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

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

DCFS B.H. IMPLEMENTATION PLAN

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DCFS B.H. IMPLEMENTATION PLAN

Introduction

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

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

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

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

This Implementation Plan sets forth the specific steps DCFS will take to begin addressing the six recommendations and the specific needs of children and youth in care with psychological, behavioral or emotional challenges. The Plan represents a core component of the overarching DCFS strategic plan which will be developed between February and July 2016. The direction of DCFS is to embed child and family centered practice into a system where all leaders, administrators and staff have a sense of urgency toward reaching the best possible outcomes for children and families in Illinois.

I. Overarching Outcome Measures

As a result of collaboration with the Expert Panel and DCFS consultant Dr. Mark Courtney, DCFS identified specific outcome metrics to assess the safety, permanency and wellbeing of class members. These metrics are intended to monitor changes in both the quality of, and capacity to provide, services and supports for children and families in the Illinois child welfare system. Notably, every state child welfare system is measured by the United States Department of Health and Human Services, Administration for Children and Families. For purposes of this Implementation Plan, DCFS will use the same safety and permanency outcome measures that are currently utilized by the federal government in the Child and Family Service Review (CFSR) process. The data for the safety, permanency, and stability metrics will be drawn from existing DCFS data sources and based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS). Though not as a measure of compliance with the Expert Panel's report, DCFS will routinely track and monitor other data indicators as part of this Implementation Plan that are discussed under Recommendation #4. See discussion *infra* at pp. 39-40.

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

A. Safety

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

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

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

B. Permanency and Stability

The selected permanency and stability measures are:

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

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

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

4. Re-entry to foster care in 12 months: "Of all children who enter foster care in a 12-month period who discharged within 12 months to reunification, living with a

relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?"

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

C. Wellbeing

Because the CFSR process does not provide for specific data measures for child wellbeing, DCFS will measure wellbeing based on a matrix that was developed by the CWAC Sub-Committee. The matrix is premised on the four functional domains (cognitive functioning; physical health; emotional/behavioral functioning; and social functioning). DCFS is working to further define measures of all aspects of wellbeing described in the matrix and has brought on national expert, Dr. Mark Courtney, to support this effort. With Dr. Courtney's support, DCFS and the CWAC Sub-Committee will specifically identify indicators of the domains of wellbeing by June 2016.

The current wellbeing matrix identifies developmentally-sensitive measures for children and youth ages 0-3 through young adulthood, and is consistent with the federal framework set forth in "Promoting Social & Emotional Wellbeing for Children and Youth Receiving Child Welfare Services." (April 17, 2012, https://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf.) See CWAC Wellbeing Matrix, attached as Exhibit C.

D. Action Steps for CWAC Wellbeing Matrix

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

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

assess the validity of CANS findings, DCFS will develop and implement in the selected immersion sites (discussed *infra* at pp. 22-30) an independent quality service and progress review consisting of the periodic collection of data from external sources, such as children and youth, foster parents and teachers to compare to CANS findings. CANS data-capturing and reporting activity is maintained by the Northwestern University Illinois Outcomes system. The Psychiatric Hospital database has been finalized. It permits DCFS to collect data regarding youth who have been and are currently psychiatrically hospitalized, critical information to confirm the CANS.

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

II. Implementation of Specific Recommendations of the Expert Panel

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

DCFS will begin implementing Recommendation #1 through four pilot projects targeted at populations of children with emotional and behavioral needs and/or youth involved in both the juvenile justice and child welfare systems ("dually involved"). The goal of the pilot projects is to reduce lengths of stay in residential facilities and increase placements in community and home-based settings. DCFS is committed to the pilot project process, and three of the four pilots described below have been launched. The fourth pilot, Therapeutic Foster Care, is in the Request for Proposals (RFP) phase and is expected to launch this summer. Each of these pilots will be rigorously evaluated. If the evaluation demonstrates that the pilots are meeting stated

goals, it is anticipated that they will be rolled out more broadly across the state. If they are not effective, they will be modified or discontinued, and alternative approaches will be pursued as appropriate and necessary.

1. Therapeutic Foster Care Pilots

a. Pilot Overview

DCFS will pilot the use of therapeutic foster care through evidence-based or evidence-informed models in three sites over the next five years. Therapeutic Foster Care (TFC) is a community-based service for children and youth whose emotional or behavioral health needs can be met through services delivered primarily by foster parents, as an alternative to residential and other forms of congregate care. TFC involves homes where at least one parent does not work outside the home, and no more than one or two children are placed in the home.

b. Requests for Proposals

DCFS issued requests for proposals for the development of TFC pilot programs. Based on an analysis of the current DCFS population by Chapin Hall at the University of Chicago (Chapin Hall), the TFC pilot programs are targeted for Cook, Kane and Winnebago counties because these areas have the highest need for alternative placements for youth with serious emotional or behavioral health needs. The RFP asked the proposing entities to identify the target population and number of youth to be served; the geographic region to be served; the particular model of TFC to be implemented; the trauma-informed interventions to be implemented; a model of sustainability including plans for recruitment and retention of foster parents; and the identification of key staff along with the qualifications of staff members and an explanation of cost efficiency.

Twenty-six responses to the RFP were received and are being evaluated. DCFS plans to complete the evaluation process, including oral presentation by finalists, and will begin contract negotiations no later than April 1, 2016.

c. Oversight of TFC Implementation Steps

After the TFC providers are selected and contracts with them have been negotiated, DCFS will take steps to ensure timely and appropriate implementation of the chosen TFC programs, using demonstrated strategies that have proven successful in implementing TFC nationwide. Unlike traditional foster homes, TFC is a treatment intervention through which the foster parent is the primary provider of mental health services and supports to the child. DCFS will set specific targets and, working with the selected providers, develop strategies for the recruitment and retention of TFC homes, the placement of children in those homes, and the services and supports those children receive. DCFS will have a structure for identifying children and youth most appropriate for TFC placement no later than April 30, 2016. In addition, DCFS will begin contract negotiations with TFC Purchase of Service (POS) providers no later than April 1, 2016, and will have developed implementation plans with those providers no later than April 30, 2016.

