	Hoyleton	1	1			
	Residential	TLC	Hoyleton	1	1			
	Group Home	Schippel House	Hoyleton Group Home	1	1	532689801	532689	DD - RESIDENTIAL - SCHIPPEL
Ibukun Comp Community Srvs	Ayo Therapeutic Group Home		Ibukun	1	1	469506403	471792	Ibukun Comprehensive Community Services
Indian Oaks Academy (Nexus)				0	1	223668412, 223668413, 223668414	223668	Indian Oaks
	Program 1, 3, 4 & 6	Program 4: NCAA	Indian Oaks	0	1			
	Program 1, 3, 4 & 6	Program 1: NFL Zone	Indian Oaks	0	1			
	Program 1, 3, 4 & 6	Program 3: Flight School	Indian Oaks	0	1			
	Program 1, 3, 4 & 6	Program 6: Sound Waves	Indian Oaks	0	1			
	Program 5	Program 5: Butterfly Island	Indian Oaks	0	1			
	Program 2	Program 2: All Stars	Indian Oaks	0	1			
	Program 7	Program 7: Studio 7	Indian Oaks	0	1	223668302	223668	
	Hemlock Harbor Grp Hm	Hemlock Harbor Group Home	Indian Oaks	0	1	511603303	540953	Indian Oaks The Lighthouse
Kemmerer Village				0	1	011289511	011289	
	Residential	Rhea	Kemmerer Village	0	1			
	Residential	Buchanan	Kemmerer Village	0	1			
	Residential	Carnahan	Kemmerer Village	0	1			
	Residential	Allemang	Kemmerer Village	0	1			
	Residential	Marsch	Kemmerer Village	0	1			
	Residential	Wheeler Cottage	Kemmerer Village	0	1			
LAWRENCE HALL YOUTH				1	1	012232406	012232	Lawrence Hall

SERVICES								
	RTC	Drake	Lawrence Hall	1	1			
	RTC	Graves	Lawrence Hall	1	1			
	RTC	Hoover	Lawrence Hall	1	1			
	RTC	Randall	Lawrence Hall	1	1	12232403		
	SST	Ewing	Lawrence Hall	1	1			
	SST	Byron	Lawrence Hall	1	1			
Little City Foundation				1	1			
	Group Home	Hastings Mill	Little City	1	0	209412411	478772	
	Group Home	Baynon	Little City	1	0	209412411	499928	Larry's home?
	Group Home	Fogila	Little City	1	0	209412411	536314	
	Group Home	Redwood	Little City	1	0	209412411	478774	
	Group Home	Spruce Home	Little City	1	1	209412411	478770	
	Group Home	Maple Home	Little City	1	1	209412411	478776	
	Group Home	Birch Home	Little City	1	1	209412411	478777	
	Group Home	Gross Pointe Home	Little City	1	1	209412411	496410	
	Group Home	Larry Home	Little City	1	1	209412411	536391	
	Group Home	Pine Home	Little City	1	1	209412411	549304	
Lutheran Child & Family Services				1	1	013006401, 013006404	013006	
	Lutherbrook	Collins Group Home	Lutherbrook	1	1	013006402	013006	
	Lutherbrook RTC	Harmony	Lutherbrook	1	1			
	Lutherbrook RTC	Field	Lutherbrook	1	1			
	Lutherbrook RTC	Seeger	Lutherbrook	1	1			
	Lutherbrook YC RTC	Lake	Lutherbrook	1	1			
	Lutherbrook YC RTC	Stream	Lutherbrook	1	1			
LYDIA HOME ASSOCIATION				0	1	013014406, 013014407	013014	
	RTC-Young Child	2 South	Lydia	0	1			

