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.	)	

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

(Corrected)

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Introduction

DCFS has commenced efforts to execute the Amended and Revised DCFS B.H. Implementation Plan [Dkt. 531], entered September 28, 2016 ("Implementation Plan"). DCFS, along with the Plaintiffs and Expert Panel, submits the following as the first triannual Report to the Court, discussing each of the projects identified in the Implementation Plan. Following this Court's approval of the Implementation Plan and the Parties' Communication Plan, there have been regular bi-weekly meetings with the Expert Panel, Plaintiffs, and Project Managers. Monthly reports for each project also are being provided to the Expert Panel and Plaintiffs. This collaboration has assisted in identifying whether projects are proceeding according to plan as well as barriers to progress. It further provides a means for the Department to determine when and whether there is a need to revise or reconsider a project. Through this ongoing process, DCFS has made revisions, large and small, where progress has been slower than anticipated.

For this Report to the Court, the status of each project was graded by the Expert Panel on a scale ranging from Exemplary, Satisfactory, Needs Improvement, to Unsatisfactory. Grading is based on the Expert Panel's assessment of the Department's actual implementation of each project, not on substantive project outcomes themselves or the extent of the Department's efforts and activities for each project. Overall, two of the projects were graded Exemplary, nine were graded Satisfactory, five were graded Needs Improvement, and two were graded Unsatisfactory. The Expert Panel arrived at these grades after each project was presented by Project Managers to the Expert Panel and Plaintiffs at a two-day meeting, dubbed "mid-term exams," that was conducted by the Expert Panel on January 5 and 6, 2017. The specific evaluation grades are as follows:

Project	**Evaluation Grade**
Application of Implementation Science	Needs Improvement
Overarching Outcome Measures	Exemplary
Therapeutic Foster Care Pilots	Unsatisfactory
Care Management Entity Pilot	Needs Improvement
Regenerations Pilot Project for Dually-Involved Youth at Cook County Juvenile Detention Center	Satisfactory
Illinois Pay for Success Pilot for Dually-Involved Youth	Needs Improvement
Immersion Sites Pilot	Satisfactory
Amended Definition of "Fictive Kin"	Satisfactory
Expanding State Funded Guardianship	Satisfactory
Family Finding Project	Unsatisfactory
DCFS Reorganization	Exemplary
Illinois Birth Thru Three Project	Satisfactory
SAFE Families for Children Project	Satisfactory
Information Systems Enhancement/Replacement Project	Satisfactory
Restore Funding for the Illinois Survey of Child and Adolescent Well-Being Study	Needs Improvement
Develop and Implement a New Plan for Monitoring Residential and Group Home Programs	Needs Improvement
Implement a Defined Communication Plan	Satisfactory
Target Group of Children and Youth in Psychiatric Hospitals Beyond Medical Necessity Pilot	Satisfactory

Apart from the grades on the projects themselves, the Expert Panel has assessed the Department's overall progress on the goals in the Implementation Plan as Satisfactory for this initial triannual report. The Department, Plaintiffs and Expert Panel would like to have seen far more progress in reducing youths' length of stay in residential facilities and increasing placements in community and home-based settings in order for youth to live successfully in the

least restrictive, most family-like setting. However, there has been some progress toward reducing the number of children in congregate care.

Drawing from Department Child and Youth Comprehensive Information System (CYCIS) information from January 2000 through September 2016, the following trends in the utilization of congregate care[1] have been observed. *See* Exhibit A, Chapin Hall and DCFS FY 17 Mid-Year Meeting, slides 6-11.

- About 3% of youth in care are placed on average each month in congregate care settings; since January 2015 utilization appears to be trending lower;
- About 32% of exits from congregate care on average per month are to less restrictive home or home-based settings; since January 2015 exit to home or home-based placements has risen on average;
- About 62% of exits on average per month from congregate care do not re-enter Residential Treatment Centers (RTC) within 6 months of discharge; since January 2015 re-entry appears to be trending lower.

In March 2016, the most recent month for which six months of follow-up data were available at the time of the analysis, 73% of congregate care discharges did not re-enter congregate care within six months of congregate exit.

There is a shared recognition that continuing to develop and sustaining needed services to children and youth with psychological, behavioral or emotional challenges requires a major "sea change" for DCFS in mindset, policy, practice, and continuing quality improvement. The Department has solidified its reorganization and strengthened its B.H. leadership positions by clarifying their responsibilities and authority. According to the Expert Panel and the Parties, there is some evidence of movement to achieve the "sea change" necessary for serving class

[1] For purposes of this analysis, Chapin Hall used the Department's CYCIS database to define congregate care placements as including group homes and other institution-private care facilities and excluding shelter placements.

members appropriately, most notably in Immersion Sites as the seeds of change begin to take root.

The Department has four Immersion Site Directors in place, each of whom has identified policy and practice barriers impeding the development and delivery of needed services, and has taken steps to address a number of these barriers. Examples of policy and practice barriers that the Immersion Site Directors have acted to modify or eliminate include: a) DCFS adoption staff are working with private agency adoption staff to resolve the backlog in adoption and guardianship subsidies; b) the state-managed "case rotation" assignment of new cases among private agencies has been replaced by a community-based team process which places children in the most appropriate placement and not the next placement on the rotation; c) phones will be provided to parents who do not have them so that they make immediate contact with their child's foster parents to continue their relationships with their children while in the foster home; and d) DCFS will share foster homes it has recruited, but is unable to complete licensure for in a timely manner, with private agencies so homes can be licensed more quickly.

The progress achieved to date will be meaningful only if it is sustained while additional measureable progress occurs with the goals of the Implementation Plan. It takes time to embed the kinds of policy, practice and mindset changes required for successful achievement of the goals in the Implementation Plan, just as it takes time to develop and sustain the needed array of intensive home and community-based services. During the next reporting period, the Department, Plaintiffs' counsel and the Expert Panel will examine the different initiatives and projects that the Department is implementing to determine how best to prioritize implementation efforts among the initiatives. The goal will be to ensure that the initiatives most crucial for addressing the needs of children and youth with serious psychological, behavioral or emotional

challenges are prioritized. It is not realistic for the Department to apply the same level of focus and resources to all of the initiatives and projects included in the Implementation Plan at the same time.

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

1. **Project Goals / Target:** The Order entered by this Court on July 11, 2016 [Dkt. 527] provides for DCFS' retention of the National Implementation Research Network (NIRN), to review and comment on DCFS' adherence to best practices in implementation science and assist with an assessment of DCFS' implementation capacity and strategy. DCFS will be working with Dr. Allison Metz, Director of NIRN, who is experienced in the application of implementation science to inform plans in child welfare. There was no deadline set in the Implementation Plan or by the Court for the Department to engage NIRN's services.

2. **Expert Panel's Evaluation Grade:** Needs Improvement.

3. **Status Report:** On August 18, 2016, Dr. Metz met with the Expert Panel and discussed NIRN's participation in reviewing the Department's adherence to implementation science. In September, Dr. Metz discussed with the Department an appropriate budget for her involvement going forward for an estimated eight hours per month. Thereafter the Department prepared the documents necessary to comply with the Illinois state procurement process: a decision memo, a small business set-aside program waiver, and a procurement business case. However, the Department experienced delays in finalizing the contract with Dr. Metz due to the length of the Department's procurement process and Dr. Metz's travel schedule. Effective February 14, 2017, the Department has an executed a contract with Dr. Metz to provide the services outlined above.

Logic models for implementation initiatives are a significant component of the implementation process. The Department, with the assistance of the Expert Panel, has developed logic models for each Implementation Plan initiative. Several logic models have been adjusted as the work has proceeded; in one case, with respect to Residential Monitoring, the pilot project and the logic model were substantially revised. See discussion *infra* at pp. 68-70. The Department provided the logic models for each initiative to Dr. Metz on February 10, 2017.

4. Revised Targets / Goals: Upon execution of the contract, Dr. Metz will provide guidance and direction on the implementation of the projects in accordance with the principles of implementation science.

II. Overarching Outcome Measures: DCFS will identify metrics to assess the safety, permanency and well-being of class members. (Implementation Plan, pp. 4-6).

1. Project Goals / Target: The Implementation Plan requires the Department to measure safety, permanency and well-being of class members and to monitor changes in both the quality and quantity of services and supports to class members and their families. This initiative follows the B.H. Implementation Plan's call for the Department to begin gathering and analyzing data, measuring outcomes, and evaluating the success of programs according to the newest and most advanced standards for public accountability in consent decree monitoring. Nationwide, the first generation of consent decree monitoring focused primarily on enforcing agency compliance with fixed performance rules, e.g. caseload ratios, timetables, etc., regardless of whether compliance actually linked to improved outcomes. The second generation focused on establishing performance targets, e.g. % reunified, % re-entered, etc., and tracking their achievement without necessarily knowing if and how the achievements linked to agency performance. The third generation, which the B.H. Implementation Plan is using, focuses on evaluating the validity and integrity of pilot demonstrations of services in actually attaining

performance targets before rolling out new services or service models system wide. This newest phase of public accountability, which the Expert Panel calls "results-oriented accountability," requires continuous monitoring of implementation integrity and tracking of overarching outcome measures in real time.

The metrics DCFS will use for measuring safety and permanency are the same measures used in the national Child and Family Service Reviews (CFSR), and the measures for well-being are based on a matrix developed by the Child Welfare Advisory Sub-Committee. Implementation Plan, pp. 4-7. The Implementation Plan provided for Mindshare, a data technology company that creates innovative analytics to monitor progress in child welfare systems, to provide dashboards[2] with the CFSR measures within 30 days after its contract was executed. The contract was signed on February 5, 2016, such that the dashboards should have been available as of March 5, 2016. Implementation Plan at 50, Ex. SS. Thereafter, further dashboards were to be delivered, but no deadlines were set for those additional dashboards. There is no specific deadline in the Implementation Plan for implementation of a system allowing the Department to track the metrics for measuring well-being.

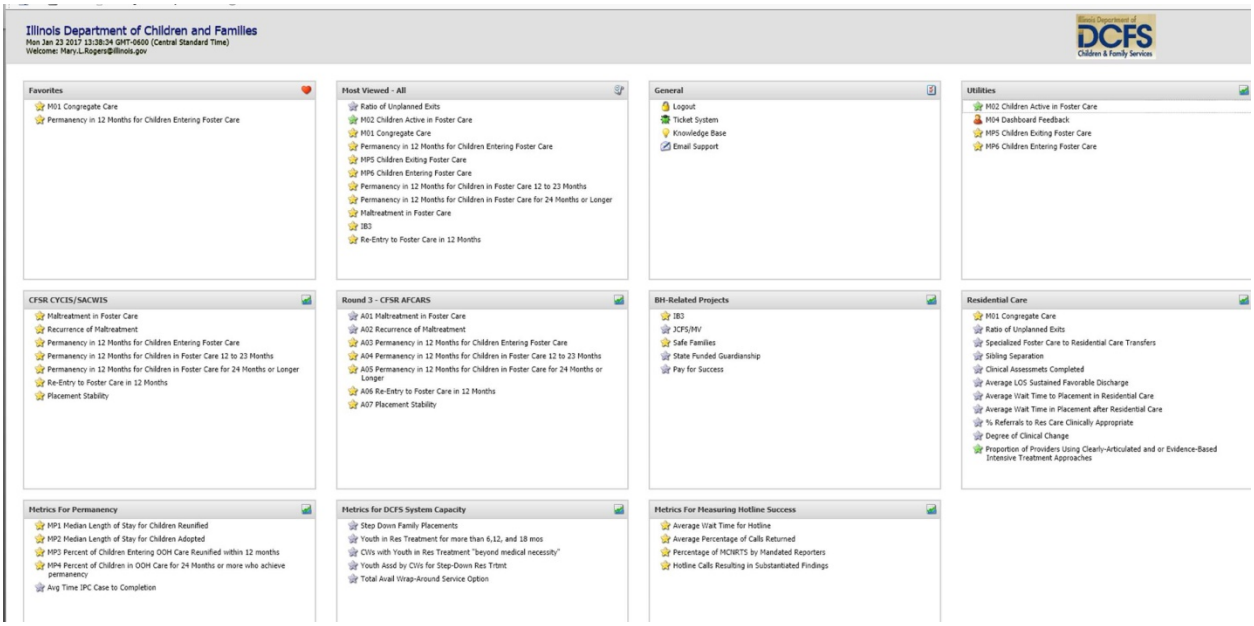
2. Expert Panel's Evaluation Grade: Exemplary.

3. Status Report: While the timeline anticipated in the Implementation Plan has not been met as to the safety and permanency measures, DCFS has made commendable progress on this difficult initiative.

