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.	)	

AMENDED AND REVISED 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 action to correct systemic deficiencies and to strive for the safety, permanence, and wellbeing of children and youth in care.

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

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

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

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

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

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

I. Implementation Plan Leadership

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

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

II. Application of Implementation Science to the Implementation Plan

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

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

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

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

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

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

III. Overarching Outcome Measures

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

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

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

A. Safety

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

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

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

B. Permanency and Stability

The selected permanency and stability measures are:

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

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

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

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

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

C. Wellbeing

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

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

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

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

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

IV. Implementation of Specific Recommendations of the Expert Panel

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

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

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

1. Therapeutic Foster Care Pilots

a. Pilot Overview

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

i. Theory of Change

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

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

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

b. Development of Therapeutic Foster Care Evidenced-Based Models

DCFS began the pilot project in September 2015 with the issuance of request for proposals for TFC programs. The programs were targeted for Cook, Kane and Winnebago counties based on an analysis of the current DCFS population by Chapin Hall at the University of Chicago (Chapin Hall), because those areas were found to have the highest need for alternative placements for youth with serious emotional or behavioral health needs. DCFS identified three groups of children and youth for the TFC pilots which include: children who without more intensive services were likely to later enter residential care (i.e., deflection group, later entry), children who were entering residential care directly upon placement with DCFS (i.e., deflection group, direct entry), and children who were ready for step down from residential care (i.e., step-down group). DCFS specifically identified these groups to correspond with the requirements of the Children and Family Services Act.[1]

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

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

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

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

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

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

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

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

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

c. Oversight of TFC Implementation Steps

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

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

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

d. Evaluation by Chapin Hall

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

e. DCFS Leadership of the TFC Pilot

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

2. Care Management Entity Pilot

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

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

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

a. Pilot Overview

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

b. Child and Family Teaming Model

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

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

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

c. CME Provider Network

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

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

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

d. Flexible Funding

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

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

e. Enhanced Mobile Crisis Response

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

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

f. Goals and Outcomes for CME Pilot

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

g. DCFS Leadership of CME Pilot

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

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

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

h. CME Pilot Time Frames and Capacity

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

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

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

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

i. CME Evaluation

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

3. Dually-Involved Youth Pilots

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

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

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

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

i. Theory of Change

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

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

ii. Pilot Overview

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

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

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

iii. Evaluation

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

iv. DCFS Leadership

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

b. Illinois Pay for Success Pilot for Dually Involved Youth

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

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

i. Theory of Change

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

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

ii. Overview

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

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

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

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

iii. Service Array

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

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

iv. Pay for Success Payment Structure and Evaluation

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

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

v. DCFS Leadership of the Pay for Success Pilot

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

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

1. Immersion Site Overview

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

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

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

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

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

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

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

a. Theory of Change

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

b. Identification of Immersion Sites

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

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

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

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

c. Immersion Site Activities

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

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

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

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

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

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

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

a. Theory of Change

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

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

b. Child and Family Teams

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

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

c. Individualized Case/Service Planning

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

d. Safe and Sustained Transition to Permanence

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

e. Disproportionality/Disparity in the Child Welfare System

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

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

f. Implementation of FTS in Immersion Sites

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

3. Description of Model of Supervisory Practice

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

a. **Theory of Change**

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

b. MoSP Overview

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

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

4. Initiation of MoSP Training Model

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

5. Core Practice Model Expert

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

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

6. Statewide Summit

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

7. Quality Service Reviews

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

a. Theory of Change

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

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

b. Implementation of the QSR Process

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

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

8. Development of Regional Capacity to Expand Service Array

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

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

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

9. Use and Oversight of Flexible Funds

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

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

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

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

10. Evaluation

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

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

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

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

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

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

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

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

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

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

a. Theory of Change

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Reorganization, Strategic Planning and Cultural Change

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

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

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

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

2. Full Implementation of Designed Initiatives

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

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

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

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

a. Illinois Birth Thru Three Demonstration Project

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

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

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

i. Current Status

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

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

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

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

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

b. SAFE Families for Children

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

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

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

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

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

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

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

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

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

i. Theory of Change

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

c. Information Systems

DCFS is reviewing the updated regulations on SACWIS to replace the existing SACWIS system to improve integration of information through web services to third parties, other internal systems, and to enhance its caseworkers' business processes through mobility. DCFS will receive federal reimbursement for the majority of this investment. https://www.federalregister.gov/articles/2015/08/11/2015-19087/comprehensive-child-welfare-information-system. Given the investment in a new SACWIS system, all current IT projects are being evaluated by the Technology Governance Board (TGB). The TGB is comprised of the Director, Chief of Staff, Chief Deputy Director, all Senior Deputy Directors and several other key executives and advisors. The State CIO, Director of HHSi2 and Director of Enterprise Applications also participate. TGB prioritizes all technology-based project work and aligns

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

i. Near Term Plan (6-12 months)

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

- Education Data Feed from ISBE
- Unusual Incident Reporting

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

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

ii. Long Term Plan (Beyond 12 months)

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

d. Predictive Analytics

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

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

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

i. Theory of Change

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

ii. Short Term

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

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

iii. Long Term (Beyond 18 Months)

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

e. Data Not Included in Overarching Outcome Measures

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

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

3. Training and Coaching Program

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

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

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

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

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

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

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

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

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

1. Theory of Change

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

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

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

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

V. Communication Plan

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

VI. Project for a Target Group of Children and Youth

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

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

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

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

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

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

ENTERED:

9/28/16

Jorge L. Alonso
United States District Judge