	RTC-Young Child	2 North	Lydia	0	1			
	RTC-Older Child	3 North	Lydia	0	1			
	RTC-Older Child	3 South	Lydia	0	1			
Maryville Academy				0	1			
	Bartlett (Eisenberg) Campus - RTC	Casa Imani Teen Parenting Program (E Home)	Maryville Bartlett	0	1	170328403	170328	MARYVILLE EISENBERG CASA SALAMA/IMANI
	Bartlett (Eisenberg) Campus - RTC	Casa Salama (B Home)	Maryville Bartlett	0	1	170328401	170328	MARYVILLE EISENBERG CASA SALAMA/IMANI
	Bartlett (Eisenberg) Campus - RTC	Casa Salama (A Home)	Maryville Bartlett	0	1	170328401	170328	MARYVILLE EISENBERG CASA SALAMA/IMANI
	Bartlett (Eisenberg) Campus - RTC	Casa Cariño (D Home)	Maryville Bartlett	0	1	170328404	170328	MARYVILLE EISENBERG CASA SALAMA/IMANI
Norman C Sleezer Youth Home				0	1	015293103	015293	
	Residential	Survivors	Norman Sleezer	0	1			
	Residential	Faith	Norman Sleezer	0	1			
Northern Illnois Academy			Northern Illinois Academy	0	1	452486301	452486	
	Residential	Bears	Northern Illinois Academy	0	1			
	Residential	Cubs	Northern Illinois Academy	0	1			
	Residential	Wolves	Northern Illinois Academy	0	1			
	Residential	Blackhawks	Northern Illinois Academy	0	1			
	Residential	Bulls	Northern Illinois Academy	0	1			

Onarga Academy (Nexus)				0	1	142395603	142395	NEXUS-ONARGA ACADEMY
	Programs 1, 2, 3, & 4	Program 2 - Older Adolescents	Onarga	0	1	142395605	142395	
	Programs 1, 2, 3, & 4	Program 3 - Older Adolescents	Onarga	0	1	142395605	142395	
	Programs 1, 2, 3, & 4	Program 1 - Younger Adolescents	Onarga	0	1	142395605	142395	
	Programs 1, 2, 3, & 4	Program 4	Onarga	0	1			
	Behavior Disorder	Hoop Dreams	Onarga	0	1			
	Group Home	Group Home	Onarga	0	1	209700601	497554	
One Hope United				1	1	010053707	544514	ONE HOPE UNITED GROUP HOME
	Northern Region CARE	Friendship	One Hope United Northern	1	1	208003311	208003	
	Northern Region CARE	Memory	One Hope United Northern	1	1	208003311	208003	
	Hudelson Region	Hicks	One Hope United Hudelson	1	1	010052803	010052	
	Hudelson Region	Wilson	One Hope United Hudelson	1	1	010052803	010052	
	Hudelson Region	Baker	One Hope United Hudelson	1	1	010052803	544514	
	Hudelson Region	Gibb	One Hope United Hudelson	1	1	010052803	010052	
Pavilion				0	1	261732601	261732	Pavilion Foundation, The DBA Pavilion
	Residential Ctr	Girls	Pavilion	0	1			
	Residential Ctr	Boys	Pavilion	0	1			
Riveredge	RTC	Riveredge SBP	Riveredge	0	1	451982401	451982	RIVEREDGE HOSPITAL

Stepping Stones of Rockford				0	1	263020303	263020	STEPPING STONES, INC.
	Older Adol Step Down	Girls Group Home	Stepping Stones	0	1			
	Older Adol Step Down	Boys Group Home	Stepping Stones	0	1			
Three Sixty (360) Youth Services	Cornerstone Grp Hm	Cornerstone Group Home	Cornerstone	0	1	093323302	193012	CORNER STONE SHELTER FOR BOYS; Cornerstone
Thresholds				1	1	025727401	025727	
	Young Adult Prgm	James Houes	Thresholds	1	1			
	Young Adult Prgm	Diane House	Thresholds	1	1			
	Young Adult Prgm	Mary Hill House	Thresholds	1	1			
Transitional Center Inc				1	1	422643703, 422643704	422643	
	Residential Ctr	Cards	Transitional Center	1	1			
	Residential Ctr	Billkens	Transitional Center	1	1			
	Sexual Beh Problems	Rams	Transitional Center	1	1			
	Sexual Beh Problems	Grizzlies	Transitional Center	1	1			
Uhlich Childrens Advantage Network				1	1	021038405, 021038412	021038	UCAN; Uhlich
	Residential Treatment Ctr	Doors	UCAN	1	1			
	Residential Treatment Ctr	Achievers	UCAN	1	1			
	Residential Treatment Ctr	Faith	UCAN	1	1			
	Residential Treatment Ctr	Glory	UCAN	1	1			
	Residential	Journey	UCAN	1	1			