Website Development That Will, inter alia, Track Permanency and Stability Measures. DCFS has made significant progress in developing a website, through the Mindshare

[2] The dashboards are tools for visualizing and communicating information about youth in care and youth in specific pilots in "real time" that can be used to understand how specific pilots may impact the outcomes of and services provided to youth in care.

platform,[3] that integrates real time data from multiple locations across the DCFS system that are needed to track permanency and stability.[4] (See Screen Shot below)



Using data sets provided by the Department, the Mindshare platform allows various dashboards and other reports to be developed and used by DCFS to monitor the implementation of pilot demonstrations and the tracking of overarching outcome measures in real time. Exhibit B, Four Month Status Report IT Mindshare, p. 1.

DCFS has developed data sets in the Mindshare platform for the safety, permanency and stability measures identified in the Implementation Plan. The safety, permanency and stability measures include: rate of victimization per day of foster care of all children in foster care during a 12 month period, permanence in 12 months for children entering foster care, permanence in 12 months for children in foster care 12 to 23 months, permanence in 12 months for children in

[3] The Department is making additional improvements in the IT area, which are discussed below at pp. 59-66.

[4] The data sets with green stars are dashboards in which the content has been validated; the data sets with yellow stars are dashboards in which the data sets are available, but not yet finalized and validated; and the grey stars are dashboards that are to be developed.

foster care 24 months or more, re-entry to foster care in 12 months, and placement stability. Implementation Plan, pp. 5-6. The data sets for the safety, permanency and stability measures are available for review. However, these data sets are not yet validated.

Integration of Well-Being Measures Into the Website. The measures for well-being are based on a matrix of well-being indicators. Implementation Plan, pp. 6-7. One of the existing sources for the well-being data will be gathered from the Child and Adolescent Needs and Strengths (CANS) tool. The CANS is a multi-purpose tool developed for children's services to support decision making (including level of care and service planning), to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 50 states in child welfare, mental health, juvenile justice, and early intervention applications. CANS generally measures life functioning domains, child strengths, behavioral and emotional needs, child risk behaviors, caregiver needs, and strengths and needs through a variety specific questions.

DCFS is currently considering what version of the CANS should be incorporated into the Statewide Automated Child Welfare Information System (SACWIS). DCFS currently has a version of CANS that can be incorporated into SACWIS, however, other human services agencies such as the Department of Healthcare and Family Services (HFS) and the Department of Human Services are developing, with the input of DCFS, another version of CANS, referred to as the Illinois Medicaid (IM CANS) CANS, to be used by those agencies. The IM CANS incorporates additional factors that are geared for the adult population and is intended to be a lifespan document, meaning the it can be used for individuals from childhood to adulthood The current plan is to implement the IM CANS in the other human services agencies in July 2017. If

DCFS were to incorporate the IM CANS in July 2017, there would be a delay in the incorporation of the data into SACWIS due to the current implementation date of the IM CANS.

Validation of CANS Data. DCFS agreed to validate information from the CANS through the use of a variety of other data set forth in the CWAC wellbeing matrix. Some of the information in the Wellbeing matrix is accessible through a variety of databases, such as developmental assessments of youth zero to three and information from the Illinois State Board of Education (ISBE). Other information in the Well Being matrix for use as a validation tool, including some health information from HFS and information from ISBE, will require significant data configuration that is estimated to take six to 12 months. For example, one of the physical health validation measures in the CWAC wellbeing matrix is emergency room visit frequency for non-chronic health diagnosis. Implementation Plan, Exhibit F, Wellbeing Matrix, p. 2. While DCFS can currently obtain emergency room visit frequency for youth in care from HFS, SACWIS is not currently configured to accept specific information from HFS such as the reason for the emergency room visit. Additionally, the data from the ISBE does not contain information regarding grade point averages and school expulsions.

In the interim, while the DCFS Office of Information Technology Services (OITS) is reconfiguring the SACWIS system to incorporate more detailed information from HFS and working to develop the data that is not contained in the ISBE data, DCFS has other health information data from the E-Health Passport and from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), that can be used to validate the CANS data. For example, DCFS has dashboards that contain EPSDT data for youth in care in congregate care settings, immunization data on youth in care, and preventive dental compliance for youth in care. Exhibit C, DCFS Office of Health Services Compliance Reports. DCFS has additional data from

the Illinois CHIPRA program and the national CHIPRA program. Exhibit D, Healthworks of Illinois, CHIPRA Measures FY2010-FY2014.[5] This information will be used to validate the CANS data in the interim period.

Expansion of Access to the Website. The Expert Panel and DCFS both agree that the Mindshare platform provides the potential to transform DCFS' access to real time data. DCFS managers can access the Mindshare platform to judge the effectiveness of various programs and policies. Immersion Site Directors and project managers were trained in Mindshare in December 2016 in Springfield. Remaining DCFS staff will be trained as the Mindshare dashboards are developed. The provision of this training will be the topic of discussion at the next in-person meeting of DCFS with the Expert Panel in April 2017.

Currently, access to the Mindshare platform is limited to DCFS administrators and Executive staff. However, it is also helpful for outside providers to have access because it assists those providers in judging the effectiveness of their programs as well. DCFS must develop a security protocol before it can allow outside providers' access to the Mindshare website since the website contains information on all youth in care.

DCFS is developing data sets in the Mindshare platform for each of the pilots and programs identified in the Implementation Plan. The addition of data sets for some of these programs has required a reprioritization of the work to track the well-being measures. Though there are no deadlines in the Implementation Plan relating to the time for incorporation of thewell-being measures. DCFS recognizes the importance of tracking these measures and

[5] Another method for validating the well-being data pulled from CANS will be the quality service review process in the Immersion Sites. Implementation Plan, p. 7. See Quality Service Review discussion at pp. 39-40.

intends to begin tracking as many as possible in the next reporting period through use of the data from e-Health passport and CHIPRA, described above.

4. Revised Targets / Goals: DCFS anticipates the safety, permanency, and stability measures to be fully validated by June 2017. The CANS data relative to the well-being is currently scheduled to be integrated into the DCFS SACWIS system in the first quarter of FY18, (i.e., July through September 2017). These targets may be altered depending on which CANS tool DCFS decides to integrate into SACWIS. DCFS will decide whether to implement the IM CANS by the next reporting period.

Representatives from the OITS, Legal Services, and Operations are meeting in Springfield on February 14, 2017, to address incorporation of the CANS data and identify barriers in obtaining the ISBE data and developing a plan to obtain the needed data.

The Department, working with the Expert Panel and Plaintiffs, will agree by April 30, 2017, on the prioritization of the different B.H. projects for completion and incorporation into Mindshare and a timeline by program stating when the data for the program and associated dashboards will be up and running on Mindshare.

III. Implementation of Specific Recommendations of the Expert Panel

Panel Recommendation #1: Institute a children's system of care demonstration program that permits POS agencies and DCFS sub-regions to waive selected policy and funding restrictions on a trial basis in order to reduce the use of residential treatment and help children and youth succeed in living in the least restrictive, most family-like setting. (Implementation Plan, pp. 7-25).

The Implementation Plan identifies several initiatives that the Department is pursuing in response to Recommendation # 1. Those initiatives are the Therapeutic Foster Care Pilots, the Case Management Entity pilot, and two additional programs that are both targeted to the needs of

"dually involved youth" – the Regenerations pilot and Pay for Success. Each of these programs has been separately graded by the Expert Panel and each is discussed individually below.

A. Panel Recommendation #1: Therapeutic Foster Care Pilots

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

At least 60% of the youth served in TFC licensed homes will be ages 12 years and older. Implementation Plan, pp. 8-9. DCFS set a two-year goal for the recruitment and licensure of therapeutic foster parents and placements. The original goal included placement of a minimum of 40 children and youth in licensed TFC homes at the end of the "first contractual year" and placement of a minimum of 100 children and youth at the end of the "second contractual year." The Implementation Plan, however, did not specify whether these "contractual year" deadlines referred to "development" contracts that the Department intended to execute with the providers or to "service" contracts that would be executed later.

2. Expert Panel's Evaluation Grade: Unsatisfactory.

3. Status Report: The Department selected three agencies for the pilot project: Lutheran Social Services of Illinois (LSSI), Jewish Child and Family Services (JCFS), and Children's Home and Aid of Illinois (CHAID). Development contracts with these agencies were signed in August, September, and October, 2016, respectively. The three agencies established projections for the number of TFC foster homes to be certified, consistent with the targets included in the Implementation Plan. The targets for the end of the first contractual year were as

follows: LSSI – 30 homes; JCFS – 10 homes; CHAID – 10 homes. To date, however, no TFC homes have been certified. As of February 1, 2017, no children have received services under the pilot program. DCFS has executed service contracts for TFC programs with JCFS and CHAID. One youth is scheduled to be placed in a JCFS TFC home in the next several weeks.

Development Contract Activities. DCFS' development contracts with the three agencies were written for a five-month period and allowed for activities such as the hiring of necessary staff for the individual TFC programs being implemented. LSSI and JCFS each hired a Program Director, clinical director, clinician, foster parent licensing worker, recruitment worker and a licensing supervisor. LSSI hired a team leader and a foster parent resource worker for each of the three geographic areas covered in the pilot. CHAID hired a Program Manager, foster home recruitment specialist and licensing worker. CHAID is in the process of hiring four additional staff. Exhibit E, Therapeutic Foster Care BH Four Month Status Report, January 17, 2017. Each of the agencies is in the process of training staff in the relevant evidence-based models they are implementing.

The three agencies also commenced recruitment activities for TFC foster parents. The recruitment activities vary by agency and include: meetings with foster parent networks and community social service agencies, outreach to various community leaders, such as state representatives and local alderman, schools and churches and use of social media platforms such as agency websites, Facebook pages and Instagram.

DCFS recognizes that continuously tracking all contact with potential foster parents from inquiry to licensure and TFC certification is essential for developing a successful TFC program, and it has directed the providers to track their recruitment activities and outcomes, by family, and provide bi-monthly reports to DCFS. LSSI is being allowed to utilize its own internal tracking

system because that it is able to generate reports containing all of the information needed to assess the success and effectiveness of its recruitment process. DCFS has directed JCFS and CHAID to use the recruitment tracking system that DCFS developed because those agencies have not provided reports containing the needed recruitment information. Exhibit F, TFC Tracking.

Status of TFC Recruitment. LSSI is actively working with ten already-licensed foster families who want to become certified as TFC homes under the TFC-O model. Six of those families were originally licensed by LSSI; the remaining four families are licensed at other agencies and seek to transfer their foster home license to LSSI and become TFC-O certified with LSSI. That transfer of license is expected to take place by June 30, 2017. LSSI is actively working with another 19 families that are not yet licensed as foster homes. LSSI expects to complete training in the TFC-O model for sixteen of those families in February 2017. For the pilot, LSSI will not place a child until a home has been licensed with or had a license transferred to LSSI and has been certified in the TFC-O model. It is anticipated that six LSSI homes certified in TFC-O model will be ready to accept children in March 2017.

JCFS has one licensed family ready to serve an adolescent TFC child. The home has not yet become TFC-certified because the TFC model JCFS is using (unlike the model used by LSSI) begins training licensed foster parents in TFC interventions coincident with the family's first TFC placement. JCFS has nine additional families in the inquiry phase who may participate in the pilot. Two families are already licensed and the other seven are not yet licensed. JCFS has a total of two homes that are active in the assessment phase that are not licensed.

CHAID has identified two families who are currently in the licensing process to become foster parents and then to be certified as TFC homes. One of these homes is slated to serve a TFC referral from CHAID's residential program.

TFC research and field experience show that the most successful recruitment efforts focus on networking with and using former and current foster parents for recruitment purposes, referred to as word of mouth recruitment. As evidence of this research and field finding, LSSI reported in its January 2017 report that more than 87% of the families actively pursuing TFC certification with their agency were identified through word of mouth recruitment.

DCFS and the agencies have established the eligibility criteria for youth to be placed in the TFC homes as part of this pilot. The Child and Adolescent Intensity Instrument (CASII) has been identified as the instrument to determine clinical eligibility for a TFC placement. Exhibit G, Therapeutic Foster Care B.H. Four Month Status Report, January 17, 2017.

4. Revised Targets / Goals:

The agencies have asked DCFS to extend the initial development contracts, and DCFS expects to do so for a limited additional period. DCFS has sent service contracts to the three agencies; two of the agencies have executed those contracts and DCFS expects the remaining contract to be executed by April 1, 2017. The service contracts will extend until the end of Fiscal Year 2017.