DCFS set a two-year goal for each program for the recruitment of therapeutic foster parents and placements. This two-year goal will include the placement of a minimum of 40 children and youth in TFC licensed homes at the end of the first contractual year; and placement of a minimum of 100 children and youth in TFC licensed homes at the end of the second contractual year. At least 60% of the youth served in TFC licensed homes will be aged 12 years and over.

d. Initial Placement and Placement Stability

TFC pilot programs will establish placement and assessment criteria, including adherence to the clinical needs of the individual child, as the main determination of the placement and development of individualized service planning to meet the specific and changing needs of the child. Participating entities in the TFC pilot programs will be required to serve all children and youth assigned to their program—there will be a "no eject, no reject" policy for children assigned to each agency.

e. Evaluation by Chapin Hall

The evaluation of the TFC pilot programs will be conducted by Chapin Hall. While the evaluation component is not complete, wellbeing measures will be included. Other outcome measures will focus on reduced length of stay and number of placements in residential facilities, number of children stepped down to traditional foster care and the number of children achieving permanency.

f. DCFS Leadership of the TFC Pilot

The implementation of this project will be led by Peter Digre, Deputy Director of Placement and Community Resources with the support of an outside expert consultant who will be hired by April 15, 2016. Mr. Digre has extensive experience in developing and implementing child welfare programs in Illinois, Philadelphia, Florida and Los Angeles, including specialized, intensive and therapeutic foster care programs. He will lead a team that will include managers from Clinical, Licensing, Operations and Training divisions. Twana Cosey will be the Strategic Planning liaison on this project.

2. Care Management Entity Pilot

a. Pilot Overview

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

b. Child and Family Teaming Model

The CME's care coordination services are provided through an intensive Child and Family Teaming (CFT) model that is implemented according to High Fidelity Wraparound standards. See National Wraparound Standards, attached as Exhibit D. When a child is enrolled in the CME pilot, a care coordinator is assigned and begins an engagement process to establish a CFT that includes the child, the permanency worker, any available family members, and other natural supports, such as teachers, friends, mentors and neighbors. The care coordinator facilitates a meeting with this CFT at least every 30 days to ensure that the child's and family's needs are being met. The CFT uses the strengths and needs that are identified through completion of a CANS when the child is enrolled to develop a Plan of Care that authorizes all services required for the child and family. Those services are provided by agencies who are members of the CME's Provider Network.

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

c. CME Provider Network

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

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

Home and community-based behavioral health services currently available within the CME Provider Network include, but are not limited to: therapy – individual, family, group, and specialty (e.g., equine); community support – individual and group; evaluation and testing services; and behavior management services. Expanded child welfare support services include, but are not limited to: team meeting participation; court hearing attendance; mentoring – educational, social, recreational, life coach, independent living skills, family and parent; tutoring;

supervised visitation; shared parenting and coaching; family support services including camp; childcare reimbursement; transportation; incentives; utilities; supplies; activities; medical; clothing; and restitution and damage repaid.

d. Flexible Funding

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

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

e. Goals and Outcomes for CME Pilot

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

f. DCFS Leadership of CME Pilot

The CME pilot is administered by DCFS's Care Coordination Office, overseen by Kristine Herman, Associate Deputy Director of Medicaid Behavioral Health and Care

Coordination within the Strategic Planning and Innovation Division. The Care Coordination Office authorizes all referrals to the CME, oversees the implementation of the pilot program and ensures that administrative issues are addressed at the field level by interacting directly with both private agency and DCFS permanency workers and other staff.

The Care Coordination Office is also responsible for ongoing oversight of the implementation of the pilot through CME compliance reviews and quarterly and annual outcomes reports by the CME. Additional baseline data, outcomes and performance benchmarks will be reported by the university partner tasked with evaluating the CME project. These reports will be used to assess the impact of the pilot as it continues to be implemented and before the final evaluation is completed.

g. CME Pilot Time Frames and Capacity

The CME pilot started in February 2014 and is currently scheduled to last for three years. The pilot is designed to serve approximately 200 children annually and 600 during the course of the three year pilot. The daily census as of February 5, 2016 is 170, and a total of 255 children have been served in the pilot since February 2014.

Lessons learned from the two years of the CME pilot have been applied to the development of the immersion sites as set forth in Recommendation #2. See discussion *infra* at pp. 22-30. Through the CME pilot, DCFS has begun to localize processes within the regional structure of the CME allowing more local control and further empowering CFTs to make decisions regarding the best services and placement types for children. For example, the Clinical Intervention for Placement Preservation (CIPP) has been eliminated for children enrolled in the CME and the centralized process for placing children in substitute care (Central Matching) is being replaced. DCFS is committed to continuing the process of reinforcing local control of

various policies and processes, since this local integration has been shown to be effective in the CME pilot.

In addition, DCFS recognizes that any system change processes, such as those undertaken in the CME pilot, must have strong administrative oversight and support. Because changing the culture of a system takes time and consistent messaging, a single administrator of the program with direct access to executive leadership was established. This administrative structure has allowed policy, procedural and other system barriers to be addressed in the pilot helping to propel culture change. This also ensures that both DCFS and private agency staff are held accountable for honoring the CFT model integral to the pilot, which represents a completely new way of doing business.

h. CME Evaluation

A full evaluation of the CME pilot project will be completed by a university partner, to be identified by March 15, 2016, at the end of the three year pilot period.

3. Dually-Involved Youth Pilots

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

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

produces the best outcomes for dually-involved youth. The pilots are described in more detail below.

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

i. Pilot Overview

The Regenerations/RUR (Release Upon Request) pilot began July 6, 2015, and serves youth ages 12 - 18 years old who are 1) in the custody of DCFS, 2) are detained in the Cook County Juvenile Temporary Detention Center (JTDC), and 3) have been determined by a judge to be ready for release (RUR). Based upon the evaluation of dual ward detention data in previous years, the pilot was developed to serve a total of 65 youth, and 38 youth are currently enrolled. Youth in this pilot receive specialized services including intensive mentoring services and priority placement in home and community settings.

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

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

ii. Evaluation

Chapin Hall anticipates finalizing its evaluation for the Regenerations Pilot by April 2016. The key outcome measures will focus on the reduction in the days youth are detained in the JTDC beyond their release date, increase in the number of youth released directly to home and community-based settings, increase in the provision of needed community-based behavioral health services, and child welfare support services resulting in a reduction in the days youth reside in a residential placment.

iii. DCFS Leadership

This project is being led by Peter Digre, Deputy of Placement and Community Services. The Strategic Innovation and Planning Division liaison for this pilot is Twana Cosey.

b. Illinois Pay for Success Pilot for Dually Involved Youth

i. Overview

The Pay for Success pilot serves dually-involved youth who are not in Regenerations. This pilot utilizes the Crossover Youth Practice Model (CYPM), developed by the Georgetown University McCourt School of Public Policy – Center for Juvenile Justice Reform. This pilot provides intensive care coordination through a fidelity wraparound model that ensures youth have access to evidence-based, community-based and non-traditional treatments and supports that address the individual's and family's behavioral health needs.

