



Rhode Island Department of Children, Youth & Families

**State of Rhode Island and Providence Plantations
Title IV-E Demonstration Waiver
Federal Fiscal Year 2013 Application**

December 2012

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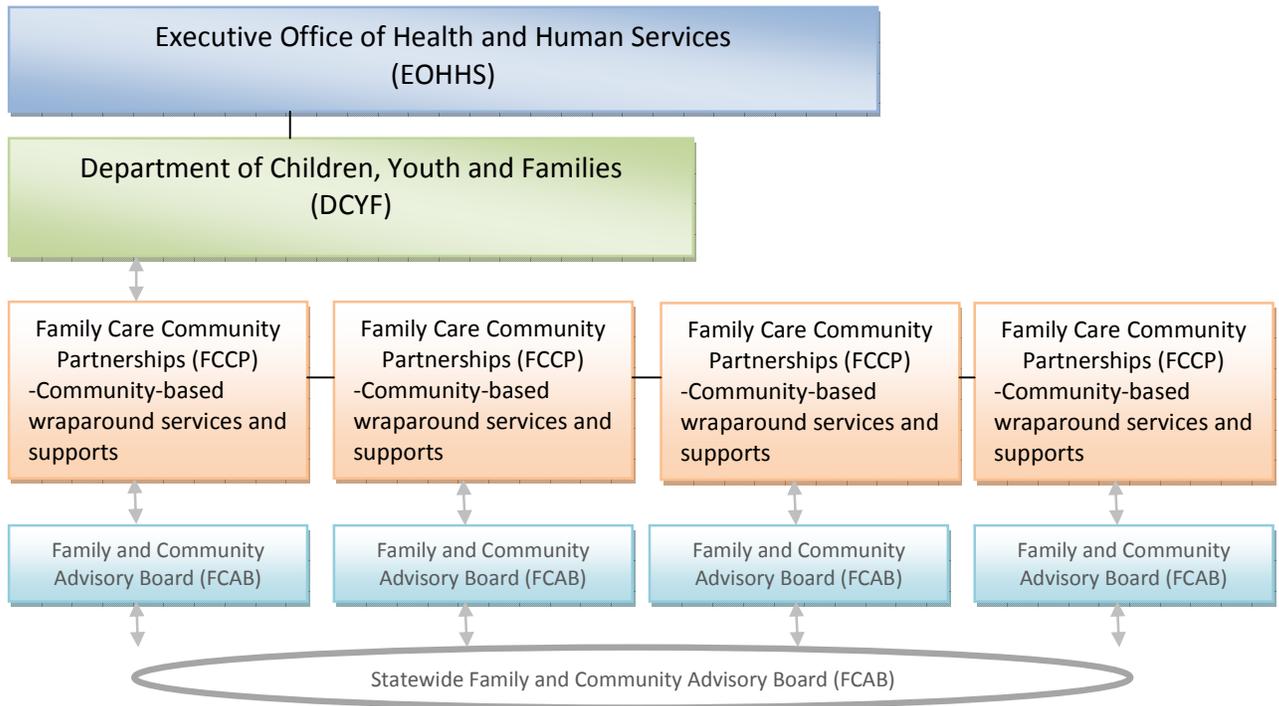
Background and waiver overview

The Rhode Island Department of Children, Youth and Families (DCYF) is guided by a strong vision that all children, youth, and families reach their fullest potential in a safe and nurturing environment. The Department was established in 1980 with the authority of the Rhode Island Legislature RIGL 42-72-5, which required state agencies to plan, develop, and evaluate a comprehensive and integrated statewide program. With this belief and founding authority, the Department has worked steadily through the years to fully develop and implement an integrated, family and community system of care (SOC) for children, youth, and families involved, or at risk for involvement, with the Department.

After initially developing a children's behavioral health SOC in the 1990s, DCYF implemented an integrated SOC serving children and families in the child welfare, behavioral health, and juvenile justice systems beginning in 2009. The integrated SOC was developed in successive phases that began in January 2009 and July 2012, respectively. The SOC was developed through a partnership among the agencies comprising the Executive Office of Health and Human Services, including DCYF, Department of Human Services (DHS), Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), Department of Health (DOH); the Rhode Island Department of Education (RIDE); the Rhode Island Family Court; family members, parent advocates, and other community stakeholders; community service providers, including social service agencies, behavioral health agencies, and children's psychiatric hospitals; and university partners, such as the Child Welfare Institute of Rhode Island College, the University of Rhode Island, Brown University, and the Yale University School of Medicine.

During the first phase of the SOC in 2009, DCYF established Family Care Community Partnerships (FCCP). The FCCPs provide effective community-based services and supports using a wraparound planning model to prevent family involvement with DCYF and to support family preservation and child well-being. Each FCCP has a Family and Community Advisory Board (FCAB), which are Regional Boards, with membership that includes youth and families, community partners, and stakeholders that support and guide SOC implementation, operation and continuous quality improvement (CQI). A Statewide FCAB also facilitates statewide collaboration, communication and advocacy for the four local FCABs.

Figure 1: Phase I of SOC Implementation



The goal of the first phase of the SOC was to support family preservation and well-being through the FCCPs as a diversionary program. During the first phase, the Department has seen a steady shift in the volume of families requiring DCYF intervention. As shown in Table 1 below, for each of the past four years there has been a steady decline in active caseloads and in the number of children in substitute care.

Table 1: Active DCYF Caseloads
Active Caseloads – Number of Children

As of December 31	2008	2009	2010	2011
# Active Caseloads	8,203	7,677	7,384	6,828
# Children in Substitute Care	2,654	2,331	2,293	1,988
# Children at Home	2,824	2,506	2,344	2,141

Concurrently, the number of children able to be maintained in their own homes under DCYF supervision was greater than the number of children placed in foster care each year. These trend lines represent steady progress for the Department, as throughout this period there was ongoing preparation with staff and the provider community toward greater emphasis on home and community-based services.

In the past three years, the FCCPs have demonstrated effectiveness in their ability to work with families to provide the necessary supports and services to keep families together, and to prevent families from being open to the Department. As a result, FCCPs

are now an effective, community-based resource for preventive services and a foundation for moving the Department towards enhancing and expanding the scope of the SOC for children and families who have more intensive needs.

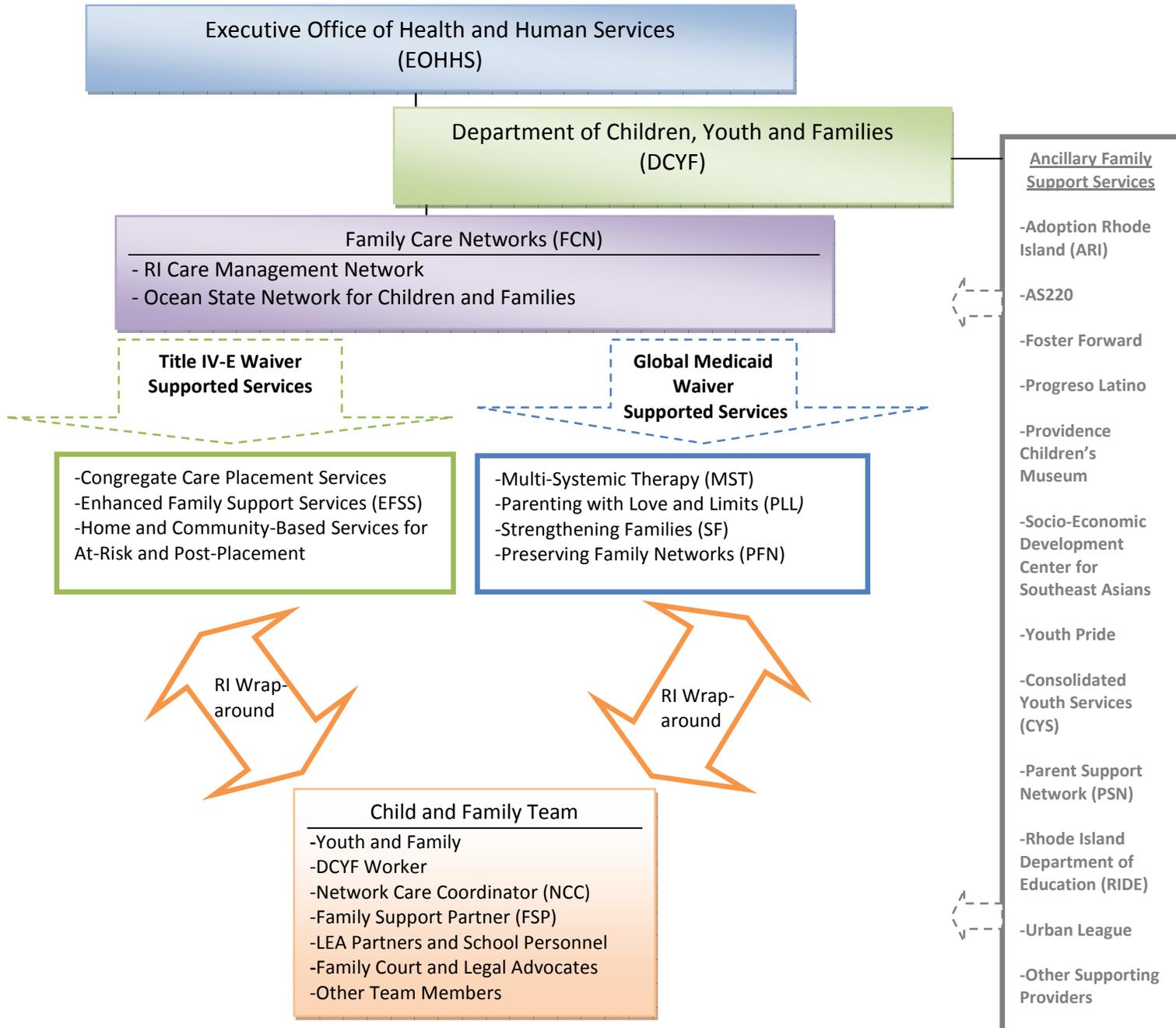
In this Title IV-E Waiver Demonstration Project, the Department intends to impact all three goals that appear in the Title IV-E statute. We intend to create a seamless System of Care joining together Phase I and Phase II of the SOC (Phase I is our FCCPs, Phase II is our Family Care Networks) with an emphasis on prevention and a focus on further reduction in congregate care.

In July, 2012, DCYF began implementing the second phase of the SOC by establishing two lead service networks, known as Family Care Networks (Networks), that would reduce reliance on congregate care services for children, youth, and families who are open to DCYF (See Figure 2). The goal of this phase of system reform is to rebalance the service delivery system for children in congregate care and treatment foster care. DCYF is working to achieve this goal by contracting for services with these newly-formed networks to provide an array of effective and appropriate community-based services and supports to children and families.

The Networks are responsible for contracting with the various agencies that provide an array of congregate care programs, including: shelter, group homes, residential treatment, intensive residential treatment, semi-independent living, independent living, and treatment foster care. The Networks also contract with agencies to provide community-based services to children and families who are transitioning from residential placements.

Two lead agencies – the Rhode Island Care Management Network, coordinated by Child and Family Service of Newport County, and the Ocean State Network for Children and Families, coordinated by Family Service of Rhode Island – provide leadership for the Networks. The Networks are responsible for overseeing placements and services for children in congregate care, in collaboration with DCYF case workers. Ancillary Family Support Services also contribute to the array of SOC community based services through the agencies and originations indicated in Figure 2 below. For more detailed information on the ancillary services currently supporting the SOC, please refer to Section 12.

Figure 2: Phase II of the SOC



The Networks also established Child and Family Teams to provide a Rhode Island Wraparound Service Model (WS) for identified children who are in, or have been in,

congregate care. WS was developed by the Networks and DCYF by leveraging the evidence from the Milwaukee model while altering the model to address specific Rhode Island realities. The WS process is a collaborative, team-based approach to service and support planning for children and families with serious or complex needs. The Child and Family Teams that provide WS include the child's family, along with natural, informal, and formal supportive individuals and service providers, including a Network Care Coordinator (NCC) and the DCYF worker. The DCYF worker and NCC are trained and experienced in a WS approach to services and have competency to engage and support families, provide care planning, and carry out service coordination tasks to address the varied needs of children, youth, and families.

Key objectives of the Networks are to ensure that children, youth, and families in need of intensive community-based services, as well as those experiencing congregate care, are able to achieve their permanency goal and be maintained safely in their own homes; to reduce out-of-home placement; to increase involvement with extended family and natural supports; and to enhance coordination of services.

2. Description of the demonstration project

DCYF will demonstrate that the flexible funding provided by the Title IV-E Waiver will allow for an expanded continuum of home and community-based supports for children that have been placed in congregate care and their families. Using federal fiscal year (FFY) 2009 as the reference year (see Section 10), DCYF will utilize the infrastructure the Department has established through Phase II of the SOC to provide children in congregate care with an integrated, child centric approach to the planning and provision of child welfare services, which could not traditionally be funded by Title IV-E. DCYF proposes a start date for the proposed Title IV-E Waiver demonstration project of October 1, 2012, assuming that DCYF is awarded a waiver in fiscal year 2013.

The SOC model that DCYF has established focuses first on ensuring that children and families with complex needs benefit from a coordinated care planning process. DCYF employs a WS approach that incorporates trauma-informed assessment tools, such as the Child and Adolescent Needs and Strengths (CANS) survey, to identify children's needs and to bring parents and community supports into the service planning process by implementing Child and Family Team meetings. The WS model approach is an evidence-based approach that establishes clear, structured service goals tailored to the family's needs and strengths, facilitates linkages with natural supports, and promotes family empowerment. Services provided are strengths-based and culturally-sensitive.