The revised timeline for the TFC pilot is to have a minimum of 40 children and youth in licensed TFC homes by April 1, 2018 and to have placement of a minimum of 100 children and youth by April 1, 2019, with at least 60% of the youth served in the age group of 12 and older.

DCFS will continue to monitor closely the progress of the three agencies to recruit and certify TFC foster homes so that DCFS can meet the deadlines set forth in the Implementation

Plan. DCFS will take the steps necessary to ensure that TFC services are developed by these or other providers or programs. If DCFS determines it will not be able to meet the targeted number of 40 TFC placements by the estimated April 1, 2018 date, DCFS, in consultation with the Expert Panel and Plaintiffs' counsel, will revise the TFC placement goals for this pilot and will explore alternative options, with these or other providers or programs, for development of TFC homes in the targeted areas.

B. Panel Recommendation #1: Care Management Entity

1. Project Goals / Target:

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

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

2. Expert Panel's Evaluation Grade: Needs Improvement.

3. Status Report: The CME pilot currently is operating in four counties in central Illinois. The pilot was designed to achieve the improved clinical and permanency outcomes identified for the program by applying system of care principles premised on (i) localized control of interventions and supports through intensive Child and Family teams, (ii) use of flexible funding for goods and services, and (iii) development of community and home based services. Implementation Plan, pp. at 17.

Program Design: Children are referred to CHOICES in several ways, including in non-crisis and emergency circumstances by DCFS child protection investigators (if DCFS has temporary custody) and by DCFS/POS permanency staff if the family meets the target population criteria. In non-crisis circumstances, a referral form is sent to the DCFS Care Coordination Office (CCO) by the child welfare referral source to ensure that target population eligibility is met, then the referral and accompanying releases/consents are sent via the Document Transfer System to CHOICES staff. In emergency situations, a crisis screening[6] (mental health crisis) of a non-enrolled youth in care by the Mobile Crisis Response group is reported to the CCO through a list created by HFS. The CCO reviews the case of the youth and determines whether the youth meets eligibility criteria. If the youth is eligible for CHOICES enrollment, the CCO sends an e-mail with the CHOICES referral form, DCFS consent form and the Choices consent form to the permanency worker. The worker completes the documents and returns the information to the CCO. The CCO then forwards information to CHOICES staff. The list is provided to the CCO one time per month by HFS.

[6] A crisis screening occurs when a youth has a psychiatric crisis. Screenings occur within 90 minutes of the crisis call being reported to Crisis and Referral Entry Services (CARES) and the Mobile Crisis Response group is dispatched.

DCFS investigative staff and permanency staff can request emergency CHOICES enrollment for a child who meets eligibility requirements. Examples of emergency requests may include children who enter care on based on dependency due to their mental health needs and placement is required; children who need placement because a caregiver issued a 14-day notice for removal of the child; and children who are approaching beyond medical necessity (BMN) or may be in BMN status during hospitalization for psychiatric concerns.

Immediately after crisis screening, youth enrolled in CHOICES have an emergency Child and Family Team Meeting (CFTM) with the youth, family members who are engaged in the team (this includes foster parents and sometimes biological parents if their rights have not been terminated), formal and natural supports, the caseworker, and the Care Coordinator to revise the individualized crisis safety plan and the plan of care. Care Coordinators from the CME also follow up with the family and bring the CFTM members together to review supports and services. The initial Child and Family Teams meetings are scheduled within 30 days of the initial referral if the child is not referred following an emergency event. If a youth is referred following an emergency event, the Child and Family Team meeting is scheduled within one week of the referral. Exhibit H, CME Four Month Status Report, p. 4; Exhibit I, Care Management Entity Care Coordination through High Fidelity Wraparound PowerPoint, p. 5. Additionally, the average number of days between each Child and Family Team meeting is 30.3 days, which is a significantly better than the required number of days outlined in DCFS policies.[7] Historically, these CFTMs have not occurred on time and often do not include a youth and family's full team of support. The CHOICES timeline ensures the Child and Family Team is engaged at significant

[7] DCFS procedure 315.105 states that permanency workers are required to have Child and Family Team meetings 14 days after protective custody, then 40 days after protective custody to review assessment documents and develop an initial service plan, then quarterly (approximately every 90 days) thereafter.

junctures in a child's life and with a level of frequency that solidifies the role of this team in decision-making for the child.

The Provider Network: The current Provider Network is comprised of providers who may hold contracts either with DCFS and CHOICES, or solely with CHOICES. There are a total of 76 unique providers in the Network. Some providers may offer multiple services, and some have single-service agreements for services with individual children. The break-out of providers is as follows:

Behavioral Health – 55 providers; 20 are CHOICES-only contracts
Behavioral Support – 69 providers; 32 are CHOICES-only contracts
Substance Use – 11 providers; 3 are CHOICES-only contracts
Mentoring – 23 providers; 14 are CHOICES-only contracts
Supervision Services – 28 providers; 4 are CHOICES-only contracts
Medical Services – 27 providers; 0 are CHOICES-only contracts
Placement – 23 providers; 0 are CHOICES-only contracts
Respite – 5 providers; 2 are CHOICES-only contracts
Single-Service Agreements for specific youth - 4 providers serving 8 youth

Exhibit J, CHOICES Provider Service Report. The growth and development of the CME community-based provider network has stabilized since service providers are being added to the CME network at a slower rate than in the past. The provider network now includes the range of traditional and non-traditional providers needed by youth served by the pilot, with the exception of (i) family-based placements equipped to provide intensive treatment services; and (ii) individualized supports for youth enrolled in the pilot, especially those placed in or at risk of being placed in congregate care settings. Exhibit H, CME Four Month Status Report, p. 4. There is still some limited growth of the provider network, however, through single-service agreements with specific providers to support individual youth. *Id.*

The primary resource gaps exist for youth at risk of entering congregate care or who are ready to step down from congregate care settings. CHOICES staff have experienced difficulty

building family care resources for youth who have experienced significant mental health or behavioral dysregulation. CHOICES staff working with children who are slated for discharge from congregate care settings encounter wait lists for placement options such as group homes, transitional living placements and Community Integrated Living Arrangements. The delay in step down can be so long that youth age out of the eligibility criteria for their step down placements and alternative placements have to be secured. CHOICES staff have also encountered challenges working with congregate care providers when the Child and Family Team believes a child is ready for step down, but the case management provider does not believe the child is ready. Currently, this is not consistently being addressed through the Non-Consensus Resolution Process, which involves CHOICES staff elevating the review to the DCFS Clinical Division, and holding the parties involved accountable to follow-through on the Clinical recommendation. In order to make sure these situations are addressed through the Non-Consensus Resolution process, DCFS Clinical will follow-up to ensure the clinical recommendations are implemented.

Recently-Added Services: Home-Based Clinical and Home-Based Support Services, which is a joint service between DCFS and HFS, was added after the Implementation Plan was entered. It is a Medicaid reimbursable service available in the pilot area to youth who are enrolled in CHOICES. This Home Based Clinical service is provided by master's level therapists using the Managing and Adapting Practice system to identify evidence-based practices that would be effective given the demographics and symptomology of the individual youth. Currently, there are nine service slots available. The nine slots available are used selectively by CHOICES administration. This includes consideration of children served by the CHOICES CME from the community who are not in care and children who are youth in care who are

already enrolled in CHOICES. The criteria for use is to provide the service to children who are in need of it most, particularly youth who are at risk of being placed in congregate care settings or in juvenile detention centers. Currently one youth in care receives these services, and eight community youth fill the other slots.

Number of Youth Served and Initial Outcomes: From the time the program began in February, 2014 through mid-January 2017, the CME has served 321 youth in care. This strongly suggests that the goal of serving 600 children by June, 2017, when the pilot concludes, will not be met. The current census is 143 youth in care; 52.4% of those youth are placed in traditional, home of relative or fictive kin placements, 32.9% of those youth are placed in congregate care settings, 3.5% are in detention, shelter, or hospitalization for psychiatric reasons, and 10.5% are placed in specialized foster care placements. Exhibit H, CME Four Month Status Report, p.1. However, there are positive indicators for the program. Monthly reports from CHOICES show over 90% of youth are participating in Child/Family Team Meetings on a monthly basis. Client satisfaction surveys reflect that at least 85% of youth and families felt satisfied or very satisfied that their voice is heard and respected in Child/Family Team meetings. Exhibit H, CME Four Month Status Report, p. 5. The data on actual outcomes to date for youth enrolled in CHOICES include:

> Forty-seven youth now enrolled in the CHOICES program reside in congregate care;
>
> The March 2015 – February 2016 report for youth who were in congregate care at the time of referral reflected a step-down rate of 15.5% at six months and 32.8% at 12 months;
>
> The February 2014-December 2016 report shows that 36% of youth in congregate care stepped down to a less restrictive setting within 12 months after their enrollment in CHOICES; and

> The DCFS Supplemental Report for February 2014-December 2016 shows 45% of youth in traditional foster care for 12 months were stable in one placement. Similarly, 51% of youth in specialized foster care were stable in the first twelve months of their enrollment.

Exhibit K, DCFS Supplemental Report for February 2014 through December 2016.

Initial results from another service, Mobile Crisis Response, also appear to be promising. The Mobile Crisis Response program is for youth in care and 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. Implementation Plan, pp. 16-17. This service has been offered since April 2016. Since April 2016, a total of 205 youth in care received Mobile Crisis Response services. Sixty-nine youth were enrolled in CHOICES and 136 youth were not enrolled in CHOICES. Exhibit L, MCR Data.

First quarter data from September 2016 showed a reduction of psychiatric hospitalization rates immediately following a crisis for all community youth in the pilot counties, not just those enrolled in CHOICES, from an average of 50% for youth assessed by Screening Assessment and Support Services (SASS) providers to 35% when screenings were completed by the pilot's Mobile Crisis Response. Mobile Crisis events for DCFS youth decreased over the course of twelve months after CHOICES enrollment: during those twelve months after enrollment, 13% of DCFS youth engaged the Mobile Crisis Response team at least one time; in months 1 through 6, 8% of DCFS youth engaged in Crisis Response; in months 6 to 12, this reduced to 7%. These reduced Mobile Crisis and hospitalization rates might be attributable to several factors, including, regularly occurring CFT meetings, individualized crisis plans that are included in the youth's overall service plan and that are reviewed and revised when new risks are identified, immediate access to care coordinator and other team members knowledgeable about the

individual youth's needs and available supports, and individualized services in place for youth that are designed to prevent and reduce crises.

Identified Program Challenges: The most significant challenges the Department has identified in respect to the CME pilot are (i) the need for family-based placements equipped to provide intensive treatment services and individualized supports for youth enrolled in the pilot, especially those placed in or at risk of being placed in congregate care settings; and (ii) permanency workers' resistance to the program. The need for development of appropriately equipped and supported family-based placements was the primary reason cited by the Expert Panel for the "Needs Improvement" rating.

Other challenges include the contracting process, such as the length of time necessary to complete required background checks for providers and their employees, and concern from providers regarding the amount of funds necessary to build new services and the sustainability of those new services. Exhibit H, CME Four Month Status Report, p. 4.

Program Evaluation: DCFS did not identify a comparison group for the CME evaluation in December 2016 as it had planned, and an interim evaluation will not be completed by March 2017. One reason for the delay was due to the change in evaluators from Chapin Hall to the University of Illinois at Urbana-Champaign. This change required the drafting of new data sharing agreements and the reconfiguration of hardware to access the necessary data.

4. Revised Targets / Goals:

Addressing Barriers to Success: The project manager and supervisor have requested assistance from DCFS Associate Director Pete Digre to clarify expectations about supporting the CME pilot with DCFS state level and regional administrative staff. State and regional administrative DCFS staff are expected to serve as champions for the pilot, and to take the steps

necessary to ensure that DCFS and private providers focus on developing new family-based placements and enhancing existing foster homes with supports and services that are available to potential foster parents through the CME. DCFS will begin to address this at the next quarterly meeting with the CME, private agency and DCFS administrative staff. At that time project staff will apprise private agencies and DCFS administrative staff of the specific service deficiencies in the pilot and, with them, develop a plan to address the service gaps, specific service capacity needs and timeframes for getting needed services in place.

In addition, while most permanency workers and court personnel support the principles and services of the pilot, the CME continues to experience resistance from some permanency workers to serve youth with intensive home and community-based services through the CME, rather than seeking more restrictive and congregate care settings for youth on their caseloads. This challenge is to be expected when developing new community-based service systems and is part of the process to change worker mindset and the culture to support individualized, community-based services. However, it is a challenge that must be overcome. Project staff and the CME will continue to enlist the support and action from agencies and workers that have made the "sea change" in their mindsets and have experienced first-hand the improved outcomes for youth served in the community.