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

The pilot supports collaboration between governmental systems to rapidly identify issues, engage in case coordination, and provide increased access to therapeutic programs.

The ramp-up phase of the pilot began January 2016 with children from Cook and Lake counties. In March 2016, referrals will begin for dually-involved youth in Franklin and Jefferson counties. The ramp-up phase will serve approximately 50 children and is designed to refine project operations, including the referral mechanisms, and the intake and service enrollment processes. At the end of the ramp-up phase, additional counties will be added starting in May 2016, and the pilot will serve approximately 800 youth over seven and a half years.

ii. Service Array

Youth enrolled in the Pay for Success pilot will have access to the following services: functional family therapy; multi-systemic therapy; brief strategic family therapy; Attachment, Regulation and Competency (ARC); Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); academic supports; counseling/therapy; recreational activities; substance abuse treatment; workforce development; and other services that will benefit the youth's functioning.

iii. Pay for Success Payment Structure and Evaluation

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

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

c. DCFS Leadership of the Pay for Success Pilot

Larry Small, DCFS Deputy Director of Clinical Practice and Development, is the DCFS point person for the Pay for Success project. The Strategic Planning and Innovation Division liaison for this pilot is Kristine Herman.

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

Child welfare best practice requires intensive family engagement, comprehensive assessment of family strengths, and development of service plans with realistic goals that can be achieved through access to home and community-based services. DCFS will implement a Core Practice Model that includes each of these elements utilizing the Family-Centered, Trauma-Informed, Strength-Based (FTS) curriculum. To assure sustainability of the FTS, the Core Practice Model will also include a Model of Supervisorial Practice (MoSP). The MoSP teaches

supervisors how to manage, coach and evaluate frontline caseworkers in their daily engagement and decision-making with children and families.

DCFS will operationalize the Core Practice Model in identified individual counties ("immersion sites"). Immersion sites will be rolled-out in a staged manner with three or four initial immersion sites being selected that collectively serve five to ten percent of children in DCFS care. Selection will be based upon criteria that include but are not limited to: geographic distribution, leadership capacity, staffing capacity and caseloads. Additional immersion sites will be rolled-out on a regular basis, as discussed below.

In each of these sites, DCFS will implement an intensive training and coaching process to ensure that all permanency workers understand and can execute FTS and that all supervisors are proficient in MoSP. In addition, DCFS will partner with its contracted private agencies, home and community-based service providers and other non-traditional providers to broaden the array of services that are available to children and families at the immersion sites. By April 2016, DCFS will retain a Core Practice Model expert to lead and direct the implementation of the model and the roll-out of the immersion sites. Under current planning, but subject to the recommendation of the Core Practice Model expert, the initial immersion sites will commence in August 2016. Additional immersion sites will launch in six month increments thereafter in different geographic locations, with statewide implementation to be completed by January 2019.

All of the pilot programs described in connection with Recommendation #1 above, support the central tenets of the Core Practice Model, such as developing family and youth voice in case planning, establishing new services within the community, creating alternative placements for children to reduce reliance on residential placements, and breaking down communication barriers between child-serving systems.

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

The FTS component of the Core Practice Model sets forth clear guidelines for caseworkers and supervisors that establish a more effective process of family engagement, assessment and case planning. The FTS requires caseworkers to engage with youth and families in a continuous, rather than episodic, manner that ensures open, honest, and culturally-aware communication with children and families. This level of engagement requires seeking out and listening to the opinions and goals of the children and families, respecting and implementing their suggestions whenever possible, and providing them with essential information and education in a respectful and understandable way. The FTS model requires that children and families are treated as full partners in assessment, planning, intervention, review, evaluation and decision-making. FTS also requires caseworkers to collaborate with all individuals who are involved with a child and family in the planning, delivery, coordination and management of services.

A key component of the FTS model is that caseworkers must establish and facilitate Child and Family Teams (CFT) that plan and coordinate interventions. The child's permanency worker is responsible for facilitation of the teams, which include the child, the family, any natural supports identified by the family and all providers of services to the child and family. The CFT is responsible for assessment, case planning and monitoring progress of permanency goals. The FTS model establishes accountability of everyone involved, because it requires a continuous review of the plans and responsibility for implementation.

a. Individualized Case/Service Planning

FTS provides guidance to ensure that all assessment and planning is backed by clearly identified goals that are measured, reviewed and revised to meet children and families' changing

needs and strengths. Individualized plans will include deliberate action steps that explain which specific individuals are responsible for implementing distinct steps. All plans must set forth meaningful and well-articulated timeframes. Relevant action steps are reviewed regularly by the permanency worker with the CFT (e.g., a minimum of every three months) to evaluate the feasibility of existing goals and appropriateness of services as the youth progresses.

b. Safe and Sustained Transition to Permanence and/or Adulthood

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

c. Disproportionality/Disparity

Issues of disproportionality and disparity are also addressed by FTS. Disproportionality relates to the under- or over-representation of a particular racial or ethnic group involved in child welfare compared to their representation in the general U.S. population. Disparity refers to the unequal treatment of individuals across racial and ethnic groups. FTS strives to reduce, if not, eliminate disproportionality and disparity through the reform of permanency workers' engagement practices. Under FTS, permanency workers and supervisors will be trained, coached and evaluated on their ability to interact with children and families in a continuous, open, honest, culturally-aware manner, with the aim of eliminating cultural biases.

2. Description of Model of Supervisory Practice

The Model of Supervisory Practice (MoSP) is the second component of the Core Practice Model. The MoSP requires the supervisor to continuously coach the permanency worker through reflective supervision. The MoSP clearly defines the duties and boundaries of supervisors, and

facilitates their ongoing learning of social work best practices. The model trains supervisors as coaches of their staff, giving supervisors enhanced techniques for teaching staff the skills to engage families, facilitate CFTs, and develop comprehensive assessments that lead to strengths-based, individualized case planning with clear pathways to permanency.