	Treatment Ctr							
	Residential Treatment Ctr	Genesis	UCAN	1	1			
	Residential Treatment Ctr	Transitions	UCAN	1	1			
	Residential Treatment Ctr	Victory	UCAN	1	1			
	Residential Treatment Ctr	Hope	UCAN	1	1			
	Residential Treatment Ctr	Junior	UCAN	1	1			
United Methodist Childrens Home				1	1	021068806	021068	UMCH
	RTC	Boys 100	UMCH	1	1			
	RTC	Girls 200	UMCH	1	1			
Webster Cantrell Hall				0	1	021750611, 021746646 (shelter)	021750	Webster Cantrell Staley GH (shelter, ID: 061479)
	Residential Ctr	A Unit	Webster Cantrell	0	1			
	Residential Ctr	D Unit	Webster Cantrell	0	1			
	Residential Ctr	B Unit	Webster Cantrell	0	1			
	Residential Ctr	C Unit	Webster Cantrell	0	1			
	Group Home	Girls Group Home	Webster Cantrell Group Home	0	1	021746622	505218	WEBSTER GIRLS GROUP HOME
Willowglen Academy	Freeport Residential Program	Washington Home	Willowglen	0	1	405054101	533033	Willowglen Academy Illinois Washington GH

***1 marks the implementation group (those included in the pilot) and 0 marks the comparison group**

EXHIBIT U

FOUR-MONTH STATUS REPORT TEMPLATE

Target Group of Children and Youth in Psychiatric Hospitals beyond Medical Necessity Pilot

Date submitted: 5/1/17

I. **Summary:**

Since the filing of the Tri-annual Interim Report in February, focus has been on filling the Stabilization Consultant position by Kaleidoscope and better defining the target population, sample group, future data collection & referral process.

Kaleidoscope posted the stabilization consultant position as planned in January 2017. Hiring has been stalled as there were initially few candidates that presented as a good fit with enough child welfare experience and knowledge. Furthermore, this is a master's level position and the salary range is equivalent to a master's level child welfare specialist position The first Placement Stabilization position has been filled and the candidate will start on May 14th. A Second candidate is also being considered with a second interview occurring May 1, 2017.

The IPS Supervisor and Executive Director continue to provide the services. Initially there were three youth identified. Services for one youth were discontinued as he was very stable, all services were in place, and the agency was providing all services. Once a stabilization consultant is hired and trained it is expected that at least 5 new youth will be assigned to the pilot. Kaleidoscope will continue to add an additional stabilization consultant for every 5-10 youth assigned to the pilot, The end date of this pilot has yet to be determined and will be better defined based on the outcomes for sustaining community based services for these youth.

The pilot population was initially defined as youth that were considered beyond medical necessity in a psychiatrically hospital. We have learned from selection of our 3 youth initially selected for this pilot that the pilot is more purposeful and useful to provide this intervention as soon as possible prior to clinical readiness to discharge form the hospital. This is directly related to our theory of change:

> Earlier intervention will allow outreach to previous caregivers to discuss the supports, education, and training to the caregiver and family which will hopefully allow a return to this caregiver whenever appropriate. An agreement has been reached that Kaleidoscope will be invited to CIPP staffings in Cook County for youth that are in the hospital This will allow for information about the program and the intervention to occur as soon as possible.
>
> The implementation of the pilot's involvement earlier in the process will aid in maintaining continuity of assigned casework agency. If we are able to preserve placement we will no longer need to transfer to an agency in search of a foster home.

We have also given approval in the pilot to enhance board payments for the caregivers as needed while receiving case management from an agency that does not have a specialized contract.

The control group is now better defined to include a random comparison of a control and experimental group. This will initially be determined by a random assignment to an Emergency Hospital Staffing (EHS). This will be determined by the last digit of the youth's ID as well as the day that the CIPP occurs.

Comparisons can be made regarding the initial randomized comparisons.

For the EHS where the Placement Stabilization Consultant participates there are these possible outcomes

- Home based services are recommended and Kaleidoscope will provide the pilot programming
- Home based services are recommended however the assigned agency is not willing to receive the pilot programming.
- Home based services not recommended so there would not be Kaleidoscope involvement.