During the next reporting period, the CME pilot will track the extent to which its actions with DCFS regional staff, community stakeholders and providers have a positive outcome on the services provided to youth in the pilot and the outcomes they achieve.

Renewed Focus on Step-Down Placements: As part of the efforts identified above regarding resource development, a renewed focus will be placed on youth enrolled in the CME who are placed in residential treatment facilities and need a step down placement. For those

youth, provider staff, working in conjunction with residential staff, will assess each youth's needs, convene a CFT meeting to identify the supports and services necessary for the child to be moved and served in a community setting, and then implement the plan for needed services. A barrier to the step down of these youth is the lack of available foster homes that are willing to take them, either because foster parents do not understand the level of individualized support and services that are available through the CME pilot or because of gaps in service availability. By the next reporting period, DCFS will have implemented improved communication to foster parents regarding the services that can be provided through the CME. In addition, pilot staff will develop a plan with specific targets and timeframes to increase the number of new foster homes in the pilot project area for step-down placements and to increase the pool of existing foster parents.

Court Outreach: Vermillion County has a new presiding judge and additional outreach efforts will continue with the judge to provide an overview on the CME pilot and to solicit feedback from the court and other stakeholders and supports for serving youth from Vermillion County in community-based settings.

Transition from Pilot to Ongoing Model: During the next reporting period, the Department, along with pilot staff, will develop plans for continuing the services (e.g., contract renewals, new contracts), along with targets and timeframes to accomplish the transition from a pilot project to an ongoing care management model.

CME Evaluation: Now that the change in program evaluators has been accomplished, it is anticipated that a comparison group can be drawn from surrounding counties to the CME pilot, such as McLean, Macon, Piatt and Livingston Counties for purposes of the program

evaluation. The new target date for the evaluation is September 2017, though efforts will be made to complete the evaluation before then.

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

1. Project Goals / Target:

The Regenerations pilot is designed to provide placements and intensive services to DCFS youth in care who are also involved in the juvenile justice system and are ready for release from the Juvenile Temporary Detention Center (JTDC). Implementation Plan, pp. 20-22. The program, using two providers (Lutheran Child and Family Services (LCFS) and Youth Advocacy Program (YAP), provides traditional mental health services, care coordination, foster care services (if needed) and individualized home and community based services through a wraparound philosophy. Id. The program goal was to serve 65 youth. There was no deadline specified in the Implementation Plan for reaching that level of service. Implementation Plan, p. 21.

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report: Since its inception in July 2015, the pilot has served 67 youth. Eight youth were not placed: 6 were awaiting placement and 2 were listed as "N/A" (meaning that the Department has not yet identified a placement). Of the 59 youth in the pilot that were placed, 81% of those youth were placed in a family-like setting as opposed to residential care. Only 17% youth in the pilot were placed in a congregate care setting. 1%, or one child, went to a transitional living placement. Most youth were placed in the homes of relatives or specialized foster care placements. Exhibit M, DCFS Regenerations Pilot, FY17Q2 Fidelity Metrics Report and Information for January 5, 2017 Mid-Term Exam, pp. 4, 6.

The services provided to the youth through the pilot included in-home supports, crisis intervention/response services, placement stabilization services, and educational and recreational activities. Moreover, YAP advocates work with the youth on a weekly basis and provide intensive one-on-one mentoring services, ranging from five to thirty hours per week, and designed around each youth's particular need. Exhibit N, Regenerations January 2017 Updated Status Report, p. 2.

During Fiscal Year 2016, the Regenerations/RUR Pilot implementation team, in conjunction with Chapin Hall, developed a logic model, program manual and components, implementer responsibilities, fidelity metrics, target outcomes and an evaluation plan for the program. Exhibit M, DCFS Regenerations Pilot, F12Q2 Fidelity Metrics Report and Information for January 5, 2017 Mid-Term Exam, p. 1.

DCFS created a Regenerations/RUR Pilot Post-Placement SharePoint site to facilitate case coordination of post-placement services between LCFS and YAP and to provide data for fidelity metrics and outcomes identified in the evaluation plan. Id. The data that is to be provided on the SharePoint site consists of providers' reports regarding individual/family counseling services, medication management services, youth employment hours, advocate (mentoring) hours provided, and any parent/child/sibling visits. Exhibit M, F12Q2 Fidelity Metrics Report and Information for January 5, 2017 Mid-Term Exam, pp. 1-2.

The SharePoint site is a less than ideal solution to managing data for the project. The system is cumbersome, and as a result, the two provider agencies have struggled to maintain accurate and timely service data in SharePoint. At present, however, the Department does not have a better alternative. The Department has clarified the data entry expectations and timelines with the provider agencies. An agreed-upon schedule has been developed for entering historical

data onto the Sharepoint site, while there is a weekly deadline by which current service data will be entered there.

4. Revised Targets / Goals: Beginning in February 2017, DCFS will explore options and implement specific strategies to ensure that the service data and the billing data for youth served through the pilot project are reconciled.

The current Regenerations Pilot will be moved from a pilot project to an ongoing DCFS program upon completion of the pilot in June 2017.

DCFS is analyzing how to expand the pool of service providers for dually-involved youth. In addition, recruitment of new traditional and other "specialized" foster homes equipped to serve dually-involved youth with co-occurring mental health and behavioral needs for youth in the pilot is essential. The Regenerations/RUR team will continue to develop strategies for the recruitment of foster parents. A plan for expansion of the foster parent resources necessary for the program has been submitted by LCFS to DCFS. Exhibit O, LCFS Foster Parent Recruitment Plan. DCFS will review the plan for expansion to ensure it meets the goals of recruiting additional foster parents.

Based on the initial implementation of the pilot and the fact that many of the dually involved youth have been placed in community and other home based settings, DCFS is in the process of developing contracts for other agencies to provide similar services to dually involved youth. Those programs will be developed with four additional agencies, including Youth Outreach Services, National Youth Advocate Program, Youth Advocate Program and Childserve. The services provided by these additional agencies for dually involved youth are currently scheduled to begin in the next reporting period.

By the next reporting period, a target date will be set for incorporating Regenerations data into the Mindshare platform. The Department will run a test of some of the youth in the Regenerations pilot in the Mindshare platform by February 24, 2017. Any necessary adjustments will be made after that test run and then all of the youth currently involved in the Regenerations pilot will be embedded into the Mindshare platform. The Department also will begin tracking the outcomes for the children who have been served through the pilot to date, with a particular focus on stability and safety.

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

1. Progress Goals / Target:

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

The Implementation Plan called for a Ramp Up phase (funded by separate foundation funds) during which 50 youth would receive services. After the Ramp Up phase a pilot was to begin in or around September 1, 2016. CCN was to raise $17 million in private funds by March 31, 2017 to pay for the services that were to be provided during the pilot period. Expansion of the pilot to three additional counties was to occur by March 2017.

2. Expert Panel's Evaluation Grade: Needs Improvement.

3. Status Report: Funding for the Ramp Up phase was secured. Fifty children were served during the Ramp Up phase, which began in January 2016 and continued until December 2016. Exhibit P, Pay for Success Four Month Status Report, Dec. 29, 2016, p. 1.

The start date of the pilot was delayed due to difficulties encountered during contract negotiations which involved issues regarding each of the parties' legal obligations under the contract and to the finalization of the evaluation plan with the University of Michigan. The pilot commenced on December 1, 2016 and intake began in January 2017. Twelve youth currently are receiving services as part of the pilot.

To date, DCFS has identified two significant issues with the program. First, there were delays in inputting information into the Unusual Incident Reporting system, which serves as a major referral pathway to the Pay for Success pilot. The delays concerned the time between the occurrence of the incident and when the caseworker inputted the information into the Unusual Incident Reporting System. In addition, there are problems with the communication path necessary for appropriate caseworkers to partner with a Wrap Facilitator from the private agency since caseworkers were not returning the calls from the facilitators. Exhibit P, Pay for Success Four Month Status Report, December 29, 2016, p. 1.

4. Revised Targets / Goals: CCN is in the midst of a fundraising period and has set a goal of raising $17 million by March 31, 2017. Those funds are intended to cover the projected cost of the pilot for four years of treatment (through March 2021) and three years of evaluation. CCN will not enroll any more than 25 youth in Cook, Lake, Franklin and Jefferson counties until after the fundraising deadline has passed. Exhibit P, Pay for Success Four Month Status Report, December 29, 2016, p. 1.

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

On the assumption that work with CCN will continue in some form, DCFS and CCN will continue to work to address the problems identified in the ramp up phase regarding communication issues and referral pathways. By the next reporting period, if the program proceeds in some form, DCFS will resolve any delays in the UIR reporting. CCN has already developed a protocol tool for their management to reach out to management of the agency with case management responsibility to work together in the pilot and rectify the communication issues.

DCFS is also currently negotiating with the evaluation team from the University of Michigan to analyze data on the 50 youth that received services during the ramp up phase.

Recommendation #2: Create four "immersion sites" of small geographic areas that coincide with judicial circuits to fully build, test and implement a core practice model that puts children and families at the center of service planning and builds community and home-based services for children and their families. (Implementation Plan at pp. 25-38).

1. Project Goals / Target:

Immersion Sites are test or pilot sites representing a small geographic area where youth, birth parents, foster parents, DCFS staff, private agency staff and multiple other stakeholders

work together to fully build and implement a "core practice model" of child welfare practice that puts children and families at the center of service planning and builds community and home based resources to service children and families. DCFS intends to use Immersion Sites as the center of its transformation to improve safety, permanency and stability outcomes. The Department identified the key components to the process as:

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

(ii) implementation of a new "Model of Supervisory Practice" or "MoSP;"

(iii) integration of its Quality Assurance Division and Monitoring Divisions in the immersion sites in order to implement a new, Quality Service Review Process (QSR);

(iv) development of community and home based services for children and families and securing Title IV-E waivers to fund same;

(v) refinement of a data tracking system to measure outcomes for children;

(vi) revision of coverage areas for DCFS offices to align them with the boundaries of the State's judicial circuits; and

(vii) decentralization and internal, DCFS structural changes to improve case flow and day-to-day operational processes.

In August 2016, before the time the Implementation Plan was filed, DCFS had begun the immersion site process in four initial sites.[8] The initial Immersion Sites encompass approximately 11% of children and youth in care. Exhibit Q, Immersion Sites Four Month Status Update, September through December 2016 (dated January 12, 2017).

The Implementation Plan set out a series of target dates for the Immersion Site process. DCFS intended to finalize Title IV-E waivers by September 2016 in order to secure out-of-home

[8] The four initial Immersion Sites are: (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.

care funds to develop and build an intensive array of services in the immersion sties. The Department planned to hold a summit to announce its new Core Practice Model (comprised of FTS and MoSP) in October, 2016. For QSR, DCFS was to begin a review of the draft review tool by October 15, 2016, and the tool was to be finalized by the middle of November 2016. Training required for use of the QSR tool (consisting of a two-day training session and two subsequent, week-long mentoring sessions) was to be completed by January 30, 2017, and pilot use of the QSR process was to begin in one immersion site by February 1, 2017, with the mentors on site during the initial reviews.

The Department projected that it would take until September, 2017 to complete the process in the first four Immersion Sites. Additional Immersion Sites then were to be rolled out on a regular basis, with the immersion process to be completed throughout the entire state by 2019.

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report:

The Summit. At a pre-Summit meeting on October 17, 2016, Immersion Site stakeholder leaders were informed of all FTS and CFTM training that would be conducted in each immersion site. Then, with support from Casey Family Programs, the Department held its planned, statewide Summit on October 17-19, 2016. The Summit did not provide formal training for implementation of services, but served as the public launch of the Immersion Site model and provided extensive information on the Department's new Core Practice Model (comprised of FTS, QSR, and MoSP) and the immersion goals and outcomes. Approximately 900 people from across Illinois attended the Summit. Summit participants were stakeholders from throughout child welfare including: DCFS, private child welfare agencies, the judiciary, current and former youth in care, foster and birth 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. See Exhibit R, Summit Program and Agenda. The Summit included sessions regarding the FTS model and the child and family team process.