Supervisors will be trained to conduct case-specific supervision that includes:

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

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

3. Initiation of MoSP Training Model

DCFS began to train 45 supervisors in MoSP in January 2016. Participants in the initial cohort include volunteers and staff from both DCFS and POS agencies. Training extends over a six-month period, with two days of classroom instruction every three weeks. Between classroom sessions, learning is reinforced by coaching and everyday practice. Upon completion of the classroom training, supervisors receive ongoing coaching and support from the MoSP training staff. MoSP training and coaching elements will be revised based on lessons learned from the initial implementation. When the training of the initial cohort of supervisors is complete, DCFS will implement future training through the roll-out of immersion sites, as outlined below.

4. Core Practice Model Expert

Because the Core Practice Model represents a fundamental shift in casework and supervisory practice in Illinois, DCFS will retain an expert to lead and direct the implementation of the model. DCFS anticipates that an expert will be retained by April 2016. The expert will assist DCFS with development of the curriculum, development and implementation of the training model, and training logistics at immersion sites. The expert will be responsible for the ongoing integration of lessons learned from the roll-out at previous immersion sites.

5. Statewide Summit

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

6. Core Practice Model Immersion Sites

DCFS will select three or four initial sites that collectively serve five to ten percent of DCFS children and youth based upon criteria that include but are not limited to: geographic distribution, leadership capacity, staffing capacity and caseloads. Before rolling out additional immersion sites, DCFS will evaluate and integrate lessons learned from the initial roll-out.

All DCFS and POS staff at the selected immersion sites will complete training in the Core Practice Model. To ensure that all community stakeholders have an understanding of the Core Practice Model, training at the selected immersion sites will be provided to DCFS Deputy Directors, private agency executive staff, Guardians Ad Litem, Court Appointed Special Advocates, youth, birth parents, foster parents, court officers, care coordinators, and residential and group home agency staff.

a. Identification and Timetable for Immersion Sites

With the recommendation of the retained Core Practice Model Expert, DCFS expects to identify the initial wave of three or four immersion sites in June 2016. These immersion sites will incorporate a total of approximately 5% to 10% of children in care (approximately 750 to 1500) and approximately 200 DCFS and private agency staff. DCFS expects the second wave will incorporate an additional 10% of the total children in care, with each subsequent wave thereafter incorporating an additional 20% of children in care.

In August 2016, pending recommendations of the Core Practice Model Expert, DCFS will initiate training and coaching in the initial immersion sites. Every two months thereafter, a new wave of immersion sites will be identified. Training and coaching in each immersion site will begin four months after their identification. Statewide roll-out of the Core Practice Model will require a minimum of six waves, each involving at least three to four sites over an anticipated 29 months.

b. Development of Regional Capacity to Expand Service Array

Within the immersion sites, DCFS will build sufficient capacity within the community to provide services to meet the unique needs of the children and families. To accomplish this, the regional offices within the immersion sites will have the authority to conduct a "gap analysis" to determine what services are currently being used, what services are available but not used, and

what services are unavailable in the community. The regional offices will also have the authority to identify barriers to expansion of needed services and to contract with providers for new services that are effective in keeping children stable in their homes. To alleviate and close regional service gaps, the regional offices will work with private providers and community stakeholders to develop the necessary service array.

Examples of potential enhanced child welfare support services that could be developed within a regional area include, but are not limited to: 1) enhanced visitation support, shared parenting and coaching services for families of origin; 2) educational supports, including services designed to enhance educational stability; 3) emergency foster care available 24/7, which will be a critical service to keep children in home-like settings; 4) increased availability of respite care for intact and foster families; and 5) in-home supportive services for intact and foster families.

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

Within the immersion sites, DCFS will expand the availability of IPS programs and services to DCFS children who are in psychiatric hospitals, residential placements, or group

home placements to assist in their transition to a less restrictive setting. DCFS also will use the existing IPS contracts and providers to develop additional critically-needed behavioral health services such as home-based services, family and youth peer support, crisis and non-crisis respite, and evidence/trauma-informed services.

c. Use and Oversight of Flexible Funds

As another avenue of ensuring that children and families receive needed supports and services, immersion sites will incorporate the use of flexible funding as part of the Core Practice Model. Flexible funds will allow permanency workers to respond to the unique needs of children and families by purchasing goods and services beyond what is available through existing contractual services. Beginning in March 2016, the DCFS Division of Budget and Finance will determine the amount of funding that will be available for flexible funding, and the DCFS Central Payment Unit will develop an approval and payment mechanism for the actual disbursement of flexible funds. Permanency workers and supervisors will be trained on appropriate services and supports that can be purchased with flexible funding, as well as on mechanisms that ensure the funds are readily available and monitored for appropriateness. With the guidance of the Core Practice Model expert, DCFS will establish time frames for the finalization of flexible funding policies and procedures.

d. Immersion Site Policy and Review Process

DCFS recognizes that there are inadequacies with the current centralized processes in Central Matching, CIPP, Integrated Assessment and Residential Monitoring. The centralization of these processes led to unintended negative consequences for children and families. To address these flaws, DCFS will establish local control of these processes, thus integrating the functions of Central Matching, CIPP, and Integrated Assessment in the regional offices of the immersion

sites. To ensure that statewide systems are not handicapped before local systems are prepared, DCFS will strategically transition to local control.

Through the Core Practice Model, caseworkers will change their level and depth of engagement with families, allowing them to gather assessment information that is relevant to the current and changing service needs of the family. This will eliminate the need for a separate Integrated Assessment process within the immersion sites.

The permanency worker will then facilitate a CFT that will have the responsibility for determining the child's placement level and the services that should be provided to that child and family. Should the CFT determine that additional assessment or clinical expertise is needed to finalize a determination of placement level and/or services, the CFT will have access to clinical and assessment resources that will help them gather additional information to complete their decision-making process. This will eliminate the need for a CIPP process within the immersion sites.

Within the immersion sites, each regional office will be responsible for recruiting, developing, and maintaining current information on placement capacity and other needed support services. Each regional office will have a primary focus on keeping children placed in close proximity to their family, fictive kin and other natural supports. Regional offices will have the authority to authorize and ensure placement in accordance with CFT recommendations. This will eliminate the need for the Central Matching process within the immersion sites.

The regional offices will also have responsibility to ensure that children are receiving adequate services while they are placed in residential or other congregate care settings. Looking to the future, the focus will be on keeping children as close to their home communities as possible, permanency workers will 1) have ready access to the facilities where children are placed, 2) visit the children regularly, 3) receive updates from children and residential staff

regarding the children's progress and obtaining information about what the children need in order to be served in a more home-like setting, 4) regularly discuss the children's progress with the CFT, and 5) notify their supervisors and CFT when issues arise with the children's treatment and placement at the residential facility. Should permanency workers determine that children were placed inappropriately at residential facilities, they will work with the CFT to identify action steps and the specific CFT member and staff person responsible for each step, as well as the timeframe to place the children in a more appropriate setting.