The experimental group will then include the first two bullets and the control group will be:

- No Kaleidoscope participation during the emergency hospitalization staffing and home based services are recommended and pursued.

II. Revised Targets / Goals

By the end of the next reporting period, it is expected that Kaleidoscope will have hired at least one additional Stabilization Consultant. Implementation of the pilot is hindered by the hiring of this position. The first Stabilization Consultant will begin on May 14th. It is expected that 5 youth will be assigned by June 30th. Kaleidoscope will add a Stabilization Consultant for every 5-10 youth added to the pilot. An end date for this pilot has not yet been determined and will be better defined based on the outcomes for sustaining community based services for these youth.

The BH Expert Panel in conjunction with the DCFS Project Manager and Kaleidoscope Executive Director are in agreement that our control group needs to be better defined. A staffing occurred with Dr. Richard Epstein from Chapin Hall to review the existing pilot and the control group is now defined as random assigned to an Emergency Hospital Staffing (EHS). The random assignment is specific to a particular day (s) and the last number of youth's ID an odd number .

The goal is that the Mindshare dashboard will be live and will allow for review of data pertaining to the target population.

The Stabilization Consultants will receive the new Child and Family Team Meeting training which will be provided by DCFS. It is anticipated that this training will be offered in the next few months and the trainers are aware of their needed participation.

III. Problem Formulation

The major concern in regards to this pilot is the inability to refer new clients until Kaleidoscope hires staff. They have recently hired for this position and she will begin May 14th.

IV. Program Outputs

Discussion continues regarding the best way to track this pilot in Mindshare. The Psychiatric Hospitalization Tracking Database (PHT) is currently used to track this data however, is manually entered. This data does not necessarily match the data that is entered in CYCIS /SACWIS as not all hospitalizations are recorded. Department of Innovation and Technology is currently working on brining the PHT into Mindshare.

Continued discussions are needed regarding formulating business rules and completed validation measures.

Program Outputs	Program	Comparison	Significance and Explanation of Difference
# of EHS that Placement Stabilization Consultant attends			
% of youth where a recommendation is made to remain with the previous caretaker (HMR, HFK, Trad, FHS, or AFC			
% of youth where recommendation is to reside in a home environment with community and agency supports			
POST EHS			
Frequency of CFT with plan revisions that occur since BMN determination			
% CFT participation by youth, family, and primary caregiver			

Total population of youth assigned as of 5/1/17	Amount
Youth Assigned since development	3
Remaining with the same agency post discharge	2
Youth that returned to the previous placement	1
Youth who were placed with a different foster family post discharge	2
Youth discharge from Pilot due to success and stability in home	1

V. Proximal and Distal Outcomes

Proximal/Distal Outcome	Program	Comparison	Explanation of Status
Randomized Comparison after CIPP occurs with or without Kaleidoscope involvement			
% of youth psychiatrically hospitalized and identified as BMN			
% of youth with recommendations for an increase to higher intensity than a community based program			
Comparison for youth who receive Kaleidoscope Enhanced IPS Services			
# of youth re hospitalized since identified hospitalization			
# of youth who remain in same placement prior to hospitalization			
# of youth who remain with the same agency and child welfare specialist since psychiatrically discharged.			

Although there are only three who have been assigned to the pilot, there are some general findings.

All three youth remain with the same agency and foster parent.

Client 1) She was initially recommended for residential treatment at the EHS, however with the added Kaleidoscope support the team agreed to the home based setting with the previous foster parent's adult sisters. This youth has been re hospitalized 2 times since Kaleidoscope's involvement. Kaleidoscope continues to work very closely with the family ensuring that all needed supports are in place.

This youth remains with the same agency however there was a Child welfare Specialist change from the adoption team.

Client 2)Has done remarkable well since discharge from the hospital. He participated in the Kaleidoscope Winter and Spring Break Art programs. Due to his stability and successful service delivery, Kaleidoscope no longer provides servicing.

Client 3) Doing well and continues to receive Kaleidoscope's involvement in the grandmother's home. There was a child welfare specialist change after the hospitalization that we were unable to control.