In January 2009, the State of Rhode Island implemented a Medicaid Global Consumer Choice Compact 1115 Waiver. This Medicaid waiver authority is designed to increase and improve home and community-based care while reducing residential, restrictive

settings for covered populations. For DCYF, the Global Medicaid waiver has provided an opportunity for flexibility to extend Medicaid reimbursement for services that were not previously Medicaid eligible. Two community-based services that are currently being reimbursed under the Global Medicaid Waiver are Multi-Systemic Therapy (MST), which is an evidence-based model, and Preserving Family Networks (PFN). Both are intensive level services designed to address the needs of youth with challenging behaviors within their home and community settings. These two services are part of the array of funded services in Phase II of the SOC. Referrals for these services can be made through the WS model in the Child and Family Team meetings. The Department sees an opportunity for maximizing the flexibility provided through both the Medicaid Global Waiver and the Title IV-E Child Welfare Waiver to complement and support the development and expansion of a full array of evidence-based and evidence-informed home and community-based services to meet the needs of DCYF's population.

The Title IV-E Waiver will support proven assessment and planning practices, as well as specific, evidence-based and evidence-informed interventions that will engender positive outcomes related to safety, permanency and well-being for children who are in congregate care or have been in congregate care. These practices will support more timely and successful permanency by reducing the number of children in congregate care. In addition, improving behavioral and mental health outcomes will reduce the number of high cost congregate placement settings DCYF uses.

DCYF will utilize the savings obtained from placement reductions in costly congregate care settings to expand in-home and community-based services for those children served through the SOC. Over the past several years, DCYF and Network providers have developed a continuum of services across graduated levels of intensity from residential to community-based services. These levels of care enable the SOC to tailor community-based services to the needs of children and families by offering a range of services and supports to maintain the children safely in their homes. As the number and intensity of placements continues to decline due to this demonstration, DCYF will continue to expand community-based supports and services for children transitioning from congregate care to their families, or to less restrictive placements. Improved outcomes for congregate care children and families will contribute to DCYF's outcome goals for all children and families that are involved with DCYF.

What is the problem or issue the demonstration project is expected to address?

Children who have been removed from their homes and placed in congregate care lack family placement resources or require a level of service in conjunction with placement that non-congregate placement settings are not equipped to provide. As a result, children in congregate care have historically posed a unique challenge because DCYF has had to provide a higher level of service in settings that were removed from the child's community and regular system of supports. Prior to the establishment of the Networks,

the Department had multiple contracts with dozens of provider agencies to provide the array of congregate care services for DCYF-involved children and youth. The differing programs and multiple contracts among varied providers created a somewhat fragmented service delivery system.

Reimbursement requirements in funding for congregate care settings created additional problems. Historically, DCYF could only use Title IV-E funding to support the placement portion of congregate care; thus, additional services were supported either with state funds or were identified as eligible for reimbursement through Medicaid. These funding restrictions and detailed eligibility criteria for Title IV-E and Medicaid reimbursement have worked against the Department's interest in reducing residential placements and providing needed home and community based supports to the most vulnerable children and families. The flexibility in funding necessary to support rebalancing the delivery of services has only recently been made available through the Medicaid Global Waiver and is not currently available through Title IV-E, thereby creating systemic barriers to sufficiently develop effective alternatives to congregate care for children and their families.

DCYF anticipates being able to use the Title IV-E Waiver to maximize the benefit of an array of home and community-based services that will be offered in conjunction with behavioral and mental health services that are supported by the Global Medicaid Waiver. Through the WS, an array of home and community-based services will be provided, including regular support services and a selection of evidence-based interventions that will offer the greatest potential for reducing DCYF's reliance on congregate care settings. Savings that are associated with reducing costly placements will be reinvested to expand in-home and community-based services for children transitioning from congregate care settings, as well as to prevent identified youth from needing higher levels of residential placement services. The flexibility of the Title IV-E Waiver funds will be particularly beneficial in helping to support the initial stages of establishing evidence-based service models.

The Hypothesis that will be tested through the implementation of the program evaluation

Under the waiver, flexible funding will allow DCYF to expand the continuum of home and community based supports provided to children and families served by the SOC through WS and other evidence-based/evidence informed interventions. The following outcomes will be achieved:

- Reduce the number of children in out-of-home placements,
- Increase permanency,
- Reduce re-maltreatment, and
- Improve indicators of child and family well-being.

How is the project innovative and how will it foster improved child and family well being

The interventions that DCYF provides through the SOC are innovative, in that they go well beyond child welfare maintenance services and integrate behavioral health services into a coordinated care model for children and families. DCYF will be able to support the SOC as well as these interventions through a braided funding model that utilizes state dollars, Title IV-E Waiver funds, and Rhode Island's Global Medicaid Waiver. Flexible waiver funding and the SOC remove many of the funding barriers that have historically restricted cross-agency collaboration and prevented child and family services agencies from providing families with an integrated service delivery approach that addresses the variety of factors adversely affecting their lives. DCYF will utilize the flexible funding afforded by the Title IV-E Waiver to fund the child welfare components of a system of care that incorporates leading evidence based/informed interventions, as well as collaborations with a variety of state and community agencies.

The waiver demonstration that DCYF is proposing will utilize a collaborative structure of joint planning and decision-making in which families, DCYF, and community partners will integrate phases and activities of a WS process in a Child and Family Team structure. The team will complete a comprehensive assessment of family strengths, needs, and cultural context; identify goals and priorities for change; and develop a family care plan that addresses safety, permanency, and child and family well-being.

The team will help the family to identify and utilize natural and community supports, and to select appropriate service providers. The team will also assist in the development of a crisis management plan to obtain necessary emergency services and supports in the event of future family crises and ongoing risk management. Since children in DCYF placement have their medical and behavioral health needs covered through the State's Medicaid managed care plan, Neighborhood Health Plan of Rhode Island (NHPRI), the team will also ensure that medical and behavioral health needs of children in the SOC will be addressed by NHPRI in coordination with other clinical services provided by the residential programs. In addition, the team will assist the family in accessing needed clinical and other supportive services through identification of appropriate resources and other funding mechanisms.

Team members will share responsibility for coordinating those clinical services with the other services and supports in the family care plan.

The roles of Child and Family Team members are described below.

- **Child, Youth, and Family** - The child, youth, parents, and other natural supports are actively and affirmatively involved in the design and

implementation of the family care plan unless it is determined that child maltreatment or other family issues rule out their participation. Family is defined broadly and includes relatives and other caregivers. The family selects other members of the Child and Family Team to support the goals established in the family care plan.

- **DCYF Worker** - The assigned DCYF Family Service Unit (FSU) or Juvenile Correctional Services (JCS) worker serve in the important role of case manager, leading the Child and Family Team with the assistance of the Network Care Coordinator (NCC). The roles of the DCYF worker and the NCC are coordinated and complementary. The DCYF staff person has the authority and responsibility to ensure that legal obligations relating to the child's involvement with DCYF and required activities on the part of the parent(s) to ensure safety are implemented. The DCYF worker also ensures that the family service plan and the crisis management plan satisfactorily address the safety, permanency, and well-being of the child as well as the safety of the community. The team shares the responsibility for the successful implementation of the family service plan. The DCYF worker further ensures that family members, providers, and all other team members are fully informed of progress in the case and changes in the legal status. Any other DCYF staff person who is working with the child and family, including a Permanency Unit staff, may also be a member of the Child and Family Team. The DCYF staff person coordinates all communication with the Family Court.
- **Network Care Coordinator (NCC)** - The NCC briefs all parties on the purpose and format of family team meetings, schedules meetings based on family preferences, and serves as WS facilitator. The NCC facilitates effective communication and validates strengths and concerns of all parties. The NCC also works to achieve consensus among members in the development of the crisis management plan and the family care plan and follows up with all parties to make sure that identified services and supports are provided. In addition, the NCC keeps the DCYF worker and all members of the team informed of the status of the family's engagement with the provisions of the family care plan.
- **Family Support Partner (FSP)** - The FSP serves as a peer mentor, with a primary role of empowering the family towards self-efficacy. The FSP also participates in the WS process at the request of the family and provides the direct supports identified in the family care plan. The FSP has experience as a member of a family who was involved with DCYF and/or experience raising a child with serious emotional disturbance (SED) or a developmental disability (DD). Additionally, the FSP has the acquired knowledge and competencies

needed to effectively support another parent or caregiver and WS training and certification.

- **LEA Partners and School Personnel** - The school representatives on the team are actively involved in the child's learning, support, and/or advocacy. This may be someone the family identifies as having taken an interest in the child's educational success. Examples of school personnel may include, but are not limited to: coach, classroom teacher, social worker, psychologist, nurse, educational surrogate, Positive Behavioral Interventions and Supports (PBIS) coach, resource teacher, principal, or educational advocate. This individual has reasonable authority to influence the school-based plan and ability to provide insight regarding strength-based approaches to behavior and success across life domains.
- **Family Court and Legal Advocates** - The legal representative of parent and child, including court appointed legal guardian, may be a member of the Child and Family Team. The Court Appointed Special Advocate (CASA) representative or the Child Advocate has the uniquely important role of ensuring that the best interest of the child is considered throughout the Child and Family Team process.
- **Other Members of the Child and Family Team** - Other members of the team vary according to the family's needs and preferences, but include formal, informal, and natural supports. With the assistance of the WS facilitator, the family may invite the participation of foster care providers, advocates, friends, neighbors, extended family members, faith-based community members, and informal and natural supports who can contribute to safety and permanency of the child and well-being of the child and family.

The service planning process that the agency uses actively explores and encourages the use of natural community supports as an important component of the family care plan. This approach promotes family voice and choice while ensuring that child safety is the paramount concern in decision-making relating to service provision, placement, and permanency planning.

WS involves a specified intervention process and is designed to promote consistent application of "common elements" of evidence based care (e.g., engagement, alliance, structured teamwork, and progress monitoring)¹ implemented in four phases. **Engagement** involves forming a WS team composed of family members, a facilitator,

¹ I Barth RP, Lee BR, Lindsey MA, et al. Evidence-based practice at a crossroads: The timely emergency of common elements and common factors. *Research on Social Work Practice*, 2012, 22: 108-119.

service providers and informal supports (e.g., relatives, and advocates) to develop and implement a family service plan. The team works to identify family strengths and needs and connect the family with critical services to stabilize initial crises and ensure child safety. **Plan development** involves drafting an integrated family service plan incorporating family strengths and needs, prioritization of family goals, and identification of formal and informal services and supports to address needs and priorities. The plan is enacted during the **implementation phase**. Family service plans focus on engaging families with an array of home- and community-based supports (e.g., outpatient or home-based therapy, parent education, respite, educational supports, and preparation of older youth for adulthood) to meet individualized priorities, as well as use of flexible funds to access other supports.² The team regularly reviews progress, assesses family satisfaction, and modifies the plan as needed. As the family prepares for **transition**, the team identifies necessary services and informal supports to assist with ongoing needs after WS concludes. Although some families do not engage in WS, they still have access to the full range of services available in the system of care but without the team-based planning and service coordination process.

The Networks have built a comprehensive network of accessible formal and informal services and supports, including residential and home-based services that will strengthen and support the home setting during and following out-of-home placement in a congregate setting. The Networks will integrate WS principles into the service delivery networks, which include strong partnerships with educational, health, and other entities in order to improve stability and success. The partners will also expand the continuum of available services for children and families and will work with DCYF to achieve reunification and other permanency goals in a timely manner. DCYF, the Networks, and their community partners will utilize the following service delivery principles to improve the well-being of children and their families while they are in congregate care and while they are in their homes:

- **Trauma-informed:** Recognizes and understands trauma and its consequences and incorporates this knowledge into all aspects of service delivery.
- **Interagency Collaboration:** Engages child and family serving agencies from the public, private, and community sectors.
- **Individualized Strength-based Care:** Acknowledges each child and family's unique set of strengths and challenges and builds care plans that optimize those strengths while meeting the challenges.
- **Cultural and Linguistic Competence:** Refers to a defined set of organizational values and principles, as well as behaviors, attitudes, policies, and structures that enable systems to work effectively cross-culturally.

² Winters NC, Metz W. The wraparound approach in systems of care. *Psychiatric Clinics of North America*. 2009;32:135-151.

- **Family and Youth Involvement:** Requires mutual respect and meaningful partnership between families and professionals at all levels.
- **Community-based Services:** Engaging home, school, and community-based resources that are flexible and responsive as the optimal method for providing care and support to children and families.
- **Accountability:** Refers to the continual assessment of practice, organizational, and financial outcomes to determine the effectiveness of services in meeting the needs of children and families.

3. Describe how the project will meet the following goals identified in statute

DCYF has worked closely with our state and local partners since 2009 to develop the SOC framework that will allow DCYF to quickly implement evidence-based/informed interventions that will result in the following outcomes detailed in the Child and Family Services Innovation and Improvement Act:

1. Increase permanency for all infants, children, and youth by reducing the time in foster care placement when possible and promoting a successful transition to adulthood for older youth.
2. Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infant, children, and youth.
3. Prevent child abuse and neglect and the re-entry of infants, children and youth into foster care.

The department has highlighted how we plan to measure the outcomes against these goals in Section 9 and 10.

4. The target population that the agency wishes to serve

Children that are in need of intensive community based services, children that are in or have been in congregate care and their families will be the target population of the Title IV-E Demonstration Waiver. The term congregate care will include children, and the families of children that reside, or have resided in the following settings, and are likely to receive aftercare services:

- Residential (includes Emergency Shelter Residential and Intensive Residential Treatment)
- Group Home (Staff Secure)

- Group Home (Non-Staff Secure)
- Semi-Independent Living
- Treatment Foster Care
- Independent Living

These children will primarily but not exclusively be between the ages of 6 to 18

Estimate of the number of children or families who would be served by the proposed project

In the first year of implementation DCYF expects to serve approximately 1,600 children and families across congregate care, including community based aftercare services. The range of the intervention services provided will all include WS, but may also be supplemented by other evidence-based/informed services based on the individual needs of the child and family. Services for the child and family will be coordinated through the Child and Family Team as described earlier. Child and Family Teams are facilitated by Network Care Coordinators (NCCs). Each Network will have three NCC teams in the first year, and each team consists of six Network Care Coordinators, two Family Support Partners (FSPs) and one supervisor/coach. Each NCC team is expected to be able to provide WS facilitation support for up to 90 children/families.