In addition, each regional office will have dedicated residential monitoring staff who will be responsible for reviewing the facilities within their region utilizing monitoring tools described below in Recommendation #6. They will also be responsible for following up on any issues with individual children's treatment and placement that are identified by permanency workers and CFTs. Regional residential monitoring staff will report to the Residential Monitoring Unit who will be responsible for tracking and addressing system-wide issues and intervening with residential providers who do not provide adequate services to children. This monitoring process will ensure that feedback from permanency workers, CFTs and monitoring staff is fully utilized to ensure that children receive the highest quality treatment possible while in residential settings. The interim structure of residential monitoring oversight in conjunction with UIC partners, described below at pp. 43-46, will be maintained throughout the development of work by regional office residential monitoring staff.

DCFS also will review and revise other current policies and procedures, such as Procedures 315, Permanency Planning, to ensure regional control over placement and resource decisions. The regional offices will act as a nucleus where policies and procedures that might otherwise be a barrier to services or permanency, can be waived if the safety of the child can be established.

e. Development of Regional Continuous Quality Improvement Capacity

Each immersion site will have an Immersion Site Director who will oversee all site functions ensuring fidelity to the Core Practice Model. The reporting structure will be established to ensure that when barriers to implementation of the Core Practice Model are identified, the Immersion Site Director can immediately access DCFS's Executive-level staff and propose appropriate solutions when necessary. It is anticipated that the DCFS Divisions will collaborate with the Immersion Site Director to work through barriers as they emerge.

Weekly meetings will be held with Strategic Planning, Immersion Site Directors and DCFS Executive-level staff to review barriers, determine action steps to be taken, the specific staff person responsible and the timeframe for the completion of the action step. The Immersion Site Director will be responsible for ensuring that action steps required within the immersion site are completed.

The Immersion Site Director is also responsible to ensure that when areas for improvement are identified, or corrective actions are recommended, those recommendations are, in fact, implemented. The Immersion Site Director will have the authority to initiate Quality Service Reviews (QSR) on individual cases; conduct follow-up reviews; and implement programmatic reviews as needed.

The Immersion Site Director will also receive all Administrative Case Review (ACR) reports for children within the immersion site. The Immersion Site Director will regularly communicate with supervisors to ensure that any problem area identified in the ACR report is addressed within the timeframe identified in the ACR. Should areas of weakness continue to be reported in an ACR, the Immersion Site Director will be responsible for informing DCFS Executive-level staff to ensure that the staff performance issues are addressed.

In addition, each immersion site will have a Quality Assurance (QA) coordinator who will work directly with the Immersion Site Director and private agencies' QA staff to support implementation of the Core Practice Model, thus creating a QA team. Although QA staff will be embedded in the immersion sites and will work with front line staff, they will continue to report to the central QA office.

The immersion site QA team will:

- ensure data is communicated effectively at all levels by completing weekly, monthly, quarterly and yearly analysis of data;
- prepare standardized reports that use a combination of outcome, practice, and compliance progress;
- complete QSRs on a random sample of cases on a quarterly basis;
- complete monthly case reviews and peer reviews within the immersion sites;
- complete regularly scheduled surveys of staff, stakeholders, families and youth;
- coach staff regarding utilizing data to improve practice, including residential facility staff;
- produce a real time profile/dashboard of all families and children served in the immersion sites.

All immersion site barriers and solutions to those barriers will be tracked by the Strategic Planning Division, which will assess what overarching changes in policy and procedure are required. The Strategic Planning Division will then ensure that those changes are executed in a timely and thoughtful manner with input from all necessary divisions.

7. Evaluation

Implementation of the Core Practice Model will comprise both a process and outcomes-based evaluation. Prior to the implementation of the immersion site coaching and training, Chapin Hall will complete a statewide baseline analysis for all areas anticipated to be impacted by the Core Practice Model including:

- Web-based survey of DCFS and POS caseworkers and supervisors around knowledge, beliefs, and practices to assess congruence with the new practice model.

- Surveys of parents (in-home and permanency planning cases) to assess their strengths and needs as well as their experience of their caseworker and services they receive through DCFS. Sample sizes within immersion sites to provide estimates that are accurate enough to allow for comparison to later assessments at the immersion site level.

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

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

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

Youth over the age of 12 require additional services and assistance to achieve permanency so they do not age out of the system without substantial relationships and community-based supports. DCFS is focusing on this population through statutory, policy and practice initiatives. Specifically, DCFS is expanding age eligibility for state-funded guardianship regardless of Title IV-E eligibility, and DCFS is expanding the definition of 'fictive

kin' to include current foster parents. Both of these efforts may result in cost savings through fully-funded Kinship Guardianship ("Kin Gap"). Finally, DCFS is implementing Procedure 315, Permanency Planning, to expand and improve its family finding strategies.

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

Current state law does not limit the age group required for state-funded guardianship. DCFS will propose a modification to Rule 302.10, which will lower the eligibility age for state-funded guardianship from 14 to 12, regardless of Title IV-E eligibility. In addition, the rule will also be modified to clarify that unlicensed relatives qualify for state-funded guardianships. The process for modifying a rule in Illinois takes approximately 9-12 months due to the public comment process.

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

Effective January 1, 2015, the Children and Family Services Act was amended to expand the definition of "relative" for placement purposes to include fictive kin. Fictive kin "means any individual, unrelated by birth or marriage, who is shown to have close personal or emotional ties with the child or the child's family *prior* to the child's placement with the individual." 20 ILCS 505/7 (emphasis added). DCFS is seeking a statutory amendment that further expands the definition of fictive kin to include current foster parents. The proposed amendment may become law in 2016 and, thereafter, DCFS will engage in the rule-making process described above.

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

After the above-described rules are amended, many current foster parents will qualify for KinGap, a federally-funded reimbursement program for guardians. The foregoing rule changes

thus should enhance the flexibility of parents to move from traditional foster care to subsidized guardianship. Conservative estimates indicate that 85 youth who are between ages 12 to 14 would be eligible for subsidized guardianship as a permanency option. This expansion would save DCFS an estimated $600,000 a year.