FTS Training and Implementation. Some progress has been made in providing the necessary training for Immersion Sites. The FTS training module is the prerequisite for all subsequent training. The FTS training module has been completed by most required participants in the Immersion Sites. The training was provided by a team of DCFS trainers. Service personnel were trained in person, and administrative and support personnel were trained via an online module. As of January 2017, the following have been trained:

Total targeted participants	
Total participants who have completed FTS training	83.02%
Total participants registered for upcoming FTS training	8.02%
Total participants not completed or not registered	12.31%
Total participants scheduled for self-directed learning	4.66%

Exhibit Q, Immersion Sites Four Month Status Update, September through December 2016 (dated January 12, 2017), p. 14. With the exception of some 50 staff scattered among the Immersion Sites, FTS training for all targeted participants in the Immersion Sites was completed in January 2017. Two make-up sessions are scheduled for February for staff who missed the trainings and if necessary an additional session will be held in March.

In addition, an abbreviated self-directed version of this FTS training has been in place during the rollout for specific populations of staff who DCFS management identified as appropriate for more limited training. This abbreviated self-directed version centers on outlining all three aspects of the practice model and discusses how those aspects interact together along with practice to encompass how staff should be engaging and working with children, youth and families.

Beyond the FTS training, all Immersion Site staff also must be trained in Procedure 315 (P315) (a permanency planning procedure that covers Child and Family Teams, Family Finding, Fictive Kin, and State-funded Guardianship expansion). Procedure 315 training was initiated within the immersion sites in January 2017.

MoSP Training. The Model of Supervisory (MoSP) training will include a combination of classroom training and individual coaching and is currently scheduled to begin in Immersion Sites in October or November 2017.

CFT / QSR Training and Implementation. Under the Core Practice Model, quality assurance will be improved by use of the Quality Services Review (QSR) model to review cases, including onsite interviews to ensure family engagement and effective child and family teams. The purpose of the QSR is to determine whether the Department is appropriately addressing the needs of individual children and assessing the performance of the service system in meeting individual youth's needs. The target population for QSRs is those youth who are placed outside the home and have serious emotional or mental health needs. Four immersion site QSR reviewers have been hired. The QSR instrument is being finalized and the reviewers received their initial two-day training on January 19-20, 2017. DCFS currently anticipates that four rounds of review of the QSR pilots will be conducted by Child Welfare Group (CWG) in the

spring of 2017 to ensure that the QSR review have fidelity to the QSR standards. The plan also includes that the QSR reviewers will have regular debriefings and case reviews with CWG to increase their skills in facilitating the reviews. DCFS' goal is to have eight skilled QSR reviewers in place by May 2017.

DCFS is working with the CWG on a plan for the Child and Family Team training and the current goal is for the CWG to provide training and coaching based on their proprietary curriculum and model. DCFS should receive the final training plan by February 28, 2017. The content of the training will focus on ways to engage and prepare families for an effective child and family team meeting and then how to effectively facilitate the meeting in such a way as to ensure that the family and youth feel supported and empowered. The first cohort of trainings is currently scheduled for early March 2017 with coaching commencing two weeks after the training. DCFS staff from the Office of Professional Development will meet with immersion site stakeholders and private agency administration staff to explain the training and coaching process and to encourage the identification of supervisors and staff to participate in the first training cohort.

Community /- In-Home Services and Title IVE. The development and implementation of an intensive array of in-home services is under design in each immersion site. Two Immersion Sites have developed their respective approaches: Mount Vernon is developing a lead agency approach integrating supervised reunification, Nurturing Parent Training, Intensive Placement Support for both intact and reunifying families, 24/7 emergency response and the intensive Multi-Systemic Therapy program. Lake County is developing an intensive wrap around approach involving ARC (Attachment and Regulation Competency), Motivational Interviewing,

Triple P parent training and 24/7 emergency access. St. Clair County and Rock Island are working to finalize their designs and anticipate doing so during the next reporting period.

Progress also has been made in increasing the availability of funds to develop in-home services in the Immersion Sites. DCFS has developed a process to allow the Immersion Sites to provide emergency cash for housing to keep high-risk families and youth together ("Norman funds"). In addition, in January 2017, a Title IV-E waiver was authorized by the U.S. Department of Health and Human Services Children's Bureau. Exhibit S, Title IV-E Waiver. The waiver provides additional funding to create and provide an array of intensive in-home evidence-based services. The Title IV-E waiver removes the prior restriction on use of federal Medicaid funds solely for out of home care and now permits use of those funds to pay for in-home services.

Program Evaluation.

DCFS is developing its Mindshare system to track permanency outcomes and to track child and youth well-being. DCFS also has a daily production report which flags both the numbers of children in shelter (currently at an all-time low of 30) and those that stay in shelter beyond 60 days, as well as all youth in residential facilities, BMN youth, and RUR youth in Cook County. All youth in residential facilities who are determined to be ready to be stepped down are reviewed every two weeks and a special team works with their case managers to support the step down process. Over 550 youth have stepped down due to this process over the past two years, though the Department cannot yet report on their subsequent placements. RUR youth are tracked weekly with data from Cook detention center; however, no data is readily available for non-Cook youth. BMN youth are also tracked daily and special calls are conducted with their case managers to move them to a non-hospital placement.

DCFS Output and Outcome data will be refined by ensuring its alignment with CFSR business rules. The University of Illinois Child and Family Research Center, Chapin Hall and DCFS business rules will each be aligned with CFSR business rules to ensure consistency in measurement.

The key outcomes listed below are also currently tracked. All outputs and distal and proximal outcomes should be accessible by March 2017 for the next four months status report, including the entire array of data called for in the CWAC Child Well Being Study as follows:

Safety and Permanence

1. Maltreatment in foster care
2. Repeat maltreatment
3. Child and Family Team Meetings
4. Supervised and Unsupervised Visits
5. Family Reunification within 5 and 12 months
6. Permanency within 12 months
7. Total permanency achievements by month and year to date
8. Placement moves
9. Time to achieve family reunification
10. Intact service levels

Permanency will be tracked by immersion site, by DCFS region, and statewide to assess progress so that prompt corrective action can be taken. Results will be provided in the monthly reports to the Expert Panel. The assessment of the immersion site pilot by way of output and outcome data is now being modified to ensure alignment with federal CFSR business rules. See Exhibit T, Immersion Site Outcome Improvement Services; Exhibit U, Outputs and Outcomes for Illinois Immersion Sites, B.H. Mid-Term (January 5, 2017).

DCFS Internal Change and Decentralization. DCFS is taking initial steps toward decentralization to allow regional decision-making in the Immersion Sites. The matching for placements of children and youth and for the case opening process has been de-centralized in all four Immersion Sites. DCFS has also transferred agency performance team monitoring to the

regions to ensure better integration of public and private sector case flow and quality of work. Plans are being developed to integrate clinical staff into the Immersion Site child and family team process during the next reporting period to ensure that accurate, thorough and strength-based assessments are developed for youth in care. These assessments will drive the development of individualized plans and the delivery of needed services for youth with serious mental health and behavioral needs.

4. Revised Targets / Goals:

Roll-Out to New Sites: It is too early to state with confidence whether the goal to roll out the Immersion Site process statewide by September, 2019. The immersion site work over the last four months, including DCFS' consultations with the CWG and Paul Vincent, have highlighted the significant length of time needed to train stakeholders, improve child welfare practice in a sustainable way, and develop and sustain the array of intensive home and community-based services youth need. The Department, in collaboration with the Expert Panel and Plaintiffs' counsel, may adjust the timeline for adding new Immersion Sites for the remainder of the state.

FTS: The handful of individuals who have not yet completed the initial FTS training will be trained by March 31, 2017. Currently 9% of caseworkers in Immersion Sites have not been trained. Additional make ups will be held in February and if needed March to compete this first round of training.

Procedure 315 Training: The targeted timeframe for completion of P315 training for immersion site staff is March 31, 2017. DCFS Operations, Monitoring and Professional Development staff are working to ensure that all other permanency and adoption staff,

supervisors and managers complete the Procedure 315 training by March 2017. Makeup sessions will be scheduled in April 2017.

MoSP: The MoSP training is projected to begin in October/November 2017. The goal of the MoSP training will be to train and coach supervisors on effective supervisory practices.

CFT / QSR. By March 15, 2017, DCFS will have finalized its plan for providing national expert coaches through the CWG in each immersion site to develop DCFS capacity to conduct independent reviews of status indicators and system performance indicators for individual youth (QSR) and to create and facilitate Child and Family Teams while coaching local staff to facilitate CFTs (CFT training). Rounds of Child and Family Team training and facilitation coaching are scheduled to begin in March 2017 and will culminate when the Child Welfare Group certifies that DCFS staff have demonstrated the skills and ongoing capacity to facilitate effective CFTs and to coach others in the principles and practices of effective CFTs. The targeted projected completion date is November 2017. At that time, it is anticipated that DCFS will have a core group of certified trainers and coaches in each immersion site to carry on the work of CFT training with the support of periodic fidelity reviews from the Child Welfare Group.

Community / In-Home Services: DCFS plans to have a contract program plan and budget in place for community / in-home services in each Immersion site by March 1, 2017 with an implementation date of April 1, 2017. The designs for the programs to be used in St. Clair County and Rock Island will be completed by March 1, 2017. Contract program plans and budgets will be in place in those sites by the next reporting period.

The DCFS Clinical Division will guide development and implementation of in-home services once the contracts for each Immersion Site are in place in April. DCFS is working on projections of the number of children who will be receiving these services by immersion site.

The Administration for Children and Youth has asked DCFS for its detailed plan for implementation of the IV-E waiver by April so it will be presented in the next four month status report. The impact of the IV-E waiver is to give DCFS discretion over the use of these federal funds so they will be a portion of the funding for these in-home services along with Medicaid. DCFS will develop a plan for use of the Title IV-E waiver during the next reporting period.

Realignment of Office Areas: Considerable progress has been made in developing a plan for realignment of DCFS Offices and Regions so that they will match the boundaries of associated Judicial Circuits. It is anticipated that the plan will be ready for the Director's review and Union negotiations by March 31, 2017.

Decentralization / Structural Change: During the next reporting period, DCFS will take the following steps toward decentralization to allow regional decision-making in the Immersion Sites: (i) retool the current Integrated Assessment process to make it timely and concise; (ii) transform the CIPP process into the CFT process; (iii) delegate to the CFT team the process of matching children with placements and deciding which cases should have active and continuing clinical involvement in the CFT process from the beginning to the end of the life of the case. This plan will be implemented in the Immersion Sites by April 30, 2017, and a plan for statewide implementation will be presented in the next Four Month Status Report.

Panel Recommendation #3: Fund a set of permanency planning initiatives to improve permanency outcomes for adolescents who enter state custody at age 12 or older either by transitioning youth to permanent homes or preparing them for reconnection to their birth families reaching adulthood. (Implementation Plan, pp. 38-42).

DCFS is pursuing two initiatives in accordance with this Recommendation – the Fictive Kin State Funded Guardianship, and Family Finding. Each initiative has been separately graded by the Expert Panel and each is discussed separately below.

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

1. Project Goals/Target

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

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report: Effective January 1, 2017, amendments to the Children and Family Services Act expanded the definition of fictive kin to include "a current foster parent if the child has been placed in the home at least one year and has established a significant and family-like relationship with the foster parent." In anticipation of that change, on June 6, 2016, DCFS had issued Policy Transmittal 2016.06 advising staff of the amendment to the definition of fictive kin. DCFS is updating various administrative rules, including DCFS Rules 300, 301, 302, 304, 309, 315, 328, 337, 338, 359 and 402 with the updated definition of fictive kin. On February 2, 2017, DCFS filed these rule revisions with the Secretary of State for publication in the Illinois Register on February 17, 2017, triggering the time for First Notice. Exhibit V, Exemplar Pages of Rule Changes.

DCFS has commenced training DCFS staff on Procedure 315, Permanency Planning, which includes training the expanded definition of fictive kin.[9] The training involves two days in the classroom and is occurring throughout the state. The status of this training is described in greater detail at p. 43. The first cohorts for training will include managers and supervisors in Immersion Sites. Once all DCFS and POS Permanency staff are trained, the Office of Professional Development will develop a shortened version of Procedure 315 to provide to intact and investigation staff. The training will focus on the components that affect all aspects of permanency.

DCFS has been tracking placements with fictive kin. From January 1, 2015, when the definition of relative was first expanded to include fictive kin in the Children and Family Services Act, to December 31, 2016, there were 1236 youth placed with fictive kin. Exhibit W, Fictive Kin Data. Data sets for fictive kin are being embedded in the Mindshare platform. These data sets will distinguish between placements with fictive kin under the old, narrower definition of 'relative,' prior to the change on January 1, 2015 with those who meet the new expanded definition of 'relative.'

4. Revised Targets / Goals:

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

Training for Procedure 315 for DCFS staff will begin in March 2017 and will be completed by all DCFS and private agency staff. Exhibit X, Procedure 315 Training Schedule. Training for Procedures 315 for Investigation and Intact staff will begin in June of 2017.