As feasible and appropriate, the Department will incrementally increase the number of WS and NCC teams throughout the course of this Title IV-E Waiver to accommodate the need for services in the target population.

Estimated number of Title IV-E foster cases involved

Estimates of target population characteristics for the Title IV-E Waiver provide detailed information about demographic information, maltreatment incidence, placement stability, and various child and family risk factors that will be used in system planning. These estimates and other data analyses are available through the Rhode Island Data Analytic Center, a public-academic partnership between DCYF and the Yale School of Medicine that was established to provide evaluation, quality assurance, and data analytic capacity to DCYF and the SOC.

Based on a recent Data Analytic Center study we completed of children in foster care, there is an average of 2,345 children in Rhode Island who enter foster care each year.³ Of this total, approximately 67 percent, or 1,571 children, will receive some form of congregate care services in a given year as defined by the target population categories

³ *Understanding Risks for Long Term Foster Care Placement: A Statewide Cohort Analysis*. Rhode Island Data Analytic Center Research Brief, 2011.

above. Of children receiving congregate care services, 34 percent, or 524 children/youth, are Title IV-E eligible. We anticipate that this will be a lower estimate of the number of Title IV-E cases involved in the waiver demonstration in a given year.

Most of these cases represent a child receiving WS in one of the Networks of the SOC. These children and families experience many challenges as our recent study of long-term foster care families shows. More than 51 percent of these children have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis or a disability/medical condition that increases their odds of long-term foster care by more than 80 percent. Importantly, several types of evidence-based practices have been found to be effective in promoting well-being with children in long-term foster care, including WS.³

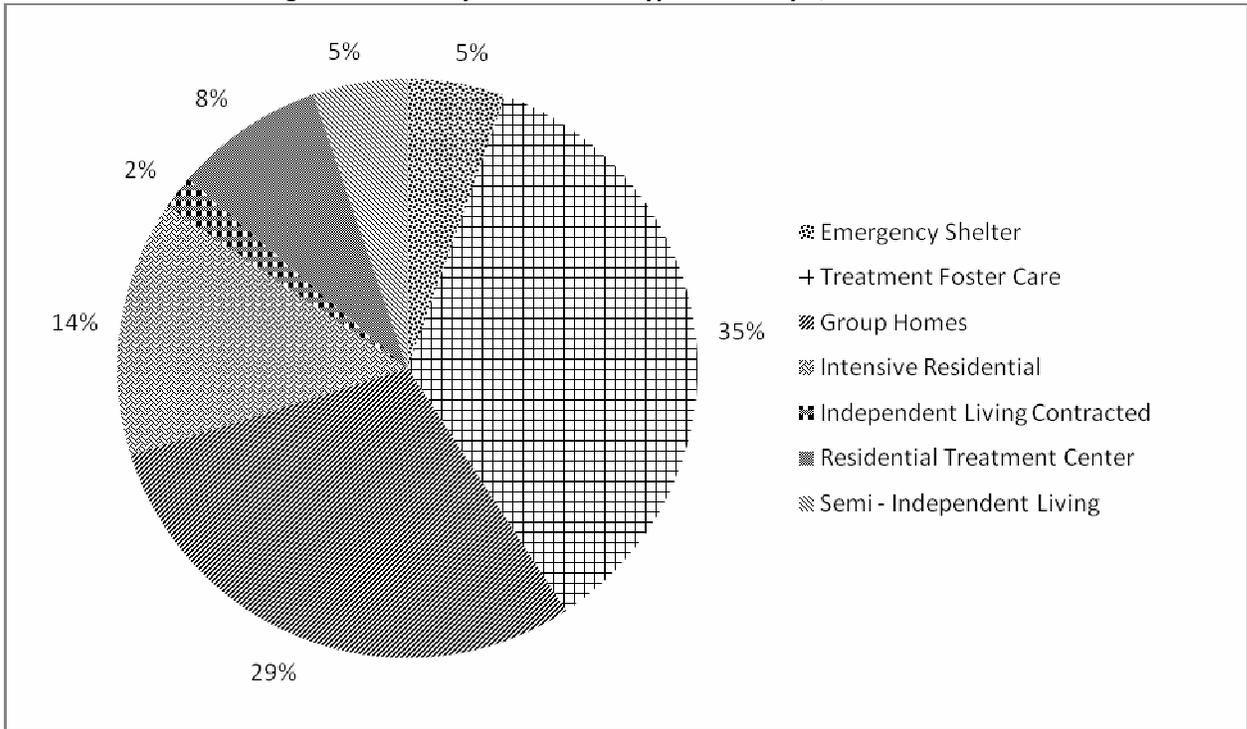
The service needs, risk status, and functioning of children likely to receive congregate care services were the focus of a second recent Data Analytic Center study. We examined multi-sector service use among children open to DCYF and its relationship to child risk status and functioning. Multi-sector service use occurs when a child who is currently receiving one major type of service, such as mental health services, also receives other types of services, such as educational, juvenile justice, or medical services. For this study, we drew a random sample of 218 children from all children open to DCYF child welfare services during a 4-month period from May to August 2011. Among this group of children in congregate care, 86 percent received some form of multi-sector services, thus demonstrating why a SOC approach, and particularly WS, is critical to ensuring that children receive integrated and coordinated services that they need across major sectors of service.

Service Mix of Target Population

Figure 3 provides a snapshot of the types of placement for children receiving congregate care services, with more than one-half (58 percent) receiving services in some form of residential setting (includes Emergency Shelter, Group Homes, Intensive Residential, Residential Treatment Center).⁴

⁴ System of Care Budget Estimate - FY 2013. DCYF. Represents congregate care data as of 7/1/2011.

Figure 3: Summary of Placement Types as of July 1, 2011



The target population also receives an array of additional mental health, educational, medical, and other services. As Table 2 below shows, as many as 44 percent of children identified at mild risk (the lowest risk category available) using a standard measure of functioning (e.g., the CAFAS), received multi-sector services; higher levels of risk were associated with a greater need for multi-sector services.

Table 2: Risk Status and Rates of Multi-Sector Service Use for Children Open to DCYF and in Congregate Care*

Service Type	Child Risk Status Based on CAFAS-C Functioning			
	Mild (n = 9)	Moderate (n = 12)	Severe (n = 15)	Extreme (n = 25)
Multi-Sector Service Use	44.4%	75.0%	80.0%	100.0%
Mental Health Service Use	55.6%	83.3%	86.7%	100.0%
Educational Services Use	33.3%	41.7%	73.3%	92.0%
Juvenile Justice System Service Use	55.6%	25.0%	40.0%	36.0%
General Medical Service Use	0.0%	33.3%	26.6%	68.0%

* Based on a random sample of 218 children open to DCYF and in congregate care during May-August 2011.

Taken together, these two recent sets of analyses provide strong evidence to support the estimated size of the target population to be served through the Waiver - and also

suggest that a comprehensive WS model has the potential to be an effective approach to address the needs of children in congregate care.

Demographic information

Rhode Island’s Child Welfare Context Data, submitted as part of the federal Safety, Permanency, and Well-Being Report, profiles the general population of children under the age of 18 and the number of children/youth involved with DCYF in which maltreatment was indicated. These data offer the Department an opportunity to track its performance quantitatively with respect to trends impacting the number, age, and race/ethnicity of children/youth involved in investigations where there is an indication of maltreatment, and the number of cases opening to the Department as a result. Each year the Data Analytic Center prepares a Child Welfare Outcomes Report and related addenda for the Department to ensure that all population estimates are consistent with the federal methodology used to generate the Safety, Permancy, and Well-Being Report submitted to the Children’s Bureau.

The information presented in the following tables represents the Child Welfare Outcomes Annual Report for SFY 2011, based on NCANDS and AFCARS data submitted to the Administration for Children and Families (ACF). Table 3 below provides an overall summary of the population in our care in terms of race/ethnicity, type of abuse, and age demographics. As the table demonstrates, an overwhelming number of the children in our care and custody are victims of neglect.

Table 3: Summary of Rhode Island Child and DCYF Population

RI General Child Population		DCYF Child Population Demographics	
Total children under 18 years	223,956*	Victims of Child Abuse and/or Neglect	3,438†
Race/ethnicity (%)		Type of Abuse:	By Age:
Native American	<1%	Neglect – 87.8%	Under 1 – 14.5%
Asian/Pacific Islander	3%	Physical – 16.1%	1-5 Yrs. – 36.6%
Black/African American	8%	Sex – 4.3%	6-10 Yrs. – 24.1%
Hispanic	20.5%	Medical Neglect – 2.6%	11-15 Yrs. – 19.2%
White	72%	Emotional – .1%	16 + – 5.6%
%Child population in poverty	19% ⁵	Other – 1.0%	Unknown – 0.1%

* Rhode Island Child Population, U.S. Bureau of Census, American Community Survey 2010

† Source: Child Welfare Outcomes Report, Rhode Island Data Analytic Center, 2011. Center at Yale University

⁵ 2012 Rhode Island KIDS COUNT Factbook/Economic Well-Being.

Child welfare status and history (e.g. substantiated reports of abuse and neglect, foster care status, lengths of stay in care)**Child Maltreatment**

Table 4 on this and the following page shows the relatively steady decline in maltreatment numbers over the past five years and relatively stable rates during that time by age and race/ethnicity. The table does show slight increases in physical abuse and medical neglect, and slight decrease in sexual abuse during this period. It is important to note that the number of maltreatment reports remained level.

Table 4: Maltreatment Cases by Age, Race/Ethnicity, and Type (2006-2011)

Age of Victims (%)⁶	2006	2007	2008	2009	2010	2011
Under 1	12.0	13.8	15.3	15.1	14.8	14.5
1-5 years	32.3	31.5	34.3	36.2	36.6	36.6
6-10 years	26.9	25.3	26.8	25.4	24.6	24.1
11-15 years	22.2	23.4	18.4	18.2	18.3	19.2
16+ years	6.7	5.7	5.2	4.8	5.7	5.6
Unknown	0.1	0.2	0.1	0.2	0.0	0.1
Total %	100	100	100	100	100	100
Number	4,400	3,857	3,082	3,065	3,632	3,438
Race/Ethnicity of Child Victims (%)	2006	2007	2008	2009	2010	2011
Alaska Native/Amer. Indian	0.6	0.5	0.4	0.5	0.8	.04
Asian/Pacific Islander	1.5	1.8	.8	1.7	0.8	1.0
Black (non-Hispanic)	12.3	11.4	12.1	9.3	11.2	11.0
Hispanic (of any Race)	21.0	24.2	22.3	22.5	23.1	22.6
White (non-Hispanic)	55.5	52.4	53.1	53.8	51.6	51.1
Two or more races	4.8	4.9	6.5	6.0	6.5	6.8
Unknown	4.3	4.8	4.7	6.1	6.1	7.1
Total %⁷	100	100	100	100	100	100
Number	4,400	3,857	3,082	3,065	3,632	3,438

⁶ Child Welfare Outcomes Annual Report, Rhode Island Data Analytic Center, 2011.

⁷ Percentages may total more than 100 because Hispanics may be counted both by Hispanic ethnicity and by race.

Maltreatment Type of Child Victims (%)	2006	2007	2008	2009	2010	2011
Emotional Abuse	0.1	0.1	0.1	0.1	0.1	0.1
Medical Neglect	1.5	1.7	1.5	1.3	2.0	2.6
Neglect	85.7	87.5	87.4	85.2	88.1	87.8
Physical Abuse	12.5	9.3	9.9	13.2	15.9	16.1
Sexual Abuse	5.7	5.6	5.2	3.9	4.5	4.3
Other	1.0	1.4	1.1	1.6	0.9	1.0
Total % ⁸	106.5	105.6	105.2	105.5	111.5	111.9
Number	4,400	3,857	3,082	3,065	3,632	3,438

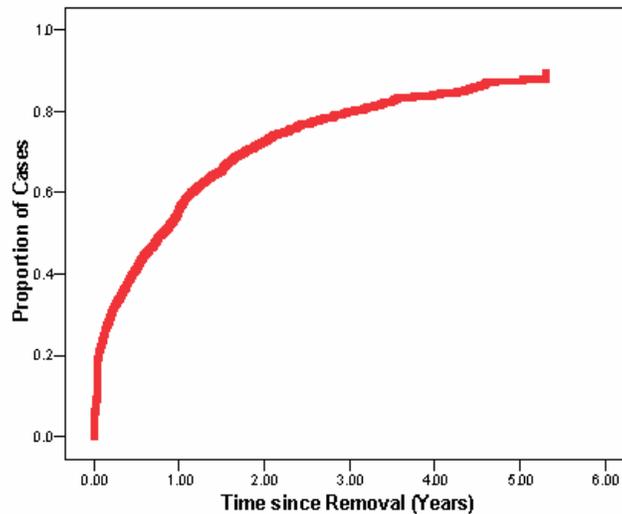
Placement Stability

Within the population of children and families that are open to DCYF, those in congregate care represent one of the most challenging groups to maintain in a stable, permanent placement. The child welfare status and history information included on the following page, demonstrates both the need for services promoting well-being for children while in care, as well as services for children and families at the time of reunification to prevent re-maltreatment and re-entry into care.