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

In 2015, DCFS proposed revised Procedures 315 related to permanency planning for all youth and children in care. These procedures provide an updated definition of permanency, to include reunification, as well as the guidelines to help children and youth achieve permanency at a timeframe in their best interest. These procedures also enhance and highlight new family finding strategies that must begin early and continue throughout the life of every child's case. Workers must speak with the youth throughout the process. ACR sets out a formalized process for semi-annual reviews of progress towards permanency. When staff have not taken the necessary steps to locate and engage family and fictive kin, ACR will flag the case and alert the worker, supervisor and DCFS or Purchase of Service manager. The training and procedures incorporate the Kevin Campbell model, "Six Steps to Find a Family." http://www.nrcpfc.org/downloads/SixSteps.pdf.

In order to expedite permanency DCFS has automated the family finding forms and tools as a step toward achieving these permanency goals. Training on Procedure 315 of all DCFS and POS permanency staff began in February 2016. Based upon feedback from the initial training cohort, the training is currently being revised and will continue upon finalization. In addition, new software that allows staff to search for family and fictive kin, referred to as family finding, is being vetted by DCFS to ensure robust technological searching support. DCFS anticipates this new software will be in place by July 2016.

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

1. Reorganization, Strategic Planning and Cultural Change

- *To oversee implementation of this plan, the Department should create a high level unit with cross-organization authority to develop an implementation plan, manage the implementation and resolve system barriers*
- *The consultant should evaluate the organizational structure and culture of DCFS; the effectiveness of DCFS' policies, procedures and programs; the effectiveness of the Department's leadership and managerial structure and function and to assess the supervisory functions of the agency.*

Director Sheldon obtained approval for a departmental reorganization of leadership and managerial structure from the Illinois Civil Service Commission. The final organization structure was implemented in October 2015. See DCFS Organizational Structure, attached as Exhibit E. As part of the process of reorganization and structural change, the Director formed the Strategic Planning and Innovation Division ("Strategic Planning") in September 2015. This division focuses on driving the implementation of innovation for DCFS, and is headed by Jody Grutza, Deputy Director of Strategic Planning and Innovation and Andrew Bridge, Senior Innovation Advisor. Strategic Planning will ensure that DCFS does not take a siloed approach to initiatives. Strategic Planning has cross-divisional authority and has responsibility for reform, including the BH Implementation Plan.

The Strategic Planning Division is expanding to include both internal and external experts to guide initiatives and act as liaisons to the projects, stakeholders and DCFS divisions. The division will partner with DCFS leadership and staff, POS providers, and other external stakeholders to support and drive consistent progress toward the goals envisioned in this Plan. Each initiative identified in the Implementation Plan will be assigned to one division member. That Strategic Planning Division member will meet with initiative leads weekly and report to

Jody Grutza during bi-weekly supervision meetings. Initiative leads will support and collect reports from each university or external partner at least quarterly as well as ensure compliance with the four-month implementation plan status reports. Ms. Grutza is responsible for tracking data and outcomes for each initiative and for supporting consistent evaluation of success, progress and lessons learned in conjunction with the contracted expert support and other members of the Strategic Planning team.

2. Full Implementation of Designed Initiatives

- *Development of new programs and retention of existing initiatives in DCFS should be done after determining how it fits in with the DCFS core mission, after a thorough review of other programs that may already be in existence to address the problem or need driving the new initiative, and that duplicate services and initiatives already in place be eliminated or revised to prevent inefficient use of resources. Mechanisms must be enacted to make effective programs and policies be self-sustaining such as through changing reimbursement strategies or revising job descriptions.*

- *Full implementation of several excellently designed initiatives, including among others: the Illinois Birth thru Three Demonstration, Integrated Assessment, Residential Services Performance-Based Contracting, DCFS Monitoring of Residential Services, and Home-Based Mental Health Services, is being stalled or undermined by a variety of systemic and external factors, such as lengthy court delays to adjudication, categorical funding restrictions, challenges of client engagement, inflexible bureaucratic rules, and discontinuities in the handoff of case management responsibilities among public and private agencies.*

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

The initiatives including Integrated Assessment (Recommendation #2), Residential Services Performance-Based Contracting (Recommendation #6), DCFS Monitoring of

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

a. Illinois Birth Thru Three Demonstration Project

The Illinois Birth thru Three Demonstration project constitutes the State's fourth Title IV-E waiver demonstration focused on developmentally informed child and family interventions. The demonstration project targets caregivers and their children aged from birth through three years of age who enter out-of-home placement regardless of Title IV-E eligibility. DCFS's demonstration project in Cook County focuses on children at risk of, or who have experienced, physical and psychological trauma as a result of early exposure to maltreatment. The evidence-based practices utilized include Child Parent Psychotherapy (CPP) and Nurturing Parenting Program (NPP). Children are identified by an enhanced screening protocol. The Demonstration Project has been in place for over two years. Although implementation challenges still exist, the intervention group demonstrates a statistically significant difference in permanency outcomes. While both CPP and NPP have progress to report, known challenges include:

- CPP continues to experience a waiting list for clients in need of services. For example, fee-for-service contracts do not allow for billing for the intensive engagement work required to get families involved in treatment and, as a result, providers are struggling.

- Challenges in engaging foster parents also exist. As the pilot shifts additional responsibility to the caregivers, additional foster parent training and supports are needed.

The Strategic Planning and Innovations Division will drive progress in overcoming the barriers discussed. Kristine Herman will be the Strategic Planning and Innovations Liaison. The

operations lead for this project is Kimberly Mann, Project Director for the IB3 Title IV-E Waiver.

b. SAFE Families for Children

Under SAFE Families for Children (SFFC), DCFS assists families in need with services to protect children and support keeping families together. SFFC places children at risk of removal in vetted volunteer families to avoid their placement into foster care. SFFC strives to meet three objectives: child welfare deflection, child abuse prevention, and family support and stabilization. SFFC has been in operation in Cook and Northern regions of Illinois for thirteen years. Due to a grant from the Arnold Foundation, SFFC was recently expanded state-wide to provide services to children and to evaluate the program. Challenges with the roll-out of the program evaluation include:

- Lack of anticipated participation by workers and identified candidates given limited education about the benefits of SAFE Families as well as various case issues related to the SAFE Families model.
- Reluctance of workers to refer children to SAFE Families out of concern that a child would be assigned to the control group and not to SAFE Families.