VI. Theory of Change Revisions

Increase Placement and Permanency

If the Pilot intervention can occur as soon as possible once the youth is hospitalized the caregiver may be more willing to continue caring for the youth post discharge with the additional interventions and support provided by Kaleidoscope.

Maintain continuity of assigned casework agency

Kaleidoscope will now be involved prior to a youth's BMN status and will be able to provide education and support as quickly as youth has a CIPP/Clinical Staffing. This will allow Kaleidoscope to work with the current agency and discourage assignment to another agency identified by the Central Matching process.

Increase the effective use of Child and Family Team Meetings

If Kaleidoscope is involved prior to BMN status then CFTM can occur while youth is in the hospital to discuss services in support needed for discharge.

VII. Overall Assessment

The major challenge is the lack of necessary staff to perform the pilot duties as stated above.

It appears that with the identified earlier intervention the pilot will be able to be more effective to this population.

EXHIBIT V

FOUR-MONTH STATUS REPORT
Project Name: ILSCAW
Date Submitted: April 30, 2017

I. Summary:

Overview: The Illinois Child Well-Being Study 2017 (ILCWB 2017) will be a point-in-time study of the well-being of the population of children in open placement cases as of a selected date during FY2017. It will replicate many of the methods of the Illinois Child Well-Being Year 3 launched in 2004, while modifying measurement of several constructs and taking advantage of data sources that have been developed in the last decade.

A sample of 500 to 600 children will be drawn from the population in care on June 30, 2017. All children will be in non-permanent substitute care placements a minimum of 3 months. Children in adoptive, guardianship, or intact family settings will not be eligible. Only one child per caregiver was eligible for children in family-based care to limit the response burden on caregivers. For human subject protection purposes, children in detention of any type and youths who are pregnant (as reported by the caseworker) will be excluded.

Progress: There is continuing progress in the preparation for data collection in the Illinois Child Well-Being Study 2017. The Survey Research Laboratory (SRL) at the University of Illinois at Chicago is working intensively on the protocol for the study. SRL is developing the protocol and IRB application based its review of the study documentation from previous Illinois child-being studies it conducted. This involves:

- describing all sampling procedures
- communicating plans for contacting recruiting participants
- detailing procedures for conducting all study interviews
- preparing copies of all instruments,
- describing methods of reducing risks to participants and providing for human subject protection
- describing methods of preparing and protecting data files (including data cleaning and storage)
- reporting plans for analysis and dissemination of study results.

The protocol will be reviewed by the UIC convened board on June 15, 2017. Dr. Parsons of UIC and Dr. Cross of UIUC have reached agreements with their respective IRBS in which UIC will have primary review of the study protocol, and the existing memorandum of understanding between the two campuses will negate the need for a separate application to the UIUC IRB.

II. Revised Targets / Goals

No changes.

See Below:

Data analysis can begin in the first quarter of FY' 2018, from July to September 2017. The final report will be available during the third quarter of FY' 2018.

Figure 1
Draft Timeline for Well-Being Study

	FY 2017			FY2018				FY2019			
	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	3rd qtr	4th qtr
Finalize research design and budget											
Develop plan and methods for integrating CANS, medical and educational data											
Draw sample											
Prepare for data collection											
Field primary well-being data collection											
Analyze primary data and prepare data tables											
Identify and merge secondary data (IDB, CANS, medical, and educational data)											
Prepare primary well-being report											
Identify secondary research questions											
Prepare relevant research briefs											

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

B.H., et al., by their Next Friend SUSAN TONE PIERCE, individually and on behalf of all others similarly situated;	)	
Plaintiffs,	)	
v.	)	**Case No. 1:88-CV-5599**
GEORGE SHELDON, Acting Director of the Illinois Department of Children and Family Services,	)	**Hon. Jorge L. Alonso**
Defendant.	)	

NOTICE OF FILING

To: See attached service list.

PLEASE TAKE NOTICE that on the 9th day of June, 2017, **Second 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.

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CERTIFICATE OF SERVICE

The undersigned, an attorney, deposes and states that a copy of the attached SECOND TRIANNUAL INTERIM STATUS REPORT ON THE B.H. IMPLEMENTATION PLAN was served upon counsel of record by electronic filing this 9th day of June, 2017. The Expert Panel listed below, who are not ECF filers, was served by email.

s/Barbara L. Greenspan
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