As is shown in Figure 4, almost 20 percent of children are reunified with their family shortly after they are removed, with about 40 percent reunified after about 6 months. Within 2 years, almost 70 percent of children are reunified with their families, and the rate of reunification levels off at that point.⁹ Although this particular figure is drawn from our original analysis of this data in 2004, the pattern of removals has been consistent for the past 8 years. Our analysis further indicated that compared to children placed in a relative foster care home, those in a non-relative foster care home or residential facility or group home were about 15 percent more likely to exit to reunification. Children in shelter placement were 80 percent more likely to be reunified.

⁸ Percentages may total more than 100 because children could have been victims of more than one type of maltreatment.

⁹ *Foster Care Exits to Reunification: Impact of Child & Case Characteristics*, Rhode Island Data Analytic Center, 2004.

Figure 4: Length of Stay in Foster Care for Children Reunified to Family¹⁰

DCYF will utilize the SOC to provide children and families with the supports they need to address trauma and improve well-being while the child is in care, as well as services to promote household stability and create a safer environment to which children can quickly return.

It is our goal to return children in congregate care to stable homes that are supported by evidence based interventions provided through the SOC. DCYF has established the SOC to be in line with the goals set forth in the ACF Child and Family Services Review (CFSR), particularly as they related to the rate of re-entry into foster care.

Although Rhode Island met the annual objectives in its Program Improvement Plan (PIP), which establishes incremental goals, our state continued to exceed the national one-year standard for re-entry into foster care. Table 5, from the most recent CFSR, summarizes differences between new entries to foster care and those re-entering within 12 months of discharge from a previous episode. The largest percentage of children re-entering care after 12 months are children in group homes (at a rate of 54.4 percent) and children in non-relative foster homes (at a rate of 26.1 percent). The table also shows that youth between the ages of 11 to 15 years old re-enter care at a higher rate. A significant percentage of these children re-enter care due to behavioral health issues that result in court orders.

¹⁰ *Foster Care Exits to Reunification: Impact of Child & Case Characteristics*, Rhode Island Data Analytic Center, 2004.

Table 5: Summary of CFSR Findings on Rate of Re-Entry by Demographic (2008 – 2009)

	New Entries	12-month Re-entries
Mean age	8.7 years	11.6 years
Age Categories		
0-1 years	23.7%	7.9%
2-5 years	13.7%	14.2%
6-10 years	13.3%	7.9%
11-15 years	33.1%	42.5%
16+ years	16.2%	27.7%
Gender		
Male	53.8%	50.3%
Female	46.2%	49.7%
Race/Ethnicity		
White	46.8%	50.3%
African American	17.8%	15.1%
Hispanic	22.6%	17.0%
Native American	0.7%	0.3%
Asian/PI	2.1%	0.9%
Unknown	10.0%	16.4%
Diagnosed Disability	20.8%	37.1%
Diagnosed Emotional Disorder	13.3%	31.8%
Other Medical Condition	9.4%	12.6%
Reasons for Removal		
Neglect	43.1%	25.8%
Physical Abuse	5.5%	2.5%
Sexual Abuse	3.4%	1.6%
Child Disability	2.7%	3.1%
Child Behavior Problem	35.6%	57.2%
Alcohol Abuse (parent)	8.2%	6.0%
Drug Abuse (parent)	23.0%	12.3%
Current Placement Setting		
Relative Foster Home	24.8%	13.8%
Non-Relative Foster Home	31.7%	26.1%
Group Home	40.9%	54.4%
Institution	1.1%	2.5%
Runaway	1.5%	3.1%

The WS intervention that DCYF will implement through the SOC for this Waiver demonstration will provide support for families to address the challenging behaviors of youth and target factors in the home that increase risk for re-maltreatment and re-entry into care. DCYF has selected the evidence based and evidence supported interventions detailed in Section 7 to address the needs of the target population for the Title IV-E Demonstration Waiver.

The need for home and community based supports following reunification is further indicated by a Data Analytic Center study that examined re-maltreatment following

reunification. This study found that about 23 percent of children that were reunified with a parent, relative, or guardian are substantiated for maltreatment within two years of exiting foster care. The risk for maltreatment following reunification is highest immediately upon return home and decreases over the first seven months.¹¹ Reducing the occurrence of re-maltreatment in Rhode Island is a primary focus for DCYF as we serve children and families through the SOC and work to improve safety, permanency and wellbeing.

Other identified risk factors of the target population (e.g. parental substance abuse)

The Data Analytic Center has also identified child and family risk factors experienced by families served through the SOC. Examination of performance indicators for eight outreach and tracking programs funded by DCYF in 2010 indicate numerous presenting problems faced by the target population. Outreach and Tracking programs are one of the community-based services that are now provided through the Networks and the Department receives Medicaid reimbursement for these services. Services include individual, group, and/or family counseling; recreational activities; culturally enriching experiences; crisis response services; and linkages to educational, vocational, and/or rehabilitation services as necessary.

The following indicators represent the key risk factors facing children and families receiving Outreach and Tracking services:

- Among children and youth served: school problems (59 percent), behavioral problems (42 percent), out of parental control (32 percent).
- Among families served: school problems (48 percent), family stress (42 percent), youth behavioral problems (37 percent), self-reported parenting problems (35 percent), and financial problems/unemployment (26 percent), Family Violence/Stress (21 percent), Self-Reported Parental Alcohol/Drug Use/Abuse (18 percent).
- Also, the majority of children and youth served (62 percent) were discharged from services within the same year, and most of these (66 percent) to a parent or guardian in the home.¹²

DCYF believes that the flexible funding afforded by the Title IV-E Demonstration Waiver will allow the Department and our partner agencies to expand the array of such high impact services with other evidence-based/informed interventions, not previously funded through traditional Title IV-E. The enhanced array of services will increase

¹¹ *Re-maltreatment following Reunification: Predictors of Subsequent CPS Contact after Children Return Home*, Rhode Island Data Analytic Center, 2006.

¹² Performance Indicator Report for Youth Outreach and Tracking Programs, Rhode Island Data Analytic Center, 2010.

opportunities for children in congregate care to transition by providing effective community-based intervention alternatives. The specific interventions the SOC will utilize are detailed in Section 7 below and indicate the target ages and characteristics of children, youth, and families that are best serviced by each specific program.

5. Geographic areas in which the proposed project will be conducted

The proposed Title IV-E demonstration project will be conducted throughout the State of Rhode Island and Providence Plantations.

6. Service interventions to be implemented

Indicate whether the proposed interventions are evidence-based or evidence-informed. Describe why the proposed interventions were selected to meet the needs of the identified target population and why these will increase permanency.

As part of the SOC, evidence-based services have been incorporated into the service delivery to improve the outcomes of the SOC target population. These interventions were chosen as a priority in that they target the emotional, behavioral, and therapeutic needs of children in congregate care. The intended goal is to shorten the length of stay, prevent re-entry or prevent removal, and support the general well-being of the children and families that DCYF serves.

- **Enhanced Family Support Services (EFSS)** is a family-focused, strengths-based model that incorporates evidence-based and evidence-informed practices, including trauma-informed treatment, in order to assist children, youth, and families with stabilizing family relationships; improving individual and family functioning; and helping parents/caregivers to develop the skills necessary for ensuring the safety, health, and well-being of all family members. Through a combination of individualized clinical services and intensive, directive, and structured casework, EFSS seeks to engage all family members, natural supports, and relevant community members and institutions in working towards the family's individualized short- and long-term goals. The primary objective of this coordinated, multi-systems intervention is to maximize the family's independence and the ability of its members to function effectively in their own home and community.
 - *Evidence Informed:* EFSS was previously developed by the Rhode Island Care Management Network to meet the presenting needs of children/youth with flexibility to ensure appropriate services for youth

who do not fit a prescribed model for service intervention. EFSS is currently in use by both Networks.

- **Rhode Island Wraparound Model (WS)** is intended to ensure that children and families with complex needs benefit from a coordinated care planning process. During the WS process, a team of individuals who are relevant to the well-being of the child or youth (e.g., Child and Family Team) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time.
 - *Based on Promising Research Evidence*¹³
- **Multi-Systemic Therapy (MST)** addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources. MST is delivered in the natural environment (in the home, school, or community). The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring weekly. MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral and pragmatic family therapies.
 - *Well Supported by Research Evidence*¹⁴
- **Parenting with Love and Limits (PLL)** provides service for out of home child/youth in a therapeutic residential setting and those that are moving to a foster home or being reunified at home with the continuation of PLL. The PLL program has demonstrated a reduction in length of stay. The target population is youth from the age of 12 through 17 in DCYF therapeutic residential placement with goal of shortening length of service in residential placement.
 - *Supported by Research Evidence*¹⁵
- **Strengthening Families (SF)** is focused on reunification to home or step-down to foster home from congregate care settings. The Strengthening Families model

¹³ The California Evidence-Based Clearinghouse for Child Welfare; January 2011

¹⁴ The California Evidence-Based Clearinghouse for Child Welfare; January 2011

¹⁵ The California Evidence-Based Clearinghouse for Child Welfare; July 2012

focuses on transitioning children/youth from residential placements to community-based care with additional work on identifying and employing protective factors for parents and children in order to prevent child maltreatment and improve family resiliency and stability. Core services include 24-hour crisis intervention, basic needs, informal counseling, time-limited psycho-educational groups, recreational supports, and respite. Strengthening Families will be provided to youth of all ages in congregate care.

- **Preserving Family Networks (PFN)** is a program that integrates with MST to provide community-based outreach to participating youth and families. Services include individual, and/or group family counseling; vocational/rehabilitative services as deemed necessary; recreational and other culturally enriching experiences; transportation to services; linkages to education; assessments and evaluations necessary to design preliminary and full treatment plans; and in-home professionally administered respite services. PFN also offers transitional services, as necessary, to help prepare a youth and their family during the transition phase of moving from residential or hospital placement to home.

DCYF plans to incorporate additional interventions as the SOC implementation evolves and cost-savings are realized to reinvest flexibly in new programs. Potential programs being considered for later in the waiver include:

- **Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT)** is a short-term treatment approach designed to address the special needs of the family systems' with parents who have demonstrated a lack of necessary skills and parenting practices for children/youth with behavioral health needs. Individual and family therapy sessions to compliment the non-traditional process approaches. For this initiative, the target population would be youth age five through 18 to prevent out of home placement.
 - *Promising Research Evidence*¹⁶
- **Multi-Systemic Therapy-Child Abuse and Neglect (MST-CAN)** is a program that provides service for out-of-home children and youth and their families with an additional focus on improving parenting skills in support of reunification efforts and the continued placement of the child/youth in his/her community. Core services include assessment, 24-hour crisis intervention, parent management training, home and community-based services and other family supports, substance abuse treatment, school consultations, and individual and family therapies. The target population is youth age 12 through 17 currently placed in a congregate care setting with the goal of reunification to home.
 - *Supported by Research Evidence*¹⁷

¹⁶ The California Evidence-Based Clearinghouse for Child Welfare; February 2012

- **Functional Family Therapy (FFT)** is a short-term, clinical treatment focused on empowerment strategies to engage child/youth in activities with their family to improve functioning and behavior in multiple settings. Core services include: traditional and non-traditional approaches guided by master's level clinicians; family therapy focusing on family communication and dynamics, and the relationship to the child's medical and mental health needs.
 - *Supported by Research Evidence*¹⁸

DCYF recognizes that other interventions will be identified over the course of the waiver. Since April 2012, DCYF and the Networks have been working the Annie E. Casey Foundation and Evidence2Success to develop a statewide survey for children and families in receipt of services through the Networks. The goal of the survey is to identify needs for services across the state as well as satisfaction with services. The results of the survey, which was launched in November 2012, will provide a blueprint for other services to be implemented, allowing DCYF to map services to family needs. We will use the results of the survey and assistance from Evidence2Success to target additional interventions to implement over the duration of the waiver project.

In addition, DCYF will continuously work with the Executive Office of Health and Human Services, our Medicaid Authority, to include future evidence-based programs as they may be identified through the Evidence2Success well-being survey under our Global Medicaid Waiver, as allowable. Taking advantage of Medicaid Waiver funding as appropriate will allow DCYF to strategically move the clinical components of home and community-based service models to reimbursement through Medicaid and utilize Title IV-E funds to further expand service arrays for children and families involved with DCYF.

7. Description of the time period in which the project will be conducted

DCYF proposes a start date for the proposed Title IV-E Waiver demonstration project of October 1, 2012, assuming that DCYF is awarded a waiver in fiscal year 2013.

DCYF plans to use the SOC service delivery model for at least the next five years. DCYF will continue to contract with the Networks to provide services as long as the SOC produces the desired outcomes.

Phase two of the System of Care was implemented as of July 1, 2012 and the system is in its early stages of implementation. With the contracts for the Network's services,

¹⁷ The California Evidence-Based Clearinghouse for Child Welfare; January 2011

¹⁸ The California Evidence-Based Clearinghouse for Child Welfare; January 2011

DCYF has laid the groundwork for many of the data elements, reporting requirements, expenditure/cost report, and outcome monitoring processes.

8. Impact the intervention(s) is expected to have on outcomes

Outline the specific outcomes the demonstration will have an impact on, including outcomes related to safety, permanency, and well-being.

DCYF has spent considerable time with our stakeholders to develop a logic model depicting short-term, intermediate-term, and long-term outcomes as a result of the SOC. The following list includes expected outcomes related to safety, permanency, and well-being:

- **Reduction of Out-of-Home Placements:** The goal of the SOC model is to move children from restricted settings to community-based services or less restrictive settings. This objective is built into all layers of services included in the SOC contract from the WS, the contractually required reduction in residential care, the ability to reinvest contract funds in community-based services, as well as use of the Network Care Coordinators. Through the SOC model, we expect to increase the number of children who are safely in the homes and who are receiving community-based services and also shift a greater portion of children to less restrictive settings.
- **Increased Permanency and Decrease Time to Permanency:** Building on WS, DCYF will also employ interventions that target the needs of children in out-of-home care as well as their family's need in the home. DCYF actively solicits feedback from the children and families we serve and clients have expressed a need for additional in-home and community-based services to help address issues in the home that lead to removal and threaten permanency. DCYF will use interventions, such as Strengthening Families and Enhanced Family Support Services to help repair family units, shorten the length of time children remain in care, and make reunifications, guardianships and adoptions timelier and establish more permanent transition options. DCYF will also stabilize family units with an increased emphasis on reunifying sibling groups into the same home and placing siblings together to promote stable and permanent family units in out of home care or adoptive homes when returning home is not an option.