B. <u>Panel Recommendation # 3: Expanding State Funded Guardianship</u>

[9] Training on fictive kin is part of the Procedure 315 training that is mandated for all DCFS and private agency staff statewide.

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

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report: DCFS issued Policy Guide 2016.09 on August 24, 2016 which announced changes to Rule 302.410 to amend the eligibility criteria for state funded guardianship. The changes expanded eligibility criteria for state funded guardianship by: (i) lowering the age of eligible youth to 12 years of age from 14 years of age; and (ii) including licensed and unlicensed relatives as placements eligible for the program. On February 15, 2017, DCFS filed amended Rule 302.410 with the Secretary of State for publication in the Illinois Register on March 3, 2017, triggering the time for First Notice.

DCFS has already expanded the responsibilities of Adoption Specialists presently assigned to each private agency to include (i) review of all cases with guardianship goals, (ii) provision of technical assistance to determining which youth are eligible for the state funded guardianship, and (iii) addressing the guardianship option with the foster parents. This process began in August of 2016 and is still in effect.

4. Revised Targets / Goals:

On March 3, 2017, First Notice for Rule 302.410 will be published in the Illinois Register.

DCFS is developing a dashboard in the Mindshare platform that will allow program managers to be able to identify youth eligible for specific subsidies like the state funded guardianship program in order to move them to permanency. Exhibit Y, New BH Related Data Elements in Mindshare Dashboard – M02 – Children Active in Foster Care. The target date for

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

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

DCFS will add questions to the Administrative Case Review (ACR) packet regarding eligibility for both state funded guardianship and the KinGAP program, which is a federally funded reimbursement program for guardians, by end of April 2017. During the next reporting period, ACR staff will be instructed to raise the issue of eligibility for state funded guardianship during each ACR and to document that discussion in their feedback. The ACR staff will additionally discuss with the permanency staff the youth's current placement type and determine if Fictive Kin was explored as a placement option.

C. Panel Recommendation # 3: Family Finding

1. Project Goals/Target: The Implementation Plan requires DCFS to implement specific "family finder" strategies as part of permanency planning for adolescents who do not have an obvious reunification plan. Implementation Plan, p. 40. The goal of the Department's Family Finding strategy is to improve permanency outcomes for all youth by identifying family that can serve as potential placements, supports or resources for youth. Implementation Plan, pp. 40-42.

DCFS committed to revising its rules and procedures to enhance family findings efforts on all levels and that 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. DCFS further committed to requiring Permanency Achievement Specialists within each DCFS region to conduct family finding tasks, and that these Specialists would be available to both DCFS and private agency staff to provide technical assistance on complex or difficult cases to identify barriers to permanency through methods of file mining, family meetings, trainings or other assistance. Training on family finding was to be provided to DCFS staff and private agency staff and administrators.

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

No dates for the above commitments were specified in the Implementation Plan.

2. Expert Panel's Evaluation Grade: Unsatisfactory

3. Status Report:

DCFS revised Procedures 315, Permanency Planning, to include family finding activities. Exhibit Z, Policy Transmittal 2016. 11: Procedures 315 Permanency Planning. 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 was revised. Implementation Plan, p. 42.

ACR began requesting documentation to show completion of Family Finding activities by the permanency worker at every ACR since August of 2016. If no documentation is provided to the ACR reviewer, notification is then sent via the ACR Alert feedback to appropriate parties to address. This allows for the supervisor to address the lack of family finding efforts in supervision. This is completed at every ACR regardless of past compliance of the activity.

Questions regarding family finding efforts also are being been added to the ACR review packet. The revisions to this packet are pending review for approval. The addition of this question will show compliance of Family Finding activities being completed from a statewide level.

4. Revised Targets / Goals: The current goal is by the end of the next reporting period, DCFS will have identified and implemented steps to refocus its family finding efforts on adolescents with emotional and behavioral health needs to locate additional placements or supports for these youth.

Training on Procedure 315 re-commenced in its revised format in December 2016 and is expected to be completed by March 31, 2017. Exhibit X, DCFS Training Schedule for Procedures 315.

Additionally, a webinar which provides more in-depth instruction on the theory of family findings is being finalized. Exhibit AA, Family Finding Four Month Status Report, p. 7. The

Webinar will be available by March 15, 2017. The training is geared to all Permanency and Investigation staff as Family Finding is required for all youth in care. The required timeframe for completion will be 60 days post-release to the DCFS Virtual Training Center. Anticipated date of staff completion of this training is May 30th, 2017. The training will continue to be available for newly hired staff and will be part of the required training.

DCFS is developing a Mindshare platform dashboard to track family finding data and has identified an outline of information to be included in that dashboard. The dates for development of the Mindshare dashboard will be developed by the Expert Panel and Parties. See discussion at pp. 14-15 *supra.*

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" (Implementation Plan, pp. 42-43).

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

A. <u>Expert Panel Recommendation # 4: Reorganization</u>

1. Project Goals / Target: The Implementation Plan called for the Department to create a high level unit with cross-organization authority to develop an implementation plan, manage the implementation and resolve system barriers. It also noted that the organizational consultant should evaluate the organizational structure and culture of DCFS; the effectiveness of

DCFS' policies, procedures and programs; the effectiveness of the Department's leadership and managerial structure and function and to assess the supervisory functions of the agency. Implementation Plan at pp. 42-43.

2. **Expert Panel's Evaluation Grade:** Exemplary

3. **Status Report:** By the time the Implementation Plan was filed with the Court, DCFS already had undertaken a reorganization. Director Sheldon had 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. Accordingly, the need for an organizational consultant was deemed moot.

Since the Department's initial reorganization, additional refinement has occurred. The Department realigned several units and reassigned senior staff as implementation of the Immersion Site pilots and the strategic plan is underway. Exhibit BB, Director's Announcement Re: Reorganization, dated January 17, 2017; Exhibit CC, Organizational Chart. Pete Digre is the Associate Director responsible for all the Implementation Plan initiatives, including the Immersion Sites. In recognition of the need to integrate clinical expertise into the front-line work of the Department, Mr. Digre also is now responsible for the Division of Clinical and Program Development, residential monitoring and Medicaid behavioral health. Further, Neil Skene, currently the Deputy Chief of Staff, is now Senior Deputy Director for Strategy and Performance. This division combines program assessment, innovation and planning, professional education, and engagement with stakeholders. Michael Ruppe remains Senior Deputy Director for Operations, responsible for Child Protection and Permanency and the DCFS Regional Administrators. The Operations division has been modified to now include Agency Performance Teams, which will report to Regional Administrators, Resource and Recruitment, and the Case

Assignment and Placement unit. The Child Intake and Recovery Unit will be part of Operations and move under the umbrella of Permanency, led by Diane Cottrell. These structural changes further the goal of regionalization by integrating more functions into operations and into local communities.

The Implementation Plan states that Pete Digre, Strategic Planning, and Project Managers will meet weekly and report to during bi-weekly supervision meetings; that 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; and that 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. Implementation Plan at p. 43. Those activities are ongoing.

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

B. <u>Panel Recommendation # 4: Illinois Birth Thru Three (IB3)</u>

1. Project Goals / Target:

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

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report: The IB3 project is in the fourth year, with one year remaining for the five-year demonstration project. There are currently 1704 children assigned to the demonstration and eight agencies that provide the evidence-based interventions. Exhibit DD, IB3 Four Month Status Report, p. 2.

Current challenges include maintaining sufficient and credentialed staff at the agencies providing the services and continued engagement of parents.[10] Specifically, current data for the Child Parent Psychotherapy demonstrates that 125 cases have been closed across the lifetime of the project, but only 24% of the cases have been closed successfully. The remaining 76% of the cases were discharged from the waiver program due to engagement challenges. Similar evidence exists for the NPP. Thirty-eight percent of the birth parents that are referred for the NPP program complete the program and approximately one third of the birth parents enroll in the NPP program several times before successfully completing NPP. Exhibit DD, IB3 Four Month Status Report, pp. 4-6.

To address parental engagement issues, the IB3 staff developed a model of on-site field support at agencies to be held several times a week to increase parental engagement with the intervention. Implementation support specialists are now assigned to specific agencies. Specific DCFS offices and agencies have been targeted for a case status reviews and permanency plans for IB3 involved families.

The Implementation Support team has increased its capacity from 1.5 to 3 implementation support specialists. Thus, the first quarter of the fiscal year focused on developing and implementing an initial onboarding plan. The target date of October 2016 for introducing the new staff and beginning implementation support in agencies was met. A few new

[10] For example, one agency lost a clinical director and two facilitators and another agency, which resumed their role as a provider, had to get new staff trained.

structures were introduced, including the assignment of Implementation Support specialists to specific intervention agencies. Implementation Support also worked toward a model which involves having onsite field support at agencies on a monthly basis. This new structure began at Cook Central as a result of implementation support receiving an open invitation from the Area Administrator to attend the supervisor meeting that occurs the first Tuesday of every month. This approach to onsite coaching is currently in 5 of the 10 intervention agencies.

Field coaching still is largely targeted to foster care staff. However, the Implementation Support team has strategically enhanced the engagement of agency licensing staff this year. The framework that was developed to support the process of implementation support is the main tool utilized by the Implementation Support specialists. The primary area of focus with supervisors and caseworkers has been permanence. During the meetings with agency staff, case status reviews are conducted, and those case updates are being used to guide engagement/ planning. Implementation Support specialists have met with approximately 166 agency staff and obtained the status of 410 families recommended for the interventions. It remains challenging to educate most agencies and courts regarding evidence-based interventions, the skill of engagement, and embracing the reality that infants and toddlers are affected by trauma exposure. While practice training modules are not yet in use, but Implementation Support continues to provide education/coaching in the areas of engagement, court testimony on progress of evidence-based interventions, and trauma-informed supervision.

4. Revised Targets / Goals:

The Department will complete the pilot as scheduled by September 30, 2017. Implementation support staff will provide support for 10 agencies that provide casework services to children enrolled in the IB3 program by 10% in an effort to improve engagement.

Reunification and Overall Permanency Rates for Infants and Toddlers (Under 4 years old) who entered care between July 1, 2013 and June 30, 2015

Proximal Outcome (per Proximal Outcome in Logic Model)	Intervention Group (%, N)	Comparison Group (%, N)	Significance and Explanation of Difference
Reunification	16.6%, 483 17.0% 483	13.1%, 457 13.3%, 457	The higher rate of reunification for intervention cases (+3.5) does not exceed the statistical threshold of significant difference from 0 but is trending in the expected direction ($p < .139$)
Overall Permanence	23.0%, 483 23.6%, 483	19.3%, 457 19.7%, 457	The higher rate of permanence by adoption, guardianship or reunification for intervention cases (+3.7) does not exceed the statistical threshold of significant difference from 0 but is trending in the expected direction ($p < .162$)

*Top row as of December 2016; bottom row as of February 2017.

C. Recommendation # 4: SAFE Families for Children (SFFC)

1. Project Goals / Target: The core objectives of SFFC include deflection of youth from child welfare custody, child abuse prevention, and family support and stabilization. The efficacy of the program cannot be evaluated until there are a total of 475 families in the control group and 475 families in the comparison group. 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. (Implementation Plan, pp. 46-47).

DCFS' goal for this program is to reexamine and modify the process for engaging families in SFFC so that the evaluation can be completed. SFFC has been in place in northern Illinois for over ten years and was expanded statewide in approximately October 2015. Implementation Plan, pp. 44-46. Nevertheless, participation in the program has lagged far behind expectations.

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report:

While the pilot design requires 475 families referred by DCFS and 475 from a control group, only 227 referrals have been made to the pilot between October 1, 2014 to September 15, 2015. This represents the total cases randomly identified and allocated to both the experimental and control group. Exhibit EE, SAFE Familes Four Month Status Report, p. 1. The evaluators originally hoped for 120 referrals from DCFS each quarter, however, in July 2016, that target was revised to 60 referrals from DCFS per quarter and a secondary computerized referral mechanism was added at SFFC. In the quarter from October 1, 2016 to December 31, 2016, which was last quarter for which there is data, there were 80 referrals to the program in total: 35 cases were identified through DCFS and 45 were identified by SFFC. *Id.* at p. 1. The evaluation period was extended for two years.