The operations leader on this project is Denise Gonzalez. The Strategic Planning team will drive the continued progress of this initiative by breaking down barriers to success. The Strategic Planning and Innovation liaison will be April Curtis.

c. Information Systems

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

https://www.federalregister.gov/articles/2015/08/11/2015-19087/comprehensive-child-welfare-

information-system. Given the investment in a new SACWIS system, all current IT projects are being evaluated by the Technology Governance Board (TGB).

The TGB is comprised of the Director, Chief of Staff, Chief Deputy Director, all Senior Deputy Directors and several other key executives and advisors. The State CIO, Director of HHSi2 and Director of Enterprise Applications also participate. TGB prioritizes all technology-based project work and aligns DCFS and Governor's Office strategy. TGB directs OITS to maximize technology and human capital.

i. Near Term Plan (6-12 months)

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

- Education Data Feed from ISBE
- Unusual Incident Reporting

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

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

ii. Long Term Plan (Beyond 12 months)

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

d. Predictive Analytics

DCFS is officially establishing an internal team in OITS to bring the reporting needs and the data analytics into a centrally managed organization.

i. Short Term

While positions are being established and filled, there will be some transitional activity including a recent sole source procurement with MindShare to provide interim services. MindShare will collaborate with the Division of Quality Assurance and Division of Strategic Planning and Innovation. This contract will be in place not later than February 15, 2016, and be in place for 18 months to help with the transition and to provide additional assistance.

MindShare will provide a dashboard view of DCFS key outcomes in real time. The CFSR measures will be delivered by MindShare via dashboards within 30 days of the finalized contract. There will be additional dashboards delivered to include the Director's 26 Metrics and others. See Contract Cover Page and Scope of Services for the ICARE Program, attached as Exhibit F.

ii. Long Term (Beyond 18 Months)

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

e. Data Not Included in Overarching Outcome Measures

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

3. Training and Coaching Program

- *The Department should initiate a program for training and ongoing coaching of project administrators on how to provide effective coordination and supervision. This training should not only include supervision on completion of responsibilities but on clinical matters as well.*

- *The training should emphasize that data should be used positively as a means for assisting managers in exploring new ways of improving program performance rather than negatively as an excuse for rendering unsatisfactory assessments of the performance of managers responsible for the program.*

DCFS is initiating the MoSP as detailed in Recommendation # 2 that includes in-depth training and coaching in recognition of the need for mid-level managers to have appropriate skills and training to manage projects from planning to implementation and for ongoing success. DCFS will implement additional training to: 1) build the knowledge and skill set of mid-level DCFS managers, 2) educate DCFS managers on the use of data to improve performance, 3) foster collegiality among DCFS managers, and; 4) enhance the effectiveness of managers as they safely and appropriately reduce the number of children and youth in care in Illinois. The additional training will include ten workshops over a six-month period, eventually including all mid-level managers, with the first cohort of up to 25 individuals starting in March 2016. Monico Whittington-Eskridge, Statewide Administrator DCFS/CSU IS & STEP Programs, will lead the project. Jody Grutza is the liaison from Strategic Planning and Innovation Division.

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

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

DCFS is working with the Children and Family Research Center to plan for reinstituting the Illinois Survey of Child and Adolescent Wellbeing. The contract is currently under negotiation. It is anticipated that the plan for data collection and analysis will take at least 60 days to complete following execution of all necessary contracts.

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

As described in the response to Recommendation #2 above, residential monitoring responsibilities will be integrated into immersion sites as they are rolled out statewide. However, the residential monitoring system will still need to be revised and an interim process will need to be in place while the immersion sites are being implemented.

DCFS will team with its university partners from the University of Illinois at Chicago (UIC), Northwestern University and Chapin Hall at University of Chicago to develop a comprehensive long-term residential monitoring system that is a partnership of DCFS and university partners. The therapeutic residential (TR) monitoring plan will be submitted by the university partners in May 2016 with implementation to begin in July 2016. An interim monitoring plan will be used until the redesign is completed.

1. Long Term Therapeutic Residential Monitoring Plan

The monitoring system will include internal and external monitoring of TR services programs and will assess the safety, wellbeing, quality of services and progress of youth in TR facilities. Further, it will be integrated into DCFS's overall strategic plan to reform residential services and assist DCFS in assessing its progress towards reform. Specifically, the university partners will work with DCFS to:

- Design a series of standardized measures and systematic assessments that will be used to identify outlier programs in terms of safety, clinical outcomes, organizational capacity, and ability to effectively address problems as they arise. This will include revision of the current Performance Based Contracting measures to understand and accurately assess residential program performance.

- Provide leadership and training to DCFS staff in how to conduct on-site utilization reviews of agencies determined to be at high risk for harmful incidents, thus

requiring a targeted intervention. This would include working with DCFS Monitoring supervisory staff to improve monitoring processes and techniques and assess the need for additional training.

- Provide clinical and organizational assistance and consultation to TR providers in the development of corrective action plans required to address the specific findings of these reviews.

- Monitor the providers' progress vis-à-vis the implementation of the corrective action plans.

In addition to the above functions, the residential monitoring system will include;

- An ombudsman function to solicit and facilitate feedback and problem-solving for stakeholders; and

- An intensive and highly specific consultation and training program for TR facilities identified as having difficulties based on best practice and evidence-informed/evidence-based treatment approaches.

The DCFS ombudsman function will include administering youth and family satisfaction surveys to all youth upon discharge from the TR and at selected intervals during the TR episode as well as obtaining feedback from primary stakeholders. This information will be made available to Chapin Hall for aggregation to provide data for the monitoring system to guide interventions and assess outcomes. The consultation and training component will include development of a technical assistance clearinghouse which would identify TR providers implementing best practices and provide support for them to develop targeted technical assistance, certified by UIC, that can be incorporated into program improvement or corrective action plans for eligible agencies.

The internal DCFS monitoring component will be adjusted as necessary to ensure development of a comprehensive and integrated monitoring system that is consistent with the TR monitoring plan designed by the university partners.

Chapin Hall will develop an evaluation methodology to detect differences between historical trends in practice and adherence to new residential monitoring protocols. A baseline

will be established using both existing monitoring tools and new tools to capture data on performance expectations. The evaluation will assess organizational culture in TR facilities as well as consumer satisfaction with the services provided. The evaluation should inform DCFS of the impact of TR monitoring on the quality of care and child and youth outcomes and help guide ongoing development of the monitoring system.