DCYF will also promote permanency by improving the rate of reunification through other evidence-based/informed interventions, such as Parenting with Love and Limits, which provides services to children in therapeutic residential settings and through enhanced coordination. WS and programs like PLL also address the needs of older youth and work to bring about successful reunifications before youth age out, reducing the number of children exiting care

due to age. Further, DCYF will utilize WS and the Child and Family Team to promote a successful transition to adulthood for older youth as they currently coordinate services for this population through the Consolidated Youth Services Program (CYS), which address the permanency, employment, educational, relational, technical life skills and transition needs of youth.

- **Reduction of Re-Maltreatment:** DCYF expects that the restructuring of services through the System of Care will allow the Networks to focus on children and youth that have returned home through the provision of WS and other support services and thus reduce the second report of maltreatment within six months. DCYF seeks to address this issue as it aligns with CFSR and national standards.

Include specific measures assessing both family capacity to provide for children's needs and child functioning in the well-being domains.

- **Child and Family Functioning:** DCYF has chosen to implement the use of CANS, the Ohio Youth Problem and Functioning Scales (Ohio Scales), and the Ages and Stages Assessment scale to focus on increasing child and family strengths, functioning and outcomes. Through the use of family-oriented services and practices, we hope to improve overall family satisfaction with services. The SOCs will work with the Parent Support Network (PSN) of Rhode Island to conduct Family Satisfaction Surveys to identify general satisfaction. The Parent Support Network is the Rhode Island affiliate of the national Federation of Families for Children's Mental Health. In addition, we have chosen the Parenting with Love and Limits (PLL) intervention as a key service as it focuses on group and family therapy not just individual youth therapy. Similarly, MST-CAN is focused on developing a plan with the family while also serving the needs of the youth.
- **Increase Well-Being Outcomes:** DCYF and our partners have worked to identify parameters surrounding well-being and how to best track outcomes. While the precise outcomes are still to be determined, we have decided to focus on increasing positive outcomes in the following areas:
 - Family Strengths and Functioning
 - Peer and Family Relations
 - Overall Mental and Behavioral Health

A predominant tool that will be used to track these indicators is the functional assessment, which will include the Ohio Problem and Functioning Scales, Ages and Stages, and CANS assessment.

Measure not only the achievement of permanency, but appropriate post-permanency measures, such as whether children re-enter care, whether adoptions or guardianships disrupt or dissolve and any other pertinent information on how children and families fare after discharge from foster care.

DCYF has categorized measures into four types:

1. Indicators of child, family, and case characteristics. These indicators are critical to the use of propensity score methods to re-balance groups who differ in their receipt of WS.
2. Indicators of child safety, such as reports of incidents of maltreatment or re-maltreatment.
3. Indicators of child permanency. Key indicators include: placement, placement transition, and reunification.
4. A range of child and family well-being measures will be used to track progress on functional outcomes indicative of child well-being.

DCYF has further detailed our measures for permanency, post-permanency, re-entry, and other pertinent information in Section 10.

9. Description of the proposed evaluation design

Justification of why the proposed approach is the most rigorous and appropriate approach to evaluation that will enable the Title IV-E agency to accurately determine the impact and effectiveness of the program.

Evaluation Readiness

Rhode Island has outstanding capacity to implement a rigorous evaluation design. Three institutional resources that support data analytic capacity will provide the foundation for the evaluation. First, the DCYF Office of Data and Evaluation provides overall leadership for all Department-funded data-related, evaluation, quality improvement, and performance improvement activities. The Director of this office reports to the Director of DCYF and is a member of the senior management team for the Department.

Second, DCYF has a strong Statewide Automated Child Welfare Information System (SACWIS) known as the Rhode Island Child Information System (RICHIST), which is managed through the Office of Data and Evaluation. Almost 15 years ago, RICHIST was one of the first state MIS platforms to fully implement SACWIS as required by the Children's Bureau. Over the years, RICHIST has continued to expand by adding modules

for children’s behavioral health services and juvenile corrections, and is now fully integrated into case work, probation, investigative, and clinical practice so that it represents an accurate compilation of a child’s safety, permanency, and well-being status in real-time.

And finally, DCYF provides leadership to the Rhode Island Data Analytic Center. The Center is a collaborative endeavor of DCYF, the Yale University School of Medicine, the two Networks, and more than two dozen community agencies and providers that serve as independent contractors in the SOC. A key feature of the Center is that it provides the Department and state with an effective partnership that can carry out state-of-the-art evaluations and data analyses of state-funded services and programs, including the SOC, while also being sufficiently independent to ensure the validity and reliability of its work. As a result, the state is able to involve nationally-recognized experts in evaluation research who have: 1) experience in child welfare, behavioral health, and juvenile justice services; 2) effective working knowledge of the state service systems and agency providers; and, 3) “arm’s length” independence to ensure that evaluations meet rigorous scientific and evaluation standards for accuracy, feasibility, utility, and propriety.

In the proposed Title IV-E waiver demonstration, Yale faculty investigators will work with their team, the Data Analytic Center, and the Office of Data and Evaluation to direct and implement evaluation activities, including preparing evaluation reports for DCYF submission to the Children’s Bureau. Considered together, these three institutional resources– the Office of Data and Evaluation, RICHIST, and the Data Analytic Center – have conducted dozens of evaluations of state-funded services and programs, and have used the results of these evaluations to promote data-driven practice and policies.

As specified in the waiver requirements, the overall waiver evaluation will consist of three components – an outcome evaluation, a process evaluation, and a cost analysis. Each of these is described in detail below.

Outcome evaluation design

The outcome evaluation will employ a ***rigorous prospective cohort design with propensity score matching to compare children and youth in the SOC who are receiving WS with those receiving traditional or other non-wraparound services (NWS)***. In previous analyses, DCYF has found that children and families referred to WS but who do not fully engage in the WS team meeting (where a service plan is developed in collaboration with the parent/caregiver and other service providers) are not systematically different on various child and family characteristics, including maltreatment history, permanency status, and well-being, to other children and families

referred to the SOC but who do not engage in WS.¹⁹ The evaluation will examine the effectiveness of WS through the application of propensity score methods within a prospective cohort design to adjust for potential group differences due to selection bias across conditions. Propensity score methods adjust for factors that influence assignment to group conditions and re-balance characteristics of the intervention and comparison groups before hypothesis testing. The use of propensity score methods within a prospective cohort design has the potential to produce rapid expansion of the knowledge base for this practice model, including its mechanisms of change, to other states and counties in which WS are offered.

In addition to the receipt of WS, some children and families will also engage in one or more evidence-based/evidence-informed services available through the SOC, depending on their individual needs and circumstances. As noted earlier, these will include:

- Enhanced Family Support Services (EFSS)
- Multi-Systemic Therapy (MST)
- Parenting with Love and Limits (PLL)
- Strengthening Families (SF)
- Preserving Family Networks (PFN)
- Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT)
- Multi-Systemic Therapy-Child Abuse and Neglect (MST-CAN)
- Functional Family Therapy (FFT)

DCYF's evaluation will account for the differential receipt and involvement in these services by modeling these two factors in the analyses (receipt as "yes/no" and involvement as determined by the fidelity score for that service). See below under "process evaluation" for more information about the fidelity measures to be gathered. Since propensity score matches will be made separately from each child's receipt of a given service and will be based on child and family characteristics, including demographics, child and family risk factors, maltreatment history, permanency status, and well-being, subsequent longitudinal outcomes for children receiving a given service will provide an estimate of the additive impact of that service above and beyond the impact attributable to WS. In addition, propensity score matching will allow us to examine whether WS involvement increases the likelihood that children and families enroll and participate in other evidence-based/informed practices; this would be a positive system-level outcome in itself in Rhode Island and be of keen interest to other states that provide WS along with other evidence-based/informed services as part of a service array offered to families.

¹⁹ Connell, C.M. & Tebes, J. K., (2012). Analyses of Levels of Care for Children and Families Receiving Wraparound Services within the System of Care. Rhode Island Department of Children, Youth, and Families. Providence, RI.

Outcome measures and data collection procedures

A number of measures will be collected that allow for a rigorous test of the goals of the demonstration waiver: 1) increase safety by preventing child abuse and neglect and reducing re-maltreatment; 2) increase permanency by reducing time in placement, and by preventing re-entry into foster care; and 3) increase well-being by promoting positive outcomes for infants, children, and families.

The table of measures on the following page describes the indicators and data sources for the outcome evaluation. Measures will be collected by the DCYF worker, network care coordinators, and evaluation staff when a child initially enters the SOC through the Child and Family Team and also at regular intervals (such as a placement transition or every 6 months), to assess progress. (As is standard practice in Rhode Island, parents from the Parent Support Network who have been trained to complete interviews with new parents will be retained by the Office of Data and Evaluation to support this work.) All measures will be entered and tracked within the RICHIST management information system, which allows for considerable flexibility to incorporate data modules as part of the child and family's case record. Consistent with current practice, staff that collect specific data elements will be responsible for entering that data into RICHIST. DCYF found this approach not only appropriately distributes the responsibility for data collection but also strengthens the sustainability of data-driven systems by incorporating data collection into each person's usual clinical, case work, or provider duties. To ensure the accuracy of data entered, ongoing training and support are provided by the Child Welfare Institute through the DCYF MIS Office and the Office of Data and Evaluation.

As shown in the table, four types of measures will be used in the outcome evaluation. The first type includes indicators of child, family, and case characteristics. These indicators are critical to the use of propensity score methods to re-balance groups who differ in their receipt of WS. A second type of measure includes indicators of child safety, such as reports of incidents of maltreatment or re-maltreatment. Child permanency measures are the third type of measure to be collected; placement, placement transition, and reunification are the key indicators for this measure. And finally, a range of child and family well-being measures will be used to track progress on functional outcomes indicative of child well-being.

Table 6: Indicators and Data Sources for the Outcome Evaluation

Indicator	Data Source
Child/Family/Case Characteristics Child Age, Gender, Race/Ethnicity Child Serious Emotional Disorder CPS/Maltreatment History Child & Adolescent Needs and Strengths (CANS) Child Risk Factors Family Risk Factors (e.g., Alc/Drug Abuse; Dom Viol; Family Income)	DCYF Worker DCYF Worker/NCC DCYF Worker NCC/Parent-Caregiver Interviewer NCC/Parent-Caregiver Interview; DCYF Worker Observations NCC/Parent-Caregiver Interview; DCYF Worker Observations
Child Safety Maltreatment (Re-maltreatment) Incidents	DCYF Worker
Child Permanency Child Placement Child Placement Transition Child Reunification	DCYF Worker DCYF Worker DCYF Worker
Child and Family Well-Being Ohio Problem & Functioning Scales Ages/Stages Questionnaire Child School Attendance Family Satisfaction with Services	NCC/Parent-Caregiver Interview NCC/Parent-Caregiver Interview NCC/Child & Family Team NCC/Parent-Caregiver Interview NCC/Parent-Caregiver Interview
<p><i>NCC=Network Care Coordinator.</i></p> <p><i>Data and Evaluation staff will support the completion of ongoing parent-caregiver interviews during the demonstration, often by employing parents as interviewers</i></p>	

Outcome evaluation data analyses

We will use propensity score methods to remove selection bias that may result from children being assigned to WS non-randomly.²⁰ Propensity score analysis involves: 1) Estimation of a (propensity) score that represents the probability of a child having been assigned to WS; 2) Re-balancing the children assigned to the WS group by matching or weighting so as to remove the selection bias from this assignment; and, 3) analysis of group differences for children receiving WS as compared to those not receiving those services or receiving only minimal WS. The primary aim of propensity score analysis is to remove selection bias to permit direct comparison of treatment effects; propensity score estimates are sample-specific and not intended to generalize to other samples. We will use RICLIST administrative and case record data to get precise estimates of propensity scores and conduct sensitivity analysis to assess the robustness of the effects observed.

²⁰ Guo S, Barth RP, Gibbons C. Propensity score matching strategies for evaluating substance abuse services for child welfare clients. *Children and Youth Services Review*. Apr 2006;28(4):357-383.

We will use logistic regression to estimate propensity scores. As noted earlier, predictors will include child and family demographic and risk characteristics; maltreatment history; and child and family clinical and functional assessment data from baseline administrative and case records. Numerous algorithms and their variants exist to balance groups using propensity score methods; best practice is to compare matches across methods to ensure a balanced study sample prior to outcome analysis. After estimating propensity scores we will compare performance of five matching methods (nearest neighbor, radius, stratification, kernel, and local linear matching) and a weighting adjustment using participants' inverse propensity scores. The procedure that produces the best match results will be used for subsequent analyses.

These analyses will be used to test the hypotheses that receipt and engagement in WS results in positive outcomes in each of the four goals of the demonstration across 6-month follow-up intervals. For hypotheses that involve a categorical outcome (e.g., maltreatment, re-maltreatment, reunification, etc.) we will examine differential rates of each outcome. For hypotheses involving continuous outcomes (e.g., functioning or problem behavior scores, satisfaction, etc.), a difference-in differences approach will be used to calculate differences between change in outcomes for children receiving WS and weighted average differences for children not receiving WS or receiving minimal WS. This method accounts for heterogeneity of WS participation by factoring distance in propensity scores between matches into calculation of treatment effects. Logistic regression will be used to compare rates of new CPS reports over time.