Identified challenges for the program are being addressed. One challenge concerned families that failed to follow through with the referral to SFFC. Administrative staff from SFFC now have access to SACWIS and are making individual contacts with families that have been referred to the program. DCFS also held information sessions for frontline staff at DCFS offices with the fewest referrals to identify whether there are problems with caseworker non-participation, which is another barrier DCFS had identified for this program. DCFS is also

addressing the challenge presented by duplication of referrals from DCFS' computerized referral system and SFFC's system. DCFS now provides SFFC with a daily report of referrals for comparison and along with the SACWIS access; a SFFC administrator is able to review cases and prevent duplicate referrals. Duplicate referrals resulted in families being assigned to both the control and experimental groups. This "flipping" of assignments impacts the integrity of the evaluation and the ability to determine the success of Safe Families in preventing children coming into foster care.

4. Revised Targets / Goals: SFFC administrative staff will continue to make individual contact with families referred to the program for the purpose of increasing family engagement and participation. By the next reporting period, DCFS also will determine how to track family engagement and whether to create a specific referral form to assist with tracking. By that same deadline, SFFC will decide whether an expansion of the program is needed to better serve the first cohort of Immersion Sites and what that expansion should entail. A meeting is being set for March 2017 with the professional evaluators, Safe Families staff and DCFS to determine next steps regarding non-participation by DCFS staff, current issues, needs for continued education and efforts surrounding expansion. As of February 1, 2017, as a first step, Associate Deputy for Child Protection is informed of the names of DCFS staff who do not respond to Safe Families inquiries regarding the status of a referred family so that proper action is taken.

D. <u>Panel Recommendation # 4: Information Systems</u>

1. Project Goals / Target:

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

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

Long-term goals, with a targeted completion date of September 2019, are replacement of the existing SACWIS system, and implementation of predictive analytics. Implementation Plan, pp. 48-52. Regarding predictive analytics, DCFS committed to establishing an internal team in OITS to bring reporting needs and data analytics into a centrally managed organization. In the short term, DCFS elected to use Mindshare as the platform for its data analytics. This product allows DCFS to merge and analyze data from multiple environments and produce reports for more informed decision making in a dashboard format. Ultimately, DCFS intends to establish a statewide enterprise data analytics platform ("Enterprise IT") to reduce reliance on external entities to collect and analyze data to drive outcomes. Implementation Plan, pp. 49-51. Achievement of that goal is not anticipated until December 2018.

2. Expert Panel's Evaluation Grade: Satisfactory.

3. Status Report:

Replacement of SACWIS: On November 29, 2016, the U.S. Department of Health and Human Services Administration for Children and Families (ACF) approved DCFS' "Planning Advance Planning Document." This federally approved plan allows DCFS to develop a request for proposal (RFP) for a feasibility study to replace SACWIS by migrating to a new "Comprehensive Child Welfare Information System" to replace SACWIS. The approval permits

DCFS to receive federal matching funds for the feasibility study through December 2017. Exhibit FF, Information Technology/CCWIS RFP BH Status Report; Exhibit GG, November 29, 2016 Letter from Commissioner Rafael Lopez to Director George H. Sheldon.

Short Term Improvement of Existing SACWIS: DCFS is replacing the current "Unusual Incident Reports" with a newly developed Significant Event Report system. A major aspect of the new system is the ability to record UIR information directly into SACWIS. Exhibit HH, Information Technology BH Status Report, p. 6. DCFS and private agencies have been receiving training on the new system.

DCFS Information Technology System staff continues to meet with staff from the State Board of Education regarding integration of educational data into SACWIS. DCFS needs to determine the data elements required from ISBE which demonstrate improved well-being for children and decide if this information should be stored by DCFS or accessed on demand by case workers. Exhibit HH, Information Technology Projects BH Status Report, p. 6.

Mobile Applications: DCFS is the first state agency in Illinois to develop and use an interactive mobile app for casework activity. The mobile app allows staff to upload contact, case notes and photographs directly into SACWIS. Notes for contacts with family members can be typed in on the iPhone or can be dictated into the Talk to Text feature on the iPhone. The notes created either in the app or on SACWIS can be edited within the app until they have been completed. The app also displays the last three months of contact or case notes. Photographs are taken and uploaded within the app simultaneously. Exhibit II, DCFS Mobile Application User Guide.

DCFS began the mobile app pilot in January, 2016, and it concluded on April 29, 2016. The program then was expanded statewide. As of January 2017, iPhones with the SACWIS

application have been provided to approximately 927 DCFS child protection and permanency staff. In December 2016, DCFS implemented PIWIK, an analytic platform that allows DCFS to track real-time data usage of the mobile app. DCFS data demonstrate that while there are still some challenges with the app, when it is used the case and contact notes are input at least 20% faster. Exhibit JJ, SACWIS Mobility Statistics/Usage State Roll-Up January 2017.

DCFS also created an on-line licensing application for foster homes. A controlled roll-out of the licensing application commenced which includes DuPage, Bloomington, McLean, Livingston, Peoria, Tazewell and Woodford counties. Licensing staff in those counties will direct interested individuals to the on-line application, but will also take a paper application as well. DCFS has received 28 online applications to date.

Predictive Analytics

The predictive analytics project developed by Mindshare, which identifies investigations with the highest probability of serious injury or death for children known to the Department, began on May 16, 2016. Exhibit KK, Eckerd Rapid Safety Feedback Update, October-December 2016. The Eckerd Rapid Safety Feedback Model began in Florida and has been used in other jurisdictions to help decrease poor outcomes (child deaths and serious harm). The program identifies the children at the highest risk, and then involves a review process that focuses on nine critical practices to support child safety. Exhibit LL, DCFS Announcement Eckerd Rapid Safety Feedback Model.

Trained reviewers from the DCFS Division of Quality Assurance and Research began work on the predictive analytics project in May 2016. The project focused on investigations involving children ages 0 to 18 years who were known to the Department that were at high risk of death or serious injury within 12 months. In early September, DCFS further narrowed the

focus to investigations of children ages 0 to 8 known to DCFS who are at risk of death or serious injury within the next 24 months. There are three teams of reviewers in Chicago, Springfield and Belleville. The investigation will be reviewed at a minimum between the 10th and 15th day, the 45th day and prior to case closure. Additional reviews can be conducted on the investigation at any time. The reviewers focus on nine areas focused on the quality of assessment and information on child safety:

- whether the totality of accessible family history (prior referrals, law enforcement and service records, etc.) is sufficiently assessed and utilized in decision making;
- whether interviews with all pertinent individuals are timely completed;
- whether interviews and observations are sufficient to assess overall family functioning and include child vulnerability and parent/caregiver capacity to protect;
- whether contacts with family are made with sufficient frequency to assess for emerging dangers;
- whether communications with other parties (collaterals, referred service providers, legal entities) are sufficient to gather information, reconcile conflicting statements and provide relevant information to stakeholders;
- whether safety assessments and resulting actions are sufficient to prevent maltreatment;
- whether services appropriate to meet the family's needs are identified and provided;
- whether safety-related communications with non-custodial parents are sufficient to gather information, reconcile conflicting statements and provide relevant information; and
- whether the supervisory review identifies gaps and provides appropriate and sufficient guidance regarding all of the above issues.

Based on the review, the reviewer may conduct a staffing with child protection staff to address concerns with the information or assessment process used during the investigation. During the staffing, action items for child protection staff may be identified and completion dates for those action items are set. Reviewers are responsible for determining if the action items have

been completed. The table below reflects the percent of cases where the reviewers determined that the information obtained during the investigation is satisfactory.

SAFETY CONSTRUCTS	First Quarter of Implementation (Baseline Data for Illinois) (5/24/16-8/23/16)	Second Quarter of Implementation (8/24/16-11/23/16)	Percent Improvement
Question 1 - *Utilizing family history in decision-making*	67.2%	70.4%	3.2%
Question 2 - *Timely interviewing*	75.6%	77.9%	2.3%
Question 3 - *Assessing child vulnerability and caregiver protective capacities*	64.8%	69.4%	4.6%
Question 4 - *Frequency of contacts*	73.6%	75.1%	1.5%
Question 5 - *Stakeholder communication*	66.0%	73.0%	7.0%
Question 6 - *Sufficiency of safety assessment and planning*	69.2%	78.3%	9.1%
Question 7 - *Service referral and linkage*	62.0%	77.2%	15.2%
Question 8 - *Safety-related communication with non-custodial parents*	50.9%	52.5%	1.6%
Question 9 - *Sufficiency of supervisory reviews*	69.2%	71.3%	2.1%
Overall	67.1%	72.5%	5.4%

The Eckerd Prediction is shared weekly with Child Protection Administration and Regional Administrators. The goal of the program is to provide reports to management that identify patterns or trends in performance, to provide data to front line staff to improve practice and to identify strong administrators, supervisors and investigators whose strategies can be modeled for other staff.

4. Revised Targets / Goals:

The integration of education data from the Illinois State Board of Education into SACWIS is expected to be completed by October 1, 2017.

The mobile development team is working toward a spring release of the updated SACWIS app version 2.0 for DCFS investigators and caseworkers both Android and iOS devices. This will facilitate use of the app by private agency partners. The timeline for roll-out to the private agencies is currently under development. The new Significant Event reporting system to replace the Unusual Incident Report system is expected to be in place by March 31, 2017. Exhibit HH, Information Technology Projects BH Status Report, p. 6

By the end of February 2017, DCFS staff from Licensing, Recruitment, Information Technology and Communications will meet in person to discuss the marketing and roll-out strategy for the mobile app for foster parent licensing. DCFS is developing a strategy for a statewide roll-out, including a media and communication strategy to advise the public of the new on-line process.

DCFS is currently developing a mobile application for DCFS licensing staff to capture data, document findings and generate compliance notices. DCFS licensing staff will be provided with tablets containing appropriate licensing forms that can be completed on site and immediately provided to the licensee. The roll-out is currently scheduled for mid-2017. The mobile application for DCFS licensing staff is currently scheduled to be completed by May 31, 2017.

DCFS anticipates completion of the RFP for system intended to replace SACWIS by May 2017. The RFP must be approved by ACF and be processed through the state procurement process by May 2017.

Project Goals/Target: Eckerd/Mindshare will build in reporting mechanisms into the Eckerd Portal to allow Illinois to provide data to share with Department Administration, Regions, and Teams for the nine practice areas being reviewed by the last quarter of FY17. DCFS is currently determining whether to renew or expand the contract for the Rapid Safety feedback program. One issue to be determined is whether to expand the model to intact family cases. This could be accomplished with current Eckerd staff within the Department. If approved, the goal would be to expand to include intact families starting in FY18.

Panel Recommendation #5: Restore funding for the Illinois Survey of Child and Adolescent Well-Being (ISCAW) that uses standardized instruments and assessment scales. (Implementation Plan, p. 53).

1. **Project Goals / Target:** The Implementation Plan contemplated restoration of funding for the ISCAW well-being study, which would be a point-in-time study of the well-being of the population of children in open placement cases as of a selected date during FY2017. No similar study has been conducted in Illinois in nine years. By August, 2016, a Steering Committee comprised of three DCFS representatives and 11 University Partners & POS providers already had been formed. The well-being study was to replicate most of the methods of the Illinois Child Well-Being Year 3 launched in 2004, with additional new features including: updated methods to enhance caseworker participation and increase caseworker response rates, and a brief measure of child life satisfaction to enhance measurement of positive child well-being. Implementation Plan, p. 53. The report is projected for the second quarter of 2018.

2. **Expert Panel's Evaluation Grade:** Needs Improvement.

3. **Status Report:** DCFS is working with the Children and Family Research Center to plan for reinstituting the Illinois Survey of Child and Adolescent Well-Being. It appeared that

the Steering Committee for the Illinois Child Well-Being Study 2017 had reached consensus on all major elements of the methodology for the study by August 2016, but issues later arose. The committee had considered incorporating data from other Illinois data sets such as health data in SACWIS and education data from the Illinois State Board of Education. However, all agreed that at present it is not practical to access and analyze these data in a timely way, expect for the CANS data.

In November 21, 2016, the Survey Research Laboratory (SRL) of the University of Illinois at Chicago (UIC) submitted a proposal to the Children and Family Research Center (CFRC) of the University of Illinois at Urbana-Champaign (UIUC) for field operations and data preparation for the study. UIUC is the contractor for the study and UIC will be a subcontractor. The SRL proposal details proposed data collection operations, deliverable data sets, a timeline and a subcontract budget. Exhibit MM, Illinois Child Well-Being Study, Presentation to DCFS/BH Panel, January 6, 2017. A sample of 500 to 600 children will be drawn from the population in care on June 30, 2017. All children will be in non-permanent substitute care placements for a minimum of three months. The Survey Research Laboratory at the UIC will calculate and apply sample weights to adjust for design effects and non-response. Id.