2. Interim Therapeutic Residential Monitoring Plan

While the above comprehensive TR monitoring system is being developed, DCFS will implement an interim monitoring plan that includes the continued use of professionals affiliated with UIC to externally monitor the quality of care provided to youth in residential facilities. DCFS and UIC will meet monthly to review and assess agencies, contracts and/or sites.

The following key changes will immediately be made to DCFS's current monitoring under this interim plan:

- Increased Observational Oversight: Unannounced on-site monitoring visits will increase to a minimum of one time per month during after school and evening hours while youth are present and a minimum of one visit per quarter during overnight or on the weekend. Thus, monitors will conduct a minimum of 16 visits per year at each facility/site as necessary to meet established standards and/or support intensive monitoring activities.

- Improved Unusual Incident Report (UIR) Audits: Monitors will review all facility/site UIRs prior to each visit. Monitors will speak to involved youth and staff about the incident to ascertain whether there are any safety concerns, case management intervention needs or operational deficiencies requiring technical assistance.

- Inclusion of the Youth Voice: Monitors will collect the comments left in the youth suggestion boxes during each site visit. Monitors must read, address and refer all suggestion box comments to the appropriate entity. All comments must be entered in the database so that Chapin Hall can aggregate the types of issues raised. Monitors will engage youth during each site visit, as appropriate.

- Increased Supervision: DCFS will increase direct supervision of monitors to three times a month in order to more readily and more quickly identify potential safety concerns and programmatic deficiencies, as well as discuss trends seen at a

facility or site. Supervision will include on-site coaching for monitors who require additional support.

- Comprehensive Administrative Oversight: Monthly assessment of each agency's sites and units, discharges, UIRs, licensing reports and other reported concerns. Administrative meetings, at a minimum, will include the program director and quality improvement staff along with other key program staff.

In addition to these key changes to internal monitoring, UIC and DCFS will conduct an initial assessment of each TR provider contract and/or site, place each contract and/or site on a level system and complete monitoring plans that will most effectively utilize limited resources. Numerous factors will inform the determination of a TR contract and/or site level (e.g. performance based contracting report, monthly monitoring reports, monthly agency reports, UIR reporting, Medicaid billing reports, licensing reports, provider matching and admission information, etc.). DCFS will ensure access to available information regarding TR provider and contract performance as requested by DCFS monitoring staff and UIC, and will include access to additional relevant data normally collected by DCFS that may inform the monitoring process. The contract/site's initial level will determine the intensity of intervention by UIC and DCFS and the development of a contract-specific TR monitoring plan that may also incorporate resources from the Clinical Division to assist in collaboration and technical assistance with TR providers, caseworkers/supervisors, and child specific consultation when appropriate.

Upon implementation of the monitoring plans by level, DCFS and UIC will integrate findings and additional information as it becomes available to adjust the levels and target monitoring activities when necessary, such as when additional safety concerns are identified. Emergent issues will be addressed immediately. Thereafter, UIC and DCFS will conduct monthly triage meetings and ensure all provider contract levels are reassessed at least quarterly. The following is a snapshot of the minimum monitoring intervention required for each level:

Level 1:

- Monthly unannounced visits by DCFS monitor to each TR site
- Monthly triage meetings between UIC & DCFS to assess the strengths and deficiencies
- Monthly administrative meetings with TR providers
- UIC will randomly and periodically conduct unannounced on-site reviews, at its discretion

Level 2:

- Monthly unannounced visits by DCFS monitor to each TR site which may be increased pursuant to the program's monitoring plan
- Monthly triage meetings between UIC & DCFS to determine the technical assistance needs and review of corrective action and/or quality improvement plans
- Monthly administrative meetings with TR providers
- UIC will randomly and periodically conduct unannounced on-site reviews at its discretion and with support from DCFS monitors when indicated by the monitoring plan

Level 3:

- Monthly unannounced visits by DCFS monitor to each TR site which may be increased pursuant to the program's monitoring plan
- Monthly triage meetings between UIC & DCFS to execute technical assistance plan and review of corrective action and/or quality improvement plans
- Monthly administrative meetings with TR providers
- UIC will conduct unannounced on-site reviews and with support from DCFS monitors when indicated by the monitoring plan

A high level of coordination and communication between DCFS monitoring staff and UIC to implement the interim plan is required. This process will also offer opportunities for UIC to work with monitoring supervisors and managers to identify training needs and develop ongoing process improvements to identify safety concerns and specific programmatic deficiencies. In addition, UIC and DCFS monitoring staff will focus on developing procedures for drafting and implementing corrective action and quality improvement plans.

The interim TR monitoring plan will also include the following activities:

- DCFS and UIC will assess additional resource requirements to support UIC's role and subsequently develop a timeline and action plan.

- DCFS will provide timely access to data pertinent to the ongoing assessment of TR provider performance and develop mechanisms to facilitate data integration.
- DCFS and UIC will initiate efforts to develop residential technical assistance and training capacity that would include provision of direct technical assistance by university partners and monitors with access to additional support including case specific consultation from the DCFS Clinical division when appropriate.
- Regular communication between DCFS Monitoring/UIC and DCFS leadership regarding identification and planning around significant system barriers that have a deleterious impact on TR providers and the effective delivery of TR services. In addition, the combined DCFS/UIC team will address issues that interfere with the operations of specific providers identified during monitoring activities that include facilitation of problem solving via the chain of command and working with DCFS staff to address barriers.

All interim TR monitoring activities will inform development of the comprehensive TR monitoring system that will be concurrently under development by the university partners.

3. Timeline

January 2016 -	DCFS & UIC monitoring meetings commence
	DCFS & UIC begin initial level assessment
	Medicaid behavioral health billing training
February 2016 -	Increased unannounced and off-hour visits by DCFS monitors
	Initial level assessment (triage) completed for all TR contracts
	UIC continues external monitoring activities guided by triage process until the TR monitoring plan developed by the University partners is implemented.
	Comprehensive TR administrative meetings commence
March 2016 -	Initial comprehensive TR monitoring planning meeting between university partners
	Stakeholder focus groups or summits on TR monitoring
	Child wellbeing and safety metrics for TR finalized

May 2016 -	University partners submit TR implementation and monitoring plan to DCFS
June 2016 -	TR Implementation plan initiated
July 2016 -	TR external monitoring plan initiated according to implementation plan
November 2016 -	Chapin Hall interim evaluation report
March 2017 -	Chapin Hall interim evaluation report
July 2017 -	Chapin Hall final evaluation report