In addition to testing the impact of WS, we will also examine the additive effect of receipt and involvement in other evidence-based/informed services over time. To test this hypothesis, differential services involvement and fidelity to WS principles will be tested using separate path models for each indicator (i.e., receipt of another evidence-based/informed service, involvement in another evidence-based/informed service, fidelity to WS, fidelity to another evidence-based/informed service). These analyses will assess the impact on outcome for each additional service and for receipt of services with varying levels of fidelity. Finally, we will conduct sensitivity analysis²¹ to determine the robustness of results. These analyses estimate confidence intervals for observed effects based on potential confounds that were not observed.

Advantages of this outcome design: Two sets of study designs were considered as alternatives to the proposed design, but each has significant limitations. Random assignment to condition is the "gold standard" for internal validity through implementation of a randomized controlled trial (RCT). However, such a design has

²¹ Rosenbaum PR, Rubin DB. Assessing sensitivity to an unobserved binary covariate in an observational study with binary outcome. *Journal of the Royal Statistical Society. Series A, Statistics in society.* 1983;45(2):212-218. Greenland S. Basic methods for sensitivity analysis of biases. *International Journal of Epidemiology.* 1996;25(6):1107-1116.

limitations for system-level implementation research due to: a) ethical concerns about assignment of children and families in acute distress to NWS when services are indicated, and b) the limited generalizability of RCTs within system-level implementation contexts (e.g., statewide, county-wide, etc.). Generalizability may be limited because implementation of an RCT results in different treatment participants than would occur in natural practice in which care decisions are driven by the court, providers, or family choice.²²

Alternatively, a quasi-experimental design could have been implemented, with baseline covariates used to adjust for pretest differences, as has been done in some previous research of the WS.²³ Such an approach is limited methodologically, since selection factors cannot be ruled out as contributing to observed differences between study conditions at follow-up. The use of propensity score methods provides a more rigorous balancing adjustment for pre-existing group differences, is suitable for system-level implementation, and produces results comparable to RCTs.²⁴ Thus, it represents both a novel and rigorous quasi-experimental design that has strong internal and external validity because it incorporates ‘real world’ referral patterns and clinical decision making procedures within a system-level intervention.

Process Evaluation

The process evaluation will employ a mixed methods approach to track several key indicators of program implementation, agency performance, and services received by children and families. The data obtained will be used as part of a continuous quality improvement framework to provide feedback about the demonstration in order to make program adjustments as necessary. In addition, data from the process evaluation will be used to inform the outcome analyses by identifying possible mechanisms that account for the outcome effects observed.²⁵

As shown in Table 7, five types of indicators will be collected for the process evaluation. Program fidelity is critical to the success of any evidence-based/informed practice, and thus will be tracked closely throughout the demonstration using both quantitative and

²² Posavac EJ, Carey RG. *Program evaluation: Methods and case studies*. Upper Saddle River, NJ: Prentice Hall; 2003.

²³ Concato J, Shah N, Horwitz RI. Randomized, controlled trials, observational studies, and the hierarchy of research designs. *New England Journal of Medicine*. Jun 22 2000;342(25):1887-1892.

²⁴ Benson K, Hartz AJ. A comparison of observational studies and randomized, controlled trials. *New England Journal of Medicine*. Jun 22 2000;342(25):1878-1886.

²⁵ Tebes, J.K, Kaufman, J.S., & Connell, C.M. The evaluation of prevention and health promotion programs. In: T. Gullotta & M. Bloom (Eds.) The encyclopedia of primary prevention and health promotion. New York: Kluwer/Academic, 2003, 46-63. .

qualitative methods. The Wraparound Fidelity Index will be obtained by Data Analytic Center Staff through phone interviews with parents whose family is receiving services through the demonstration. This approach was used with success during Phase I of SOC implementation to monitor the effectiveness and impact of program implementation and to make program adjustments.²⁶ These data will be supplemented by indicators of adherence to the team planning process that will be collected by NCCs as part of their ongoing monitoring of the team process. DCYF is currently conducting a self-study of the team observation form that will be used by teams to improve their performance. A third measure will track the fidelity of implementation for any of the other evidence-based/informed practices that families may be receiving. This will enable us to carefully monitor the quality of additional services that families are receiving so as to assess the additive impact of those services beyond that provided by WS.

Another type of process data that will be obtained is detailed information from the case record about the documentation, timeliness, and quality of the child's assessment, initial plan, and plan review. DCYF utilization management (UM) staff routinely capture this data in the case record, but recently, we have completely revised our UM form to incorporate the system changes instituted in both phases of the SOC reform. This data will also allow us to examine the relationship between documentation of services as well as services received with outcome evaluation data.

Finally, our process evaluation will also include conducting annual focus groups with Network agency providers that ask about key barriers and successes encountered when implementing services, and seek suggestions for program improvements. A similar methodology was used in California when implementing WS in a child welfare context with considerable success.²⁷

Table 7: Indicators and Data Sources for the Process Evaluation

Indicator	Data Source
Wraparound Fidelity Index (WFI-EZ) Adherence to WS model	Data Analytic Center Staff
Wraparound Team Observation Form Adherence to the Wraparound team planning process	NCC
Fidelity Indices of Other Evidence-Based/Informed Practices* Adherence to EBP model	Data Analytic Center Staff
Quality Assurance Medicaid Record Review Documentation, timeliness, and quality of child's assessment Documentation, timeliness, and quality of child's initial plan Documentation, timeliness, and quality of child's plan review	DCYF Utilization Management Staff DCYF Utilization Management Staff DCYF Utilization Management Staff

²⁶ Connell, C. M., Genovese, M., & Tebes, J. K. Phase I Fidelity of Wraparound Services. Providence, RI: Rhode Island Data Analytic Center, 2012.

²⁷ Ferguson, C.M. The implementation of wraparound in the California Title IV-E Welfare Waiver Demonstration Project. *Children and Youth Services Review*, 2012, 34: 1331-1336.

Indicator	Data Source
Focus Group with Network Agency Providers Implementation barriers and successes Recommendations for program improvement	Data Analytic Center Staff Data Analytic Center Staff
<p><i>* Enhanced Family Support Services (EFSS); Multi-Systemic Therapy (MST); Parenting with Love and Limits (PLL); Strengthening Families (SF); Preserving Family Networks (PFN); Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT); Multi-Systemic Therapy-Child Abuse and Neglect (MST-CAN); Functional Family Therapy (FFT).</i></p> <p><i>NCC=Network Care Coordinator.</i></p> <p><i>Data and Evaluation staff will support the completion of ongoing parent-caregiver interviews during the demonstration, often by employing parents as interviewers</i></p>	

Process evaluation data analyses

Data from the process evaluation will be analyzed in various ways. Quantitative data will be incorporated into the propensity score analyses as mediators or moderators of hypothesized program effects. For example, we hypothesize that WS will reduce re-entry into foster care. If this effect is observed, we will then examine process data for likely mechanisms of those effects (e.g., Was this positive outcome associated with higher fidelity scores on the WFI?). Qualitative data will be used to inform outcome effects observed (e.g., what barriers identified are also seen in the scores of children who present with certain risk factors) as well as make program improvements (e.g., What program advantages result from consistent meetings of the Child and Family Team?). Careful integration of process and outcome data will enable us to address complex questions about the various services provided through the waiver.

Cost Analyses

DCYF, through its Data Analytic Center, has experience in conducting rigorous cost analyses of the SOC and will carry out similar analyses for the waiver project. Analyses will be conducted by the Data Analytic Center partners – DCYF Data and Evaluation, Yale, and the Networks – and be supplemented with support from the Director’s Office and the DCYF Office of Management and Budget. The Data Analytic Center includes researchers who have conducted cost outcome and cost analysis studies in the past²⁸, and has access to experts in health economics and financial management who have prior experience conducting cost analyses in the system of care. For example, among the cost analyses completed by the team is an early study of the children’s behavioral health SOC, which showed that children referred for services to a multi-agency planning team – a DCYF forerunner to the Child and Family Team described earlier – were more likely to have reduced overall service costs than comparable children not referred to the team.²⁹

In another cost analysis, we found that the overall DCYF service costs were 7 times higher for families whose children remained in parental custody after a substantiation of maltreatment but who were only minimally engaged early on in intervention services; that is, long-term costs were much lower for families who had a prior contact with the Department and who had engaged in early intervention services.³⁰ This suggested that earlier intervention with families could have reduced both costs and remaltreatment. These analyses were instrumental in the planning of Phase I of the SOC.

Finally, we completed cost estimates of residential services using DCYF data from the Office of Management and Budget³¹ and have done forecasting to predict occupancy trends in DCYF-funded residential services in the SOC³² - each of which have been critical in SOC planning.

²⁸ Wolff, N., Helminiak, T.W., & Tebes, J.K. Getting the cost right in cost-effectiveness analyses. *American Journal of Psychiatry*, 1997, 154, 736-743

²⁹ Tebes, J. K., Helminiak, T., Kaufman, J. S., & Ross, E. *Costs and Cost-Outcomes of Children’s Community-Based Mental Health Services*. Providence, RI: Rhode Island DCYF, 2000.

³⁰ Tebes, J. K. *Characteristics of children who remain in parental custody following substantiated maltreatment*. Presentation to the DCYF No Legal Status Workgroup. Providence, RI: Rhode Island DCYF, 2005.

³¹ Tebes, J. K., & Connell, C. M. *Residential placement cost estimates*. Rhode Island Data Analytic Center Research Brief #3. Providence, RI: Rhode Island DCYF, 2004.

³² Connell, C. M. & Tebes, J. K. *Forecasting in-home & foster care service rates across levels of care: A preliminary analysis*. Rhode Island Data Analytic Center Research Brief . Providence, RI: DCYF, 2011.

For this waiver demonstration, the evaluation team will be responsible for obtaining the most relevant cost data, documenting the procedures of data extraction, aggregating data across appropriate units of service, and reporting findings. Our detailed tracking of service units using RICHIST for the process evaluation will enable us to provide accurate and reliable data about service units and to aggregate units and costs for each child served and for the child's family. RICHIST allows for careful counting of costs incurred over time, thus making it possible to examine the relationship of particular types of services received to costs incurred. In addition, the rigor of our outcome design, in which propensity score methods will be used to adjust for statistical bias among children receiving different levels of WS as well as between those receiving only WS and other evidence-based/informed treatments, will enable us to examine the relationship of services received, outcomes, and costs. Longitudinal monitoring of key outcomes, made possible because of our ongoing baseline and 6-month assessments of children in the SOC, will enable us to identify the relationship of costs to outcomes, given a specific array of services received. Thus, these analyses will enable DCYF to report on the cost effectiveness of services for children and families in the SOC.

A challenge when conducting cost analyses is alignment of costs with service units, since MIS and financial management systems are rarely developed to correspond to one another.²⁷ To ensure that findings from the cost analyses inform child welfare planning, particularly the cost outcome findings reported, we will work closely with the DCYF Office of Management and Budget to carefully record the underlying assumptions that guided the alignment of costs and services, and identify the perspective taken when reporting costs (e.g., case, agency, societal). In this connection, we will also make every effort to identify cost-offsets so as to increase the chance that the findings will have direct relevance to policy development, particularly in the use of evidence-based/informed services implemented system-wide.

Description of the basis for projecting that the project would be cost-neutral overall.

DCYF wishes to cap the Title IV-E foster care maintenance and foster care administration payments received by the State of Rhode Island at the FFY 2009 level. As a result of hiring of SOC staff that will perform allowable Title IV-E administrative activities, DCYF anticipates an increase in Title IV-E administration similar to that of FFY 2009.

10. Provide a reliable method for measuring and ensuring Federal cost-neutrality

During Rhode Island's waiver development and SOC development process, DCYF evaluated congregate care placement figures over the last two years in order to identify expected decreases in residential settings in year 1 of the SOC implementation. DCYF expects to see a decrease in the number of residential placements over the duration of the SOC contracts with the Networks, allowing DCYF to realize cost savings and invest the funds in an array of community-based services.

For example in year 1 of the contract, DCYF has set the expectation that the Networks will decrease residential care placements by 4.7 percent across the state from 766 to 730. This allowed DCYF to identify the portion of costs that can be utilized for WS in year 1 and the proportion of costs associated with congregate care purchase of service.

Year 1 will establish a contract baseline for the Networks and DCYF. DCYF looks forward to discussing the first year baseline with ACF. The Department is working on an analysis that will be used with the Networks, based on the first year results, to establish benchmarks for future years. DCYF will work in partnership with the Networks to establish the standards for reducing congregate care placements. As DCYF and the Networks move into years 2 through 5, we would expect a graduated decrease in congregate care placements to support broad community-based services.

As state and Title IV-E funds are freed up under the Title IV-E Waiver project for child welfare services, the DCYF intends to achieve a continuous reinvestment in the expansion of the array of home and community-based services through the operations of its Networks.

In addition, DCYF will work with the state Medicaid Authority to identify programs and expenses that may become eligible for funding under the Global Medicaid Waiver, allowing DCYF to expend Title IV-E demonstration funds on additional community-based services over the duration of the waiver.

11. Describe impact on any similar projects already underway

The State's development and expansion of the SOC was supported through collaboration of multiple state agencies that have developed an integrated family and community system of care. The state agencies that have worked closely to develop and expand the SOC include publicly-funded community mental health agencies and psychiatric hospitals, the Rhode Island Executive Office of Health and Human Services

(EOHHS), the Rhode Island Department of Education (RIDE), and the Rhode Island Family Court.