DCFS anticipated that the study would begin in the 3rd quarter of 2017. The start date will be delayed due to the time that was needed to develop the research strategies for the study. UIUC has begun to negotiate data-sharing with Northwestern to incorporate data from Child and Adolescent Needs and Strengths (CANS) scale that DCFS routinely collects on all children entering care. This data on well-being will provide a baseline to relate to data at time of study data collection.

4. Revised Targets / Goals: By the next reporting period, the Department and its university partners will have worked together to establish a date to commence the survey, finalize the research strategies for the study, and establish a target date for completion of the study.

Panel Recommendation #6: Develop and implement a new plan for monitoring residential and group home programs, utilizing external partners. (Implementation Plan at p. 53).

1. Project Goals / Target: The goals set out in the Implementation Plan were for the Department, with the University of Illinois at Chicago and Northwestern University, to develop a redesigned residential monitoring program, the goal of which is to increase the safety of youth placed at residential treatment facilities and to enhance the effectiveness of the residential services provided at the residential treatment facilities. As described in the Implementation Plan, the program called for development of regional multi-disciplinary monitoring teams that would assess residential programs' effectiveness utilizing multiple data sources and inputs. Residential monitoring teams were to have been identified and training was to have begun by December 2016. Implementation Plan, Exhibit YY [Dkt. 531-51].

2. Expert Panel's Evaluation Grade: Needs Improvement.

3. Status Report: Despite significant efforts made toward the development and implementation of the monitoring plan, an evaluation of the plan during the design discussions led all participants on the Residential Monitoring Redesign Group, including the Expert Panel, DCFS, Northwestern University and University of Illinois at Chicago, to conclude that a substantial redesign of the plan was required in order to effectively monitor the safety and quality of care provided to youth in residential treatment facilities. That conclusion was based on agreement that the primary focus of the initiative should be to monitor *youth* and their progress from a clinical perspective, in addition to the regulatory requirement to monitor

programs and facilities from a compliance perspective. The prior monitoring program the Department had used focused heavily on facilities' compliance (or lack thereof) with safety and facility standards, and had not focused on youth outcomes.

A comprehensive, revised plan for monitoring now has been developed. That plan addresses the safety, well-being and clinical outcomes of youth in residential facilities *in addition* to a review of the facilities themselves. The new monitoring program, Therapeutic Residential Performance Management Initiative (TRPMI), calls for a team approach and collaborative decision making. The primary focus will be on the clinical progress of youth that are deemed clinically ready for discharge and/or in Phase II of their treatment. Each TRPMI team is made up of five functions: Team Coordinator, Monitor, Clinical Specialist, Quality Improvement Specialist and Manager. See Exhibit NN, DCFS Residential Monitoring Redesign 4-Month Status Report, dated 1/17/2017.

The TRPMI pilot consists of three teams (1 each in the Northern, Southern and Cook DCFS regions). Implementation of the TRPMI pilot began on January 9, 2017 in the Northern and Southern regions. The Team members are a mix of DCFS staff and university partners' staff. Each team consists of 1 Team Coordinator, 2 Monitors, 2 Clinical Specialists and 1 Quality Improvement Specialist. The 3 teams will be led by one TRPMI Pilot Manager (from UIC) and their progress will be monitored by the TRPMI Steering Committee and evaluated by Chapin Hall. Collaboration with leadership of the Immersion Sites, QSR, Family Finding and Training is mandatory. See Exhibit OO, DCFS TRPMI Logic Model – Last Updated 1/12/17.

4. Revised Targets / Goals: Cook County is the remaining region to participate in the pilot. The TRPMI pilot will become operational in Cook by March 31, 2017. After the pilots have been completed, Chapin Hall will provide data regarding the effectiveness of the pilots.

Upon successful completion of the pilots, the TRPMI strategies will be used to build the internal capacity of DCFS staff to effectively monitor the safety, well-being and permanency of youth receiving residential treatment. The TRPMI monitoring model will then be implemented statewide. The evaluation of the three pilot regions consists of three phases: baseline year (CY16), implementation year (CY17), and post-implementation year (CY18). Chapin Hall collected baseline survey data (CY16) on all residential treatment providers, including those in the three pilot regions. During the implementation year (CY17), TRPMI will be implemented in these three pilot regions, in which process and implementation data will be collected to guide implementation. During the post-implementation year (CY18), a follow-up survey will be conducted. In addition, outcomes data leveraged from administrative data will be analyzed to compare outcome changes from the baseline year to the post-implementation year (CY16-CY18) between providers in the pilot regions vs. providers not in the pilot regions. It is anticipated that the monitoring program will identify youth who are ready for step-down but do not have an appropriate placement.

Using the Child and Family Team process, the TRPMI teams will collaborate with relevant stakeholders, including case management, residential and immersion site staff, to develop effective and timely resolutions to the identified barriers. Concurrently, the TRPMI team will draft Procedures that clarify the roles, responsibilities and communication strategies for assuring completion of tasks identified by the team. The draft Procedures will be completed by February 21, 2017.

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

1. **Progress Goals / Target:** A Communication Plan, entered by the Court on September 28, 2016 [Dkt. 530], provides for bi-weekly conferences with the Expert Panel and the Parties, during which the pilots and programs identified in the Implementation Plan are discussed. The plan provides for DCFS to provide a monthly report to the Expert Panel and Plaintiffs' Counsel which details the specific steps that have been taken in actual implementation of each initiative set forth in the Implementation Plan, the actual results achieved, any barriers that exist and strategies to eliminate or resolve the barriers, and an evaluation of program results. The Plan also provides for DCFS to make efforts proactively to share information "beyond that which directly relates to the specific initiatives described in the Implementation Plan" that nevertheless is significant.

2. **Expert Panel's Evaluation Grade:** Satisfactory.

3. **Status Report:** The Department generally is meeting compliance requirements. Bi-weekly Expert Calls occur with DCFS, the Expert Panel and Plaintiffs' counsel. Project Manager calls, to which the Expert Panel and Plaintiffs' counsel are invited, occur weekly. B.H. Steering Committee calls, to which the Expert Panel and Plaintiffs' counsel are invited, occur weekly. Agendas for both the Project Managers and Steering Committee Calls are distributed to participants prior to each meeting. Monthly reports are being provided to the Expert Panel and Plaintiffs' counsel using the templates developed by the Expert Panel, which is based on the Design, Test, Spread, and Sustain (DTSS) Framework commissioned by the U.S. Children's Bureau.

Improved communication has resulted in improved collaboration, with the Expert Panel participating in meetings with stakeholders statewide. This collaboration has facilitated DCFS' adjustment of some pilots and programs on an ongoing basis. There have been glitches,

however. In several instances, communications or information was provided to the Expert Panel, but not to Plaintiffs' counsel. In those instances, the Expert Panel has shared the relevant information with Plaintiffs' counsel. And the Expert Panel has identified some instances where the Department was not sufficiently proactive in sharing information, most specifically in connection with issues that have arisen during the development of the QSR process.

4. Revised Targets / Goals: The Department will continue in its efforts to comply with all requirements of the Communication Plan. In addition, the parties and the Expert Panel will meet by March 31, 2017 to reach a more refined agreement as to the information that presumptively should be provided both to the Expert Panel and to Plaintiffs' counsel.

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

1. Progress Goals / Target

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

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

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

2. Expert Panel's Evaluation Grade: Satisfactory

3. Status Report: During calendar year 2015, a total of 1,826 youth were hospitalized; 22.4 % of those youth were hospitalized more than once. A total of 244 youth were identified as having remained in hospitals beyond medical necessity in 2015.[11]

During 2016, 1841 youth were hospitalized and 419 (22.8 %) of these youth have been hospitalized more than once. A total of 265 youth were identified as having remained in hospitals beyond medical necessity.[12]

Prior to instituting this BMN project, the Department had increased its focus on the BMN population. In October 2016 the Department instituted twice weekly staffings with involved parties, including caseworker/supervisor, Central Matching, PHP, and DCFS Clinical. These meetings focused on ensuring that all parties are actively working on solutions and arranging case coordination and step-down services to further reduce the amount of youth that are BMN. Since the BMN project start, as of February 10, 2017, 11 youth were considered BMN as compared to 18 youth that were BMN December 8, 2016, and significantly fewer than the number of BMN youth in December 2015. As the pilot originally was envisioned, it was assumed that youth in the BMN pilot would already have developed a strong relationship with a caseworker and that it would be important to preserve those strong relationships. It soon became obvious however, that many of the youth who have been categorized as BMN were new to foster care and did not have an established relationship with a caseworker. For example, of the 18 youth who were BMN as of December 8, 2016, nine of the youth were new to DCFS custody, with custody being taken either after hospitalization or less than three months prior to hospitalization.

[11] DCFS Psychiatric Hospital Database
[12] Id.

Accordingly, the pilot has been revised as follows: 1) the pilot will serve 50 youth who reside in Cook County and collar counties, who are psychiatrically hospitalized BMN, and who have an assigned caseworker; 2) the selected youth must have been recommended for a home setting; 3) the selected youth's caseworker must work for a case management agency that is willing to receive coaching and support by a Kaleidoscope Stabilization Consultant[13]; and 4) the assigned case management agency must commit to continuing the case management role for the youth even if the service or placement setting of the youth changes. Exhibit PP, Enhanced IPS Program Beyond Medical Necessity Pilot, January 3, 2017, p. 1. The pilot contemplates that five days before a youth's clinical staffing at the psychiatric hospital, DCFS will be notified of the upcoming staffing and will participate if there is a risk that a youth could become beyond medical necessity or there is a risk that no appropriate placement is available. Once a youth is identified as appropriate for the pilot, a Stabilization Consultant will be assigned to the case management team. The Stabilization Consultant will model, teach, guide and assist the case management team and work to improve the case management team's assessment, engagement and individualized planning. Id.

The Child and Family Team (CFT) will serve as the hub of the decision making, service planning and assessment process. The CFT will meet monthly and review the plan for the youth, and review whether the youth is achieving placement stability, and emotional and educational stability. The CFT will make adjustments and modifications as necessary to the youth's services and supports. Id.

Each Stabilization Consultant will be assigned five to ten cases. The small number of assigned cases is designed to allow the development of a stronger relationship with the case

[13] Kaleidoscope is the selected provider for this project.

management team and increased contact with clinical, community and other service providers. Id. The Stabilization Consultant will ensure that the casework relationship with the youth and the family considers strengths-based approaches to best engage the youth and family since engagement is the foundation upon which trust must be built. Id.

The youth and the family will have access to Intensive Placement Stabilization services provided by Kaleidoscope, regardless of catchment area in Chicago. The service array can include immediate crisis response. Flexible funds will be available for the purchase of services outside of the case management agency's current programming as necessary to meet the needs of the youth and family. Id.

Most youth who are identified as BMN move to a congregate care setting. Therefore, the theory of change for this pilot is that the provision of intensive and clinically knowledgeable consultation and coaching by stabilization consultants will enable caseworkers to resolve problems that otherwise would impede the youth from maintaining placement stability in a family-like setting. Exhibit OO, DCFS TRPMI Logic Model – Last Updated 1/12/17.

The pilot will be evaluated against a comparison group. The comparison group will be identified to show the impact of the services delivered for youth included as part of the BMN Pilot compared to BMN and other youth who were psychiatrically hospitalized and received post-discharge services as usual. DCFS will work with Chapin Hall to define the comparison group and will identify the comparison group by March 30, 2017. This comparison group will receive services as usual and may include youth that are already in specialized, adolescent or therapeutic foster home programs. Exhibit PP, Enhanced IPS Program Beyond Medical Necessity Pilot, January 3, 2017.

Since implementation of the amended pilot began in January 2017, three children have been identified to receive services through the pilot. Services that are being provided for these youth by Kaleidoscope since the implementation include: supportive care coordination provided by the stabilization consultant, mentoring and facilitation of Child and Family Team Meetings, IPS servicing and transportation to services and flexible funding when needed.

4. Revised Targets / Goals:

DCFS will amend the current contract with Kaleidoscope for Intensive Stabilization Services in light of the substantial changes that have been made to this initiative. Kaleidoscope must hire staff for this pilot and expects to post new positions for the Stabilization Consultants in January 2017. Exhibit PP, Enhanced IPS Program Beyond Medical Necessity Pilot, January 3, 2017, p. 5. The target date for hiring and necessary training to occur for the first stabilization consultant is March 31, 2017. Until then, no more than three youth will be served through the pilot. By April 30, 2017 it is expected that at least five new youth will be assigned to the pilot. Kaleidoscope will add a Stabilization Consultant for every five – eight BMN youth added to the BMN pilot. An end date for this pilot has not yet been determined and will be better defined based on the outcomes for sustaining community based services for these youth.