DCYF was awarded an infrastructure grant from ACF in October, 2012 for the Rhode Island Early Learning Partnerships to Expand Protective Factors for Children with Child Welfare Involvement. This two year grant supports a project between DCYF and the Sherlock Center at Rhode Island College that focuses on building out an infrastructure between child welfare and early childhood systems to ameliorate the effect of exposure to trauma and improve social-emotional well-being for infants and young children in the child welfare system. This work will also coordinate with activities of the early childhood Race to the Top Initiative in which DCYF is a collaborative partner with the Department of Education. The Statewide FCAB will serve as an advisory body for this initiative and infrastructures developed will further support DCYF's cooperative approach to services through the SOC and the positive outcomes engendered by the first and second phase of the SOC to date.

In addition, DCYF has also been awarded a four year System of Care Expansion Implementation Cooperative Agreement from the Substance Abuse Mental Health Services Administration (SAMHSA). The grant will support DCYF's capacity to build and sustain an infrastructure with the Networks and enhance coordination with the FCCPs to unify the two phases into one sustainable system of care. The primary focus of this effort is in relation to children with serious emotional disturbances (SED), a demographic that constitutes a large number of children served by DCYF through the SOC. ***There is a significant connection between the goals of DCYF's proposed Title IV-E Waiver demonstration project, which will allow DCYF to build-up an array of community-based services, and the SOC Expansion Implementation grant, which will support Rhode Island in building an infrastructure to maintain the quality and fidelity of community-based services.***

The Statewide FCAB will provide an oversight and advisory role for this grant. The expansion grant will also maintain the communication network that DCYF has established across stakeholder agencies that facilitate an integrated approach to the funding and execution of programs through the SOC.

The following state agencies are connected to the FCAB and SOC and will continue to be consulted and accounted for as the Title IV-E Waiver is implemented.

- **Executive Office of Health and Human Services (EOHHS)** is the single state agency for health care financing and Medicaid.
- **Department of Human Services** manages all state level functions related to Social Security Administration benefit programs (SSI/SSDI) as well as Temporary

- Assistance to Needy Families (TANF), Special Nutritional Assistance Program (SNAP), state and federal child care assistance, and elderly services.
- **Department of Health** is the single state agency for health policy and is the lead for early childhood policy and programming, which includes Maternal and Child Health (MCH/Title V), Project Launch and the Early Childhood Comprehensive Systems (ECCS) Grant.
 - **Department of Behavioral Health, Developmental Disabilities and Hospitals** is the single state agency for adult mental health and disabilities and for child, youth and adult substance abuse; it manages the Mental Health and Substance Abuse Block Grants as well as the Access to Recovery Systems (which provides SAMHSA supported vouchers for substance abuse treatment.)
 - **Department of Elementary and Secondary Education** is the single state agency for all public educational activities for elementary and high school aged children and youth and is the regulatory and training arm for all of the state's 36 independent school districts.
 - **Yale University School of Medicine**, Data Analytic Center Team has agreed to conduct the evaluation of this Title IV-E demonstration project. Yale was involved in evaluations of children's mental health systems of care for more than a decade and served as the evaluators for Rhode Island's prior SAMHSA SOC development awards which include Project REACH, Project Hope, and Positive Education Partnership SAMHSA grants, and was the founding partner in establishing the Rhode Island Data Analytic Center through a Building Analytic Capacity for Child Welfare in the States grant to Rhode Island DCYF from the Children's Bureau.
 - **The Child Welfare Institute of Rhode Island** has provided professional development and support for systems change since 2001, when Governor Lincoln Almond signed an agreement between DCYF and the RI College School of Social Work. Since its establishment, the Child Welfare Institute (CWI) has enjoyed the partnership and support of the faculty of the School of Social Work. CWI staff serve as teaching resources to the undergraduate and graduate social work programs, as well as DCYF staff and our provider network. CWI provides introductory, intermediate and advanced training for professionals in mental health, juvenile justice, child welfare, and human services on application and uses of system of care core approaches.
 - **Neighborhood Health Plan of Rhode Island (NHPRI) and Beacon Health Strategies** ensure children and youth in the care of DCYF have their health and

behavioral health needs covered. NHPRI is a Medicaid managed care health plan contracted with EOHHS. The agreement between EOHHS, DHS and DCYF to enroll children and youth in substitute care into the managed care plan for medical, dental and behavioral health care coverage is now more than a decade old. As of November 30, 2012 there were 2,388 DCYF children/youth enrolled in NHPRI. This initiative is integral in providing children served by the SOC with comprehensive and coordinated medical and mental health services. Coordination with DCYF is detailed further in section 17.

In addition to ongoing coordination with the stakeholder agencies and organizations listed above, **the SOC will be supported by existing, Ancillary Family Support Services.** The agencies and organizations below are not directly incorporated into the Family Care Networks' funded services, but their ongoing directives contribute to the delivery of integrated services to children and families served by DCYF.

- **AS220** is a Providence-based arts program that provides positive role models to enhance youths' personal, educational, occupational and social development through Mentor programming as well as after school and post secondary arts classes focusing on performance/dance, visuals, writing/publishing and photography.
- **Adoption Rhode Island (ARI)** works solely with DCYF as the adoption exchange information and referral program. ARI provides matching services for waiting children and interested families, and also provides support services for children waiting for adoption. The program has expanded to provide additional support for the Department in development of the Regional Permanency Support Teams.
- **Consolidated Youth Services (CYS)** provides comprehensive youth development services, directly or through access to existing services funded by other agencies that address the permanency, employment, educational, relational, technical life skills and transition needs of youth in the care and custody of the Department, as well as youth aging out and former foster youth. CYS members also drafted the Sibling Bill of Rights, which will bring youth advocacy and increased focus on maintenance of siblings as a family unit to foster permanency.
- **Foster Forward** – formerly RI Foster Parents Association - ensures that foster parents are able to receive guidance and support in their role and responsibilities as substitute caregivers for children who have been Court-ordered into the care and custody of DCYF; works with DCYF in the Regional Permanency Support Teams; provides resources and supports for members of the foster parent community through activities including:
 - Mentoring Program

- Monthly Newsletters
 - Holiday Gifts Distribution Program
 - Community Engagement and Support
 - Permanency Support
 - Teen Grant Program
 - Website
- **Providence Children’s Museum – Therapeutic Visitation Program** - serves parents and children, between the ages of 2 and 11, who have been placed into DCYF care. The Families Together Visitation Program provides recreational visitation opportunities for children with their families at the Children’s Museum as well as in a real home-like setting for families in preparation for reunification, and provides clinical consultations for DCYF caseworkers.

 - **Rhode Island Department of Education (RIDE)** has cooperated with DCYF as a part of the Joint Task Force on the Education of Children and Youth Involved with DCYF to ensure that children birth to five in DCYF care are adequately prepared and supported for educational achievement. The Joint Task Force will achieve these goals by working with the SOC to provide interventions through the SOC that increase placement stability and linking children with Early Intervention and Child Find resources as appropriate.

 - **Progreso Latino** is a Central Falls-based multi-service community-based social service agency providing services and support to the Latino community in Rhode Island, including youth services that provide opportunities for volunteering in business and community agencies for young people to learn skills beyond the classroom. Other services include:
 - Adult Education
 - Citizenship
 - Early Education
 - Health and Wellness
 - Immunization
 - Family Leadership

 - **Socio-Economic Development Center for Southeast Asians** is contracted by DCYF for the hiring of interpreters for a large number of foreign languages as needed. This project indirectly contributes to the SOC by ensuring that Linguistic barriers do not pose barriers to administering programs in a linguistically and culturally competent manner.

- **Urban League of Rhode Island** is contracted to assist the Department in recruiting and supporting families interested in becoming foster or adoptive parents. The agency recruits, conducts home studies, and provides pre-service training for foster and adoptive families interested in fostering children from African American and Latino backgrounds. The contract includes the provision of training and home studies in Spanish for Spanish speaking applicants.
- **Youth Pride** is a comprehensive community education program that provides youth to youth and professional trainings and workshops, including The Way Out and OUTspoken, throughout Rhode Island, with a message of understanding around the issues facing LGBTQQ youth. Young people, educators, direct care providers and other interested individuals learn increased cultural competence with regard to being sensitive while providing services or interfacing with LGBTQQ youth. The Way Out is a peer-to-peer support group that allows young people to interact with their peers to address common issues and concerns that impact their life-experience. OUTspoken trainings are offered to service providers in a variety of areas including secondary education, higher education, family services, mental health services, health care, social services, and recreation.

Finally, Evidence2Success has already made significant efforts assisting DCYF and partner agencies to assess well-being and to identify evidence-based programs well-targeted to address risk factors and support well-being. This has prepared DCYF to implement specific evidence-based interventions, as highlighted in Section 7, through the waiver demonstration project.

Explain to what degree (1) the proposed collaboration can be accomplished through coordination within the other program's existing authority or a plan amendment; or (2) whether coordinated activities will require approval of waivers in another program.

The State of Rhode Island's collaboration through the Global Medicaid Waiver for the SOC will continue with or without a Title IV-E Waiver. The commitment to utilize available resources to support and strengthen children and families is evident from our initiation of the SOC. The State established authority early on to meet a July 1, 2012 start date for the SOC and has addressed cost allocation plan amendments to capture the structure. As implementation continues, we will be mindful of plan amendments that will have to be revised and provide them for review.

The Department of Human Services has a separate network of providers known as CEDARR Family Centers, specifically designed to provide support and services for families of children with special healthcare needs. CEDARR Family Centers

(Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation) provide assessments and service linkages for families to ensure that their children are able to receive the care they need. To be eligible for CEDARR Family Center services, a child must be eligible for Medical Assistance, under age 21, a Rhode Island resident, live at home and have a disabling or chronic condition that is cognitive, physical, developmental and/or psychiatric. The potential for overlap between the Family Care Networks population and with CEDARR Family Centers is not an issue as the number of children in congregate care who receive CEDARR services is relatively low (63 out of a total enrollment of 2,756 as of 10/31/12).

12. Accounting of any other sources of funding over the previous two years

The State of Rhode Island currently offers some community-based services under Medicaid, Title IV-B, Title IV-E Independent Living Program (ILP), and Child Abuse Prevention and Treatment Act (CAPTA). We anticipate that the additional services being implemented under the SOC will fall under the Title IV-E Waiver funds. As programs are approved to be included under the Medicaid Global Waiver, we will move the funding source to Medicaid, allowing DCYF to fund new community-based services benefiting the child welfare population.

An accounting of the funding for these services in federal fiscal years 2010 and 2011 is shown in Table 8.

Table 8: Sources of Funding (2010, 2011)

Community-Based Services		
	FY 2010	FY 2011
Title IV-E (ILP)	\$ 791,380	\$ 789,998
Title IV-B	1,181,920	1,171,920
CAPTA	375,028	342,210
WIC	-	245,000
TANF	-	-
Title XIX (Medicaid)	7,202,986	9,631,300
SSI	-	-
State General Fund	14,322,018	10,033,871
Local investment	-	-
Private Investment	-	-

13. Provide an assurance that the Title IV-E agency will continue to provide an accounting of spending

As the Title IV-E agency, DCYF will provide an accounting of the same spending for each year of the approved demonstration project as reported above in Section 12.

14. Identify the statutory and regulatory requirements under Titles IV-B and IV-E of the Act

DCYF requests that ACF waive the following provisions of Titles IV-B and IV-E of the Social Security Act:

- Section 472 (a) (b) (d), (e) (f) (g) and (i)
 - This will allow DCYF to expend Title IV-E funds for children and families who are not normally eligible under Part E of title IV of the Act as described in the Terms and Conditions.
- Section 474(a)(3) (A) (B) (D) and (E) and 45 CFR 1356.60(c)(3)
 - This will allow DCYF to include services that are not normally covered under Title IV-E.

15. Describe any effect on the agency's automated child welfare information system

A central component of the system of care's success is the ability to make data-driven decisions for service improvements on an ongoing basis. In preparation for Phase II implementation of the SOC, DCYF has already made significant efforts to address the data collection needs. RICHIST will serve as the central repository for all data elements, with Network staff responsible for inputting data directly into RICHIST and DCYF workers responsible for ensuring that all essential data is available for each child as necessary.

DCYF is also working toward implementing additional changes in RICHIST, highlighted below, which will further support the SOC:

- Integrate FCCP data into RICHIST
- Modify the "Assessment" window to collect CANS data elements in RICHIST
- Addition of a utilization management window (may not be directly related to the waiver) to RICHIST
- Ability to scan a copy of the Service Plan into RICHIST

- Ability for CPS staff to create network referrals in RICHIST
- Ability for Network staff to perform a “child” search in RICHIST

The table below provides a high level overview of data fields in RICHIST already created for the Networks:

Table 9: Summary of RICHIST Data

Data relevant to child/family individual-level outcomes:	Data relevant to child/family systems-level outcomes:
<ul style="list-style-type: none"> • Demographic information (e.g., age, gender, race, ethnicity, living situation, custody status, parental occupation, family household income), • Child and family behavioral health characteristics (e.g., psychiatric diagnosis and history, substance use and substance use history), • Assessments (Ohio Scales, CANS, Ages and Stages), and • Child/youth satisfaction surveys. 	<ul style="list-style-type: none"> • Referral source and type, • Admission and discharge information, • Service plan characteristics, • Length of stay, continuity of care, • Placement stability, • Readmission rates, • Transition to less or more restrictive levels of care, • Length of time to engagement in appropriate services, and • Fidelity to the WS system.

In order to collect the outcomes highlighted above, the following high level changes have occurred within RICHIST in preparation for the demonstration project.

- **Document and Record the Results of Team Meetings:** Within thirty days of case opening, the Networks will hold first team meeting. Children who are open to the Department are included in the meeting as deemed appropriate by the Parent(s), DCYF, and the Family Care Network organization. DCYF has altered RICHIST to capture documentation of the Team Meeting, including the initial meeting, subsequent meetings, meeting attendees, the results of the strengths/needs analysis, progress throughout meetings, and transition planning meetings.
- As network referrals are created by DCYF, FSU or Probation workers, an automated notification process was created in RICHIST so that Networks intake workers receive notification of new case assignments. The Network will begin work on a case after a notification is received through RICHIST.
- **Change Family Care Network Referral/Intake windows to collect additional pieces of data:** The existing intake and referral screen in RICHIST was altered so that the Network can collect additional data fields including: referral, intake, diagnostic, education, and legal information.

- **Populate fields to transition/discharge cases from Networks:** DCYF has created a transition/discharge window so that Networks can transition families from Network of Care services to DCYF when children obtain their permanency goal.
- **Add additional components to collect other pertinent assessment and case information:** DCYF has created the following key windows in RICHIST to allow the Networks to input key case data. Many of these fields will allow DCYF and our evaluator to conduct SOC evaluation.
 - **Case Activity Notes:** DCYF modified the “Case Activity” window to allow data entry by a Network worker and allow view-only access by DCYF workers.
 - **Safety Plan:** Allow the Network to view Safety Plan for the family populated by DCYF caseworker.
 - **Assessment Scores:** This window allows DCYF and the Network to view the various assessments performed for each child. For example, DCYF and Network workers can view the factors identifying risks and strengths, parental capabilities, family interaction, child well-being and other scores associated with the selected assessment tools.
 - **Referral Management:** DCYF created a window that allows the Network to manage and create referrals and approve pending referrals.
 - **Case Assignment:** When a case is assigned to a Network, the Network intake worker must assign one of the organization’s supervisors to that case.

16. Demonstration of readiness

Over the past ten years, DCYF has gradually established an integrated service system in child welfare, behavioral health, and juvenile corrections that is oriented toward the delivery of family-focused, child-centered, culturally-competent, and community-based services. This paradigm shift is consistent with a SOC philosophy, and particularly in the use of family-focused wraparound services that are integrated with appropriate evidence-based/informed service models. DCYF worked continuously to plan for and implement this SOC and is now well-positioned for a Title IV-E waiver demonstration, as indicated by the following:

- A focus on improving outcomes for children.
- Cross-collaboration and coordination between DCYF and Network Leads as well as across Rhode Island agencies.

- Our efforts to select relevant and valuable evidence-based interventions that can be tailored to specific target populations.
- The provision of coordinated health care oversight and psychotropic medication management.
- Ongoing partnerships with community agencies and stakeholders.
- Robust RICHIST system improvements.
- An established Data Analytic Center to support rigorous evaluation, quality assurance, and performance monitoring in the SOC.

DCYF's demonstration of readiness is evident through the following accomplishments and activities. First, DCYF has made efforts to improve outcomes for children and families through a focus on home and community-based preventive services. From 2007 through 2012 as part of Phase 1 of the SOC:

- DCYF has reduced the number of Child Protective Services (CPS) removals by 32 percent.
- DCYF has reduced total number of all removals by 38.5 percent.
- DCYF has reduced the number of children / youth in out of home care by 36 percent.
- Between FY 2010 and FY 2012 DCYF has reduced congregate care placement (as defined in Section 5) by 25 percent.
- DCYF has reduced its expenditures on residential placements from \$85.4 million in FY 2007 to \$62.2 million in FY 2012.
- DCYF has reduced reliance on out of state placements. Between FY 2007 and FY 2012 DCYF has reduced the number of youth in out of state programs by over 50 percent. The DCYF has reduced its expenditures on the costs of funding youth in out of state programs from \$18.7 million in FY 2007 to \$7.7 million in FY 2012.
- Between July of 2006 and June of 2012, the Department increased its utilization of foster home placements from an average of 60.1 percent in FY 2007 to 66.9 percent in FY 2012. As of July 1, 2012, 68.5 percent of children in out of home placements resided in foster home placements.

DCYF has achieved positive outcomes for children and families through Phase 1 of the SOC, which demonstrates our ability to design and implement collaborative systems of care that bring meaningful change to DCYF, our partners, and the clients we serve. We are now prepared to achieve positive outcomes, through Phase II of the SOC, for a population of children and families that require a higher level of services coordination and integration, which will be made possible by flexibility in federal funding.

DCYF made considerable efforts over the last three years to implement a coordinated SOC. We not only focused on integration between our agency staff and the Network staff, we also fostered an environment of cross-collaboration and partnership with

EOHHS, our Medicaid authority, and Neighborhood Health Plan of Rhode Island (NHPRI) and Beacon Health Strategies, our managed care health plan provider. This allowed DCYF to provide a braided and seamless funding stream for health and behavioral health services for our children.

Prior to Phase II implementation, DCYF and the Networks sat at the same table to plan for a successful transition and implementation. This was crucial to a seamless and integrated continuum of care. The Networks will serve as a collaborative and integrated structure for planning and decision-making of the services provided in the community, in particular, WS.

In addition, ***DCYF has made significant progress in identifying evidence-based practices and interventions and integrating those services across our partners.*** The SOC infrastructure that DCYF and our partners have in place, and the flexibility of the Title IV-E Waiver, will allow the department to quickly expand WS and interventions such as MST, PLL and PFN through a coordinated effort with EOHHS.

As aforementioned, DCYF and the Networks have been working with the Annie E. Casey Foundation and Evidence2Success to implement a statewide well-being survey for children and families in receipt of services through the Networks. Together, we have a strong sense of the interventions that have proven successful. Rather than implement just those, DCYF has chosen to survey the children and families we serve to identify the specific risk and protective factors they experience that contribute to well-being outcomes. The survey, which was launched in November, will be used to identify additional interventions to implement over the duration of the waiver. We will work with Evidence2Success to crosswalk the needs of the children and families to interventions that yield positive outcomes.

Through close cooperation with EOHHS, the State's Medicaid agency and health care financing agency, ***our agencies have coordinated the strategic provision and funding of evidence-based services through Rhode Island's Global Medicaid Waiver.*** DCYF was able to demonstrate the value of programs such as MST and PFN to EOHHS and obtain funding based on the strength of these models. DCYF's existing partnership with EOHHS will allow us to expand home and community-based programs with an integrated approach through braided and coordinated funding. If a program supported by the Title IV-E Waiver is successful and demonstrates applicability to Medicaid, it may be possible to cover the cost of allowable services under Medicaid and refocus Title IV-E funds towards new interventions.

As referenced earlier, children and youth in placement are covered through the Neighborhood Health Plan of Rhode Island (NHPRI) and Beacon Health Strategies. One of the goals of the health plan is effective medication management for the high risk population we serve. The Intensive Case Management (ICM) program is designed to

provide services to those who are at high clinical risk due to mental health, psychosocial, and/or co-morbid circumstances. Case management is provided by licensed clinicians within the scope of their licensure to manage medical services and medication.

DCYF is also making strides on psychotropic medication management. DCYF is currently working with ACF to develop new policy to guide the utilization of psychotropic medication to add to our Residential Child Care Regulations. In addition, DCYF recently was appointed to a three-year grant from the Center for Health Care Strategies to improve the use of psychotropic medication among children and youth in foster care. Dr. Janice DeFrances, DCYF Director, will be developing new regulations with a team that includes representatives from DCYF, DHS, NHPRI-Beacon Health Strategies, as well as Adoption Rhode Island.

As part of the planning process, DCYF worked with community-organizations to assist with the development of the SOC and the communication associated with its implementation. DCYF utilized two family-run advocacy organizations to participate and recruit youth to join the SOC expansion team. DCYF also recruited the state's leading cultural organizations to develop the SOC: Progresso Latino, the Urban League, and the Socio-Economic Development Center for Southeast Asians. The planning process yielded a detailed, implementation-oriented strategic plan as well as a culturally-competent social marketing plan to assist with community readiness.

Finally, DCYF is also ready from a systems perspective to implement the Title IV-E waiver project. In advance of SOC implementation, DCYF's IT team made most of the necessary changes to RICHIST to capture the referrals from the Networks, the assessment results, and other pieces of data vital to our evaluation component through the operation of the Data Analytic Center. We are well-positioned to collect data points for our waiver evaluation and to be able to analyze that data as part of a continuous quality improvement process to make effective changes to system operations as necessary.

For further information on our system readiness, please refer to Section 9 of this application.

17. Identify steps taken to assure cooperation and copies of memoranda of agreement.

The State's development and expansion of the SOC was supported through collaboration of multiple state agencies that have developed an integrated family and community system of care. The state agencies that have worked closely to develop and expand the SOC include publicly-funded community mental health agencies and psychiatric hospitals, the Rhode Island Executive Office of Health and Human Services

(EOHHS), the Rhode Island Department of Education (RIDE), and the Rhode Island Family Court. EOHHS will work with DCYF to ensure all agencies under its authority are cooperative and seek to maximize the benefit of the SOC to the children and families they help serve.

Please find attached a letters of support from EOHHS, the Networks, Adoption RI, Foster Forward, and the Socio-Economic Development Center for Southeast Asians.

18. Relationship of the project to the state's CFSR and PIP.

Describe how the proposed project responds to the findings of the State's Child and Family Service Review and how it will affect implementation of the State's CFSR PIP.

Rhode Island's 2010 CFSR PIP addresses five main goals:

1. Formalize concurrent planning in practice
2. Ensure a timely and appropriate permanency plan for each child and family
3. Enhance supervision practice
4. Integrate the key principles of the system of care into casework practice
5. Enhance service array through interagency collaboration

As DCYF designed Phase Two of the SOC, DCYF took these goals into consideration as the desired outcomes for the SOC. The outcomes to be achieved through the implementation of the SOC directly tie to the CFSR child and family level outcomes.

19. Effect the intervention is expected to have on certain court orders.

At this time, there are no court orders in effect anywhere in the State by which a court has determined that the State's child welfare program failed to comply either 1) with State child welfare laws or 2) with Title IV-B, Title IV-E or the U.S. Constitution.

20. Summary of public input

Describe methods used to obtain public input, a summary of comments received, and how public input shaped the development of the proposal.

As part of the Title IV-E Waiver planning process, DCYF involved a wide range of stakeholders to discuss the System of Care as the waiver demonstration project and garner feedback on the process. DCYF conducted targeted meetings with specific stakeholders. An overview of those meetings is provided below:

- DCYF Waiver Meeting
 - Included representation from across the DCYF agency including fiscal, program, and other staff.
 - The purpose was to educate the agency about the Title IV-E Waiver opportunity and DCYF's proposed project of the SOC model.
- Medicaid Global Waiver and Title IV-E Waiver Meeting
 - Included representation from DCYF, the Networks Leads, the Rhode Island Medicaid agency, SAMSHA grant managers at DCYF, and our Managed Care Organizations (MCOs): BEACON Health Strategies and Neighborhood Health Plan.
 - The purpose was to educate our partners about the Title IV-E Waiver project and identify linkages between the Medicaid Global Waiver and Title IV-E funding. Meetings will continue as we move to implement the Title IV-E Waiver.
- Evidence-Based Practice Meeting
 - Included representation from DCYF, the Networks Leads, and our partners at Casey Family Programs including Evidence2Success.
 - The purpose of this meeting was to discuss evidence-based practices and community-based services already incorporated in the SOC model and to identify their projected impact. The group then discussed additional interventions that would benefit the SOC target population and could be implemented once cost savings are realized from the decrease in residential placements.
- Evaluation Planning
 - Included representation from DCYF, the Networks Leads, and Yale University.
 - The purpose of this meeting was to engage with our evaluator, Yale University, so that they were aware of the Title IV-E Waiver and could

assist in the evaluation components for the waiver proposal and additional parts as we move forward.

Prior to the Title IV-E Waiver reauthorization and the implementation of the System of Care, Rhode Island DCYF conducted numerous stakeholder meetings to plan and implement the SOC model. A lengthy process of community meetings took place in 2008 with community providers to discuss the original SOC concept paper.

Prior to the release of the SOC RFP and subsequent to the RFP, there were informational meetings to assist providers in the preparation of proposals. Subsequent to the tentative award letters, contract negotiations with the two Networks clarified further details of the SOC contract and implementation. Once the contracts were signed, DCYF held meetings with the provider agencies affiliated with each of the Network lead agencies to educate them on SOC model and how the purchase of service would change within in the Network operation.

21. Assurance of health insurance coverage

Provide an assurance that the Title IV-E agency provides health insurance coverage for all special needs children for whom the Title IV-E agency has entered into an adoption assistance agreement (included those not supported by the Title IV-E funds).

Per Rhode Island Policy 700.0090, *Adoption Subsidy, Section B. Medical Subsidy*, the state provides health insurance coverage for all special needs children for whom the Rhode Island Department of Children, Youth and Families has entered into an adoption assistance agreement, including those not supported by Title IV-E funds.

22. Demonstration of implemented or planned child welfare program improvement policies

Identify which of the Child Welfare Program Improvement Policies identified in Section 1130 (a)(3)(C) of the Act the Title IV-E agency has implemented or intends to implement within three years of the date on which the Title IV-E agency submits its application or two years after the Department approves the demonstration (whichever is later). At least one of the child welfare program improvement policies to be implemented must be a policy that the Title IV-E agency has not previously implemented as of the date on which it submits an application to conduct the demonstration project.

Policy 1:

Per General Law 40-11-12, 40-11-12.3: Abused & Neglected Children, Rhode Island Policy 700.045: Legal Guardianship & Kinship Guardianship Assistance, and Title IV-E State Plan, Section 6: Guardianship Assistance Program Guardianship Assistance Agreement
Rhode Island has fully implemented the use of Kinship Guardianship Agreements and received federal approval of our State Plan Amendment effective November 16, 2009.

Policy 2:

In addition, the proposed Title IV-E Waiver demonstration project lays out DCYF's plan to reduce the use of congregate care and shifting resources to the community-based and preventive services. Approval of DCYF's waiver application will allow us to fully implement the Child Welfare Program Improvement Policy of reducing the use of congregate care as of the implementation date of the waiver.